LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

SERIOUS INCIDENT RESPONSE SCHEME FOR COMMONWEALTH FUNDED RESIDENTIAL AGED CARE – FINER DETAILS OF OPERATION- CONSULTATION PAPER

Submission, 11 October 2019

A strong voice and a helping hand for all providers of age services

Leading Age Services Australia

Leading Age Services Australia (LASA) is a national association for all providers of age services across residential care, home care and retirement living/seniors housing. Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion – always.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

LASA would like to thank Hall & Wilcox, especially Ms Alison Choy Flannigan, for their analysis of what impact the proposed Serious Incident Response Scheme may have on aged care providers which has informed this submission.

Executive Summary

The Aged Care Quality and Safety Commission (ACQSC) undertakes the regulation and education of providers of aged care services regarding quality of care provision. LASA proposes that one main purpose of the Serious Incident Response Scheme (SIRS) should be to provide a tool to achieving a reduction in the number of 'serious incidents'. In LASA's view, this purpose is best accomplished through a sector-wide learning approach supported by the ACQSC's education powers. Providers report under SIRS in good faith. If reporting under SIRS commonly results in regulatory responses that providers may interpret as punitive, this constitutes a disincentive to engage in the free and frank reporting essential to quality improvement.

A well-developed SIRS would provide a comprehensive data source which can be analysed to support learning and quality improvement for individual providers, care outlets as well as all-of-industry. In the interest of quality improvement, LASA strongly believes that SIRS should take an educational approach to all SIRS reports in the first instance. If providers do not trust that they can safely report to SIRS, then an important opportunity for quality improvement via a dialogue between SIRS and the provider will be lost. An increase in the number of reported incidents may be the result of a culture of compliance and encouragement of responsible reporting. Therefore, examination of SIRS data should not be solely based upon the number of incidents but upon a proper analysis of the reports. Outliers in relation to over and under-reporting should be identified and de-identified averages should be published so that providers have a benchmark against which they can measure themselves against.

A key weakness of the SIRS consultation paper is that it insufficiently distinguishes incidents from 'serious incidents'. LASA considers that incidents are investigated, managed and resolved by providers within their quality improvement and compliance frameworks whereas 'serious incidents' are additionally reported to regulators. To distinguish 'incidents' from 'serious incidents' LASA proposes that a discussion of vignettes and case studies would facilitate the carving out of the nuances and thresholds involved.

LASA welcomes that different definitions for 'serious incidents' are used depending on whether the perpetrator was a member of staff or a fellow resident. However, overwhelmingly LASA Members are concerned that the definitions given are too broad, thus providing insufficient guidance as to what is considered an incident serious enough to warrant reporting under SIRS. If the Government were to provide vignettes and hypothetical case-studies, these could illustrate to providers how the definitions should be interpreted and applied. A real concern is that the SIRS may be overwhelmed with reports of incidents that may not be 'serious' in nature. Further, the ethical issue concerning a resident's ability to give consent when suffering from dementia will also require addressing.

LASA Members would like to see 'serious incidents' which come to the knowledge of providers, which are caused by third parties, such as family members of residents included in their SIRS reporting obligations. SIRS envisages obliging providers to report 'serious incidents' involving residents suffering from dementia. A concern is that residents with dementia who consistently display aggressive behaviours may not be admitted to residential care as such behaviour may now require mandatory reporting. In view of providers' security of tenure obligation they may eschew the regulatory risk such a resident may pose for their aged care service.

LASA Members strongly reject a proposal for a *proportionate reporting* provision under which not all providers need to report all 'serious incidents'. Members consider that proportionate reporting may undermine the purpose and integrity of the SIRS.

LASA does not support the publication of SIRS data because the SIRS as a newly instituted Scheme is likely to experience issues with its design and implementation. These are not likely to be identified until the SIRS has been operationalised for some time with several waves of reports received and analysed. Fundamental to requiring individual providers to publicly report their SIRS performance is the risk-adjustment of their resident casemix. Reporting without such risk adjustment is misleading for all consumers of this data, but in particular for the general public. Public reporting should only occur once the regulators and industry are comfortable that the system is fair and robust.

Introductory remarks

LASA's view regarding the purpose of the Serious Incident Response Scheme (SIRS)

LASA believes that the main purpose of the SIRS should be providing a tool to achieve a reduction in the number of 'serious incidents' in aged care through taking a learning approach that includes:

1. Monitoring the rate of 'serious incidents' in aged care.
2. Collecting information on providers' actions taken to prevent further such incidents.
3. Analysis of the information provided, including identifying outliers and trends to inform systemic improvements, such as further education and guidance
4. Using the analysis of the information provided to support the prevention of 'serious incident's by facilitating system-wide organisational learning about:
    a. factors causing and/or contributing to 'serious incidents'; and
    b. organisational changes undertaken to prevent further such incidents.

