POLICY

catholic healthcare

HCS Client Incident Management Policy

Policy Purpose

The purpose of this policy is to outline roles and responsibilities for managing and reporting client incidents across Home & Community Services (HCS).

Scope & Applicability

This policy applies to all Catholic Healthcare Limited (CHL) HCS staff, which includes employees, volunteers and contractors providing direct services to clients.

All HCS client-related incidents (including near misses) are in scope for this policy. CHL staff (including employees, volunteers and contractors) incidents are out of scope of this policy. For more information about managing incidents related to staff refer to the WHS Policy.

Definitions

	Explanation
ACQSC	Aged Care Quality Safety Commission – regulatory body for Aged Care and Home care Services
Critical Assessment Scale (CAS)	CAS is used to assess the severity level of an incident and to assist with escalation processes.
Elder abuse	A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.
Home service Provider	Commonwealth funded aged care and services, delivered in the home or community
Incident	An incident is any act, omission, event or circumstance **that occurs in connection with the provision of care or services that:** • has (or could reasonably be expected to have) caused harm to a consumer or another person (such as a staff member or visitor), or; • is suspected or alleged to have (or could reasonably be expected to have) caused harm to a consumer or another person, or; • the provider becomes aware of and that has caused harm to a consumer. Examples may include allegations or suspicions of incidents, a client who has absconded or is missing (including non-response to a scheduled visit), alleged stolen or damaged property, or aggressive behaviour from a client, family or staff member, near misses, injuries, psychological injury, etc.
Near Miss	An occurrence, event or omission happens that does not result in harm to a consumer or

	another person but had the potential to do so.
Open Disclosure	Refers to open communication when something goes wrong. The elements include: • Identify when something goes wrong • Address immediate needs and provide support • Acknowledge and apologise or express regret • Find out and explain what happened • Learn from the experience and make improvement
Regulators	○ ACQSC- Aged Care Quality and Safety Commission - Reporting SIRS ○ Safe Work NSW Or Safe Work QLD - We are required to notify the safety regulator where there has been a 'notifiable incident' in the workplace. For safety regulators a 'notifiable incident' is an event arising out of the conduct of a business or undertaking at a workplace resulting in: • The death of a person • A serious injury or illness • A dangerous incident
Reportable Incident	An incident that must be reported to the program funding body or another external regulatory body. For example, all incidents listed under the Serious Incident Response Scheme are to be reported to the Aged Care Quality Commission (see below). Reportable incidents include: • A serious injury to a client in connection with care (ACQSC) • An allegation of significant misconduct of a criminal nature made by any person in relation to the approved provider or staff member including employees, volunteers, or contractors - (Police and ACQSC) • A fire, natural disaster, accident, pandemic or other incident that will or is likely to: ○ Prevent the delivery of all or part of an activity ○ Result in the closure of premises, or significant damage to premises or property; or pose a significant threat to the health and safety of any person (ACQSC and emergency services)
Serious Incident Response Scheme (SIRS)	Serious Incident Response Scheme (SIRS)- aimed to reduce the risk of abuse and neglect of Older People receiving Aged Care Services. SIRS requires providers to effectively manage risk, maintain an effective incident management system and externally report serious incidents to the ACQSC as part of the regulatory requirements commencing in December 2022. • Reportable Incidents Under SIRS include any incident or allegation related to: ○ Unreasonable use of force including alleged domestic assault. ○ Unlawful sexual Contact or inappropriate sexual conduct ○ Psychological or emotional abuse ○ Unexpected death of a consumer ○ Stealing from or financial coercion

HCS Client Incident Management Policy

	○ Neglect of a consumer ○ Use of restrictive Practice ○ Unexplained absence of a consumer Priority 1 incidents is an incident that: ○ caused or could reasonably been expected to have caused a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve ○ where there are reasonable grounds to report the incident to police ○ involving unlawful sexual contact or inappropriate sexual contact inflicted on a consumer ○ an unexpected death of a consumer, or ○ where the consumer goes missing in the course of provision of home services. Priority 2 incidents include all reportable incidents that does not meet the Priority 1 criteria. Where there are reasonable grounds Must be reported to the line manager as soon as possible Must be reported to NSW Police where criminal activity is suspected or alleged. (Refer to Appendix 1 & 2)

