Australian Nursing and Midwifery Federation submission to the

SERIOUS INCIDENT RESPONSE SCHEME FOR IN-HOME AGED CARE SERVICES

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 300,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

With regard to care of older people, ANMF members work across all settings in which aged care is delivered, including over 40,000 members who are currently employed directly in the aged care sector. Many more of our members are involved in the provision of health care for older persons who move across sectors (acute, residential, community and in-in-home care), depending on their health needs. Being at the forefront of aged care, and caring for older people over the twenty-four hour period in acute care, residential facilities and the community, our members are in a prime position to make clear recommendations to improve the care provided and enhance processes for access to that care.

The ANMF welcomes the opportunity to provide feedback on the consultation for the Serious Incident Response Scheme (SIRS) for Commonwealth funded in-home aged care services. The ANMF has keenly engaged in the consultation and implementation of the SIRS for residential care and supports the expansion of the scheme to include in-home aged care delivery. People have the right to be treated with respect and dignity, whether they are being cared for in their own homes, a community setting, acute or residential aged care.[1]

The Royal Commission into Aged Care Quality and Safety, *Final Report: Care Dignity and Respect* outlined that there is an unacceptably high level of neglect and abuse in residential care. The report suggests that it is estimated there were between 32,193 and 44,131 alleged assaults in 2018-2019 and the alleged incidents of unlawful sexual contact could be as high as 2,520 in the 2018-2019 period.[2] Alarmingly, the data regarding neglect and abuse within in-home care is even less available and transparent. It is therefore essential for public safety that the SIRS is implemented for in-home care delivery. This scheme will not only ensure providers have structured governance and reporting systems in place but it will also enable the Aged Care Quality and Safety Commission (the Commission) to monitor and oversee in-home care providers response to managing serious incidents.

Whilst the ANMF supports the SIRS, it must be acknowledged that as long as the significant issues with staffing workloads and skills mix in aged care are neglected, any serious incident reporting process implemented in aged care in-home services is not going to be manageable. ANMF members have described at length the ongoing issues and impact SIRS has created on their workloads in residential care. They have experienced less time to care for residents in an already understaffed environment as outlined by the Commission in their final report.[3] A SIRS for in-home care must include an element that requires approved providers to allocate protected additional staff time to complete the reporting and to ensure further reporting requirements do not take the nurse or care worker away from their direct care responsibilities.

In addition to the above mentioned essential staffing required for the Scheme, the ANMF recommends that for the system to work effectively it must also be consistent with the following principles:

- Serious incidents must be reported and managed safely irrespective of the context of the care being delivered;
- The workforce must be supported and trained to understand how to assess and provide immediate management of any identified serious incident and the associated reporting requirements;
- Individuals receiving care are made aware of the SIRS and understand that they can report an incident directly to the Commission at any time;
- The workforce can directly report an incident to the Commission when required;
- Nurses and care workers should feel safe, supported and protected in reporting an incident;
- The workforce is engaged in reviewing incidents and provided with ongoing education and support where required;

- The SIRS assessment and monitoring, at both a provider and Commission level, must consider the context in which the incident occurred, including systemic influences, such as the number of nurses and care workers allocated to provide all elements of assessed care;
- The Commission has a system which not only elicits information on serious incidents, but focusses on actions, outcomes and open disclosure[4], to effectively deliver a safety agenda of continuous improvement rather than blame for the aged care sector.

With the above principles being included as the basis of a SIRS for in-home care, the ANMF supports Option 2 of the KPMG's final report, *Improving Aged Care Quality Protections: Options for a Serious Incident Response Scheme (SIRS) in home and community aged care* outlined in the consultation paper.

This option states:

SIRS for residential aged care is implemented in the home and community care setting with amendments to acknowledge the different care setting.

Questions

1. **I consent to the Department collecting the information requested in Citizen Space about me, including any sensitive information, for the purposes indicated above.**

   Yes, the ANMF consents to the Department collecting the information requested.

