ELDER CARE WATCH

NEWSLETTER
September 2021 Edition 85

Serious Incident Response Scheme passed by federal parliament

new provider responsibility wide range of 'incidents'

Parliament House
The site of some important small steps for improving aged care in 2021

Whistleblower protection

law now protects those who report incidents

Early days

first report on Scheme

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Aged care wage case

Government hands off approach means a long and winding road to better wages

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Home Support and Home Care

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Serious Incident Response Scheme
the changing landscape
narrow 'reportable assaults' law replaced by broader 'reportable incidents' law

Origins
A scheme for reporting serious incidents was advocated in two 2017 reports namely, the Carnell-Paterson report and the Law Reform Commission report on *Elder Abuse,* as well as in 2020 by the Royal Commission *(R100).*

New responsibility
The Government acted on this and providers now have a legal obligation to manage incidents of abuse and neglect and take reasonable steps to prevent them (Aged Care Act, s.54-1(1)(e)) as well as reporting them.

The law applies to residential care and to flexible care provided in nursing homes. It does not apply to home care.

Wide range of incidents
Previously only physical and sexual assaults were included but there is now a wide range of incidents which are reportable *(see Text Box).*

Reportable incidents

Any of the following which have occurred, or are alleged or suspected to have occurred, to a resident

*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;
*use of physical or chemical restraint, other than in circumstances set out in the *Quality of Care Principles;*
*neglect; or
*unexplained absence from the nursing home

Aged Care Act , s. 54-3(2)

Resident-on-resident assaults
The Serious Incident Response Scheme has removed the exemption from reporting assaults which applied to resident-on-resident incidents where the alleged perpetrator has a cognitive or mental impairment ... (Australian Government Response to Final Report of the Royal Commission, May 2021, page 64). This exemption existed under the former 'reportable assaults' law which had been introduced in 2007 following the rape of a resident by a staff member at a nursing home in Mt. Eliza,Victoria.

Enforcement
The Quality and Safety Commission's powers to enforce both the requirements of the Scheme and provider responsibilities are expanded. The powers include: infringement notices, injunctions and applications to a court for civil penalties.

Following Disability Act
The Scheme is similar to the incident management and disclosure protection scheme added in 2017 to the *NDIS Act 2013*.

Whistleblower protection
recommendation accepted by Government but with variation: provisions placed within the limits of Serious Incidents rather than at large in the Aged Care Act

Royal Commission
The Royal Commission recommendation for whistle-blower protection stood alone and covered *"complaints, a suspected breach of the Quality Standards or another* [meaning any other] *requirement under the Aged Care Act" (R99).*

In the Commission's Final Report protection was discussed under the general heading of *'Complaints'*.

Government narrowing
The Government incorporated the principle of protection but within the (limits of) the *Serious Incident Response Scheme* and used the term *discloser* rather than *whistle-blower.*

"Comprehensive whistle-blower protections should be implemented in aged care legislation to protect people who make complaints or report suspected breaches of legislative requirements to the Quality Regulator, the Inspector-General of Aged Care or key personnel of an approved provider"

Royal Commission,
Final Report, volume 1:140

It is however notable that the very broad issue of *neglect* is included in the list of reportable incidents *(see page 2).* You will recall that **Neglect** was the arresting title of the Royal Commission's Interim Report. As we know, neglect covered a multitude of sins.

DID YOU KNOW?

Compulsory reporting 2019-2020

During 2019-20, there were 4,867 instances of alleged or suspected unreasonable use of force and 816 instances of alleged or suspected unlawful sexual contact while 35 instances were recorded as both.

Report on the Operation of the Aged Care Act 2019-2020, page 90.

Whistleblower protection

as a relative, volunteer or advocate you can speak up knowing the law is on your side

Who is protected?

*existing and former staff;

*current and past residents;

*resident’s family member, carer, representative, advocate or significant other;

*volunteers who provide care or services for the nursing home.

Protected against what?

*against retribution or vilification;

*against repercussions such as civil or criminal liability;

*in the case of staff, against dismissal.

Disclose to whom?

any of the following:

*Commissioner (Aged Care Quality and Safety Commission);

*the nursing home (the provider);

*one of the home’s *key personnel;*

*police officer;

*staff member;

*another person prescribed by the *Quality of Care Principles.*

Conditions on the discloser

you must:

*give your name before you make the disclosure;

*have reasonable grounds to suspect that the information indicates that a *reportable incident* has occurred;

*make the disclosure in good faith [honest or sincere intention].

Aged Care Act, ss 54-4 to 54-8.

Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Bill 2020, Explanatory Memorandum.

Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Act 2021 (operative from 1 April 2021).

Early days
Serious Incident Response Scheme in operation
first report May 2021
important features not revealed; avoiding bureaucratic silos

Incident	Number
Unreasonable use of force	778
Unlawful sexual contact or inappropriate sexual conduct	149
Psychological or emotional abuse	94
Unexpected death	192
Stealing or financial coercion	30
Neglect	448
Inappropriate chemical or physical restraint	22
Unexplained absence	163
TOTAL	1,876

Initial requirements
Since 1 April 2021 providers have been required to notify *Priority 1* incidents. From 1 October 2021 notifying *Priority 2* incidents is mandated.

Incident number & type
In the first six weeks of the Scheme, 1,876 incidents were notified and the most common incidents were *unreasonable use of force* and the catch-all *neglect.*

What is missing
We are not given a breakdown by *discloser,* for example, how many incidents were disclosed by relatives, how many by volunteers and so on. Nor is it revealed to whom the incidents were disclosed in the first instance, for example, how many were disclosed to the Quality and Safety Commission, how many to a police officer and so on.

