Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Serious Incident Response Scheme (SIRS)
Insights Series: Report 1 - 2023

Unreasonable use of force:

Notifications of resident to resident incidents.

Contents

Introduction

This is first in a new series of Insights reports produced by the Aged Care Quality and Safety Commission on the Serious Incident Response Scheme (SIRS).

The series will explore the 8 reportable incident types under the SIRS in residential aged care.

The SIRS was established in April 2021 to help providers reduce and prevent these incidents and the harm they cause.

The Insights report series aims to help providers:

- improve how they respond to serious incidents with a focus on the consumer experience
- identify and apply learnings to put in place preventative measures at an operational and governance level.

Many serious incidents that occur in aged care are preventable. Improvements in providers' response to serious incidents is crucial to reducing harm to consumers and preventing reoccurrence.

An important education resource

The Insights reports are intended to provide a valuable learning resource for providers. The guided questions from each case study can be used to facilitate team workshops to identify learnings that can be applied to your service.

We also include questions for boards and senior leadership to help guide consideration and actions when an incident occurs. Effective incident management requires visible leadership at all levels of an organisation, starting with the board and entire leadership team.

Message from the Commissioner

Janet Anderson PSM

All Australians have the right to feel safe and live dignified, self-determined lives that are free from exploitation, violence and abuse. This includes older Australians receiving government-subsidised aged care services, who have specific rights and protections.

The Serious Incident Response Scheme (SIRS) was introduced into residential aged care in April 2021 to protect Australians receiving aged care services from harm and abuse.

To support this objective, I am pleased to present this report, as part of our series of Insight reports on SIRS, using the intelligence we have gathered as the national regulator. The Insight series is designed to help lift providers' prevention and management of serious incidents through education and reflection.

Each report will draw on de-identified case studies, which are offered as learning opportunities for all who seek to improve their practices.

We have chosen to focus this report on unreasonable use of force because it consistently accounts for 6 out of 10 of all serious incident reports notified to the Commission by residential aged care services – more than all the other incident types combined.

Of these, more than 8 in 10 incidents of unreasonable use of force reported to the Commission involve residents using force on another resident. This is the focus of this report.

Through case studies, the report offers insights that will guide providers to take measures across all levels of their services to significantly reduce the occurrence and impact of such incidents.

An important message of our report is that just because incidents are happening and mainly involve residents with cognitive impairment, that does not make the incident low impact or unavoidable.

Nearly one in 10 notifications of unreasonable use of force involve staff. This concerns us and will be addressed in a future publication in this series.

I encourage you to consider how the insights offered in this report can be applied within your services and to share your learnings with us.

J. M. Anderson

Janet Anderson PSM
Commissioner

Message from the Chief Clinical Advisor

Dr. Melanie Wroth MB BS, FRACP

This report focuses on unreasonable use of force incidents in residential care involving residents.

Taking a case study approach, the report provides insights and guidance to help providers and their staff better understand response, impact assessment and incident management. Lessons from these case studies will guide providers to take measures at an operational and governance level which could significantly reduce the chance of such incidents reoccurring.

Unreasonable use of force incidents in residential aged care account for almost two-thirds (62 per cent) of all incidents notified to the Commission in the first 15 months of the Serious Incident Response Scheme (SIRS) – 1 April 2012 to 30 June 2022 (see Appendix A, Figure 1).

The high proportion of notifications of unreasonable use of force, compared with other incident types, is partly attributable to the broad range of incidents that can be captured under this heading (including squeezing, grabbing, pinching, rough handling, hitting, pushing, and forcing someone to move against their will).

However, there are many other contributing factors and therefore opportunities to reduce these numbers. They include:

- an effective incident management system that includes preventative action could reduce repeat incidents involving the same residents or similar circumstances
- recognising impact, which is fundamental to responding to incidents appropriately
- improving behaviour support planning and behaviour management. Sector-wide gaps in this area are likely to be contributing to the higher rates of incidents involving people with cognitive impairment
- improving governance, including Board scrutiny and responses when serious incidents occur and supporting staff to recognise and act early in situations which could otherwise escalate.

The case studies we have selected are not necessarily the most common types of incidents reported. They have been included because they highlight themes, particularly around impact and incident management, that we are concerned about. They are based on and developed from common themes in numerous individual reports we receive and further information we obtain under the formal powers of the Commission.

