Transcript

Aged Care Quality and Safety Commission

SIRS and Quality Aged Care   
Serious Incident Response Scheme

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**Presented by:**

**moderator:**

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**Attendees:**

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[The visuals during this webinar are of each speaker seated at a long table and speaking to camera with Janet Anderson appearing via video]

**Nicola Dunbar:**

Hi. Welcome to the fifth in our series of webinars about the Serious Incident Response Scheme or SIRS. My name is Nicola Dunbar from the Aged Care Quality and Safety Commission.

I’d like to begin by acknowledging the traditional owners of the lands on which we’re all meeting here today and pay my respects to our Elders past, present and emerging.

In our webinars leading to the commencement of SIRS on 1st of April, a week ago today, we looked at the use of incident management systems, reporting requirements and the role of the Commission. Today we’re going to take a different focus. We’re going to be looking at how SIRS can help you provide the best care for your residents, so how you can actually use the scheme as a driver for improvement and for providing the best care. We will be revisiting some of the basic components of SIRS and also giving you some feedback from the first week of the operation of the new scheme.

If you need more information about SIRS I strongly encourage you to look at the webinars, the four that we’ve had so far – they’re all on our website – to make sure that you have an overview of how SIRS exists and what it means as a whole.

So first of all I’d like to introduce the speakers who will be part of the webinar today. Firstly Janet Anderson, the Commissioner at the Aged Care Quality and Safety Commission, Ann Wunsch, Director of Approvals, Compliance and Investigations at the Commission, and Dr Melanie Wroth, our Chief Clinical Advisor.

To start with I’m going to hand to Janet first to give us a recap of the key components of SIRS.

**Janet Anderson:**

Thanks Nicola. Hello everyone. By now I expect you will have familiarised yourselves with the core elements and the new expectations associated with the Serious Incident Response Scheme and I will go back over some of that information briefly. But I wanted to start somewhere a little different by underscoring that SIRS is about so much more than simply recording, responding to and where required reporting serious incidents. Of course those are the core elements of the scheme but they’re also a means to an end not an end in themselves.

At a broader level SIRS offers providers a new way of looking at incidents affecting people living in residential aged care, managing those incidents effectively and learning from them to prevent and reduce abuse and neglect. Now let me unpack that briefly. Fundamentally SIRS is designed to promote an aged care system that protects aged care consumers from harm and empowers them by reinforcing their right to be safe. Think about those words. A consumer’s right to be safe. Residents in an aged care facility have a right to assume that they will be protected from harm. But you as providers can never take that expectation for granted. We know that serious incidents can and do happen in aged care that can adversely affect one or more residents. So providers have a responsibility not just to minimise the risk of serious incidents in aged care but to respond to such incidents in a way that mitigates any impact on residents and also to take whatever actions necessary to prevent any recurrence of the incident.

So a pithy summary of the full import of SIRS might go like this. SIRS establishes responsibilities for providers to prevent and manage incidents and to report serious incidents and it also introduces an expectation that providers will use incident data to drive quality improvement. And by that means of course SIRS supports you as individual providers and the aged care sector more generally to continuously improve the safety and also the quality of care that you provide to consumers.

And we turn now to a short outline of the key features of SIRS. As you know the scheme introduces two central legal obligations for providers of residential aged care. The first is to maintain and use an effective incident management system for recording, managing and learning from incidents, and the second obligation for providers is to report certain serious incidents to the Commission. And indeed the requirement to have an effective incident management system is now found within Standard 8 Organisational Governance and complements the existing responsibilities to reduce incidents of abuse and neglect in aged care.

There are eight incident types that are reportable under SIRS. I’m not going to recite the eight here because that information is available to you in a number of other places including on our website. But as of the 1st of April, last Thursday, you should be notifying the Commission of all Priority 1 reportable incidents within 24 hours of becoming aware of the incident. Now again the definition of Priority 1. Priority 1 incidents are the subset of reportable incidents that have caused or could reasonably be expected to have caused physical or psychological damage or discomfort to a consumer that requires medical or psychological treatment. Priority 1 incidents also as you know include all incidents that involve the unexpected death of a consumer or a consumer’s unexplained absence from care.

Now it’s clear from the reports submitted since last Thursday, the 1st of April, and also the questions we’ve received that there is still some uncertainty about what needs to be reported to the Commission. And I can say to you that as of yesterday morning we had received over 600 reports and almost half of those are actually not Priority 1 incidents. By your own categorisation – and you’d be familiar with the notification report which has serious incidents and critical incidents – by your own categorisation you are recording them as serious rather than critical but you are also reporting them. You’re not obliged to report Priority 2 incidents until the 1st of October. So incidents which have a low or zero impact or harm for consumers are not reportable until the 1st of October. You should definitely record those incidents in your IMS, learn from them and take whatever action is necessary, but your obligations in relation to reporting to the Commission pertain only to Priority 1 incidents until the beginning of October.