2. **Do you give consent for your submission to be published in whole or in part?**

   Yes, the ANMF provides consent for the submission to be published in whole.

3. **What is your name?**

   Annie Butler, ANMF Federal Secretary.

4. **If you are submitting a response on behalf of an organisation, what is your organisation's name?**

   The Australian Nursing and Midwifery Federation.

5. **What stakeholder category do you most identify with?**

   Other (please specify)

   Union, professional and industrial organisation.

6. **If you are a consumer carer or consumer representative - do you, or the person/s you care for or represent, identify with or belong to one or more of the following groups?**

   N/A

7. **If you are an approved provided of in-home care services, please let us know if your organisation is:**

   N/A

8. **Where does your organisation operate (if applicable)? Otherwise, where do you live?**

   All states and territories in Australia.

Questions 9 and 10 refer to uploading the submission and have therefore not been addressed.

10. **Should the requirements described in Divisions 1 – 3 of Part 4A of the Quality of Care Principles (relating to incident management and prevention) also apply to providers of in-home services?**

The content preceding this question in the consultation paper refers to Part 4B of the Quality of Care Principles. The ANMF is presuming 4A is written in error in the question and will provide a response based on the question referring to 4B not 4A of the principles.

The consultation paper outlines the following provider responsibilities described in the Quality of Care principles:

- *manage incidents, with a focus on the safety, health and wellbeing and quality of life of care recipients;*
- *respond to incidents by taking certain actions;*
- *assess the incident;*
- *collect data relating to incidents to enable the provider to continuously improve its management and prevention of incidents;*
- *include certain procedures in its incident management system and ensure that roles and responsibilities of staff are clear in relation to the management, resolution and prevention of incidents; and*
- *keep certain records.*

The ANMF supports all of the outlined provider responsibilities being included in a SIRS for home-care as this would be consistent with the requirements for residential care. However, the emphasis of the legislation must focus on prevention of incidents as well as the effective management. A component of an effective SIRS must include an evaluation and review of processes that contributed to the incident and may be modified to prevent further serious incidents from occurring.

It is also important to note that there are many in-home care providers who may not currently have efficient incident reporting processes within their organisations. This must be established and consistently monitored. Nurses and care workers working for these providers will need further time, support and education to understand their responsibilities under the new SIRS.

11. Are there any adjustments that need to be made to these requirements to reflect the different in-home services context?

There are a number of considerations which will require adjustment to the context of an in-home care SIRS. Inadequate staffing is a core issue contributing to the risk of serious injury or preventable death of people being cared for in aged care. The frequency of serious incidents for individuals will reduce when the staffing level and skills mix meets the assessed needs of the individual receiving care.

The workload for nurses and care workers caring for individuals in an in-home care context is often unmanageable. The ANMF has been voicing our members' concerns for many years, regarding the increasingly dire situation they experience in reduced staffing, inadequate time to care and the poor skills mix of care staff in in-home care delivery. The time allocated for each individual often does not meet the care needs and nurses and care workers find themselves alone in difficult situations, making decisions on priorities for care delivery. These situations are further compounded when a nurse or care worker is allocated to provide care for an individual who has been assessed as requiring a level 4 home care package but is only funded for a level 2 package due to delays on the wait list.

It is clear that the implementation of a SIRS in home care will impact the workload of a nurse or care worker. As previously articulated, we know these workers will require additional protected time to implement a SIRS system and then to maintain the additional reporting requirements of the scheme. Given the paucity of time already available to nurses and care workers, it is essential that the current workload concerns are considered, monitored and regulated, particularly during the implementation phase to ensure allocated staffing and skills mix are meeting the assessed needs of the individuals care requirements.

Another difference between in-home care and residential care is that the majority of in-home care delivery is provided autonomously by the nurse or care worker, often on a one to one basis. This means for a SIRS to be effective, all aged care workers employed in the sector will need to understand the reportable requirements and be well informed about a clear, accessible escalation process when an incident occurs. Aged care workers will require a culture of support and not blame to encourage reporting. The SIRS also needs to be strongly focused on a systems approach of good clinical governance, continuous improvement and evaluation to learn from serious incidents when they do occur and to assist with prevention.