The SIRS should facilitate learning and quality improvement at the level of individual providers and/or care outlets as well as on an industry level.

Already in 2005 the WHO observed that it is a missed opportunity if care services cannot learn from preventable errors that occurred in other services and consequently take preventive measures. The quote below demonstrates this WHO insight[1].

> *In seeking to improve safety, one of the most frustrating aspects for patients and professionals alike is the apparent failure of health-care systems to learn from their mistakes. Too often neither health-care providers nor health-care organizations advise others when a mishap occurs, nor do they share what they have learned when an investigation has been carried out. As a consequence, the same mistakes occur repeatedly in many settings and patients continue to be harmed by preventable errors.* (p.7)

A SIRS designed to support quality improvement through learning

SIRS should include feedback to (1) reporting providers and (2) industry nationally to facilitate learning about preventing and managing 'serious incidents' and to inform quality improvement.

[1] World Health Organisation 2005, DRAFT Guidelines for Adverse Event Reporting and Learning Systems, *Purposes of reporting*.

Health care has been using incident reporting systems for some time as a key tool to improve safety and enhance organisational learning. For example, the Australian Commission for Safety and Quality in Health Care states that:

> *Approaches to reducing and managing patient safety incidents involve a complex series of steps including:*
>
> • *identification*
>
> • *investigation and analysis*
>
> • *management of the incident(s)*
>
> • *feedback and learning*[2].

One option of facilitating learning from 'serious incidents' at the industry-wide level could be making SIRS data for an individual provider available alongside de-identified national SIRS data in quarterly or bi-annual reports. If data are appropriately risk adjusted, these reports would enable providers to compare their own performance against a national average, as well as high and low levels of 'serious incidents'.

SIRS could further support provider learning for the purpose of quality improvement by making available case studies about 'serious incidents'. These case studies could involve de-identified incidents in a multi-factorial analysis of the key factors that contributed to the incident and describe the steps taken to remedy these factors.

Implementation issues

The SIRS related amendments to the legislation should not be retrospective as that would be administratively impossible for providers. SIRS reporting obligations should only apply to occurrences after the commencement of the legislation and providers should be provided with at least 3 months prior notice of commencement to change policies and train staff.

Definitions

LASA Members considered as positive the use of different definitions for 'serious incidents' depending whether they were committed by staff or residents or third parties.

However, many of the types of incidents envisaged to require reporting under SIRS present in shades from somewhat or slight to serious. This is particularly true for the concepts of inappropriateness, improper, inhumane, injury and neglect. For providers it is of utmost importance that the **degree** of inappropriateness, injury or neglect that constitutes a 'serious incident' is clearly defined. Overwhelmingly, Members are concerned that the definitions given are too vague and provide insufficient guidance as to what is considered an incident serious enough to warrant reporting under SIRS.

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[2] Page 47 of *Measurement for Improvement Toolkit, ACSQHC,* https://www.safetyandquality.gov.au/wp.../measurement-for-Improvement-toolkit-a.pdf

Distinguishing 'incidents' from 'serious incidents'

LASA believes that the consultation paper has not been successful in clearly identifying the characteristics that denote a 'serious incident'. No clear test is proposed that providers can use to identify as to what should be reported.

The consultation paper contains a section headed *What won't be considered a 'serious incident'?* (pp.16-17) which explains that a 'serious incident' does not include:

> '*reasonable management of care'* that takes account of '*any relevant code of conduct or professional standard*' and matters that on investigation are *'held to be trivial or negligible'* (p.16).

This statement is followed by examples that describe actions of ordinary care delivery such as: touching a consumer to guide them, accidental physical contact and a staff member raising the voice to attract attention. LASA Members did not find these examples helpful in assisting them to determine what constitutes a 'serious incident'.

LASA believes that a binary approach to classifying care as either *normal care* or 'serious incident' fails to acknowledge the reality of care-giving. Rather than being binary in character and quality, acts of care-giving are highly nuanced, as are the contacts between residents as they relate to each other in this setting. Any examples given to providers to determine whether they are dealing with a reportable 'serious incident' should acknowledge this complex reality of care provision.

LASA suggests that a continuum exists with thresholds between 'normal care'; 'incidents' and 'serious incidents. It is LASA's view that 'incidents' should be investigated, addressed, resolved and documented by the provider according to organisational policy and procedure and quality improvement framework and Commonwealth accreditation standards.

A discussion of edge cases would facilitate the carving out of the nuances and thresholds involved when distinguishing 'incidents' from 'serious incidents'. A suitable test case may be whether a care act constitutes an incident such as 'rough handling' or a 'serious incident'. Members suggested that the Department may consider establishing a panel comprising consumers, aged care advocates, relevant clinicians and providers who discuss test cases to distinguish 'incidents' from 'serious incidents'. The test cases and the determination of their severity can be made available to providers to assist them in working out whether reporting under SIRS is required.

