

EXPLANATORY STATEMENT

Issued by the authority of the Minister for Senior Australians and Aged Care Services

Aged Care Act 1997
Aged Care Quality and Safety Commission Act 2018

Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021

Purpose

The purpose of the *Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021* (Instrument) is to prescribe arrangements relating to the Serious Incident Response Scheme (SIRS) in residential aged care, including flexible care delivered in a residential aged care setting. This includes arrangements relating to an approved provider's responsibility to manage incidents and take reasonable steps to prevent incidents. The Instrument includes arrangements on the implementation and maintenance of incident management systems including the notification and management of reportable incidents by approved providers. The Instrument also makes consequential amendments to legislative instruments made under the authority of the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care Quality and Safety Commission Act 2018* (Quality and Safety Commission Act) as a result of the SIRS replacing the current reportable assault arrangements. Consequential amendments are also made in relation to the new enforcement powers of the Aged Care Quality and Safety Commissioner (Commissioner). This instrument is a legislative instrument for the purposes of the *Legislation Act 2003*.

Background

The Instrument will specify the details of the SIRS framework that approved providers will be required to comply with. This framework aims to enable approved providers to better respond to, and take steps to prevent, the incidence of abuse and neglect of older Australians in residential aged care, including flexible care delivered in a residential aged care setting.

The SIRS will implement key recommendations in the Australian Law Reform Commission's report *Elder Abuse – A National Legal Response* and the *Review of National Aged Care Quality Regulatory Processes* by Kate Carnell AO and Professor Ron Paterson ONZM (the Carnell-Paterson Review). The SIRS is also consistent with the *National Plan to Respond to the Abuse of Older Australians* and addresses issues raised in the Counsel Assisting's final submissions to the Royal Commission into Aged Care Quality and Safety.

The SIRS will replace current responsibilities of approved providers in relation to reportable assaults and unexplained absences. Amendments to the Aged Care Act by the *Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Act 2021* (Serious Incident Response Scheme and Other Measures Act) require approved providers to manage incidents and take reasonable steps to prevent

incidents, including through implementing and maintaining effective incident management systems.

As part of these responsibilities, approved providers will be required to manage all incidents, focusing on the safety, well-being, dignity and the quality of life of the person impacted, especially where that person is a residential care recipient. Approved providers will also be required to use incident data to drive quality improvement, and to respond to incidents by:

- putting supports in place for those affected;
- taking action to continuously improve and reduce the likelihood of incidents re-occurring (while ensuring resident choice and autonomy is maintained); and
- using information to inform organisation wide management of risk.

Under the SIRS, approved providers will have specific responsibilities to establish and maintain incident management systems, including establishing procedures to be followed in identifying, managing, recording and resolving incidents.

The SIRS will also require approved providers of residential aged care, including flexible care delivered in a residential care setting, to report all serious incidents affecting residential care recipients, which occur, or are alleged or suspected to have occurred, to the Aged Care Quality and Safety Commission (Commission).

Reportable incidents include unreasonable use of force, unlawful sexual contact or inappropriate sexual conduct, psychological or emotional abuse, unexpected death, stealing or financial coercion by a staff member, neglect, inappropriate physical or chemical restraint, and unexplained absence from care. Approved providers will also be required to report incidents to police where the provider suspects that the incident may be criminal in nature.

Importantly, the SIRS will also remove the existing exemption for reporting assaults where the alleged perpetrator is a residential care recipient with an assessed cognitive or mental impairment and the victim is another residential care recipient.

The SIRS will commence on 1 April 2021, although mandatory reporting will have a phased implementation. From 1 April 2021, a two stage reporting process will be required for all priority 1 reportable incidents which are those that result in, or could reasonably result in, physical or psychological injury or discomfort requiring onsite medical or psychological treatment or more significant treatment (for example where the victim requires off-site medical and/or psychological treatment). This will involve initial reporting within 24 hours of becoming aware of the incident, and if requested by the Commission, a follow up incident report provided within five days (or by a date specified by the Commissioner). The Commissioner may also request, on a case by case basis, an approved provider to submit a final report within 12 weeks of the incident.

From 1 October 2021, providers will be required to report all priority 2 reportable incidents within 30 days. Priority 2 reportable incidents would be categorised as incidents where there is low or no impact on the victim. Until these reporting requirements commence, providers must still identify, record, manage and take

reasonable steps to prevent these types of incidents in accordance with other responsibilities under the SIRS.

The health, safety, dignity and well-being of older Australians is of utmost importance to the Australian Government. Any abuse or neglect of a person is unacceptable and the SIRS will take steps to ensure that these incidents taking place in residential aged care are reported, managed and prevented from occurring in future.

Authority

Section 96-1 of the Aged Care Act provides that the Minister has the power to make instruments providing for matters required or permitted, or necessary or convenient, in order to give effect to the relevant Part or section of the Aged Care Act. The *Quality of Care Principles 2014* (Quality of Care Principles) are made under section 96-1 of the Aged Care Act, and set out matters for the purposes of Part 4.1 of the Aged Care Act. Item 1 of Schedule 1 to the Serious Incident Response Scheme and Other Measures Act inserts new paragraph 54-1(1)(e) in Part 4.1 of the Aged Care Act, which provides that an approved provider of residential aged care or flexible care provided in a residential aged care setting has a responsibility to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system, that complies with any requirements specified in the Quality of Care Principles. This instrument amends the Quality of Care Principles to specify these requirements.

Further, section 54-2 of the Aged Care Act provides that the Quality of Care Principles may set out Aged Care Quality Standards, which are standards for quality of care and quality of life for the provision of aged care. This instrument also amends the Quality of Care Principles to clarify that effective risk management systems and practices includes managing and preventing incidents, including the use of an incident management system under the Age Care Quality Standards.

The *Aged Care Quality and Safety Commission Rules 2018* (Quality and Safety Commission Rules) are made by the Minister under section 77 of the Quality and Safety Commission Act. Item 3 of Schedule 1 to the Serious Incident Response Scheme and Other Measures Act inserts new subsection 21(7), which provides that the Quality and Safety Commission Rules may provide for matters in relation to how the Commissioner will deal with reportable incidents. The Instrument amends the Quality and Safety Commission Rules to specify these matters.

The Instrument also repeals reportable assault arrangements under the *Accountability Principles 2014* (Accountability Principles). The enabling provision for the arrangements under the Accountability Principles (subsection 63-1AA(3) of the Aged Care Act), is repealed by item 4 of the Serious Incident Response Scheme and Other Measures Act so these provisions have no legal effect from the commencement of that Act.

Further, reportable assault arrangements under the *Records Principles 2014* (the Records Principles) made under section 96-1 of the Aged Care Act are repealed. The Instrument will set out a legislative requirement for the length of time records must be

kept in the Quality of Care Principles, as this requirement relates to the responsibility of approved providers to implement and maintain an incident management system.

Under subsection 33(3) of the *Acts Interpretation Act 1901* (Acts Interpretation Act), where an Act confers a power to make, grant or issue any instrument of a legislative or administrative character (including rules, regulations or by-laws), the power shall be construed as including a power exercisable in the like manner and subject to the like conditions (if any) to repeal, rescind, revoke, amend, or vary any such instrument.

The Instrument has been made in anticipation of the commencement of the Serious Incident Response Scheme and Other Measures Act. Section 4 of the Acts Interpretation Act provides that a power to make a legislative instrument in an Act may be exercised between the enactment and commencement of an Act. The new instrument-making powers introduced by the Serious Incident Response Scheme and Other Measures Act have been exercised to make this instrument before that Act commences. It is important that the Instrument be made between the enactment and the commencement of the Serious Incident Response Scheme and Other Measures Act to ensure that the SIRS requirements are made publicly available prior to commencement, and enable the provisions of the Instrument to commence at the same time as the new SIRS responsibilities under the Aged Care Act.

Commencement

This instrument will commence on 1 April 2021.

Consultation

The Department of Health (Department) has undertaken extensive consultation in relation to the SIRS and the Instrument. During 2019, comprehensive public consultation was undertaken on the finer details of operation of a SIRS for residential aged care. A consultation paper was developed and used as a basis for face-to-face workshops, an online survey and targeted consultation with key stakeholders, including with National Aged Care Alliance, and the Aged Care Sector Committee. The parameters in this instrument are consistent with the SIRS model paper that summarises the scheme developed through the consultation process. The SIRS model paper is available on the Department of Health's website:

<https://www.health.gov.au/resources/publications/serious-incident-response-scheme-for-commonwealth-funded-residential-aged-care-model-for-implementation>

The Department also undertook consultation on a draft of the Instrument with a group of key stakeholders who represent persons affected by the Instrument. This included representatives from consumer representative groups, advocacy organisations, industry peak bodies, professional and industrial organisations, and other government agencies. As these key stakeholders were consulted and contributed to the SIRS design throughout the process, input received on the draft instrument did not seek to revise any of the overarching policy or key design settings. Stakeholder feedback identified a number of areas for further clarification. Feedback also identified scenarios or examples that were unintentionally excluded or included in the scope of the SIRS.

Revisions made in response to the feedback included:

- making it explicit that rights of residential care recipients, including choice and autonomy, are protected through the process of an approved provider's management and prevention of incidents;
- aligning drafting more closely with the policy intent and improving readability and interpretation; and
- making some of the strict requirements more flexible to take into account operational issues.

Several suggestions were also taken into account when drafting this explanatory statement, communications materials and policy guidance to provide clarification and examples to assist readers understanding how the SIRS will operate.

Regulation Impact Statement

The Department of Health has certified that the Carnell-Paterson Review undertook a process and analysis similar to that required for a Regulation Impact Statement (RIS). The Carnell-Paterson Review and certification are available on the Office of Best Practice Regulation's RIS website: <https://ris.pmc.gov.au/2018/09/19/more-choices-longer-life-package>

Availability of independent review

The Instrument empowers the Commissioner to make a number of discretionary decisions in relation to reportable incidents. This includes the ability for the Commissioner to decide whether or not additional information is required in relation to a reportable incident and whether a final report is needed. The Commissioner has the discretion to take a number of actions in response to reportable incidents including referring incidents to relevant persons (including police), requiring remedial action to be taken, or for an inquiry or an internal investigation to be undertaken.

The Commissioner also has the discretion, in very limited circumstances, to determine that a reportable incident does not need to be reported. These decisions are not subject to independent merits review, and this is justified below in accordance with Chapter 4 of the Administrative Review Council Publication *'What decisions should be subject to subject to merit review?'* (ARC Merit Review Publication). Chapter 4 of the ARC Merit Review Publication outlines factors that may justify exclusion of merits review.

