OFFICE OF THE HEALTH OMBUDSMAN

Health Service investigation - snapshot report

Investigation focus: Obligations and standards for personal emergency alarm services provided in residential settings (August 2025).

Wider learnings and recommendations

The investigation identified learnings relating to:

- Role clarity for support services: Entities providing support services to health services, even if not direct care providers, must understand their obligations under health and safety legislation.
- Personal emergency alarm providers: these services can fall within the definition of a health service and be subject of a health service complaint.
- Precision in emergency communication: Emergency response services should anticipate that panic and multiple speakers may impair clarity during calls. Structured questioning and confirmation procedures are critical in triaging effectively.
- Early intervention: Introducing protocols for immediate escalation in cases of dropped or incoherent calls is a vital safeguard against communication breakdowns during emergencies.

Background

The Office of the Health Ombudsman (OHO) initiated an investigation following a complaint related to the provision of emergency support services (personal emergency alarms).

OHO's jurisdiction

During the assessment and investigation process, the provider challenged the OHO's jurisdiction, asserting that they neither provided a health service nor a support service to a health service. Independent advice obtained indicated that a provider facilitating emergency assistance or an emergency response (a support service) for an entity providing a health service (an aged care provider) fell within the definition of a health service under the *Health Ombudsman Act 2013*.[1]

Issues investigated

The investigation examined whether the service provider adhered to relevant standards and guidelines governing the provision of Personal Emergency Response Systems. Particular focus was given to compliance with the Australian Standard 4607-1999 Personal Response Systems, the PERSL Industry Guideline, and the concerns outlined in the complaint. Key concerns investigated included whether there was:

- Failure of the personal emergency activation alarm
- Delayed or incorrect communication to emergency services
- Adequate staffing and training compliance
- Appropriate policy and procedure frameworks which are consistent with industry standards, and capable of ensuring a high-quality, reliable service.

[1] *Health Ombudsman Act 2013* (Qld) s7; sch 1

Key findings

Key findings from the investigation were:

- The personal emergency activation alarm was not activated correctly, and no failure occurred on the organisation's part in receiving the initial activation.
- The emergency call was affected by multiple speakers, panic and unclear information, resulting in the call centre misidentifying who needed assistance. Incorrect information was relayed to QAS, contributing to delayed emergency response and inadequate triage.
- Issues with staff onboarding meant that one staff member's training did not meet the requirements of the Standards.[2]
- The organisation introduced substantial improvements to its emergency call policies and procedures, including:
  - Revising call scripts to include mandatory queries about life-threatening situations
  - Default ambulance dispatch protocol unless clear refusal is given
  - Communication clarification processes (e.g. identifying the speaker and limiting interruptions)
  - Clear protocols for dropped or incoherent calls

The support service provider and residential retirement community provider provided detailed evidence outlining the steps the personal emergency alarm provider had taken to review and adjust their systems and processes in response to the incident under scrutiny. These changes reflected a collaborative commitment to the wellbeing of the service's consumers.

[2] Australian Standard 4607-1999