LASA acknowledges that it may not be possible to have definitions for 'serious incidents' that can be interpreted and applied to the aged care setting without causing difficulty from time to time. Guidance will also be required through the provision of vignettes and case-studies illustrating how the definitions should be interpreted and applied. Such a case-study approach is used by the Australian Health Practitioner Regulation Authority to demonstrate to health care professionals how the Codes of Conduct and Codes of Ethics are applied to real life disciplinary actions.

Potential for over reporting

LASA agrees with the consultation paper that 'the definition of a 'serious incident' is a critical factor in a SIRS' (p.17) as this will determine the number of reports submitted to the SIRS. If definitions remain unclear and/or are inadequately supported with guidance material as to their reporting thresholds then providers are likely to report all incidents to ensure compliance with the Scheme.

Code of conduct

LASA assumes that the consultation paper when referring on page 16 to 'any relevant code of conduct' this may mean the *National Code of Conduct for health care workers* which may apply to personal care workers. It would be helpful if the Department could provide information whether this is the Code alluded to and which Australian States have implemented this Code.

Source materials used

The consultation paper draws much on the NDIS for definitions and other supporting material. LASA observes that the NDIS has been operational for a short time only and the definitions may not have undergone 'proof of concept' in the operational setting and the legal meaning of terms may not be established. The *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* currently underway also casts doubt on the effectiveness of these definitions.

Provider reporting

Clearly stated reporting requirements

The actual reporting requirement is not clearly stated in the consultation paper. Wording similar to the wording in the Health Practitioner Regulation National Law Section 141 should be considered. For example: the words 'a reasonable belief' and in the course of providing aged care services' should be used. Inclusion of these phrases would:

- Avoids confusion with knowledge gained in a professional capacity as compared to a personal capacity;
- Should also exclude knowledge gained when providing medico-legal advice or for quality assurance;
- Should exclude where there is no reasonable belief that the incident occurred – e.g. when the complainant suffers dementia and there is no evidence of abuse, vexatious complaints, allegations provided by rumour or third hand without any other evidence. Multiple complaints about the same incident should only be required to be reported once.
- Providers are not required to provide information which is subject to legal professional privilege.

First response to providers should be educational

Providers report under SIRS in good faith. If reporting under SIRS commonly results in consequences that providers may interpret as punitive, this response constitutes a disincentive for providers to engage in free and frank reporting.

In the interest of quality improvement, LASA strongly believes that SIRS should take an educational approach to all SIRS reports in the first instance. If providers do not trust that they can safely report to SIRS, then an important opportunity for quality improvement via a dialogue between SIRS and the provider will be lost.

LASA believes that providers should only be penalized for not reporting a 'serious incident' unless they were proven to have recklessly not reported.

Further, in relation to the amount of information which is required to be reported, the Government should take into consideration that providers have a number of rights and obligations, including the privacy rights of individuals and the right to protect their position including in relation to legal professional privilege.

Any proposed reporting scheme also needs to take account of the protocols used by providers in remote locations. LASA proposes that existing protocols by remote providers be investigated while the SIRS is under development to ensure remote providers can successfully participate in the Scheme.

Intersection of SIRS with other laws

If a registered health care professional is a perpetrator of abuse reported under SIRS, how will SIRS intersect with the Health Practitioner Regulation National Law? Looking to the future, would SIRS also intersect with any registration body for personal care workers, should such a scheme be introduced?

How will the proposed SIRS intersect with state-based elder safeguarding laws? Some jurisdictions differ in reporting protocols, and the proposed SIRS should be able to be consistently applied. The SIRS design should also minimise any duplicate reporting requirements. For example, in Victoria any unexplained deaths in residential aged care also require reporting to *Worksafe* which may result in duplicate reporting for Victorian providers.

The consultation paper on page 5 under the heading of *Regulatory Context* refers to a 'broader range of Commonwealth, state and territory laws' as well as the Charter of Aged Care Rights, Aged Care Quality Standards and Aged Care Quality and Safety Commission. LASA considers that further and more fine-grained consideration needs to be given to how in practice the SIRS will intersect with these other regulatory instruments.

LASA is querying whether Commonwealth-funded aged care services other than residential aged care will be included under the SIRS reporting requirements. In this case providers will likely require clarification as to which services are included and which are excluded and which entities are required to report (e.g. approved providers under the Aged Care Act).

LASA proposes that reporting of elder abuse should also be made obligatory for registered health care providers and hospitals.

Consultation questions and definitions

Questions:

1. *Are there any other components/definitions that should be in scope for a SIRS?*
   LASA Members did not identify any other components or definitions that should be included in the scope for SIRS apart from the inclusion of 'serious incidents' committed by family members or visitors (see below).