There’s another subset of incidents we’re receiving reports on which are in fact entirely out of scope. So they’re neither Priority 1 nor Priority 2. And as providers you need to consider the circumstances of each incident to determine whether or not it constitutes reportable incidents. And I can give you an example in relation to falls. A fall experienced by a resident is not in and of itself a reportable incident. It is the circumstances in which the fall occurred that would render it reportable in certain instances. So if a fall occurred where a care plan identified that assistance was necessary when the individual consumer was moving and that assistance was not provided and the consumer fell as a result of the absence of assistance that would constitute a reportable incident.

So I know you’re feeling your way and you’re learning about this. I reinforce the point Nicola made. There is more guidance, fact sheets on our website that you can check to ensure that you have the best and most accurate understanding of the definitions of Priority 1, Priority 2, what’s in scope, what’s out of scope, what the eight reportable incident types are. I commend the website to you. That is where you will get the information you need. Thanks Nicola.

**Nicola Dunbar:**

Thanks Janet. And just to reinforce that I think there is a lot of information on the website. It’s important we will be keeping on building on that to help guide you around these things and to understand those definitions and what the things are that you need to report.

Janet at the last webinar you spoke about the role of the Commission and including our role around identifying risks to consumers and taking action to mitigate those risks. What does that mean in the context of SIRS?

**Janet Anderson:**

Okay. The Commission is responsible for administering SIRS and our core priority under SIRS is to effectively identify risks to consumers and to ensure that you as providers are taking all necessary action to mitigate those risks. That’s it in a nutshell. So that involves firstly receiving and assessing notices or reports about reportable incidents and assessing particularly the risk to consumers, the adequacy of the actions you have taken to manage and mitigate those risks, and then when we’ve undertaken that initial assessment following up and if necessary undertaking further regulatory actions to ensure that you as approved providers are meeting your obligations under SIRS.

There is not always a second step. If we are satisfied that there is low risk and it’s been adequately managed by you there may be no further action taken by the Commission. We deal with every single notification in a proportionate risk-based way that holds you as a provider to account in relation to your legal responsibilities. And that includes determining whether providers are responding appropriately and effectively to incidents, to each incident, to ensure the safety, health and wellbeing of consumers.

We have a number of options available to us for dealing with reportable incidents and I’m going to give you a bit of a list as to what we may choose to do depending on our initial assessment of the report that you submit. We may request more information from you. We may undertake monitoring or a performance assessment activity in relation to that incident. We could refer the matter to another body such as the police if you’ve not done that yourselves, the Coroner or AHPRA for example. We may require or request you as the provider to undertake remedial action in relation to an incident. We can require you to conduct an investigation into the incident or to engage a qualified expert external to the organisation to conduct an investigation and then to submit that report to us. Or we could carry out an inquiry into an incident particularly where the risk to consumers appears to be ongoing.

Now we also have other options available to us where we are concerned about identified non‑compliance with your legal obligations. And you are very familiar with some of the existing enforcement powers that the Commission has and uses and we have gained additional powers through the SIRS legislation that we may choose to use very selectively and on a proportionate basis depending on the perceived or finding of non-compliance and where we are concerned about escalating levels of risk or unmitigated risk to consumers. We will choose the most effective option or combination of options in response to the circumstances of each case that best mitigates the risk that the incident report discloses and is also most likely to lead to an improvement in the safety and quality of the care provided at the service.

**Nicola Dunbar:**

Thank you Janet. One of the things that you mentioned in that answer was that when we are responding to some findings or to incidents coming through is that we’ll be looking at how specific incidents might be dealt with and whether and how individual providers are responding, whether they’re responding appropriately, effectively to ensure the safety, health and wellbeing. So we take into account the way in which they’re responding. Can you talk about that a bit more? I think that this is part of what we want to focus on today is that issue about how providers are responding.

**Janet Anderson:**

And indeed this is the link with the closing remarks I made at the end of our fourth webinar. This notion of provider posture is actually key and one that may not be well understood by all providers. So I’m really pleased to take this opportunity of expanding on it here. In determining how we at the Commission will respond to particular notifications of serious incidents including where there is identified non-compliance by the provider we will consider all the evidence about that incident including the risk or potential for harm to the safety, health, wellbeing and quality of life of individual residents and the posture of the provider including the extent to which the provider demonstrates they can prevent and manage risks to consumers.

So if a provider demonstrates that they are willing and able to comply and to take all reasonable steps to do so then the action that provider faces by the Commission will be different from actions we would take for a provider who cuts corners on quality and safety or who deliberately avoids compliance obligations and perhaps even places consumers at risk of harm. So thinking specifically about SIRS this means that we will consider factors such as a provider’s demonstrated understanding of incident management and their focus on consumer’s safety, their reporting of the reportable incident, their capacity and capability to manage the incident when it has occurred and their reporting compliance and complaints history, their track record.

