Aged Care Quality and Safety Commission

Sector performance report

Quarter 4 | April – June 2024

Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Contents

Artwork by Dreamtime Creative

In the spirit of reconciliation, the Aged Care Quality and Safety Commission acknowledges the Traditional Custodians of Country throughout Australia and their connections to land, water and community. We pay our respect to their Elders, past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples.

Message from the Commissioner

Welcome to the Commission's Sector Performance Report (SPR) for Quarter 4 (Q4), 1 April to 30 June 2024.

This report is part of our commitment to keep improving the experience of older Australians receiving government-funded aged care services, and to protect them from harm.

The SPR gives an overview of the data we use to assess the performance of the sector and to monitor risk to older people receiving aged care.

We use this information to work out where to focus our attention to improve provider and sector performance.

In Q4 2023–24, 81% of residential care providers were fully compliant with all requirements of the Aged Care Quality Standards (Quality Standards). This is a big improvement from the 58% compliance we saw at the beginning of the previous financial year 2022–23.

Residential care providers' compliance with the Quality Standards has stayed fairly stable for most of the past 4 quarters, with a small drop recorded between Q3 and Q4. However, providers' performance has improved compared with the first half of last financial year.

Compliance rates in home services still lag well behind residential care, and have remained stable for this financial year. However, there has been much improvement since last year.
In Q4, 65% of home services providers were fully compliant with the relevant Quality Standards, compared with a 46% compliance rate at the beginning of the previous financial year.

While this improvement is welcome, the rate of compliance in home services remains unacceptably low. We increased our audit program for home services in 2023–24 and that focus continues in 2024–25. Home service providers can expect our audits to include:

- careful review of management processes and how they apply across services
- close examination of risk management systems and governance arrangements.

Issues in governance and leadership directly affect the quality and safety of care. Organisational governance is therefore a major focus for the Commission. Residential and home services providers continue to fall short in the requirement to have effective governance systems and a clinical governance framework.

Janet Anderson PSM

As well as using information to identify sector risk such as governance, we also join the dots to decide where we should focus our attention at a provider level. This approach has informed how we have developed our new Provider Supervision Model.

We describe provider supervision in more detail in this report's 'In focus' feature article (page 63). It includes 5 case studies, based on real examples of providers that we have tested our model with over the past year.

Provider supervision is part of our strategy to drive the delivery of high-quality care. We supervise providers in a way that encourages them to fix problems quickly and improve their performance. We use a range of regulatory strategies and tools to monitor if providers are doing the right thing.

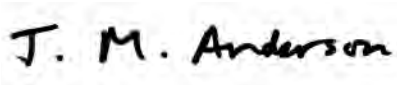
We give all providers a supervision status. Providers that we assess to be high risk will be under a greater level of supervision and engagement.

We don't hesitate to use our regulatory powers where a provider shows that they are not willing or capable of fixing issues. In these cases, and when we find serious failures in care, we take compliance and enforcement actions to protect older people.

Providers can move between supervision levels at any time based on the level of risk and their capacity and willingness to manage that risk. This can include moving straight from the lowest level of supervision to the highest, if necessary. If there are no specific risks or compliance concerns, providers will have a 'risk surveillance' status.

Provider supervision is a key part of the Commission's recently released 2024–25 Regulatory Strategy. The Regulatory Strategy explains how we will protect older people and how we hold providers and workers to account. The Strategy explains what we expect from providers and workers, as well as what they can expect from us.

This report can support providers to keep improving. It is most useful when providers compare the data with their own and act on it.



Janet Anderson PSM
Commissioner

We want to hear from you!

What data would you like to see included in the Sector Performance Report? And what would make this report a more useful resource for you?

Let us know by completing this short survey.

At a glance

Residential care providers' compliance with the 8 Quality Standards has stayed fairly stable this financial year, although we saw a drop of 3 percentage points to 81% compared with Q3. This is an improvement compared with Q1 2022–23, when only 58% of providers were fully compliant.

Compliance with the Quality Standards is still much lower in **home services** than in residential care. Only 65% of home services were fully complaint with the relevant Quality Standards in Q4. As with residential care, compliance among home services providers has improved compared with the start of the previous financial year, when less than half (46%) of providers were fully compliant.

We see issues with **clinical governance** reflected in the complaints we receive. Complaints about clinical issues still account for 3 of the top 5 issues complained about in residential care. In Q4, complaints about falls and post-fall management increased significantly. This risk warrants closer scrutiny by providers.

Compliance with **Quality Standard 8** (Organisational governance) fell in Q4, to 88% in residential care and to 70% in home services, compared with the previous quarter. This drop follows an improvement from 73% compliance with this Quality Standard in residential care and 52% in home services at the start of last financial year. Even though there was considerable uplift this year, there is still room for improvement in corporate governance and clinical governance frameworks. This is an area of ongoing focus for the Commission.

Fees and charges, and **management of finances** still account for 3 of the top 5 most complained about issues in home services. Issues with consultation and communication are still the most common concern in complaints about home services. Providers need to have clear and transparent pricing statements. They must consult with, and get consent from, people receiving care or their representatives before making changes to their home care package.

At a glance (continued)

We see the effect of poor clinical governance in lower compliance with **Quality Standard 3** (Personal care and clinical care). Compliance with this standard in residential care fell by 3 percentage points to 89% in Q4 compared with Q3. This result is still a clear improvement from the 70% compliance we recorded at the beginning of the previous financial year. In home services, compliance with Quality Standard 3 fell 9 percentage points in Q4 from the previous quarter, to 81%. Of concern, the compliance rate among home services providers is now lower than it was at the beginning of the previous financial year.

The number and rate of **serious incidents** in residential care reported to us has increased since the start of last financial year. However, the rate has stabilised over the past 2 quarters. We have also seen a steady increase in serious incident notifications in home services since the Serious Incident Response Scheme (SIRS) was extended to home services in December 2022. However, the number of notifications in home services has stayed much lower than in residential aged care. We are working with home services to make sure they understand their reporting responsibilities and the need to have in place an effective incident management system.

For the first time we have seen non-compliance with **Quality Standard 6** (Feedback and complaints) as one of the top 3 issues in home services. In Q4, compliance with the requirement to have an accessible and fair system to resolve complaints fell by 9 percentage points from the previous quarter, to 80%. One in 5 providers is not complying with this standard. Specifically, providers are not meeting their obligation to use feedback and complaints to improve quality. The Commission will be taking action on this.

Quality Standard 7 (Human resources) now has the third lowest rate of compliance in residential care and the highest number of requirements that are 'not met'. To comply with this standard, providers must have skilled and qualified workers to deliver safe, high-quality care. Residential providers must also have a registered nurse onsite and on duty 24 hours per day and meet their care minutes target. As of June 2024, 92% of providers complied with this responsibility. Concerns about the number of staff, however, are still the fourth most complained about issue in residential care in Q4.

Year in review

Over the 2023–24 financial year, providers' rates of compliance with the Quality Standards have stayed fairly stable in both residential aged care and home services. When we compare results with the 2022–23 financial year, there has been a considerable and welcome uplift in performance in both service types.

Compliance rates for residential aged care have improved from 58% in Q1 2022–23 to 81% in Q4 2023–24. Over the same period, compliance in home services also improved from a low of 46% to 65%.

Residential care and home services: compliance rates

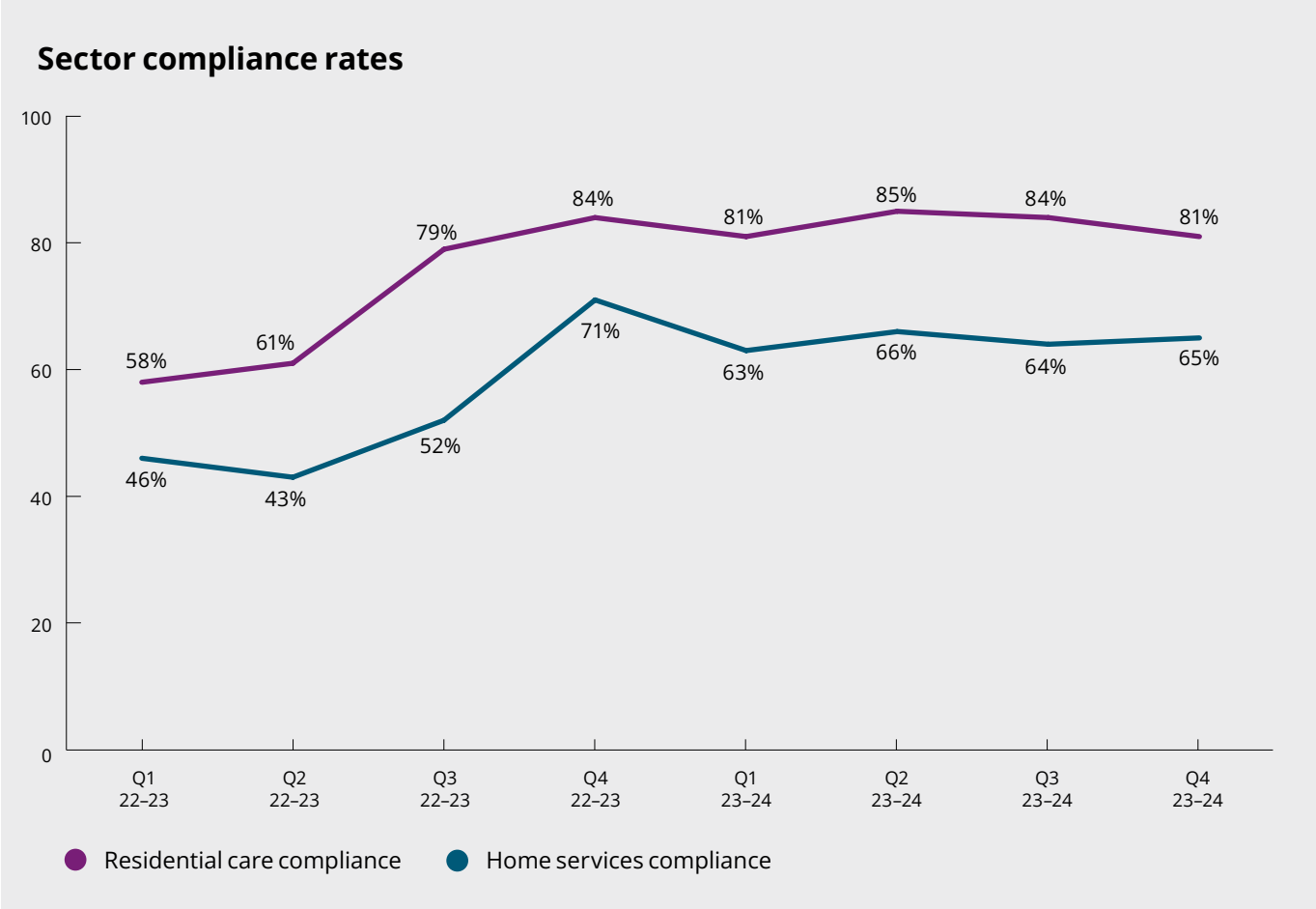
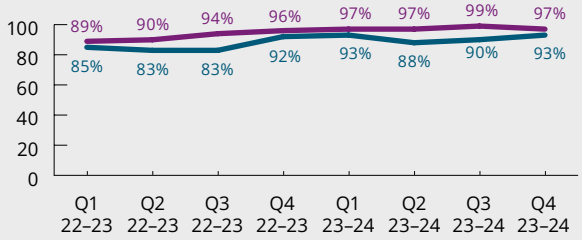


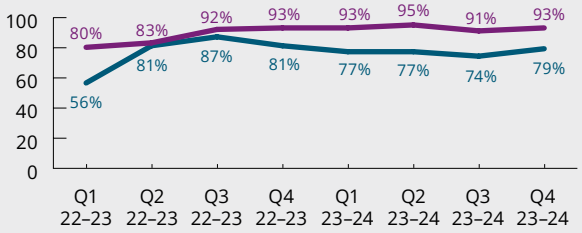
Figure 1: Residential care and home services compliance rates with the Quality Standards over the past 8 quarters

Residential care and home services: compliance with the individual Quality Standards

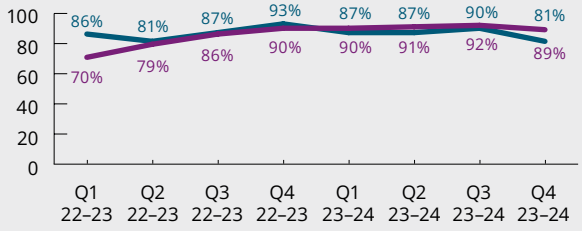
Quality Standard 1: Consumer dignity and choice



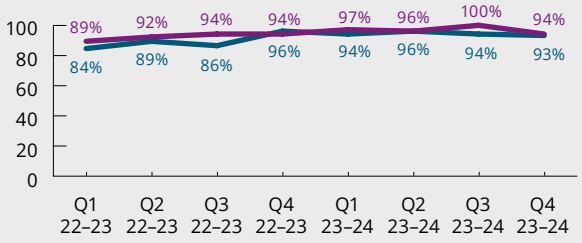
Quality Standard 2: Ongoing assessment and planning with consumers



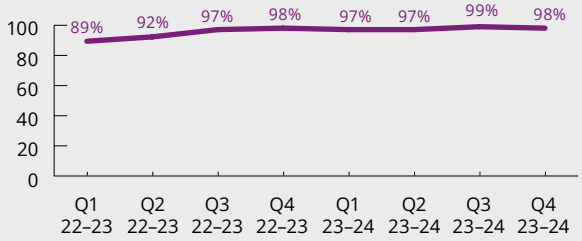
Quality Standard 3: Personal care and clinical care



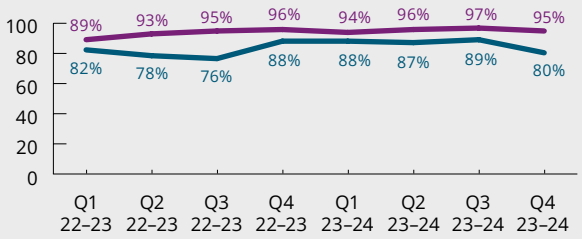
Quality Standard 4: Services and supports for daily living



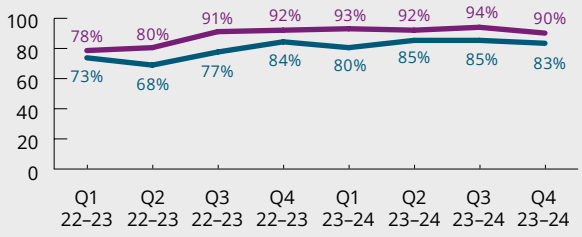
Quality Standard 5: Organisation's service environment



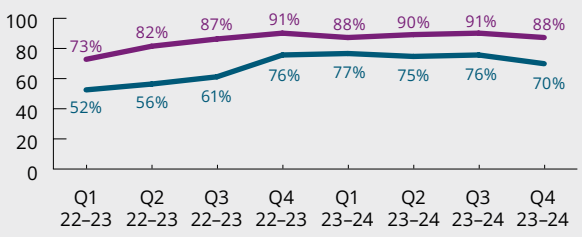
Quality Standard 6: Feedback and complaints



Quality Standard 7: Human resources



Quality Standard 8: Organisational governance



● Residential care ● Home services

Figure 2: Residential care and home services compliance rates over the past 8 quarters for each Quality Standard

- Performance in **Quality Standard 2** (Ongoing assessment and planning with consumers) for residential care has improved by 13 percentage points in Q4 2023–24 to 93%, compared with 80% in Q1 2022–23. Compliance with this Quality Standard also increased significantly in home services to 79%, compared with 56% at the beginning of the previous financial year.

- Compliance with **Quality Standard 3** (Personal care and clinical care) in residential care has improved significantly from 70% in Q1 2022–23 to 89% in Q4 2023–24. However, it has fallen slightly in Q4 compared with Q3 2023–24, and we are monitoring this trend.

- In both residential care and home services, compliance with **Quality Standard 7** (Human resources) has also increased significantly from Q1 2022–23 to Q4 2023–24.

- Compliance with **Quality Standard 8** (Organisational governance) has increased in residential care to 88% in Q4 2023–24, from 73% in Q1 2022–23. In home services, compliance with this standard has improved from 52% to 70%. Despite these year on year improvements, this Quality Standard has had the lowest rates of compliance throughout 2023–24, in both residential care and home services.

- The difference in compliance between home services and residential care is greatest for **Quality Standards 8, 6** and **2**. For home services providers, this points to priority areas for attention in lifting performance.

Serious Incident Response Scheme (SIRS)

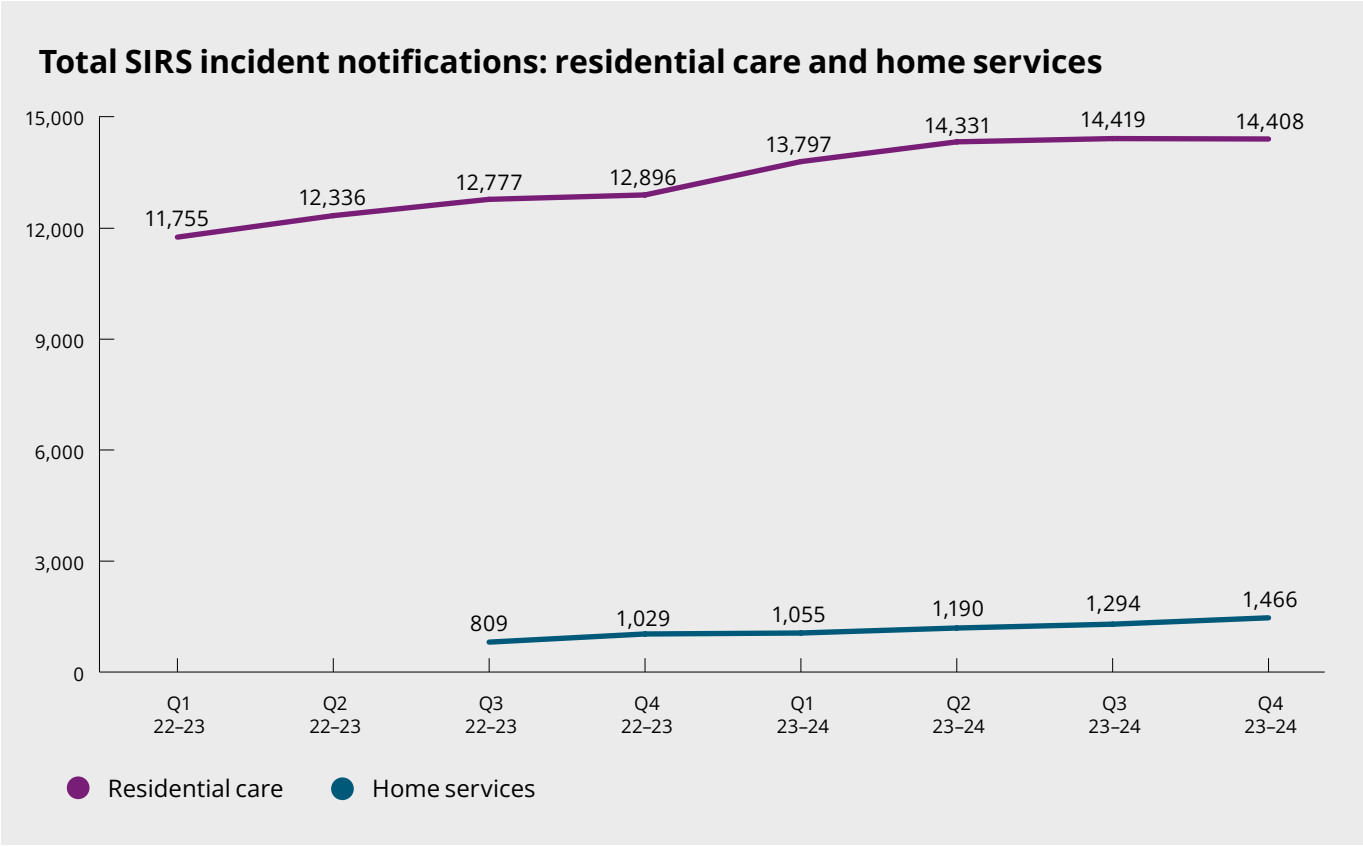


Figure 3: Residential care and home services SIRS incident notifications over the past 8 quarters (SIRS for home services was introduced in Q3 2022–23)

- The number and rate of serious incidents in residential aged care reported to the Commission has increased significantly since the start of the 2022–23 financial year. The rate has however stabilised over the past 2 quarters.
- Since the Serious Incident Response Scheme (SIRS) was introduced in home services in December 2022, we have seen a steady increase in notifications every quarter.
- The number of notifications in home services remains significantly lower than in residential aged care. We are working with home services providers to ensure they understand their responsibilities to report all serious incidents that occur as well as to have in place an effective incident management system.