Policy

- All HCS staff are responsible for identifying, responding to and reporting client incidents that occur in connection with service delivery. If in doubt, report.
- Incidents must be reported immediately via the Customer Service Centre free call number 1800 225 474 or by logging an incident report in the Incident Register on Connect. Staff can access the Customer Service Centre using the staff number 8878 5910. Staff with network access enter incidents into Connect Incident Register directly. Incidents that occur after hours must be reported to the on-call manager.
- Incidents should be recorded using clear, accurate and objective language. Information recorded is to be factual, including what led to the incident, those involved, the impact of the incident on the client or others, any equipment involved and timelines.
- Documenting the incident must occur as close to the time of the incident to ensure a true and accurate account.
- All HCS staff should understand their responsibilities to their individual roles to recognise, respond and escalate incidents based on the severity of the incident.
- Managers must understand their responsibilities under relevant regulation for reporting to external bodies such as police, emergency services, ACQSC and Safe Work.

- The investigation of a client incident must be initiated as soon as possible after the incident is logged. For all SIRS incidents, investigations must commence immediately upon notification to the manager.
- Catholic Healthcare is committed to an open disclosure approach when something goes wrong. Refer to CHL's Open Disclosure Policy. We demonstrate open disclosure by:
    - Identifying when something goes wrong
    - Addressing immediate needs and provide support to clients and their carers
    - Acknowledging and apologising or expressing regret
    - Finding out and explaining what happened
    - Learning from the experience and making improvements

Responsibility

- All HCS staff must complete mandatory education on CHL HCS Incident Management Systems. Managers are responsible for ensuring each team member has completed this education.
- When an incident occurs, HCS staff are responsible for ensuring the environment and persons involved are safe. Take steps to ensure immediate risk is managed by providing first aid and contacting emergency services as appropriate.
- It is the responsibility of HCS staff to report client incidents immediately. Incidents must be reported via the Customer Service Centre free call number 1800 225 474 or by logging an incident report in the Incident Register on Connect. Once a client related incident is logged, the incident must also be documented as an interaction in the client's ORCA file including documenting the incident number.
- When an incident is logged, it is the responsibility of the person entering the incident into the register to consider if the incident fits the criteria of a SIRS Reportable Incident and if so to document this in the form (using the drop-down feature).
- It is the responsibility of the Regional Managers to ensure client incidents of a serious nature are escalated to GM, Home and Communities and reported to the appropriate external regulatory and funding bodies within required timeframes (>24 hours Priority 1- and 30-days Priority 2).
- If a serious client incident occurs HCS staff and management must:
    - Respond to the immediate needs of the individual and any others who might be directly or indirectly affected by the incidents (including staff, volunteers, contractors)
    - Establish a safe environment if possible
    - Immediately contact Customer Service Centre (if you do not have access to incident register in Connect)
    - Log an incident in the HCS Incident Log on Connect Community Incidents - New Item (sharepoint.com)

  - Escalate to Business Manager via phone (during business hours) or on-call manager outside business hours. If unable to contact Business Manager, escalate to a Regional Manager or GM, HCS.

