**Catholic Health Australia's (CHA) response to the Consultation Paper – Serious Incident Response Scheme (SIRS) for Commonwealth funded residential aged care**

CHA supports the general thrust of the SIRS consultation paper noting that the intent is to broaden the types of reportable events and to change the emphasis from requiring providers to report the occurrence of an incident to also placing an emphasis on investigation and response to incidents by providers.

CHA also notes that the SIRS is intended to operate in conjunction with the open disclosure provisions in the new Quality Standards and the implementation of a risk-based quality regulatory framework.

***Definition of Serious Incident***

The definition of serious incident as outlined in the consultation paper includes both alleged, suspected or actual abuse and neglect by a staff member against a consumer, and alleged, suspected or actual abuse and aggression by a consumer on another consumer. It also includes separating out the definition of incidents by perpetrator. In general terms, CHA supports the proposed definition but with some modifications discussed below. CHA also highlights the need for detailed guidance to support the implementation of SIRS, especially in relation to several incident types, as discussed below.

CHA also highlights that, even with guidance, there will be a considerable degree of interpretation and judgement required by staff to identify whether an incident is of a serious nature and as such, the program will take some time to settle into a steady state once implemented, necessitating a post-implementation review of the guidance and periodic updating of the guidance material.

CHA does not support the inclusion under SIRS of incidents perpetrated by family and/ or visitors, noting that providers have limited powers to investigate such incidents or to take independent action against family members and visitors. Such incidents are more appropriately reported to the elder abuse authorities in each state or to the police, as appropriate.

Members also do not support including unexplained deaths under SIRS given the established processes whereby the GP or appropriate medical officer refers unexplained deaths to the Coroner for investigation. Including unexplained deaths under SIRS would duplicate the investigative process that already exists. Any obligation on the provider certainly should not extend beyond reporting that an unexplained death has been referred to the Coroner. It would be more appropriate for the Quality and Safety Commission to rely on appropriate protocols negotiated with the Coroner to gain timely access to the Coronial reports of unexplained deaths in order to assess the implications of the incident for the provider and the sector overall.

***Alleged, suspected or actual serious incidents by a staff member against a consumer***

CHA members have raised concerns about the inclusion of "unlawful contact' in relation to the definition of physical abuse, as well as "assault and unreasonable use of physical force, injury, physical coercion".

The emphasis on "unlawful contact" in the definition presupposes familiarity of aged care staff with provisions of criminal and civil law as to what constitutes "unlawful contact". In other contexts, whether an incident is unlawful or not is determined in each case by the courts. This raises the issue as to whether the Commission will have jurisdiction over whether the physical contact was unlawful or not and whether it needs such a role to fulfil its purpose. In the circumstances, it is not clear why the definition requires a legal basis as well as the other descriptors (assault and unreasonable use of physical force, injury, physical coercion), noting that the physical abuse definition is the only one for which this legal connection is drawn. Accordingly, CHA considers that the reference to "unlawful contact" is unhelpful and unnecessary.

CHA does not support the inclusion of financial abuse in the definition of serious incident in its current form as it would encompass financial abuse perpetrated by family members and others over which providers have limited or no authority. When such cases come to light, it would be more appropriate for the approved provider to engage with the relevant elder abuse arrangements in each state/territory.

With regard to financial abuse committed by staff (such as stealing and financial coercion), there are existing processes for such incidents to be reported to and investigated by police, and also to be reported to APRA in terms of professional conduct. Therefore their inclusion under SIRS needs to be tailored to recognise these existing processes in order to avoid unnecessary duplication and administrative cost. It should be sufficient to take into account the existing record keeping requirements whereby approved providers are required to maintain an internal register of all incidents of financial abuse by staff that are referred to both APRA and the police for further investigation.

With regard to seriously inappropriate, improper, inhumane or cruel treatment, the current definition is so open-ended that it may prove impractical and confusing to implement. CHA notes that the dot points provided in the consultation paper to explain this incident type provide clearer meaning of the intended coverage of this definition. Accordingly it would seem appropriate to incorporate the substance of these dot points in the definition.

The proposed definition of "neglect' as outlined in the consultation paper refers to the public liability concept of "duty of care", meaning that there is a legal duty to take reasonable care not to cause harm to another person that could reasonably have been foreseen. As with "unlawful contact", establishing whether a duty of care breech applies in each case is a matter for the courts, and best not introduced under a SIRS. CHA considers that a more appropriate definition would exclude the reference to "duty of care" and instead read as "Intentional or reckless failure in the care of an aged care consumer that may also be a gross breach of professional standards."

***Alleged, suspected or actual incidents between aged care consumers***

In relation to the definition of sexual abuse perpetrated by one consumer on another, there needs to be greater clarity regarding what constitutes "consent", especially in cases involving people living with cognitive impairment and in cases where family members may have their view as to what constitutes "consent" or what they consider is appropriate consensual sexual behaviour on the part of a family member. Detailed guidance material will be required to ensure providers have clarity on managing potential cases of serious incidents in this regard.

As was mentioned earlier in relation to the inclusion of "unlawful contact" in the definition of staff on consumer physical abuse, CHA considers that including "unlawful contact" in the definition of physical abuse perpetrated by one consumer on another consumer also is neither helpful nor necessary.