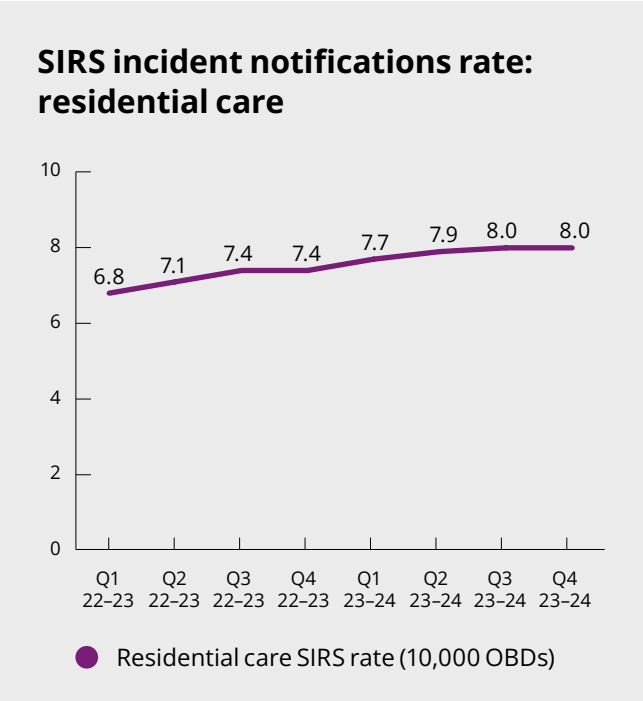


Figure 4: Residential care SIRS rates over the past 8 quarters

Complaints

Complaints received about residential care

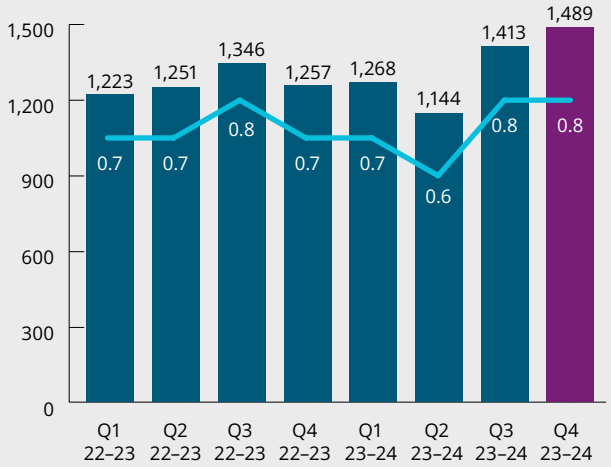


Figure 5: Residential care complaints rates and total numbers over the past 8 quarters

- The total number of complaints about residential care and home services have remained stable over the past two financial years. However, the numbers have varied between quarters. There was a significant fall in complaints in Q2 2023–24 and numbers have been increasing since that time.
- While there is no definitive answer as to why there was a drop in Q2 2023–24, there can be many reasons why the number of complaints varies between quarters, such as seasonal variation. A higher rate of complaints can also show that a provider is helping people receiving care to give feedback and raise concerns.
- The Commission is working to help people receiving care and workers feel more confident about raising concerns or complaints with providers directly, and/or the Commission.

Complaints received about Home Care Packages (HCP)

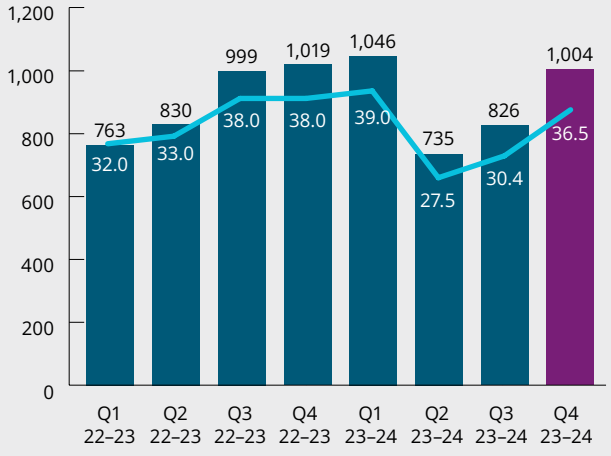


Figure 6: Home Care Packages (HCP) complaints rates and total numbers over the past 8 quarters

Complaints received about the Commonwealth Home Support Programme (CHSP)

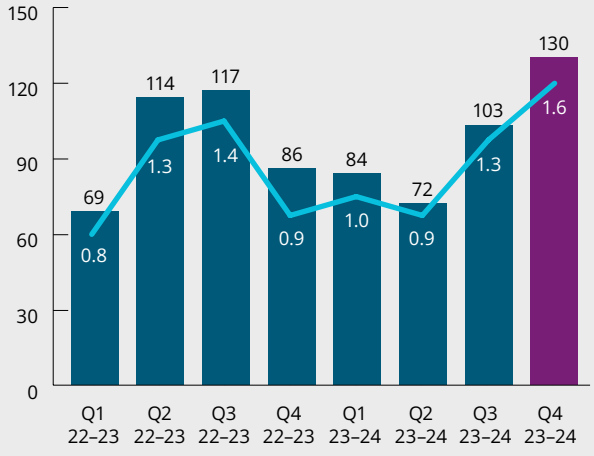


Figure 7: Commonwealth Home Support Programme (CHSP) complaints rates and total numbers over the past 8 quarters

Sector overview

Older people using aged care

1,289,211

Nearly 1.29 million older people use aged care services

- **198,103*** **Residential care**
- **274,976**** **Home Care Packages (HCP)**
- **816,132***** **Commonwealth Home Support Programme (CHSP)**

Figure 8: Number of people receiving aged care in residential care, HCP and CHSP

* Number of people receiving residential care. Distinct count of people receiving care, extracted from the Department of Health and Aged Care data warehouse, as of 30 June 2024 on 16 July 2024.

** HCP Consumer Data extracted from Department of Health and Aged Care data warehouse on 16 July 2024.

*** CHSP Consumer Data extracted on 16 July 2024 (numbers from 2022–23 financial year).

Residential care: by size

736

By size, small providers are the most common type of residential provider

- **557** Small providers
- **128** Medium providers
- **51** Large providers

Figure 9: Number and percentage of residential care providers by provider size, as of 30 June 2024

2,617

By size, large providers run most residential care services

- **656** Small provider services
- **596** Medium provider services
- **1,365** Large provider services

Figure 10: Number and percentage of residential care services owned by different size of providers, as of 30 June 2024

Residential care: ownership type

736

By ownership type, not-for-profit providers are the most common type of residential provider

- **243** For-profit providers
- **412** Not-for-profit providers
- **81** Government providers

Figure 11: Number and percentage of residential care providers by ownership type, as of 30 June 2024

2,617

By ownership type, not-for-profit providers run most residential care services

- **905** For-profit services
- **1,503** Not-for-profit services
- **209** Government services

Figure 12: Number and percentage of residential care services owned by different types of providers, as of 30 June 2024

Home services

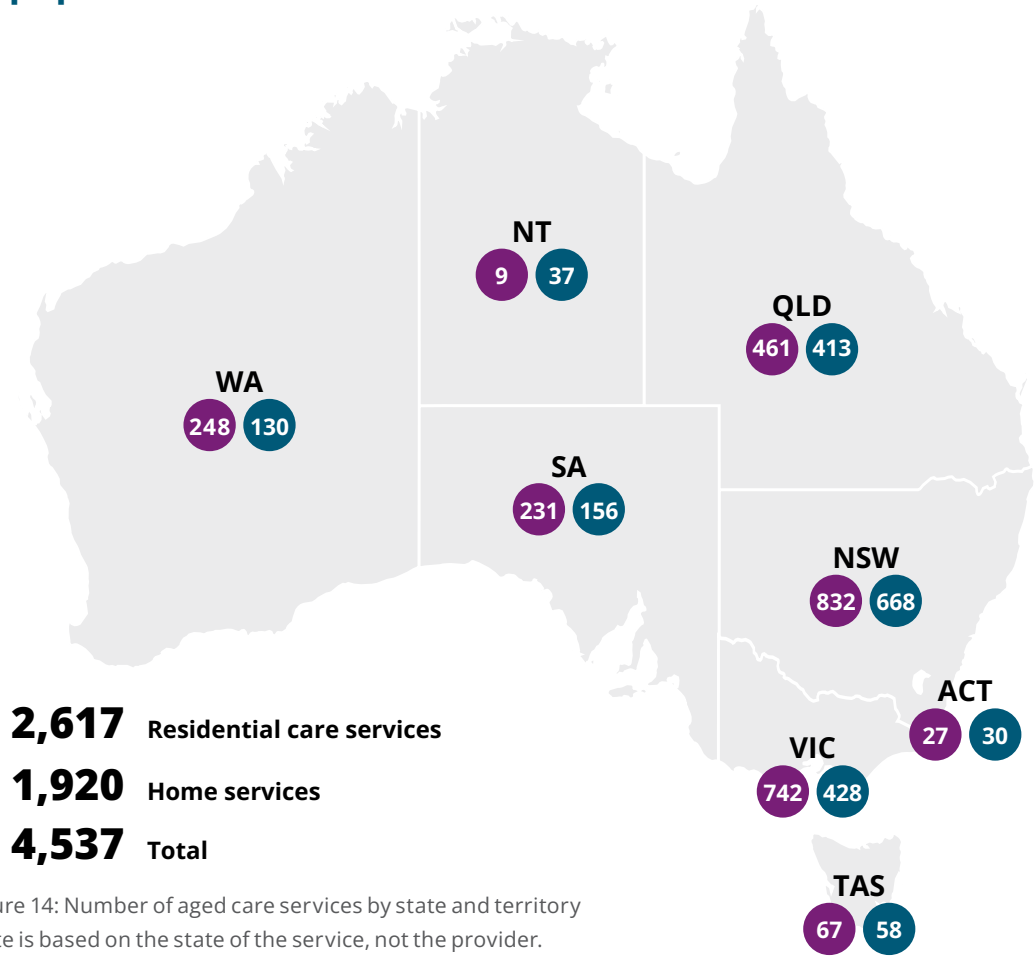
People receiving care

- **274,976** HCP*
- **816,132** CHSP**

1,920
Home services
(HCP and CHSP)

Figure 13: Home services providers, as of 30 June 2024
* Home Care Packages (HCP)
** Commonwealth Home Support Programme (CHSP)

The distribution of services is roughly proportional to population distribution



- **2,617** Residential care services
- **1,920** Home services
- **4,537** Total

Figure 14: Number of aged care services by state and territory
State is based on the state of the service, not the provider.

Sector performance

Measuring performance in aged care is complex. There are many ways that the Commission understands and measures the performance of providers and detects risk to people receiving care including:

- site audits (residential care) and quality audits (home services)
- risk based monitoring and assessments
- complaints about services
- the Serious Incident Response Scheme (SIRS)
- compliance with the Code of Conduct (the Code) and workforce responsibilities
- the National Aged Care Mandatory Quality Indicator Program
- financial information, through the Quarterly Financial Report and the Aged Care Financial Report.

As part of our monitoring of risk in the sector, we look at changes over time to see if we can identify any trends.

In this report, we deal with the different performance measures separately. Strong performance against one measure does not always mean strong performance against other measures.

There can also be differences between quarters. That may not mean that there has been a change in performance, but rather that there have been minor changes in data collected at different times. This can particularly be seen in measures with small numbers.

How we calculate rates and what it means for a typical service

For compliance rates in residential care, we provide the rates as a proportion of the audit decisions we made in that quarter.

For the SIRS and complaints, we use the number that providers use for claiming subsidies with Services Australia. We then multiply it by 10,000 to get a meaningful rate.

What that means is that if you are a provider with a 110-bed service and your rate of SIRS notifications is 8.7, the same as the sector average for a large provider, you would expect about 9 incidents a quarter or 36 a year. If you are significantly below that, or above, you should investigate your own data to find out why.

Using sector averages as an indicator, providers should expect approximately 70% of their serious incidents notifications to be Priority 2 and 30% to be Priority 1. If you meet the sector average but the proportion of Priority 1 and Priority 2 incidents are reversed (70% Priority 1), you should be investigating your data to find out why.

For complaints, if the rate of complaints reported to the Commission for a 110-bed service is the same as the sector average of 0.8, the service would expect between 3 and 4 complaints to be reported to the Commission in a year.

Compliance with the Aged Care Quality Standards

All aged care providers must comply with their responsibilities including the Aged Care Quality Standards (Quality Standards). The Commission checks residential care and home services providers' compliance with the Standards periodically through site audits and quality audits. For most providers we audit every 3 years. During a residential site audit, we interview at least 10% of the people (and/or their representatives) using the service. For a quality audit, older people receiving care from their home services provider are invited to give feedback to the Commission. They may also make arrangements to speak with us before or on the day of our visit.

However, these are not the only assessments we do. Importantly, we also monitor the quality of care and services through a program of risk-based monitoring and assessments including site visits. We do these assessments if we identify risks to people receiving aged care (see risk-based assessment page 27).

In this report, the compliance rates are based on our reaccreditation site audits for residential aged care, and quality audits for home services. This gives us the clearest picture of overall sector performance.

81%

All 42 requirements met

Residential care

65%

All relevant requirements met

Home services

Figure 15: Compliance with Quality Standards for audited residential care and home services providers

Site audits in residential care

To calculate compliance rates, we divide the number of audits that met all 42 Quality Standard requirements by the total number of site audits where we made a decision. We do not always make a decision about a provider's compliance in the same quarter that we do their audit. This is why we base the compliance rates on when we made the decision rather than when we did the audit.

Site audits, decisions and compliance rates in residential care

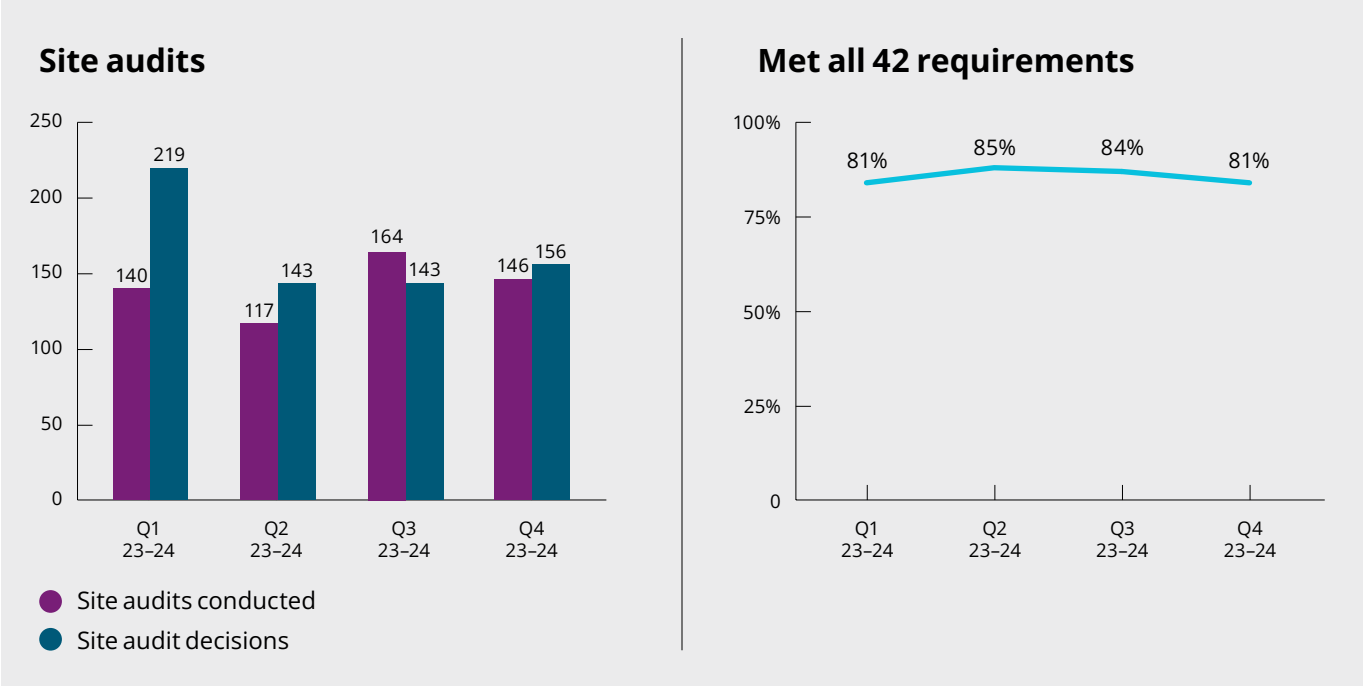


Figure 16: Number of site audits and proportion of services that met all Quality Standards in residential care
Site audits done in one quarter may have had their decision made in the next quarter.

Compliance with the Quality Standards fell this quarter to 81%, compared with 84% in Q3. This means that in Q4, around one in 5 residential care services were below the minimum standard in at least one area of the care they provide.

Residential care: Quality Standards 3, 7 and 8 have the lowest compliance rates

Figure 17: Compliance with the Quality Standards in residential care over the past 4 quarters

- Compliance fell between Q3 and Q4 for all Standards, except for Quality Standard 2 (Ongoing assessment and planning with consumers). Compliance with this standard increased by 2 percentage points.
- Quality Standard 8 (Organisational governance) is still the Quality Standard with the lowest level of compliance in residential care. Compliance dropped 3 percentage points in Q4.
- Compliance with Quality Standard 3 (Personal care and clinical care) dropped 3 percentage points this quarter after improvements in the past 3 quarters.
- Compliance with Quality Standard 7 (Human resources) dropped 4 percentage points in Q4 after improving in Q3.
- Compliance with Quality Standard 4 (Services and supports for daily living) fell 6 percentage points this quarter to 94%, compared with 100% in Q3. We are monitoring this.
- We find providers have not complied with a Quality Standard if they do not meet one or more requirements of that Standard. We are particularly concerned about Standards that have high rates of non-compliance across multiple requirements.
- In Quality Standard 8 (Organisational governance), providers are most likely to not meet:
  - 8(3)(c) Effective governance systems
  - 8(3)(e) Clinical governance framework.
- In Quality Standard 3 (Personal care and clinical care), providers are most likely to not meet:
  - 3(3)(a) Safe and effective personal and clinical care. This is the requirement with the lowest compliance in residential care
  - 3(3)(b) High impact or high prevalence risks managed effectively.

Figure 18: Quality Standard requirements with the lowest compliance in Q4 in residential care

The compliance rates for all the 42 Quality Standard requirements per quarter are in our online data tables.

- In Quality Standard 7 (Human resources), providers are most likely to not meet:
  - 7(3)(a) Number and mix of workforce
  - 7(3)(d) Recruitment training and support
  - 7(3)(e) Regular assessment, monitoring/ review/performance of workforce.

The final report of the Royal Commission into Aged Care Quality and Safety (2021) found that issues in governance and leadership affected the quality and safety of care. Our 'In focus' (page 63) also finds that issues with governance are common in cases where we place providers under supervision when we have identified risks to people in their care.

The Governing for Reform in Aged Care Program supports governing body members, leaders and rising leaders. It helps them to improve their corporate and clinical governance and make vital changes. Subscribe to our mailing list and keep up to date with Governing for Reform in Aged Care events and information.

Quality audits in home services

We conduct quality audits of a home service at least once every 3 years to assess performance against the Quality Standards.

Since February this year, we have improved how we do those quality audits. All of a provider's home services are included in a single quality audit. This is shown in an increase in quality audits in Q3.

Our quality audits look at a provider's management systems and processes and how they are put into action across their services. Providers must be able to demonstrate effective risk management systems, including appropriate governance that supports the delivery of safe and quality care.

Quality audits, decisions and compliance rates in home services

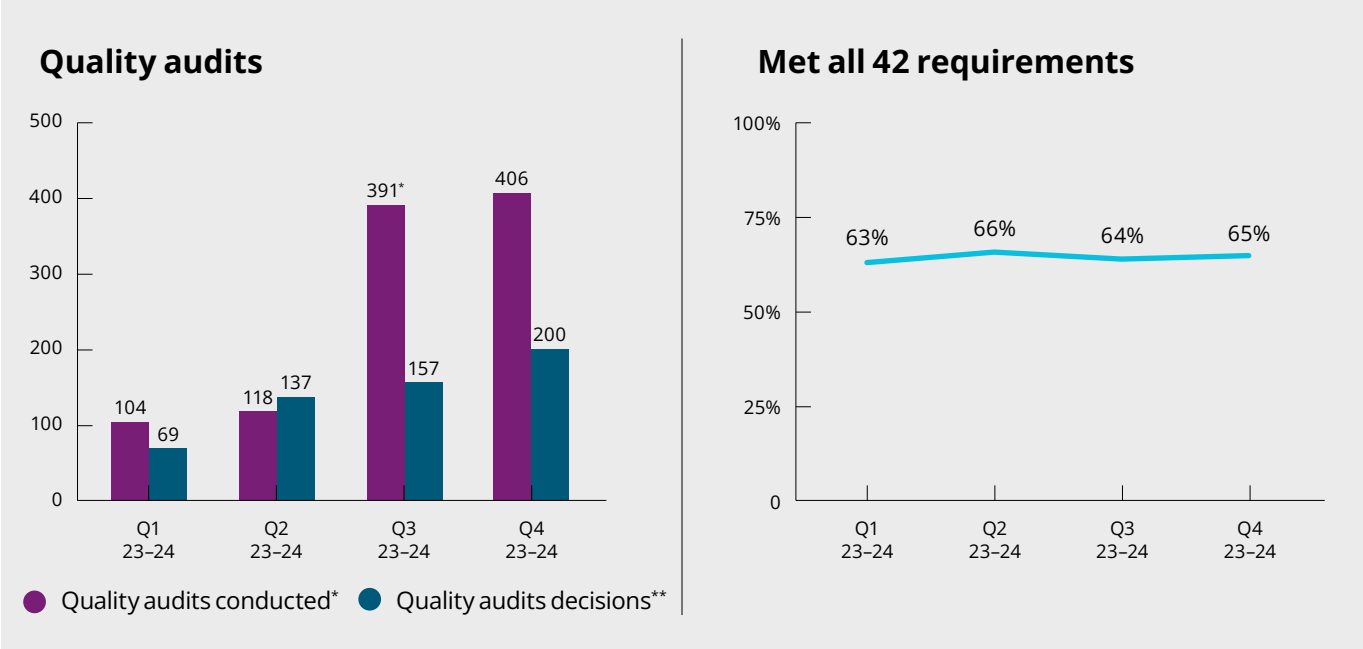


Figure 19: Number of quality audits and proportion of services that met all the relevant Quality Standards in home services

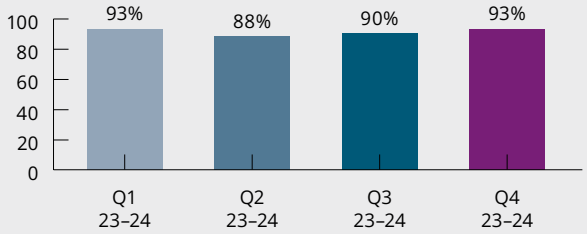
* The higher number of quality audits carried out in Q3 and Q4 reflects the introduction of multi-service audits from February 2024 where we include all home services of a provider in a quality review (multi-service quality reviews)

** A single decision is made for the one provider, covering all quality audits for all home services managed by that provider. This explains the gap between number of quality audits and decisions made.

