QUALITY AGED CARE ACTION GROUP INC

QACAG Submission

SIRS in Home Care Services

9 August 2021

About QACAG

Quality Aged Care Action Group Incorporated (QACAG) is a community group in NSW that aims to improve the quality of life for people in residential and community aged care settings. QACAG is made up of people from many interests and backgrounds brought together by common concerns about the quality of care for people receiving aged care services.

QACAG Inc. was established in 2005 and became incorporated in 2007. Membership includes older people, some of whom are receiving aged care in NSW nursing homes or the community; relatives and friends of care recipients; carers; people with aged care experience including current and retired nurses; aged care workers and community members concerned with improving aged care. Membership also includes representatives from: Older Women's Network; Combined Pensioners & Superannuants Association of NSW Inc.; Kings Cross Community Centre; Senior Rights Service; NSW Nurses and Midwives' Association and the Retired Teachers' Association.

QACAG members welcome the opportunity, through this submission, to provide input to the *SIRS in Home Care*.

Margaret Zanghi
President
QACAG Inc.

Kind Regards,

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President
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KMPG's final report, *Improving Aged Care Quality Protections: Options for a Serious Incident Response Scheme (SIRS) in home and community aged care*, identifies four policy options for expanding the SIRS to in-home services:

- Option 1 No change to the current arrangements (SIRS for residential aged care only)
- Option 2 SIRS for residential aged care is implemented in the home and community care setting with amendments to acknowledge the different care setting
- Option 3 SIRS for residential aged care is implemented in the home and community care setting, to the extent possible, although incidents associated with low or no harm are not reportable incidents.
- Option 4 Expanded scope and definition for SIRS for residential aged care is implemented

Option 2 is the preferred option, noting concerns in relation to the operation of SIRS in the home and community would need to be addressed. A key factor to the implementation of the SIRS in home care is education about the scheme for the carers, the consumers and their families. Knowledge of their rights and responsibilities for the whole consumer/ carer cohort is vital in facilitating optimal practice. There is lack of acknowledgement of the power imbalance between the provider and worker who may be the reporter. In addition, what education will be provided to consumers, their carers and families on the SIRS. Can they make a report to the SIRS? There is also a bias towards acts and omissions on the part of the worker with little recognition that many incidents arise from high workloads and lack of training, supervision and support. Such matters are beyond the control of the worker. There must be greater recognition of organisational failures that impact incidents, and rectification of the same in management of serious incidents and less emphasis on the actions of individual workers. Increased recognition of reporting from consumers of care, whether via the SIRS or through pre-existing pathways, needs to be considered due to the fact that care is being administered in the home environment. When presented with Charter of Rights, consumers should get a fact sheet informing them of SIRS.

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 emphasis of the legislation is on the effective management of the incident rather than resolving the underlying issue. Being focused on the process only allows for examination of a system for identifying and reporting, rather than prevention of serious incidents by other means. Quality of Care Principles should apply to providers of in-home services with prevention of serious incidents being a key focus.

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

Home services is different to residential care due to the nature of the home environment. Multiple contractors may be attending. The consumer may be self-managing their care services, or they may be utilising a provider (or multiple providers) to do this for them.

Noting concerns around greater independent variables in home care, there already exists additional systems for protection through the NSW Ageing and Disability Commission and other bodies that should not deter from applying the SIRS into home care.

On page six of the Final Report it is noted that where an incident occurs in the home, but does not have a connection with care, it should fall outside the scope of SIRS so that these incidents need not be reported to the Commission. However, these matters should be reported to the police or other State and Territory authorities which can address elder abuse, and that home care providers should have a safeguarding regime. This is because workers may observe conduct or circumstances such as signs of abuse, neglect or exploitation by another person that no one else may be aware of. However, the Final Report noted that expanding the SIRS to in-home aged care services needs to be sufficiently targeted to reduce the risk of the scheme becoming overwhelmed. For robust protections for the elderly receiving care wouldn't it be advantageous to strengthen these to make mandatory requirements for providers to report these matters (that fall outside the Commission's powers) to the State or Territory authorities? This would fall in line with reporting protections afforded to children. This would be a sensible approach as, like children, those who are receiving aged care services are often vulnerable and have no voice of their own.

Are the requirements for reporting to police and others also able to be implemented for in-home services?

Yes. Reporting to police is afforded to all members of the community. Reporting to police would always be included in criminal matters, however there must be clear processes, guidance and timeframes put into place (with adequately resourced supporting structures and infrastructure) to ensure a SIRS requirement is able to be followed.

Despite extended operating hours being a recommendation of a 2016 Inquiry into elder abuse in NSW, it is concerning most of these services (including those in other States and Territories), except for 000 calls, only operate during office hours. This would be inconsistent with the timeframe for reporting of SIRS priority one incidents if an incident occurs after 5pm on a Friday. Whilst supportive of the need to have SIRS applied to home care, workers, carers and recipients of care would require clarity regarding which organisation to report issues of concern to, and the different expectations around timeframes to report.

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?

Ideally, consent should be gained with the recipient or, as appropriate, their next of kin/guardian/representative. Wherever possible, matters should be discussed with the consumer, or their nominated representative. The consumer needs to be involved. There may be personal matters that the approved provider is unaware of, therefore an opportunity to discuss the incident with the consumer may be advantageous. Considerations for consumers with cognitive impairments/deficits must be considered. In addition, consumers from Indigenous and CALD backgrounds must be accounted for, including the need to utilise culturally sensitive communication methods. The safety of the person making the report also is paramount, as such there may be situations where the reporter may wish to remain anonymous. There should be systems and processes in place to enable the reporting person to access information and advice in a timely manner to assist them in making a report, regardless of time or day.

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?