Many of the discretionary decisions introduced by the Instrument are considered preliminary or procedural decisions for the purposes of the operation of the SIRS. Paragraphs 4.3 and 4.4 of the ARC Merit Review Publication state that preliminary or procedural decisions that include decisions that facilitate or lead to the making of a substantive decision may not be suitable for merits review. This is because review of such decisions may impact the intended operation of administrative decision making and result in the process becoming frustrated or delayed.

Many of the discretionary decisions introduced by the Instrument relate to the process of the Commissioner considering the details of a reportable incident, and requesting further information or actions to be taken by the approved provider in relation to that consideration. Any potential benefit of merits review would be outweighed by the disruption to this process, which would likely cause delays in the approved provider

taking action to remedy an issue resulting from an incident or for the Commissioner to take enforcement action in response to an incident. As these decisions deal with matters relating to reportable incidents, any delay may significantly increase the risk of continued abuse and neglect of residential care recipients.

Information obtained by the Commissioner may lead to the Commissioner being satisfied that an approved provider is not complying with the provider's responsibilities under new paragraph 54-1(1)(e) of the Aged Care Act, or suggest that an approved provider is not complying with the incident management provisions. This may lead to a compliance notice being issued under section 74EE of the Quality and Safety Commission Act (a substantive decision). It should be noted that decisions under section 74EE of the Quality and Safety Commission Act are subject to merits review under section 74J of that Act.

Lastly, paragraph 4.49 of the ARC Merit Review Publication states that exclusion of merits review may be justified in circumstances where there would not be appropriate remedy by reviewing a decision. This is relevant in relation to the Commissioner's discretions under new paragraph 95G(1)(a) and new subsection 95H(5) of the Quality and Safety Commission Rules. Once the Commissioner has made a discretionary decision and taken the relevant action (for example referred the incident to police), an appropriate remedy may not be available because the action cannot be reversed.

Judicial review of administrative action undertaken in accordance with the Instrument is not limited or excluded.

Details of the Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021

Section 1 provides that the name of the instrument is the *Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021*.

Section 2 states that the whole of the Instrument commences on 1 April 2021.

Section 3 provides that this instrument is made under the Aged Care Act and the Quality and Safety Commission Act.

Section 4 provides that each instrument that is specified in a Schedule to this instrument is amended or repealed as set out in the applicable items in that Schedule, and any other item in that Schedule has effect according to its terms.

Schedule 1 – Incident management and prevention

Part 1 – Amendments of the Quality of Care Principles

Quality of Care Principles

Item 1 inserts new Part 4B to the Quality of Care Principles, which sets out requirements relating to incident management and prevention. It is appropriate to include these matters in delegated legislation to ensure there is the ability to promptly respond to unforeseen implementation issues and sector feedback to ensure timely responses to matters affecting the well-being of residential care recipients.

Personal information acquired under this new Part is protected by the protection of information provisions in Part 6.2 of the Aged Care Act, and the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act. Approved providers also have a responsibility to protect a care recipient's personal information under section 62-1 of the Aged Care Act.

New Division 1 sets out the purpose of new Part 4B of the Quality of Care Principles.

New Section 15K – Purpose of this Part

New subsection 15K(1) provides that new Part 4B is made for the purposes of subparagraphs 54-1(1)(e)(i) and (ii) of the Aged Care Act relating to an approved provider's responsibilities to manage incidents and take reasonable steps to prevent incidents.

New subsection 15K(2) provides that new Part 4B applies to incidents that consist of acts, omissions, events or circumstances that:

- occur, or are alleged or suspected to have occurred, in connection with the provision of residential care, or flexible care provided in a residential setting, to a residential care recipient of the approved provider; and
- either:
 - have caused harm to the residential care recipient or another person;
 - or

- could reasonably have been expected to have caused harm to a residential care recipient or another person.

The phrase ‘in connection with’ is broad and includes incidents that may have occurred during the course of providing care and services to a residential care recipient. This is intended to capture a range of incidents, for example, a fall during an outing facilitated by the residential care service, a residential care recipient being aggressive towards staff members, or a visitor slipping on a wet floor.

Other examples may include a staff member being burnt in the kitchen of the residential care service, or a plumber being physically abused by a residential care recipient while repairing a leak at the residential care service.

However, this phrase is not intended to capture incidents that have no connection to the care and services provided to a residential care recipient. Such an example may be a residential care recipient tripping during an outing with a family member away from the service, where there was no physical or psychological harm to the residential care recipient. Another example may include a staff member being injured in a car accident on a day they are not at work.

The concept of harm in this context is broad and is not limited to serious harm or injury. It encompasses emotional and psychological as well as physical harm.

The phrase ‘could reasonably have been expected to have caused’ is included to account for circumstances where an incident involves conduct that is not acceptable and would ordinarily cause harm, even though the conduct may not have had such an effect in the circumstances of that specific incident. For example, where a staff member takes photos of a residential care recipient while they are showering and shares those photos with other staff members, although that residential care recipient may not suffer psychological anguish or humiliation because their individual level of cognitive functioning did not allow them to recognise or remember the incident.

Another person in the context of this provision may include, but is not limited to, a staff member of the approved provider, or a visitor to the residential care service.

New paragraph 15K(2)(b) is not intended to limit the meaning of ‘reportable incident’ in section 54-3 of the Aged Care Act and is included for clarification of the meaning of ‘incident’ in the Aged Care Act.

New subsection 15K(3) provides that Divisions 2 and 3 of new Part 4B of the Quality of Care Principles also apply to incidents not covered by new subsection 15K(2) that consist of acts, omissions, events, or circumstances that:

- the approved provider becomes aware of in connection with the provision of care to a residential care recipient of the provider in residential care, or flexible care provided in a residential aged care setting; and
- have caused harm to the residential care recipient.

For example this may include circumstances where a family member is stealing money from a residential aged care recipient by using their internet banking password and the approved provider becomes aware of the incident and the residential care

recipient is emotionally distressed. This may also include circumstances where a residential care recipient is taken on an outing by a family member, and upon return the residential care recipient seeks medical attention because they were physically abused by a family member and sustained a physical injury.

The scope of incidents for the purposes of incident management and prevention, including the incident management system, are broader than the scope of incidents that are 'reportable incidents' under the SIRS. This is because an approved provider's incident management system must apply across their services, while acknowledging that the Commissioner's regulatory and monitoring capabilities have a primary focus on the health, safety, well-being and quality of life of residential care recipients.

New Division 2 sets out the requirements for approved providers to comply with in managing and preventing incidents.

New Section 15L – Purpose of this Division

New section 15L provides that new Division 2 is made for the purposes of subparagraph 54-1(1)(e)(ii) of the Aged Care Act and specifies requirements that an approved provider must comply with in managing and preventing incidents.

The note following new section 15L clarifies that the incidents for which new Division 2 applies to are provided at new subsections 15K(2) and (3).

New Section 15LA – Requirements for managing incidents

New section 15LA sets out the requirements of the approved provider to manage or prevent incidents. These requirements, working in conjunction with the requirements in new section 15LB, are intended to result in continuous improvement of services by preventing future avoidable incidents.

New subsection 15LA(1) provides that the approved provider's management of incidents must be focused on the safety, health, well-being and quality of life of residential care recipients of the provider. This is the core intention of the SIRS, which is being introduced to protect older Australians in residential aged care, including flexible care delivered in a residential aged care setting.

New subsection 15LA(2) provides that the approved provider must respond to an incident by:

- assessing the support and assistance required to ensure the safety, health and well-being of persons affected by the incident; and
- providing that support and assistance, that was assessed as being required, to the persons affected by the incident; and
- assessing how to appropriately involve each person affected by the incident, or a representative of the person, in the management and resolution of the incident; and
- involving each person or representative in that way; and
- using an open disclosure process.

Open disclosure requires approved providers to openly communicate with aged care recipients when their care does not go to plan. Depending on the circumstances, this

may require open and timely communication, acknowledgement, apology and expression of regret, as well as continuing to support the aged care recipient.

New subsection 15LA(3) provides that the approved provider must assess the incident in relation to the following, taking into account the views of persons affected by the incident:

- whether the incident could have been prevented;
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm;
- how well the incident was managed and resolved;
- what, if any, actions could be taken to improve the provider's management and resolution of similar incidents;
- whether other persons or bodies should be notified of the incident.

New subsection 15LA(4) provides that the approved provider must undertake the remedial action assessed as needing to be undertaken to prevent further similar incidents. For example, repairing flooring that is causing falls, or ensuring additional staff are available during a group activity where, on a previous occasion, a person had acquired a burn injury.

The approved provider must also take actions assessed to improve the approved provider's management and resolution of incidents that are reasonable in the circumstances. For example, if a family member has been taking money from their relative (a residential care recipient) while visiting the residential care service, it may be appropriate for the approved provider to put in place reasonable arrangements to prevent reoccurrence. In this example this may include securing the residential care recipient's wallet during future visits by that family member.

The approved provider must also notify the persons and bodies assessed as being persons or bodies that should be notified of the incident, for example, the family of the person affected or the Australian Health Practitioner Regulation Agency.

Notifying police of an incident

New subsection 15LA(5) provides that if there are reasonable grounds to report the incident to police, the approved provider must notify a police officer of the incident within 24 hours of becoming aware of the incident. For example, if the approved provider reasonably suspects that the incident may be an assault they should report the incident to their local police within 24 hours of becoming aware of the incident.

New subsection 15LA(6) provides that if the approved provider later becomes aware of reasonable grounds to report the incident to police (not within the 24 hours of becoming aware of the incident), the provider must notify a police officer of the incident within 24 hours of becoming aware of those grounds. For example, the approved provider might initially become aware of an incident and at that time did not consider there were reasonable grounds to report the incident to police. However, if they later determine that there are grounds to report the incident to police, the 24 hour timeframe commences when the approved provider becomes aware of the grounds to report the incident to police (e.g. when they become aware of the additional information).

The phrase ‘reasonable grounds’ may be taken to include a scenario where the approved provider is aware of facts or circumstances (alleged or known) that lead them to believe that it is likely that the incident is of a criminal nature and therefore should be reported to police (e.g. if the approved provider suspects the incident involves an indecent assault or if there is an ongoing danger).

New section 15LB – Requirements for improving management and prevention of incidents

New subsection 15LB(1) provides that the approved provider must collect data relating to incidents that will enable the provider to continuously improve the provider’s management and prevention of incidents, including to enable the provider to:

- identify and address systemic issues in the quality of care provided by the provider; and
- provide feedback and training to staff members of the provider about managing and preventing incidents. For example, building staff capability through awareness raising and education activities.