Together with the risk of harm to consumers the Commission’s trust in the capacity of the provider to prevent or mitigate harm is a fundamental element of our regulatory approach. So if you were to point to any provider with a strong, successful track record of delivering good experiences and outcomes for their residents you will find a service culture of quality, safety and risk management. Such a service culture doesn’t happen by chance or good luck. It’s built and sustained through skilful, engaged, committed leadership within that service from the top down by leaders such as those participating in this webinar who understand that if you reduce SIRS to yet another provider obligation you’ll be missing the point. Thanks Nicola.

**Nicola Dunbar:**

Thanks Janet. I think it would be good to explore this in more detail. So the concept of provider posture and our trust in providers and how they can build that positive service culture that you just described is something that influences the way we interact with providers but also what we feel they should be aiming for. Can we pull that apart a bit more in terms of explaining the ways in which we think about this?

**Janet Anderson:**

Okay. When the Commission thinks about provider posture we think about it as a two by two matrix. And you will find this referred to on page 15 of our regulatory strategy which is published on our website. So think of it as two axes, a horizontal axis and a vertical axis. Along the horizontal axis we have the compliance approach and the compliance history of the provider. So we’re looking for providers who can demonstrate good or possibly poor compliance along that axis from zero to maximum if you like. And then on the vertical axis we have the provider’s approach to continuous improvement. So providers on that axis can demonstrate at the far end, at the maximum, a very positive approach where they are willing to learn, or conversely closer to the right angle at the intersection of the axes we have providers who demonstrate they’re not really that interested or focused on improvement.

So it’s where we combine those two axes and intersect them in a right angle that we get a rich understanding of how providers approach the way they provide care. So let’s combine the two axes as is done on page 15 of our regulatory strategy and come up with the four quadrants. Now we’ll label them one, two, three, four, although I’m going to deal with them backwards, four, three, two, one, and it will be a general orientation guide but I commend the matrix to you so that you can get the visual image in front of you as well.

Let’s start with the fourth quadrant which is the one furthest away from the intersection of these two axes. So it’s the farthest distance away from that right angle. The fourth quadrant is high compliance, high continuous improvement. So what we have is a high performing provider who complies with their obligations and takes a positive, energetic approach to continuous improvement and that needless to say is where the Commission wants all providers to be and indeed where consumers expect providers to operate.

Now the third quadrant is the one that we label as lower on the compliance score but higher on the continuous improvement. And what that means is the providers are taking a positive approach to continuous improvement but not always getting the compliance right, not always fully in tune with their compliance obligations. And these providers are willing to improve and demonstrably trying even if they’re not always succeeding.

Now the second quadrant – and we’re getting closer to the right angle here – second quadrant is an adequate score on compliance but lower on continuous improvement. These providers tend to be focused only on compliance. They do what’s necessary to meet their obligations but don’t actively look for opportunities to improve.

And then the first quadrant – four, three, two, one – the first quadrant is the quadrant closest to the right angle, low compliance, low continuous improvement. Essentially we have providers who are failing. These providers demonstrate a serious failure to comply and are not committed to continuous improvement. Now with SIRS I know that all providers are currently preoccupied by ensuring that you are complying with the new reporting obligations so that you are classifying incidents correctly and reporting them in the right timeframes. And obviously that’s important. What’s more important and what I hope will occupy more of your thinking time going forward is to contemplate what you can do to move yourself on SIRS into that fourth quadrant, that high performing box furthest away from the right angle where you go beyond complying with your reporting obligations and are also effectively managing specific incidents, learning from them and leaning into continuous improvement. These are providers who analyse your data, identify any patterns or trends and actively think about how you can prevent incidents from happening in the first place. You’re thinking about what you can do to provide the best possible care to residents.

So managing and reporting incidents is important but it’s only part of what is generally expected of you within the SIRS program. Thanks Nicola.

**Nicola Dunbar:**

Thanks Janet. And I think what we’ll do now is to take that description which is a really useful abstract description and let’s look at it in more depth and look at what it means in practice. So we’ll start first with the first quadrant, quadrant one. This is about providers who are failing both in terms of their compliance obligations and looking at their approach to continuous improvement. So I’m now going to turn to Melanie and to Ann around their experiences to give us a sense of okay what does that actually mean. What does it actually look like for me as a provider in practice if I was in one of these quadrants?

So firstly Ann from your experience as your current role around Executive Director of Approvals, Compliance and Investigations but also previously around Executive Director of Quality Assessment and Monitoring you’ve obviously had considerable experience with providers in this first quadrant. Can you describe some of the characteristics of these providers where from our perspective we see them failing both in terms of their compliance and also in terms of their thinking about continuous improvement?