Since the intent of the legislation is around the protection of the consumer, there should be scope for everyone to make a notification. Where workers accountable to professional bodies (Nurse Practitioners, Registered Nurses and Enrolled Nurses) identify concerns, they have a professional duty to the consumer to report these. Regarding SIRS, specifically, both staff and those receiving care should have the ability to make a report.

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?

Workers in home care should report via SIRS, as workers in residential care are required to do. In respect to workers, protections should be put in place to protect reporters from reprisals or retribution. There may be impacts on contractual arrangements for those providing care, outsourcing or brokering care delivery. This must be considered. There are concerns here regarding confidentiality and ensuring that disclosure protections are adhered to.

The worker making the report may be compromised through disclosing the report to another employer to whom they are not accountable. If there is an immediate risk to the consumer, or worker, this should be dealt with by the Police who would be responsible for making the necessary notifications. In all other circumstances the Commission should ensure it has capacity to make the required notifications in a timely manner. Putting the onus on workers making a report in good faith leaves them vulnerable. Protection for workers making a report must be put in place.

Consumers and carers must also be provided with comprehensive information regarding the SIRS process and also the processes by which they can make a report, where necessary.

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

No.

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

The definition of unlawful sexual conduct and inappropriate sexual conduct should apply equally in all contexts. The consultation paper notes the definitions are based on feedback from the operation of the SIRS in residential settings. There have been few opportunities for workers, workforce representatives, consumers and consumer representatives to evaluate this scheme. Therefore, we take the opportunity to identify concerns with the current SIRS scheme that would need to be clarified in its application to home care. Definitions do not account for provider responsibility where high workloads, for example, impact on a worker's ability to provide care in an unhurried manner. Often cases of unreasonable use of force arise where a worker, operating within unreasonable workloads, may provide rushed care that results in allegations of unreasonable use of force. Some consideration to quantifying 'unreasonable' is needed as sometimes safe actions may appear unreasonable to an observer.

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?

Yes.

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

Yes. Examples including 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 the consumer are given. Emotional neglect arising from high workloads would be a common occurrence in aged care. Again, given the lack of consultation regarding the operation of the existing SIRS with consumer and workforce representatives means the examples are heavily weighted towards individual failures on the part of workers and fail to recognise organisational factors beyond workers control. Research shows loneliness is a major issue for older people, failure of approved providers to schedule sufficient staffing to enable workers to fulfil both physical and emotional needs of consumers is an example of an organisational failure which could be included.

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?

Normally a coroners' enquiry is already required. Clear guidelines need to be provided on reporting. There must be provision of evidence-based staffing levels of suitably qualified workers. Missed care episodes, due to insufficient staffing numbers and lack of suitably qualified staff, leads to exacerbation of issues leading to increased levels of morbidity and mortality. It may be problematic for a provider, or individual reporter to determine an unexpected death. However, it is important to include this as a safeguarding measure.

Blaming the staff for an incident resulting in death is not appropriate without first reviewing the underlying cause. This is where it is imperative to consider Work Health and Safety considerations here as a preventative measure. This may include the ensuring of appropriate WHS risk assessments regarding worker safety as well as consumer safety.

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?

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 and is a loophole both in the existing SIRS and in its proposed home-care application. We would recommend this is re-worded to acknowledge the possibility of an approved provider also committing these offences including charging for additional services fraudulently or not providing a service due to poor scheduling of staff. Stealing or financial coercion by an approved provider, or employee would provide better safeguards and clearer advice.

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?

Lack of care provision that leads to neglect can include lack of suitable numbers of appropriately trained and qualified staff. Providers should not be able to use schemes such as SIRS to obfuscate their responsibilities by laying blame on the worker. Given the lack of consultation with the SIRS prior to the rollout in residential care, it is essential to point out that blaming staff when the approved provider's systems of work have constraints out of the staff members control is not appropriate. Similarly, blaming workers/staff for an incident resulting in neglect is not appropriate without first reviewing the underlying cause.

There needs to be clear parameters regarding an approved provider agreeing to provide care to a consumer when they know they are not able to provide the level of care required.

How is the Department of Health and the Commission monitoring the impacts of the SIRS on staff and consumers?

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?

Whilst noting the examples that constitute restrictive practices, most workers would not be responsible for making decisions regarding the use of medication, or equipment and might unwittingly undertake a potentially restrictive practice through lack of training or by following advice from their employer. Given the power imbalance that exists between employer and worker in aged care, whatever context that care is delivered, it would be more appropriate to provide further examples that do not solely place blame on the actions of the individual worker, such as circumstances where an approved provider has failed to seek a timely review.

Also, is there consideration to the use of locking the consumers doors when they have a cognitive deficit, as a physical restraint. Often the need to maintain a loved one in their home has led to decisions about locking doors to ensure the consumer stays within the home until others visit.

It is difficult to determine if reporting of restrictive practices should be under the SIRS for in-home care without evidence and data on whether it is currently occurring frequently or not.

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)?

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?

All reportable incidents should be reported within a 24 hour timeframe with an adequately resourced structure to deal with reports in a timely manner.

Given the level of confusion that exists amongst workers in relation to the SIRS, a single reporting timeframe is preferable. The SIRS was established to reduce the risk of elder abuse; therefore, it is important that workers can continue to report within a short timeframe of 24 hours. It should be recognised that care is delivered 24/7 and as acuity rises among home care consumers the amount of out of hours in-home care delivered will inevitably rise, and acuity amongst the cohort of consumers increase, raising their vulnerability and the need to ensure a timely system to respond when issues of concern are identified.

As there is no data of what is currently occurring in the in-home care delivery setting, all things need to be reported within 24 hrs. If you limit the reporting, you limit the data collection and then you are unaware of the risks that are occurring.