Issues highlighted by our case studies include:

Triggers and contributing factors

Providers may not recognise or address issues that have been building up over time, until one resident becomes frustrated and lashes out.

We see this in the case of Josie and Nico (case study 1), who had been involved in tussles over cigarettes for many weeks before the reported incident. A key difference between this case study and other case studies is that the provider investigated the cause of this incident and put in place strategies to prevent similar incidents occurring. These strategies formed part of the incident notification and demonstrated the value of a proactive approach.

In case study 4, by contrast, the same resident was involved in repeated incidents. In this case, the provider did not take any preventative actions until they were required to do so by the Commission. This lack of action had serious consequences.

Invisible impacts

An incident can still have an impact even if the victim does not remember it or the psychological impact is not immediately obvious. We see that in the case of Cora and Sam (case study 2). The provider failed to recognise that Cora was being harmed because she could not remember the incident. Sam, who was the subject of the allegation (the person who had caused harm) was also not recognised as having been impacted, despite confining himself to his room and refusing to eat.

Delayed impact

Physical impacts may not be apparent at the time of the incident. It was not recognised until weeks after the reported incident that Ari (case study 3) had developed a chronic subdural haematoma that could have led to premature death. Other common delayed physical impacts include joint injury and deep tissue injury.

Repeated incidents with the same resident

When notifications repeatedly involve the same resident, it is common to find that the first incident had not been investigated or responded to adequately and future risks had not been managed.

Steph, the subject of allegation in case study 4, had been involved in several other incidents with other residents prior to this notification. Yet, a later review by the Commission found that there was no behaviour support plan in place for Steph. Strategies also needed to be put in place, and eventually were, to allow staff to intervene when they saw risky patterns of behaviour developing. The provider's lack of action had serious consequences for the affected resident Boris.

Inappropriate blaming

Trying to establish who is 'at fault' or who 'caused' the incident may not always be easy and is often not clear cut. Therefore, it is important not to blame or punish a resident. Several of our case studies illustrate how a resident may lash out after weeks of being exposed to unwanted behaviour from others. The resident may be extremely upset before and after they lash out. They may demonstrate this by staying in their room, not joining in activities, or losing their appetite. We see examples of this in case study 2 (Cora and Sam) and case study 4 (Boris and Steph). Understanding and managing the risks leading up to the incident not only prevents a major incident from happening but also prevents harm and distress to both parties involved.

Impact must be carefully considered

Just under 20,000 unreasonable use of force notifications were reported to the Commission from 1 October 2021 to 30 June 2022. Of these, more than 6,000 were reported as Priority 1. Priority 1 means the incident caused, or could reasonably have been expected to cause, physical or psychological injury. Yet, in 9 out of 10 of all unreasonable use of force notifications reported, providers assessed the incidents as having minor or no impact (see Appendix A, Figure 2).

Recognising the impact of stressful or violent events is fundamental to responding appropriately to incidents and to the assessment and management of risks associated with incidents in a service.

Strategies for prevention

The high volume of reports of this incident type, and the tendency of providers to assess the impact of even serious incidents as minor, is of concern to the Commission. It suggests that there may be insufficient understanding of impact, and insufficient attention to behaviour support plans and other strategies that can prevent such incidents from happening or reoccurring. It is also important to remember that people living with dementia can suffer an impact from such incidents. Physiological and psychological effects of pain and fear can be severe and can persist even if the event cannot be effectively communicated.

Providers are not only required to report on the actual harm they might observe or have evidence of, but also to make a reasonable assessment of impact or harm based on what has occurred. This means providers must identify impacts which do not have physical or visually demonstrable evidence such as psychological harm or discomfort. Providers must also recognise when consumers are not able to or are limited in their ability to convey the impact themselves.

Record near misses in Incident Management System

Harm includes not just actual harm, but potential for harm. Near misses present a great learning opportunity for providers and should be investigated as thoroughly as an event which caused actual harm, to inform how a future event with actual harm can be prevented. Near misses should be recorded in a provider's incident management system and may also need to be reported under the SIRS, depending on the incident. The decision support tool has been designed to help providers determine whether an incident must be reported to the Commission.

