Aged Care Act 2024 Rules 2025 – Stage 3 Consultation

Prepared by
Estia Health

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Department of Health and Aged Care

Release 3 Consultation

Box 9848
Canberra ACT 2601
Australia

[redacted]

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Aged Care Act Rules – Stage 3 Consultation – Provider obligations

Thank you for the opportunity to comment on the Stage 3 consultation draft of the *Aged Care Act Rules 2025* (**Rules**).

Estia Health operates 78 residential aged care homes across Queensland, New South Wales, Victoria and South Australia, with more than 12,000 team members providing care to almost 7,500 residents each day.

We support the Government's aged care reform agenda and particularly the changes that make it clear that the aged care system regulated by the Commonwealth and increasingly funded by user contributions (post 1 July 2025), has individuals as the focus of service delivery.

In making this submission we have not commented on those clauses which have been carried forward from the (current) Aged Care Principles authorised by the *Aged Care Act 1997 (Cth)* (**the Act**).

In considering the draft Rules, we first considered how each proposed Rule might lead to better outcomes for individuals, and then, what information the Commonwealth needs to ensure the protection of older Australians in our care and to plan for the future. For example, we note that the language of the Rules reflects an update of the language in the Strengthened Quality Standards document, particularly the term "Supporters" to replace "family" and/or "family and carers." This is an important change that reinforces the pre-eminent place of the individual.

Following a focus on resident outcomes, we then considered the practicalities of implementation and whether there were unintended consequences for any stakeholder group.

Looking through a public policy lens, the link with some of the Rules to the Objects of the *Aged Care Act 2024*, we believe, reflects an unnecessary overreach by the drafter.

Record Keeping and Administration

The draft Rules continue the recent trend for Commonwealth agencies to collect information for seemingly obscure reasons and from which consumers and providers derive no discernible benefit.

There is already substantial reporting to the System Governor or the Aged Care Quality and Safety Commissioner. It is not always clear why Government agencies sought (or seek) to receive such information and how it could be used, or if in fact that they have the resources to utilise it.

In particular, the Rules (154-1120) propose information provision requirements that significantly increase the level of reporting, such as the provision of individual worker names, addresses, date of births and screening details (to be drafted) on the Government Provider Management System (**GPMS**).

In this example, we note the manual process of managing Key Personnel information as part of the current requirements. The interface and timeliness of response for providers managing their information has recently improved but remains problematic. In the case of Estia Health, an expectation of the maintenance of 12,000 records (as opposed to a few hundred Key Personnel), would require significant investment in administrative resources for questionable benefit. Any introduction of this type of requirement would compel a material technical improvement in the GPMS to facilitate a direct upload of a large volume of records on a frequent basis. We also suggest that the

privacy concerns relating to the personal information of workers being provided via the GPMS is reviewed and that there are robust reasons for its pursuit.

There are also frequent references to aged care workers and the registered provider's responsibilities regarding workers. This broad characterisation creates the impracticality of meeting some obligations for 'agency' staff over which the provider has control only for the periods they are a worker for the provider. While the definition of aged care worker and the provider obligations regarding a worker's conduct at any time they are under the direction of the provider is appropriate, the extension to training requirements and recording personal details on GPMS is impractical regarding workers who may appear once only or irregularly at a site.

Duplication and Level of Detail

Some of the sections in the Conditions on Registration are unnecessarily detailed to the extent they are more akin to procedures, and in doing so place the provider, engaging in continuous improvement (itself a Condition on Registration under s147 of the Act) at regulatory risk.

By way of example, the detail regarding incident management in Part 10 Division 1. We are curious that the drafter saw fit to propose two regimes for the same topic under the guise that the Condition on Registration will 'Complement the requirements of the Quality Standards'.

Further, the Condition on Registration on complaints, feedback and whistleblowers applies to all registered providers and prescribes further details than those set out in the Quality Standards. It states that *'A provider should reflect both requirements in a single complaints and feedback procedure to meet conditions of registration'* (Page 5 supporting document).

Another example of overreach in the proposed Rules relates to whistleblowers. For example, the Rules requires that providers *'communicate regularly, and at least monthly, to the provider's aged care workers and responsible persons that disclosures that qualify for protection under section 547 of the Act are welcome'*. This requirement also applies to 'individuals to whom the provider delivers funded aged care services'. There is no need to add the 'and at least monthly' in the drafting. It is not reasonable or practical for Estia Health to communicate such a reminder to more than 12,000 aged care workers or 7,500 residents on a monthly basis: the requirement to communicate 'regularly' is sufficient.