2. *Should acts by family and/or visitors be covered by a SIRS?*
   LASA Members strongly supported the inclusion of 'serious incidents' by family members or visitors in the SIRS because providers have a duty of care for the wellbeing of their residents. Further, the inclusion of these acts would enable a system-wide view to be gained about family violence directed at elders in this setting and would provide data to inform a system-wide response. A particular concern for LASA Members is financial abuse that they observe being inflicted on residents and which they feel powerless to prevent or intervene in or communicate without risk of breaching the privacy of third parties. The reporting should also include allegations of abuse perpetrated by others who may not be visitors such as contractors to the provider.

3. *Should a SIRS include an unexplained death, noting the role of the Coroner?*
   In our consultation Members raised the issue that unexplained deaths are not a rare occurrence in residential aged care as people living there tend to be in the last phase of their life. Including unexplained deaths in SIRS may thus not reflect 'serious incidents'. If SIRS includes reporting of potentially unexplained deaths, consideration should be given to the requirement of reporting unexplained deaths to the Coroners (which differs in each State) to avoid duplication of reporting.

Alleged, suspected or actual 'serious incident's by a staff member against a consumer

Definition: Physical abuse

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

In the main Members felt that this definition lacks clarity. What would constitute unlawful contact by staff? What would constitute unreasonable use of physical force? Members suggested that the staff's intention and a resident's outcome should be included in the definition or in an explanatory note to the definition. For example, reasonable force may have been used that resulted in the resident developing bruising but the staff's intention was to prevent the greater harm of the resident falling.

Members suggested following resident outcomes for inclusion in the definition of 'physical abuse' or in any explanatory material:

- Transfer to hospital
- Assessment by medical doctor or nurse practitioner
- Change in care plan

Members thought that the terms 'injury' and 'coercion' require clarification. It was thought that this could be dealt with in an explanatory statement by saying: 'injury' such as:……, or 'coercion' such as…. .

Unclear is how this definition would capture 'physical abuse' that is inflicted on a lower level but in a consistent pattern over time (weeks and months) such as a degree of 'rough handling' during care delivery.

Definition: Sexual abuse

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

The definition uses 'sexual activity' not 'sexual assault'. 'Sexual activity' could be broadly defined and should include the concept of 'consent', for example "any sexual assault (without consent) inflicted on…". The Member comment below demonstrates that an absence of consent is important when talking about 'sexual abuse' in terms of 'sexual activity':

> *'We had an issue a few years ago where a staff member kissed a resident in celebration. We reported it as he had crossed boundaries and the resident hadn't consented but this definition doesn't include the concept of consent.'*

It will be important for the SIRS to clearly spell out that 'sexual activity' does not include a consensual hug or even consensual kiss offered in greeting or to comfort or support a resident.

Definition: Financial Abuse

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

Members felt strongly that the stealing from residents of any amount of money, regardless how small, is a serious offence.

'We would treat any report of such action by staff seriously'

For this reason Members considered that the definition of financial abuse by staff should **not** include the amount of money stolen.

Definition: Seriously inappropriate, improper, inhumane or cruel treatment

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

Question:

4. Is this definition of seriously inappropriate, improper, inhumane or cruel treatment appropriate?

The reporting of events on the basis of 'breach of duty of care" or breach of a relevant code of conduct or professional standard is problematic because it (by definition) requires an admission of liability which could adversely prejudice the provider in civil litigation and quite often it is not until the litigation is resolved that a finding of breach is made.

LASA Members propose that clarification be provided on what is "unreasonable behaviours" and that verbal abuse which amounts to bullying and harassment should be included under this definition.

Overall, Members expressed concern that the definition may result in SIRS being overwhelmed with reports under the definition. LASA appreciates that this definition is intended to be a flexible category to capture a range of serious, abusive behaviours by staff. However, the definition given needs to be further clarified for providers who seek to determine whether they deal with an incident or reportable 'serious incident'.

'Suggest clearer guidelines and more examples'

Terms identified by Members as requiring clarification are:

- unreasonable behaviours;
- serious breach of duty of care; and
- relevant code of conduct.

Members raised the issue that Personal Care Workers do not work to a professional code of conduct but their conduct and behaviour should be included in the definition of seriously inappropriate, improper, inhumane or cruel treatment. LASA believes that there should be a professional code of conduct for Personal Care Workers and perhaps Personal Care Workers working in aged care should be subject to some form of (affordable) registration and regulation.

Again, reference as to whether and how the *National Code of Conduct for health care workers* may apply to Personal Care Workers would have been helpful here. In particular useful information would have been the identification of which Australian States have introduced the Code.

Definition: Inappropriate physical and chemical restraint

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

Members expressed concern that the list of drugs deemed chemical restraint continues to be changed and expanded by the Aged Care Quality and Safety Commission (ACQSC). The SIRS needs to include information about medications considered chemical restraint under SIRS so there is certainty about what constitutes chemical restraint. Further, many drugs which may be considered as chemical restraint have significant therapeutic benefit for mental health separate to the calming effect.