12. Are the requirements for reporting to police and others (as described above) also able to be implemented for in-home services?

Notifying the police

The ANMF supports a consistent approach with the residential care SIRS which would require an in-home care provider to report an incident to the police, where there is reasonable grounds, within 24 hours of becoming aware of an incident.

Notifying other persons or bodies

As identified in the consultation paper, there are many existing protections and reporting systems in all jurisdictions that a provider may be required to use to report an incident. Examples of these include the Nursing and Midwifery Board of Australia that regulates nurses and midwives or a state and territory based elder abuse authority such as the NSW Ageing and Disability Commission.

Incidents that occur in an in-home care delivery context may not be the remit of the Commission, such as a health concern impacting a registered health practitioner's practice. It is essential these incidents are reported to the appropriate regulator. Therefore, in-home care providers must be aware of the jurisdictional reporting requirements pertinent to their service. They must also be clear about the expectations of the SIRS for in-home care, identifying when and where to report an incident. Further, the SIRS implementation messaging, should communicate that it is 'better to report, then underreport' and clearly identify the processes that follow a report being made. Creating an environment for providers who are hesitant to make a report to engage with the process is essential.

13. Should providers report incidents to police, family or other bodies without the consumer's consent, or should reports only be made with the consumer's consent?

Registered and enrolled nurses, as regulated health practitioners are required to act in accordance with professional codes and guidelines[5] including mandatory reporting requirements. Nurses are required to make a mandatory notification to the Nursing and Midwifery Board of Australia (NMBA) for four reasons: impairment; intoxication while practicing; significant departure from accepted professional standards; and sexual misconduct.[6] If a SIRS for in-home care mandates individuals receiving care must provide consent before an incident is reported and an individual did not provide consent, this may contradict the reporting requirements for regulated health practitioners.

The ANMF supports the importance of a meaningful exchange with individuals receiving care in relation to serious incident reporting. It is essential that consumers are involved and engaged in an incident. However, in cases where gaining a consumer's consent may compromise the safety of the individual or the staff member, or impede any subsequent investigation, advice should be available for nurses and care workers 24 hours a day on the most appropriate course of action.

14. Does the different in-home services context mean that there needs to be adjustments to the requirements for notifying the Commission of reportable incidents? If so, what should these adjustments be?

The ANMF agrees the proposed requirements for in-home care providers should have the same overarching responsibility to notify the Commission of reportable incidents as in residential aged care.

The ANMF also supports the governance structure outlined in the consultation paper which states the following:

> *Any person, including staff, who are concerned that the care of a consumer is being compromised, should raise their concerns directly with the provider in the first instance. If a person alerts the provider of a reportable incident, the provider will be responsible for notifying the Commission within the relevant timeframe (commencing from the time that the provider becomes aware of the reportable incident).*

However, in addition to this process, when necessary, both staff members and individuals receiving care should be able to make a report regarding an incident. A number of ANMF members have experienced situations where they believed an incident in residential care has met the criteria to be reported under the established SIRS, however the provider has assessed the incident as not meeting the criteria. This situation can be further compounded for nurses who are required to meet their regulated professional standards. Enabling all parties involved in an incident to have the opportunity to report directly to the Commission provides accessible and transparent reporting.

15. Specifically, if a provider suspects or is aware of an allegation about another provider (relating to the care of a consumer to whom both providers deliver services) should that provider be responsible for notifying the other provider, as well as the Commission?

As an individual can often have a number of providers delivering their care it can become complex with increasing numbers of staff, numbers of providers and even sub-contracted staff and providers. As is widely acknowledged, fragmented care can result in gaps in care provision and confusion of reporting responsibilities which can have serious consequences for an individual's health outcomes.

