catholic healthcare

INCIDENT MANAGEMENT SYSTEM (IMS) MANUAL

Included Incident Management System, Elder Abuse and Serious Incident Response Scheme (SIRS) Policy

PROVIDE SAFE, QUALITY CARE AND SERVICES FOR AGED CARE RESIDENTS.

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Incident Management System and Prevention

Purpose

The purpose of this policy is to ensure CHL RAC Homes:

- provide safe, quality care and services for residents
- promote a culture of reporting, with a focus on understanding, learning and improvement
- take a systematic approach to minimising the risk of incidents occurring
- support residents, their families/representatives and staff appropriately should an incident occur
- resolve any incidents that may occur
- take action to prevent incidents from recurring
- Carry out ongoing reviews of internal incident management systems and processes with a view to learning and improvement
- ensure that the appropriate regulatory authorities are notified in instances where the criteria for a notifiable incident are met.

In relation to incidents and near misses including acts or omissions, the CHL incident management system will determine,

- what happened
- how and why, it happened
- who was involved
- who was affected (directly or indirectly)
- what support was offered to all affected persons
- was open disclosure practiced
- were all affected persons were consulted and involved in the review practice
- what can be done to reduce the risk of recurrence and support safer care
- was the incident management and investigation process reviewed as a whole for effectiveness
- what were the learnings and how they can be shared?

Applicability / Scope

This policy applies to Residential Care Employees, Residents, Volunteers, Students, Contractors, and Visitors of CHL. This policy also applies to an National Disability Insurance Scheme Participants who reside in RAC homes.

Principles of Resident and/or Authorised Representative Consultation

- CHL recognises:
  - That consumer engagement is a two-way stream of required communication.
  - The RAC Home is considered the home for each resident.
  - Each resident and/or their authorised representative has the right to participate in decision making processes concerning their life and the formulation of their care planning.
- Residents and/or their authorised representatives/NDIS support coordinator will be a partner in consultation in matters concerning both their care and the overall management of the Home
- Refer to RAC Advocacy, Consultation & Resident's Right to Make Informed Choices Policy for more information.

Definitions

Aged Care Act 1997 (the Act)	The Act is the overarching legislation that outlines the obligations and responsibilities that aged care providers must follow to receive subsidies from the Australian Government and includes all Principles under that Act and related legislation such as the Aged Care Quality and Safety Commission Act and the Aged Care Quality and Safety Commission Rules.
Aged Care Quality and Safety Commission (the Commission)	The national regulator of aged care services, and the primary point of contact for residents and providers in relation to quality and safety in aged care in Australia. The Commission's primary purpose is to protect and enhance the safety, health, wellbeing, and quality of life of aged care residents; to promote aged care residents' confidence and trust in the provision of aged care services; and to promote engagement with aged care residents about the quality of their care and services.
Aged Care Quality Standards (the Quality Standards)	The Quality Standards with which organisations approved to provide aged care services in Australia are legally required to comply. Refer to the Commission's website for Quality Standards guidance and resources.
Approved Provider	An approved provider receives subsidies for the delivery of aged care to and is responsible for making decisions about the delivery of quality care to residents, the financial management of subsidies and for managing resident's fees and payments.
Chemical Restraint	Chemical Restraint is the practice or intervention that is, or that involves, the use of medication or a chemical substance for the primary purpose of influencing a resident's behaviour, but does not include the use of medication prescribed for: a) the treatment of, or to enable the treatment of, the resident for: (i) a diagnosed mental disorder; or (ii) a physical illness; or (iii) a physical condition; or b) end of life care for the resident.
Cognitive Impairment	Declining ability in judgement, memory, learning, comprehension, reasoning and/or problem solving. Cognitive impairment can result from several conditions including Dementia, delirium, and/or depression. Cognitive impairment may be present at birth or can occur at any point in a person's lifespan.

Critical Incident	An unexpected traumatic event, involving personal or professional threat, which evokes extreme stress, fear, or injury. It includes any clinical or non-clinical situation in which an incident, adverse event or a near miss has occurred and placed an individual or individuals in a situation which compromised their physical, emotional, or clinical status or caused significant concern. Examples of what may constitute a Critical Incident in Catholic Healthcare include but are not limited to: • A priority 1 SIRS incident. • Incidents to a resident, worker, or others where the resulting damage leads to **fatality or severe permanent physical or psychological impairment**. • Notifiable Illness Outbreak - COVID-19. • Natural Disaster resulting in the evacuation of Residents from the Home. • Loss of functional utilities at the Home requiring evacuation of the Home or which have significantly impacted on the Home's operational capacity for an extended period. • Incidents which may negatively impact upon CHL's reputation or negative media attention. • Incidents that may constitute malpractice and/or litigation. • Breach of privacy/confidentiality which could result in unwanted media exposure or litigation. • Breach of security resulting in significant loss and/or injury including information technology.
Elder Abuse	Elder abuse is any act which causes harm to an older person and is carried out by someone they know and trust, such as a family member or friend. Elder abuse can occur in aged care homes. The abuse may be physical, social, financial, psychological, or sexual, and can include mistreatment and neglect. CHL staff have a responsibility to identify abuse of older people and respond appropriately.
Incident	Incidents are any acts, omissions, events, or circumstances that occur, are alleged to have occurred, or are suspected to have occurred in connection with the provision of care to a resident and have (or could reasonably be expected to have) caused harm to a resident or another person (such as a staff member or visitor to the service).
Natural Justice	Without Bias. Open and transparent.
National Disability Insurance Scheme (NDIS) Participants	Participants of the NDIS under the meaning of the National Disability Insurance Scheme Act 2013. Unless specifically separated, NDIS Participants will be referred to as Residential Care Recipients or Residents throughout this Policy.
NDIS Quality and Safeguards Commission (the NIDS Commission)	The NDIS Quality and Safeguards Commission is responsible for a range of functions under the National Quality and Safeguarding Framework aimed at protecting and preventing harm to people with disability in the NDIS market. The Commission will build the capability of NDIS participants and providers to uphold the rights of people with disability and realise the benefits of the NDIS.

NDIS Reportable Incident	This includes the following incidents that are alleged to have occurred in connection with providing supports or services to a person with disability: a) any death of a person with disability; or b) serious injury of a person with disability; or c) abuse or neglect of a person with disability; or d) unlawful sexual or physical contact with, or assault of, a person with disability; or e) sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or f) the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.
Near Miss	A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness, or danger to health) to a resident or another person but had potential to do so.
Notifiable Incident under the Work Health and Safety legislation	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 of a person • a potentially dangerous incident.
Open Disclosure	An open discussion with a consumer about an incident or incidents that resulted in harm to that consumer while they were receiving aged care services. The elements of open disclosure are an apology or expression of regret (which must include the word sorry), a factual explanation of what happened, an opportunity for the consumer to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
Priority 1 SIRS Incident	A SIRS Priority 1 incident is a SIRS reportable incident: • that has caused, or could reasonably have been expected to have caused, a resident physical or psychological injury or discomfort that requires medical or psychological treatment to resolve; or • where there are reasonable grounds to report the incident to police; or • an unexpected death or unexplained absence has occurred.
Priority 2 SIRS Incident	A Priority 2 SIRS incident is a reportable incident that does not meet the criteria for a Priority 1 SIRS incident.
Procedural Fairness	The right to be heard, equality and decisions based on the same set of established rules.
Residential Aged Care	Provides a range of care options and accommodation for older people who are unable to continue living independently in their own homes.

Residential Care Recipient	A person is a residential care recipient of an approved provider if the person is receiving residential care, or flexible care provided in a residential setting, in respect of which the provider is approved; and either a subsidy is payable for provision of care to the person, or the person has been approved as the recipient of the care. For the purpose of this Policy, this includes NDIS Participant Residents unless otherwise specified.
Restrictive Practice	Any practice or intervention that has the effect of restricting the rights or freedom of movement of a resident. Requirements for the use of a restrictive practice are set out in the Quality of Care Principles 2014.
Serious Incident Response Scheme (SIRS)	SIRS is a new initiative to help ***prevent and reduce incidents of abuse and neglect*** in residential aged care services subsidised by the Australian Government.
SIRS Incident	SIRS incidents include (but not limited to) those listed below: 1. Unreasonable use of force against the resident. 2. Unlawful sexual contact, or inappropriate sexual conduct, inflicted on the resident. 3. Psychological or emotional abuse of the resident. 4. Unexpected death of the resident. 5. Stealing from, or financial coercion of, the resident by a staff member of the provider. 6. Neglect of the resident. 7. Inappropriate use of restrictive practices in relation to the resident. 8. Unexplained absence of the resident from the residential care services of the provider. That have occurred, are alleged to have occurred, or are suspected of having occurred, in connection with the provision of residential care provided to a resident.
Staff Member	Staff member is defined in Schedule 1 – Dictionary – 1 Definitions of the Act to mean 'an individual who is employed, hired, retained or contracted by the approved provider (whether directly or through an employment or recruiting agency) to provide care or other services' and the Accountability Principles 2014 extends this definition to certain volunteers of an aged care service where appropriate.
Subject of the Allegation	A staff member, resident or any other person who has been accused of being involved with a SIRS incident that has occurred or was alleged or suspected to have occurred.
Triangulation	Evidencing data/information through multiple sources (at least three).
Unwanted Media Exposure	The threat of or actual negative representation of CHL in any media type, including National, State, or local forums.