We do not believe there is a requirement to duplicate or enlarge the requirements of the Quality Standards in the Rules.

The Rules also move current requirements from the 'general' to each individual 'person or incident/complaint'.

It is proposed in 154-205 (1) that for each complaint or feedback (noting the breadth of the term 'feedback') the registered provider must keep and retain:

f) an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;

g) a record of the number of days taken to resolve each complaint and feedback;

h) the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback.

In 166-210, the provider is then required to submit a report to the System Governor and the Commissioner within 4 months after the end of the reporting period with information about each complaint and feedback received, including all the information stipulated in 154-205 (1).

For Estia Health, this is likely to be thousands of items and would require material changes to systems, resources and processes to facilitate this level of reporting, for questionable benefit to the System Governor or Commissioner, rather than an enterprise level report with complaint and feedback volumes and trends. It should also be noted that not every individual complaint or feedback will require the steps outlined in 154-205 (1), such as 'education and training', nor would items of feedback be routinely 'resolved', particularly if it is positive feedback.

Overall, some of the reporting requirements are unnecessarily detailed and onerous. The benefit to stakeholders is unclear and the Rules should be reviewed in this regard to find an appropriate balance.

Vaccination

Under the Act, Parliament has established conditions requiring the provision of certain vaccinations to individuals and aged care workers at no cost. The proposed Rules seek to expand on this list by adding two additional vaccinations. However, not all individuals will qualify for free vaccination (including shingles) under the National Immunisation Program. Under the draft Rules, providers may be responsible for covering the costs associated with administering and supplying these additional vaccinations, potentially imposing a significant financial burden.

We have provided more detailed comments and recommendations to the specific provisions of the proposed Rules in the following pages.

As always, we welcome the opportunity to engage in more direct and detailed engagement on the issues outlined in our submission.

Yours sincerely,

Sean Bilton
Chief Executive Officer
Estia Health

Attachment A

Section

Definition - representative, of a consumer: see section 6-10

Concern

The Act is clear regarding how supporters are identified and registered and their role. Section 6-10 creates a (post 30 June 2025) category of "representative". This addition, particularly clause 6-10 (1) (b) subverts the role and empowerment of the individual by:

a) creating a role not envisaged in the Act; and

b) permitting the authority of a person to be (in practice) a supporter based on their assertions rather than a formal appointment process.

By allowing someone to act as a "representative" based on their own assertions and provider recognition, the provision undermines the individual's autonomy and could sideline the formal supporters designated under the Act. The Act explicitly prioritises the individual's control and had eliminated the ambiguous "representative" role to avoid confusion. Reintroducing it via the Rules conflicts with the Act's person-centred framework and risks eroding trust by granting undue authority to third parties and potentially diminish the clarity of who speaks for the individual.

The Act provides a clear framework for how supporters are chosen and their role in assisting the person. Introducing an extra representative category via the Rules might unintentionally undermine that clarity and the primacy of the individual's choices. It is also unclear how someone would qualify as a "representative" under this rule, which could lead to inconsistent application by providers.

Recommendation

Remove the "representative" category in section 6-10 of the Rules. The focus should remain on individuals and their appointed supporters as provided in the Act. Eliminating this provision will uphold the Act's principles and prevent a parallel authority that could override or conflict with the individual's wishes.

Section

7-22 Serious injury or illness

For the purposes of the definition of serious injury or illness in section 7 of the Act, each of the following is a serious injury or illness:

a) malnutrition;

b) dehydration.

Concern

Malnutrition and dehydration can vary in severity, ranging from mild to life threatening. Established assessment tools, such as the Mini Nutritional Assessment (MNA), are commonly used to determine the seriousness of malnutrition. Similar validated tools exist for assessing dehydration.

Recommendation

The definition be revised to specify the threshold at which malnutrition or dehydration would be considered serious. While the intent and purpose of the inclusion of malnutrition and dehydration is acknowledged, it is important to note that neither condition is classified as an *injury or illness* (AIHW 2010). Clarifying their classification within the legislative framework may be necessary.

Section

Code of Conduct

14-5 Requirements

When delivering funded aged care services to individuals, I must:

a) *act with respect for individuals' rights to freedom of expression, self-determination and decision making in accordance with applicable laws and conventions.*

Concern

Including "applicable laws and conventions" provides no clear guidance to providers or workers and creates unnecessary regulatory risk. Most aged care workers would not be familiar with all relevant laws or international conventions, making this requirement confusing and unrealistic.

