Beaudan Dupen BNg, MNg, MACN

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This document is in relation to **Release 3 of the Aged Care Rules consultation**. This consultation document aims to inform the Commonwealth regarding obligations of registered providers and conditions on registration of registered providers under Chapter 3 of the new laws and in particular address concerns related to:

- **Incident Management (section 164)**: The rules will provide further details as to the requirements of registered providers' incident management systems that they must implement and maintain, as well as how incidents must be managed and prevented.

- **Reporting and Recordkeeping requirements - Serious incident response scheme (section 154 and 166):** The rules will prescribe the way in which registered providers must report on and keep records in relation to serious incidents.

The Imperative for Patient Safety Science and Systems Thinking in Aged Care: Addressing Blame Culture and Enhancing Outcomes for Older Australians through Evidence-Based Legislation

The aged care sector in Australia is at a critical moment, grappling with an impending nursing shortfall projected to reach 70,000 by 2035. This workforce crisis is compounded by an entrenched culture of blame that undermines both patient safety and workforce sustainability. Despite the best efforts of any

healthcare provider, including aged care, adverse events, or incidents persist. The recurrence of these incidents highlights systemic vulnerabilities associated with the complex sociotechnical nature of the sector, rather than individual failings.

Patient safety is a cornerstone of modern healthcare, employing evidence-based safety science to build reliable systems that minimise likelihood of preventable harm and maximise quality of life. Although consumers of aged care services are not normally labelled as "patients," this term appropriately reflects the relationship between consumers, clinicians, and the care system, particularly in the context of clinical incidents. Adopting patient safety principles and terminology across aged care invites alignment with contemporary safety science, establishes a universal standard of care, and promotes the adoption of proven safety tools.

The **Serious Incident Response Scheme (SIRS)** *aims* to help aged care providers identify, manage, and prevent harm, but its design is flawed and counterproductive. By conflating clinical errors with criminal acts, it undermines efforts to improve care and lags far behind the latest research on healthcare improvement—by over a decade. Instead of fostering honesty, learning, and progress, SIRS inadvertently promotes a culture of fear, secrecy, and silence around risks. This is evident as the scheme considers the same approach for a sexual assault or theft as it does for consumer falls, pressure injuries and medication errors. Although SIRS mandates that aged care providers must implement robust incident management systems and report a subset of incidents, its current approach falls short of prioritising the safety, health, and well-being of Australians receiving aged care services in a meaningful and sustainable way. Under SIRS, providers must report a range of serious incidents to the Aged Care Quality and Safety Commission, under the following classifications:

- Unreasonable use of force
- Unlawful sexual contact or inappropriate sexual conduct
- Neglect
- Psychological or emotional abuse
- Unexpected death
- Theft or financial coercion by staff
- Inappropriate use of restrictive practices
- Unexplained absences

While well-intentioned, SIRS has inadvertently fostered a culture of blame by conflating clinical incidents—often attributable to systemic failures—with unjustified recklessness or criminal acts. For example an inadvertent clinical error caused by complexities and risks associated with the environment (system factors) of care may result in an incident that is *serious* but the reporting categories are fixed to titles such as *Neglect* defined as *a breach of duty of care* or *professional misconduct*. This approach has several unintended consequences, undermining both patient safety and workforce morale.

A punitive approach to clinical incidents, or even the perception of a punitive approach, discourages open reporting of errors or near-misses, depriving organisations of critical learning opportunities. Fear of personal repercussions deters staff from acknowledging mistakes, leading to unresolved risks and diminished safety outcomes.

The aged care sector already suffers from severe workforce shortages. A blame-driven culture exacerbates stress, burnout, and job dissatisfaction, prompting nurses and caregivers to leave the profession. Furthermore, intrinsic drivers such as stress, fatigue and anxiety are known contributing factors to the

occurrence and recurrence of clinical incidents. This compromised environment jeopardises recruitment and retention efforts, worsening the predicted nursing shortfall.

Unjust blaming individuals for errors obscures the systemic factors that often underlie adverse events, such as design flaws, distractions, environment pressures, work culture, resourcing deficits, insufficient training, unclear protocols, or unintentional human error. This misdirected focus prevents organisations from implementing meaningful reforms, increasing the likelihood of recurrence.

The current SIRS framework mandates the reporting of both clinical errors (e.g., medication errors) and criminal acts (e.g., abuse or theft) under the same reporting requirements. This lack of differentiation has profound consequences:

- Healthcare workers are unfairly labelled as "subjects of allegation" for errors resulting from systemic issues, such as medication administration errors or unrecognised clinical deterioration.
- Investigations often emphasise punitive measures over systemic learning, eroding trust and diminishing morale.
- Incident assessors, often lacking clinical expertise, may misinterpret errors, leading to unjust outcomes and missed opportunities for improvement.

For example, labelling a nurse who inadvertently administers the wrong medication as the “subject of allegation” for "neglect" perpetuates a culture of fear and distrust. In other healthcare safety systems clinicians are deidentified and the terminology of “patient safety event” is used with the intent of ensuring an **objective and fair** approach to the assessment. Comments from affected

staff in the aged care sector highlight the emotional toll, with individuals reporting feelings of depression, paranoia, and anxiety.