**Ann Wunsch:**

So I’ll pick three characteristics to refer to. The first one would be in management and staffing and this is evidenced in instability in management, often characterised by poor governance, particularly a lack of clinical governance arrangements where there is insufficient oversight of the delivery of clinical care. It could be because of a high turnover in managers. Then in the staffing area it’s the inability to attract and maintain staffing or inadequate staff training programs that don’t deliver any discernible difference in staff practice.

The second area is communication. Poor communication with consumers and families where families or representatives don’t know who to contact in relation to a particular problem, they are unaware perhaps there have been changes in management or they’re unable to identify a person or the system to enable them to raise a complaint or a concern. And this is particularly when they are visiting, and it could be on weekends or evenings out of hours.

The last area is in assessment and delivery of care. And this is around poor planning for admissions and poor decision making in arranging the delivery of care following admissions and it essentially is about a lack of understanding of a consumer’s needs. So it’s a poor assessment and therefore poor delivery of care.

**Nicola Dunbar:**

So Ann in your role you’re not only seeing the providers that might be failing but also working with them you’re seeing the ones who are improving, returning to compliance, taking a more positive approach around continuous improvement. What are some of the strategies, what are some of the things that providers can do to kind of start to move out of that first quadrant and taking a more positive approach?

**Ann Wunsch:**

So providers need to start from first principles and that is start communicating with each consumer and their family or representative on an individual basis to establish or re‑establish trust. And this will lead to improvements. The first thing a provider must do is to really understand each consumer and their family or representative in terms of their preferred means of communication whether it’s face to face meetings, whether it’s via email. It’s really important to establish a communication that works for the audience that you’re communicating with. It’s also really important that providers don’t over promise. Particularly when they are in a situation where they’re failing, they are likely to be dealing with people who have already become very disaffected, are holding issues and grievances that haven’t been resolved for some time and therefore they need to get the reset right. And that is starting with establishing communication then understanding what those unresolved issues are that have caused difficulty and together develop what will be sustainable solutions.

**Nicola Dunbar:**

Okay. I’m going to bring Melanie in now from a clinical perspective. So Melanie as our Chief Clinical Advisor and experience as a geriatrician the issues around what are the clinical risks, what are the clinical issues that can occur for residents for when they are in a facility where the provider might be in that quadrant, in that failing quadrant? What are some of the risks and harms that we need to think about?

**Dr Melanie Wroth:**

Sure. Well in talking about this I think it’s important to remember that really the diametric opposite of this is where we would like people to be. But where there is a failure to identify risk of harm or even sometimes to identify harm or where it’s identified too late and therefore nothing changes as a result of these things. So often a provider in this space will have policies that are completely disconnected from the processes where management is unaware of what’s actually going on so that many of the adverse events will be hidden from them either deliberately or just because the processes aren’t there and therefore as Ann discussed the oversight is always going to be insufficient. So it’s where problems are ignored on the floor or where people fail to understand the significance. So warning signs are not noticed and are not responded to. So staff I’d encourage at all levels to engage with that process. So where somebody might see something and might be the eyes and ears that would ultimately lead to a risk not coming to harm, where they are perceiving that it’s not their job to notice, it’s not their job to report things, it’s somebody else’s job, and even if they were to report something who would they report it to – because the mechanism isn’t the clear. The person I report it to isn’t going to be very interested and even if they are interested in it nothing’s going to change. So what’s the point? If your workforce are thinking what’s the point then you’ve really got a problem.

There’s also sometimes a perception of this is how we do things here and everyone has to fit in with that, so that even when problems then emerge that way of doing things is unable to change when that’s the mindset. There is sometimes a perception that because there was no adverse outcome well then everything’s okay, without any concept of the fact that there could have been an adverse outcome which is actually the point. And there’s also a failure to see that fear, anxiety, social withdrawal are all actually adverse outcomes after an event. It doesn’t have to be a broken bone.

Neglect is particularly difficult because neglect really is the absence of some aspect of care that should have been provided and so that’s very hard to detect what an absence actually is. And it can of course take many forms. Providers will often find that there’s a culture of a punitive or adversarial approach to anybody who raises a concern or anyone who complains and that in itself is a disincentive to raise these concerns, that it’s poorly received. So even if you say you want to hear about problems, if they’re poorly received when you raise them you’re going to stop raising them. And I’ll give examples as to how those things can progress to being clinical problems.

So it does come down partially to culture, the behaviour, attitude and response of all levels of management really, that if things are to be nipped in the bud that all that can possibly go wrong is recognised and none of this occurs in providers that are doing those things. So if you’re giving somebody a medication and you realise you’ve given them the wrong medication or actually you don’t realise you’ve given them the wrong medication and all of what I’ve just said is present then you are extremely unlikely to let anybody know. So the opportunity to look at the contributors of why that might have happened rather than to punish the person to whom it happened is missed.