Providers should report if they are aware of an incident that meets the criteria for the SIRS. As discussed earlier, this will also require an established governance process to be in place for the provider to ensure when an incident is identified that it is managed and documented appropriately.

Further, as also outlined earlier in situations where a nurse or care workers making a report may compromise the safety of the individual or the staff member, or impede any subsequent investigation, advice should be available for nurses and care workers 24/7 on the most appropriate course of action.

16. Are there other circumstances where the Commission should not be notified of a reportable incident for in-home services?

The ANMF supports the proposed outlined incidents in the consultation paper which include:

- unreasonable use of force against the consumer;
- unlawful sexual contact, or inappropriate sexual conduct, inflicted on the consumer;
- psychological or emotional abuse of the consumer;
- unexpected death of the consumer;
- stealing from, or financial coercion of, the consumer by a staff member of the provider;
- neglect of the consumer;
- inappropriate use of restrictive practices in relation to the consumer; and
- unexplained absence of the consumer from the care of the provider.

These incidents are consistent with the residential SIRS and at this stage of the consultation there are no further additions recommended.

17. Is the definition of unreasonable use of force equally applicable in the in-home services context? If not, what adjustments are required and why?

Proposed definition:

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

The consultation paper proposes the definition for unreasonable use of force used in the established SIRS for residential care is also used in in-home care. The ANMF supports the use of this definition for consistency across residential and in-home care.

It is important to note however, when an incident of unreasonable use of force is being assessed by the provider and the Commission, it is essential that all contributing factors to the incident are considered.

High workloads impact on a worker's ability to provide care in an unhurried manner, which in turn, can increase the potential risk of rough handling reports. Some cases arise where a worker, with an unrealistic workload, may provide care that could be perceived to be rushed, resulting in an allegation of unreasonable use of force. Whilst acknowledging unreasonable use of force is never acceptable, the system impact on the staff member's care delivery must be considered and recognised as a contributory factor to the incident. Serious incident reporting must include the context and space in which the incident occurred, who was present, the staff member's report of the incident and the staffing levels. These factors are essential to fully understand a serious incident and acknowledge that accountability does not rest solely on the staff member involved but also the provider. Without this context, meaningful systemic change cannot occur to prevent the incident from recurring.

18. Is the definition of unlawful sexual conduct and inappropriate sexual conduct equally applicable in the in-home services context? If not, what adjustments are required and why?

Proposed definition:

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

The ANMF agrees with the proposed definition for unlawful sexual conduct and inappropriate sexual conduct for the residential care SIRS being used for in-home care.

19. Is the definition of psychological or emotional abuse equally applicable in the in-home services context? If not, what adjustments are required and why?

Proposed definition:

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

The proposed definition of psychological or emotional abuse used for the residential care SIRS is supported by the ANMF for use in the SIRS for in-home care.

20. Should 'unexpected death' be a reportable incident under the SIRS for in-home aged care services? If so, does the in-home services context necessitate adjustments to the proposed definition of 'unexpected death'? If so what and why?

Proposed definition:

> ***Unexpected death of the consumer includes death in circumstances where:***
>
> - ***reasonable steps were not taken by the provider to prevent the death; or***
> - ***the death is the result of:***
>   - ***care or services provided by the provider; or***
>   - ***a failure of the provider to provide care or services.***

As individuals receiving care live independently within their own home and 24 hour care delivery is not provided, unlike in residential care, it is reasonable that this definition of reporting is adjusted to be consistent with the context of care delivery.

Care delivery in this setting may not be holistic in its approach and a provider, along with other providers, may only be delivering and understand a portion of the package of care being delivered. It therefore may be problematic for a provider or individual reporter to determine an unexpected death in the timeframe required.

However, the ANMF does believe it is important to include unexplained death within the SIRS and the proposed definition should be expanded to include an unexpected death when the death has occurred during care delivery and/or if the unexpected death has been reported to the Coroner.

21. Is the definition of 'stealing or financial coercion by a staff member' equally applicable in the in-home services context? If not, what adjustments are required and why?