1. Incident Management Principles

CHL acknowledges a responsibility to provide a safe and secure environment for Residents, employees, contractors, volunteers, visitors, and others. All parties are encouraged to raise any concerns regarding risk, incidents, or safety.

CHL is also committed to a culture of continuous quality improvement which includes undertaking a planned and systematic approach to Incident Management to inform future systems and practice.

This manual provides practical advice and resources to support an Incident Management process which:

- Recognises that all parties involved in an incident need to be treated with respect
- Provides for natural justice and procedural fairness
- Meets our statutory obligations regarding risk management and safeguarding of residents, employees, volunteers. visitors, contractors, and other assets, and CHL functions, operations and objectives against losses or injury.

This manual will be made available to:

- Residential Care Recipients (a comprehensive summary version will be added to the Resident handbook and a brochure has been provided and will be made available at each Home for all residents)
- All Staff Members (on Connect and in addition a comprehensive summary flipchart version has been sent to all Homes and will be added to the staff handbook and Agency Guide); and
- Family members, carer, representatives, advocates, and any other person significant to a Residential Care Recipient (a brochure has been provided and will be made available at each Home).

CHL will assist the abovementioned people to understand how the comprehensive summary version operates.

CHL manages incidents based on the following principles:

- Consumer-Centred,
- Outcomes-Focused,
- Open Disclosure,
- Accountable,
- Clear, simple, and consistent,
- Timely,
- Continuous Improvement.

2. Incident Management Systems

The CHL Incident Management Systems contains **10 elements**:

2.1. Governance and Incident Management Responsibilities,
2.2. Responding and Reporting,
2.3. Critical Assessment Scale (CAS) and Incident Escalation,
2.4. Investigation and Recommendations,
2.5. Documentation,
2.6. Evaluation and Feedback,
2.7. Support for Stakeholders,
2.8. Stakeholder consultation and involvement
2.9. Education and training,
2.10. Data Collection.

2.1 Governance and Incident Management Responsibilities

2.1.1. CHL RAC Leadership Team is committed to minimising and controlling risk through:

- Overseeing the incident management system including monitoring, reviewing, and reporting on its effectiveness
- The establishment and maintenance of service agreements with external providers to promote consistency in service provision and facilitate an evaluation process of the services provided
- Reviewing the policies and procedures to be followed in identifying, managing, and resolving incidents
- Written policies and procedures regarding CHL incident management system which must be made available to residents and staff, and to family members, carers, representatives, advocates, and any other person significant to residents. It is CHL's responsibility to support people to understand how CHL incident management system operates.

2.1.2. Employees of CHL are required to

- Comply will all requirements of the Incident Management System; and
- Report all identified incidents (clinical and non-clinical) including allegations, critical incidents, near misses and complaints and document appropriately
- Identify and engage in the minimisation of clinical, non-clinical and corporate risk that may exist in their area of employment
- Demonstrate knowledge of:
    - The required initial response to an incident and or a near miss, including the provision of appropriate initial treatment
    - The reporting process required to escalate an incident and or a near miss to the relevant people.
- Follow Incident escalation procedures (i.e., Report a Critical Incident **immediately** to the Home Manager and ensure affected/injured parties are provided with appropriate emergency responses and care)
- In the case of the death of a person, adhere to the legislative requirements for a potential Coroner's Case by **not touching the body or any equipment**.

- Preserve the area involved in the Critical Incident in accordance with regulatory requirements including and as appropriate:
  - Isolating the area and surrounds in which the Critical Incident occurred
  - Isolating any equipment that was being used in the events preceding the Critical Incident
  - Identifying and actioning any remaining danger.
- Complete training and assessment on induction, and at regular intervals as requested by CHL, in relation to:
  - The use of CHL's Incident Management System Manual and Serious Incident Response Scheme Policy.
- Compliance with NDIS law in relation to Incident management and Reportable Incidents (where a Staff member provides care or services to a NDIS Participant)
- Compliance with the provisions of CHL's Incident Management System Manual and Serious Incident Response Scheme Policy.

2.2 Responding and Reporting

- Employees, residents, contractors, volunteers, family members, visitors, and others are informed of emergency procedures through induction, handbooks, at meetings and through emergency response training
- The Homes have a responsive risk management hazard, incident, and reporting system in place
- Fire officers are trained and available for each Home and at a Corporate Level
- The Home Emergency Procedure Guide and Emergency Plan Manual are accessible in key areas
- Daily registers of resident, staff, contractors, and visitors' movements are maintained
- A current list of all residents and their individual evacuation requirements/ information is maintained in the event of Home evacuation
- In any situation involving an incident and or a near miss; employees, and management act comprehensively and in a timely manner to ensure the ongoing safety and security of all persons directly or indirectly involved
- All incidents of any nature are recorded through the Home Incident Management Systems, including incident and hazard reporting.

2.2.1. Notification to other Organisations / Bodies

Immediately after the occurrence of a notifiable incident, the Residential Manager is to contact the Regional Manager.

The Regional Manager is responsible for making the appropriate notifications through CHL systems which include, depending on the circumstances of a particular case, notifying, for example:

- The CHL General Manager – HR and/or the Health, Safety and Wellbeing (HSW) Manager so that they can make a notification to Safe Work NSW or Workplace Health & Safety QLD by telephone or in writing, by fax or email, (depending on the circumstances)
- QLD and NSW Coroner (See RAC_Death of a Resident Care Policy)
- The local police
- The Aged Care Quality and Safety Commission and/or the NDIS Commission
- AHPRA

The notification must provide the information required by the respective regulator.

2.2.2. Notifiable Incidents under the Work Health and Safety legislation

As an employer, CHL is obligated to notify the relevant state safety regulator in instances where a notifiable incident has occurred.

A notifiable incident is an incident resulting in the death or a person; a serious injury or illness; or a dangerous incident.

Notifiable incidents relate to **any person** including employees, contractors, or members of the public. This also includes **residents and visitors at any of our RAC Homes.**

Examples of notifiable incidents are outlined in the table below:

Incident Type	Reportable	Comments
Injury to resident relating to equipment. For example: • faulty manual lifter • improper use of equipment e.g., wheelie walker, slide.	Yes, if serious injury or death. Yes, if there is admission as an in-patient to hospital as a consequence.	If death or hospitalisation occurs after a number of days, the incident is still reportable. This **does not** include out-patient treatment provided by the emergency department of a hospital.
Injury to resident caused by failure in the service environment. For example: • burns arising as a result of failure/defect in fire safety systems • slip and fall arising because of cracked/slippery pavers.	Yes, if serious injury or death. Yes, if there is admission as an in-patient to hospital as a consequence.	If death or hospitalisation occurs after a number of days, the incident is still reportable. This **does not** include, for example, a burn that merely requires washing the wound and applying a dressing, or a fall that results in a minor laceration which is treated with a dressing.
Death/serious injury to a resident resulting from a failure to follow medical/treatment process/procedures at a facility.	Yes	
A fire resulting from a kitchen incident where no residents or staff are injured.	Yes, If the fire is 'uncontrolled'.	
Death/serious injury to a resident during an excursion to a shopping centre.	Yes, if the incident occurred whilst the resident was under the care or supervision of CH staff.	Depending on where the incident occurred, the occupier of the premises may also have to report the incident.
Electrocution of an electrical contractor who has come on site to undertake repairs or install electrical equipment.	Yes	The contractor's employer will also be required to report the incident.

Note: The CHL Health, Safety and Wellbeing Team have also been included in the SIRS email notification list and will review SIRS reports to ensure that any potential notifiable incident is identified.

2.3 Critical Assessment Scale (CAS) and Incident Escalation

- The CHL CAS provides a prioritisation rating for each incident to ensure a standardised objective measure of severity is allocated to each incident to:
  - Inform the level of investigation
  - Implement the required actions and
  - Identify the appropriate reporting, including escalation and referral to relevant CHL Committees
- Each Residential Manager will review every incident and with appropriate consultation prioritise them as either:
  - CAS 1 – Extreme Risk
  - CAS 2 – High Risk
  - CAS 3 – Moderate Risk
  - CAS 4 – Low Risk
  - CAS 5 – Negligible Risk

  (see Decision Matrix: Critical Assessment Scale contained within this Policy for more details)

- Any WHS incidents, near misses and or hazards must be referred to the CHL Corporate Human Resources Department for management by the Health, Safety and Wellbeing Management team as appropriate.
- Details of incidents are to be documented through the CHL Incident Management Systems.