If for example somebody is becoming unsteady and that’s not noted or recognised or escalated or reported then that will progress to a fall. If somebody doesn’t get fed repeatedly and it’s not detected until weight loss well then that’s another missed opportunity. Where agitation is not responded to and it escalates to assault. Where unchanged continence pads are not reported or not responded to and that progresses to skin problems and ulceration. Where somebody’s left for a long time in a bed or a chair and that progresses to a pressure injury. And where residents are not believed. So where staff are believed over residents when residents in their vulnerable position of lack of power are not believed at all and that progresses to inappropriate staff behaviour becoming embedded as acceptable practice. So I think all of those things really can be seen as missed opportunities to address risk and they actually end up as incidents.

**Nicola Dunbar:**

Thank you. I think that’s a – some of those examples are really evocative of what can happen and where the organisation and the culture doesn’t support good performance. I want to move to the second quadrant which is about providers who might be complying with their obligations but they’re focused on compliance. They’re focused on okay this is what we need to do to meet the standards. We’re not thinking about how do we continuously improve. Melanie from your perspective are there also risks for residents in those services? So surely if they’re meeting their obligations from a compliance perspective things should be fine.

**Dr Melanie Wroth:**

Yes. So compliance if it is seen as that’s good enough and it leads to a complacency then there is much less likely to be a culture of continuing improvement. And if you see continuous improvement as something where you’re working towards perfection and therefore that’s not achievable that’s not really what I’d like you to think of continuous improvement as. Because continuous improvement really would involve when things are going well, if something changes that you respond to that change by detecting the risks proactively and responding to the new risk. So it’s a continuous looking at things and improving the risk profile of your service in response to change. And changes can be staff changes. It can certainly be resident cohort changes, so new residents, but also residents developing new problems. And of course any environmental changes which occur. So every time something changes is an opportunity to say what can possibly go wrong and look proactively at those things and improving your risk profile if you like, your risk processes for what’s inevitably going to be a continually changing environment.

**Nicola Dunbar:**

Thank you.

**Dr Melanie Wroth:**

So I just want to also say that it’s a way of thinking. It’s a way within the whole service of thinking which is a culture where you are looking at engaging all staff in identifying the risks and really looking at what everyone can see as what can possibly go wrong and using everyone in your facility as the eyes and ears that are welcomed. And examples of that really are – and these are things that I have been told about – where a gardener might notice that somebody’s been left outside for an unusually long time and knows who to go and tell about that or actually feels empowered to help the person back in. Where kitchen staff notice when food is uneaten. Where the day staff notice that things do not seem to be all okay at night, that there are several things that you would expect to be done are not done and that they are supportively looking at what the issues are there. And particularly of note was where a cleaner noticed that somebody was alone and distressed and was able to both talk to them and let other people know that there was a problem.

So all of those little things are easy for staff to do and understand and they do help with preventing things becoming adverse events.

**Nicola Dunbar:**

Thank you. And is there anything that you want to add from your perspective about those providers who are in quadrant two, so the ones where they’re compliance focused but not necessarily thinking about those little things that Melanie mentioned to improve?

**Ann Wunsch:**

These services are focused on passing the test rather than as Melanie talked about opportunities to improve. Often they’re using care practices that they’ve established over a long period of time that broadly meet people’s needs but may not be sufficiently tailored to support individual quality.

In order to move from this compliance quadrant and look at how to continually improve this requires engagement with consumers and their families in codesign. And so they move from a more generic approach to one that is more specific to an individual. Now some of these services may well have previously complied with the accreditation standards but they are now challenged by the Aged Care Quality Standards and that’s because of the codesign element that is required in order to deliver quality care to individuals.

**Nicola Dunbar:**

I’m going to go to Ann. We’re going to move to the next quadrant now but before I do I think I forgot to say at the beginning about putting questions in. So if you have questions along the way please put them in chat function and we’ll see whether we can get time for them. But please put those through.

Ann I want to continue with you as we move to the next quadrant which is about providers who are trying, they’ve got this approach about improvement and getting better but they’re not always succeeding. And what might be some of the reasons that providers are not quite getting it right even though that will is there to improve?

**Ann Wunsch:**

So sometimes it’s the case that there are structural barriers that inhibit improvement. It could be the local management is responsive but the overarching governance structure above that local management impedes improvement. Sometimes the culture in the service is the impediment. The best place to find solutions as I said in my earlier answer is in codesign where services engage with people that will benefit from the improvement. That means listening to consumers and families and actively considering their views and not imposing universal solutions. Sometimes transient things can cause these difficulties and they could be a focus on another element of the service which isn’t about care like a building program.