New subsection 15LB(2) provides that an approved provider must regularly analyse and review the data relating to incidents collected to assess:

- the effectiveness of the provider’s management and prevention of incidents, and
- what, if any, actions could be taken to improve the provider’s management and prevention of incidents.

New subsection 15LB(3) provides that if the approved provider has assessed actions that could be taken to improve the approved provider’s management and prevention of incidents, the approved provider must take any actions that are reasonable in the circumstances.

New Division 3 sets out the requirements for approved providers relating to their responsibilities in maintaining and implementing an incident management system.

New Section 15M – Purpose of this Division

New subsection 15M(1) clarifies that it is a responsibility of an approved provider who provides residential care, or flexible care provided in a residential aged care setting, to implement and maintain an incident management system.

The note following new subsection 15M(1) provides that this is a responsibility of the approved provider under Chapter 4 of the Aged Care Act, referring to section 54-1.

New subsection 15M(2) provides that, for the purposes of subparagraph 54-1(1)(e)(i) of the Aged Care Act, the incident management system of the approved provider must comply with the requirements set out in new Division 3 of the Quality of Care Principles (this Division).

New Section 15MA – Incidents that must be covered

New section 15MA provides that the incident management system of an approved provider must cover all incidents which this new Part applies, including reportable incidents. A ‘reportable incident’ is defined in new subsection 54-3(2) of the Aged

Care Act as inserted by item 2 of Schedule 1 to the Serious Incident Response Scheme and Other Measures Act.

Note 1 that follows new section 15MA refers to new subsections 15K(2) and (3) (explained above) for the incidents to which this new Division applies.

Note 2 refers to new Division 4 (explained below) for additional requirements that apply to reportable incidents.

New Section 15MB – Incident management system procedures

New section 15MB prescribes the procedures and requirements that must be included in an incident management system. The approved provider may include additional procedures and requirements if appropriate to the needs of the provider.

New subsection 15MB(1) prescribes that the incident management system of the approved provider must establish procedures to be followed in identifying, managing and resolving incidents. This must include procedures that specify certain matters.

New paragraph 15MB(1)(a) provides that the system must include procedures that specify how incidents are identified, recorded and reported. For example, the incident management system prescribes where and how incidents are recorded.

New paragraph 15MB(1)(b) provides that the system must include procedures that specify to whom incidents must be reported. For example, an incident management system may require incidents be reported to a supervisor, manager or member of key personnel. The person to whom an incident must be reported may vary depending on the type and nature of the incident.

New paragraph 15MB(1)(c) provides that the system must include procedures that specify the person who is responsible for notifying reportable incidents to the Commissioner. For example, this could be the person who first becomes aware of the incident, the manager or supervisor on duty at the time of the incident, or another person.

New paragraph 15MB(1)(d) provides that the system must include procedures that specify how the provider will provide support and assistance to persons affected by an incident to ensure their safety, health and well-being (including providing information about access to advocates such as independent advocates). For example, the procedures may include a set of actions or list of questions that the provider may ask a person affected by an incident to ensure their safety, health and well-being. The procedure may also include a list of advocates and their contact details that the approved provider may provide to the persons affected.

New paragraph 15MB(1)(e) provides that the system must include procedures that specify how persons affected by an incident (or representatives of the person) will be involved in the management and resolution of the incident. For example, the incident management system sets out when and how information about the incident is provided to the person affected and how that person's concerns will be considered in the management and resolution of the incident.

New paragraph 15MB(1)(f) provides that the system must include procedures that specify when an investigation by the provider is required to establish the causes of the particular incident, or the harm caused by the incident, or any operational issues that may have contributed to the incident occurring, and the nature of that investigation.

New paragraph 15MB(1)(g) provides that the system must include procedures that specify when remedial action is required and the nature of that action. For example, if system failure or the actions of a staff member contributed to an incident, it is expected that the incident management system would set out a process for addressing those issues.

New subsection 15MB(2) provides that the procedure may vary depending on the seriousness of the incident. For example, there may be different procedures in place regarding reporting of incidents and how an incident must be recorded where a person affected requires medical attention.

New subsection 15MB(3) provides that the incident management system must set out procedures for ensuring that the requirements of new sections 15LA and 15LB are complied with. These set out requirements for managing incidents and requirements for improving management and prevention of incidents.

New subsection 15MB(4) provides that the incident management system must provide that, if the incident is a reportable incident, the incident must also be notified and managed in accordance with Division 4 of the Quality of Care Principles (explained below).

New Section 15MC – Documentation, record keeping and data analysis

New section 15MC provides that the approved provider must document its incident management system procedures. It is important that the incident management system is documented so that compliance with the system can be monitored and enforced, including by the Commissioner.

New section 15MC sets out the requirements in relation to record keeping. It is necessary for approved providers to keep accurate records to enable them to identify any systemic issues and to provide those records to the Commission if necessary.

New subsection 15MC(1) provides that an approved provider must document its incident management system procedures and make the documented procedures available, in an accessible form, to the following persons:

- residential care recipients of the provider;
- each staff member of the provider;
- family members, carers, representatives, advocates (including independent advocates) of the residential care recipients and any other persons significant to those residential care recipients.

The approved provider must assist such persons to understand how the incident management system operates.

Subsection 15MC(2) provides that the incident management system must provide for the following details to be recorded in relation to each incident:

- a description of the incident, including the harm caused to, or could reasonably have been expected to have been caused to, each person affected by the incident and, if known, the consequences of that harm;
- whether the incident is a reportable incident;
- if known, the time, date and place at which the incident occurred or was alleged or suspected to have occurred;
- the time and date the incident was identified;
- the name and contact details of the persons directly involved in the incident;
- the name and contact details of any witnesses to the incident;
- details of the assessments undertaken in accordance with new subsections 15LA(2) and (3), which requires the approved provider to assess and respond to an incident;
- the actions taken in response to the incident, including actions taken under new subsections 15LA(2), (4), (5) and (6) which require the approved provider to:
 - respond to an incident;
 - take remedial action and action to improve the provider's management and resolution of incidents;
 - to notify persons and bodies that should be notified of the incident (e.g. the family of those directly involved; and
 - if there were reasonable grounds to do so, report the incident to police.
- any consultations undertaken with persons affected by the incident;
- whether persons affected by the incident have been provided with any reports or findings regarding the incident;
- if an investigation is undertaken by the provider in relation to the incident, the details and outcomes of the investigation;
- the name and contact details of the person making the record of the incident.

The approved provider may collect other information if appropriate in circumstances. For example, an approved provider may decide to collect information about demographics or diversity characteristics if they consider this relevant to their incident management procedures and if they consider it may assist in the prevention of incidents.

New subsection 15MC(3) provides that details recorded for the purposes of subsection 15MC(2) must be retained for seven years after the incident was identified. This provision replaces record requirements for the purposes of the reportable assaults scheme (which is replaced by the SIRS) that are currently prescribed in the Records Principles, noting that these provisions will be repealed by item 12 to Schedule 1 to the Instrument.

A period of seven years aligns with comparable incident management arrangements under the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018*. All other existing record keeping requirements under the Aged Care Act require that records be retained for a period of three years after the 30 June of the year that the record was made. This period is considered reasonable for other purposes, however, given that some incidents under the SIRS may result in civil or criminal proceedings, three years is not considered enough time to ensure evidence is kept for such proceedings.

Further, if an incident is a criminal offence, there may be an associated statute of limitation that is longer than seven years. Approved providers may want to consider retaining records in relation to certain incidents until the relevant statute of limitation has expired.

New subsection 15MC(4) provides that the incident management system must provide for the collection of data in relation to incidents that will enable the approved provider to:

- identify occurrences, or alleged or suspected occurrences, of similar incidents;
- comply with section 15LB, regarding the use of information to continuously improve the provider's management and prevention of incidents; and
- provide information to the Commissioner, if required or requested to do so by the Commissioner.

Information recorded under new section 15MC is intended to be used by the approved provider to manage incidents and for the purposes of identifying trends which may inform steps taken to prevent incidents from occurring in future. The information is also collected so that an approved provider may comply with any request(s) made by the Commission under their compliance and monitoring powers. The collection of information is appropriate as it is an integral part of the incident management process.

New subsection 15MC(5) clarifies that this section does not limit new paragraph 15MB(1)(a), which provides that an incident management system of an approved provider must include procedures that specify how incidents are identified, recorded and reported.

New Section 15MD – Roles, responsibilities, compliance and training of staff members

New section 15MD addresses the roles and responsibilities of staff members of the approved provider in relation to the incident management system.

New subsection 15MD(1) provides that the incident management system must set out the roles and responsibilities of staff members of the approved provider in identifying, managing and resolving incidents and in preventing incidents from occurring.

New subsection 15MD(2) provides that without limiting new subsection 15MD(1), the incident management system must provide that each staff member of the approved provider must comply with the incident management system.

New subsection 15MD(3) provides that the incident management system must include requirements relating to the provision of training to each staff member of the approved provider in the use of, and compliance with, the incident management system.

The form, method and extent of training is expected to be appropriate to the size of the approved provider and the care and supports provided, as well as the role of the staff member.

New Division 4 sets out the requirements for dealing with reportable incidents in relation to the incident management system. It is appropriate to include these matters in delegated legislation as they relate to operational matters such as process and procedure. These matters will go into the specific detail of notification arrangements such as the fields of the notice.

This Division will further define and provide clarification on the terms in subsection 54-3(2) of the Aged Care Act, and will also specify when an incident is, or is not, a reportable incident. This will provide further detail about what the terms may include, and provide examples of what the terms do not include.

Including these matters in delegated legislation will allow for responsiveness in the changing aged care environment. As these arrangements relate to the reporting of abuse and neglect in residential aged care, it is appropriate that these aspects of the SIRS can be adapted and modified in a timely manner. Allowing flexibility to promptly respond to unforeseen risks, concerns and omissions, aligns with community expectations and the key intention of the SIRS which is to protect residential care recipients from abuse and neglect.

New section 15N – Purpose of this Division

New section 15N provides that new Division 4 is made for the purposes of subsection 54-3(1) of the Aged Care Act and makes provision for dealing with reportable incidents.

New subsection 15N(2) provides that under subparagraph 54-1(1)(e)(i) of the Aged Care Act the incident management system of an approved provider must comply with the requirements set out in this new Division in relation to reportable incidents.