2.4 Investigation and Recommendations

- The RAC Leadership Team will ensure that each incident is investigated with an appropriate investigation methodology and that corrective management processes are implemented and evaluated
- The Care Excellence Manager in association with the Residential Manager is responsible for coordinating incident management activities within the area of their responsibility including the development of recommendations and their implementation and evaluation
- In the case of a criminal act or breach of legislation, the relevant authorities will be notified according to the applicable regulatory requirements. In these circumstances a Critical Incident Investigation may be required and conducted as directed by the CHL General Manager
- Findings from incident investigations will be documented in Home and/or Corporate Plans for Continuous Improvement and discussed at relevant CHL Committees/Meetings as appropriate
- Each investigation should establish, at a minimum:
  - The causes of the particular incident
  - The harm caused by the incident
  - Factors (operational and non – operational issues) that have contributed to the incident occurring; and
  - The nature of the investigation.
- If an external investigator is engaged, they should be provided with our Critical Incident Report Template.

2.5 Documentation

- All information is gathered with due regard to privacy and confidentiality and is recorded factually and comprehensively and stored securely
- All clinical incidents should be documented in the ***eCase Residents' Incident Register*** and ***Progress Notes (including the post incident review progress note),*** and the SIRS Register in eCase if necessary. If the incident has been identified because of a complaint, the complaint details should be recorded in the ***CONNECT Complaints & Feedback***
- Staff/Home Incidents should be documented in the ***CONNECT- Log an Incident***
- All service impact incidents must be documented in the ***CONNECT*** – Log a Service Incident
- All incident records must be retained for a period of 7 years after the incident was identified
- Incident reports are to include at a minimum:
    - A description of the incident including: The harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident; and
    - If known, the consequences of that harm
    - Whether the incident is a reportable incident in accordance with *CHL's Serious Incident Response Scheme Policy or NDIS Reportable Incidents*
    - the time, date, and place at which the incident occurred or was alleged or suspected to have occurred
    - the time and date the incident was identified
    - the names and contact details of the persons directly involved in the incident
    - the names and contact details of any witnesses to the incident
    - the names and contact details of all other persons directly or indirectly affected by the incident
    - details of the assessments undertaken in accordance with *CHL's Support for Stakeholder Requirements at 2.7 and Stakeholder Involvement Requirements at 2.8*
    - the actions taken in response to the incident, including:
        - actions taken in accordance with *CHL's Support for Stakeholder Requirements at 2.7*
        - Remedial actions to prevent further similar incidents from occurring, or to minimise the harm arising from similar incidents
        - Notifying the police of the incident where required.
    - any consultations undertaken with the persons affected (directly or indirectly) by the incident in accordance with *CHL's Support for Stakeholder Requirements at 2.7 and Stakeholder Involvement Requirements at 2.8*
    - whether persons (directly or indirectly affected) by the incident have been provided with any reports or findings regarding the incident
    - if an investigation is undertaken by the provider in relation to the incident—the details and outcomes of the investigation; and
    - the name and contact details of the person making the record of the incident.

2.6 Evaluation and Feedback

- Residents, employees, and other stakeholders involved in the incident should be advised of the findings and recommendations of the incident investigation (this must be recorded in progress notes)
- Openness about failures is acknowledged and Residents and their families/support persons are offered an apology and told what went wrong and why (this must be recorded in progress notes)
- Information may be reported through the meeting system or to individuals
- Review incident reports monthly and identify trends and areas for improvements
- Reviews of policy, procedure and equipment may occur because of the incident.

2.7 Support for Stakeholders

- An assessment must be made and documented of how to appropriately provide support and assistance to persons affected to ensure their safety, health, and wellbeing (this must be recorded in progress notes)
- Any employees, Residents, volunteers, visitors, contractors, and others involved in or affected by an incident **(person/s affected by the incident)** must be assessed to determine the support they require to ensure their safety, health, and well-being (this must be recorded in progress notes)
- Once the required support has been determined this must be deployed to the person/s affected by the incident and documented (this must be recorded in progress notes)
- Throughout the incident process, you must seek feedback from the person/s affected by the incident to determine that the support deployed remains effective and suitable (this must be recorded in progress notes)
- At all times an open disclosure process must be followed see CHL Open Disclosure Policy for more information (this must be recorded in progress notes)
- Support must be provided to the Residents affected by an incident (including information about access to advocates), to ensure their health, safety, and wellbeing (this must be recorded in progress notes).

2.8 Stakeholder Involvement

- An assessment must be made and documented of how to appropriately involve each person/s affected by the incident or their representative, in the management and resolution of the incident. Each person should also be consulted to determine how they would like to be involved (this must be recorded in progress notes)
- Following this assessment, each person or representative must be involved in the process as determined by the assessment (this must be recorded in progress notes)
- The views of each person/s involved in the incident should be ascertained and recorded in the progress notes in respect of:
    - Whether the incident could have been prevented
    - What remedial action needs to be undertaken to prevent further similar incidents
    - How well the incident was managed and resolved
    - Any suggestions as to how CHL could improve its management and resolution of similar incidents
    - whether other persons or bodies need to be notified of the incident.
- At all times an open disclosure process must be followed see CHL - Open Disclosure Policy and Procedure for more information.

2.9 Education and Training

- The Clinical Governance and Safe Care Team, in consultation with Regional, Residential and CHL Corporate Department Managers, will facilitate employee and volunteer education and training as appropriate.

2.10 Data Collection

- All information gathered in the Documentation process (see above 2.5) must be stored securely on eCase with due regard to privacy and confidentiality
- The data collected on eCase will be regularly reviewed by the Residential Manager, Deputy Residential Manager, and the Quality Education Manager to:
  - Identify occurrences of similar incidents
  - Identify and address systemic issues in the quality of care provided by CHL
  - Provide feedback and training to staff about managing and preventing incidents; and
  - Provide to the Aged Care Quality and Safety Commission as required.
- Data collected in accordance with this section will be regularly reviewed and analysed by CHL to assess:
  - The effectiveness of CHL's management and prevention of incidents; and
  - To identify actions which can be taken to improve CHL's management and prevention of incidents.

3. Critical Incident Management

Critical Incidents include but are not limited to incidents to a resident, worker, or others where the resulting damage leads to fatality or severe permanent physical or psychological impairment.

3.1 Resident:

- Priority 1 SIRS incident; and NDIS Reportable Incident
- Notifiable Illness Outbreak – COVID-19 only.

3.2 Complaints:

- Issues regarding serious events or grossly substandard care, or death of a resident as a result of receiving care in a manner that is unrelated to the natural course of the illness and differing from the expected outcome of management of resident care.

3.3 Staff, Volunteer, Contractor, or Visitor:

- Accidental or Unexpected Death of a Staff Member, Volunteer, Contractor, or Visitors
- Incidents instigating a visit by Safe Work
- Incident leading to a permanent injury to staff member.

3.4 Service Impact:

- Complete Loss of Service Due to Natural Disasters/Fire or Widespread Equipment Failure
- Evacuation of Service
- Bomb Threat, Armed Hold Up
- Improvement or Penalty Notice Issued by Safe Work.

3.5 Roles and Responsibilities

3.5.1. All Staff

- Complete mandatory training in incident management and SIRS
- Inform their supervisor if any aspects of incident management or SIRS is unclear to them
- Report all critical incidents to their supervisor, RN in charge or manager immediately after ensuring that any resident impacted by the incident is attended
- Update resident progress notes as required
- Report all other incidents to their supervisor, RN in charge or Manager as soon as possible
- Follow the instructions of their supervisor, RN in charge or Manager as soon as possible.

3.5.2. The Clinical Governance and Safe Care (CGSC) Team

- Will provide timely Board Reporting of relevant results and analysis of incident investigations
- Will monitor the actions of a Critical Incident Management Team
- Will meet the obligations under the Serious Incident Response Scheme, reporting SIRS incidents to the ACSQC within the statutory timeframes
- Will meet the obligations under the NDIS, reporting NDIS Reportable Incidents to the NDIS Commission within the statutory timeframes
- Will provide appropriate responses and resolutions to Critical Incidents
- Is to incorporate the learning (e.g., Safety Alert or In The Loop) from Critical Incident Investigations into the CHL Continuous Quality Improvement System
- Is to ensure that all Clinical Critical Incidents are recorded and reported through the Clinical Governance Committee
- Is to Ensure that all Non-Clinical Critical Incidents are recorded and escalated appropriately through RAC Executive Meeting and the Home's forum for reviewing Quality and WHS matters.

3.5.3. The Residential Management (RM) is Required to:

- Coordinate incident management activities including the development of recommendations and agreed remedial actions at a Home level
- Ensure that all Residents, staff, authorised representatives, and visitors to the Home have access to incident reporting mechanisms
- Ensure that all residents, staff, authorised representatives, and visitors to the Home have been orientated to incident management processes
- Provide education and counselling for staff where required
- Provide support to all persons affected (directly and or indirectly)
- Escalate and report any Critical Incident to their Regional Manager by telephone as soon as possible of the incident occurring
- Complete the Critical Incident Brief and email to Regional Manager as soon as possible
- Inform the Regional Manager of results and analysis of any preliminary investigation that has occurred
- Work with the Critical Incident Management Team (CIMT)
- Co-ordinate Critical Incident Management activities within their area of responsibility including implementing any directives and recommendations from the CIMT
- Record Critical Incidents through CHL Incident Management and Quality Systems
- Ensure serious and critical incidents are reported to relevant external regulatory bodies (ASQSC, Safe Work,) within the statutory timeframes.