- In the case of a death of a client, HCS staff should immediately report to Customer Service Centre. The client and the environment should not be touched, in accordance with the legislative requirements for a potential Coroners Case. Emergency services must be contacted and would take over the ongoing management of the situation.
- Investigations for CAS 1 and 2 incidents must be started within 24 hours of notification unless there is advice from the legal team to do otherwise (this can occur where a police investigation is in progress). CAS 3, 4, and 5 Incidents are to be investigated and where possible closed within 14 days of the incident being logged.
- Serious Incidents involving the following matters must be escalated to the CGSC Investigation Team for investigation. Serious Incidents to be referred to the CGSC Investigation Team include:
  - Unexpected death
  - Significant physical and/or psychological abuse,
  - Unlawful sexual/indecent conduct
  - Stealing /financial coercion but only where:
  - The amount is greater than $20k, or
  - The stealing/financial coercion is alleged to be systemic – multiple occurrences over time.
  - Circumstances where independence from the Operations Team is critical. This may be because management is/may be implicated, media or other significant interest or significant exceptional circumstances.
- Regional Managers are responsible for ensuring SIRS reportable incidents are identified and reported to ACQSC within the reporting timeframes. (>24 hours Priority 1- and 30-days Priority 2) in My Aged Care Portal. A more detailed report about the incident and actions taken in response must be sent by email to ACQSC (citing SIRS reference number) within five (5) business days. (Refer to Apendix1)
- Regional Managers are responsible for notifying and seeking advice from CHC Work Health and Safety Manager serious injuries, illnesses and dangerous incidents that happen at work. In case a report is required to Safe Work in the appropriate jurisdiction (NSW or QLD).
- Managers should seek advice from the GM, HCS, legal team or the Clinical Governance and Safe Care team if they are unsure of how to respond to a serious incident.

Investigation

- Investigations must adhere to the principles of impartiality, confidentiality and transparency. They must be clearly and accurately documented and stored within the incident management system (where appropriate to do so). Investigations involving confidential information involving staff must be stored

securely with limited access to those who require it. A file reference to the confidential documentation should be included in the incident register.

- The management of an incident must include an investigation where the cause and/or contributing factors of the incident and corrective actions are identified and put in place to prevent or reduce the risk of harm and/or the incident occurring again. An incident cannot be closed in the system until the corrective actions have been put in place.
- The investigation and management of incidents are the responsibility of the manager of the staff or client involved. Where both a client and staff are involved, managers must work together to investigate the incident objectively and ensure corrective actions are taken that reduce the risk for both the client and staff members.
- The Clinical Governance and Safe Care Team are responsible for providing advice, guidance and governance to ensure investigations are conducted and reported in line with investigation guidance (Refer to Appendix 3: Investigation Guidance).

Monitoring

- Regional are responsible for monitoring and analysing client incidents and providing information to GM HCS and their teams on trending data.
- Regional Managers or their delegate are responsible for monitoring and reviewing incidents on the Community Services Dashboard on a weekly basis. This is to ensure actions are updated on the Incident Management System and provide support to staff where needed.
- The Regional Manager is responsible for reviewing and providing any additional information for SIRS incidents as and when requested by Aged Care Quality and Safety Commission.
- Monthly review and analysis of incident trends should inform the continuous improvement plan.

Continuous Improvement

- Incidents and incident trends should inform continuous improvement activities that promote the safety and wellbeing of clients and reduce the number and impact of incidents.
- Moving on Audits is the platform used for collating, monitoring and reviewing continuous improvement.
- The continuous improvement plan should identify and address systemic issues, including the provision of feedback, and training, about managing and preventing incidents.

Review History

Date of update	Outline of change

catholic healthcare

HCS Client Incident Management Policy

September 2011	Created
March 2020	Version 5
November 2021	Version 6
January 2022	Version 7
June 2022	Version 8
November 2022	Version 9
November 2025	Due for Review

Related Policies & Documents

- HCS Client Incident Reporting and Management Procedure
- HCS Recognising and Responding to Elder Abuse Policy
- HCS Complaints Management Policy
- CHL Open Disclosure Policy
- Health safety and Well-being Policy Health Safety and Wellbeing Policy.pdf (sharepoint.com)

Key words for search

Incident, hazard, injury, near miss, reporting, risk reduction, investigation, continuous improvement, SIRS, neglect,

Appendix 1: Serious Incident Response Scheme (SIRS)

- Reportable Incidents under SIRS – Reportable incidents are "incidents that 'occur in connection with provision of care' and services to consumers." Refer to the Serious Incident Response scheme – Guidelines for providers of Home services. The SIRS decision-making tool can be used to assist in making decisions regarding reportable incidents under SIRS. This Includes:
    - Any acts, omissions, events or circumstances that occur, are alleged to have occurred, or are suspected of having occurred in connection with the provision of care and services to a consumer, and
    - That have, or could reasonably have expected to have, caused harm to a consumer or another person.