The note following new subsection 15N(2) clarifies that an approved provider who provides residential care, or flexible care provided in a residential aged care setting, has a responsibility under Chapter 4 of the Aged Care Act to implement and maintain an incident management system, and refers to section 54-1 of the Aged Care Act (the location of this requirement).

New section 15NA – What is a *reportable incident*?

New subsection 15NA(1) provides that this section is made for the purposes of subsection 54-3(4) of the Aged Care Act. It defines or clarifies the meaning of expressions used in subsection 54-3(2) of the Aged Care Act which lists the kinds of incidents which are covered by the definition of *reportable incident*. New section 15NA clarifies the meaning of the following expressions:

- unreasonable use of force against the residential care recipient;
- unlawful sexual contact, or inappropriate sexual conduct, inflicted on the residential care recipient;
- psychological or emotional abuse of the residential care recipient;
- unexpected death of the residential care recipient;
- stealing from, or financial coercion of, the residential care recipient by a staff member of the provider;
- neglect of the residential care recipient;
- unexplained absence of the residential care recipient from the residential care services of the provider.

Note 1 following new subsection 15NA(1) clarifies that under subsection 54-3(2) of the Act a *reportable incident* is an incident that has occurred, is alleged to have occurred, or is suspected of having occurred, in connection with the provision of residential care or flexible care in a residential setting, to a residential care recipient of an approved provider, and is any of the incidents in paragraphs 54-3(2)(a) to (h) of the Aged Care Act. This includes the incidents listed above, as well as use of physical restraint or chemical restraint in relation to the residential care recipient (other than in circumstances set out in the Quality of Care Principles). The note also refers to new subsection 15K(2) for incidents to which this new Part applies.

Note 2 following new subsection 15NA(1) clarifies that the use of physical restraint or chemical restraint in relation to the residential care recipient (other than in circumstances set out in the Quality of Care Principles) is also a reportable incident under paragraph 54-3(2)(g) of the Aged Care Act, and Part 4A of the Quality of Care Principles (explained in more detail below).

Note 3 following new subsection 15NA(1) clarifies that subsection 54-3(5) of the Aged Care Act allows the Quality of Care Principles to provide that specified acts, omissions or events are, or are not, reportable incidents, and that the Quality of Care Principles can override subsection 54-3(2) of the Aged Care Act in this regard, and refers to new section 15NB of the Quality of Care Principles (explained below) which is made for the purposes of subsection 54-3(5) of the Aged Care Act.

Unreasonable use of force

New subsection 15NA(2) provides that the expression ‘unreasonable use of force against the residential care recipient’ in paragraph 54-3(2)(a) of the Aged Care Act includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force. Examples may include kicking, hitting, pushing, shoving and rough handling.

Importantly, the previous exemption from reporting assaults where the alleged perpetrator is a residential care recipient diagnosed with an assessed cognitive or mental impairment and the victim is another residential care recipient no longer applies under the SIRS. This means that where a residential care recipient uses unreasonable force against another residential care recipient (regardless of whether they have an assessed cognitive or mental impairment or not) this is a reportable incident.

New subsection 15NA(3) provides that, to avoid doubt, the expression ‘unreasonable use of force against the residential care recipient’ does not cover gently touching the residential care recipient to:

- provide care; or
- attract their attention; or
- guide them; or
- provide comfort when they are distressed.

Unlawful sexual contact, or inappropriate sexual conduct

New subsection 15NA(4) provides that the expression ‘unlawful sexual contact, or inappropriate sexual conduct, inflicted on a residential care recipient’ in paragraph 54-3(2)(b) of the Aged Care Act includes the following:

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

Examples may include a staff member or other person (including another residential care recipient):

- showing their own genitals to a residential care recipient;
- masturbating in front of a residential care recipient;
- using sexual innuendo, or explicit comments that are vulgar or would reasonably cause the residential care recipient discomfort;
- forcing a residential care recipient to view pornography;
- sexually grooming of a residential care recipient (preparatory process with an intent to be sexually abusive);
- crossing professional boundaries with a residential care recipient;
- touching a residential care recipient’s genitals, breasts or anus without a care need; or
- sexually penetrating a residential care recipient with a body part or an object.

In general, this includes sexual offences against the residential care recipient including sexual assault, aggravated assault and indecent assault (noting that each state or territory may use a variety of terms for these types of offences, and may have more specific categories of sexual offences).

Importantly, the previous exemption from reporting assaults where the alleged perpetrator is a residential care recipient with an assessed cognitive or mental impairment and the victim is another residential care recipient no longer applies under the SIRS. This means that where a residential care recipient inflicts unlawful sexual contact, or inappropriate sexual conduct on another residential care recipient (regardless of whether they have an assessed cognitive or mental impairment or not) this is a reportable incident.

However, new subsection 15NA(5) provides that the expression ‘unlawful sexual contact, or inappropriate sexual conduct, inflicted on the residential care recipient’ in paragraph 54-3(2)(b) of the Aged Care Act does not include consensual contact or conduct of a sexual nature between a residential care recipient and a person who is not a staff member of the provider. This includes where the other person is a residential care recipient themselves, or the other person is a person who provides care or services for the provider, such as a volunteer, (except while that person is providing care or services).

For example, where the long term partner of the residential care recipient is not a residential care recipient themselves and volunteers their time to facilitate a weekly craft activity session at the service. In these circumstances it would not be a reportable incident for the long term partner to have a sexual relationship with a residential care recipient.

Psychological or emotional abuse

New subsection 15NA(6) provides that the expression ‘psychological or emotional abuse of a residential care recipient’ in paragraph 54-3(2)(c) of the Aged Care Act includes conduct that either:

- has caused the residential care recipient psychological or emotional distress; or
- could reasonably have been expected to have caused a residential care recipient psychological or emotional distress.

The phrase ‘could reasonably have been expected to have caused’ is included to account for circumstances where an incident involves conduct that is not acceptable and would ordinarily cause psychological or emotional distress, even though the conduct may not have had such an effect in the circumstances of that specific incident. For example, where a residential care recipient is yelling at and threatening another residential care recipient and that residential care recipient does not display distress as their individual level of cognitive functioning did not allow them to recognise what was happening. Although that residential care recipient may not suffer psychological or emotional distress, it is intended that such incidents would be considered reportable incidents for the purposes of the SIRS.

New subsection 15NA(7) provides that conduct covered by the expression ‘psychological or emotional abuse of a residential care recipient’ includes, without limitation, the following:

- taunting, bullying, harassment or intimidations;
- threats of maltreatment;
- humiliation;
- unreasonable refusal to interact with the residential care recipient or acknowledge the recipient’s presence;
- unreasonable restriction of the residential care recipient’s ability to engage socially or otherwise interact with people;
- repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which:
 - has caused the residential care recipient psychological or emotional distress; or

- could reasonably have been expected to have caused a residential care recipient psychological or emotional distress.

Examples may include yelling, name-calling, threatening gestures, making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity or religious identity, or repeatedly flicking, tapping, or bumping of a residential care recipient.

The use of the term 'unreasonable' in relation to refusal to interact with a residential care recipient and restriction of their ability to engage socially or otherwise interact with people is used to exclude circumstances where this is done for a legitimate reason. For example, if a residential care recipient is being violent towards other residential care recipients and is temporarily not permitted to attend a group activity in a common area of the service while their behaviour is being assessed and addressed. Another example may be not allowing a residential care recipient to leave the service or have visitors during an outbreak, in order to protect the residential care recipient from the risk of disease.

Unexpected death

New subsection 15NA(8) provides that the expression 'unexpected death of a residential care recipient' in paragraph 54-3(2)(d) of the Aged Care Act includes death in circumstances where:

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

For example, this would include circumstances where a residential care recipient has a fall while being moved or shifted and the recipient sustains injuries during the fall resulting in the recipient's death. Other examples may include where a coronial inquest is being held in relation to a residential care recipient's death, or in a circumstance where an untreated pressure injury becomes infected, and appropriate medical assessment and or treatment was delayed or not given, which resulted in the death of the residential care recipient.

Stealing or financial coercion

New subsection 15NA(9) provides that the expression 'stealing from, or financial coercion of, the residential care recipient by a staff member of the provider' in paragraph 54-3(2)(e) of the Aged Care Act includes the following:

- stealing from the residential care recipient by a staff member of the approved provider;
- conduct by a staff member of the approved provider that is coercive or deceptive in relation to the recipient's financial affairs, or unreasonably controls the financial affairs of the recipient.

For example this includes a staff member coercing a residential care recipient to change their will in favour of a staff member, or a staff member stealing money or valuables, from a residential care recipient. Another example may include a staff member influencing a residential care recipient to provide them with a large gift

(expensive or of sentimental high value), or a circumstance where a staff member takes a residential care recipient's wallet and will allow the recipient to spend money, although a recipient may have the cognition to make decisions about the spending of their funds.

Neglect

New subsection 15NA(10) provides that the expression 'neglect of the residential care recipient' in paragraph 54-3(2)(f) of the Aged Care Act includes the following:

- a breach of the duty of care owed by the approved provider, or a staff member of the provider, to the residential care recipient,
- a gross breach of professional standards by a staff member of an approved provider providing care or services to the residential care recipient

The use of the term 'gross' in relation to breaches of professional practice is intended to delineate between poor practice and deliberate or intentional neglect.

Examples of neglect of the residential care recipient may include:

- a reckless act or a failure to act by the provider, such as:
 - not providing a residential care recipient access to medical care or allied health
 - untreated wounds
 - failure to change soiled continence aids in a timely manner
- supervisory neglect by the provider;
- grossly inadequate care by the provider such as:
 - a staff member withholding personal care such as showering or oral care;
 - ongoing errors in the administration of essential medication;
 - lack of wound care resulting in maggots on or in the residential care recipient; or
 - a residential care recipient being left outside unprotected from the sun resulting in sunburn.

Other examples include where a residential care recipient's meals are not appropriately modified to account for difficulty swallowing (dysphagia) as recorded on their meal plan, or insufficient assistance is given to a residential care recipient to eat their food, resulting in the residential care recipient either not being able to eat or choking on their food. Further examples may include where a residential care recipient is repeatedly not being given an appropriate meal, for example, where an approved provider refuses to supply kosher or halal food or vegetarian meals in accordance with the care recipient's choice. In addition this may include a circumstance where a staff member decides, against care directives, to move a residential care recipient without the use of a hoist because it would take too much time to set up and the residential care recipient has a fall and sustains injury.