3.5.4. The Regional Manager is required to:

- Escalate any **CAS 1 incident** to the CHL General Manager **by telephone as soon as possible to the incident occurring**
- Liaise with the CHL General Manager and Residential Manager regarding information contained in the Critical Incident Brief and actions required at a local level
- Determine whether the Critical Incident will require investigation by a Critical Incident Management Team. This decision will be informed by:
  - Consultation with the Manager, Quality and Care
  - The impact on CHL's operational systems and processes
  - The impact on CHL's reputation
  - Consideration for the organisational learning that may be forthcoming from an investigation into an incident such as a near miss.
- Ensure the Critical Incident Report Template is provided to any external investigators
- Initiate the process for CHL insurer notification.

3.5.5. The RAC General Manager will

- Notify the **CEO and forward the completed** Critical Incident Brief **within 2 hours and CEO to escalate to the Board**
- Notify General Manager of Marketing and Communications
- Contact and inform Legal.

3.6 Critical Incident Management Team (CIMT) If Required

- The management of each critical incident in CHL will be undertaken by a group of staff from the Clinical Governance and Safe Care Team comprised of members suitably equipped to deal with the subject matter of the investigation. The members of the team should be one step removed from the Critical Incident. For example: The Chair would be a team member in the Clinical Governance and Safe Care Team
- The CIMT is responsible for managing and organising a proportionate response to a Critical Incident. The organisation's response and communications with all relevant stakeholders will be managed by the RAC General Manager Form the members of a Critical Incident Management Team (CIMT) if required.

3.6.1. CIMT - Minimum Structure

CIMT Role	Suitability for the Role
Coordinator	Manager, Quality and Care or an independent investigator of equivalent level once approved by the CHL General Manager.
Lead Investigator	Independent personnel of equivalent level once approved by the CHL General Manager.

Other Seconded Team Members may include:

- Regional Manager
- Residential Manager
- Workplace Health & Safety Manager
- Marketing & Communications Manager
- Human Resource Manager
- Finance Manager
- Legal Department
- Pastoral Care

Expert Advice will be sought as required. This may include:

- Relationships Australia (EAP Provider)
- Legal Consultants
- Subject matter specialists in particular fields.

3.6.2. The CIMT Coordinator is Responsible for:

- Initiating and forming the CIMT response to a Critical Incident
- Communicating with the Regional Manager and CHL General Manager
- Reporting to the CHL GM
- Co-ordinating the investigation process
- Maintaining the relevant reporting documentation
- Ensuring the team members meet their specific deadlines and directives
- Capturing the learning from the investigation in CHL's Continuous Quality Improvement System.

3.6.3. The Lead Investigator is Responsible for:

- Collecting the documentation to support the investigation
- Undertaking interviews in line with the investigation plan
- Escalating any identified, ongoing risk to the Chair immediately
- Providing a preliminary report to the CIMT within 48 hours of commencing the investigation in the form of a Critical Incident Briefing
- Compiling a full report for consideration of the CIMT prior to submission to the RAC Executive in line with the time frame of 3 days as determined in the investigation plan
- Providing the CIMT Coordinator with all records.

3.6.4. The CIMT Members are Responsible for:

- Timely and accurate follow-up of the Critical Incident as directed
- Communicating with Key Stakeholders as directed by the CMIT Coordinator
- Maintaining reporting documentation
- Reporting to the CIMT
- Providing specific recommendations and information according to their role in the organisation
- Making themselves available at all times during the investigation.

3.6.5. Investigation Principles

The CIMT must abide by the following principles when investigating:

- Natural justice and procedural fairness
- Privacy and confidentiality including disclosure of information to third parties
- Openness and transparency in consultation with the RAC Executive
- Process relating to recording interviews
- Follow CHL process when dealing with external agencies
- Procedures relating to conflict of interest and defamation
- Procedures relating to protecting information and legal privilege
- Sound documentation management/preservation and recording.

Serious Incident Response Scheme (SIRS) For Residential Aged Care

4. What is SIRS?

The Serious Incident Response Scheme (SIRS) is a Government initiative that commenced on 1 April 2021 to help prevent and reduce the risk and occurrence of incidents of ***abuse and neglect*** in residential aged care homes subsidise by the Australian Government. The SIRS establish:

- The obligations of approved providers to manage all incidents, focusing on the safety and well-being of the impacted resident/s and to use incident data to drive quality improvement
- The mandatory reporting of alleged, suspected, or actual serious incidents.

5. What is a SIRS Incident?

A SIRS incident is any of the following incidents that **have occurred**, are **alleged** to have occurred, or are **suspected** of having occurred to a resident in residential aged care. These incidents **must be** reported to the Commission:

1. Unreasonable use of force against a resident – refer to unreasonable use of force fact sheet
2. Unlawful sexual contact, or inappropriate sexual conduct, inflicted on a resident – refer to unlawful sexual contact or inappropriate sexual conduct fact sheet
3. Psychological or emotional abuse of a resident – refer to psychological or emotional abuse fact sheet
4. Unexpected death of a resident – refer to unexpected death fact sheet
5. Stealing from, or financial coercion of, a resident by a staff member of the provider – refer to stealing or financial coercion fact sheet
6. Neglect of a resident – refer to neglect face sheet
7. Inappropriate use of restrictive practices of a resident (other than in the circumstances set out in the Quality of Care Principles) – refer to inappropriate use of restrictive practice fact sheet
8. Unexplained absence of a resident from the Home – refer to unexplained absence from care fact sheet.

SIRS incidents involving another resident at the Home must be reported irrespective of whether that resident has an assessed cognitive impairment. For example, if a staff member witnesses an incident involving unreasonable use of force on a resident by another resident with a diagnosis of dementia, this must be notified. The exemption from reporting under the previous compulsory reporting scheme no longer applies.

The Home **must** notify the Commission of all SIRS incidents, even where the Home believe that they have acted and responded appropriately, or where an internal or police investigation is underway.

The Home's legislated responsibility to notify the Commission of a SIRS incident applies regardless of whether the resident and/or their representative or family wish the incident to be notified.

The Home are required to determine how to appropriately involve people affected by the incident (or their representatives) in managing and resolving the incident, but this does not mean they can decide whether the incident is reported to the Commission or not.

5.1. Unreasonable Use of Force Against a Resident

The definition of unreasonable use of force for the SIRS is:

> *Unreasonable use of force on a resident, ranging from deliberate and violent physical attacks on residents, to the use of unwarranted physical force.*

This category of SIRS incidents **does not include** touching an aged care resident to attract their attention, to guide them, or to comfort them if they are distressed. It is recognised that in the aged care environment, there may be circumstances where a staff member could be genuinely trying to assist a resident, and despite their best intentions the resident is injured because the person bruises easily or has fragile skin. Injury alone therefore may not provide evidence of either the use of unreasonable force or the seriousness of an assault.

The below examples are illustrative only.

Please refer to Unreasonable Use of Force Fact Sheet.

What is not unreasonable use of force?	What is unreasonable use of force?
• Gently touching a resident to attract their attention or to guide them. • Gently touching a resident to comfort them if they are distressed. • Accidental contact (unless it is careless or negligent). • Physical contact that has lawful justification. For example, pushing a resident out of harm's way (such as out of the way of an oncoming car that would otherwise hit them or out of the way of a falling item). • Reasonable management or care of a resident considering any relevant code of conduct or professional standard. For example, where a staff member is genuinely trying to assist a resident and is acting in accordance with applicable professional standards and, despite the staff member's best intentions, the resident receives a small scratch that causes them no discomfort. • Minor disagreements between residents. For example, where one resident taps another resident on the hand as the result of a disagreement over a card game. • Potential incidents. For example, where a resident is prevented from harming another resident through the intervention of a staff member or other person.	• The use of unwarranted or unjustified physical force against a resident, including **any rough handling** of the resident in the delivery of care and services. • Physical force includes actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards residents, or making threats of physical harm. • Deliberate physical attacks or assaults on a resident. • Any physical behaviour towards a resident that is an offence under the law of a state or territory. • Incidents of physical contact that in isolation may not be significant but when they occur over an extended period of time, have an impact on the resident. For example, a pattern of rough handling during the provision of care.

5.2. Unlawful or Inappropriate Sexual Contact Inflicted on a Resident

The definition of unlawful or inappropriate sexual contact for the SIRS is:

> *Unlawful sexual contact, or sexual misconduct committed against, with, to, or in the presence of a resident.*

It is important to note that residents of aged care homes have the right to sexual freedom and to give and receive affection. In the Charter of Aged Care Rights, residents have the right to:

> *"have control over and make choice about my care and personal and social life, including where the choices involve personal risk"*

This category **does not include** consenting sexual relations between aged care residents, or between an aged care resident and a partner that is not a resident at the Home (e.g., that may visit or volunteer at the Home).