This Does Not Include:

- Suspected, alleged or witnessed incidents that DO NOT occur in connection with the provision of care.

Reportable incidents under SIRS include:

Unreasonable use of force

- Defined as conduct ranging from deliberate and violent physical attack to use of unwarranted physical force.
- It includes conduct such as shoving, pushing, hitting, punching, kicking or rough handling of a consumer.
- Incidents that DO NOT occur within the connection of giving care do not need to be reported to the commission. If a staff member suspects or becomes aware of an allegation of elder abuse unrelated to the care being provider to the client. This should be discussed with the manager. Alternative supports for elder abuse are ADC, APOC's

Unlawful Sexual Contact or inappropriate sexual conduct. – All Priority 1

- Unlawful sexual contact or inappropriate sexual conduct includes:
- If the contact or conduct is inflicted by a person who is a staff member of the provider or a person who provides care or services for the provider and is providing such care and services at the time of the incident (e.g. while volunteering):
- – any conduct or contact of a sexual nature inflicted on the consumer, including but not limited to sexual assault, an act of indecency or the taking and/or sharing of an intimate image of the consumer
- – any touching of the consumer's genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the consumer
- • any non-consensual contact or conduct of a sexual nature, including but not limited to sexual assault, an act of indecency or the taking and/or sharing of an intimate image of the consumer
- • engaging in conduct relating to the consumer with the intention of making it easier to procure the consumer to engage in sexual contact or conduct.

Psychological or emotional abuse

- Psychological or emotional abuse of a consumer includes conduct that has caused, or that could reasonably have been expected to have caused, psychological or emotional distress to a consumer, including actions such as:
    - taunting, bullying, harassment or intimidation
    - threats of maltreatment
    - humiliation
    - unreasonable refusal to interact with the consumer or acknowledge the consumer's presence

- unreasonable restriction of the consumer's ability to engage socially or otherwise interact with people
- repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which has caused, or could reasonably have been expected to have caused, the consumer psychological or emotional distress

Unexpected death

- Unexpected death is where the death is the result of care or services provided by the provider or a failure by the provider to provide care and services.
- Providers are required to notify any death where the provider, including staff and health professionals engaged by the provider:
  - made a mistake resulting in death
  - did not deliver care and services in line with a consumer's assessed care needs, resulting in death
  - provided care and services that were poorly managed or not in line with best practice, resulting in death.
- A consumer's death may occur immediately, or some time after the care and services were provided or failed to be provided.
- Where a consumer is reliant on regular care and services and dies as a result of lack of services
- where a staff member repeatedly fails to attend (noting this would also be considered 'neglect').(3)
- You may not be aware for some time that a consumer has died or the circumstances of the consumer's death. The consumer's family is not obligated to share this information with you and, as such, you may not know the circumstances of a consumer's death.

Stealing or financial coercion

- Stealing from, or financial coercion of, a consumer by a staff member includes:
  - stealing from a consumer by a staff member of the provider
    conduct by a staff member of the provider that:
    - is coercive or deceptive in relation to the consumer's financial affairs
    - unreasonably controls the financial affairs of the consumer.

Reportable incidents or allegations of stealing or financial coercion under SIRS are limited to the actions of a staff member of the provider. A staff member includes an individual who is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruiting agency) to provide care or other services.