Another concern voiced by Members was how SIRS would consider the issue of resident consent for chemical restraint not currently included under the *Minimising the Use of Restraint Principles 2019.*

Members thought that the issue of whether the resident experienced harm as a result of the restraint may constitute a useful threshold to distinguish incident from reportable 'serious incident'. The concept of harm requires further clarification – see LASA's contribution to the definition of 'neglect' below.

Definition: Neglect

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

Question:

5. Are there any additions or refinements required to the definitions of incidents by staff against consumers? If so, which definitions, and what additions/refinements should be made?

Again, requiring reporting which refers to a breach of professional standards can also be problematic from an admission point of view.

Further guidance is required on the definition of 'neglect' needs to clarify the meaning of the words 'intentional and reckless failure' so Members clearly understand how to apply these concepts to real-life situations.

Members consider that it could be difficult to determine the threshold at which neglect may have been a cause of death.

Even more contestable is whether harm was suffered by the resident as the result of neglect. Does the concept of harm used in SIRS include the full continuum from minimal harm of no lasting consequence through to serious harm resulting in lasting adverse outcomes for the resident?

Families may claim a resident is being neglected because they are dissatisfied with the services being provided even though on investigation no substance to the allegation could be found.

Further, allegations are often made by people lacking mental capacity and have significant dementia where there is no substance to the allegation found. There are also vexatious and repetitive complaints by some families. This is problematic for providers.

SIRS needs to include procedures that ensure procedural fairness for all parties involved in a claim of neglect.

Question:

6. Are there any definitions that require specific thresholds? If so, which ones and what should the threshold be? (For example, financial abuse would only be considered a 'serious incident' when it was in relation to a certain dollar value or above).

Following definitions were identified by Members as requiring specific thresholds:

- Physical abuse
- Sexual abuse
- Seriously inappropriate improper, inhumane or cruel treatment
- Neglect

LASA is of the view that the lack of establishing a threshold for distinguishing an incident from a 'serious incident' is a key weakness in this draft of the SIRS. We refer to the section under the heading *Definitions* on pp.5-6 in our submission in which we propose some ways to resolve threshold issues. The risk is that they system will be overcome with minor incidents and the more significant incidents will not be identifiable.

Further, actual physical harm may be defined by an outcome for the resident such as the harm resulting in:

a. Transfer to hospital and/or
b. Assessment by medical doctor or nurse practitioner and/or
c. Change in care plan

In this submission LASA's contribution includes where possible a discussion of threshold issues specific to a definition at hand.

Alleged, suspected or actual 'serious incident's between aged care consumers

Definition: Sexual abuse

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

Members consider that the definition of sexual abuse in terms of 'sexual activity' sets a very low threshold and may result in a high rate of reports arising from dementia settings. Some sexual

activity that may be displayed by people with dementia, such as masturbation in public spaces, would be more appropriately viewed as offensive behaviour, rather than sexual abuse.

> *'This is potentially an issue with dementia residents as self-touching (not touching of other residents) could be considered sexual activity in the presence of another resident without consent'*

A further concern is that an issue that is managed as a behaviour may now also become a regulatory issue. This may result in providers seeking ways of managing this new regulatory risk, such as not admitting residents who display inappropriate sexual behaviours or feeling compelled to segregate such residents.

> *'There may also be sexual contact with another resident that while without consent doesn't cause significant impact such as kissing or touching of parts of anatomy even accidently. This issue can be a common occurrence and is currently managed as a behavioural issue.'*

Alternatively, providers may seek to affect the rate of SIRS reporting by restricting residents' freedom of expression of their positive emotions towards fellow residents through physical gestures of affection such as described above. LASA believes that this outcome is unlikely to have been intended by SIRS. LASA recommends that the definition of 'sexual abuse' should be reviewed to ensure that the sexual acts included under the definition are abusive in nature.

Over-reporting of sexual acts that are not abusive in nature is likely to cause unnecessary distress and possible harm to residents and their families.

Further, the issue of consent is central to the definition of 'sexual abuse' and consent therefore requires additional explanation. This is of particular importance for people with dementia whose ability to consent may not extend to all life situations.

What view does SIRS take on peoples' ability to consent to sexual acts if they have a diagnosis of dementia? If SIRS considers people with dementia to be able to consent to sexual acts, then SIRS needs to explain how consent to sexual acts may be validly expressed by people with dementia. For example, a Member reported how two residents with dementia were found cuddling in bed. When the male resident was removed from the setting, the female resident wanted to know why this step was being taken (see quote below).

> *'Why are you taking him away?'*

On observation of the female resident's reaction it is highly possible that these two residents engaged in sexual activity the consent to which they expressed through their actions. Would this event have been reportable under SIRS? And if yes, would reporting to SIRS breach the residents' right to privacy?