Furthermore, it is not clear which conventions this refers to (for example, international human rights treaties), and expecting staff to know and apply them is unreasonable. Compliance with Australian laws is already mandatory without stating it here. All other Code requirements are straightforward and reinforced elsewhere in the Act and draft Rules. This particular phrasing stands out as an unnecessary complication that does not tangibly benefit individuals in care. For workers, the core expectation is to respect each person's rights; referencing unspecified conventions offers no practical guidance and could introduce legal ambiguity.

Recommendation

a) Delete the phrase "in accordance with applicable laws and conventions" from section 14-5(a). Removing this language will simplify the Code of Conduct, ensuring it remains clear and actionable. Staff will still be expected to respect individuals' rights and follow the law, but without referencing undefined conventions that complicate compliance.

b) Retain the obligation to respect rights, freedom of expression, and self-determination, but ensure the wording is clear, practical, and enforceable.

Section

Unexpected death definition

16-5 (9) (a) and (b)

Concern

The definition of "Unexpected Death" lacks specificity, creating interpretation challenges and potential for regulatory confusion. This lack of clarity could lead to confusion about which deaths in care must be treated as reportable incidents. It is unclear whether "unexpected" is determined by medical assessment, provider judgment, or family perception.

In aged care, many deaths are anticipated due to illness or end-of-life conditions. If "unexpected death" is not clearly defined, providers might over-report natural expected deaths or, conversely, miss reporting genuinely unexpected ones. The term should explicitly exclude deaths resulting from known health conditions or expected palliative outcomes. For example, a resident passing away under scheduled palliative care should not be deemed an "unexpected" death. Clear criteria (such as death from causes not reasonably foreseeable or unrelated to the person's known health status) would focus attention on genuine failures or unforeseen events.

Recommendation

a) Revise section 16-5(9) to clearly define "unexpected death." For instance, specify that it refers to a death that was not an anticipated outcome of the person's condition or care and is not simply the natural progression of an illness or aging. This clarity will help providers appropriately identify and respond to reportable incidents without ambiguity.

b) Provide examples or a threshold for reporting to ensure consistency across providers.

Section

Chapter 1, Part 6, Division 2 – The Standards

Concern

The supporting document (page 11) says

- *Please note: the Actions are not included in the Rules, as they are examples of how the provider can demonstrate conformance with the legally enforceable Outcomes of the strengthened Quality Standards contained in the Rules.*

This note reflects the appropriate and universally accepted stance that standards should be about outcomes and leave the 'how' to the provider of the service.

However, this stance is not carried forward into some conditions on registration e.g. incidents and complaints, where the 'how' to achieve the outcome is frequently made as a requirement and in doing so creates the risk of leaving the reader with the impression that one size fits all and inhibiting innovation and process improvement.

Recommendation

The wording of the Quality Standards remains as drafted and any required actions that address process be deleted from the Conditions of Registration.

This topic is explored later in this Submission.

Section

153-15 Other vaccinations

For the purposes of paragraph 153(2)(c) of the Act, the following vaccinations are prescribed:

a) a pneumococcal vaccination;

b) a shingles vaccination.

Concern

These vaccinations are in addition to those set out in the Act. They must be provided at the provider's cost to individuals and staff and the provider is required to promote the benefits of the vaccination.

The reference to the Australian Immunisation Handbook in s153-10 is appropriate. However, it should be clear in any material and reporting of vaccination rates that not all individuals and 'service staff' are members of a cohort for whom vaccination is recommended.

In fact, promoting the benefits of a specific vaccine to a person who is not part of the clinically recommended cohort creates risk for the provider and the person.

Recommendation

This section should include a clause that the vaccination must be offered free of charge where the vaccination of the individual or worker meets the clinical guidelines for vaccination under the National Immunisation Program and there must be consideration of the costs of providing such a program.

Section

154-10 Records about service staff—influenza vaccinations

154-15 Records about service staff—COVID 19 vaccinations

Concern

The description of a category of a person engaged in an approved residential care home as 'service staff' appears exclusively in relation to vaccinations. There is no definition.

The total number of service staff in relation to the approved residential care home lacks clarity and utility as a concept. During a year, the number of staff in all categories who are engaged in the home may well be 150% + of the base number of workers in all categories given staff turnover and the utilisation of casual/agency staff. This situation has been exacerbated recently as providers strive to meet care minute targets.