Neglect

- Neglect of a consumer includes:
    - a breach of the duty of care owed by the provider, or a staff member of the provider, to the consumer
    - a gross breach of professional standards by a staff member of the provider in providing care or services to the consumer.
- Neglect includes an action, or a failure to act, by the provider or a staff member towards a consumer that has resulted in or contributed to (or could reasonably have been expected to have resulted in) harm and/or discomfort, injury, poor health outcomes, emotional distress or the death of a consumer. It can be a single incident where, for example, a carer fails to fulfil a duty, resulting in actual harm to a consumer or where there is the potential for harm to a consumer. Neglect can also be ongoing, repeated failures by a provider to meet a consumer's physical or psychological needs
- If a client is not provided care according to the needs of their care plan, due to a missed or cancelled scheduled visit, this may constitute a reportable incident for Neglect under SIRS. A Risk assessment for the missed shift or visit requires consideration to ensure the health and safety of the client.

Inappropriate use of a restrictive Practice

- Restrictive practice includes any practice or intervention that has the effect of restricting the rights or freedom of movement of a consumer.
- Whether the use of a restrictive practice is a reportable incident (i.e., it is an inappropriate use of restrictive practice) depends on the circumstances in which it is used (as described in the Quality of Care Principles).
- Any use of a restrictive practice that is not in line with the consumer's documented needs as described in their care and services plan, is a reportable incident.
- This includes where the restrictive practice is being used in an emergency situation.

Missing Consumers

- Missing consumers is a reportable incident type specific to the provision of home services. This does not include non-response to a scheduled visit.
- Where a consumer goes missing in the course of a home services provider delivering care and services to the consumer and there are reasonable grounds to report that fact to police, this is a reportable incident.

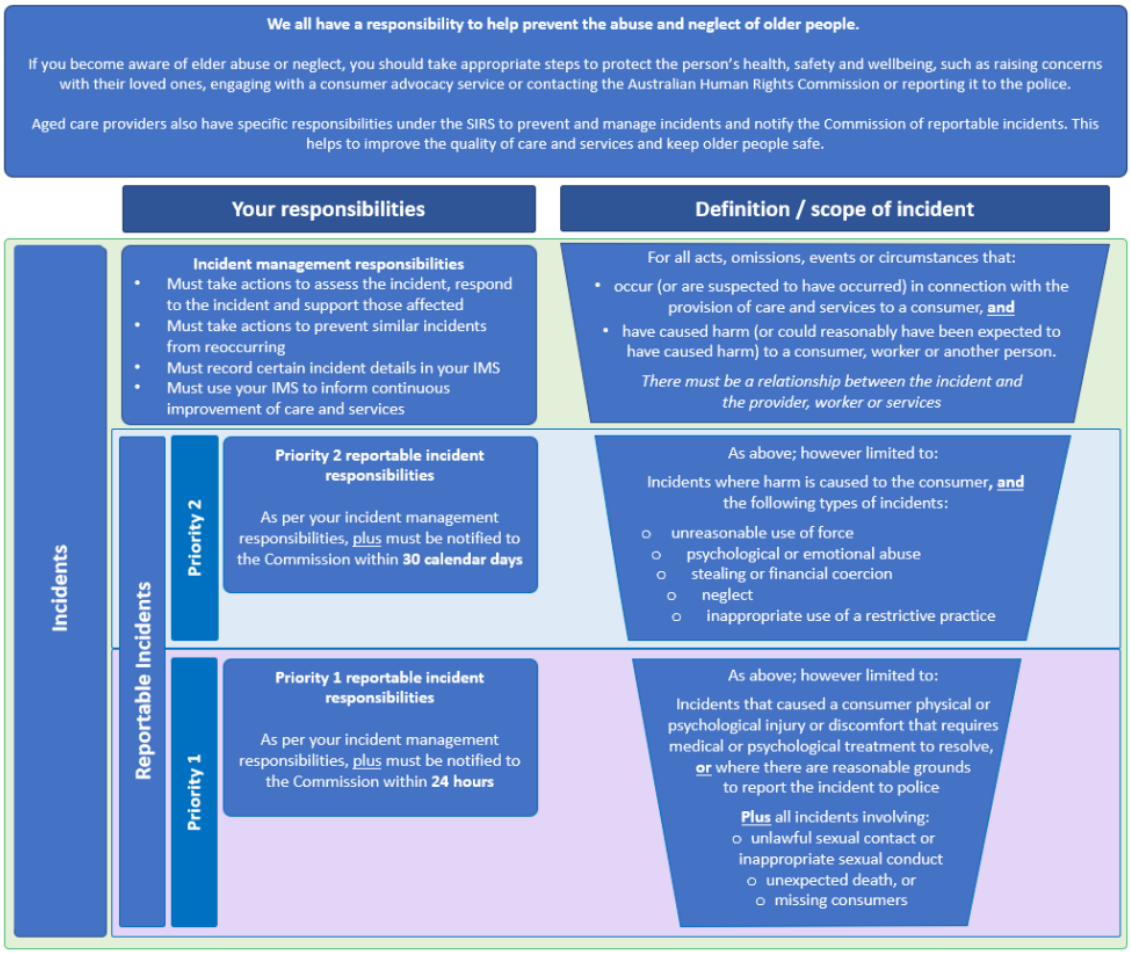
- This definition is intended to capture situations where a provider has the consumer in their physical care immediately prior to their absence. For example:
    - a staff member has taken a consumer to the shops and the consumer has gone missing during the outing
    - a consumer goes missing while in overnight respite, receiving care at a day therapy centre, receiving transport services or on a scheduled outing with the provider
    - a consumer goes missing while a staff member is delivering care and services in the consumer's home and there is reason for concern (e.g. the consumer could be harmed if they were wandering alone).