It should be noted that under new subsection 15NB(3) (explained below), an incident is not a reportable incident if the incident results from a residential care recipient deciding to refuse to receive care or services offered by the approved provider, and the refusal has been documented in the care plan.

Unexplained absence

New subsection 15NA(11) provides that the expression ‘unexplained absence of the residential care recipient from residential care services’ in paragraph 54-3(2)(h) of the Aged Care Act means an absence of the residential care recipient from the residential care services in circumstances where there are reasonable grounds to report the absence to police. For example, where a residential care recipient is not able to be located and does not have sufficient cognition to care for themselves or would miss a dose of essential medication.

Use of physical or chemical restraint

The use of physical restraint or chemical restraint in relation to a residential care recipient (other than in circumstances set out in the Quality of Care Principles) is also a reportable incident under paragraph 54-3(2)(g) of the Aged Care Act. Sections 15F and 15G of the Quality of Care Principles set out the responsibilities of an approved provider relating to the use of physical restraint and chemical restraint. New section 15NB (explained below) also identifies circumstances where use of physical and chemical restraint in relation to a residential care recipient is not a reportable incident.

New section 15NB – What is not a reportable incident?

New section 15NB is made for the purposes of paragraph 54-3(5)(b) of the Aged Care Act, which provides that, despite the list of reportable incidents at subsection 54-3(2) of the Aged Care Act, an incident is not a reportable incident if it is listed in this new section.

New subsection 15NB(2) provides that, despite use of chemical restraint or physical restraint (other than in circumstances set out in the Quality of Care Principles) being a reportable incident under paragraph 54-3(2)(g) of the Aged Care Act, it is not a reportable incident if it is used in a transition care program in a residential care setting. However the use in a transition care program must be consistent with arrangements under sections 15F and 15G of the Quality of Care Principles, assuming that those sections applied to the residential care recipient in relation to that care.

Sections 15F and 15G of the Quality of Care Principles set out the responsibilities of an approved provider relating to the use of physical restraint and chemical restraint. The sections state that an approved provider must not use physical or chemical restraints, unless certain conditions are met in relation to the use of the restraint.

Any use of restraint that is inconsistent with the requirements in the Quality of Care Principles is a reportable incident. For example, where physical or chemical restraint is used without prior consent or without notifying the care recipient’s representative as soon as practicable; where physical restraint is used in a non-emergency situation; or when a provider gives a medication to a consumer to influence their behaviour as a form of chemical restraint.

The responsibilities under sections 15F and 15G of the Quality of Care Principles are limited to approved providers of residential aged care (including residential respite care and multi-purpose services) or flexible care services in the form of short-term restorative care, meaning the responsibilities do not apply to approved providers of a transition care program in a residential care setting.

As the SIRS arrangements, including reportable incidents, apply to approved providers of a transition care program in a residential care setting, new subsection 15NB(2) ensures that the use of physical or chemical restraint in a transition care program is not a reportable incident if it is used in a way consistent with arrangements under sections 15F and 15G of the Quality of Care Principles.

For example, in relation to use of physical restraint, if an approved provider of a transition care program is satisfied that:

- an approved health practitioner who has day-to-day knowledge of the residential care recipient has assessed the care recipient as posing harm to themselves or another person, and as requiring the restraints, and has documented this assessment; and
- alternatives to restraint have been used for a residential care recipient to the extent possible and the alternatives to restraint that have been considered or used have been documented; and
- the restraint used is the least restrictive form of restraint possible; and
- informed consent was received from a residential care recipient or their representative before use of the restraint; and
- the care and services plan of a residential care recipient identifies the behaviours that are relevant to the need for restraint, that the alternatives to restraint have been used (if any), the reasons the restraint is necessary and the care to be provided in relation to the behaviour; and
- the restraint is being used for the minimum time necessary; and
- while a residential care recipient is subject to the restraint, they will be regularly monitored for signs of distress and harm, and the necessity for the restraint will be monitored and reviewed;

then, if the approved provider were to use a physical restraint on a residential care recipient, this would not be considered a reportable incident for the purposes of the SIRS.

Similarly, in relation to use of chemical restraint, if an approved provider of a transition care program is satisfied that:

- a medical practitioner or nurse practitioner has assessed a residential care recipient as requiring chemical restraint and has prescribed the medication for the purposes of restraint; and
- the decision to use restraint is documented in a residential care recipient's care and services plan; and
- the residential care recipient's representative is informed of the use of restraint; and
- the provider regularly monitors the residential care recipient and records information in their care and services plan

then, if the approved provider were to use chemical restraint on a residential care recipient, this would not be a reportable incident for the purposes of the SIRS.

New subsection 15NB(3) provides that, despite the list of reportable incidents at subsection 54-3(2) of the Aged Care Act, an incident is not a reportable incident if the incident results from the residential care recipient deciding to refuse to receive care or services offered by the approved provider. For example, if a residential care recipient

refuses to shower, or if a residential care recipient with diabetes refuses to eat a diabetic diet and as a result develops a wound with a poor healing prognosis.

It is important for approved providers and their staff members to maintain the rights of residential care recipients, including their autonomy and choice. However, an approved provider and their staff members remain responsible for ensuring choices made by care recipients are informed, that any tension between refusal of care and services and professional or legal obligations are managed, and that any relevant discussions and consideration are appropriately documented (for example, in the individual's care plan).

New section 15NC – Approved provider must notify reportable incidents in accordance with this Division

New section 15NC provides that an approved provider must take all reasonable steps to ensure that reportable incidents are notified to the Commissioner in accordance with this Division.

New section 15ND – Approved provider must ensure that staff members notify reportable incidents

New section 15ND provides that an approved provider must ensure that a staff member of the provider who becomes aware of a reportable incident notifies one of the following of that fact as soon as possible:

- one of the provider's key personnel;
- a supervisor or manager of the staff member;
- the person specified for the purposes of 15MB(1)(c), which is the person who is responsible to give notice to the Commissioner of a reportable incident.

New section 15NE – Priority 1 notice must be given within 24 hours

New subsection 15NE(1) provides that if an approved provider becomes aware of a reportable incident, and the provider has reasonable grounds to believe the incident is a priority 1 reportable incident, the provider must give the Commissioner a notice (a priority 1 notice) in accordance with new subsection 15NE(3) (explained below) within 24 hours of becoming aware of the reportable incident.

The note following new subsection 15NE(1) clarifies that notice about certain incidents is not required and refers to new section 15NG, which sets out circumstances where a notice is not required.

New subsection 15NE(2) defines a 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 residential care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve.

This includes physical injury or illness requiring onsite medical or psychological treatment, for example applying an ice pack to a bruise, elevating a limb to reduce swelling, or escalation to a residential care recipient's medical officer for review. Other examples include the need for a residential care recipient to be offered specific emotional support as a result of the incident, or be involved in an onsite or offsite counselling session.

The phrase ‘could reasonably have been expected to have caused’ is included to account for circumstances where an incident involves conduct that is not acceptable and would ordinarily cause physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, even though the conduct may not have had such effect in the circumstances of that specific incident. For example, where a staff member sexually penetrates a residential care recipient with an object, which would ordinarily be traumatic for a person, with psychological intervention recommended, although in this circumstance the residential care recipient did not display psychological or emotional distress because their level of cognitive function did not enable them to either register the incident or communicate its impact. Although that residential care recipient may not have displayed the effect of such injury or discomfort, it is intended that such incidents would be considered to be a priority 1 reportable incident for the purposes of the SIRS.

A priority 1 reportable incident is also where there are reasonable grounds to report the incident to police.

Unexpected deaths of a residential care recipient or unexplained absences of the residential care recipient from the residential care services of the provider under paragraphs 54-3(2)(d) or (h) of the Aged Care Act are also priority 1 reportable incidents.

Information to be included in notice

New subsection 15NE(3) provides that subject to new subsection 15NE(4) (explained below), the priority 1 notice must include the following information about the reportable incident:

- the name and contact details of the approved provider;
- a description of the reportable incident including the kind of reportable incident, the harm that was caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and, if known, the consequences of that harm;
- the immediate actions taken in response to the reportable incident, including actions taken to ensure the safety, health, and well-being of the residential care recipients affected by the incident and whether the incident has been reported to police or any other body;
- any further actions proposed to be taken in response to the reportable incident;
- the name, position and contact details of the person giving the notice;
- if known, the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
- the names of the persons directly involved in the reportable incident;
- if known, or the extent to which it is known, the level of cognition of the residential care recipients directly involved in the reportable incident (any temporary or permanent medical or diagnosed condition/s which change or affect memory, thinking insight or judgement of the residential care recipient; for example no impairment, mild impairment, moderate impairment or severe impairment, which may include, but not be exclusive of, dementia, delirium, psychosis, intellectual disability).

Under new subsection 15NE(4) the approved provider is not required to include information in the priority 1 notice if that information is not available within 24 hours.

Additional information

New subsection 15NE(5) provides that the approved provider must give the Commissioner a notice, including the following information about the reportable incident, within five days after the start of the 24 hours, or within a different period that the Commissioner determines under new subsection 95C(1) of the Quality and Safety Commission Rules (see item 3 of the Instrument, explained below):

- any information required by new subsection 15NE(3), not provided in the priority 1 notice;
- any further information specified by the Commissioner under new subsection 95C(1) of the Quality and Safety Commission Rules.

New subsection 15NE(6) provides that the approved provider is not required to give a notice to the Commissioner under new subsection 15NE(5) if the Commissioner decides otherwise under new subsection 95C(1) of the Quality and Safety Commission Rules.

Form of notices

New subsection 15NE(7) provides that a notice given under new section 15NE must be in writing and in the approved form.

The note following new subsection 15NE(7) clarifies that the Commissioner must approve forms for the purposes of this Division, and refers to new section 95F (see item 3 of the Instrument, explained below) of the Quality and Safety Commission Rules, which sets out the requirements for the making of approved forms.

New section 15NF –Priority 2 notice must be given within 30 days

New subsection 15NF(1) provides that if an approved provider becomes aware of a reportable incident and the approved provider has not given a notice under new section 15NE, regarding priority 1 reportable incidents, the provider must give the Commissioner a notice (a priority 2 notice) in accordance with new subsection 15NF(2) (explained below) within 30 days of becoming aware of the incident. This means that where an approved provider becomes aware of a reportable incident that is not a priority 1 reportable incident, in that it does not cause, or could not reasonably have been expected to have caused, a residential care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, it is a priority 2 reportable incident.

The note following new subsection 15NF(1) clarifies that notice about certain incidents is not required and refers to new section 15NG, which sets out circumstances where a notice is not required.