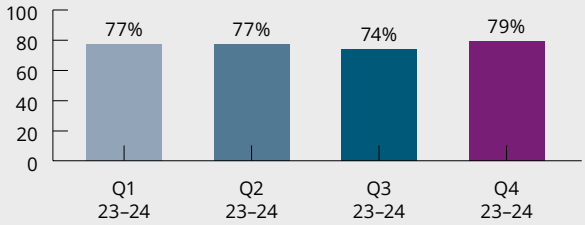
- Compliance with the Quality Standards is still much lower in home services than in residential care. In Q4, 35% of home services providers (over a third) provided care that did not meet all the requirements of the Quality Standards.
- We have seen a significant improvement in compliance with the Quality Standards over the past 2 years in home services. However, we have not seen a significant uplift over the course of the past year.
- We assess all a provider's services together as part of a single quality audit. This has meant that we have audited more services in both Q3 and Q4 compared with Q2.
- We want to understand if risks and issues we identify are about how the provider runs their business or if they are specific to an individual service. We typically see that there is a relationship between service level issues and absence of effective controls at the provider level.
- Through our audit process we seek to understand how organisations are run and how this translates to safe and quality care at a service level.

Home services: compliance rates were lowest in Quality Standards 2, 3, 6 and 8

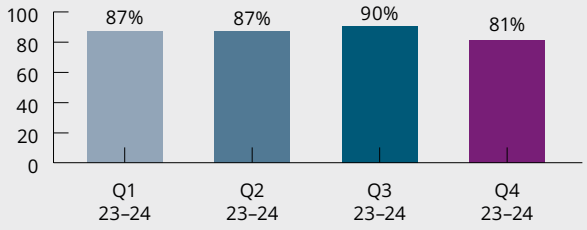
Quality Standard 1: Consumer dignity and choice



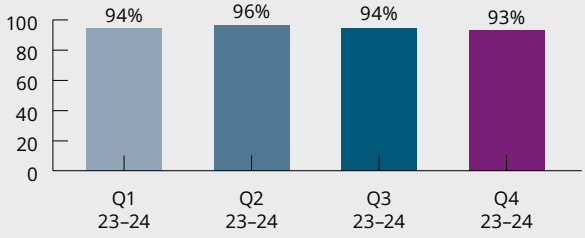
Quality Standard 2: Ongoing assessment and planning with consumers



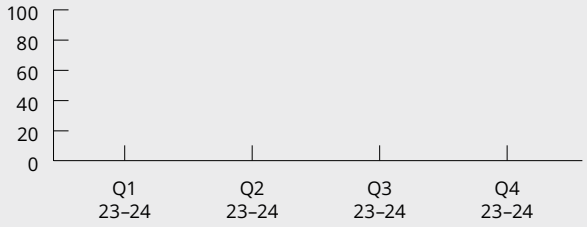
Quality Standard 3: Personal care and clinical care



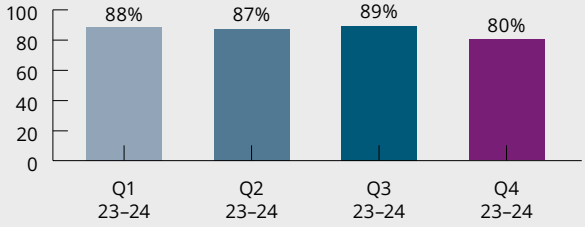
Quality Standard 4: Services and supports for daily living



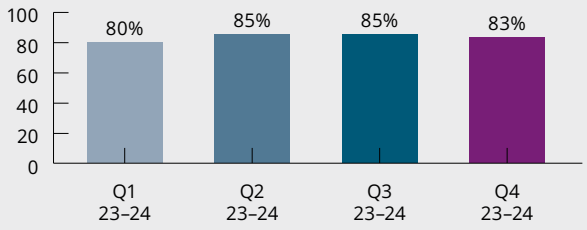
Quality Standard 5: Organisation's service environment*



Quality Standard 6: Feedback and complaints



Quality Standard 7: Human resources



Quality Standard 8: Organisational governance

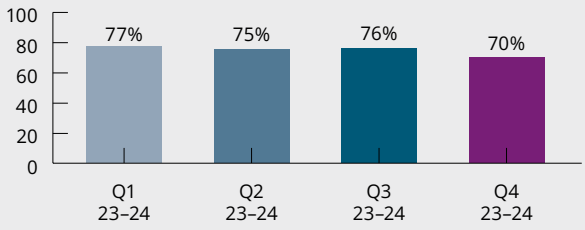


Figure 20: Quality Standard compliance in home services over the past 4 quarters

* We have not included rates for Quality Standard 5. We assess very few services against this standard as most services are delivered in a person's private home. Quality Standard 5 does not apply to these situations. However, it does apply to day care and respite services.

The compliance rates for all the 42 Quality Standard requirements per quarter are in our online data tables.

- Compliance with **Quality Standard 8** (Organisational governance) has gone down in home services. Three in every 10 home services providers that we audited in Q4 did not meet one or more requirements of this Quality Standard. Compliance was steady over the past 3 quarters but has dropped 6 percentage points since Q3.

- **Quality Standard 6** (Feedback and complaints) has emerged as a top 3 compliance concern in home services for the first time. One in 5 home services providers are not fully compliant with the requirements of this Quality Standard. We encourage providers to support people receiving care to raise any concerns directly with them or their staff and to take actions to resolve those concerns. Providers also need to review the types and numbers of complaints they receive to identify areas for ongoing improvement to the care being delivered.

- One in 5 providers do not meet one or more requirements of **Quality Standard 3** (Personal care and clinical care). Compliance with this standard has dropped 9 percentage points since Q3.

- Despite some improvements in Q4, one in 5 home services providers (21%) do not meet one or more requirements of **Quality Standard 2** (Ongoing assessment and planning with consumers). Compliance with this Quality Standard had dropped steadily over the past 3 quarters but improved this quarter by 5 percentage points.
- Issues related to **Quality Standard 2** also show up in our complaints data. Communication and consultation is the most complained about issue in home services. Case management, coordination and care planning is the third most complained about issue (page 52).

- Three out of 5 of the requirements of Quality Standard 8 are in the 10 requirements with the lowest compliance. These are:
  - 8(3)(c) Effective governance systems
  - 8(3)(d) Risk management systems and practices
  - 8(3)(e) Clinical governance framework.
- The higher rates of non-compliance in the requirement to have a clinical governance framework are reflected in increased non-compliance with Quality Standard 3, which dropped 9 percentage points this quarter.
- The 2 requirements of Quality Standard 3 with the lowest compliance are:
  - 3(3)(b) High impact or high prevalence risks managed effectively
  - 3(3)(e) Sharing information to optimise care.
- The 2 requirements of Quality Standard 2 with the lowest compliance are:
  - 2(3)(a) Assessment and planning informs safe and effective services
  - 2(3)(b) Assessment and planning identifies current needs.

Figure 21: Quality Standard requirements with the lowest compliance in Q4 in home services

Risk-based assessments

The Commission monitors residential care and home services quality of care and services through a program of risk-based monitoring and assessments. We do these assessments if we identify risks to people receiving aged care. We aim our risk-based monitoring at higher risk services and providers.

The Commission undertakes risk-based monitoring by visiting a provider's premises or requesting information by correspondence or a phone call. The Commission's monitoring approach will depend on the nature of the risk that is being monitored and how information relating to that risk may be best collected and understood.

We also use assessment contacts to check how providers are doing in identified areas of sector risks. These are areas where many providers are potentially falling short or where they may need help with improving and understanding how they might reduce harm to older people receiving care. In residential care we are currently focusing on 4 key areas of risk including:

- infection prevention and control
- COVID-19 vaccinations
- food, nutrition and dining
- workforce responsibilities.

For most sector risks, such as food, nutrition and dining, and workforce responsibilities, we are prioritising those providers where our information indicates a heightened risk of harm for people receiving care.

We prioritise site visits for those services where we are most concerned about the risks of non-compliance for specific obligations or where we have identified a capability issue around particular aspects of care. If, during our visits, we identify an issue with the risk we are focusing on, we will work with the provider to identify the underlying cause so that the provider addresses the issue as quickly as possible and takes steps to prevent it re-occurring.

See page 29 for how the Commission responds to non-compliance.

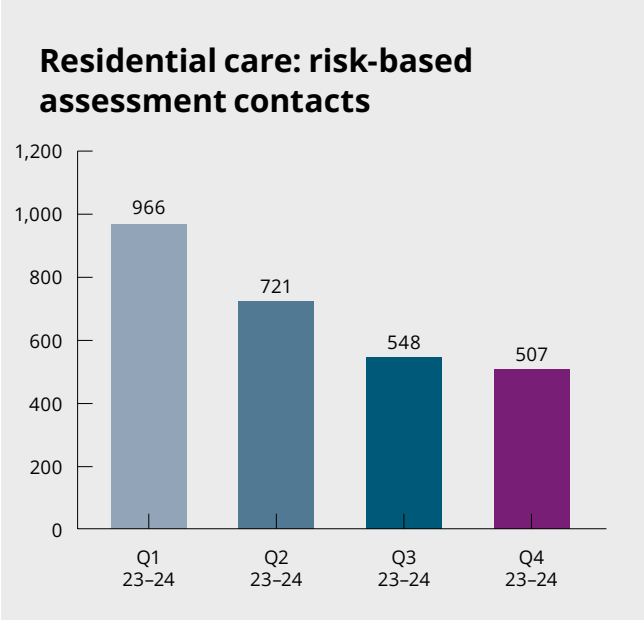


Figure 22: Assessment contacts over the past 4 quarters in residential care

See data tables for a breakdown of performance and monitoring assessments.

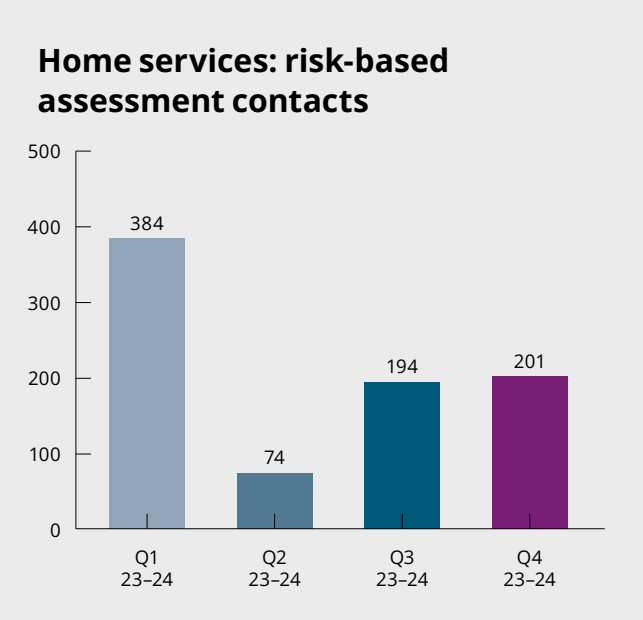


Figure 23: Assessment contacts over the past 4 quarters in home services

Over the past 4 quarters, more than half of our onsite assessment visits in residential care have been focused on risks that we consider are broadly present across the sector.

COVID-19 and infection prevention and control

In response to low COVID-19 vaccination rates and a growing number of COVID-19 outbreaks in residential aged care, the Commission commenced unannounced targeted assessment contacts at **107** services, including 21 onsite activities in Q4. Some services were subject to both an offsite and onsite activity.

A small number of providers were found to be non-compliant with vaccine related requirements under the Aged Care Quality Standards and are now under case management. They have been required to advise us of their proposed actions to address the non-compliance which include:

- immediate vaccination clinics
- training for staff
- updating policies and procedures
- increasing communications with residents and representatives.

We continue to engage with these providers to ensure that the agreed actions are taken quickly and deliver the intended outcomes. More information about providers' responsibilities relating to COVID-19 vaccinations and infection prevention and control can be found on our website.

Food, nutrition and dining

In Q4, the Commission undertook **202** site visits to monitor the food, nutrition and dining experience at residential aged care services (up from 116 in Q3). Some of these visits to higher risk services were supported by a dietitian or speech pathologist from the Commission's Food, Nutrition and Dining Advisory Support Unit. We have found examples of both good practice and poor resident experience through these activities. We have found that provider challenges include:

- processes to support people to eat and drink with acknowledged risk
- malnutrition screening and management.

Where the Commission finds shortcomings in a residential service's food, nutrition or dining arrangements, we seek their commitment to fix the problem. Most providers will take the necessary action to improve their performance. Where a provider is unwilling to act or does not have the capability to fix the problem quickly, the Commission will use its regulatory powers to compel them to take the necessary action.

Workforce responsibilities

The Commission has commenced a program of targeted risk-based activities to monitor provider compliance with residential care workforce-related responsibilities. This includes the responsibility to have a registered nurse (RN) onsite 24/7 and to meet care minutes targets.

We carried out **282** risk-based activities, both on-site and off-site, this financial year to monitor provider compliance with residential care workforce-related obligations.

Where we found significant gaps in a provider's 24/7 RN coverage, clinical issues were the most common risk identified followed by poor governance. A small number of providers have been found non-compliant with the related Quality Standards, including sufficiency of staffing. Where we have concerns about risk to older people receiving care, we engage providers in accordance with our provider supervision model.

See page 63 for more information on our provider supervision model and page 36 for workforce responsibilities.

Commission responses to risk and non-compliance

Where non-compliance is identified, the Commission manages this by engaging with providers and workers to address our concerns. The action we take depends on 2 things:

- the level of risk posed to people receiving care and the seriousness of any failures in care
- a provider's demonstrated willingness and ability to fix the issue and make changes, and our confidence that those changes will last.

The Commission uses a case management approach where we work intensively with the provider to:

- ensure a shared understanding of the causes of non-compliance and the actions required to return to compliance
- enable ongoing assessment of the level of risk to older people receiving care
- inform, shape and monitor the provider's actions to address the risks, including the provider's open communication and engagement with older people in their care.

If a provider demonstrates that they are unwilling or unable to address risks or non-compliance, the Commission will increase its level of intervention consistent with provider supervision. This includes using our compliance powers to direct and compel the provider's response. For more information and case studies of our provider supervision approach, see our 'In focus' section on page 63.

Where non-compliance has resulted in significant harm to older people, or is serious or systemic in nature, the Commission may take enforcement action. For information on these powers and actions, see Chapter 5 and 6 of our Regulatory Strategy.

Figures 24 and 25 show shows when we have used these powers in Q4.

Case management

Over the past 12 months we have been changing how we oversee providers to incentivise them to quickly correct any problems including non-compliance. We recognise and support providers who are willing and able to fix issues quickly.

Where we see a problem, we raise it with the provider. They must show us that they can fix the issue quickly and then convince us that it is fixed. Where this happens, we do not issue a formal notice as these providers are doing the right thing by fixing their non-compliance without delay. This gives the best results for older people and the care they receive.

Much of the non-compliance and risks we find is now dealt with in this way. This is good news for older people receiving care because issues are resolved quickly. This also allows us to focus on providers who are not doing the right thing (see our 'In focus' section on page 63 for case studies of how we manage risks this way).

Directing actions

If providers need a further prompt to fix a problem, we issue a Direction to Revise a Plan for Continuous Improvement. We issue a Direction if we are confident that the provider can fix an issue but may need time to develop and implement their action plan.

Compelling actions

If providers cannot, will not, or do not fix the problem quickly, we use our enforceable regulatory actions. These include non-compliance notices and sanctions to compel providers to fix the issue.

In previous sector performance reports, we showed the proportion of cases of non-compliance against the Quality Standards that were handled through early remediation, directing actions or compelling actions. This presentation is not consistent with our current case management approach under provider supervision.

With the introduction of provider supervision (see page 63), the Commission is more actively managing risks or non-compliance relating to either of the Quality Standards and/or broader provider obligations. We are also focused on managing higher risk providers before there is a finding of non-compliance. We are currently developing metrics and reporting that will allow us to present this more complex picture. These will be included in future reports.

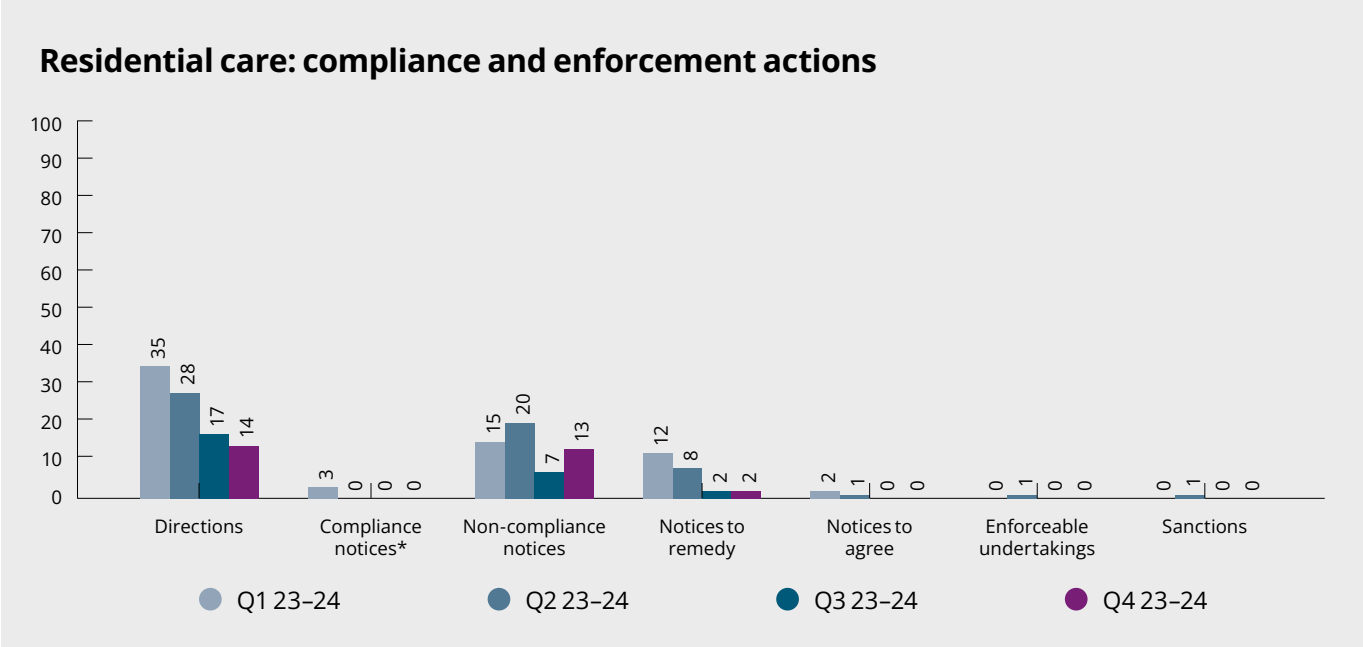


Figure 24: Directions and enforceable actions in response to non-compliance in residential care
* Incident management notices and Incident management restrictive practices compliance notice.

- In Q4, 11 of the 13 non-compliance notices we issued were for providers not submitting their quarterly financial statements on time. As financial risk happens in real time and can directly affect the provider's ability to continue in business, we need to be aware of these financial risks as they happen.
- We are working with providers using a case management approach where we have identified high to severe risk. This change in how we regulate, and providers' improved compliance is reflected in reduced numbers of directions and enforceable actions.