The staffing of a residential aged care home at any point in time will include workers (in all work types) who are casual employees engaged directly or through a labour hire arrangement (agency staff). These engagements may be once off or intermittent. Many of these workers will be engaged by multiple employers in any month. Seeking and recording vaccination status (where vaccination is not required by law) is onerous. Any aggregation of the numbers will overcount due to multiple employers.

Recording the 'raw' number and providing such information to the System Governor or the Aged Care Quality and Safety Commission is of no utility because it pays no heed to identifying the characteristics of the workforce.

The reference to 'if any' regarding 'the registered provider's influenza vaccination scheme' (s154-10 (b)) is confusing given that s153 of the Act requires the provider to offer the vaccination free of charge.

Recommendation

a) 'Service staff' should be defined.

b) The section should be clear that while the provider is required to record the number of staff who informed the provider, they have received a vaccination, it is not mandatory for staff to inform the provider. This is relevant because, not infrequently, the take up rate of vaccinations reported by the Department is seen to reflect on provider performance.

c) The recording of the number of staff who informed the provider about their vaccination status should be for permanent employees.

d) Delete: 'if any' in s 154-10 (b).

Section

154-20 Records about individuals receiving residential care—influenza vaccinations

154-25 Records about individuals receiving residential care—COVID 19 vaccinations

Concern

The requirement to record and report along the lines proposed (individuals during a year), provides no useful information regarding the sector as a group or a single home. This is because of the likely ~30% exit rate in any year and is influenced by the (decreasing) length of stay and variable case-mix between homes.

The count of 'individuals **who informed** the registered provider' is unnecessary regarding vaccinations organised by the provider. In this case providers will know and not be required to be informed by the individual. While this may seem a nuance, the increasing regulatory requirements enforced by the potential use of civil penalties demands precision in the requirements.

The benefit is found in recording an individual's vaccination status and support for vaccination where that is clinically recommended.

Recommendation

a) If public benefit can be found in reporting vaccination rates there should be a census date.

b) An individual's vaccinations must be recorded in their care documentation, which is currently expected.

Section

154-205 Requirements for records of complaints and feedback

1) *For the purposes of paragraph 154(a) of the Act, each of the following kinds of records are prescribed kinds of records that the registered provider must keep and retain:*
    a) *complaints and feedback received each year;*
    b) *the nature of complaints and feedback;*
    c) *the action taken to resolve complaints and feedback;*
    d) *responses provided to individuals about their complaints and feedback;*
    e) *any improvements made by a registered provider in relation to complaints and feedback;*
    f) *an evaluation of the effectiveness of the actions taken and their related outcome in relation to each complaint and feedback;*
    g) *a record of the number of days taken to resolve each complaint and feedback;*
    h) *the education and training that has been delivered to the staff of the registered provider in relation to each complaint and feedback.*

Concern

This section is linked to the (later) section requiring detailed (line item) responding to complaints. It appears to adopt a one-size-fits-all approach, which may not be practical in an operational setting where the severity of complaints varies.

Additionally, the prescribed record-keeping requirements conflate collective complaint records with records of individual complaints, creating potential ambiguity.

Most of the specified requirements align with those expected in a complaints management system that meets the Quality Standards and internationally recognised ISO standards for complaints management.

The Victorian Health Complaints Commissioner standards provide a more contemporary and practical model. For example, The Commissioner's standard states *'The health service provider regularly analyses complaint data to identify potential trends and uses analysis to inform actions to continuously improve the quality of their health service'*. This is a clear, outcome focused approach that is easy to understand.

Furthermore, the classification of a statement as either feedback or a complaint is inherently subjective. The requirements should acknowledge that while complaints management systems typically accept complaints at face value, a formal review may not always substantiate them.

Recommendation

Redraft S154-205 (1) to provide greater clarity and remove requirements that are more germane to a complaints management system rather than regulatory compliance.

Ensure the requirements should reflect those of the Aged Care Quality Standards rather than imposing overly prescriptive or impractical obligations.

Section

166- 210 Requirements for reporting information relating to complaints and feedback management

a registered provider must give a report about the management of complaints and feedback (the complaints and feedback management report) to the System Governor and the Commissioner within 4 months after the end of the reporting period for the registered provider.

The subsequent sections require the provider to provide detailed information about each complaint and feedback received.

Concern

The provision of the detailed information in the form required will created considerable work in system redesign and data capture.

There is no compelling reason why the regulatory authorities should routinely receive information about each complaint or piece of feedback.