There is significant judgement necessary in determining what form of 'repeated behaviour' is contemplated under the definition and what constitutes 'a pattern of abuse' that is of a serious nature. CHA considers that clear guidance material will be required to assist staff in understanding the intent of the definition.

***Unexplained death or serious injury***

As noted earlier, CHA considers that the inclusion of unexplained death under the SIRS would duplicate existing formal processes for referral to the Coroner. Accordingly CHA considers that unexplained serious injury be included under SIRS, but unexplained death not be included.

***Rationale and evidence/timeframes for reporting***

CHA considers that the approved provider should determine the appropriate key personnel within their organisation responsible for reporting and managing incidents under the SIRS. Determining appropriate key personnel will depend on the management and governance arrangements employed by each approved provider, which can vary considerably depending, for example, on portfolio size and geographic distribution of services.

Whilst CHA members support incident notification to be within 24 hours of the incident being identified, CHA members consider that up to 10 business days is required to investigate and prepare a status report on an incident. Undertaking a fair and robust investigation of all staff involved to ensure a balanced and accurate incident status report will require adequate time as many staff working in aged care are part time, and ensuring a comprehensive interview process is limited if the timeframe is only 5 days.

CHA notes that the *Aged Care Act 1997* currently provides protections for approved providers and staff reporting reportable assaults (Section 96-8). Given that the proposed SIRS would extend the scope of reportable incidents, Section 96-8 will require amendment so that it provides coverage for reportable incidents under a SIRS.

***Proportionate reporting***

CHA supports the adoption of proportionate reporting based on each provider's risk profile and performance. This is in line with the intent of SIRS reporting, where providers who have a proven track record of documenting SIRS and have in place strong learning frameworks to address systemic issues are rewarded with exemption from reporting certain matters.

CHA also considers that the principle behind proportionate reporting based on risk profile and performance should apply to requests for a final report within 60 business days.

***Powers of the Commission in relation to reportable incidents***

As part of the broader quality and safety reforms in relation to open disclosure, transparency of reporting is paramount to the future of continuous improvement. To introduce punitive measures in relation to specific incidents beyond those that currently apply under criminal and civil law would be contrary to this reform process.

A primary role of the Aged Care Quality and Safety Commission under the SIRs should be to identify national systemic issues and trends in the sector and to provide a mechanism for the sector and policy makers to learn from these issues as part of a process of open disclosure and continuous improvement. The results of the Commission's analysis of serious incidents should be publicly reported and should extend to making recommendations on reforms to deal with systemic problems including, for example, recommendations concerning changes to training regimes and access to medical services under Medicare.

Adopting a punitive approach for specific incidents would be counterproductive to continuous improvement. Instead, performance in relation to specific incidents should contribute to the Commission's overall assessment of provider performance in an accreditation context and, when developed, performance rating.

Application of penalties to individuals, civil and otherwise, should remain the province of other existing jurisdictions, including the courts and professional standards. However, there would be a role in this regard for any register of staff for the aged care industry developed and maintained by the government.

***Public Reporting by the Commission on SIRS***

Public reporting on SIRS by the Aged Care Quality and Safety Commission should be at a national level which includes an analysis of trends in incidents to inform public policy formulation, as discussed above. CHA agrees with the potential perverse outcomes listed in the consultation paper if incidents were to be published at the provider or facility level.

Public information about service quality would be more effective and more easily understood if presented as overall service performance ratings. Reporting individual provider SIRS data is likely to raise unnecessary concern for consumers without an accurate understanding of the open disclosure context, learnings and continuous improvement strategy that should underpin the SIRS.

**Concluding comments**

As previously noted, there will be considerable judgement required on the part of aged care staff in assessing the seriousness of incidents. There is therefore the potential for significant variation across staff in the exercise of this judgement, with the potential for both under and over reporting, neither of which would be beneficial to the objectives of a SIRS. As such, CHA considers that it is essential that comprehensive guidance material be provided well before the implementation of SIRS which includes a variety of examples of incidents to guide judgements on the seriousness of incidents. It is important that provision is also made for a timely independent post-implementation review of the guidance material. Moreover, such guidance material will by necessity have to be a 'living document' which is continually updated with relevant examples as the program matures.

CHA also notes that training and education sessions will be offered by the Department and the Commission. As well as allowing time for these education sessions, given the seriousness and complexity of incident reporting, providers will also need to be given ample time to undertake staff training and systems development within their organisations. For large organisations, this translates to training thousands of staff. It will be important to allow providers sufficient notice and time once the details of the SIRS are agreed by government to arrange staff training, appropriate governance arrangements and systems modifications, including to incident management data bases and registers, in order to implement SIRS in each of their services. It is also noteworthy that the Christmas/New Year holiday period does not lend itself to implementing cost-effective training programs.

Finally, CHA members have also highlighted the challenges if SIRS were to be introduced on 1 January 2020. It is important to the successful introduction of SIRS that timing coincide with the availability of a fuller complement of senior management to support the introduction of SIRS and to iron out any unanticipated governance and system complications.

**Catholic Health Australia**
**9 October 2019**