Proposed definition:

> ***Stealing from, or financial coercion of, the consumer by a staff member of the provider includes stealing from the consumer by a staff member of the provider; or***
>
> ***Conduct by a staff member of the provider that is coercive or deceptive in relation to the consumer's financial affairs, or unreasonably controls the financial affairs of the consumer.***

The proposed definition of stealing or financial coercion by a staff member outlined in the consultation paper requires amendment to include an in-home care approved provider. The assumption that stealing or financial coercion is the remit of a staff member excludes the circumstance where a provider might be responsible for this action. This is a loophole both in the existing residential care SIRS and in the proposed in-home care application. The ANMF recommends this is re-worded to acknowledge the possibility of an approved provider also committing these offences, for example charging for additional services fraudulently or not providing a service due to poor scheduling of staff. Including the following statement in the definition would provide better safeguards and clearer advice:

Stealing from, or financial coercion of, the consumer by a staff member of a provider or an approved provider includes stealing from the consumer by a staff member of the provider or by an approved provider; or

Conduct by a staff member of the provider or an approved provider that is coercive or deceptive in relation to the consumer's financial affairs, or unreasonably controls the financial affairs of the consumer.

22. Should the definition of 'neglect' be clarified by including reference to the impact on the consumer? If so, should this adjustment also be made in relation to SIRS residential aged care? Is there anything else about the in-home services context that would require adjustment to the proposed definition of 'neglect'? If so, what and why?

Proposed definition:

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

As stated earlier in the submission the Royal Commission into Aged Care Quality and Safety, *Final Report: Care Dignity and Respect* outlined that there is an unacceptably high level of neglect and abuse in aged care.[7] The report also identified that the SIRS must protect people receiving care from harm and ensure providers respond appropriately to incidents.[8] Therefore the ANMF agrees with the proposed definition.

Safe staffing levels are obviously included in this definition, as a breach of duty of care must include unsafe staffing levels, unsafe time to care and an unsafe skills mix. The provision of safe staffing and skills mix in aged care is intrinsically linked to safety and protection against neglect. Providing assessed nursing and personal care requirements for older people takes time, resources and expertise. Often cases of neglect, or missed care, arise where a worker is operating within unreasonable workloads. ANMF members report that care is often compromised due to unsafe staffing levels and insufficient time to provide effective, evidence-based care required for optimal outcomes. This is organisational neglect and a factor which is outside the individual control of workers providing in in-home care.[9] Therefore, unsafe staffing levels must be reported to and regulated by the Commission as critical elements of both the residential aged care and in-home care SIRS in the section of neglect.

Further, there need to be clear parameters regarding an approved provider agreeing to deliver care to a consumer when they know they are not able to provide the level of care required. When this occurs, it is important that staff are not then blamed for neglect of not delivering care, when it is known that the assessed care needs of the consumer is far higher. For example, offering and providing a level 2 in-home care package when they know the consumer is assessed as requiring a level 4 in-home care package.

The ANMF does not support the proposed definition being adjusted to include reference to the impact on the consumer. All incidents of neglect meeting the outlined definition need to be reported to the Commission to ensure, as the Royal Commission into Aged Care Quality and Safety's Final Report outlines, there is a requirement for oversight to ensure providers respond appropriately to serious incidents. Further, it is essential that data is collected on incidents of neglect to ensure it is monitored and that data-informed policy and care delivery can follow.

23. Should inappropriate use of restrictive practices be a reportable incident under the SIRS for in-home aged care services? If so, how should the existing definition in residential aged care be applied for in-home services (noting that the current definition is linked to obligations on providers in residential aged care that do not apply to in-home services)? Could inappropriate use of restrictive practices for in-home services instead be reported under a different category of reportable incident?