Understanding Capacity to Consent

When considering the nature of a sexual contact, it can be useful for providers to consider the following questions:

- Does the resident have the capacity to consent to this particular activity, at this time?
- Does the resident have the capacity to refuse participation in the activity?
- Does the resident have the capacity to agree to participate in the activity?
- Does the resident show sign of distress?

Determining a resident's capacity to consent to sexual activity is a decision that may also be informed by an assessment by a health professional, which should be considered on a case by case basis. If it is determined that the resident has the capacity to consent to the particular activity at that particular time, and the resident's family and/or carer disagree with that assessment, providers should manage that through careful and sensitive discussion.

Capacity to consent should be reviewed on a regular basis. If you have doubt about a resident's capacity to consent to an incidence of sexual contact, then the incident should be notified. Any incident of sexual contact that results in a resident being distressed or upset should also be notified.

Notes:

Any allegation or suspicion of unlawful sexual contact **must be assessed by the Medical Practitioner (MP) immediately**. **If MP unavailable within 2 hours, transfer resident to hospital**. **Do not** shower, remove clothing, or alter the Resident and Environment in any way. DNA evidence may be required for investigation. To get this evidence, a MP or the emergency department will need to take samples of Resident's saliva, urine, blood, clothing and pubic hair, and swabs from the Resident mouth, rectum, and genitals.

The below examples are illustrative only.

Please refer to Unlawful Sexual Contact or Inappropriate Sexual Conduct Fact Sheet.

What is not unlawful sexual contact or inappropriate sexual conduct?	What is unlawful sexual contact or inappropriate sexual conduct?
• Consensual acts of affection such as greeting someone with a kiss on the cheek or a hug. • Consensual sexual relations between residents, or between a resident and their partner who is not a resident at the Home. • Gestures of comfort, for example a carer rubbing a resident's back or patting a resident on the knee where this aligns with resident's personal preferences. • Helping a resident to wash and dry themselves, where the carer is acting in accordance with applicable professional standards.	• Any conduct or contact of a sexual nature inflicted on the resident by a staff member or a person who provides care or services for the provider, while that person is providing such services (e.g., while volunteering). • Sexual contact without the resident's consent, against their will or where consent is negated for other reasons such as lack of capacity to consent. • Having sexual intercourse or sexually penetrating a resident (with a body part or an object) without consent. • Touching resident's genitals (or other private areas) without a care need. • A person masturbating, showing their genitals to a resident, or exposing themselves in the presence of a resident. • Undressing in front of a resident or watching residents undress in circumstances where supervision is not required. • Inappropriate exposure of residents to sexual behaviour of others. • Sexual innuendos, sexually explicit language or showing pornography to a resident or using a resident in pornography. • Grooming, stalking, or making sexual threats to or in the presence of a resident. • Forcing, threatening, coercing, or tricking a resident into sexual acts. • Unlawful sexual contact encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory, or the Commonwealth.

5.3. Psychological or Emotional Abuse of a Resident

The definition of psychological or emotional abuse of a resident for the SIRS is:

> *Verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person or acknowledge the person's presence.*

In addition to single event incidents such as a staff member yelling at an aged care resident, this category includes incidents that are part of a pattern of abuse. While the behaviour may not cause significant harm or suffering to the individual in each instance, the repetitive nature of the behaviour (over time) has a cumulative effect which intensifies the level of harm to the individual or in some circumstance's individuals.

Approved providers' incident management systems must be able to record incidents in a way that allows for repeated minor instances of these types of behaviour to be identified easily so that any pattern of abuse can be identified and reported as a single SIRS incident.

The below examples are illustrative only.

Please refer to Psychological or Emotional Abuse Fact Sheet.

What is not psychological or emotional abuse?	What is psychological or emotional abuse?
• A person raising their voice to attract attention or speak with a resident who has hearing difficulties. • Minor disagreements between residents. • Making reasonable requests of a resident to enable the safe and effective delivery of care and services (for example, asking a resident to cooperate or encouraging a resident to eat their dinner).	• Yelling, name calling, bullying, or harassing a resident. • Humiliating or intimidating a resident. • Making threatening or aggressive gestures towards a resident or feigning violence. • Unreasonably ignoring a resident, threatening to withhold care or services from a resident or threatening to mistreat a resident. • Unreasonably refusing a resident access to care or services (including as a punishment). • Taunting, making disparaging comments about a resident's gender, sexual orientation, sexual identity, cultural identity, or religious identity or constantly criticizing a resident. • Making repeated actions such as flicks, taps and bumps to a resident (which of itself does not constitute physical assault but the repetitive nature causes psychological or emotional anguish, pain, or distress). • Any action inflicted on a resident where the individual is knowingly causing anguish or distress to a resident (for example, calling a resident by the wrong name or ignoring a resident expressed (and reasonable) preferences).

5.4. Unexpected Death of a Resident

The definition of unexpected death for the SIRS is:

> *Death that is unexpected, where steps may not have been taken to prevent the death, or the death results from an intervention.*

A death may occur immediately, or some time, after a 'mistake' was made or a 'failure' or incident occurred. Where the death could reasonably be considered to be related to a mistake, failure, or incident, this should be notified to the Commission, even where a coroner has not yet determined the cause of death, or where the provider is advised of such a death which may not have occurred at the Home.

The Home is not required to notify the Commission of all deaths where the cause of death is yet to be confirmed, **only those that could reasonably be considered to be related to a mistake, failure, or incident.**

All unexpected deaths are considered Priority 1 SIRS incidents for the purposes of notifying the Commission.

The below examples are illustrative only.

Please refer to Unexpected Death Fact Sheet.

What is not an unexpected death?	What is an unexpected death?
• Where a resident dies because of an ongoing illness, disease or condition that was appropriately assessed, monitored, and managed (including where the resident was receiving palliative care and appropriate end-of-life medications). • Where a resident is involved in an incident and later die because of an unrelated condition or illness. • Deaths resulting from outbreaks of disease (for example, separate reporting processes have been established in relation to outbreaks of COVID-19).	• Where a resident falls while being moved or shifted, with the injuries sustained contributing to or resulting in the resident's death. • Where poor quality clinical care is provided to a resident contributing to or resulting in their death. For example, a pressure injury or wound is untreated or not regularly tended to and becomes infected resulting in the resident's death. • Where medical assessment or treatment is delayed, contributing to, or resulting in a resident's death. For example, a resident fall and is not assessed immediately afterwards and later dies because of injuries sustained from the fall.

5.5. Stealing From, or Financial Coercion of, a Resident by a Staff Member

The definition of stealing from or financial coercion of a resident by a staff member is:

> *Stealing from an aged care resident or behaviour that is coercive, deceptive, or unreasonably controls the finances of an aged care resident by a staff member.*

Incidents of stealing or financial coercion notifiable under the SIRS are limited to the actions of a staff member of the Home. A staff member is defined in the legislation to include an individual who is employed, hired, retained, or contracted by the provider (whether directly or through an agency) to provide care or other services.

When assessing whether the Home are required to report an incident, suspicion, or allegation of stealing by a staff member, not every missing item must be notified to the Commission. However, the Home are required under the SIRS to notify the Commission if there is a reasonable belief that a staff member is responsible for a missing or stolen item or items.

Missing Items and Unknown Offenders

Where a resident's money or valuables go missing without explanation, the Home should try to help the resident to locate the item(s). **If they cannot be found and the resident believes that a staff member is responsible and appears concerned or distressed about the loss, this should be notified to the Commission.** If the item is subsequently located, the Home should provide an update to the Commission.

It is acknowledged that the Home may not always be able to identify the subject of the allegation at the time of reporting an incidence of stealing. However, it is expected that the Home will conduct an investigation to try to locate the item and/or to identify who stole the item or how it came to be missing/reported stolen.

The below examples are illustrative only.

Please refer to Stealing or Financial Coercion by a Staff Member Fact Sheet.

What is not stealing or financial coercion?	What is stealing or financial coercion?
• Where a resident willingly, of their own volition, buys a staff member a coffee while out for an appointment. • Where a resident or their family give a carer a gift to thank them for their support. • Where items go missing but are quickly found to have been misplaced.	• Where a staff member coerces a resident to change their will in favour of the staff member. • Where a staff member steals money or valuables from a resident. • Where a staff member asks or coerces a resident to buy something for them or another person. • Where a staff member uses power of attorney to steal money from a resident. • Where an item goes missing and the resident (or their family) have alleged or suspect that a staff member is involved.

5.6. Neglect of a Resident

The definition of neglect for the SIRS is:

> *Intentional or reckless failure in the duty of care for an aged care resident that may also be a gross breach of professional standards resulting in significant harm or the potential to result in death or significant harm.*

Neglect may be because of systemic issues within an aged care home, for example lack of appropriate policies, procedures and/or practice resulting poor quality care for aged care residents. Neglect may also be the deliberate and negligent conduct of one individual either as a one-off incident or repeated incidents.

Noting residents have the right to have control over and make choices about their care. This category **is not** intended to capture situations where a resident chooses not to shower, or a resident with diabetes refuses to eat a diabetic diet and as a result have a wound with poor healing prognosis.