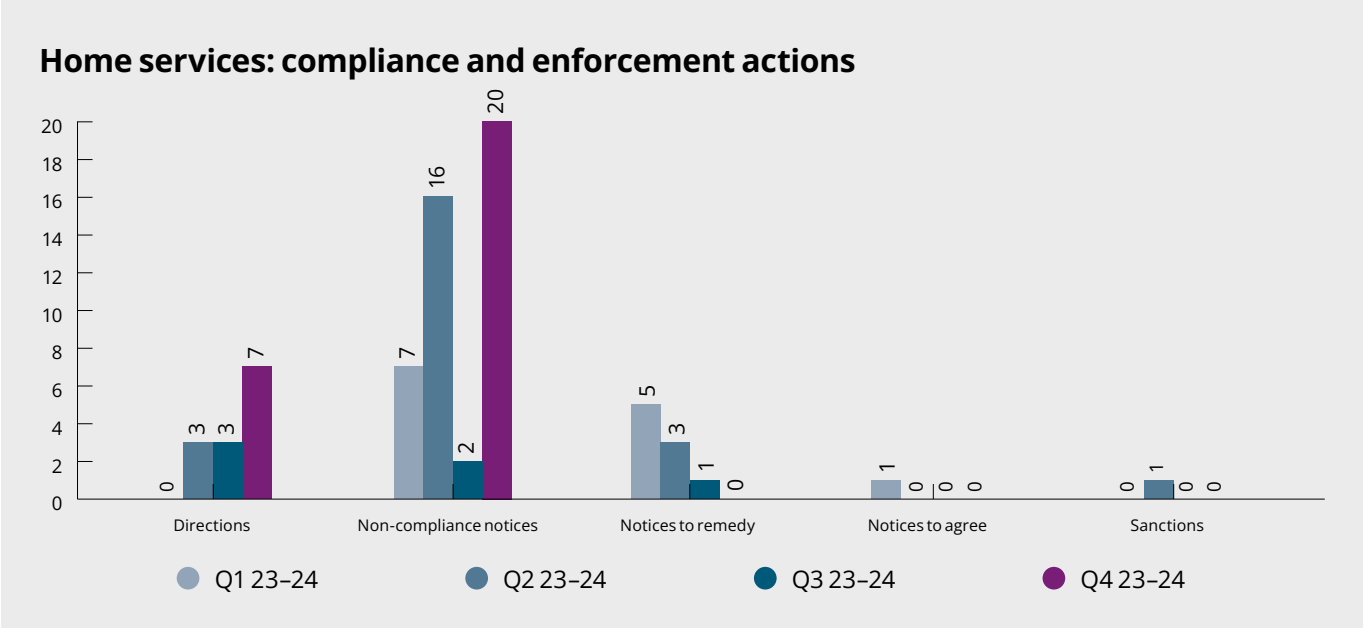


Figure 25: Directions and enforceable actions in response to non-compliance in home services

- We issued 20 non-compliance notices to home services providers in Q4. This is a significant increase compared with Q3. Most of these were because providers submitted their quarterly financial reports late.
- We are working with providers through a case management approach where we have identified high to severe risk. Depending on the provider's demonstrated willingness and ability to fix the issue, we may not need to take a directing or compelling action (see page 70 for a case study of a home services provider we have worked with to manage risks).

Find out more by clicking the links below:

- Regulatory Strategy 2024–25
- Aged Care Quality Standards
- Home services quality reviews
- Residential care review audits
- Compliance and enforcement policy – Aged care services performance and enforceable actions

Worker regulation

The Commission monitors risks to people receiving aged care that are caused by:

- worker actions, inactions or behaviours
- a person's suitability to be involved in providing aged care.

We act when we are concerned about the behaviours of a governing person or worker, or if a person is not suitable to be involved in providing aged care.

The Code of Conduct for Aged Care (the Code) describes how approved providers, their governing persons (such as board members) and workers (including volunteers) must behave and treat people receiving aged care.

The Code helps older people to have confidence and trust in the quality and safety of the care they receive, no matter who provides that care.

You can find information about the Code for approved providers, aged care workers and governing persons on our website.

Providers and workers are each responsible for complying with the Code. Providers also have an obligation to ensure that their workforce complies with the Code including people they employ and their volunteers.

22

Total investigations

Source of investigation

19 Internal intelligence

3 External intelligence

Figure 26: Worker regulation investigations

Data extracted from Commission systems on 10 July 2024. Reported figures may change as cases in the database are updated.

25

Caution letters to individuals

14

Reminder of responsibilities letters

Figure 27: Letters sent

How we respond when a worker breaches the Code depends on:

- the type of risk
- the harm caused, or the possible harm that could be caused, to people receiving care
- how likely it is that the worker's provider can manage the risk.

We identify worker risks through our regulatory activities, including SIRS incident notifications and complaints.

We also identify worker risks through information from:

- the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission
- the Department of Health and Aged Care
- other regulatory agencies
- the media.

If we believe there is a risk to the person receiving care we may:

- issue the worker with a reminder of responsibilities letter
- issue the worker with a caution letter
- conduct an investigation.

A reminder of responsibilities letter encourages compliance through education and awareness and is designed to help and support a worker to understand and improve their compliance with the Code.

- We issued 14 of these this quarter, up 9 from Q3.

We will issue a caution letter to tell a worker about our concerns and underscore their responsibilities under the Code. It also lets them know about potential consequences of any reoccurrence, and the Commission's ongoing role in detection of these risks.

- We issued 25 caution letters this quarter, up 14 from Q3.

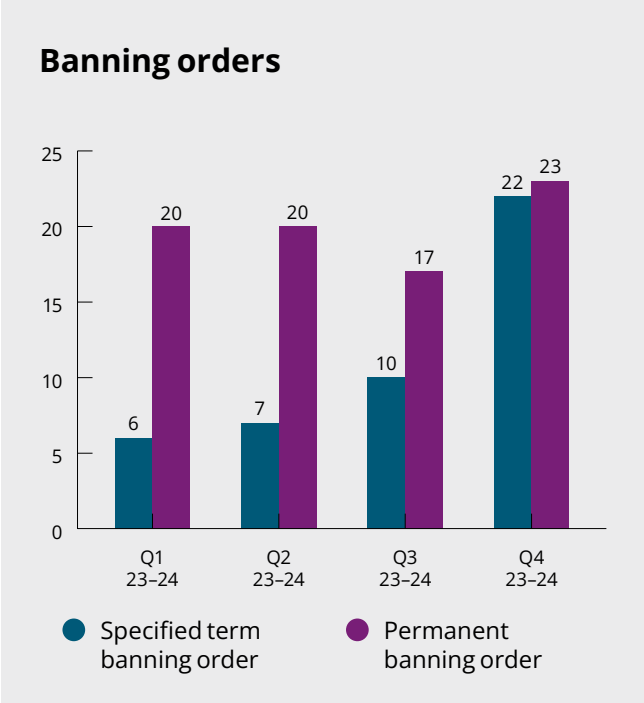


Figure 28: Banning orders in the last 4 quarters

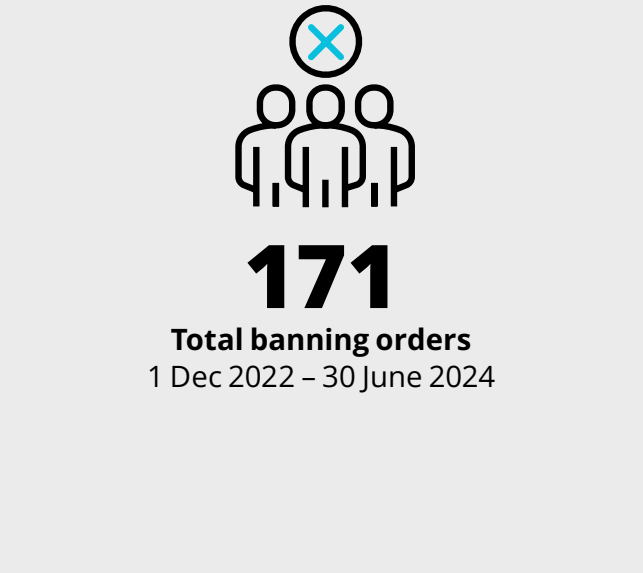


Figure 29: Total banning orders

An investigation may result in the Commission issuing a banning order to stop a person from working in aged care or restrict their activities. A banning order is our most serious enforcement action against a person.

A banning order can be:

- permanent or for a certain time
- subject to conditions.

We issued 45 banning orders in Q4, greatly increased from 27 in Q3. Of these 45:

- 22 banning orders were for a specific length of time
- 23 banning orders were permanent.

We can make a banning order against:

- a current or former aged care worker of an approved provider
- a current or former governing person of an approved provider
- people who have not worked or been engaged in aged care before.

Banning orders can stop a person from:

- being involved in providing any type of aged care
- being involved in providing specific types of aged care
- taking part in specific activities as an aged care worker or governing person.

We have a register of banning orders that lists all banning orders we have made. You can also find more information about banning orders on our website.

Find out more by clicking the links below:

- Code of Conduct for Aged Care
- Regulatory Bulletin: Banning Orders
- Aged Care Register of banning orders

Workforce responsibilities

Residential aged care providers must make sure that people receiving care have access to a registered nurse (RN) onsite and on duty 24 hours a day, 7 days a week. Providers also need to meet mandatory care minutes targets. These targets are the amount of care time that each resident must receive each day. These new responsibilities make sure that residents get the care they need, when they need it.

Every approved provider must meet all their workforce-related responsibilities.

24/7 RN responsibilities

Each month providers of residential aged care services must report to the Department of Health and Aged Care on:

- whether or not an RN was onsite and on duty at all times
- every period of 30 minutes or more that an RN was not onsite and on duty and why
- the alternative clinical care arrangements they had in place when an RN was not available, such as on-call clinical supports.

We monitor provider compliance with workforce responsibilities, including their 24/7 RN cover. For providers with gaps in their 24/7 RN cover, and to identify potential risk to the delivery of safe and quality care, we consider:

- how long and often those gaps were
- other quality measures.

In 2023–2024, we carried out 282 targeted activities focused on workplace responsibilities. These activities included risk-based monitoring and assessment site visits.

92%

of all services delivered 24/7 RN care in June 2024

Figure 30: Registered Nurse (RN) coverage in residential aged care June 2024

282

Total targeted activities
1 July 2023 – 30 June 2024

Figure 31: Total targeted activities

Where we found significant gaps in a provider's 24/7 RN coverage, clinical issues were the most common risk identified followed by poor governance. A small number of providers have been found non-compliant with the related Quality Standards, including sufficiency of staffing.

Mandatory care minutes

Since 1 October 2023, all residential aged care service providers need to meet mandatory care targets. These targets show the amount of care time they need to deliver to each resident each day. Providers must report this to the department quarterly.

The care minutes responsibility is based on a sector-wide average of 200 minutes of care for each older person receiving care per day, including 40 minutes of direct RN care. From October 1 this will be increased to 215 minutes per day including 44 minutes of direct RN care.

More information on care minutes is available on the Department of Health and Aged Care Dashboard.

Care minutes reporting gives the department and the Commission valuable information to understand how providers are allocating workers to direct care.

All providers are expected to comply with their mandatory care minutes targets and we monitor provider compliance with their targets. As with any provider responsibility, how we respond to non-compliance depends on any risks to people receiving care and the reasons for the non-compliance. We also consider what the provider has done to meet their responsibilities.

Where a provider is not complying because of a shortage of staff or other challenges, we expect them to develop solutions and will provide guidance if required. We want to see that they are committed to fixing the causes of their non-compliance, quickly and for the long term.

Registered nurse coverage: June 2024

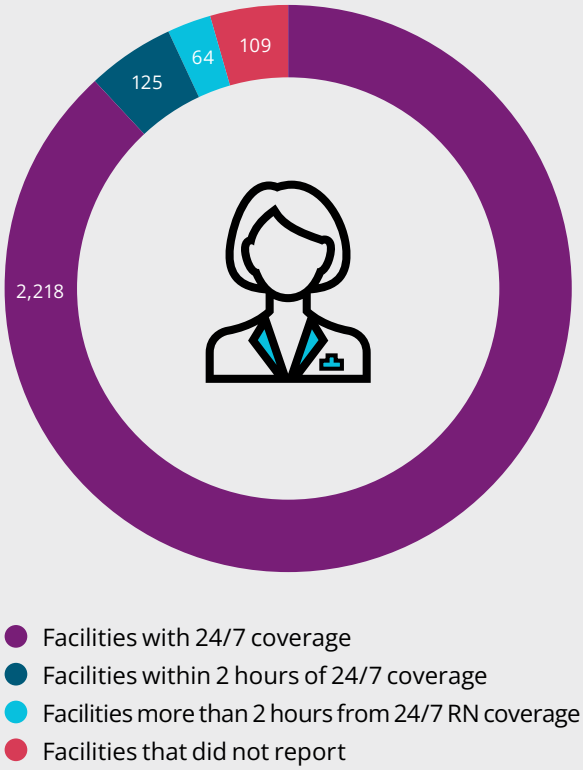


Figure 32: Registered nurse coverage in residential aged care
Published by Department of Health and Aged Care 30 June 2024. Updated 30 July 2024

In some cases, we identify that shortcomings in a provider's workforce strategy or business decisions are the reason they are not meeting their mandatory care minutes targets. In these cases, if they have not taken reasonable steps to comply and manage the risk to people receiving care, we will take compliance or enforcement action.

Find out more by clicking the links below:

- Workforce-related responsibilities – including 24/7 registered nurse and care minutes

Serious Incident Response Scheme

Residential aged care providers and home service providers must notify the Commission about 8 types of reportable incidents through the Serious Incident Response Scheme (SIRS).

Every provider must have an effective incident management system in place. Providers should use this system to reduce the risk of incidents and to respond effectively when they happen. This is a requirement under Quality Standard 8 (Organisational governance).

In this report we present both the numbers and rates of SIRS incidents reported to the Commission. Knowing the rate of SIRS notifications for the sector can help providers to understand how their rate of notifications compares with the sector average. We use these rates, combined with other information on provider performance, to identify risk of harm to people receiving care. We are concerned by rates that seem too high or rates that seem too low compared with the sector or similar types of providers.

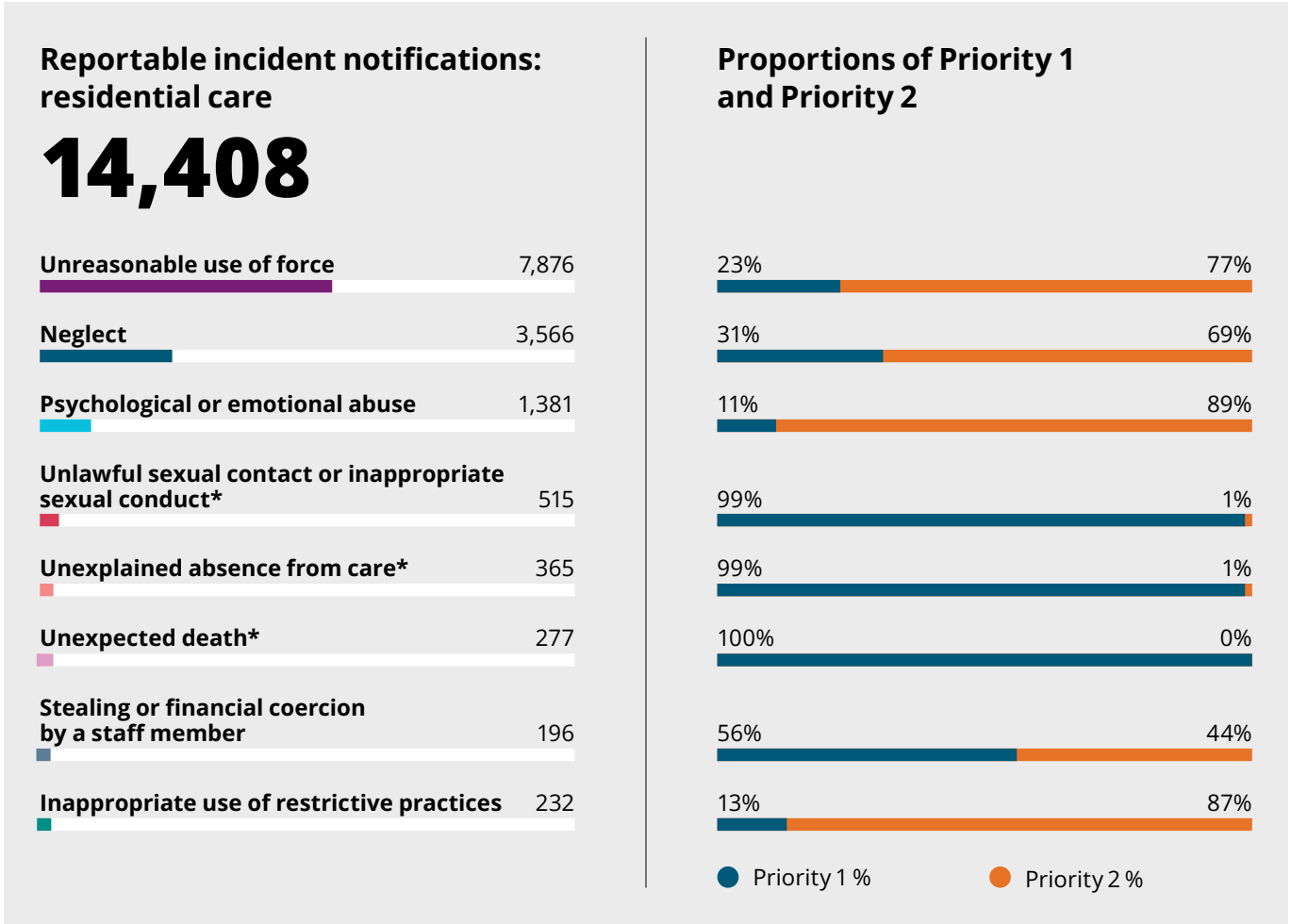


Figure 33: All reported incidents in residential care and percentage of Priority 1 and Priority 2 incidents in Q4

* Reportable incidents of unlawful sexual contact or inappropriate sexual conduct, unexplained absence or unexpected deaths are Priority 1 reportable incidents. The notifications recorded in this table as Priority 2 are because providers incorrectly selected Priority 2 when they submitted the notification.

- There has been a slight increase in the overall numbers of notifications of serious incidents reported to the Commission under the SIRS since Q4.
- Notifications of Priority 2 incidents account for over two thirds (69%) of SIRS notifications in residential care. These need to be reported to the Commission within 30 days of happening. This gives providers an opportunity to:
  - further investigate the Priority 2 incidents
  - address the risk by taking action to support the individual/s impacted by the incident
  - reduce the chance of more serious incidents happening.

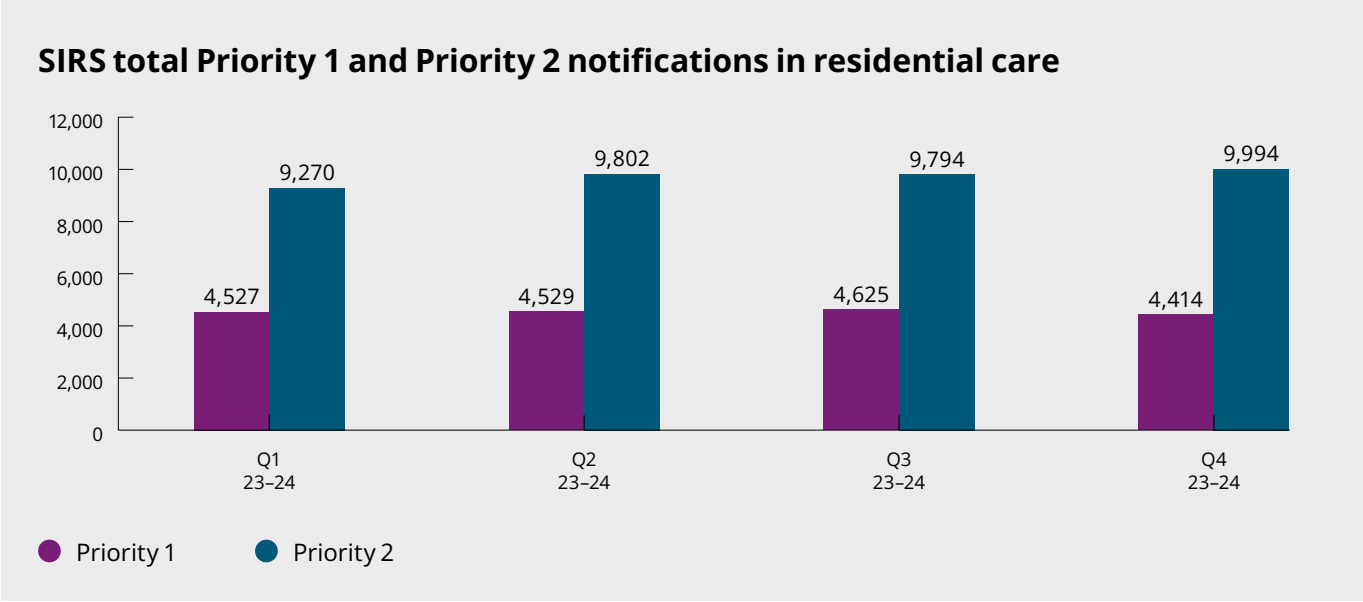


Figure 34: SIRS Priority 1 and Priority 2 notifications in residential care over the past 4 quarters

Getting it right – assessing the impact of serious incidents

Providers regularly underassess the impact of serious incidents on people receiving care. Our review of notifications in the SIRS Insights Report: Unreasonable use of force found that 9 out of 10 providers are reporting that this incident type has minor or no impact. We find that providers are underassessing impact across all incident types.

Providers may not be considering less obvious impacts that can be harder to identify. Examples include where a resident is not able to reliably describe what happened, or the impacts are delayed where a physical injury is noticed later.

The benefits of accurately assessing impact include:

- improved quality of care, as treatment meets the individual's needs
- providers meeting their continuous improvement responsibilities, through changes to processes
- providers using effective processes under their incident management system to prevent incidents from happening again because they better understand the negative impact on the person receiving care
- improved quality and accuracy of incident notifications and reported responses.

To improve how providers assess impact, the Commission has worked with providers to design an impact assessment tool. We workshopped this with providers, using real case studies, during the Commission's National Provider Conference in April.

Providers were encouraged to 'walk in the shoes 'of people receiving care to better understand the physical, emotional and cultural impacts of an incident. The impact assessment tool is available on our website.