But all providers should try and understand what aspects of care they’re getting right and build on their strengths. And a recent example that I just wanted to mention was a service that is encountering significant difficulties at the moment but they have a particular practice that is a really important practice. And that is they use photos of familiar objects to assist residents with dementia to identify their rooms. So for those folk that are no longer able to identify their own photo they still may be able to identify a photo of a family pet or of the family home that they grew up in. And this can be a positive opportunity for the service to demonstrate its commitment not just to the person but also to the family.

Now that feedback from a family member who’s reassured by this personalised aspect of care also provides the service with some reinforcement. It’s positive feedback. This can also generate goodwill and go a long way to assist the service demonstrate its commitment to getting other critical care related matters remedied. So playing to strengths, identifying where they are getting aspects of care right can really support a provider to build on those matters to get the other critical care related matters right.

**Nicola Dunbar:**

That’s a great example. Thank you. We know that providers are often concerned that the Commission will take regulatory action against them if they don’t meet their obligations. How do we think about our regulatory approach when we know that providers are willing to take action to improve? How does that affect how we might respond?

**Ann Wunsch:**

So as Janet mentioned earlier the provider posture is critical here. We’re using a risk-based proportionate approach and where we identify that a provider is trying, is well intentioned but is still failing, we may issue a direction or a non-compliance notice instead of a notice to agree or a sanction because we are taking into account their posture and the provider’s commitment to engage with the matters and to remedy them. Now where there is a direction issued or a non‑compliance notice issued the Commission will still engage with the provider on a regular basis. This will be a frequent meeting to understand how that provider is making progress because we need to see evidence of improvement. But it is risk-based, it’s proportionate and it is certainly cognisant of the provider’s posture.

**Nicola Dunbar:**

Okay. And Melanie I’ll just come to you in terms of this quadrant. So these are the providers who are trying, not quite getting there. Are there things that providers can think about in terms of supporting better clinical outcomes, better outcomes for their residents if they’re kind of wanting to hit the mark a bit more?

**Dr Melanie Wroth:**

I think it comes down to going back to basics and asking the right questions. So for example we’ve already spoken a bit about how you need to have processes to identify and predict incidents preferably before they happen but also to critically look at why they have happened and therefore what can be changed. And so then you can step back and say well why didn’t we identify that risk? How can we change things so that it would be easier next time, that the same problems aren’t going to occur next time? Who should have known about this and why didn’t they know about it? And how can we change things so that everyone is empowered and encouraged and that the processes are there to support them? And I don’t mean the minutia. I just mean that if somebody raises a concern even if it’s to the wrong person that person will not let go of it until it’s reached the right person so that the right people know and the right questions are being asked. And that it’s enquiring enough not just to say well this person fell because of this reason when there may be many reasons that co-contributed. And I’m sure that all the providers here are well aware about the inter-relationship between the various different illnesses and medical issues and medications that people are on that inter-relate and that it’s rarely one problem. It’s rarely one problem causing one issue. It’s often lots of contributing causes. And unless you’re looking at everything and really asking the broad questions it’s going to be more difficult.

**Nicola Dunbar:**

Okay. And now let’s turn to the final quadrant, quadrant four, which is the one about they’re doing it well. So they’ve got their ducks lined up in terms of compliance, they’ve got a really strong quality improvement, continuous improvement approach. And I’m sure that you both have examples of providers that you’ve seen where they are doing this well. I think it would be great to hear about some of those examples. Melanie would you like to start?

**Dr Melanie Wroth:**

Yeah. Sure. Well one of the challenges I suppose is always open disclosure. It’s a mea culpa. This is what’s happened. We’re terribly sorry about it. This is what we’ve identified as causes. We’d really welcome you to tell us whether you can think of anything else and let’s work together. So that sort of approach to things which should be really occurring immediately, but where that’s absolutely embedded and where everyone can see that the benefits in that approach are clear. So that’s almost like a higher level of dealing with it. It’s who you’re engaging with the dealing, it’s including the communication and it’s getting a really genuinely open look at what could possibly happen. So I think it’s really just all the things we’ve spoken about where there’s a fully empowered and engaged workforce which actually anecdotally is a workforce that is more likely to stay and more likely to get satisfaction from their own work, and where the majority of incidents are identified before they occur, and where the governing body is interested in knowing not just the bad things but how bad things have been averted and what things can continue to be supported and strengthened.

And really what the Commission wants to know is really the same as what providers would want to know, that how did this happen and how can we be satisfied it’s not going to happen again at its most basic. And if the provider has already done that, that is a much more robust process than the Commission having to ask all the questions that the provider could be asking themselves.

**Nicola Dunbar:**

Okay. Thank you. Ann from your perspective, lots of different services that you’ve been working with. What are some of the examples of where people are doing all of this really well?