New subsection 15NF(2) provides that the priority 2 notice must include the following information about the reportable incident:

- the name and contact details of the approved provider;
- a description of the reportable incident including the kind of reportable incident, the harm that was caused (or that could reasonably have been

- expected to have been caused) to each person affected by the incident and, if known, the consequences of that harm;
- the actions taken in response to the reportable incident, including actions taken to ensure the safety, health and well-being of the residential care recipients affected by the incident and whether the incident has been reported to police or any other body;
 - any further actions proposed to be taken in response to the reportable incident;
 - the name, position and contact details of the person giving the notice;
 - if known, the time, date and place at which the reportable incident occurred or was alleged or suspected to have occurred;
 - the names of the persons directly involved in the reportable incident;
 - if known, the level of cognition of residential care recipients directly involved in the reportable incident.

Additional information

New subsection 15NF(3) provides that if under new subsection 95C(2) of the Quality and Safety Commission Rules (see item 3 of the Instrument, explained below), the Commissioner requires the approved provider to give a notice including specified further information about the reportable incident within a specified period, the provider must give the Commissioner a notice including that information with the specified period.

Form of notices

New subsection 15NF(4) provides that a notice given for the purposes of new section 15NF, must be made in writing and in the approved form.

The note following new subsection 15NF(4) clarifies that the Commissioner must approve forms for the purposes of this Division, and refers to new section 95F (see item 3 of the Instrument, explained below) of the Quality and Safety Commission Rules, which sets out the requirements for the making of approved forms.

Application

New subsection 15NF(5) provides that new section 15NF applies to an incident that an approved provider becomes aware of on or after 1 October 2021. This is because under the SIRS, mandatory reporting will commence in two tranches:

- the first tranche provides for the reporting of priority 1 reportable incidents from 1 April 2021; and
- the second tranche provides for the reporting of priority 2 reportable incidents from 1 October 2021.

New section 15NG – Reporting not required in certain circumstances

New section 15NG provides that despite new sections 15NE and 15NF, which outline how and when an approved provider should provide a notice to the Commissioner about a reportable incident, the provider is not required to give a notice to the Commissioner about a reportable incident if the Commissioner has decided that the approved provider is not required to report the incident under new section 95D of the Quality and Safety Commission Rules (see item 3 of the Instrument, explained below). New section 95D provides that the Commissioner may decide that an

approved provider is not required to report a specified reportable incident if the Commissioner is satisfied of certain criteria.

New section 15NH – Significant new information must be notified

New subsection 15NH provides that an approved provider must notify the Commissioner of significant new information relating to a reportable incident as soon as reasonably practicable after becoming aware of the information if:

- the provider notifies the Commissioner of a reportable incident under new sections 15NE or 15NF, which outline how and when an approved provider gives a notice the Commissioner of a reportable incident; and
- the provider later becomes aware of significant new information.

New subsection 15NH(2) provides the notification must be made in writing and in the approved form.

Examples of significant new information relating to a reportable incident may include:

- where the level of harm to a residential care recipient is more significant than originally thought, for example:
 - where an injury was originally assessed to be minor bruising when reported, although it has now been determined that there is a broken bone;
 - where the harassment of a residential care recipient was originally reported to have caused no harm, although due to the trauma it is later found to have caused a significant psychological injury on a residential care recipient; or
 - where a residential care recipient later dies from injuries sustained from the incident.
- where it is later determined that the incident is another kind of reportable incident, for example:
 - the incident was originally reported as neglect of a residential care recipient, although the neglect has led to the death of the residential care recipient so it would now also be considered unexpected death;
 - the incident was originally reported as unreasonable use of force against a residential care recipient, although it is later found that there was also psychological or emotional abuse of the residential care recipient at the same time.

The note following new subsection 15NH(2) clarifies that the Commissioner must approve forms for the purposes of this new Division, and refers to new section 95F (see item 3 of the Instrument, explained below) of the Quality and Safety Commission Rules, which sets out the requirements for the making of approved forms.

New section 15NI – Final report about reportable incident must be given if required

New subsection 15NI(1) provides that, if required by the Commissioner under new subsection 95E(1) of the Quality and Safety Commission Rules (see item 3 of the Instrument), which allows the Commissioner to require a final report, an approved provider must give the Commissioner a final report about a reportable incident.

New subsection 15NI(2) provides that the final report must be provided within 84 days (60 business days, or 12 weeks) of the day the notice about incident was first given to the Commissioner under new sections 15NE or 15NF (which provide detail on when and how notices should be provided to the Commissioner) or within a different period as is specified by the Commissioner under new subsection 95E(2) of the Quality and Safety Commission Rules.

New subsection 15NI(3) provides that the final report must be made in writing, in the approved form, and contain the information specified by the Commissioner under new subsection 95E(1) of the Quality and Safety Commission Rules.

The note following new subsection 15NI(3) clarifies that the Commissioner must approve forms for the purposes of this Division, and refers to new section 95F (see item 3 of the Instrument) of the Quality and Safety Commission Rules, which sets out the requirements for the making of approved forms.

Item 2 adds new subparagraph 8(3)(d)(iv) to paragraph 8(3)(d) of Schedule 2 to the Quality of Care Principles. Schedule 2 of the Quality of Care Principles sets out the Aged Care Quality Standards, which comprise of eight individual standards. Standard 8 relates to organisational governance. Paragraph 8(3)(d) provides that the organisation should demonstrate effective risk management systems and practices. New subparagraph 8(3)(d)(iv) more explicitly states that this includes managing and preventing incidents, including use of an incident management system.

Part 2 – Amendments of the Aged Care Quality and Safety Commission Rules

Quality and Safety Commission Rules

Item 3 inserts new Part 6A after Part 6 of the Quality and Safety Commission Rules. Part 6A sets out provisions relating to incident management and prevention under the SIRS.

Item 3 specifies how the Commissioner deals with matters in relation to reportable incidents including requests for further information or a final report, requiring provider investigations, carrying out inquiries, approving forms, and other actions by the Commissioner, for example referral to police or requesting a provider to take remedial action to ensure the health, safety and well-being of residential care recipients.

It is considered reasonable that these matters be dealt with in delegated legislation as they relate to operational matters such as process and procedures. Including these arrangements in delegated legislation will allow flexibility to respond to unforeseen issues and respond to community and sector concerns in a timely manner. As these matters relate to actions taken in response to reportable incidents it is appropriate (including from a community expectations perspective) that there is flexibility for the Commissioner to take appropriate and prompt action in response to any unforeseen matters. It is intended that the Australian Government's ability to undertake such actions will prevent abuse and neglect of residential care recipients.

Existing delegation arrangements under subsection 76(1) of the Quality and Safety Commission Act will apply in relation to the Commissioner's new powers and functions under new sections 95C, 95D, 95E, 95F, 95G and 95H inserted by this Item. Under subsection 76(1) of the Quality and Safety Commission Act, the Commissioner may delegate to a member of staff of the Commission all or any of the Commissioner's functions or powers under the rules. Subsection 76(1B) of the Quality and Safety Commission Act provides that the Commissioner is not able to delegate a function or power under subsection 76(1), unless the Commissioner is satisfied that a person has suitable training or experience to properly perform the function or exercise the power. As such, the Commissioner is expressly required to be satisfied that a delegate has suitable training or experience to exercise the relevant powers and functions.

The delegation of these powers is necessary to effectively and efficiently manage the work of the Commission and ensure the quality of Commonwealth funded aged care services and the safety of individuals in care. The new powers introduced by this Item may be delegated to appropriate officers in the Commission in accordance with the existing arrangements under the Quality and Safety Commission Act.

Personal information acquired under Part 6A of the Commission Rules is protected by the protection of information provisions in Part 6.2 of the Aged Care Act and the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act.

New Division 1 introduces the requirements for the SIRS by setting out a simplified outline.

New section 95A – Simplified outline of this Part

Provides a simplified outline for new Part 6A of the Quality and Safety Commission Rules.

New Division 2 sets out the Commissioner's powers and functions in relation to reportable incidents for the purposes of the SIRS.

Subdivision A sets out the purpose of new Division 2.

New section 95B – Purpose of this Division

New section 95B provides that new Division 2 of the Quality and Safety Commission Rules is made for the purposes of subsections 21(1) and (7) of the Quality and Safety Commission Act.

Subdivision B sets out the Commissioner's powers in relation to reportable incidents, including in relation to the approved provider's obligation to give notices about reportable incidents to the Commissioner, and providing for the Commissioner to approve forms for notifications and reports of reportable incidents.

New section 95C – Commissioners powers relating to notices about reportable incidents

Priority 1

New subsection 95C(1) provides that, in relation to a notice about a priority 1 reportable incident required to be given by an approved provider under new

subsection 15NE(5) of the Quality of Care Principles (see Item 1 of the Instrument, explained above, which relates to the additional information an approved provider must give to the Commissioner about a priority 1 reportable incident), the Commissioner may do any of the following:

- require the provider to include in the notice specified further information that the Commissioner requires to deal with the reportable incident;
- require the provider to give the notice within a specified period (which may be more or less than 5 days);
- decide that the provider is not required to give the Commissioner a notice about the reportable incident under that subsection.

Priority 2

New subsection 95C(2) provides that if an approved provider gives a priority 2 notice about a reportable incident under new subsection 15NF(1) of the Quality of Care Principles (see Item 1 of the Instrument, explained above), which outlines how and when the provider must give the Commissioner a notice about a priority 2 reportable incident, the Commissioner may require the approved provider to give the Commissioner, within a specified period, a notice under new subsection 15NF(3) (see Item 1 of the Instrument, explained above), that includes specified further information that the Commissioner requires to deal with the reportable incident.

Notice of decision

New subsection 95C(3) provides that the Commissioner must give the approved provider written notice of a decision under this section as soon as practicable after making the decision.

When making a decision to request additional information under new subsections 95C(1) and (2), the Commissioner may consider factors including:

- whether there is information that was not provided in the first notice; or
- other matters such as whether:
 - additional information would assist the Commissioner to better understand the circumstances of the incident
 - appropriate action has been taken in relation to the incident.

When specifying the period within which this information is provided, the Commissioner will make an assessment of the impact of timing. For example, the Commissioner may decide on a shorter timeframe if there is a high risk of harm to residential care recipients if this information is not received and acted upon quickly. This discretion is needed to ensure that appropriate and proportionate actions are taken in relation to each incident, as the implications and seriousness of obtaining such further information will vary depending on the individual circumstances.