What Commission does
The Commission adds the serious incident data to all the other information it holds on a particular nursing home so that all staff, working in different sections, have access to the same data.

Avoiding silos
The above practice is clearly a response to the Royal Commission's scathing comments about the bureaucracy operating in silos and asleep at the wheel. This was evident for example in the *Earl Haven* disaster when a subcontracted management 'pulled the pin' requiring a fleet of ambulances to rescue residents from the home.

Priority 1 incidents

"An incident in a nursing home that has caused or could potentially have caused, physical or psychological injury to a consumer, requiring medical or psychological treatment"

Providers to report within 24 hours of becoming aware of the incident.

Aged Care Quality and Safety Commission, Serious Incident Response Scheme (SIRS), Insight Report, May 2021.

Wage case
a long and winding road

The Government is the primary source of funds for a wage increase. Its silence on whether there is a case for a wage increase means the tortuous process of arbitration, requiring detailed evidence about the nature of the work and changes in the work over time, will have to be followed. In other words, this will be a case of arbitration rather than collective bargaining.

Schedule: submissions and hearings

23 July 2021	Australian Government to complete filing data and information requested by the Unions.
8 October 2021	Unions to file evidence and submissions.
19 November 2021	Unions to file any agreed position involving unions, employers, employer associations and/or the Australian Government.
18 February 2022	Employers and employer associations to file evidence and submissions.
14 April 2022	Unions to file evidence and submissions in reply.
19 April 2022	Matters listed for mention before the Commission to discuss witness scheduling and which witnesses will be called for cross-examination.
26 April - 11 May 2022	Hearing of evidence.
3 June 2022	All parties to file closing written submissions regarding the evidence.
24 June 2022	All parties to file submissions in reply regarding the evidence.
6-7 July 2022	Oral hearing.
???????	Decision on wages by Fair Work Commission

Fair Work Commission, Aged Care Award 2010 (AM2020/99, AM2021/63, AM2021/65), Amended Directions 2 August 2021.
The timetable is subject to change as any party may apply to change the scheduled dates, in which case the Commission considers the argument and makes a decision.

COVID deaths at St Basil's, Fawkner, Victoria
Coroner's inquest begins

John Cain
State Coroner, Victoria
appointed 2019

"Evidence collected by the Court …. suggests certain features of the home, its management and the way the outbreak was addressed by external agencies, combined for the tragic outcome that materialised".

P. Rozen quoted in E. Pearson, 'Aged 'left to die alone' in St Basil's crisis' The Age, 19 August 2021:4

Peter Rozen QC
Counsel assisting the Coroner and formerly part of the legal team assisting the Aged Care Royal Commission

Pre inquest hearing
On 18 August, Counsel Assisting the Coroner, Peter Rozen QC, foreshadowed core elements of disturbing evidence of events from 9 July, when a staff member tested positive to the virus, to 23 August when the 45th resident died from COVID. Another five residents who died during that time did not have COVID.

Reluctant managers
The home's manager Vicky Kos and chairman Kon Kontis had declined to take part in investigations and would need to be compelled to give evidence.

Compounding errors
The staff member who tested positive had worked, without PPE, while waiting for test results, notifying management on 9 July. The manager then allegedly failed to notify the Department of Health and instead called the coronavirus hotline.

Critical delays
The Department did not learn of the outbreak until 14 July and Counsel Assisting said the home declined help from a provider of a surge workforce, Aspen, until it was too late to provide a smooth handover from existing staff. They had been ordered to isolate due to their exposure to the rapidly spreading virus.

Appalling conditions
By 24 July, when the residents began to be evacuated to hospitals they were *"malnourished, dehydrated, in poor general health and had pressure sores"*. The virus eventually spread to a further 93 staff and to a total of 94 of the 150 residents.

Spotlight on ...
In addition to the home's management, the Coroner will examine the response of the federal government, which is responsible for aged care and of the Victorian government which was managing the state's response to the pandemic.

F. Vinall, 'Covid horror at aged care facility laid bare in coronial hearing', www.news.com.au/national/victoria/courts-law, 18 August 2021.

Home Support and Home Care

Currently there are two separate programs for receiving aged care services at home: the Home Support program (*Commonwealth Home Support Program)* and the Home Care Program (*Home Care Packages)*.

Some differences

Home Support only provides entry level care while Home Care provides for increasing care and services as needs increase. Home Support has a simple income test to determine how much you pay. It is more heavily subsidised so, for example, cleaning is likely to cost you less per hour than under Home Care. The two programs have separate assessment processes: Regional Assessment Service (RAS) and Aged Care Assessment Team (ACAT) but these are shortly to be merged with the longer term aim of merging both programs.

The Home Care program involves more paperwork but once you are granted a package you decide what kinds of care and services you wish to spend the money on. There is the well known problem of a long waiting list: once eligibility is established you enter the *National Prioritisation System* (the waiting list) and you are offered a package when one becomes available. You then choose a provider and discussions begin…...

Home care: national median prices

Pricing Type	Cost per fortnight
Care management	
Fully managed by provider	
Level 1	$56
Level 2	$100
Level 3	$204
Level 4	$299
Self-managed by consumer	
Level 1	$34
Level 2	$54
Level 3	$103
Level 4	$142
Package management	**Cost per fortnight**
Level 1	$34
Level 2	$60
Level 3	$131
Level 4	$198
Common services	**Per standard hour**
Nursing	$95
Personal care	$56
In-home respite	$56
Cleaning & Household tasks	$55
Light Gardening	$58

Extract from Department of Health, National summary of home care prices, May 2021.

Independence
Elder Care Watch is independent. It does not seek or accept funds from governments or private organisations.

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