Priority 1 reportable incidents are incidents:

- that must be notified to us within 24 hours
- that have caused, or could reasonably have caused, a person receiving aged care physical or psychological injury or discomfort that needed medical or psychological treatment
- where it is reasonable to contact the police (this includes all incidents involving alleged, suspected, or witnessed sexual assault)
- where there is the unexpected death of a person in aged care or their unexplained absence from the service.

Priority 2 reportable incidents are incidents:

- that do not meet the criteria for a Priority 1 reportable incident
- where providers must notify us within 30 days of becoming aware of the incident.

SIRS notification rates

SIRS notification rates can help providers to identify if their reporting rate is significantly different from the sector average. We have also included reporting rates by provider size and ownership type, so providers can also check their performance compared with similar types of providers.

We calculate rates based on 10,000 occupied bed days (OBDs). OBDs are the number that providers use for claiming subsidies with Services Australia. For a residential service fully occupied by 110 residents, the current sector average SIRS notification rate of 8, is equal to 8 incidents across the quarter or 32 a year.

Providers should review their incident management system to look for ways they can improve how they stop incidents from happening and how they respond to incidents when they do happen.

Many reported incidents are preventable. We expect providers to be able to show how they keep improving to reduce the likelihood of incidents. This includes studying what happens when things go wrong, listening to people affected by the incident, and introducing changes to stop it from happening again.

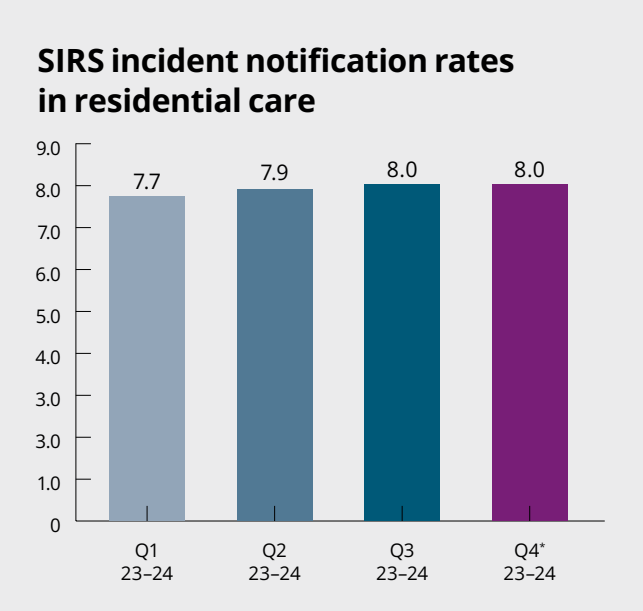


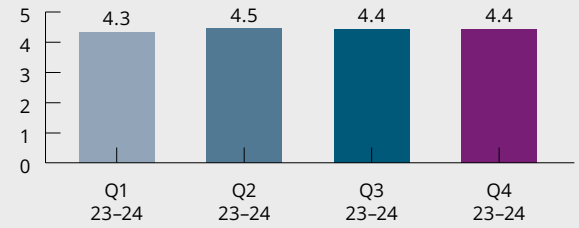
Figure 35: SIRS notification rate for residential care

SIRS notification rate is number of notifications per 10,000 OBDs.

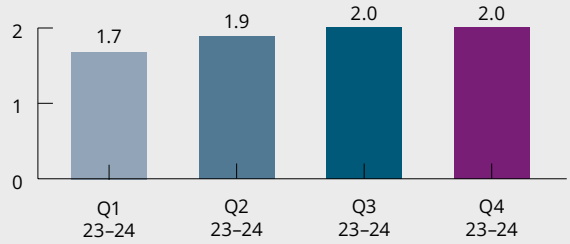
*The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details page 79.

Residential care reporting rates per quarter for each incident type

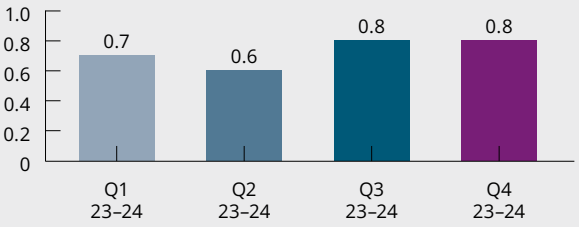
Unreasonable use of force



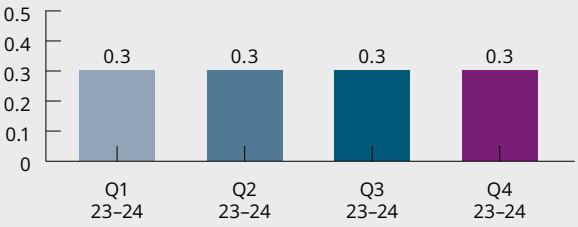
Neglect



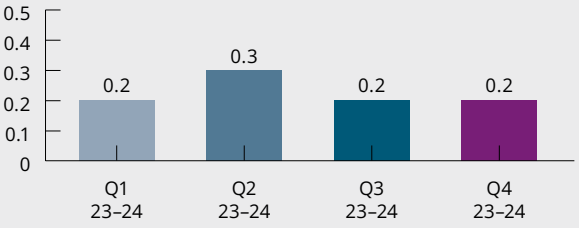
Psychological or emotional abuse



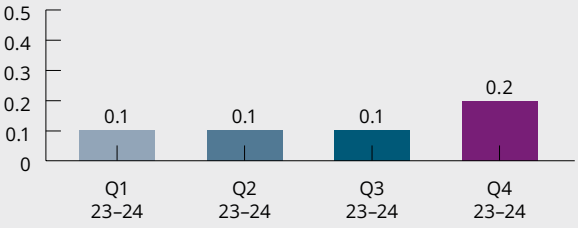
Unlawful sexual contact or inappropriate sexual conduct



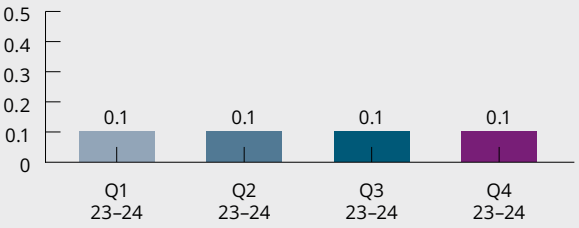
Unexplained absence from care



Unexpected death



Stealing or financial coercion by a staff member



Inappropriate use of restrictive practices

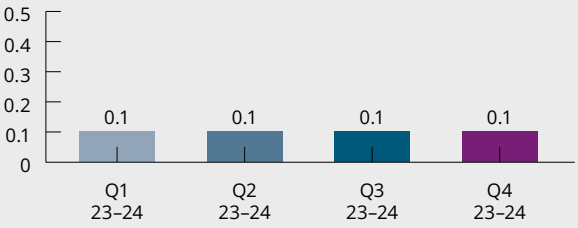


Figure 36: SIRS reporting rates for each notification type in residential care. All rates are notifications for every 10,000 OBDs
The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details page 79.

- In Q4, the overall rate of SIRS reporting in residential care is 8.0 for every 10,000 OBDs.
- This has increased from 7.7 for every 10,000 OBDs in Q1. This is consistent with the 4.5% overall increase in the number of notifications from Q1 to Q4, from 13,797 to 14,408.
- Notifications of unreasonable use of force still account for more notifications than the other incident types combined in residential care.
- Notifications of neglect and psychological or emotional abuse, the second and third most commonly reported incidents, are still increasing each quarter but at a slower rate than in past quarters.
- Neglect notifications have increased by 13% since Q1. The rate has increased from 1.7 to 2.0 for every 10,000 OBDs.
- Neglect includes many kinds of clinical incidents. When providers notify us of incidents of neglect, they should also check their data to look for other clinical issues and review their clinical governance. This includes the data they collect and submit under the Quality Indicator Program (QI Program).

Inappropriate use of a restrictive practice

- This quarter there were 232 notifications of inappropriate use of a restrictive practice, an increase of 20% (45) since Q3. This increase is from a low base and providers are most likely under-reporting this incident type. Of these incidents, 87% were reported as Priority 2 in Q4.
- The Commission's Behaviour Support Unit works directly with providers and through education to improve understanding of inappropriate use of a restrictive practice with people receiving care. Provider learning resources include webinars and online learning modules.
  - Webinar 1: Restrictive practices: myth busting
  - Webinar 2: Restrictive practices – myth busting part 2
- It is reported in the QI Program (see page 63) that the use of physical restraint has been going down. This covers all types of restrictive practices, both appropriate and inappropriate, except for chemical restraint.

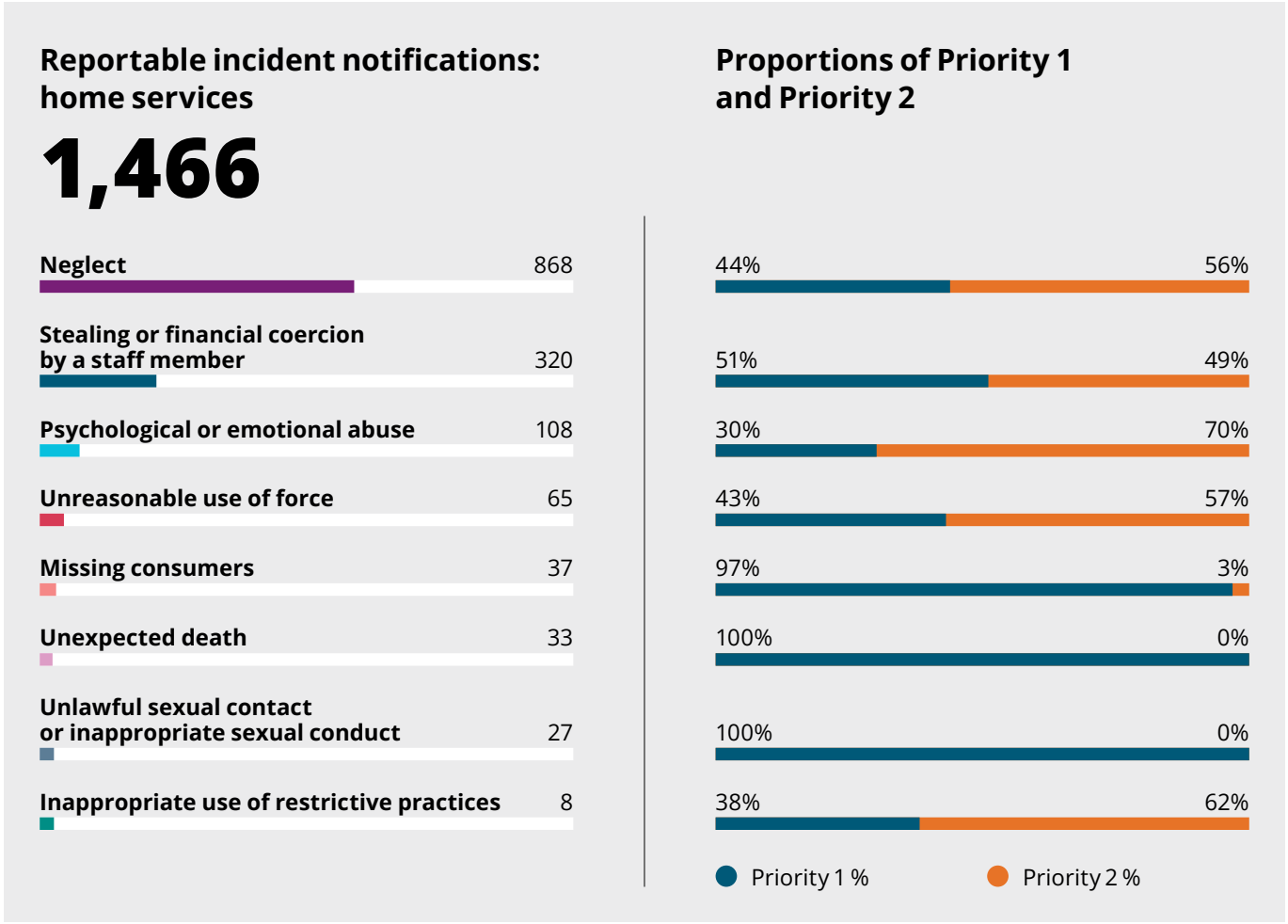


Figure 37: All reported incidents in home services and the percentage of Priority 1 and Priority 2 incidents

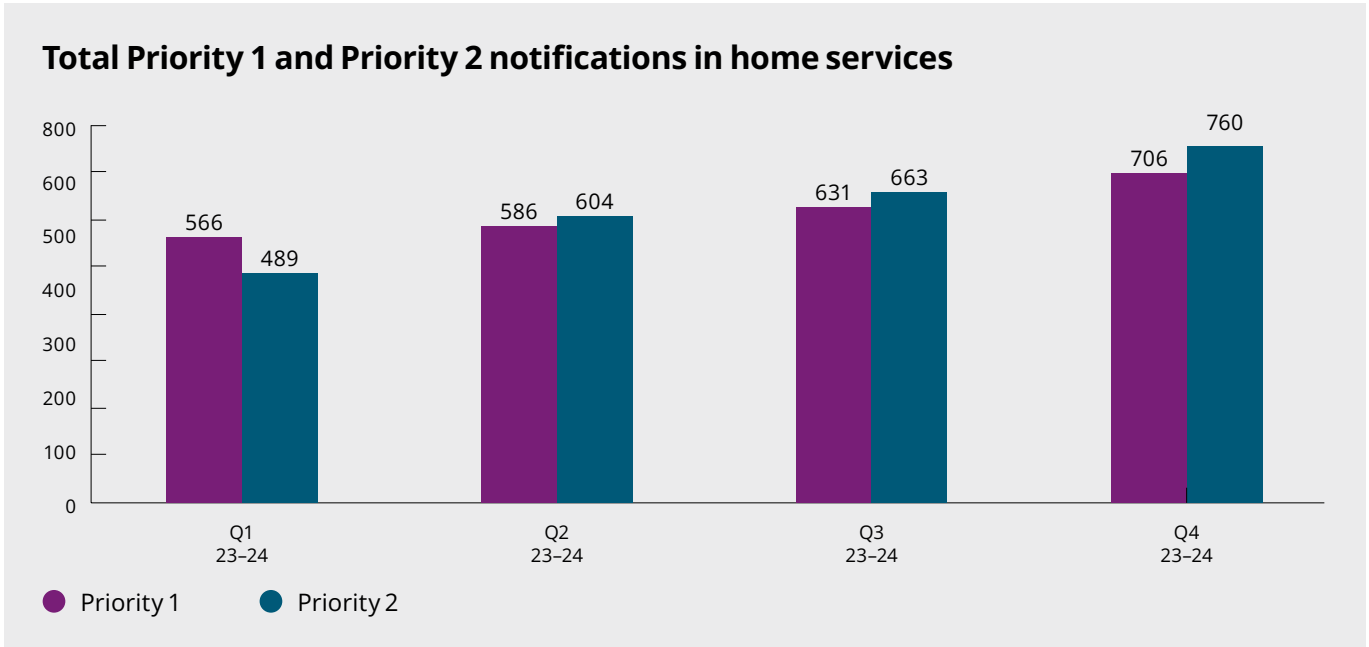


Figure 38: SIRS Priority 1 and Priority 2 notifications in home services over the past 4 quarters

- Notifications of serious incidents reported by providers of home services have continued to increase. In Q4, Priority 1 notifications increased by 11% and Priority 2 notifications increased by 13% compared with Q3.
- From Q1 to Q4, notifications increased by 38%, but this is still much lower than in residential care. This may be due to:
  - under-reporting of incidents
  - different settings where services have lower contact hours
  - lower risks for many home services.
- We are working with providers to remind them of their reporting responsibilities.
- Unlike in residential care, the proportions of Priority 1 and Priority 2 notifications are fairly evenly split. Priority 1 notifications account for 48% of notifications and Priority 2 account for 52%.
- Reports of neglect are the most common notification in home services, accounting for nearly 60% of all notifications. In home services, neglect includes a care worker missing a shift.
- The second most common incident type reported through the SIRS is stealing or financial coercion by a staff member. This is another area of concern. Good incident and complaints management systems help providers to identify stealing and financial coercion. These systems help people receiving care and their representatives to have their concerns heard and dealt with.
- We are working on, and will publish, rates of notifications for SIRS in home services in future editions of this report.

Find out more by clicking the links below:

- Serious Incident Response Scheme Insight Reports
- SIRS information for providers
- SIRS information for consumers
- SIRS information for home services providers
- Information on Quality Standard 8 – Organisational governance
- Clinical governance resources

Complaints

Complaints give providers and the Commission valuable information about the issues that are concerning people receiving care and their families or representatives. Aged care workers also contact us with their concerns about the quality of care that people are receiving. In this section, we list the most common issues that are raised with us.

The rates below are for complaints that were lodged with us. Providers have their own internal complaints data that they can use, along with the insights we provide, to improve their service.

We expect providers to support people receiving care to feel confident to raise any concerns directly with staff when there is an issue with their care. We also expect providers to encourage and support their staff to resolve concerns when they arise. Good communication and good complaint handling, with a focus on a person-centred approach, builds better relationships with the people in your care.

Residential care

1,489
Complaints received

0.8
Complaints rate per 10,000 occupied bed days (OBD)

Home services

1,134
Complaints received
(HCP = 1,004 + CHSP = 130)*

36.51 (HCP) | **1.59** (CHSP)
Complaints rate
per 10,000 consumers

Figure 39: Number of complaints and complaints rate in residential care and home services in Q4
* Home Care Packages (HCP), Commonwealth Home Support Programme (CHSP).

- In Q4, the number of complaints made to the Commission about residential care increased by 5% – much lower than the 23% increase in Q3.
- The rate of complaints was 0.8 for every 10,000 OBDs. For a typical 110-bed service, that is less than 1 complaint each quarter and less than 4 a year.
- The number of complaints does not necessarily reflect the quality of the service. For example, a service with a positive complaints culture will encourage feedback and complaints and use these as a way to improve their services.
- Complaints are one of the key information sources that we use when identifying harm or possible harm to people receiving care.
- Commission quality assessors consider complaints data during their monitoring and assessment site visits.
- We are working to help people receiving care, families, representatives and workers feel more confident about raising issues with providers directly, with us, or both.
- Only 8% of complaints made to us about residential care are from people receiving care (Figure 42) and 50% are made by a representative or family member.
- Providers should review their complaints processes to make sure they resolve issues directly with people receiving care. Providers also need to make sure that people receiving care know that they can contact the Commission, or have someone do that for them, if they are still concerned about their care and services.

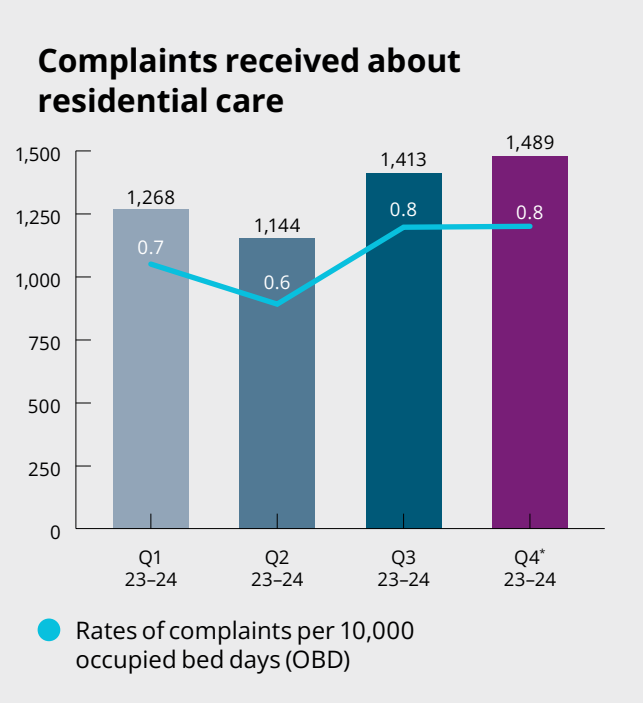


Figure 40: Number of complaints and complaints rate for residential care over the past 4 quarters

* The rate for Q4 is an estimate as the number of OBDs for this quarter has been estimated. See notes on data (page 79) for details.

Rates of complaints are calculated by the number of complaints received in the quarter per:

- 10,000 occupied bed days (OBDs) in residential care
- 10,000 people receiving care in home services.

This allows us to track changes over time and account for services with different numbers of:

- residents in residential care as well as occupancy
- people receiving home services.

OBDs are not used in home services, so we have calculated rates using the numbers of people receiving care. The rates for residential and home services are therefore not comparable with each other.

Where possible, we have also broken down home services by program type. The 2 programs are the Commonwealth Home Support Programme (CHSP) and Home Care Packages (HCP). This allows providers to compare their results with similar types of providers.