Definition: Physical abuse causing serious injury

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

A definition needs to be provided on what constitutes an '*unlawful contact'* between residents. The inclusion of the term '*unreasonable use of force'* may be difficult to apply when people with

advanced dementia are involved who may have limited reasoning capacity. LASA proposes that explanatory guidance to assist providers determine whether an incident requires reporting may include resident outcomes such as evidenced by:

- Transfer to hospital
- Assessment by medical doctor or nurse practitioner
- Change in care plan
- Complaint by staff or other resident

Definition: An incident that is part of a pattern of abuse

Repeated behaviour towards an aged care consumer that forms part of a pattern of abuse (whether or not against the same or different consumers), but may not be seen as instances of abuse in isolation.

This definition may intend to capture behaviour by dementia residents who are regularly aggressive towards other residents but do not necessarily cause physical injury. Providers tend to treat this concern as a behavioural issue. As such a behavioural issue will now also become a regulatory issue, providers may seek to manage the regulatory risk. For example, providers may seek not to admit residents who consistently display aggressive behaviours in view of their security of tenure obligation as such behaviour may become a compliance issue requiring mandatory reporting. People with dementia and aggressive behaviours may experience difficulties with finding a Residential Aged Care Facility prepared to admit them for permanent care.

Questions:

7. Are there any additions or refinements required to the definitions of incidents between aged care consumers? If so, what?

LASA's discussion to the definitions above proposes where refinements could be made to assist in realising the intent of the SIRS.

8. Are there any definitions that require specific thresholds? If so, which ones and what should the threshold be? (For example, physical abuse causing serious injury between aged care consumers would only be considered a 'serious incident' if the injury required immediate medical attention).

LASA's discussion to the definitions above proposes thresholds where appropriate. At the beginning of this submission on page 5 LASA suggests strategies that the Department of Health could use to clarify threshold issues.

Definition: Unexplained death or serious injury

Definition

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

Question:

9. Should unexplained death or serious injury be included in the definition of a 'serious incident'?

LASA Members take the view that if unexplained deaths are be included as a 'serious incident' under SIRS, measures should be implemented to avoid duplication of reporting between SIRS and the

Coroner. LASA Members observe that unexplained deaths do occur in the residential age care setting where many people live in the last phase of their lives. A medical doctor considers whether a death is unexplained in deciding whether or not to sign the death certificate and should thus be referred to the Coroner for investigation[3]. In this case it is the Coroner's decision whether the death was unexplained. Also see LASA's comment to question 3 in this submission.

Question:

10. What is an appropriate threshold for 'serious injury' that would ensure reporting is appropriately targeted? Please provide detail.

LASA Members considered that attendance at and/or admission to hospital or evaluation by a medical doctor/nurse practitioner may be a good indicator whether a 'serious injury' was sustained by a resident.

Class and kind exemptions

Question:

11. Should the ability to exempt certain classes or kinds of incidents be a power of the Aged Care Quality and Safety Commission or the Minister?

LASA believes that the Minister should exempt certain classes or kinds of incidents on recommendation by the Aged Care Quality and Safety Commissioner.

What won't be considered a 'serious incident'?

Question:

12. Are the examples provided appropriate and clear on what would not be considered a 'serious incident'?

The examples on what would not be considered a 'serious incident' were not appropriate as they demonstrate normal care delivery. LASA reiterates that what is required is distinguishing incidents from reportable 'serious incidents'. Incidents are managed by the provider within organizational policy and procedure, the quality improvement framework, Aged Care Quality Standards and other relevant regulation, while 'serious incidents' are additionally reported to SIRS. These 'serious incidents' undergo a SIRS process of investigation, reporting and resolution including preventive action.

Who must/will be able to report

Question:

13. Is there a need to define 'key personnel' that can report an incident on the approved provider's behalf? If so, who should be considered 'key personnel'?

The provision of a definition by the Department of Health of who is considered 'key personnel' to undertake the reporting to SIRS would be helpful. Care staff should report to the personnel identified as reporting to the SIRS.

Timeframes and information to be provided for reporting

Question:

14. Are the proposed reporting timeframes appropriate? If not, what changes should be made?

[3] In Victoria any unexplained resident deaths also need to be reported to Worksafe.

LASA Members observed that it may take some investigation to determine whether the incident meets the reporting threshold. The 24 hour reporting obligation may not give enough time to confidently come to a threshold determination in every case.

One solution to this issue Members offered is to have the 24 hour reporting obligation for more serious incidents only. Other incidents requiring some initial investigation to determine whether they are in fact reportable may have a longer timeframe for notification.

LASA suggests that a mechanism should be put in place for providers to seek an extension of time should they be unable to secure all of the information required in the reporting timeframe given.

Question:

15. Is the proposed level of information to be provided at each stage appropriate? If no, what changes should be made and why?