New section 95D – Commissioner may decide certain reportable incidents not required to be notified

New section 95D provides that the Commissioner may decide that an approved provider is not required give a notice under new sections 15NE or 15NF of the Quality of Care Principles (see Item 1 of the Instrument, explained above) about a specified reportable incident if the Commissioner is satisfied that the same incident has been repeatedly alleged by a residential care recipient to have occurred; and the

allegation is the result of a delusion of the residential care recipient (which has been diagnosed and documented).

For example, where a residential aged care recipient with dementia regularly reports the same incidents to staff members based on delusions, the Commissioner may decide that these are not reportable incidents where the approved provider can provide evidence that the behaviour is related to a cognitive impairment.

When making a decision to not require certain reportable incidents to be notified, the Commissioner will consider the evidence provided by the approved provider and determine whether they can be satisfied that a residential care recipient has a cognitive impairment that would result in repetitive delusions of a very similar nature. The Commissioner will also make an assessment of the likelihood that repetitive allegations may be delusions depending on the circumstances of the case.

New section 95E - Commissioner may require final report on reportable incident

New section 95E provides that if an approved provider gives a notice under new sections 15NE or 15NF of the Quality of Care Principles (see Item 1 of the Instrument, explained above), which outline how and when the provider should give the Commissioner a notice about a reportable incident, the Commissioner may require an approved provider to give the Commissioner a final report containing specified information about the reportable incident. The Commissioner may specify the period in which the report is to be provided, which may be greater or less than the period in paragraph 15NI(2)(b) of the Quality of Care Principles (see Item 1 of the Instrument, explained above), which requires the report within 84 days (60 business days, or 12 weeks) of the day the Commissioner was first notified of incident.

When deciding whether and when to require a final report the Commissioner will consider factors such as the circumstances of the case, the seriousness of the incident (e.g. if there was significant injury), whether effective remedies were put in place when the initial report was provided, and the overall quality of care and safety of residential care recipients in the care of the relevant provider. Details required to be provided in the final report may inform the Commissioner's decision to take other actions under new section 95G or for an inquiry to be undertaken under new section 95H.

New section 95F – Approved forms

New section 95F provides that the Commissioner must, in writing, approve one or more forms for the purposes of a provision of Division 4 of Part 4B of the Quality of Care Principles that provides for something to be done in an approved form.

New Subdivision C sets out the kind of actions the Commissioner may take, or inquiries they may carry out, in dealing with reportable incidents.

New section 95G – Actions the Commissioner may take in dealing with reportable incidents

New section 95G provides that the Commissioner may, upon receiving a notice about a reportable incident given by an approved provider under section 15NE or 15NF of the Quality of Care Principles (which outline how and when an approved provider

should give the Commissioner a notice about reportable incidents), do one or more of the following:

- refer the incident to police or another body with responsibility in relation to the incident (such as a relevant State or Territory agency (e.g. Victoria State Government Department of Health and Human Services or the Government of South Australia's Office for Ageing Well), the Australian Health Practitioner Regulation Agency, or the National Disability Insurance Scheme Quality and Safeguards Commission));
- require or request the provider to undertake specified remedial action in relation to the incident within a specified period, including remedial action to ensure the safety, health and well-being of residential care recipients affected by the incident;
- require the provider to carry out an internal investigation into the incident, in the manner and within the period specified by the Commissioner, and give the Commissioner a report on the investigation;
- require the provider to engage an appropriately qualified and independent expert, for example a practicing or retired geriatric physician or an eminent person with expertise in and knowledge of residential aged care, at the expense of the provider, to carry out an investigation into the incident, in the manner and within the period specified by the Commissioner and give the Commissioner a report on the investigation;
- carry out an inquiry in relation to the incident in accordance with new section 95H of the Quality and Safety Commission Rules (explained below);
- take any other action to deal with the reportable incident that the Commissioner considers reasonable in the circumstances.

New subsection 95G(2) provides that if a reportable incident is investigated, the Commissioner may take any action to deal with the outcome of the investigation that the Commissioner considers appropriate.

When deciding whether to take actions in dealing with reportable incidents the Commissioner will consider factors such as the circumstances of the case, the seriousness of the incident (e.g. if there was significant injury), whether effective remedies were put in place when the initial report was provided, and the overall quality of care and safety of residential care recipients in the care of the relevant provider.

New section 95H – Commissioner's inquiries in relation to reportable incidents

New subsection 95H(1) provides that the Commissioner may inquire into any of the following:

- a reportable incident;
- a series of reportable incidents that relate to the aged care provided by one or more approved providers; or
- the compliance of one or more approved providers with Division 4 of Part 4B of the Quality of Care Principles (see Item 1 of the Instrument, explained above), which relates to reportable incidents under the SIRS.

New subsections 95H(2) and (3) provide that the inquiry may be carried out regardless of whether or not the Commissioner has been notified of any of the

reportable incidents by the approved provider, and that the inquiry may be carried out as the Commissioner sees fit.

New subsection 95H(4) provides that without limiting new subsection 95H(3), the Commissioner may consult with other persons, organisations and governments on matters relating to the inquiry. The Commissioner may also request information that is relevant to the inquiry from any person, and provide opportunities for residential care recipients to participate in the inquiry.

New subsection 95H(5) provides that the Commissioner may prepare and publish a report setting out the Commissioner's findings in relation to the inquiry.

When deciding to undertake an inquiry into a reportable incident or a series of reportable incidents, the Commissioner may consider the factors such as the circumstances of the case or cases, the seriousness of the incidents (e.g. if there was significant injury), whether effective remedies were put in place when the initial report was provided, and the overall quality of care and safety of residential care recipients in the care of the relevant provider.

New section 95J – Taking of other action not prevented by this Part

New subsection 95J(1) provides that new Part 6A of the Quality and Safety Commission Rules (this Part, regarding incident management and prevention) does not prevent the Commissioner from taking action under the Quality and Safety Commission Act in relation to:

- an incident, including a reportable incident, or
- information received by the Commissioner under this new Part or new Part 4B of the Quality of Care Principles (see Item 1 of the Instrument, explained above).

New subsection 95J(2) provides that this new Part does not prevent the Commonwealth from taking action under a funding agreement that relates to a Commonwealth-funded aged care service in relation to an incident (including a reportable incident) or information received by the Commissioner under this new Part or new Part 4B of the Quality of Care Principles (see Item 1 of the Instrument, explained above).

New section 95J makes it clear that the Commissioner and the Commonwealth are able to take compliance and or enforcement action regardless of any other action taken (or not taken) under the new provisions in the Instrument.

Part 3 – Consequential amendments ***Accountability Principles***

Item 4 repeals paragraph (d) of the note to the heading of section 4 of the Accountability Principles. Section 4 of the Accountability Principles defines certain terms used in the Accountability Principles. The note to the heading of section 4 of the Accountability Principles clarifies that a number of expressions used in the Accountability Principles are defined in the Aged Care Act, and includes a list of these terms. Paragraph (d) is the term 'reportable assault' and is repealed, as this term

was repealed from the Aged Care Act by the Serious Incident Response Scheme and Other Measures Act.

Item 5 repeals Part 7 to the Accountability Principles. Part 7 specifies circumstances in which the requirement to report an allegation or suspicion of a reportable assault does not apply, specifically where the assault was committed by a care recipient with a cognitive or mental impairment. The enabling provision for this provision, section 63-1AA of the Aged Care Act, was repealed by the Serious Incident Response Scheme and Other Measures Act and this exemption does not apply under the new SIRS arrangements.

Quality and Safety Commission Rules

Item 6 inserts ‘residential care recipient’ as a new defined term in section 4 of the Quality and Safety Commission Rules, which includes other defined terms used in the Quality and Safety Commission Rules. Item 6 provides that ‘residential care recipient’ has the same meaning as in the Aged Care Act.

Item 7 inserts the phrase ‘or section 74EB, 74EC, 74ED or 74EE’ after the phrase ‘Part 7B’ in paragraph 17(1)(d) of the Quality and Safety Commission Rules. Subsection 17(1) of the Quality and Safety Commission Rules sets out circumstances that the Commissioner must be satisfied of before deciding to end a resolution process in relation to an issues raised in a compliant or through provider responsibility information. Paragraph 17(1)(d) provides that a decision can be made to end a resolution process if the relevant provider for the issue is the approved provider of an aged care services and the Commissioner has initiated action under Part 7B of the Commission Act that related to the issue. Item 7 extends these arrangements so that the Commission may also end a resolution process if the relevant provider for the issue is an approved provider of aged care services and the Commission has initiated action under:

- section 74EB regarding infringement notices;
- section 74EC regarding enforceable undertakings;
- section 74ED regarding injunctions; or
- section 74EE regarding compliance notices.

Sections 74EB, 74EC, 74ED and 74EE were inserted in the Quality and Safety Commission Act by the Serious Incident Response Scheme and Other Measures Act.

Item 8 inserts the phrase ‘or Part 8A’ after the phrase ‘Part 7B’ in note 1 following subsection 21(2) of the Quality and Safety Commission Rules. Sections 19 to 21 of the Quality and Safety Commission Rules allow for the Commissioner to issue directions to relevant providers as part of a complaint resolution process or in relation to provider responsibility information. Note 1 that follows subsection 21(2) of the Quality and Safety Commission Rules clarifies that if the provider fails to comply with the direction the Commissioner may initiate action under Part 7B of the Quality and Safety Commission Act. Item 8 extends this note to also include Part 8A of the Quality and Safety Commission Act which includes a number of enforcement powers that were inserted in the Quality and Safety Commission Act by the Serious Incident Response Scheme and Other Measures Act.

Item 9 omits the phrase ‘Part 7B of’ from subsection 23(1) to the Quality and Safety Commission Rules. Subsection 23(1) refers to other actions that could be taken by the Commissioner, although this is limited to actions under Part 7B of the Quality and Safety Commission Act, which outlines the sanctions for non-compliance with aged care responsibilities of approved providers. The reference to Part 7B is removed so that the actions the Commissioner may take are extended to the new powers introduced by the Serious Incident Response Scheme and Other Measures Act.

Quality of Care Principles

Item 10 inserts new paragraphs (c), (d) and (e) to the note to the heading of section 4 of the Quality of Care Principles. Section 4 of the Quality of Care Principles defines certain terms used in the Quality of Care Principles. The note to the heading of section 4 of the Quality of Care Principles clarifies that a number of expressions used in the Quality of Care Principles are defined in the Aged Care Act, and includes a list of these terms. New paragraphs (c), (d) and (e) add the terms ‘reportable incident’, ‘residential care recipient’, and ‘staff member’ to the list of terms. These are new terms used in the context of the new SIRS arrangements and were inserted in the Aged Care Act by the Serious Incident Response Scheme and Other Measures Act.