The ANMF has raised concerns about restrictive practices in aged care over a number of decades. The Royal Commission into Aged Care Quality and Safety, Final Report: Care Dignity and Respect reinforces these concerns, and states 'restrictive practices have been identified as a problem in aged care in Australia for more than 20 years'.[10]

Although, there has been a number of initiatives being implemented in residential care attempting to improve the inappropriate use of restrictive practices, the in-home care sector has not had the same focus. People have the right to be treated with respect and dignity irrespective of the context of care delivery. Use of restrictive practices is unacceptable and the in-home care sector, like the residential sector, needs support and tools to enable individual's receiving care to be free from abuse and harm. Data on incidents of restrictive practices in in-home care is poor. To inform care delivery and change this care, data relating specifically to restrictive practices needs to be collected, monitored and analysed. The ANMF therefore supports the inclusion of restrictive practices being identified as a standalone category.

The current definition in the residential care SIRS for inappropriate physical or chemical restraint is: where physical or chemical restraint is used without prior consent or without notifying the consumer's representative as soon as practicable; where physical restraint is used in a non-emergency situation; or when a provider issues a drug to a consumer to influence their behaviour as a form of chemical restraint.[11]

This definition is supported by the ANMF, noting that it will need to be applied in the context of in-home care delivery.

24. Is the 'reasonable ground to report the absence to police' threshold appropriate for the in-home services context? Should the definition be revised in the in-home services context and if so, how? Should this only be a reportable incident for certain in-home services that do not operate in the consumer's home (for example cottage respite, community transport and outing services)?

The ANMF does not support the inclusion of unexplained absence as part of the SIRS for individuals receiving in-home care, as they have the right to be at home or not. It is common for individuals to be absent for in in-home care services due to scheduling conflicts and the ANMF would caution against automatic reporting of these incidents to the Commission due to the frequency in which they may occur. There needs to be a balance between detecting serious incidents and onerous reporting without an outcome.

However, it is essential that in-home providers have clear governance processes in place to ensure people's safety and wellbeing if there is an unexplained absence. An emphasis on safety must be paramount and escalation processes must be in place. Advice should also be available for nurses and care workers 24 hours a day on the most appropriate course of action when they require decision support.

25. Should tiered reporting categories be adopted under a SIRS for in-home aged care services? If yes, should the reporting timeframe remain 24 hours for priority 1 reportable incidents? If no, should all incidents be reported within 24 hours if tiered reporting were removed? If not, what other timeframe would you suggest and why?

Tiered reporting categories are not supported. As the SIRS is being established to protect individuals receiving care from harm and to ensure providers respond appropriately to incidents of abuse and neglect, it is important that providers continue to report these serious incidents within a short timeframe of 24 hours.

It should be noted that in-home care is delivered 24/7, not just 9am to 5pm and as acuity rises among individuals receiving care the amount of out of hours in-home care delivered will inevitably rise. With this increased acuity, vulnerability will also be raised as will the need to ensure a timely system to respond when incidents of concern are identified.

A 24 hour reporting requirement will also enable data to be collected in a timely manner providing a clear picture of serious incidents occurring across in-home care. If reporting is limited then the sector remains unaware of the risks occurring. As more data is collected and there is transparency of these incidents, the reporting timeframes can be adjusted.

Additionally, to assist with implementation and understanding of the SIRS a single reporting timeframe is preferable to reduce confusion.

26. Are there any other matters you would like to raise in relation to the design or operation of the SIRS for in home aged care services?

The ANMF does not have any additional comments.

CONCLUSION

Thank you for this opportunity to provide feedback on the consultation for the Serious Incident Response Scheme for Commonwealth funded in-home aged care services. The ANMF is committed to processes that enhance and improve the care and safety for individuals receiving aged care services. The SIRS introduced into in-home care must provide a requirement to ensure additional staff time to complete the reporting requirements and ensure these further reporting requirements do not take the nurse or care worker away from their direct care responsibilities. Further, education for nurses and care workers about the new system for reporting is essential to the success of the scheme and more importantly to ensuring safety of older people. The ANMF looks forward to being involved in the next phase of the consultation for the SIRS for in-home care.

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