Addressing the challenges of severe cognitive impairment

Reports of unreasonable use of force are significantly more likely to involve consumers with severe to moderate levels of cognitive impairment (see Appendix A, Figures 3 and 4). The incidents explored in our case studies involve one or more residents with significant cognitive impairment. Although sometimes challenging, such incidents should never be considered unavoidable. Providers who are genuinely concerned to improve things for everyone in their care can make a difference to the risk. Providers who do not understand the effect of measures such as individualised behaviour support plans will find avoidable risk is always present.

Staff who see things going wrong and have clear mechanisms to escalate a response can make a dramatic difference. Every person working to care for older Australians at whatever level has the potential for their eyes and ears to add value.

Case study 1:
Ongoing arguments over cigarettes leads to physical altercation

Incident description

A resident, Josie, was found forcibly pinning another resident, Nico, to a chair with her body. The SIRS notification detailed the provider's analysis of the incident and strategies in place to prevent reoccurrence.

The provider reported this incident as a Priority 2. Their assessment concluded that the incident did not cause injury or discomfort requiring 'medical or psychological treatment to resolve'. The provider determined that there were no reasonable grounds to notify the police of the incident.

Commission action

The Commission reviewed the SIRS notification and assessed that the provider's response and action taken were appropriate. The Commission also reviewed its records about the provider. Having assessed the risks to consumers, and the provider's ability to manage the risk and reduce the likelihood of reoccurrence, the Commission did not require further information.

Background and insights

During and after the incident, Nico was visibly distressed and struggling to stand up. He scratched Josie's arms in the process. The following day, Nico developed bruising on his chest. There was no ongoing pain reported and an assessment of his breathing and mobility was completed.

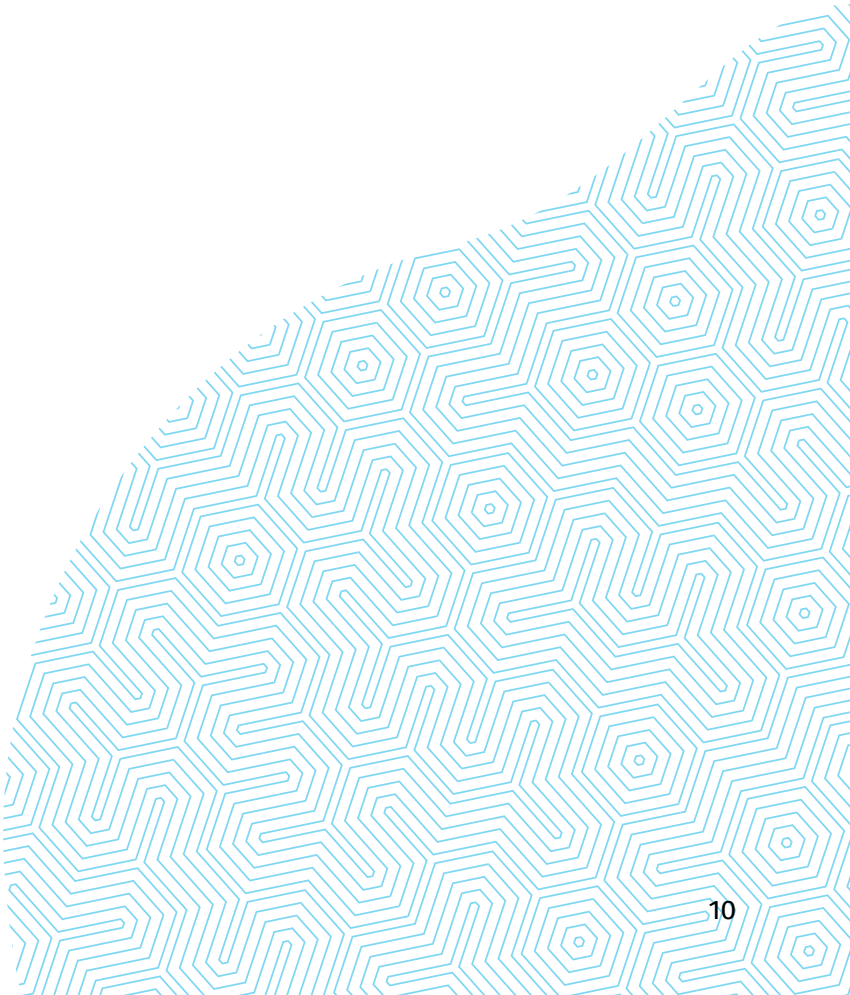
The provider's review of this incident found that Nico had been repeatedly asking Josie for cigarettes, and that she was concerned he was going to go into her room to find some. Both people involved were upset. They were separated and reassured that they were listened to and would be helped.