State frameworks, such as Queensland's Hospital and Health Boards Act 2011, provide valuable models for addressing these challenges. This legislation **differentiates** systemic errors from blameworthy acts and halts investigations when evidence of public risk or professional misconduct arises. Such distinctions preserve the integrity of safety investigations while ensuring accountability for intentional wrongdoing. Other states and territories in Australia have similar provisions or frameworks to the Queensland Hospital and Health Board Act 2011 about conducting clinical investigations, particularly when a potentially blameworthy action is believed to be involved. However, the specifics and procedures can vary by jurisdiction. These approaches to and informed legislation help to ensure fairness, avoid conflicts of interest, and maintain the integrity of both the safety improvement and accountability processes. Furthermore, health departments who are under such legislation that distinguish between blameworthy and blameless clinical errors demonstrate that very few adverse events are actually due to individual fault (often reported at <1%) - the vast majority are caused by systemic issues.

The forthcoming **Aged Care Act** and its relevant subordinate legislation offers an **opportunity** to embed patient safety science and systems thinking into national legislation. Key reforms should include:

- **Clear Differentiation of Incident Types**
    - Establish distinct categories for clinical and non-clinical incidents.
    - Ensure clinical matters are handled by appropriately qualified professionals who are informed by contemporary patient safety science.

- **Definition of Blameworthy Acts**
    - Provide explicit criteria for identifying blameworthy conduct.
    - Separate processes for addressing criminal behaviour from those aimed at systemic improvement.
- **Promotion of a Just Culture**
    - Encourage transparency and reporting by protecting staff from unjust blame.
    - Align incident management systems with international best practices in patient safety.

It is acknowledged that the proposed changes to the legislation indicate a change to *Neglect* language to include ***recklessness*** *and intentional harm*. This proposed change is reflective of Just Culture terminology according to Patient Safety literature and the work of David Marx where "human error" refers to an inadvertent action or mistake, "at-risk behaviour" describes a choice that increases risk where the individual doesn't recognise the danger or mistakenly believes it's justified, and "**reckless behavior**" as a conscious choice to disregard a substantial and unjustifiable risk, signifying a deliberate disregard for safety. These terms are well understood in Patient Safety and considered key components of the "Just Culture" framework for analysing and addressing errors in high-risk industries like health and aged care. Given this, it is critical that clarification and protection is embedded in legislation, comparable to that of state legislation, to ensure that clinical events of human error and at-risk behaviour are not misidentified as *Neglect* and clinicians are unjustly blamed.

Conclusion

The aged care sector must move beyond a punitive culture to one that embraces safety science and systems thinking. A repertoire of action is necessary to see

meaningful change and by learning from state models and integrating proven frameworks, the Commonwealth can take this opportunity to foster a culture of trust, accountability, and continuous improvement and empower the legislation to ensure quality and safety outcomes for older Australians. Legislation reforms will ensure patient safety informed incident management across Australia and improve overall safety and sector performance. These reforms are not only critical for safeguarding patient safety but also for ensuring the sustainability of the aged care workforce in the face of unprecedented challenges. A failure to consider this and retain features of current legislation into the future could lead to worsening workforce challenges and perpetuation of recurrent incidents and harm to older Australians.

Beaudan Dupen

The above report has been reviewed and endorsed by The Australian Institute of Health Innovation, Professor Sidney Dekker and Mr Thomas Loveday PhD

> **The Australian Institute of Health Innovation (AIHI)** at Macquarie University is a leading research institute dedicated to transforming healthcare systems through evidence-based innovation. Working at the intersection of health services, digital health, and patient safety, AIHI conducts groundbreaking research that directly influences healthcare policy and practice in Australia and globally. Their multidisciplinary teams study complex healthcare challenges, from implementation science to artificial intelligence in healthcare, fostering practical solutions that improve patient outcomes and system efficiency. Through partnerships with healthcare providers, government agencies, and industry leaders, AIHI translates research into real-world improvements, making healthcare safer, more effective, and more sustainable for all Australians.

https://www.mq.edu.au/research/research-centres-groups-and-facilities/healthy-people/centres/australian-institute-of-health-innovation

Prof. Sidney Dekker is a global thought leader and pioneer in safety science, transforming the way industries understand and manage risk, human error, and accountability. Known for his **groundbreaking work** on resilience engineering, just culture, and the complexity of human factors, Dekker challenges conventional blame-focused approaches to safety. **Through his thought-provoking books, research, and consulting, he has empowered organizations across aviation, healthcare, and beyond to embrace systems thinking and foster environments where learning, trust, and improvement thrive**. Sidney Dekker's insights continue to shape the future of safety, inspiring leaders to build cultures that protect both people and progress. https://sidneydekker.com

Thom Loveday (PhD) is the managing director of Design Psychology Pty. Ltd, a senior healthcare and transport safety expert specialising in human factors engineering and organisational psychology. After completing his PhD in decision-making across high-risk industries, he established Australia's first Clinical Human Factors program in 2014, strengthening patient safety through expert guidance and system evaluation. At eHealth NSW, he launched the Design Program in 2019, integrating user experience and inclusive design into health ICT projects, including COVID-19 vaccination rollout applications. His recent establishment of the Health Prototyping Centre provides a 1000-square-meter simulation facility for safely testing healthcare innovations before implementation, demonstrating his commitment to enhancing patient safety through innovative design solutions. https://www.linkedin.com/in/thomloveday/

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