Item 11 inserts new defined terms in section 4 of the Quality of Care Principles. Section 4 of the Quality of Care Principles defines certain terms used in the Quality of Care Principles. Item 6 inserts the terms Quality and Safety Commission Rules, which means the rules made under the Quality and Safety Commission Act and priority 1 reportable incident which has the meaning given by new section 15NE of the Quality of Care Principles.

Records Principles

Item 12 repeals section 8 to the Records Principles. Section 8 provides that an approved provider must keep consolidated records of all incidents involving allegations or suspicions of reportable assaults and what a record for each incident must include. This section is repealed as the new SIRS replaces the reportable assault arrangements (see new subsection 15MC(3) of the Quality of Care Principles to be inserted by item 1 above).

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021

This legislative instrument is compatible with human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Instrument

The purpose of the *Aged Care Legislation Amendment (Serious Incident Response Scheme) Instrument 2021* (Instrument) is to prescribe arrangements relating to the Serious Incident Response Scheme (SIRS) in residential aged care, including flexible care delivered in a residential aged care setting. This includes arrangements relating to an approved provider's responsibility to manage incidents and take reasonable steps to prevent incidents. The Instrument includes arrangements on the implementation and maintenance of incident management systems including the notification and management of reportable incidents by approved providers. The Instrument also makes consequential amendments to legislative instruments made under the authority of the *Aged Care Act 1997* (Aged Care Act) and the *Aged Care Quality and Safety Commission Act 2018* (Quality and Safety Commission Act) as a result of the SIRS replacing the current reportable assault arrangements. Consequential amendments are also made in relation to the new enforcement powers of the Aged Care Quality and Safety Commissioner (Commissioner).

Human rights implications

The instrument engages the following rights:

- the right to protection from exploitation, violence and abuse – Article 16 of the *Convention on the Rights of Persons with Disabilities* (CRPD),
- the right to an adequate standard of living – Article 11(1) of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), and Article 28 of the CRPD,
- the right to health – Article 12(1) of the ICESCR, and Article 25 of the CRPD,
- the right not to be subjected to cruel, inhuman or degrading treatment – Article 7 of the *International Covenant on Civil and Political Rights* (ICCPR), and Article 15 of the CRPD, and
- the right to privacy – Article 17 of the ICCPR.

Right to protection from exploitation, violence and abuse

The Instrument engages the right to protection from exploitation, violence and abuse in Article 16 of the CRPD by implementing measures to protect aged care recipients, who may have impediments to their full and effective participation in society.

The Instrument requires effective management, response to and resolution of incidents affecting the health and welfare of vulnerable aged care recipients. This reflects that the Australian Government has no tolerance for abuse and neglect in aged care.

The Instrument requires that reportable incidents including physical, sexual, psychological or emotional abuse, inappropriate physical or chemical restraint and neglect to be reported to the Aged Care Quality and Safety Commissioner (Commissioner). Stealing or financial coercion by a staff member, unexpected deaths and unexplained absences from care are also reportable incidents. The Instrument promotes Article 16 of the CRPD by implementing measures to protect aged care recipients, who may have impediments to their full and effective participation in society, from exploitation, violence and abuse.

The Instrument's requirement for aged care providers to identify, manage and resolve incidents of abuse and neglect suffered by aged care recipients also promotes Article 16 of the CRPD. The Instrument provides arrangements that will require aged care providers to implement appropriate measures to respond to incidents, including promoting the physical, cognitive and psychological recovery of persons in residential aged care who become victims of exploitation, violence or abuse. The requirements relating to incident management and reportable incidents implement the commitment for effective legislation to ensure that such instances of exploitation, violence and abuse are identified, investigated, managed and prevented from occurring in future.

Right to an adequate standard of living

The Instrument also engages the right to an adequate standard of living under Article 11(1) of ICESCR and Article 28 of the CRPD. The Instrument introduces arrangements that promote the right to an adequate standard of living by taking steps to reduce the instance of abuse occurring in residential aged care settings. The SIRS will strengthen measures to prevent infringement of the quality of care provided to aged care recipients. Under the SIRS additional measures are introduced to respond to, learn from and prevent incidents from reoccurring. The Instrument promotes the right to an adequate standard of living by aiming to reduce the occurrence of incidents, therefore providing continuous improvement of living conditions for individuals in residential aged care.

Right to health

The Instrument also engages the right to health under Article 12 of the ICESCR and Article 25 of the CRPD. These articles refer to the right of individuals to the highest attainable standard of physical and mental health. The Instrument promotes the right to health by providing greater protections to the physical and mental health of individuals in residential aged care. The SIRS will expand reporting requirements to broader instances of abuse and neglect and will introduce more robust requirements for governance systems to ensure better reporting, management and prevention of instances of abuse and neglect in residential aged care environments.

Right not to be subjected to cruel, inhuman or degrading treatment

The Instrument also engages the right not to be subjected to cruel, inhuman or degrading treatment under Article 15 of the CRPD and Article 7 of the ICCPR. The arrangements in the Instrument requiring approved providers to identify, manage and resolve abuse or neglect of aged care recipients promote Article 15 of the CRPD and Article 7 of the ICCPR by ensuring such people are not subjected to cruel, inhuman or degrading treatment.

Under the Instrument, an approved provider has a responsibility to manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system. Regardless of whether an incident is alleged, suspected or a known occurrence, these incidents must be managed, and reasonable steps taken to ensure resolution. In addition, serious incidents are reportable to the regulator, and where the incident is criminal in nature, to police. This promotes Article 15 of the CRPD and Article 7 of the ICCPR by ensuring that individuals subjected to cruel, inhuman or degrading treatment have their case promptly, impartially examined by competent authorities.

The Instrument also engages Article 15 of the CRPD and Article 7 of the ICCPR in relation to arrangements for reportable incidents that involve use of physical restraint or chemical restraint. Under paragraph 54-3(2)(g) of the Aged Care Act use of physical restraint or chemical restraint in relation to a residential care recipient (other than in circumstances set out in the Quality of Care Principles) is a reportable incident.

Sections 15F and 15G of the *Quality of Care Principles 2014* (Quality of Care Principles) set out the responsibilities in relation to use of restraint. This means that under the Aged Care Act the only use of physical or chemical restraint that is not a reportable incident is use of restraint consistent with sections 15F and 15G of the Quality of Care Principles. However, these arrangements only apply to approved providers of residential aged care or approved providers of short-term restorative care in a residential aged care setting and not approved providers of a transition care program delivered in a residential aged care setting (TCP).

The Instrument introduces arrangements so that if a provider of a TCP uses physical or chemical restraint, and that use is consistent with arrangements under sections 15F and 15G of the Quality of Care Principles (if those arrangements were to apply to an approved provider of a TCP) then that use of restraint is not a reportable incident. Inadvertently this exemption may imply what is considered ‘appropriate’ use of physical restraint or chemical restraint for an approved provider of a TCP.

However, while it is arguable that these rights are engaged by the Instrument, the rights are not limited because currently there is only a general expectation that use of restraint be minimised within a TCP. Therefore the arrangements in the Instrument could instead be seen as introducing additional restrictions on the use of restraints rather than including any new authorisation for use. The Instrument does not introduce a permission to use restraint. The Instrument regulates the reporting of what is considered inappropriate use of restraint (reportable incidents). To the extent that the exemption for approved providers of a TCP may be inferred as imposing restrictions on use of restraint, it would also be imposing safeguards and conditions on the appropriate use of restraint, therefore promoting the rights of residential care recipients.

Further, it is important to note that under aged care law there is no exception which authorises the use of restraint where it is otherwise unlawful. Restraint is only ever appropriate as a last resort or in an emergency situation and where, if not restrained, the residential care recipient would likely cause harm to themselves or another person,

which promotes other rights including the right to protection from exploitation, violence and abuse and the right to health.

Right to privacy

The Instrument also engages the right to privacy under Article 17 of the ICCPR. The arrangements under the Instrument require approved providers of residential aged care to collect and store information about incidents and to include a subset of this information (about reportable incidents) in notifications to the Commissioner. The Commissioner will review and store information they are notified of and may also access information collected by approved providers for the purposes of their compliance and monitoring functions. Article 17 of the ICCPR states that no person should be subject to interference with their privacy. As the Instrument will authorise the handling of personal information, some of which is sensitive, this right is engaged.

To the extent that handling of personal information under the Instrument may limit this right, existing arrangements protect this right by ensuring personal information acquired is protected. Personal information handled under the Instrument is subject to the protection of information provisions in Part 6.2 of the Aged Care Act, and the information sharing and confidentiality provisions in Part 7 of the Quality and Safety Commission Act. The existing harsh penalties for misuse of protected information will protect and ensure safe handling of the personal information that is collected. Approved providers also have a responsibility to protect a care recipient's personal information under section 62-1 of the Aged Care Act.

The collection and use of personal information under the Instrument is reasonable, necessary and proportionate. The personal information collected under this Instrument is to be used by providers to identify systemic issues and make improvement in their management of incidents, which in turn further promotes the right to health, the right not to be subjected to cruel, inhuman or degrading treatment, and the right to protection from exploitation, violence and abuse by reducing the instance of abuse and neglect of vulnerable older Australians. The Commissioner will also use information received through notifications and investigation and monitoring to focus capability uplift, and to intervene in circumstances to protect individuals from abuse and neglect, also promoting these rights.

In addition, the Instrument requires approved providers to store the information collected on incidents for a period of seven years. If incidents result in civil and criminal proceedings, this period will ensure evidence is kept long enough, given the length of time proceedings tend to take. This promotes the right to effective remedy under Article 2(3) of the ICCPR, by ensuring there is evidence to provide justice and to support a fair hearing for individuals subjected to abuse and neglect.

Conclusion

The Instrument is consistent with human rights because it promotes the protection of human rights of aged care recipients by implementing measures to ensure greater protection from exploitation, violence, abuse and cruel, inhuman or degrading treatment. The Instrument also implements measures aimed at ensuring individuals in residential aged care have the highest attainable standard of physical and mental health and adequate standard of living free from neglect and abuse. To the extent that

the Instrument may limit the right to privacy, this limitation is reasonable, necessary and proportionate to uphold other rights and protect vulnerable individuals.

**Circulated by the authority of the
Minister for Senior Australians and Aged Care Services,
Senator the Hon Richard Colbeck**