The provider investigated the incident to prevent similar incidents happening. Strategies were devised to increase opportunities for Nico to purchase his own cigarettes. Josie was given a lock and key to her room so she felt her possessions were safe.

Staff were made aware of the need to support both residents in the new arrangements, and to ensure that they were not left alone together. Staff followed-up how this was working for each of them. Accordingly, further Commission action was not required.

Guided questions
Case study 1

1. Given that Nico and Josie both had injuries and one resident was being pinned down by the other, was the immediate response by the provider appropriate?
2. Was the assessment as Priority 2 and low impact correct? Discuss with reference to the definitions of Priority 1 and 2.
3. The arguments had been going on for some time. Would action have been taken earlier at your service if a similar situation took place? If so, what action would have been taken? If not, why not?
4. Eventually, Josie was given a lock to her room and Nico was provided with opportunities to buy his own cigarettes. Is this sort of person-centred care prioritised in your service? If so, can you share any examples?



Case study 2:
Frequent calling out ends in a slap

Incident description

A resident living with dementia, Cora, was slapped in the face by Sam, another resident. Cora had been calling out all morning and Sam had repeatedly told her to be quiet in more and more unpleasant terms.

The provider reported this incident as a Priority 2. Their assessment concluded that the incident did not cause injury or discomfort requiring medical or psychological intervention.

The provider determined that there were no reasonable grounds to notify the police of the incident.

Commission action

After reviewing the SIRS notification, the Commission determined that more information was required to assess the risks to consumers and the provider's ability to manage the risk and prevent reoccurrence.

A review of previous SIRS notifications indicated that both residents had been named in multiple previous incidents.

The Commission issued the provider with a formal notice requiring them to provide further information.*

Following the Commission's request for further information, an analysis by the service allowed them to understand the factors contributing to the incident and address them. As a result, the service greatly reduced the risk of it happening again – not just to Cora and Sam, but also to other residents. Staff were also debriefed and educated so that future similar incidents would be managed before they escalate.

* Issued under section 95C of the *Aged Care Quality and Safety Commission Rules 2018*

Background and insights

On the day of the incident, Cora had been calling out all morning and Sam had repeatedly told her to be quiet. At the time of the slap, Cora cried out and was tearful and holding her face. When questioned about it later she had no recollection of the incident and denied any distress. However her face was noted to have a red welt on it for a considerable time afterwards. Sam was remorseful and tearful. He went to his room for many hours and refused to eat.

The provider assessed the impact as low because Cora could not remember it. However, the distress at the time was well documented and the physical mark was persistent. She was visibly fearful when people came near her. At the time, staff did not recognise the impact on Sam or other residents.

Cora had been calling out a lot in the weeks before the incident. The provider had not tried to understand what she was trying to communicate, what could have assisted her to settle, or what might have helped her focus on something else enjoyable. She had no behaviour support plan.

Sam had been indicating that he was losing patience. The calling out was a clear trigger to the slapping incident. Little had been done to separate the two residents or to help prevent Sam becoming increasingly annoyed and agitated.

Guided questions

Case study 2

1. What might you look for to better understand whether a resident was distressed, even if they cannot express it or said they did not recall the incident?
2. Sam withdrew to his room after the incident, but staff did not recognise any impact. What can be done to help staff recognise the different forms impact can take?
3. What sort of impacts do you think can be experienced by the instigator of a serious incident?
4. Sometimes it may not be clear cut who or what caused an incident. How do you avoid attributing blame in incidents where both parties may have experienced harm?

Case study 3:
Failure to manage a resident's triggers leads to multiple notified incidents

Incident description

A 90-year-old resident, Ari, was pushed over by Steve who was walking behind him. Ari fell over his walker awkwardly, bumping his head on the wall and landing on the floor.