Section

154-1120 Records of aged care workers

A registered provider must keep, and keep up to date, a record for each aged care worker of the provider that includes the following information and documents:

a) *the worker's full name, date of birth and address;*

b) *[to be drafted...;*

c) *how the provider has ensured that the worker:*

i) *has appropriate qualifications, skills, or experience to provide the funded aged care services that the registered provider delivers to individuals (see section 152 35 of this instrument); and*

ii) *is given opportunities to develop their capability to provide those services (see paragraph 152(d) of the Act).*

154-1140 Information to be recorded in the Government Provider Management System [transitional and full implementation periods]

(1) (a) the information mentioned in paragraphs 154 1110(a) and 154 1120(a);

Concern

This section links to a later section requiring the provider to report worker personal details through GPMS.

Aged care worker's address – While no single law explicitly mandates an employer to record an employee's address, various regulatory obligations effectively make it a standard requirement in employment practice. Typically, there is a cogent reason. However, there is obvious reason why the aged care laws should require a provider to record an employee's address and in doing so create a regulatory obligation. An employee's address is not relevant. This is further confounded by the fact that employees routinely do not notify changes of address and the considerable effort to input to GPMS (see next paragraph).

The Rules further provide that the provider who has collected the address is required to provide that information to the System Governor through GPMS. There is no cogent reason why the Department should hold personal information provided without the consent of the worker.

The retention of this information is contrary to the spirit of the privacy laws in that the Commonwealth is collecting personal information for which it does not appear to have any lawful use.

There would be considerable effort in updating these employee records on GPMS and, in any event, the dataset will be inaccurate because the typical employment contract does not require an employee to notify a change of address.

We suggest that this proposal regarding collect personal details and the role of GPMS is more appropriately discussed in the consultation *'A national registration scheme to support personal care workers employed in aged care'*.

Recommendation

a) The requirement for the employer to record an employee's personal information is removed from the Rules because it is unrelated to the Objects of the Aged Care Act 2024.

b) The requirement for an employee's personal information to be reported to the System Governor through GPMS be deleted except for information about Responsible Persons that is germane to their role.

Section

156-5 Access to individuals

(2) … a requirement is that a registered provider must allow and facilitate access (whether physically, by visual link or other reasonable means requested by the individual) by a supporter of an individual … at any time requested, or consented to, by the individual.

Concern

We support the change introduced in the draft Rules that references 'requested by the individual.' Our primary concern is the unqualified "at any time" access mandate, in a residential care setting, allowing supporters or advocates to have access at any time, day or night, without appropriate boundaries could disrupt care routines, infringe on other residents' privacy, or be practicably difficult at certain times of the day (such as during late night hours when staffing levels are lower).

Aged care homes must balance each individual's preferences with the rights and well-being of others on the premises (consistent with section 24 of the Act, which recognises the rights and freedoms of other individuals, including aged care workers of the registered provider and other individuals accessing funded aged care services). Providers, as the responsible property managers, also retain the right to control entry for legitimate reasons like security and health and safety concerns. The intent should be to facilitate reasonable access, not to create an absolute right that might endanger or disturb others.

Recommendation

Introduce a reasonableness qualifier for supporter access. For instance, specify that providers should not unreasonably refuse or delay a supporter's access. Alternative means of contact (phone or video) should be facilitated during those times. This ensures individuals can connect with supporters without compromising overall safety and security at the home or unduly impacting the rights of other individuals at the home.

Section

Part 10—Management of incidents and complaints

Division 1—Incident management

Division 2—Complaints, feedback

The Act provides that the provider must implement and maintain an incident management and complaints management systems in accordance with any requirements prescribed by the Rules.

The Act sets out which aspects are to be covered by Rules.

Concern

The Rules about each system are detailed and can be characterised as procedural in construct to the extent that they have the potential to inhibit process improvement. We note that having a commitment to continuous improvement and having a continuous improvement plan is a Condition on Registration in the Act (s147).

The level of detail is unnecessary given the requirements of the Aged Care Quality Standards which focus on outcomes for individuals and similar requirements that are recognised through International Standards Organisation standards. Characteristics of complaints and incident management systems are well established in health and aged care around the world. There is no value created by 'reinventing the wheel' in the Australian aged care sector by importing procedural content into the Rules.

Some of the narrative leading into the introduction of the Bill pointed to including topics that are in the Aged Care Standards and the Aged Care Principles into the Act for the purpose of creating a penalty regime for failure to meet specific requirements. At no time was it suggested that a provider be subject to two (different) sets of requirements regarding the same topic.