Members did not propose any changes to the type of information sought at each stage of the reporting process.

Question:

16. Does the proposed level of information/details required adequately cover incidents between consumers?

Members did not propose any changes to the type of information sought at each stage of the reporting process for incidents between residents. However, the mandatory reporting of all incidents between residents who have a diagnosis of dementia is new, previously there was a discretion.
LASA proposes that the Department schedule regular reviews with the sector of this requirement to identify and address any problems arising.

Question:

17. If the incident is between consumers, what additional information should be reported at each stage (e.g. details of any cognitive impairment that had been assessed by an appropriate health professional)?

The inclusion of any medical or mental health diagnosis of any of the residents involved (e.g. Brodaty tier and associated Behavioural and Psychological Symptoms of Dementia) may contribute important explanatory information as to the reason(s) the incident occurred[4]. It also appraises the ACQSC of the rationale why the reporting provider responded in the way they did to resolve this incident and to prevent future incidents.

Question:

18. Would providers know the relevant information needed within these timeframes to allow reporting to be met (i.e. is the level of information appropriate to the specified timeframe)? What changes should be made and why?

Please see LASA's response to question 14 above.

[4] For example, a resident with dementia may have developed a delirium which contributed to the behaviour causing the incident.

Proportionate reporting

The consultation paper proposes that the SIRS include proportionate reporting based on provider risk profile and performance:

> *It is proposed that the Commission will be able to apply a risk-based approach to regulation and establish proportionate reporting based on provider risk profile and performance. It is proposed that the Commission have powers to exempt certain matters from being reported, by agreement with providers if the Commission is satisfied the exemption will not increase the risk of harm to consumers.* (p.20)

LASA Members strongly reject any inclusion of proportionate reporting in the SIRS. They consider such an arrangement to undermine the SIRS's purpose of monitoring the rate of serious incidents and prevention of harm to residents. Members fear that proportionate reporting may undermine the integrity of SIRS, thus potentially defeating the SIRS's important purpose of protecting aged care residents.

> *'All providers should report. There should be no outs for anybody'*

LASA Members also believe that aged care residents and their families would want reportable incidents reported by all providers.

Questions:

19. Should proportionate reporting have time limits? (For example, all proportionate reporting agreements are to be reviewed every 12 months).

Please see comment above.

20. Are there any incident types that should be excluded from a proportionate reporting agreement (for example, sexual abuse by an aged care worker)?

Members' comment to question 20 was:

> *'Compulsory is compulsory'*

LASA Members strongly believe that there should no proportionate reporting and no exclusion of incidents from reporting that meet the definition of 'serious incident'.

Record keeping requirements

Question:

21. Are the proposed record keeping requirements sufficient? If no, what changes should be made?

Members expressed no concern about the sufficiency of the proposed record keeping requirements.

Powers of the Commission in relation to reportable incidents

Question:

22. Are the proposed powers for the Commission adequate, for example in relation to investigation and the ability to respond to reports?

LASA would prefer the Commission's education powers be more consistently based on concepts from quality improvement to include core concepts such as 'root cause analysis', 'organisational learning', 'feedback to frontline staff and learning' and 'review of policy and procedure'. The concept of corrective action (page 23 of the consultation paper) should be removed as it is incompatible with the aim of organisational learning facilitated in a non-punitive environment[5]. The core concepts underpinning a learning approach to 'serious incident' reporting are well accepted in health care and demonstrated in the *WHO Draft Guidelines for Adverse Event Reporting and Learning Systems*[6].

> ***Core concepts***
>
> *The four core principles underlying the guidelines are:*
>
> - *The fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health-care system.*
> - *Reporting must be safe. Individuals who report incidents must not be punished or suffer other ill-effects from reporting.*
> - *Reporting is only of value if it leads to a constructive response. At a minimum, this entails feedback of findings from data analysis. Ideally, it also includes recommendations for changes in processes and systems of health care.*
> - *Meaningful analysis, learning, and dissemination of lessons learned requires expertise and other human and financial resources. The agency that receives reports must be capable of disseminating information, making recommendations for changes, and informing the development of solutions.* (p.12)

Question:

23. What compliance and enforcement responses should the Commission have for example civil penalties, sanctions, enforceable undertakings?

A learning approach to serious incidents does not exclude that providers who engaged in neglectful conduct be disciplined by civil penalties, sanctions and/or enforceable undertakings. Further clarified should be the relationship between the SIRS and the Commission's (ACQSC) complete set of regulatory and disciplinary functions.

The Australian Commission for Safety and Quality in Health Care may be able to advise on appropriate thresholds for actions against providers. Further, LASA recommends that the Department consult extensively with the sector and other stakeholders on this issue.