The provider reported this incident as a Priority 1. Their assessment concluded that the incident caused injury or discomfort requiring formal medical or psychological treatment to resolve.

Commission action

After reviewing the notification, the Commission determined that more information was required to accurately assess the risks to consumers and the provider's ability to manage the risk and reduce the likelihood of reoccurrence.

A review of previous SIRS notifications indicated that Steve had been named in multiple previous incidents. We issued the provider with a formal notice requiring them to provide further information.*

Following the request for further information, the provider sought specialist clinical advice and implemented appropriate strategies, including plans for measuring the effectiveness of those strategies.

Background and insights

At the time of the incident, Steve became impatient when he was walking behind Ari and pushed him over. Ari fell over his walker awkwardly, bumping his head on the wall and landing on the floor.

Ari had pain after the fall and struggled to bear weight and he was transferred to hospital. X-rays showed no fractures and he recovered with physiotherapy support and paracetamol.

While the pain and physical harm were detected and responded to, there was little recognition of the psychosocial impact. Ari was frightened and stopped going to activities and outings when Steve would be present.

* Issued under section 95C of the *Aged Care Quality and Safety Commission Rules 2018*

A couple of weeks after the reported incident Ari become increasingly unsteady, drowsy and vague, requiring more assistance with activities. Mindful of the recent head bump, Ari had a brain CT which revealed a chronic subdural haematoma. This did not require intervention and resolved slowly with staff support to maintain function. This is an example of delayed impact which was detected successfully. There had been no open disclosure or discussion with Ari and his family initially, but this occurred later.

Steve had been named in five similar prior incidents. There was no indication that the service had any strategies in place for managing Steve's behaviour other than increasing the protections for other residents when he became impatient.

Guided questions
Case study 3

1. Steve had been involved in numerous other incidents. What strategies could be put in place to understand, prevent and manage Steve's behaviour? What expert or external advice and support is available to your service and to residents like Steve?
2. In your service, at what stage would you communicate with Ari's family about the significance of the event? How would you do this?
3. Describe how you would approach Steve's family? What outcomes would you seek from that conversation?
4. What indications are there that there was a psychosocial impact and not just a physical impact on the residents involved?

Case study 4:
Impulsive action leads to serious injury and Commission investigation

Incident description

Boris was sitting at the table in a common room. Another resident, Steph, pushed him off his seat causing him to fall. Boris was unable to get up and an ambulance was called.

The provider reported this incident as a Priority 1. Their assessment concluded that the incident caused injury or discomfort requiring medical or psychological intervention. The provider did not take any action to investigate the context of the incident.

Commission action

After reviewing the notification, the Commission determined that more information was required to accurately assess the ongoing risks to residents, and the provider's ability to manage those risks.

A review of previous SIRS notifications indicated that Steph had been named in multiple previous incidents. We issued the provider with a formal notice requiring them to provide further information.*

Given the severity of the injuries and apparent lack of action by the provider to investigate and take preventative measures, the Commission escalated the matter by undertaking its own investigation.

After the investigation, the provider introduced risk mitigation strategies to prevent similar incidents from occurring. Staff were given mechanisms to raise concerns when they thought that risky interactions or behaviour were developing, so these could be addressed early. The prevention strategies included enabling residents and their families to select their preferences for activities, seating and social interactions.

* Issued under section 95C of the *Aged Care Quality and Safety Commission Rules 2018*

Background and insights

Immediately before the incident Boris, who is frail, was sitting at the table in a common room. Steph, who has dementia but is physically robust, pushed him out of the way because she wanted the seat. Boris fell and was unable to get up with severe pain in his hip. A staff member shouted at Steph, who was sobbing and shaking and saying 'I didn't mean to' repeatedly. Carers present blamed themselves for not preventing the push.

Boris was taken to hospital by ambulance and admitted. He was diagnosed with a fractured neck of femur. He had a prolonged stay and was not able to walk independently again. Steph became withdrawn and anxious.

Commission investigators attended the service. They interviewed staff and residents and reviewed the incident management system records.

When Boris returned from hospital, he was given special attention to explain how staff would keep him safe and how physiotherapy would continue to try to improve his function. Using the open disclosure process, staff had ongoing discussion with Boris and his family and expressed how sorry they were that this had happened. A psychologist helped him with the trauma and the loss in quality of life.