**Ann Wunsch:**

So high performing providers know their person, are able to walk in their shoes. And one example that we were discussing recently was a provider that rostered the day shift staff, including the manager on occasions, to sleep overnight at the service periodically to provide feedback to the nightshift staff about noise levels, lighting, issues with consumers that were crying out, seeking attention or disrupting others’ sleep. So this information was not only valuable to the nightshift staff to understand some of the challenges and to prioritise their work but it also assisted the dayshift staff understand how to better deliver care during the day noting some of the issues that were occurring at night.

We know when we walk into an unfamiliar environment that we immediately understand that environment from the ambience, the temperature, the smell and the level of calm or chaos. And we know that in familiar environments we can become quite desensitised. So staff can become desensitised and it’s important that they actively seek feedback from consumers, from visitors to ensure they have a really clear understanding about whether the space that people live in is welcoming, comfortable and whether it facilitates people’s engagement.

One provider commented to us that during the COVID pandemic when communal items such as salt and pepper shakers were removed from dining tables that people at dining tables spoke less to each other. They looked down, they opened their individual sachets of salt and pepper but they didn’t engage, they didn’t look up at each other, they didn’t ask questions, they didn’t talk as much. We know that conversations and relationships are key to people’s sense of wellbeing. So high performing providers understand how to facilitate and ensure that opportunities are there to maximise engagement.

Music is a significant tool that can be used to calm and also to stimulate and also create connections for people. And the services that invested during COVID in iPads and headsets and iPods and other technologies to support communication should seek to continue to maximise the value of this technology post COVID and also maximise the skills that people develop, both staff and consumers, in using these devices.

And lastly when I look at the numbers of reports that we have received under the previous compulsory reporting scheme and also now that we’re seeing through SIRS around physical assaults that involve rough handling I really think it’s a challenge out there now to providers who are seeking to be identified as high performers about the investment that needs to be made in residential aged care in gentle care.

And that’s a few more minutes that it takes to assist a person to extend their arm when you’re assisting them to put on a cardigan or ensuring that you have another person with you so you can gently ease a person into a sitting position rather than pull them. Gentle care I think could really change the experience of residential aged care for many elderly Australians.

**Nicola Dunbar:**

Thank you Ann. That’s lovely. So we’ve got about ten minutes left. We’ve got some questions. And we’re not going to be able today to kind of go into detail about some of the specific questions that you have around what should be reported and how things should be reported. We won’t have time for that unfortunately. But we will take those issues and we’ll take those questions and we will build them into our FAQs, into our case studies and examples. We know from the information coming through that we’ve got some more targeted advice that we need to provide to you and we will be learning from the information that’s coming in and doing that over the next week. So thank you for all of those questions and thank you for the queries that are coming through to our queries line. And I’ll go through some of the places to get advice in a sec.

I guess what I want to do now is kind of bring together some of the other threads of questions to kind of get views from Melanie and Ann and Janet around this concept of how providers can kind of move through these different quadrants. What I’ve been struck as we’ve been talking this afternoon is about I guess a couple of things, about the interconnected nature of the examples that Ann and Melanie provided and the kind of sense of this could feel overwhelming. If I want to have my service in that number four quadrant, that high performing quadrant, how on earth do I get there? So I’m kind of interested to get from each of you, because I know that each of you will have a different perspective, around where do I start, what might be some of the places to start with in terms of what might be the things. Melanie you talked about the little things. So what might be some of those places – I’ll start with you around okay, if we want to get to that high performing place what might be some of the ways in which providers can think about that, that it’s not this insurmountable mountain to climb?

**Dr Melanie Wroth:**

I think that trying to develop an awareness of what should be your priority areas and that would be by a genuine attempt at direct observation, not necessarily sleeping there overnight, but that would be actually a fantastic start. But actually being on the floor and trying to see from the residents’ perspective what are the things that really could make their lives better, how can this person’s life be made better. They really look bored. They really look lonely. They really are expressing that they’re worthless. And then just identifying how those – any change that’s identified as being fundamental, how that can be done, how you can model the care that you want. So which of your visible levels of management are going to take that on board, where when you’re caring for somebody you’re talking to them. Whether or not you think they can understand you they will understand your tone and the fact that you’re with them rather than talking to the other staff member across the top of their head. When you’re talking kindly to people, when you’re explaining things to them, even if you don’t think they can necessarily engage with all of the detail of that. Where you’re looking to see if somebody’s bored, who knows what things they enjoy doing. So start with the little things.

But that’s looking at it from the patient perspective, the resident perspective. But if you can at the same time see where the staff challenges are, and so that if you are putting expectations on staff that are unrealistic where are the priority areas to deal with that and how can you take some of the burden off staff that cannot get to things that you want them to be doing. So I think that’s where I would start. It would be prioritise and really getting an idea of what the important things are. And other things flow from it.

**Nicola Dunbar:**

Okay. Thank you. Ann from your perspective?