We recommend that, in passing legislation on this issue to facilitate transparency that the Government consider the existing mandatory report regimes in the health sector (for example, under the Health Practitioner Regulation National Law) to ascertain what does and doesn't work. For example, please consider how mandatory reporting in SIRS interrelates with defamation laws (particularly absolute and qualified privilege if a mandatory report to SIRs is made - in defence to a claim of defamation associated with the report) as well as the protections provided to private hospital operators in relation to root cause analysis and admissibility as evidence in civil litigation, for example, section 46 of the Private Health Facilities Act 2007 (NSW).

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[5] Page 47 of *Measurement for Improvement Toolkit, ACSQHC,* https://www.safetyandquality.gov.au/wp.../measurement-for-Improvement-toolkit-a.pdf

[6] https://apps.who.int/iris/handle/10665/69797

LASA has no further comment to make to the ACQSC's regulatory powers listed on page 23 of the consultation paper. LASA welcomes that any proposed changes to the Commission's powers will be subject to further consultation (also page 23).

Question:

24. Should these penalties be able to be applied to individuals or approved providers or both? If individuals, who?

Members observed that in the long-term care setting failures in care rarely rest with one individual alone. Failures in care are usually the result of a number of root causes aligning and allowing the failure to occur. Members cited two common root causes to be failure of team functioning/culture and failure in corporate and/or clinical governance.

We do not recommend that penalties be imposed against individuals except in the most exceptional circumstances. The aged care industry is currently experiencing great difficulty attracting highly qualified and experienced candidates onto Boards and individual penalties will only make this more difficult, particularly for not-for-profit operators.

Public reporting by the Commission on SIRS

Question:

25. Is there additional information the Commission should publish? If so, what?

LASA is strongly of the view that information only be published if it is risk-adjusted for providers' resident-mix. Resident characteristics that may affect the rate of SIRS reports may be:

- percentage of residents with dementia
- the distribution of Brodaty tiers for the resident population with dementia
- percentage of residents with a mental health diagnosis other than dementia
- percentage of residents requiring behaviour management
- clinical casemix of residents (e.g. clinical factors in the resident casemix that affect outcomes such as falls)
- socio-economic characteristics of the casemix.

The above list is not meant to be complete and consultation with aged care providers and researchers may identify other factors influencing a provider's risk profile for serious incidents. LASA believes that the Registry of Senior Australians (ROSA) may usefully inform any work on the risk-adjustment of providers for the purpose of SIRS reporting, particularly relevant clinical issues.

It is really important that the reporting does not result in perverse behaviours of under-reporting and that the data be analysed and benchmarked appropriately.

Question:

26. Should individual providers be required to publicly report SIRS data? If so, what and how often?

LASA does not support public reporting of SIRS data at this point in time because the SIRS will be a newly instituted Scheme. Any design and implementation issues are likely not to be identified until the SIRS has been operationalised for some time and several waves of reports were received and analysed. In particular, some of the definitions on which the SIRS rests have not been proven in the operational setting and some may have to be changed to become fit-for-purpose. LASA believes that

monitoring and fine-tuning of the SIRS in consultation with providers and consumers should be undertaken until all parties feel confident that SIRS is working well, providing a representative picture of any serious incidents occurring.

Public disclosure of any incident reporting scheme is problematic (particularly when the definitions are as uncertain as they are in this case) because much of the difference is likely to be driven by variation in interpretation of the reporting requirements. Public reporting will also encourage a stricter approach to the definition of incidents that require reporting to avoid appearing to potential consumers to be a service with a high number of serious incidents.

A fundamental precondition to requiring individual providers to publicly report their SIRS performance is the risk-adjustment of their resident casemix. Reporting without such risk adjustment is misleading for all consumers of this data, but in particular for the general public.

LASA proposes that initially providers are supplied with their own reporting data so they can compare and benchmark their performance to that of providers with a similar casemix. Public reporting of individual provider data should not be undertaken until a robust system for casemix-risk adjustment has been developed.

Sector-wide trend data may be publicly reported once the sector and Government are confident that any teething problems have been resolved.

We note that sanctions imposed on providers by the ACQSC are currently reported.

Question:

27. What might be the consequences of requiring public reporting by approved providers?

The introduction of public reporting of SIRS prior to a robust system of casemix adjustment may result in the public being ill-informed. Further, LASA is deeply concerned that public reporting by approved providers without risk-adjustment for their casemix may motivate providers not to admit residents with potentially reportable behaviours.

Public reporting should only occur once the regulators and industry are comfortable that the system is fair and robust.

Question:

28. Are there any additional matters of significance to consider in relation to reporting? If so, please explain further.

Members raised that any public reporting should include an opportunity for their voice so they can explain how they addressed any issues causing ‘serious incidents’. Members saw this as a matter of procedural fairness.

Any other matters

Question:

29. Are there any other matters of significance that need to be defined for the design or operation of a SIRS? If so, please explain further.

LASA has no other matters of significance to raise that need to be defined for the design or operation of the SIRS.