Steph was supervised closely when moving between locations, and a behaviour support plan was commenced to help avoid situations where she might be impulsive or impatient. Staff were reminded that Steph was not to be blamed for the actions and to understand what had happened in the context of her dementia.

Staff were interviewed extensively in the investigation of the incident, to identify warning signs leading up to this and similar incidents.

Guided questions

Case study 4

1. Was the staff response to Steph's actions appropriate and consistent with the principles of the Code of Conduct for Aged Care? What steps could staff have taken to support a positive culture when serious incidents happen?
2. Do you or team members ever use loaded words like 'troublemaker' or 'difficult'? What effect might these words have on staff responses and person-centred care?
3. The open disclosure with the family started after Boris returned from hospital. When should it have started?
4. After assessing the incident, the provider introduced person-centred care, allowing residents to choose their own seating and activities. Could you implement similar solutions in your practice? If so, what are the barriers to implementing this, and how would you overcome them?

Unreasonable use of force: key take-aways

- Resident-to-resident incidents usually have a component of cognitive impairment and behaviour management issues in one or both parties.
- Many incidents are provoked, and this is key to understanding and prevention. The person using force often also needs support, and their needs may have been dismissed or neglected leading up to the incident.
- Psychological harm and distress must be assessed and predicted.
- For residents living with dementia, being unable to recall the incident or articulate their feelings should not be taken to mean there is no impact.
- Many incidents are recurrent, with the same individuals involved. Repeat incidents involving the same residents suggest that the response to the first incident was insufficient.
- Blame and punishment of residents must be avoided. Staff must be helped to understand a resident's behaviour in the context of the setting, the resident's underlying conditions and how they might be feeling.
- Predicting incidents by understanding risks and introducing preventive and proactive behaviour support should be part of a service's incident management process with clear governance protocols.
- Assessment of impact should not be confined to the immediate physical harms. Physical impact can be delayed or hidden and can include, for example, deep tissue injury, internal bleeding and joint injury. Psychological impact always needs to be considered and may not be obvious.
- There are potential intersections between unreasonable use of force and sexual contact issues where detail, intent and perception need careful thought when responding to the incident and selecting the correct incident type for reporting purposes.
- There are potential intersections between unreasonable use of force and neglect, where neglect of a person's needs may be the cause of the force incident. Again, careful thought must be given to how best to respond to the incident and to selecting the correct incident type for reporting purposes.
- If a response to an incident involves consideration of use of restrictive practices, then early attention must be given to behaviour support and fulfilment of all the legislative requirements.
- If a resident poses serious ongoing risks to others, urgent intervention (including escalation to expert advice) should occur.

Questions for boards and governing bodies to ask when investigating an incident

Providers have a responsibility under the *Quality of Care Principles 2014* to manage incidents. This includes assessing whether the incident could have been prevented and what actions could be taken to improve the prevention, management and resolution of similar incidents.

As indicated in the Quality Standards, providers must use an open disclosure process when things go wrong. This means that providers should facilitate an open discussion with consumers (and their representatives) when something goes wrong that has harmed or had the potential to cause harm to a consumer. Providers are expected to practise open disclosure in their prevention and management of any incidents impacting consumers.

Questions to ask include:

- Was the response to the incident appropriate?
- How was this incident able to occur?
- Could this have been predicted?
- What are the factors that could have triggered, caused or contributed to the incident?
- Could these factors have been prevented or modified?
- Could this happen again to this person or to others?
- What actions will be taken to reduce risk and prevent reoccurrence?
- How and when will we check that these actions are implemented, effective and sustained?
- Are we confident that our service is actively engaging in open discussions with affected residents for each incident?
- Does our incident management system enable us to identify trends, issues and areas for improvement?
- Is there a trend in our service which, if identified, would have prevented this incident?
- Is our team recording near misses - incidents that have the potential to cause harm but do not do so?
- Could this incident have been prevented if the service was actively recording near misses that happened prior to this incident occurring?
- Are our responses to an incident reflective of the principles of consumer dignity and choice?

What works for you?