The below examples are illustrative only. Please refer to Neglect Fact Sheet.

What is not neglect?	What is neglect?

• An isolated incident of late or missed administration of medications where there is no significant impact on the resident.
• Rapid weight loss because of disease, where all reasonable efforts are made to ensure the resident is receiving adequate nutrition.
• Where a resident chooses not to receive care and services in line with their assessed care need, for example:
  ▪ where a resident with dysphagia chooses not to eat a liquified diet and is appropriately supervised while eating.
  ▪ where a resident with diabetes chooses not to eat a diabetic diet.
  ▪ where a resident with liver disease chooses to drink alcohol.
  ▪ where a resident chooses not to shower, brush their teeth, or brush their hair.
  ▪ where a resident with a chronic condition or disease chooses not to undergo clinical treatment.
  ▪ where a resident chooses to smoke despite having a chronic respiratory condition or other condition exacerbated by smoking.
	• Depriving a resident of basic necessities, including food, drink, or clothing.
	• Withholding personal care, such as showering, toileting or oral care.
	• Regular late or missed administration of medications, or failure to administer time critical medications.
	• Failing to supervise a resident in an environment that leaves them susceptible to injury. For example:
	  ▪ leaving a resident outside unprotected in the sun resulting in significant burns.
	  ▪ leaving a resident enclosed in a vehicle on a hot day where the temperature in the vehicle is likely to increase rapidly and cause significant harm to the resident.
	  ▪ failing to supervise residents where they may wander into unsafe environments such as busy roads, construction sites or bodies of water.
	• Failing to monitor a resident's nutrition and hydration, resulting in rapid weight loss and clinical complications.
	• Failing to seek appropriate medical assessment and treatment for a resident

What is not neglect?	What is neglect?
	where they appear unwell or are injured. For example: ▪ failure to treat injuries or wounds. ▪ failure to assess and manage pain. ▪ failure to seek medical diagnosis or treatment when a resident shows signs of illness. ▪ failure to call an ambulance when the resident's injuries or illness require treatment in hospital. • Failing to ensure a resident is reviewed regularly by a health professional or specialist in line with their documented care needs. • Failing to appropriately modify a resident's meals to account for their difficulty of swallowing as recorded in their care plan, or failure to give sufficient assistance to a resident to eat their food, resulting in the resident not being able to eat meals or choking. • Lack of consistent clinical oversight exacerbating conditions requiring acute care, such as, lymphedema, contractures, catheter care and infections.

5.7. Inappropriate Use of Restrictive Practices of a Resident

The definition of inappropriate physical or chemical restrictive practice for the SIRS is:

> *The use of restrictive practice that does not meet the requirements of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019. Note: From 1 July 2021, the term of physical and chemical restraint will be replaced with the term of restrictive practice to align with the NDIS approach.*

From 1 July 2019, the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 requirements apply to approved providers of residential care to minimise the use of physical and chemical restrictive practice. Only when providers have explored alternatives to restrictive practice, and satisfied a number of conditions, can restrictive practice be used as a last resort. The requirements were amended on 1 July 2021.

Any use of restrictive practice that is inconsistent with the requirements in the Quality of Care Principles must be notified to the Commission.

The below examples are illustrative only.

Please refer to Inappropriate Use of Restrictive Practice Fact Sheet.

What is not inappropriate use of restrictive practice?	What is inappropriate use of restrictive practice?
• Where a RAC Home uses restrictive practices consistent with the requirements in the Quality of Care Principles. • Where a RAC Home uses restrictive practices without consent in an emergency situation and the restrictive practices substitute decision-maker is informed as soon as practicable after the restrictive practice starts to be used. • Where a RAC Home administers a drug to a resident as prescribed for the treatment of a diagnosed health condition and this is documented.	• Restricting a resident's movement other than in line with the appropriate use of restrictive practices. For example, inappropriate use of bed rails or a lowered bed that makes it difficult for a resident to get out; placing a table or something in front of a resident in order to limit their ability to move; using vortex illusions (such as floor rugs) that prevent the resident from moving because of their fear of the illusion. • Seclusion or confinement of a resident where voluntary exit is prevented or not facilitated. • Use of a bed belt or lap sash restraint. • Physically blocking a resident's path, holding onto a resident to prevent their movement, or holding a resident down. • Removing the battery out of a resident's electric wheelchair or putting mobility aids out of a resident's reach to limit their movement. • Restrictive practices used in an emergency that do not comply with the requirements in the Quality of Care Principles. • Any drug that is used to control, sedate, or restrict the movement or behaviour of a resident instead of for the treatment of a diagnosed health condition.

5.8. Unexplained Absence of a Resident from the Home

A SIRS report of an unexplained absence from the Home will occur where the:

- resident is absent from the Home; and
- the absence is unexplained (i.e., the resident is missing from the Home, and you are unaware of any reason for their absence); and
- there are reasonable grounds for reporting the absence to the police (whether or not the absence has been reported to the police).

It is expected that the Home will report an unexplained absence to the police within a reasonable timeframe so an appropriate response and actions can be taken to locate the resident. The Home are also required to report the absence to the Commission as soon as reasonably practicable, and **within 24 hours** after becoming aware of the incident.

All incidences of unexplained absence of a resident are considered to be **Priority 1 SIRS incidents** for the purposes of notifying the Commission.

Absent Residents Who Return

If a resident returned to the Home before the Home became aware that they were missing, there is no requirement to notify this to the Commission. However, the Home must notify the absence to the Commission if the police are aware of the resident's absence or where the resident has been returned to the Home by the police.

All unexplained absences of a resident should be recorded in the Home incident management system, and the resident's care plan, so that resident behaviours or wandering patterns can be understood and appropriately managed.

6. What is Elder Abuse?

The definition of elder abuse is 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.

Abuse of older people may take different forms and can include financial, psychological, physical, sexual abuse or neglect. These forms of abuse may occur at the same time. The definition of abuse ***does not include self-neglect or self-harm***.

All elder abuse must be reported immediately to the most senior staff member on duty at the home who will report to Residential Manager. This means you must make a report if you suspect that an elder abuse may have occurred or if you have witnessed or been informed of an elder abuse.

Residential Manager to determine whether the elder abuse incident is a priority 1 or Priority 2 SIRS reportable incident and follow the below point 10 Decision Matrix: 'SIRS Incident' to report to the police and the Commission.

7. Distinguishing Types of Incidents as Priority 1 or Priority 2

When determining if an incident is a SIRS reportable incident, we encourage staff to use the Aged Care Quality and Safety Commission's SIRS Decision Tool.

Categorising Incidents as Priority 1 or Priority 2

The relevant timeframe for reporting a SIRS incident to the Commission is dependent on the type of the incident and the assessed impact of the incident on the resident.

A SIRS incident can be categorised as either:

- a Priority 1 SIRS incident, or
- a Priority 2 SIRS incident.

Priority 1 SIRS Incident

A SIRS Priority 1 incident is a SIRS reportable incident:

- that has caused, or could reasonably have been expected to have caused, a resident physical or psychological injury or discomfort that requires medical or psychological treatment to resolve; or
- where there are reasonable grounds to report the incident to police; or
- an unexpected death or unexplained absence has occurred.

SIRS incidents will be Priority 1 regardless of whether:

- the impact on the resident is temporary or permanent
- the medical or psychological treatment is provided at the Home or elsewhere.

Priority 2 SIRS Incident

A Priority 2 SIRS incident includes any SIRS reportable incident that **does not meet** the Priority 1 criteria as outlined above.

Examples of a Priority 2 SIRS incident may include:

- Stealing or financial coercion
- Unreasonable use of force
- Psychological or emotional abuse
- Neglect
- Use of a restrictive practice outside the scope of the Quality of Care Principles

In these cases, where medical or psychological **treatment for the resident is not required**, the SIRS incident will be a Priority 2.

NDIS Reportable Incidents

Note this section is only applicable to NDIS Participants and those who are providing care and services to them. For more information about NDIS Participants at CHL, refer to the RAC National Disability Insurance Scheme (NDIS) Policy Guideline.

CHL is only required to notify the NDIS Commission of reportable incidents which have occurred, or are alleged to have occurred, if those incidents happened in connection with the provision of supports or services provided by CHL. The phrase 'in connection with' is intentionally broad. It covers any incident that may have occurred during the course of support/services being provided, any incident that arises as a result of the provision, alteration, or withdrawal of supports/services, and any incidents that may not have occurred during the provision of supports but are connected to supports/services CHL provides.

8. How do NDIS Reportable Incidents Differ from SIRS?

The NDIS Reportable Incidents are very similar to the SIRS Reportable Incidents, and it is highly likely that two reports will need to be made in the event of an incident involving a NDIS Participant. Reports must be made to the NDIS Commission through the NDIS Commission Portal, which is accessible through PRODA. Only the roles 'Authorised Reportable Incidents Notifier' and 'Authorised Reportable Incidents Approver' in the NDIS Commission Portal can report incidents. CHL Management is responsible for ensuring these roles are filled. The NDIS Commission must be notified of an incident in the prescribed timeframe . The definitions of reportable incidents differ slightly from SIRS. Further details of these incidents are set out below.