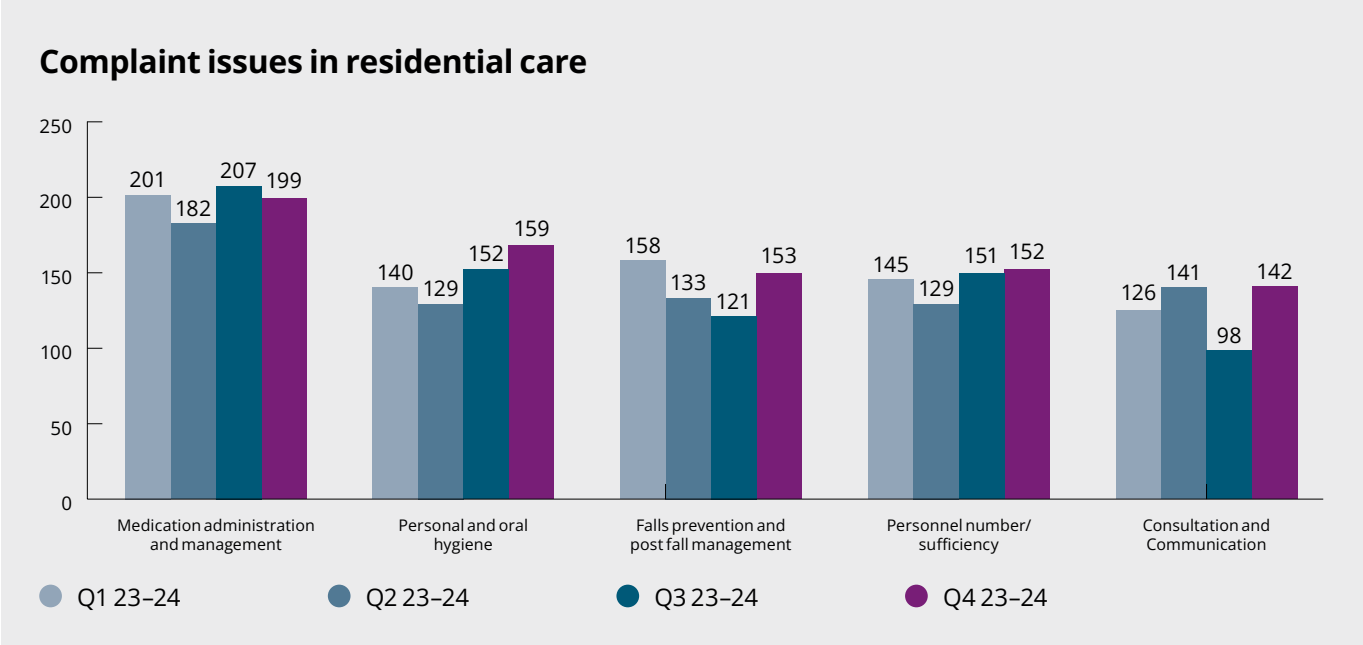


Figure 41: Top 5 complaint issues in residential care over the past 4 quarters

* The top 20 complaint issues and rankings for each quarter are in our online data tables published with the report

- Medication management and administration is the most complained about issue in residential care.
- Clinical complaints account for 3 of the top 5 complaint issues in residential care. This is followed by complaints about the number and capability of staff, and lack of communication and consultation.
- Common examples we see in complaints about medication include:
  - medications being given to the wrong person or a near miss
  - administering the wrong dose of medication or a near miss
  - late and missed medication.
- We have also seen an increase in complaints about falls and about communication.
- In Q4, compliance with Quality Standard 3 (Personal care and clinical care) fell (Figure 17). However, the QI Program data shows steady improvement across the sector in several clinical areas.
- The number and capability of staff is also consistently in the top 5 most complained about issues. Common complaints are about:
  - reduced staff numbers on weekends
  - people not receiving timely care or help to leave their beds and rooms.
- These types of workforce issues are related to providers' ability to meet mandatory targets for care time delivered to each person each day (page 37).

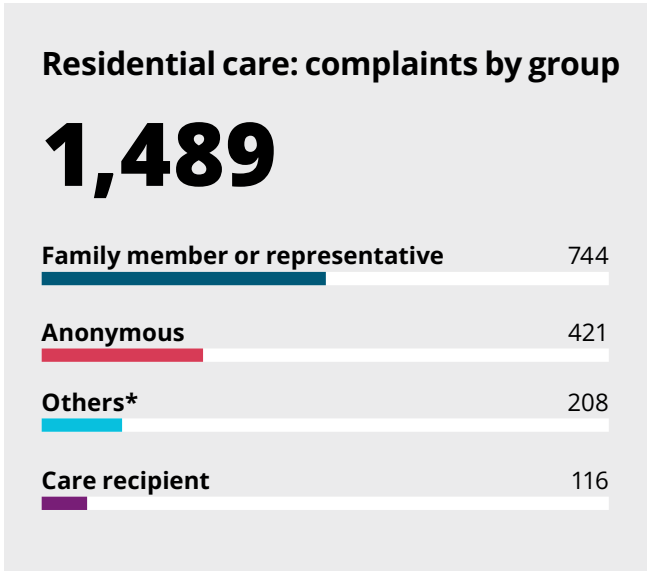


Figure 42: Complaints by the group that made the complaint in residential care

* Others include staff, external agencies, media, internal referrals, providers or other interested people.

We encourage you to calculate your own complaints rates to compare with the sector averages and averages for similar types of providers.

If your own rates are very different from the averages, it is important to know why.

- Has an unresolved issue come up at your service?
- Are there any problems with your complaints system?
- Are people receiving care confident that management and your staff can resolve an issue quickly or do they feel the need to involve the Commission?
- Are people receiving care confident to come forward and complain, and do they know how to make a complaint?
- Are you communicating well and practising open disclosure at every opportunity to maintain good relationships with the people in your care?

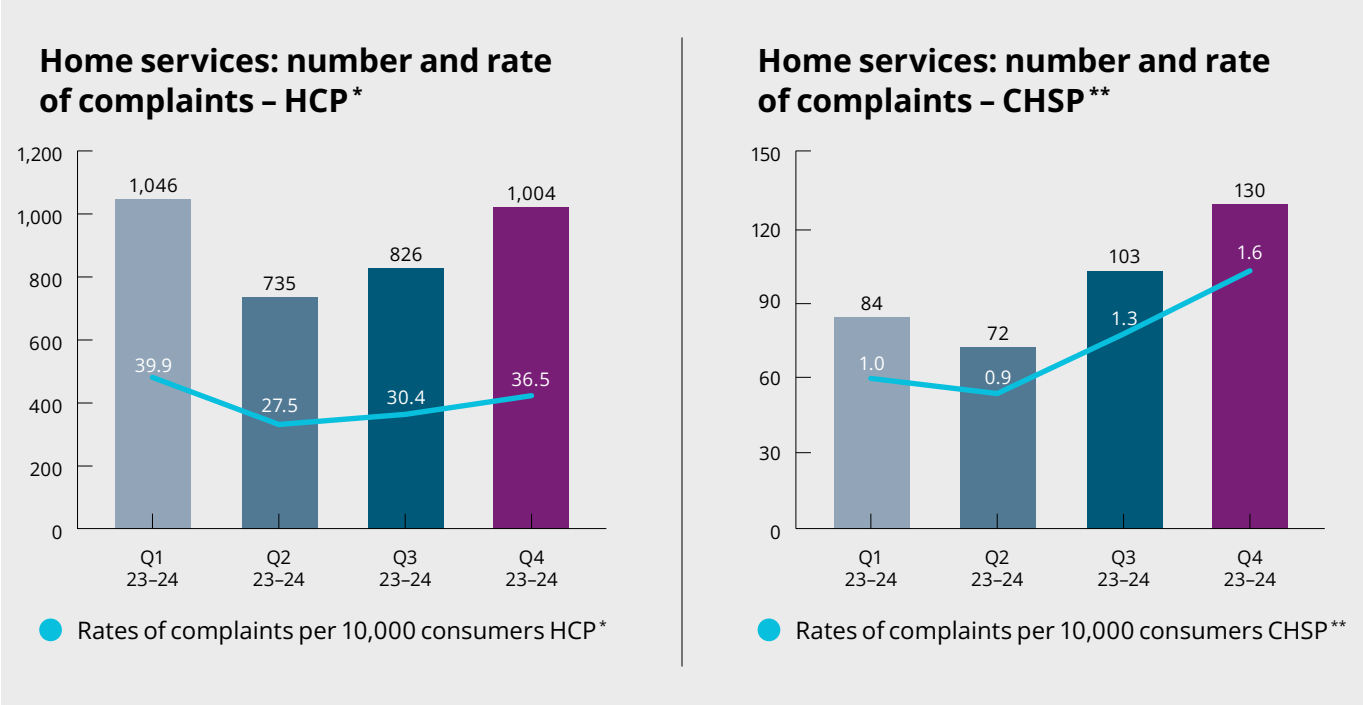


Figure 43: Number of complaints and the complaints rates for every 10,000 people receiving care in home services for the past 4 quarters
* Home Care Packages (HCP)
** Commonwealth Home Support Programme (CHSP)

- The number of complaints received and the complaints rates for both HCP and CHSP have increased over the past 3 quarters, after a drop in Q2.
- Through our quality audit program, we encourage people receiving care to give feedback and make complaints directly to their provider and to the Commission. This helps providers to keep improving and to manage risks.
- Unlike in residential aged care, nearly half of complaints about home services we receive are made by people receiving care.

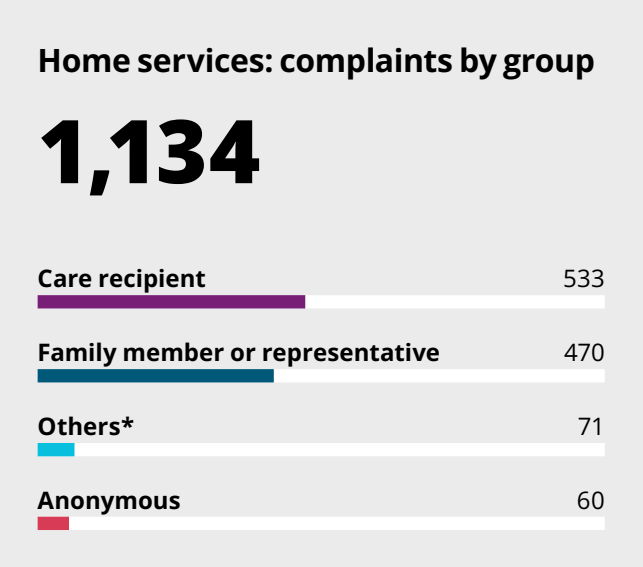


Figure 44: Complaints by the group that made the complaint in home services
* Others include staff, external agencies, media, internal referrals, providers or other interested people.

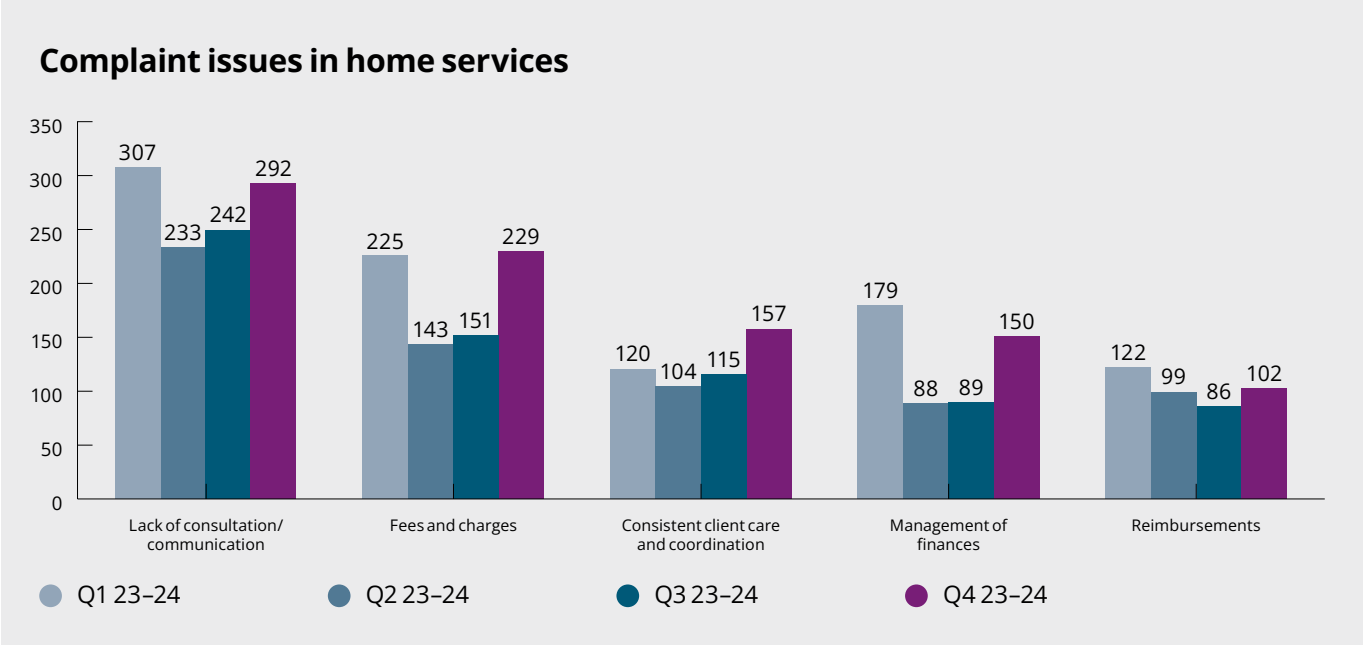
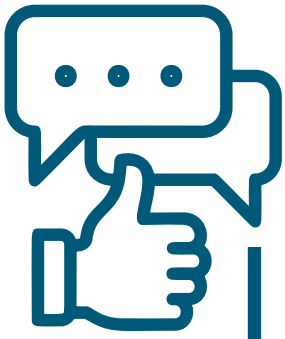


Figure 45: Top 5 complaint issues in home services over the past 4 quarters

* The top 20 complaint issues and rankings for each quarter are in our online data tables published with the report

- The top 5 complaint issues for home services continue to be financial concerns, communication, and coordination of care.
- Complaints about lack of consultation and communication remain the number one complaint topic in home services. Good communication with the older person to explain 'what, when, why and how' can go a long way to resolving concerns. Common complaints about communication include not:
  - answering or returning calls or emails
  - responding to requests for goods and services.
- In Q4, complaints about fees and charges, and management of finances, account for 3 of the top 5 most complained about issues in home services. However the number of complaints we received on these topics has fallen significantly since Q1 2023–24. Complaints we receive include:
  - charging for services that are no longer provided
  - service fees being added to purchases, such as a motorised scooter, without explaining why.
- Providers must:
  - have reasonable and transparent pricing and itemised statements
  - consult with and get consent from people receiving care for any changes to home care packages
  - deliver care that is consistent with the needs and preferences of people receiving care.
- Complaints about consistent client care and coordination are still the third most complained about issue in home services. We are giving this greater attention in our quality audit program in 2024.
- These issues can also be seen in providers' non-compliance with Quality Standard 2 (Ongoing assessment and planning with consumers). Compliance with this standard has improved this quarter but it has the second lowest rate of compliance in home services (Figure 20).



How we resolve complaints

We want complaints to be resolved as quickly as possible. We support people making the complaint and providers to resolve the issues themselves (early resolution). The proportion of complaints resolved this way has stayed steady over the past 4 quarters.

A small number of the complaints we receive need to go through a formal resolution process. This can include using an external mediator or conducting a Commission or provider investigation into the issue.

Providers should review their complaints management system. This can help them to understand why people receiving care feel the need to come to us and why complaints needed our involvement.

We are looking for evidence that providers have resolved the complaint, have restored the trust and confidence of the person receiving care or their representative, and that they have taken steps to prevent further harm. By doing this, providers will build better relationships with the people in their care and with the local community more broadly.

Find out more by clicking the links below:

- How to make a complaint
- Complaints and the complaints process
- Complaint rights review
- Quality Standard 6 – Feedback and complaints
- Quality and safety in home services – 5 key areas of risk
- Complaints about aged care services – Insights for providers report – 2023.

Residential care by provider size and ownership type

Throughout this report we have provided data for residential care against specific performance measures and categories. There can be different outcomes for providers depending on their size and ownership type.

This segmented data is useful for benchmarking performance to compare with similar types of providers. However, performance outcomes against a particular measure cannot be used to determine that one type of aged care provider is better than others.

For residential care services, we have broken down the compliance, complaints and Serious Incident Response Scheme results in Q4 by the size of the provider that runs the service and the ownership type. We work out the size of the provider by the number of services they run.

The 3 sizes of a provider we have used are:

- small provider — operates 1 or 2 residential care services
- medium provider — operates between 3 and 10 residential care services
- large provider — operates 11 or more residential care services.

The 3 categories of ownership type we have used are:

- for-profit
- not-for-profit
- government.

As we develop these models, we will also be including other categories including financial performance and geographical location. We will also be extending these models to home services.

Residential: proportion of site audit decisions that met the Quality Standards by provider size over the past 4 quarters

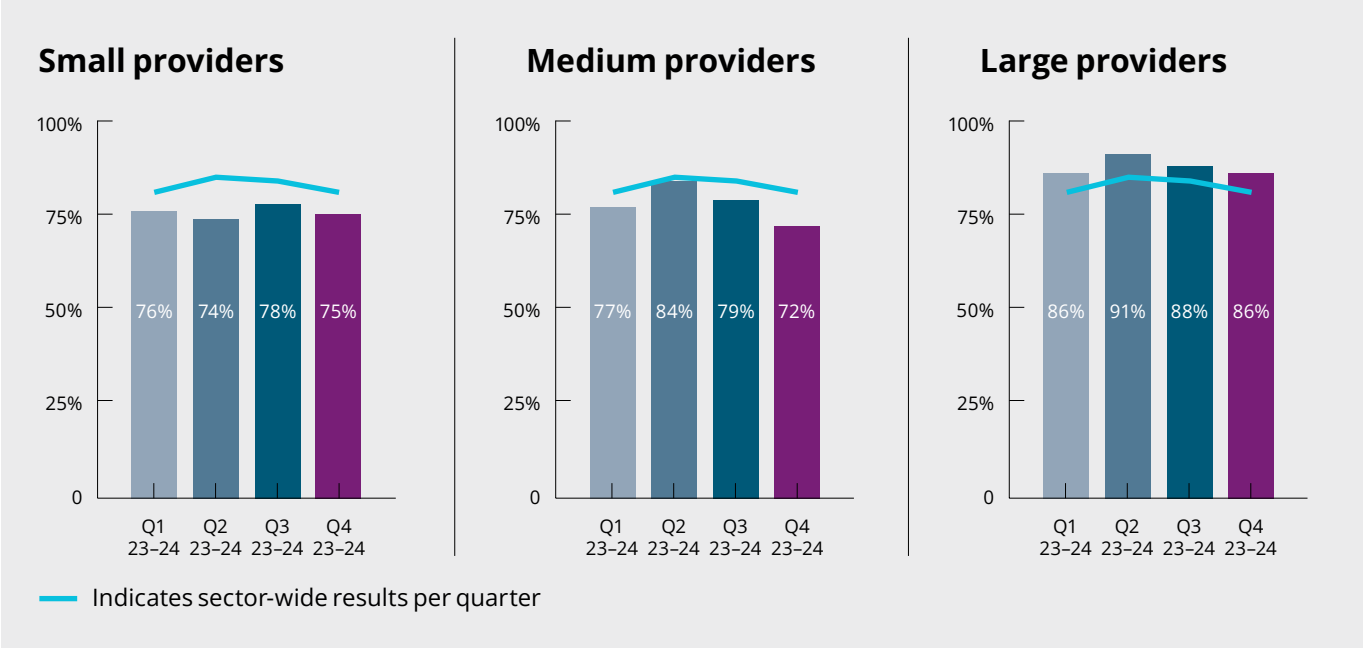


Figure 46: Proportion of compliance decisions by size of provider in residential care

- Large providers continue to have higher compliance rates than small or medium-sized providers.
- These differences could be for several reasons, including governance arrangements, staffing and mix of people receiving care. We are investigating other possible reasons for these differences.
- Compliance rates for medium providers have fallen by 7 percentage points in Q4 to 72%, 9 percentage points below the sector average.
- Compliance rates for small providers have fallen by 3 percentage points in Q4 to 75%, 6 percentage points below the sector average.

Residential: proportion of site audit decisions that met the Quality Standards by ownership type over the past 4 quarters

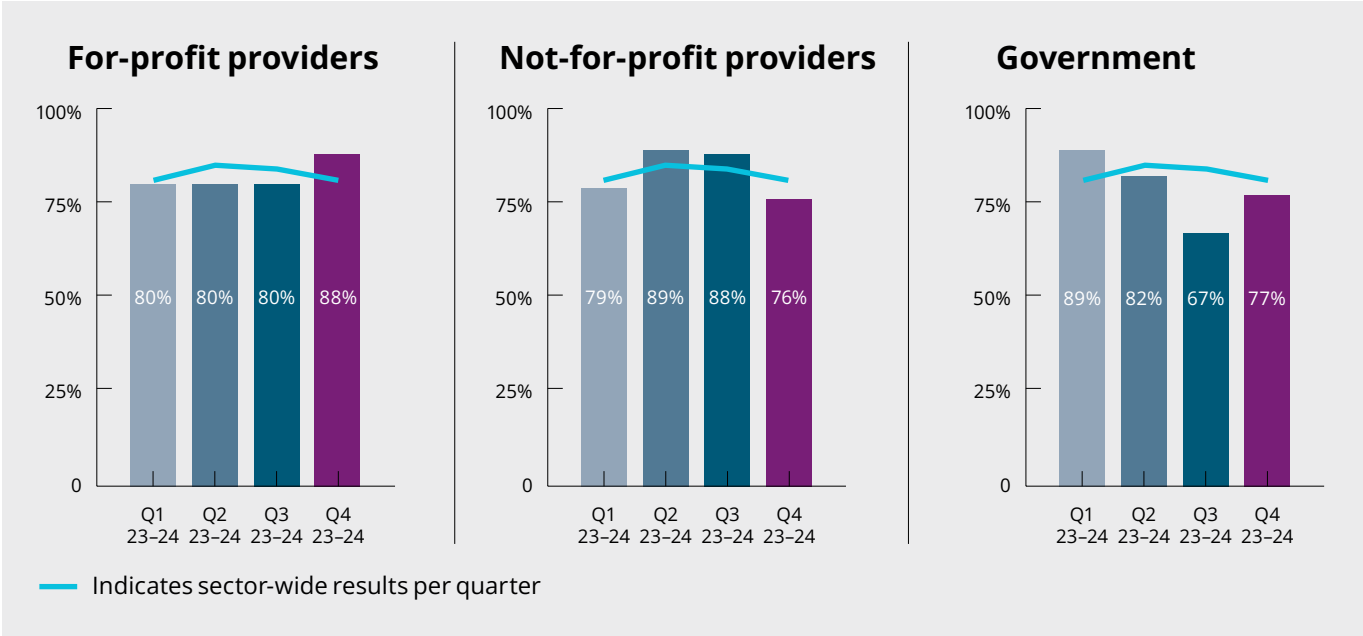


Figure 47: Proportion of compliance by ownership type in residential care

- Compliance rates for government-owned providers have improved by 10 percentage points this quarter. They are still below the sector average by 4 percentage points and are 8 percentage points lower than in Q1. We are monitoring this trend. Due to the smaller number of government providers, the results of a few providers being found non-compliant during a quarter can have a bigger impact than the for-profit or not-for-profit groups.
- Not-for-profit providers' compliance rates in Q4 are now below the sector average, having fallen by 8 percentage points from Q3.
- For-profit providers' compliance rates have increased by 8 percentage points this quarter and are now much higher than the sector average.