If you have some examples of how you have effectively managed similar scenarios, please email us on SIRSinsights@agedcarequality.gov.au

Useful resources

The following resources are available to support providers in meeting their requirements under the SIRS to manage and take reasonable action to prevent serious incidents:

1. Effective incident management systems
2. Incident management resources
3. Introduction to SIRS
4. SIRS reportable incidents – Unreasonable use of force
5. SIRS guidelines for aged care providers
6. Creating behaviour support plans
7. Dementia Australia
8. The decision support tool
9. Alis - Incident Management and SIRS Unreasonable use of force
10. The 'your role in SIRS' online guide
11. Open disclosure in aged care
12. Code of Conduct for Aged Care

1 https://www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance
2 https://www.agedcarequality.gov.au/sirs/incident-management-resources
3 https://www.agedcarequality.gov.au/sirs/introduction-sirs
4 https://www.agedcarequality.gov.au/resources/sirs-reportable-incidents-unreasonable-use-force
5 http://www.agedcarequality.gov.au/resources/serious-incident-response-scheme-guidelines-residential-aged-care-providers-0
6 http://www.agedcarequality.gov.au/news-centre/clinical-alerts/behaviour-support-plans
7 http://www.dementia.org.au/
8 https://www.agedcarequality.gov.au/sirs/decision-support-tool
9 https://learning.agedcarequality.gov.au/learner/course/viewcourse/cid%2C193
10 https://www.agedcarequality.gov.au/sirs/welcome-your-role-sirs
11 https://www.agedcarequality.gov.au/resources/open-disclosure#%3A~%3Atext%3DOpen%20disclosure%20is%20the%20open%2Cperson%20receiving%20aged%20care%20service
12 https://www.agedcarequality.gov.au/providers/code-conduct-aged-care-information-workers

Appendix A

The following tables present key data and information collected through the SIRS reporting arrangements.

Table 1: Overview of SIRS notifications by incident type for 1 April 2021 to 30 June 2022

	1 Apr–30 Sep'21	1 Oct'21–30 Jun'22			
Incident Type	**Priority 1**	**Priority 1**	**Priority 2**	**Total**	**% of total notifications**
Unreasonable use of force	5,033	6,209	13,195	24,437	62%
Neglect	1,260	2,445	2,082	5,787	15%
Psychological or emotional abuse	424	536	2,092	3,052	8%
Unlawful sexual contact or inappropriate sexual conduct ^	655	1,080	388	2,123	5%
Unexplained absence from care *	734	1,237	85	2,056	5%
Unexpected death *	374	517	12	903	2%
Stealing or financial coercion by a staff member	172	256	161	589	1%
Restrictive practices	75	200	247	522	1%
Total notifications	**8,727**	**12,480**	**18,262**	**39,469**	**100%**

Note: Notifications made between 1 April 2021 and 8pm on 27 February 2022 were assessed by the Commission as Priority 1 or Priority 2 based on information providers supplied in the notification. From 8pm on 27 February 2022 onwards, providers assigned Priority 1 or Priority 2 in the My Aged Care portal.

* Under the SIRS legislation, notifications of this type are Priority 1 notifications. Where notifications of this type are reported as Priority 2, it is because the Approved Provider selected Priority 2 in the My Aged Care form on submission of the notification.

^ The majority of notifications of this type were assessed by the Commission as Priority 1 notices. From 8pm on 27 February 2022, the priority classification was submitted by providers through the My Aged Care portal. On 3 October 2022, the legislation changed to make notifications of this type Priority 1.

Priority 1 reportable incidents are incidents:

- that have caused or could reasonably have been expected to cause, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or
- where there are reasonable grounds to contact the police (this is taken to include all incidents involving alleged, suspected or witnessed sexual assault), or
- where there is the unexpected death of a consumer or a consumer's unexplained absence from the service.

Priority 2 reportable incidents are those that do not meet the criteria for a Priority 1 reportable incident. They are notified to the Commission within 30 days of the provider becoming aware of the incident.

The Commission reviews all incident notifications within 24 hours of receipt and will take appropriate and proportionate action as required.