HCS Client Incident Management Policy

Appendix 2: Summary of Incident Management and Reporting Responsibilities

Australian Government
Aged Care Quality and Safety Commission

Figure 1. Summary of incident management and reporting responsibilities



Appendix 3: Investigation Guidance

Purpose and Principles of Investigation	
The purpose of an investigation is to understand the events leading up to the incident, the causes and contributing factors of the incident and how to minimise or eliminate the risk of the incident reoccurring. **1. Impartiality – each incident/allegation should be approached with an open mind, and the facts and contentions in support of an incident/allegation should be weighed objectively in line with principles of natural justice and procedural fairness.** **2. Confidentiality – a complaint should be investigated confidentially, and care should be taken when disclosing to others any identifying details of an incident/allegation.** **3. Transparency – there should be openness and transparency. Those involved in the incident/allegation should be told about the steps in the investigation process and be given an opportunity to comment on adverse information or before an incident/allegation is closed.** **4. Documentation – there must be sound documentation management and recording of information collected and provided to support the investigation's findings, outcomes, and recommendations.**	
I. Plan the Investigation	• The investigation and response must be proportionate to the issue/s being complained about. While all complaints must be taken seriously, some complaints require greater attention and resources to ensure satisfactory resolution. • The person undertaking the investigation should consider preparing a short, written plan for investigation of those incidents that require greater attention. The plan should: 1. define what is to be investigated 2. list the steps involved in investigating the incident including whether further information is required, either from those involved in the incident or from another person or organisation 3. list the document that need to be reviewed to investigate the incident, including client file and care plan, Community Worker feedback, clinical assessment, education and training records, etc. 4. list observations of environments if this is relevant to the investigation
II. Conducting an Investigation	• Conducting an investigation is a dynamic and ongoing process. It is not always possible to know at the outset how an investigation will develop, and more complex investigations can take a long time. • The investigator should establish the sequence of events which resulted in the incident and understand the factors which contributed to the incident. To do this, the investigator should: 1. review relevant documentation 2. interview relevant people, including staff 3. observe relevant environments and practices 4. obtain factual and chronological statements from staff. • When interviewing staff, ensure they are offered the support of a colleague attending the interview if they so wish, or in critical events/circumstances, Employee Assistance Program (EAP) input can be offered.
III. Document the Investigation	The steps and findings of the investigation should be captured and recorded in the system. Evidence to support the findings, including a written record of evidence that is provided orally, should also be maintained, and attached in the system, if possible.

POLICY

catholic healthcare

HCS Client Incident Management Policy