Residential: SIRS notification rates by provider size

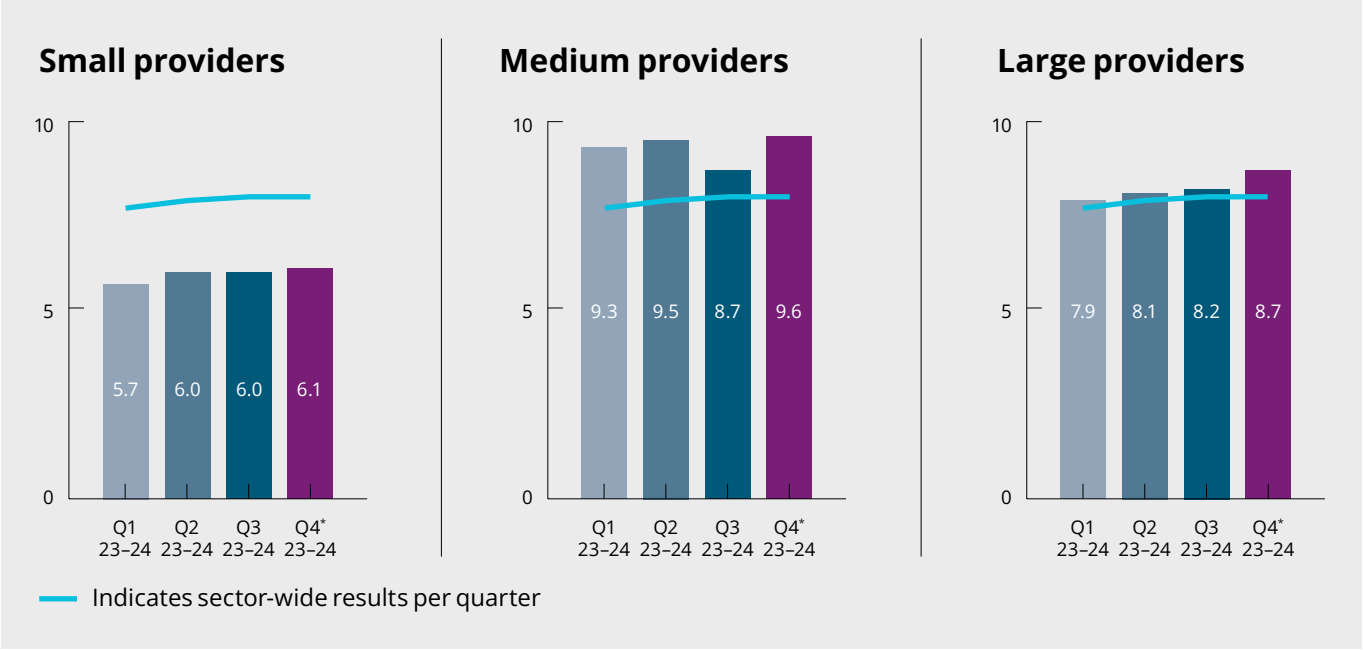


Figure 48: SIRS notification rates for the last 4 quarters by provider size in residential care. All rates are notifications per 10,000 OBDs
* The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details.

- The SIRS notification rate for small providers of 6.1 is well below the sector average of 8.0. This rate has been consistent for the past 3 quarters.
- The SIRS notification rate for medium-sized providers has increased to 9.6 in Q4. This is much higher than the sector average of 8.0. For a 110-bed service, this would account to about 32 incidents a year.
- Large providers' SIRS notification rate has increased over the past 4 quarters to 8.7 in Q4. This is higher than the sector average.

Residential: SIRS notification rates by ownership type

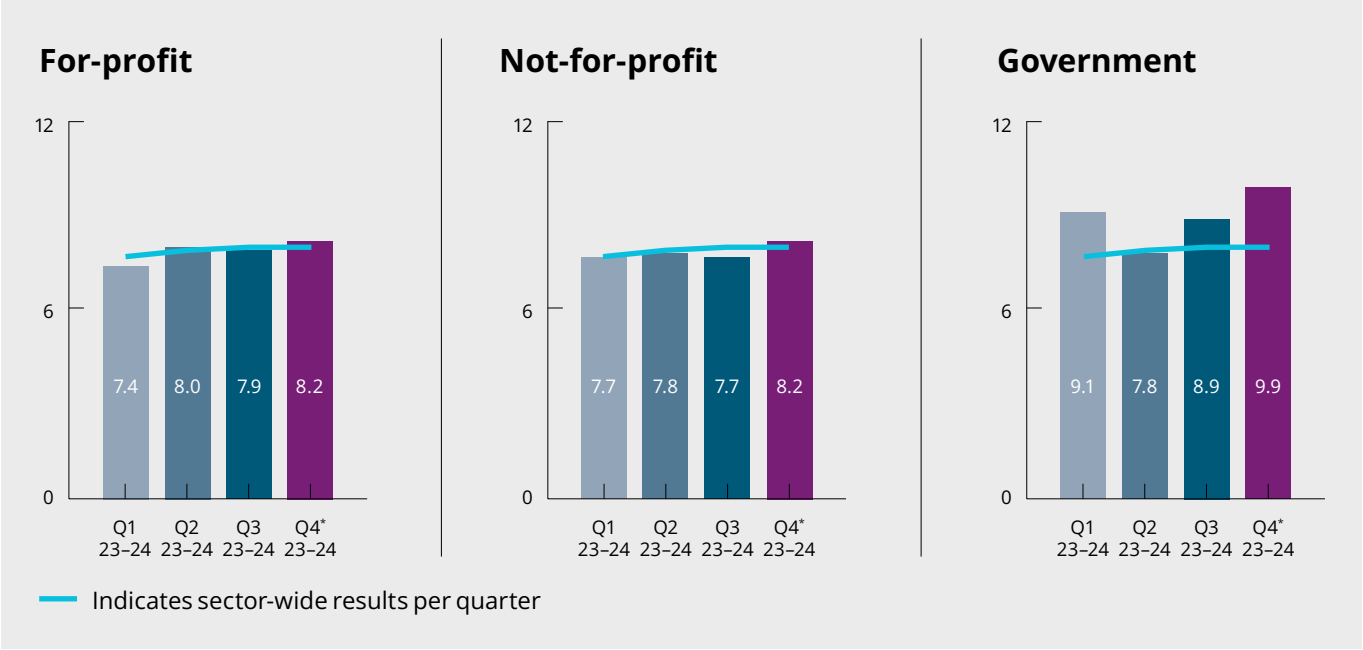


Figure 49: SIRS notification rates for each quarter by ownership type in residential care. All rates are notifications for every 10,000 OBDs
* The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details.

- Rates of SIRS notifications for for-profit providers and not-for-profit providers are close to the sector average of 8.0. For a 110-bed service, this would account to about 32 notified incidents a year.
- SIRS notifications rates for government providers have varied over the past 4 quarters. At 9.9, this is now nearly 2 percentage points higher than the sector average. For a 110-bed service, this would be about 40 notified incidents a year.
- No general conclusions about the comparative performance of provider types can or should be taken from this data. SIRS notifications are only a single view of performance. The reasons for any differences in notification rates are not always clear and are likely to be affected by many different factors. Providers should look at their own SIRS data and incident management system to find trends and ways they can improve.

Residential: complaints rate by provider size

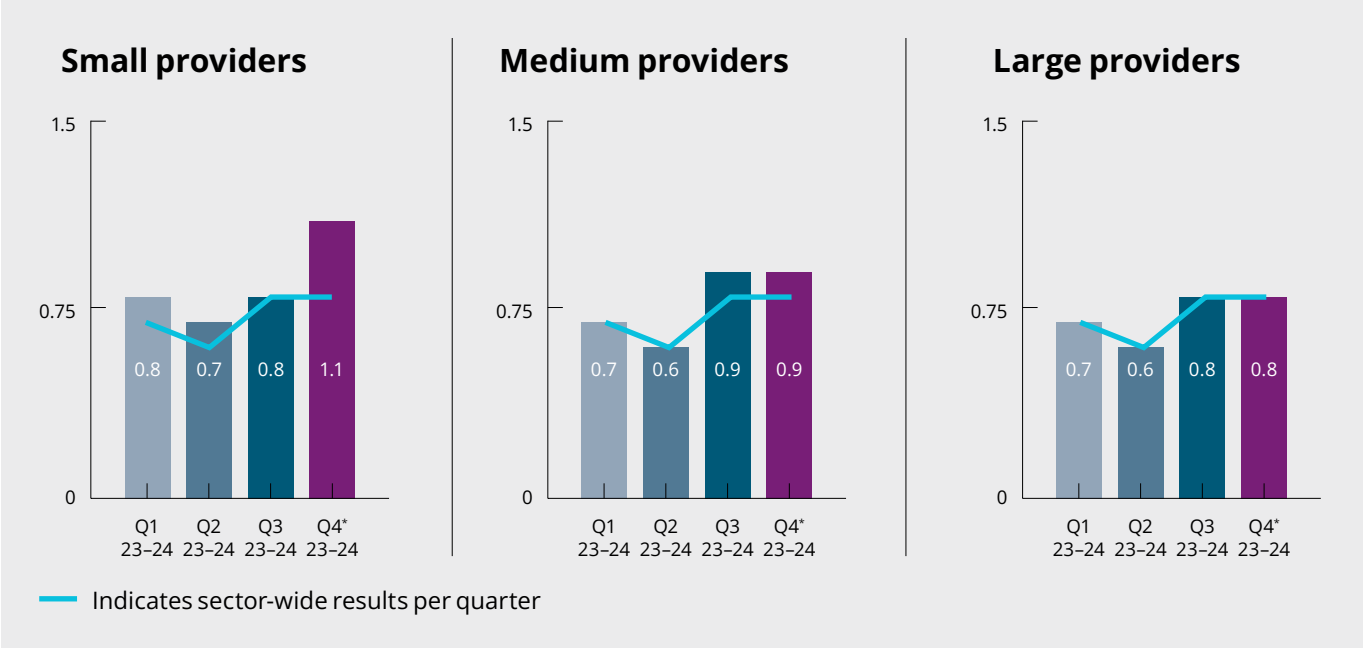


Figure 50: Residential care complaint rates for every 10,000 OBDs by provider size over the past 4 quarters

* The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details.

- Smaller providers' complaints rate, at 1.1 for every 10,000 OBDs, was above the sector average. This equals just over 4 complaints to the Commission a year, for a 110-bed service. This compares with a sector average of 3 complaints a year.
- Medium-size providers' complaints rate has not changed since Q3 and is just over the sector average, having risen by 50% from Q2 to Q3.
- Large providers' complaints rate in Q4 has stayed the same as the sector average. There was no change from Q3.
- Published complaints rates are for complaints made to the Commission. Providers should look at their own data to find trends in complaints. This includes complaints that they resolve themselves without the person needing to raise the matter with the Commission.

Residential: complaints rate by ownership type

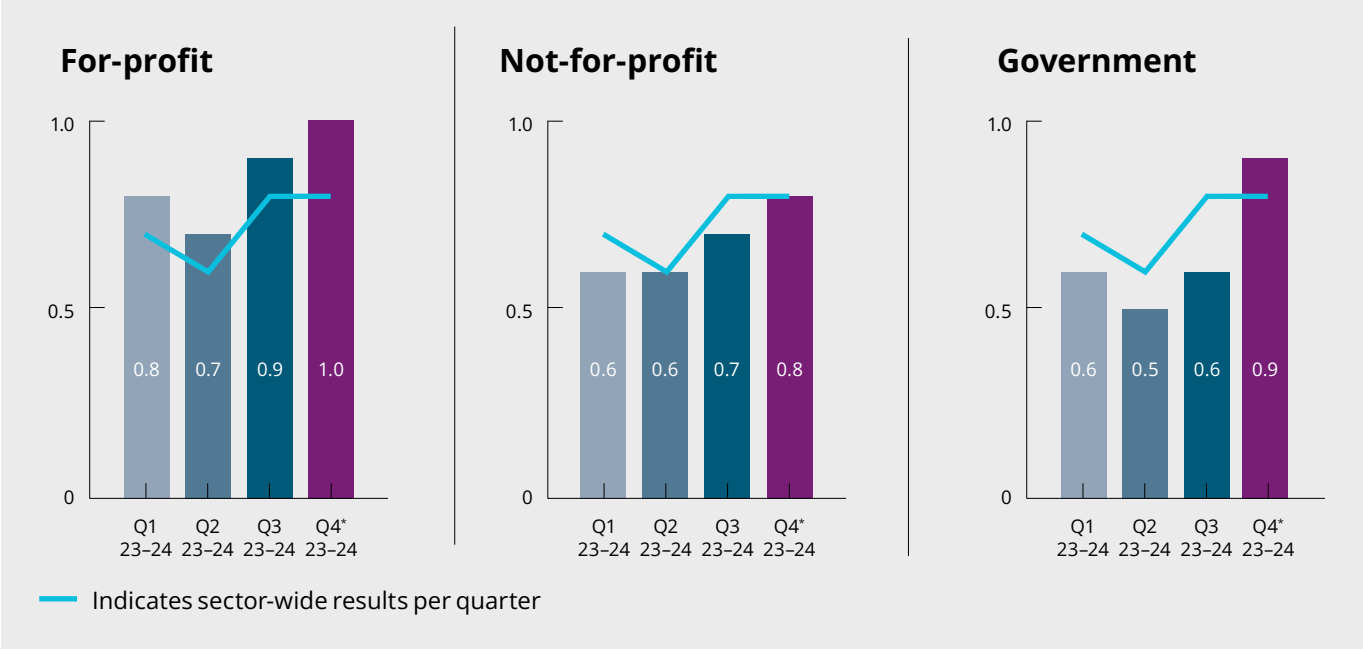
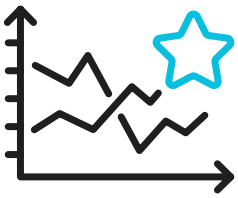


Figure 51: Residential care complaint rates for every 10,000 OBDs by ownership type over the past 4 quarters

* The rate for Q4 is an estimate as the number of OBDs for this quarter has not been updated. See notes on data for details.

- The complaints rate of for-profit providers is above the sector average. In Q4, a 110-bed service would expect to receive about 4 complaints compared with a sector average of 3 complaints a year.
- The not-for-profit providers' complaints rate is consistent with the sector average of just over 3 complaints a year for a 110-bed service.
- Government providers' complaints rate is slightly above the sector average.
- As with complaints by provider size, providers should look at their own data to find trends. This includes complaints that they resolved directly, without the person needing to raise the matter with the Commission.

National Aged Care Mandatory Quality Indicator Program
– for residential care



Quality Indicators (QI) measure the parts of an aged care service that support the quality of care that people receive in residential care. The QIs we have included here are about harm or risk of harm, so the lower the rate the better.

Providers collect and submit their own QI data and can access their QI rates from the Government Provider Management System.

For benchmarking purposes, providers may find it useful to consider QI data alongside data relating to compliance with the Quality Standards, Serious Incident Response Scheme and complaints – at both provider and sector levels.

Some QIs can be considered 'lag indicators'.

This means that the issues may show up in other data before they show up in QIs. For example, while we are pleased that QIs show that issues of unplanned and consecutive weight loss are going down, providers should also look at other data. This data could include feedback and complaints from residents about their food satisfaction and feedback from staff involved in planning and serving meals. This will help give a sense of whether improvements are already happening – rather than waiting for weight loss data.

Trends in QI performance over time

Over the past 2 and a half years, there has been an improvement (decrease in reports) in the QIs for:

- polypharmacy
- antipsychotic medication use
- falls that resulted in major injury
- use of physical restraint
- physical restraint exclusively through the use of a secure area
- significant unplanned weight loss and consecutive unplanned weight loss.

There has been no significant change in the proportion of residents experiencing falls.

Six new QIs were introduced on 1 April 2023 and the first results have been published in the Australian Institute of Health and Welfare's January to March 2024 report. These are:

- activities of daily living
- incontinence care
- hospitalisations
- workforce turnover
- consumer experience
- quality of life.

Find out more by clicking the links below:

- Residential Aged Care Quality Indicators January – March 2024
- Guidance for providers on using QI data to inform quality improvement: National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part B

Sector rates on some indicators are heading in the right direction

Trends in quality indicator performance over time, Q1 2021–22 to Q3 2023–24

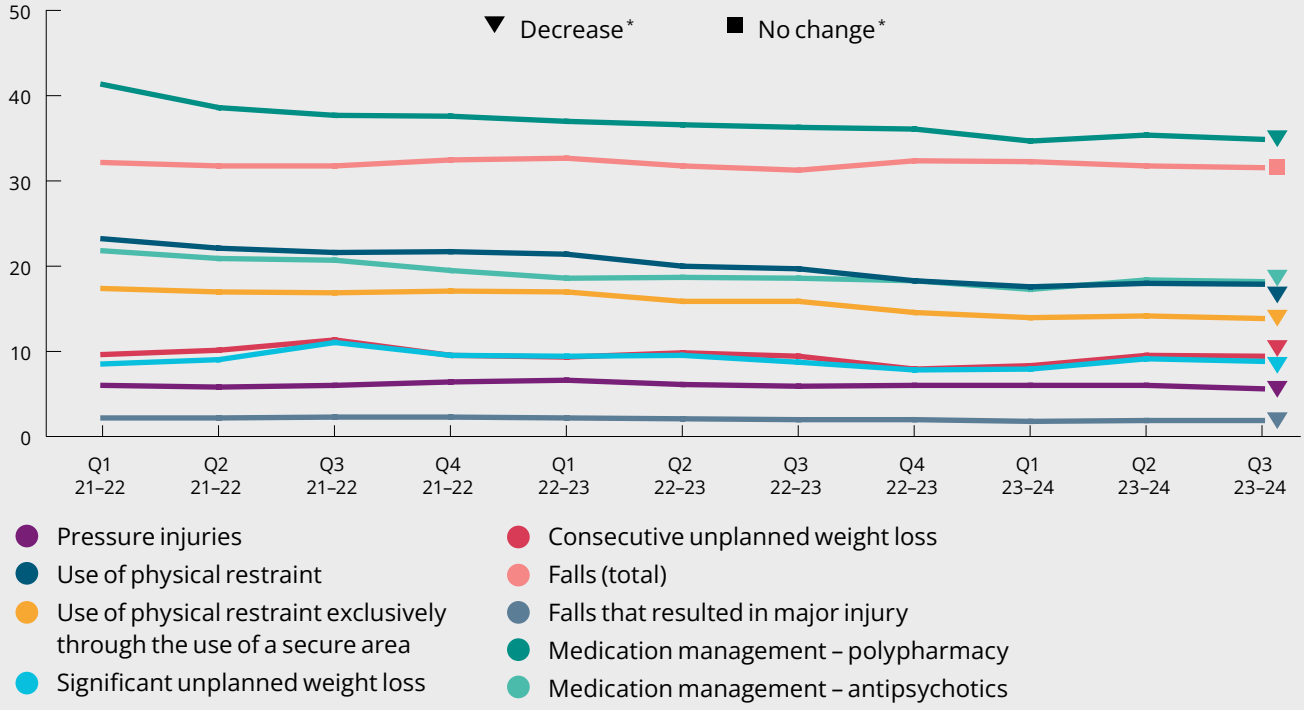


Figure 52: Trends in QI performance across the past 11 quarters

* A trend here means that there must have been a change up or down of at least 0.05.

Source: Department of Health and Aged Care, data extracted 21 May 2024, published on GEN-agedcaredata.gov.au

In focus: provider supervision

As part of the Commission's updated regulatory strategy we are introducing a new provider supervision model.

Under this model providers that are assessed to be high risk will experience a greater intensity of supervision and engagement from the Commission in response to the risks identified.

How we supervise the sector

Provider supervision is part of the Commission's strategy to improve the delivery of high-quality care by supervising providers in a way that encourages them to address risks and lift their performance.

To do this the Commission uses a range of regulatory approaches and tools to monitor if providers are doing the right thing and will take compliance and enforcement actions to protect older people when we identify serious failures to provide safe care.

We are constantly monitoring data from providers to identify any risks or failures of care. We scan all the information we collect through:

- mandatory reporting
- complaints
- reports of serious incidents
- our audits
- other regulatory interactions.