8.1 A Death of an NDIS Participant

In contrast to Aged Care Laws, where a death of a resident need only be reported if it was unexpected, all deaths of a NDIS participants must be reported to the NDIS Commission.

When reporting a death, staff will not need to consider the cause of death. However, they will need to consider if the death happened in the course of their involvement in providing supports or services to the person. The location of the death does not affect whether the death is a reportable incident as long as there is a connection between the death and service provision. As NDIS Participant residents are living in a CHL RACF, the vast majority of deaths of NDIS residents will be reportable incidents, as services are constantly being provided.

Consideration must also be had to whether the Coroner or Police should be notified.

8.2 A Serious Injury of a NDIS Participant

In determining whether an injury is 'serious', consideration should be given to the level of harm caused. A serious injury includes, but is not limited to:

- Fractures
- Burns
- Deep cuts
- Extensive bruising, including large individual bruises, or a number of small bruises over the impacted person
- Head or brain injuries which might be indicated by concussion or loss of consciousness
- Any other injury requiring hospitalization.

8.3 Abuse or Neglect of an NDIS Participant or Allegations of the Same

Types of abuse that meet the criteria for being a reportable incident, include:

- Physical abuse
- Psychological abuse
- Financial abuse
- Systemic abuse
- Neglect can include a number of specific categories that must be reported including:
    - Grossly inadequate care
    - Failure to access medical care
    - Supervisory neglect
    - A reckless act or failure to act
    - Failure to protect from abuse.

8.4 Unlawful Physical Contact with, or Assault of, a NDIS Participant or Allegations of the Same

This category encompasses any physical behaviour towards a person with disability that is a criminal offence and includes allegations. A physical assault generally includes any act by which a person intentionally uses unjustified physical force against a person without the person's consent. A physical assault can also occur if a person causes another person to reasonably fear that unjustified force would be used against them.

This category does not need to be reported if the contact was negligible. This means that the contact made, and the impact of it on the person with disability, were too small to consider, or were insignificant to the person with disability A record of this decision making process should be documented in eCase.

8.5 Unlawful Sexual Contact with, or Assault of, an NDIS Participant or Allegations of the Same

Unlawful sexual contact or assault encompasses any behaviour of a sexual nature that is a criminal offence. In addition to sexual acts, this includes:

- Unlawful sexual conduct
- Sexually explicit comments and overtly sexual behaviour
- Crossing professional boundaries in a way that has sexual implications or connotations
- Grooming of the person for sexual activity.

8.6 Unauthorised Use of a Restrictive Practice in Relation a NDIS Participant

Any use of a restrictive practice outside the NDIS participant's Behaviour Support Plan is a reportable incident. See the NDIS Policy for further details about unauthorized uses.

8.7 Reporting Timeframes

NDIS Reportable Incidents must be reported to the NDIS Commission within the required timeframes as follows.

Reportable Incident	Required Timeframe
A death of an NDIS Participant all deaths including expected and unexpected death	24 hours
A serious injury of an NDIS Participant	24 hours
Abuse or Neglect of an NDIS Participant (including allegations)	24 hours
Unlawful sexual or physical contact with, or assault of an NDIS Participant (including allegations)	24 hours
Sexual misconduct, committed against, or in the presence of an NDIS Participant including grooming (including allegations)	24 hours
Unauthorised use of a restrictive practice including use without a Behaviour Support Plan or use not in accordance with a Behaviour Support Plan	5 business days

9. Steps to Notify the NDIS Commission of a Reportable incident

It is the responsibility of the Home to report all reportable incidents to the NDIS Commission through the NDIS Commission Portal.

STEP 1 - Notify the NDIS Commission:

- For a 24 hour Report (all reports except for unauthorised use of restrictive practice):
  a) Login to the NDIS Commission Portal using the role 'Authorised Reportable Incidents Notifier.'
  b) Follow the prompts and complete the form within 24 hours of key personnel becoming aware of the incident.
- For reporting the use of an unauthorised restrictive practice:
  a) Login to the NDIS Commission Portal using the role 'Authorised Reportable Incidents Notifier.'
  b) Follow the prompts and complete the form within **5 business days** of key personnel becoming aware of the incident.

STEP 2 - Submit a 5 Day Form:

The 5 Day Form is only for incidents that must be reported within 24 hours (all except unauthorised use of restrictive practices). The initial 24 hour report only gives brief details about the incident. The 5 Day Form allows you to add more in depth information about the incident and is due 5 business days from the date the initial report was submitted.

a) Login with the role 'Authorised Reportable Incidents Approver' and follow the prompts to complete the 5 day report within **5 business days** of completing the 24 hour report.

STEP 3. - Submit a final report, if required

The Home may be required to provide further information. When this is the case, the NDIS Commission will notify the Home via email and tell the Home the date this is due.

If the Home is required to submit a final report, the Home will have access to the final report fields on the NDIS Commission Portal for that incident.

10.Decision Matrix: Critical Assessment Scale (CAS)

Category	CAS 1	CAS 2	CAS 3	CAS 4	CAS 5
All Critical Incidents per CHL Policy definition are CAS 1					
Resident Incident	• PRIORITY 1 REPORTABLE SIRS/ NDIS REPORTABLE INCIDENT: o Unexpected Death of a Resident/ NDIS Participant with or without disability. o Unexplained absence from the Home with the police involvement. o Unlawful sexual contact or inappropriate sexual conduct committed against/in the presence of a person with disability, including grooming of a person for sexual activity. o Unexpected Death of a Resident/a NDIS Participant due to Clinical Deterioration. • Notifiable Illness Outbreak - COVID-19.	• PRIORITY 1 REPORTABLE SIRS/NDIS REPORTABLE INCIDENT: o Incident that causes, or could have reasonably caused, a resident physical or psychological injury or discomfort that requires medical or psychological treatment. o Unreasonable use of force. o Stealing or financial coercion. o Neglect. o Inappropriate use of restrictive practice. • **NDIS REPORTABLE INCIDENT:** Serious Injury of a NDIS Participant. • Transfer to Hospital due to unrecognized Clinical Deterioration Which Resulted in Admission to Hospital. • Missing S8 Medications. • Notifiable Illness Outbreak (Influenza/Gastro). • The use of a restrictive practice in relation to a person if the use is not in accordance with a required state or territory authorisation and/or not in accordance with a behaviour support plan.	• PRIORITY 2 REPORTABLE SIRS INCIDENT o Any SIRS incident that does not meet the criteria for a Priority 1 SIRS incident. • **NDIS REPORTABLE INCIDENTS** that are not death or serious injury. • Transfer to Hospital due to Unrecognised Clinical Deterioration Not Requiring an Admission.	• Onsite Treatment **(Physical or Emotional or Psychological)** by Staff Following an Accident or Incident. • New Infections and wounds.	• No Treatment or Injury Following an Accident or Incident. or a near miss.

Category	CAS 1	CAS 2	CAS 3	CAS 4	CAS 5
Complaint	• Issues regarding serious events or grossly substandard care, or death of a resident as a result of receiving care in a manner that is unrelated to the natural course of the illness and differing from the expected outcome of resident management.	• Significant issues with clinical management, quality of care or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment.	• Issues with the potential to impact on service provision/delivery. Legitimate resident concern, especially about care and services, or clinical management, but not causing lasting detriment.	• Issues raised about care and services that can be easily resolved at the frontline, where there is no risk to the Client but may require a temporary increased level of care and/or services.	• Any minor issue that can be resolved on the spot or within 24 hrs of receipt of complaint.
Staff, Volunteer, Contractor of Visitor Incident	• Accidental or Unexpected Death of a Staff Member, Volunteer, Contractor, or Visitors. • Incidents result the visit by Safe Work. • Staff: permanent injury to staff member.	• All Other Accidents or Incidents Involving Staff, Volunteers, Contractors, or Visitors. • Theft of Personal Property/Money. • Hospitalisation of a staff member. • Staff experiencing lost time or restricted duty or illness.	• Staff injury requiring: first aid treatment only, with no lost time or restricted duties.	• Staff with no injury or review required.	N/A
Service Impact Incident	• Complete Loss of Service Due to Natural Disasters/Fire or Widespread Equipment Failure. • Evacuation of Service. • Bomb Threat, Armed Hold Up. • Improvement or Penalty Notice Issued by Safe Work.	• Major Disruption to Service Caused by Equipment or Utility Failure. • Any Incidents Requiring Police or Emergency Services Visit. • Theft or Vandalism of Catholic Healthcare Property/Money.	• Minor Disruption to Service Caused by Equipment or Utility Failure.	N/A	N/A