We note with concern page 5 of the Supporting Document which states;

'Some conditions of registration complement the requirements of the Quality Standards. For example, the condition of registration on complaints, feedback and whistleblowers applies to all registered providers and prescribes further details than what is in the Quality Standards. ***A provider should reflect both requirements in a single complaints and feedback procedure to meet conditions of registration****.'*

The suggestion that the Conditions prescribe 'further details' is misleading. In fact, the Conditions impose additional requirements.

It seems incongruous that there are two sets of requirements for the same topic and those requirements are enforced by the one body.

The logical conclusion is that a provider could be found compliant with the Quality Standards and non-compliant with the Condition because there is a lower test for compliance with the Standards. We note that the Standards have been subject to rigorous review over the past two years by experts and all stakeholder groups. The same cannot be said regarding the additional process requirements set out in the draft Rules.

Recommendation

a) The Rules are redrafted to require headline characteristics only.

b) The provider requirement for compliance with the Condition on Registration should be compliance with the Aged Care Quality Standards or an internationally recognised complaints or incident management standard.

c) The Rules should be drafted as performance-based regulation that prescribes the outcomes to be achieved rather than focusing on the step-by-step processes to which providers must comply. This allows providers the flexibility to take different (and optimal) approaches to achieving outcomes or performance targets.

Section

Whistleblower Framework – (165-40 to 165-60)

Concern

We recognise the importance of robust complaints handling and protections for whistleblowers in aged care. Many providers already have internal policies encouraging staff to speak up about issues and ensuring complaints from residents or families are addressed transparently and confidentially.

While supportive of the intent of the new whistleblowing provisions, we have concerns about regulatory duplication and practicality. Notably, many aged care providers (especially larger ones and those that are companies) are already subject to whistleblower requirements under the *Corporations Act 2001* (Cth) or the Australian Charities and Not-for-profits (NFP) Commission governance standards for NFP, which mandate having a whistleblower policy and protections. The draft aged care Rules appear to overlay another set of obligations, which could lead to confusion or inconsistency. For instance, the criteria for a "disclosure qualifying for protection" under the Aged Care Act may not perfectly align with the Corporations Act's definition of protected disclosures, potentially creating two classes of whistleblowing processes within one organisation. This is an unnecessary complication for compliance.

Further, the draft whistleblower provisions (e.g., sections 165-40 and 165-50(1)(f)) impose heavy administrative requirements on providers. In particular, section 165-50(1)(f) mandates (at least) monthly reminders to all residents, staff and responsible persons that whistleblower disclosures are welcome, which is excessive.

While fostering a speak-up culture is vital, overly prescriptive rules can undermine their own intent. Requiring formal communications every month may lead to message fatigue—staff might start ignoring the notices, diminishing their impact. It also creates a significant compliance task to prepare, send, and record these frequent communications, diverting resources from care delivery. Many providers are already subject to corporate whistleblower laws and maintain internal whistleblowing policies; duplicating these obligations with even stricter rules (like giving all employees and even residents copies of policies regularly) is burdensome. The focus should be on ensuring effective, accessible whistleblowing channels and protections, rather than rigid communication frequency.

Recommendation

a) If a provider already complies with the whistleblower requirements of another applicable regime (e.g. Corporations Act or state public sector whistleblowing laws for government-run services), that should be deemed to satisfy the aged care requirement. The Rules or guidance could state that an existing whistleblower policy that meets Corporations Act standards is acceptable, to avoid duplication.

b) Often, a whistleblower disclosure might relate to the same issues as a complaint or feedback (e.g. a staff member complaining about care quality). The Rules should clarify, as they partially do, how such disclosures integrate with the complaints management system. Guidance should ensure that providers are not required to maintain completely separate processes if one integrated system can cover both confidential whistleblower reports and open complaints.

c) Simply mandating a policy is not enough; providers and staff need education on the whistleblower provisions of the new Act. We urge the Department to work with the Aged Care Quality and Safety Commission to include whistleblower system requirements in provider guidance and staff training programs. Support could include confidential reporting tools or advice lines for providers handling a sensitive disclosure for the first time.

d) Remove or relax the requirement for monthly whistleblower reminders and align obligations with existing best practices. For example, require that providers have a whistleblower policy and ensure staff are educated about it (at induction and via periodic refreshers or updates) rather than mandating monthly notices.