We also review other information we receive through things like the QI Program, Quarterly Financial Reports and the Annual Statement of Provider Operations.

The intensity of supervision varies based on our understanding of risks potentially posed to older people. To determine a provider's supervision status, we consider:

- the provider's risk profile, as determined by the data available to us
- other intelligence we have collected
- the outcomes of regulatory actions.

The 4 levels of provider supervision are:

- Risk surveillance.
- Targeted supervision.
- Active supervision.
- Heightened supervision.

Risk surveillance

There is ongoing monitoring and risk surveillance of all providers **all** the time to protect and safeguard older people receiving aged care. In the absence of any specific risk or compliance concerns, providers will have a **risk surveillance supervision** status.

The Commission's risk analysis model

Daily
- Enquiries and feedback
- Complaints
- Workers concerns
- Reportable incidents
- Media

Quarterly
- Financial
- Staffing
- Food and nutrition
- Quality indicators (e.g. pressure injuries, unplanned weight loss, medication management, physical restraint, falls)

Annually
- Financial statements
- Prudential compliance statements
- Consumer experience interviews
- Provider governance and operations information
- Provider governing body statement

As required
- Site audits
- Risk based monitoring
- Material changes
- Referrals from other agencies
- Research and publications

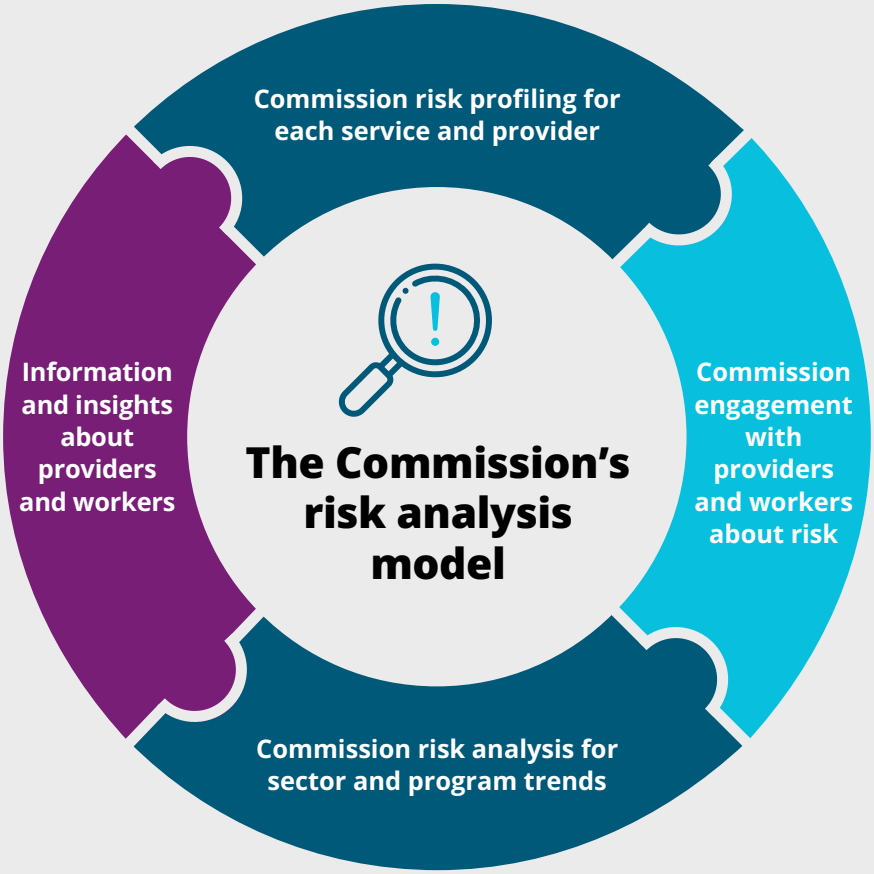


Figure 53: The Commission's risk analysis model

Targeted supervision

Where the Commission requires a provider to take corrective action to manage specific events or issues, and we have confidence in their ability to do this in a timely and appropriate manner, we will engage with the provider and seek the required assurance that the actions have been taken. In these cases, the provider will have a **targeted supervision** status. Where the provider has done what is required and there are no other ongoing issues, they may return to a risk surveillance supervision status. Where they are unable or unwilling to do what is required, or other concerns are identified which increase the level of risk, a provider may move **into active or heightened supervision**. We will be providing figures about targeted supervision in future reports.

Active supervision

We actively case manage providers where we:

- identify a high level of risk and the potential for harm to older people receiving care
- are not confident that the provider is willing or able to do what is required.

We regularly engage with the provider to ensure that they are taking the required actions. Our case managers may use regulatory powers to push the provider to:

- change their behaviour
- deliver the required actions that will appropriately manage risk
- demonstrate their compliance.

Heightened supervision

We actively case coordinate a broader range of stakeholders where there are:

- severe levels of risk to the safety of older people
- risk to ongoing continuity of care
- high levels of public interest.

These stakeholders include the Department of Health and Aged Care who we work with to manage these complex risk scenarios and protect older people's safety and ongoing access to care.

When we find a risk to older people receiving care or a failure of that care, we respond based on what we know about the situation. We work with the provider to make sure that they:

- are willing and able to fix the problem
- do actually fix the problem
- have restored the trust of the people who were affected.

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Active supervision

5

Heightened supervision

Figure 54: Number of providers in active supervision and heightened supervision as of 30 June 2024

The following case studies are from our trial of the new supervision model. We have changed the names of the services and providers in the case studies. We have also changed some details of the cases to protect confidentiality.

Case study 1:

A provider's lack of independent board directors adds to concerns about their willingness and ability to manage risk and prevent harm

After a site-based assessment against the Quality Standards and an initial period of engagement with the Commission, we issued a non-compliance notice to Dolphin Side*, a small provider with 2 services. We issued the notice because our assessment showed that we needed a structured approach to make sure that the non-compliance and identified risks were addressed quickly.

The provider agreed to fix the problems. However, after receiving a complaint about the service, we organised a second site visit. At this visit we found that the problems were worse than originally reported. There were high levels of non-compliance, with actual harm to residents.

The provider also had a rate of complaints 3 times higher than the sector average and a rate of notifications of unreasonable use of force around 60% higher. This confirmed our view that the provider was not making enough progress to put in place the necessary systems and controls to manage risks.

Our engagement with the provider led us to conclude that the provider's governance arrangements were a significant contributor to the problems. The board did not have a majority of independent non-executive directors, a legal requirement for approved providers. This meant that there was less independent assessment and oversight of risks. There were particular issues around:

- falls
- wound management
- behaviour support
- nutrition and hydration.

* Approved provider, not their real name

It was also clear that the board was not using its data to inform risk or drive improvement. They were failing to make the changes needed in the timeframe that had been agreed to in their response to the non-compliance notice. This led to us putting a sanction in place which made them ineligible for subsidies for new care recipients.

The provider is still under heightened supervision. We are in close contact with the provider and they must submit progress reports twice a month. Through our work with them, the provider understands what they need to do to lift their performance and improve how they manage risk. This includes what they need to do to address their non-compliance with governance arrangements. The provider also understands the consequences if they do not make these changes, including us possibly revoking their approved provider status.

Performance and governance

Performance is lifted when governing bodies:

- understand their accountabilities
- ensure that they remain informed about risk levels, including by requiring relevant reports from executives
- have integrated systems, practices and controls
- are invested in improvement.

Case study 2:

Heightened supervision helps a service return to compliance, find a buyer and maintain continuity of care for residents

Faraday Cove* has one residential service. There are no other residential aged care services in the town. If the service closes the residents would need to move up to 100 km away. We increased the intensity of our supervision of this provider, due to a concerning pattern of serious incidents at their service.

These concerns prompted a full on-site audit against the Quality Standards, which found that the service was non-compliant with most of the requirements of the Quality Standards. This confirmed that the provider had insufficient systems, controls and governance in place to effectively manage risk to prevent foreseeable incidents.

We also found that the provider was:

- not financially viable
- having ongoing staffing issues including high turnover.

When we became involved, the provider had the service up for sale. The non-compliance of the service and the financial viability issues were a barrier to another provider purchasing the service. This uncertainty put residents' wellbeing and continuity-of-care at risk.

Working with the provider, we aimed to:

- make sure the provider immediately implemented safeguards to mitigate risks to those people receiving care
- support the provider to invest in strategies to deliver sustainable improvement in their performance, that would also make the service more attractive to potential buyers, thereby helping to maintain continuity of care for existing residents.

As the provider initially failed to satisfy us that they would fix the areas of non-compliance, we forced them to act by issuing a non-compliance notice and then a sanction which made them ineligible for subsidies for new care recipients. The sanctioned ensured there was a disincentive for the provider to take in new residents until required remedial action had been taken. We placed them under heightened supervision and worked

* Approved provider, not their real name

with the Department of Health and Aged Care to look at options. We told their board to take a much more active role in managing risk and holding staff accountable for using the required systems and controls.

The board showed that they were committed to managing the needed changes by offering us an enforceable undertaking.

The undertaking focused on developing strategies, frameworks and systems to improve:

- staff education
- communication between the provider and residents
- clinical governance
- risk management.

We actively supervised the service to make sure that they successfully followed the actions in the enforceable undertaking. We closely engaged with the board to ensure all non-compliance was fully addressed.

A large provider of residential aged care, respite services and home services has since bought the service. We have continued to monitor the service under the new provider and have found no issues with compliance or quality of care, and the workforce is stable.

This case study is a good example of working with the provider to bring them to full compliance and protecting the continuity of service where residents did not have easy access to other services. Our intervention also enabled the service to become viable for another provider to buy.

Case study 3:

Home services provider in remote area placed under heightened supervision

Red Sands Care* is an Aboriginal and Torres Strait Islander provider that offers care and services in remote areas.

A quality audit of this provider showed that there were issues with their governance of sub-contracted clinical care for the home care packages they delivered. It is the only provider that covers a very large, remote area including many Aboriginal and Torres Strait Islander communities. Our main concern was that they did not have the structure, capability or capacity to meet the needs of people receiving care with complex needs. This meant there was a critical shortage of aged care services for high-needs Elders in that region.

There were no active complaints with us about the provider. We were concerned about information we received from the Department of Health and Aged Care that showed people receiving community and home care packages were not happy with the provider. We placed them under heightened supervision due to the level of risk to the people receiving care.

We worked with the provider to monitor the risk to the people receiving care and understand how they were addressing the risk. We visited all of the provider's home care services in the affected communities. We spoke with people receiving care, community leaders and service delivery partners to understand more about the risk.

We also worked with the Department on an emergency plan if the provider suddenly decided to stop delivering services in the area. They had mentioned in the past that this might happen.

We worked with the provider to understand the issues in the care they were delivering. They agreed to use the expertise of a specialist advisory service (funded by the Department). The service will help the provider to develop a strategy to fix the issues in the quality and the appropriateness of their home care packages for higher risk people receiving care.

The Commission will :

- monitor the provider closely with regular meetings
- hold them accountable for fixing the issues
- continue to monitor them under the heightened supervision model
- reassess this strategy if the risk to people receiving care changes.

* Approved provider, not their real name

Case study 4:

Active supervision successful in reducing high risk

We received 2 complaints about an approved provider, Higher Tide*, about:

- medication management
- the management of a person receiving care who had complex and challenging behaviours.

We considered that these issues posed a potential high risk to all people receiving care. We immediately began a process of active supervision.

We engaged with the provider and discussed our concerns and the regulatory actions we would take if they did not address them. We also explained the outcomes if they did engage with us and fix the risks to people receiving care.

They responded positively by:

- taking appropriate action
- talking openly with us about the issues.

They spoke honestly about struggling to support the person receiving care who had challenging and complex behaviours. They told us that the person was:

- being aggressive to other people receiving care
- putting other residents at risk
- causing complaints from other residents and their families.

We organised an announced visit from our quality assessors and also our specialist advisors from our Behaviour Support and Restrictive Practices Unit. We encouraged the provider to have an open conversation with the person with challenging behaviours and that person's legal representative, after which the provider commenced and subsequently successfully completed a process to find a more suitable residential facility for the individual.

We removed the provider from active supervision.

Positive outcomes can be achieved without the use of formal regulatory powers. This happens when a provider recognises there are issues and is willing to work hard to fix them. We will provide guidance and continue to monitor them.

* Approved provider, not their real name

Provider level regulation

- Risks identified at a service level are considered a symptom of problems at a provider level.
- It is extremely unlikely that all services will be fully compliant all the time. Rather, at any given time, it is likely that there will be some level of transient non-compliance in some services.
- Providers should have risk detection and management mechanisms in place so they know about and mitigate risk before we require them to.
- Changes (that is, improvements) in practices and behaviour at the service level are more sustainable when the provider is the one implementing the reform.

Case study 5:

Financial and prudential targeted supervision

We visited Mawson Living* to carry out a targeted review on room prices and approvals for charges above the cap. This provider had 10 residential services, with Refundable Accommodation Deposits (RADs) of over $20 million.

The focus of the review was to improve their understanding of the:

- approval process
- legislative requirements when pricing and charging for a room above $550,000 (the current RAD cap).

We asked them to submit a range of documents as part of the assessment. We found that they had charged above the RAD cap without approval. The provider did not get re-approval for the room price from the Independent Hospital and Aged Care Pricing Authority when their last approval had ended because of their poor record keeping and governance.

We worked to help them:

- understand the requirements
- improve their governance and recordkeeping processes to avoid this breach happening again.

We also made sure that they told affected residents about the situation, and provided appropriate refunds, in line with legislated requirements.

This is an example of targeted supervision where we actively work to identify and respond to non-compliance with aged care requirements. The goal of targeted supervision is to make sure that providers understand and meet their requirements. Like active and heightened supervision, our goal is always focused on the outcome for care recipients. Where we find providers are not complying, we address this as quickly as possible to protect people receiving care.

* Approved provider, not their real name

Your questions answered

Why am I in active or heightened supervision when I achieved 100% compliance in my most recent audit?

An audit is specific to a point in time.

We continue to check for emerging risks to people receiving care, using the most up-to-date information we have.

If we see risk but have not confirmed there is non-compliance, we may put you under active supervision for a short period of time. This will last until we are satisfied you are managing the risks effectively. If we find out about a risk through a complaint or SIRS notification, and we are concerned about the safety of people in your care, we may put you under immediate heightened supervision.

If our supervision prompts a provider to prevent harm, this is the best outcome for people receiving care.

We will not necessarily take formal regulatory action as this will depend on how you respond. It will be your choice whether we need to force you to do something you could have done voluntarily.

How do I show that I am willing and able to fix a problem?

We want to see that a provider understands what is causing the issue and shows that they can make a plan and fix it. If you do not seem able or willing to do that, we will talk to you about whether we intend to formally direct you to take action.

You need to provide evidence of the actions you have taken to fix the issue, through documentation and case-management conversations.

Depending on the type of risks, we will visit the site and assess how the actions you have taken have improved your understanding of your responsibilities and improved practice.

We also consider how reliable a provider has been when we have worked with them in the past. We look at past actions that indicate if the provider has:

- not met the promises made
- not shown improvements by a particular date
- shown a lack of commitment
- shown a lack of understanding about the problem
- shown they are not able to do the necessary planning.

This affects the confidence we have in a provider's ability to make improvements and the choices we make about what we need to do.

Does this mean that you are not giving out notices anymore?

We still issue notices, but they may not be the first action we take. We base this decision on the situation or risk when we place a provider under active supervision. Our decision to issue a notice, sanction or revocation order depends on how a provider responds to our concerns and whether it is confirmed non-compliance or risk.

The level of the risk determines how much time we spend making that assessment. Where there is immediate and severe risk we will:

- contact the provider immediately
- explain our concern to them
- place them under active or heightened supervision.

We would then assess what action the provider is taking to control these risks. If we do not get an adequate response to our concerns, then we will:

- take immediate action using our formal powers (for example, issue a Notice to Agree or a Sanction)
- stay in contact to make sure that the provider is taking the necessary action.

How to use this report

Calculating rates

The calculations we have used can help you to compare services and providers. For example, we have used the following calculations to make it easier to compare these rates:

- Fully compliant audits as a percentage of the site audits we have conducted.
- Different types of responses to non-compliance as a percentage.
- Serious Incident Response Scheme notifications per 10,000 occupied bed days (OBDs).
- Complaints rate per 10,000 OBDs in residential care and per 10,000 consumers in home services.

Residential care by size and type

Providers are the organisations that operate aged care services. For residential care services, we have broken down the result by the size of the provider that runs the service and the ownership type (page 13). We work out the size of the provider by the number of services they run.

All residential care services fit within these sizes and types. Where we cannot break down the result into size or type, the figure will be for all residential care services together.

We are currently reviewing how we break down data for providers, and will incorporate improvements in future reports, including breaking down data for home services providers.

Quality Indicator Program

This report includes rates and trends from the National Aged Care Mandatory Quality Indicator Program (QI Program) from the Australian Institute of Health and Welfare's quarterly reports. The QI Program is an important source of information about how the residential aged care sector is performing. It is particularly helpful in understanding how the sector is performing in the key areas of providing quality care and outcomes for older Australians.

Providers calculate their own rates when they submit their QI Program data to the Department of Health and Aged Care every quarter. We encourage providers to keep using QI Program data to identify where they need to improve. Providers can also use it with Commission data to compare their performance.

How to calculate your own rates

How to calculate your own Serious Incident Response Scheme (SIRS) notification rate for a quarter.

1. Take the number of incidents in your service that you reported to the Commission over the quarter.
2. Take the number of occupied bed days (OBDs) for your service during the quarter. This number is what you used for claiming subsidies with Services Australia and should also match the figure you entered for 'Occupied Bed Days' in your Quarterly Financial Report.
3. Divide the first number by the second number and multiply by 10,000.

Example

Good Care ABC is a large size government provider. One of its services has 300 residents and is fully occupied throughout the year. It has 109,500 OBDs in a calendar year. For Q4 there are 91 days, and the service would have 27,600 OBDs. The service notified the Commission of 30 SIRS related incidents in this quarter.

Its SIRS notification rate per 10,000 OBDs would be 30/27,600 x 10,000 = 10.87

The SIRS sector average incident notification rate is 8.0 (Q4) incidents per 10,000 OBDs. Good Care ABC's incident notification rate for the quarter of 10.87 is above the sector average rate.

How to calculate your own residential complaints rate (per 10,000 OBDs) for a quarter.

1. Take the number of complaints about your service lodged with the Commission over the quarter.
2. Take the number of OBDs for your service during the quarter. This number is what you used for claiming subsidies with Services Australia and should also match the figure you entered for 'Occupied Bed Days' in your Quarterly Financial Report.
3. Divide the first number by the second number and multiply by 10,000.

Example

Excellent Care ABC is a residential aged care provider that runs one residential care service of 100 residents. It is fully occupied throughout the year. It will have 36,500 OBDs in a calendar year. In Q4 there are 91 days, and the service would have 9,100 OBDs. The Commission received 2 complaints about the service in that quarter.

Its complaints rate per 10,000 OBDs would be:

2/9,100 = 0.00022

0.00022 x 10,000 = 2.2

The sector average complaints rate is 0.8 complaints per 10,000 OBDs. Excellent Care ABC's complaints rate for the quarter 2.2 is above the service average complaints rate.

How to calculate your own home services complaints rate per 10,000 consumers for a quarter.

1. Take the number of complaints about your service lodged with the Commission over the quarter.
2. Take the number of people receiving care for your service during the quarter.
3. Divide the first number by the second number and multiply by 10,000.

Example

Compassion Care ABC is a home service provider that operates one service providing care for 600 people. The Commission received 5 complaints about the service in the quarter.

Ratio of complaints per 10,000 people receiving care is:

= 5/600 X 10,000 = 83.33

The sector average complaints rate is 0.8 complaints per 10,000 OBDs. Compassion Care ABC's complaints rate for the quarter 83.33 is above the service average complaints rate.

Note on data

We take sector performance data at a point in time from Commission systems.

Reported figures may be superseded as database records are updated.

As the Commission systems are updated regularly, the published numbers for past quarters may be slightly different in this report, where the same periods are quoted here for comparisons.

The information about the number of active home services as of 30 June 2024 was taken from the Commission systems on 8 July 2024 and for residential care on 15 July 2024.

The numbers of people receiving residential care were extracted from the Department of Health and Aged Care data warehouse as of 30 June 2024, on 16 July 2024. State is based on the service state.

Home Care Packages (HCP) data on people receiving care was extracted from the Department of Health and Aged Care data warehouse as of 30 June 2024, on 16 July 2024. HCP consumer state is based on service.

Commonwealth Home Support Programme (CHSP) consumer data is from consumer state from the 2022–23 Financial Year, extracted from Commission systems as of 16 July 2024.

Reportable incident data was extracted from Commission systems on 2 July 2024.

Occupied Bed Days (OBDs) data was extracted on 7 August 2024. The number of OBDs data for Q4, from the 2023–24 financial year was not available on 7 August 2024. So, we have estimated OBDs for Q4 from the unique consumer counts in the residential sector for the quarter.

Residential Aged Care Quality Indicators data was taken from the Australian Institute of Health and Welfare website published on 21 May 2024.

Where a consumer changed services, they may be counted across multiple states. The sum of the state totals may therefore exceed the total national count. In the past the state came from CHSP Outlet/Service state, however this was changed to the consumer state in line with other Gen-Aged Care reporting.

Data about quality assessment and monitoring activities and outcomes in this report includes care delivered flexibly (for example, services provided through short-term restorative care).

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.

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