Appendix A

Table 2: Unreasonable use of force - Subject of Allegation Type for 1 April 2021 to 30 June 2022

	Notification	
Subject of Allegation Type*	**Number**	**Percentage**
Another care recipient	20,914	86%
Staff member	2,268	9%
Other	305	1%
Unknown	713	3%
Family/friend of care recipient	130	1%
Blank	107	<1%
Total	**24,437**	**100%**

* Notifications of certain incident types can be reported to the Commission as involving more than one Subject Of Allegation (SOA). The data included in this table reflects only the primary SOA reported, and does not include any additional subjects reportedly involved in a single incident. Additionally, the My Aged Care portal SIRS form allows providers to submit notifications reporting the SOA to be both another care recpient as well as having an additional relationship to the affected consumer (e.g. staff member, family/firend of the consumer, etc.). Where the SOA was reported in this way on a notification, the SOA has been counted as 'another care recipient' only in the above table.

Table 3: Percentage of SIRS notifications by maximum reported impact (physical and psychological) for 1 April 2021 to 30 June 2022

		Some harm					
Incident Type	**A**	**B**	**C**	**D**	**E**	**F**	**Total**
Unreasonable use of force	47%	42%	7%	3%	0%	0%	100%
Neglect	30%	24%	22%	22%	1%	1%	100%
Psychological or emotional abuse	32%	61%	5%	1%	0%	0%	100%
Unlawful sexual contact or inappropriate sexual conduct	61%	34%	4%	1%	0%	0%	100%
Unexplained absence from care	76%	14%	3%	7%	1%	0%	100%
Unexpected death	21%	0%	0%	0%	0%	79%	100%
Stealing or financial coercion by a staff member	82%	17%	1%	0%	0%	0%	100%
Restrictive practices	81%	13%	3%	2%	0%	0%	100%
Total	**46%**	**37%**	**8%**	**6%**	**0%**	**2%**	**100%**

1. Column (A) refers to no harm or no impact.

2. Columns (B) to (F) refers to 'Some harm' as classified: (B) minor impact, (C) impact requiring onsite treatment, (D) impact requiring hospitalisation (not permanent), (E) permanent impairment, (F) severe permanent impairment/fatality.

Appendix A

Table 4: SIRS notifications by the reported cognitive impairment level of the affected consumer, by incident type, for 1 April 2021 to 30 June 2022

	Affected Consumer – Reported Level of cognitive impairment (% of row total)						
Incident Type	**Severe**	**Moderate**	**Mild**	**None**	**Unknown**	**Blank**	**Total**
Unreasonable use of force	53%	29%	11%	6%	1%	<1%	24,437
Neglect	29%	33%	23%	14%	1%	<1%	5,787
Psychological or emotional abuse	21%	29%	28%	19%	3%	<1%	3,052
Unlawful sexual contact or inappropriate sexual conduct	45%	31%	15%	8%	1%	<1%	2,123
Unexplained absence from care	26%	45%	22%	6%	1%	<1%	2,056
Unexpected death	26%	30%	26%	15%	2%	<1%	903
Stealing or financial coercion by a staff member	11%	23%	36%	29%	1%	<1%	589
Restrictive practices	52%	33%	9%	5%	1%	<1%	522
Total	**44%**	**30%**	**16%**	**9%**	**1%**	**<1%**	**39,469**

Table 5: SIRS notifications by the reported cognitive impairment level of the subject of allegation, where the subject of allegation was reported to be another consumer, by incident types, for 1 April 2021 to 30 June 2022

	Subject of allegation – Reported Level of cognitive impairment (% of row total)						
Incident Type*	**Severe**	**Moderate**	**Mild**	**None**	**Unknown**	**Blank**	**Total**
Unreasonable use of force	62%	29%	6%	2%	1%	<1%	20,914
Psychological or emotional abuse	37%	37%	16%	9%	1%	<1%	1,861
Unlawful sexual contact or inappropriate sexual conduct	41%	35%	16%	6%	2%	1%	1,542
Total	**59%**	**30%**	**7%**	**3%**	**1%**	**<1%**	**24,317**

* Please note that other incident types (Neglect, Unexplained absence from care, Unexpected death, Stealing or financial coercion by a staff member, and Restrictive Practices) are not applicable in this case as providers can no longer choose 'consumer' as an SOA type for notifications of this type.

Note: Reported level of cognitive impairment information is only available when the subject of allegation is reported to be another aged care consumer. The subject of the allegation can only be reported to be a consumer for specific incident types. As a result, the information reported in the table above is a sub-set of the total notifications received by the Commission.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

March 2023

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city