**Ann Wunsch:**

I think the issue about how do you ensure that each staff member regardless of their role has sufficient information to support their engagement with residents is really critical. We know that some services have moved to a dedicated staffing model because they find that by reducing the number of individuals that have contact with a person will one allow a better environment for staff to work in and also will support more a meaningful engagement because people can share information.

**Dr Melanie Wroth:**

One of the things that’s come to mind as Ann was talking is that often when people are looking for a residential facility to go into newly they will say to me ‘What should I be looking for?’ And I say number one what’s important to the person? If seeing a garden or being able to go outside is important look for that. If smell is important look for that. If the food is important look for that. But in the end when you’re there look at how the carers are interacting with the residents. That is a cultural thing that unless you’re there and looking at it you’re not going to know that the most beautiful facility may not be providing good care. So look at the caring.

**Nicola Dunbar:**

And Janet from your perspective where would you advise people to start if they’re wanting to move into that fourth quadrant?

**Janet Anderson:**

Three comments if I may and briefly. The journey to quadrant four starts with the quality standards, the principles of care, the Charter of Aged Care rights. That’s the scaffolding. That’s the structure within which all providers are required to operate and from which they will benefit most. So start with your scaffolding. Understand it, understand the expectations that attach to each of those instruments, and look in the first instance at the extent to which you are fulfilling your obligations against those statutory requirements.

Secondly understand that your operating environment is everchanging. So there is no set and forget here. There is no ‘I’ve made it now I can relax’. No. You’re an aged care provider. It is always about looking to improve where you are, how you are caring for your residents or consumers and their experiences of that care.

And the third observation to make is it is a journey. It’s everchanging but it is a progression towards rather than arrival at and satisfaction that there is no further work to be done. And it’s a journey that requires leadership but also fellow travellers. And the key fellow travellers are the consumers of the service and the care and the staff, the people who provide that care. And heading back in the direction of Melanie’s observation it’s what those key stakeholders are contributing to the journey which will ultimately see you arrive where you want to arrive and be able to maintain performance in that fourth quadrant of a high performing provider.

**Nicola Dunbar:**

Thank you Janet. We’ll start to wrap up now. We’ve got a few minutes left. Janet final comments from you in terms of drawing this all together?

**Janet Anderson:**

Thanks Nicola. I’ve been using the phrase game changer when describing SIRS to various different stakeholder groups and I hope you’ll see it that way too. This new scheme is an opportunity to think about how you as a provider and your staff provide care and what you can do as a provider not only to keep your residents safe and protect them from harm but more holistically to provide care that respects and responds to each individual’s unique identity, values, goals and preferences.

Your current focus in relation to SIRS is probably going to be on making sure that you have the right system in place, that your staff are trained and understand what they need to do if an incident occurs, and that you are submitting reports to the Commission as required. And that’s logical. I get that for now. But my hope and expectation is that you will come to understand SIRS as an integral part of a larger picture and it’s only by taking that broader view that you’ll be able to fully harness the benefits available to you through the new scheme. Remind yourselves that the best aged care doesn’t just protect older people from harm. It enriches their lives.

So implemented successfully SIRS is truly another means for achieving that end. Use it to leverage the kind of improvements in care that will deliver tangible benefits for your consumers including improving the quality of their lives. Now that might feel like a huge stretch target right now and I do understand that. But we’re only at the starting point and we do acknowledge that. The scheme is a week old and we have a long way to go before it’s fully bedded down across the aged care sector. There is more for all of us to learn and particularly by providers in terms of preventing, managing, resolving incidents and indeed about reporting serious incidents to the Commission.

We in the Commission will continue to work with you and provide you with further guidance and information about the issues that will arise and that have arisen already that will assist you in taking the steps necessary not only to fulfil your legal obligations but to strive for continuous improvement and to reach for excellence.

If you’re a provider the ball is now in your court. So show us at the Commission what you can do. But even more importantly show your consumers and families what you can do. Thanks Nicola.

**Nicola Dunbar:**

Thanks Janet. And thanks to everybody for joining us on the webinar today. Just to recap about the resources that are available we have a dedicated SIRS page on our website that has all of the guidance, the fact sheets, links to the webinars, other resources there to help you as you start to bed this down.

One of the things that is really important is about staff training. We’ve talked about that throughout the session. And just as a reminder, we’ve said this before, but free licences for ALIS, our online learning platform are now available through to October and we have modules that will be coming through that you will be able to use to train your staff.

Please take the time to look at the material that’s on the website, to go through those modules because that will help you understand what does need to be reported and what doesn’t and the details about SIRS. Keep your questions coming. We have an email address, SIRS@agedcarequality.gov.au. Keep your questions coming. We will respond to you. They will also help us understand the information that you need so that we can better target and give you what you need. So thanks again for joining us and we’ll all keep working together around SIRS. Happy first week birthday for SIRS. Thank you very much everybody.

[End of Transcript]