Action Required	
Note: Please refer to Decision Matrix: 'SIRS Incident' (page 39) for Priority 1 and Priority 2 Incident. • Priority 1 SIRS Incident — A Priority 1 SIRS incident is an incident that causes, or could have caused, a resident physical or psychological injury or discomfort that requires medical or psychological treatment to resolve; or an unexpected death or unexplained absence from the home and an unexplained absence from the home where there are reasonable grounds for reporting the absence to the police. • Priority 2 SIRS Incident — A Priority 2 SIRS incident includes any SIRS incident that does not meet the Priority 1 criteria as outlined above.	
CAS 1 – Extreme Risk	Incidents or events of an extreme severity requiring immediate attention and notification. The Residential Manager must notify the Regional Manager *immediately*. *Regional Manager* to ascertain if the Incident is reportable and support with fulfilling necessary obligations. *Regional Manager* to lead the investigations. All Critical Incidents per CHL Policy definition require an initial 'Critical Incident Brief' document to be sent to the RAC General Manager *within 2 hours* of the incident being identified.
CAS 2 – High Risk	Incidents or events of a high severity requiring immediate attention and notification. The Residential Manager must notify the Regional Manager ***immediately.*** *Regional Manager* to ascertain if the Incident is reportable and support with fulfilling necessary obligations. *Regional Manager* to lead the investigations. Requires investigation by the Residential Manager or as delegated within 24 hours of the incident being identified.
CAS 3 – Moderate Risk	Incidents or events of a moderate severity requiring management by the Residential Manager in consultation with the Regional Manager. Residential Manager must ***notify the Regional Manager within 48 hours***. *Regional Manager* to ascertain if the Incident is reportable. Requires investigation by the Residential Manager or as delegated under the supervision of the Regional Manager.
CAS 4 – Low Risk	Incidents or events of a low severity requiring management by the Residential Manager following normal routine policies and processes. Requires investigation by the Residential Manager or as delegated or Registered Nurse.
CAS 5 – Negligible Risk	Incidents or events where there is no physical or psychological injury to the Resident and no treatment is required - normal routine policies and processes can be followed to minimise recurrence. Requires investigation by the Registered Nurse or Team Leader.

11.Documentation and Process Map for Managing CAS 1Incident

Step 1	Documentation	Role Responsibility
Escalation	*Residential Manager to:* • Gather relevant information • Notify the Regional Manager by telephone as soon as possible of the incident occurring • Complete the Critical Incident Brief and email to Regional Manager as soon as possible • Action further as directed and in line with CHL policy	Residential/Regional Manager
	Regional Manager to: • Notify the RAC General Manager by telephone as soon as possible of the incident occurring • Notify **Clinical Governance and Safe Care Team via** RAC Care Excellence Team email • Provide action instruction in line with CHL policy • Initiate the process of CHL Insurer notification (following GMs confirmation of an investigation)	
Step 2	**Documentation**	**Role Responsibility**
Decision-Making Process	*The RAC General Manager determines:* • Option 1: **The incident is not a CAS 1** - manage as per usual Incident Management System • Option 2: **The incident is a CAS 1 but does not require a CIMT Investigation** - manage as per usual Incident Management System • Option 3: **The incident is a CAS 1** and **requires a CIMT Investigation** • Notify the Managing Director • Notify GM of Marketing and Communications • Notify Legal • Form the team	RAC General Manager
Step 3	**Documentation**	**Role Responsibility**
Development of a Critical Incident Management Team (CIMT)	*The General Manager will:* • Act in the capacity of CIMT Co-Ordinator until one is appointed • Determine the best structure of the team to meet the needs of the investigation and actions required • Decide upon the most appropriate response for the team to action	RAC General Manager CIMT Co-Ordinator
	The CIMT Coordinator will: • Ensure each of the team members are aware of their responsibilities and response to the situation	

Step 4	Documentation	Role Responsibility
Planning an Investigation	When commencing the investigation, the following key issues must be considered: • **Confidentiality** – Names/details are not for release. Matters under investigation cannot be discussed • **Sensitivity** – Persons may be distressed or shocked and communications should be strictly handled by the RAC General Manager • **Accuracy** – Ensure that any information provided to the RAC General Manager is accurate and factual. Avoid speculation and personal opinions • **Authority** – Only the CEO and the RAC General Manager of Catholic Healthcare have the authority to communicate with the media • **Timeliness** – Investigation findings need to be issued in a timely manner • **Legality** – No comments are to be made about matters which are the subject of legal proceedings or under investigation by the Police • **Liaise** with the Residential Manager of the Home to: o Confirm their understanding of their responsibilities o Provide notification of what will be required as part of the investigation process. For example, the documents required, and the staff interviews to be conducted o Provide a clear expectation of the time by which the Residential Manager needs to have these items available to the Investigation team	CIMT Co-Ordinator
Step 5	**Documentation**	**Role Responsibility**
Conducting Interviews and Investigations	• The Lead Investigator should collect documentation and material related to the incident as soon as possible to: o Ensure the information is available for use in the investigation o Allow for development of a description of the sequence of events leading up to the incident o Maintain the integrity of the documentation and material and pass this information to the CIMT Coordinator for appropriate storage • A list of all documents collected and reviewed will be recorded on the Critical Incident Documentation Reviewed Form of Critical Incident Report	Lead Investigator

Step 5 Continued	Documentation	Role Responsibility

Conducting Interviews and Investigations	• Information that may be relevant includes, but is not limited to:
	  ○ Resident Records, e.g., progress notes, medication chart
	  ○ Relevant Policies and Procedures
	  ○ Local Clinical Process documentation (Nursing Handover sheets, staff meeting minutes, Doctor's Communication Books)
	  ○ Relevant Physical Evidence
	  ○ Observations and comments from staff involved
	  ○ Comments and information from residents /representatives
	  ○ Information about the environment and conditions (staffing numbers, time of day)
	  ○ Staff education and training records
	  ○ Personnel records
	• When obtaining observations and comments there should be a focus on determining:
	  ○ The sequence and timing of events
	  ○ The individual's involvement in the process
	  ○ Any specific conditions or issues that were experienced or observed
	• The Lead Investigator and HR team are to undertake interviews with the people relevant to the Critical Incident. This may include management, clinicians, other employees, residents, and authorised representatives. It may also include persons involved with Catholic Healthcare systems, policy and/or processes related to the Critical Incident
	• The Lead Investigator is required to:
	  ○ Escalate any identified, ongoing risk to the Coordinator immediately
	  ○ Provide a preliminary report to the CIMT **within 48 hours** of commencing the investigation in the form of a Critical Incident Briefing update
	  ○ Maintain a Timeline Record that is supported by a triangulation of the evidence (wherever possible)
		Lead Investigator

Step 6	Documentation	Role Responsibility
Analysis – Reviewing and Evaluating Information	Analysis of the Critical Incident includes: • Determining the sequence of events and the context in which they occurred and completing an Incident Timeline Record which also identifies relevant events leading up to the Critical Incident • Determining the Contributing Factors leading to the event and any links between the identified Contributing Factors • Determining what controls were in place and how effective or ineffective these were • Developing recommendations which are: o S – Specific o M – Measurable o A – Achievable o R – Realistic o T - Timely	Lead Investigator
Step 7	**Documentation**	**Role Responsibility**
Writing the Critical Incident Report	• The Lead Investigator will complete a Critical Incident Report, to be reviewed by the CIMT, using the template provided and guided by the prompts. Appendices should be attached as appropriate to support the report and allow the reader to obtain more in-depth information if required • The characteristics of a comprehensive Critical Incident Report are as follows o Complete o Concise o Specific o Factual & Objective o Minimal Use of Abbreviations	Lead Investigator
Step 8	**Documentation**	**Role Responsibility**
Review and Reporting	• The CIMT will review the Critical Incident Report provided by the Lead Investigator and provide a final report to the RAC General Manager which includes recommendations for remedial action and the dissemination of learning from the investigation • The General Manager or delegate will make recommendations, and this will include: o Providing appropriate responses and resolutions to Critical Incidents o Incorporating the learning from Critical Incident Investigations into the CHL RAC Continuous Quality Improvement System o Recommending education and counselling of staff where required o Ensuring that all Clinical Critical Incidents are recorded and reported through the Clinical Governance Committee o Ensuring that all Non- Clinical Critical Incidents are recorded and reported through the RAC Executive Meeting from where they will be directed to the appropriate Quality/WHS department for actioning o Monitoring the effectiveness of the remedial actions through ongoing Quality and Clinical Indicator Reporting	CIMT RAC General Manager

12.Decision Matrix: 'SIRS Incident'

Alleged, Suspected or Actual SIRS Incidents include

1. Unreasonable Use of Force
2. Unlawful or Inappropriate Sexual Contact
3. Unexpected Death
4. Psychological or Emotional Abuse
5. Stealing or Coercion by a Staff Member
6. Neglect
7. Inappropriate Use of Restrictive Practice (**NB:** As per current My Aged Care Provider Portal).
8. Unexplained Absences

SIRS Incident

Residential Manager to determine whether it is a Priority 1 or 2 incident

- Priority 1(P1) - Contact Regional Manager Immediately.
- Priority 2 (P2) - Contact Regional Manager next business day.

Residential manager to contact Regional Manager immediately for Priority 1 Incident and the next business day for Priority 2 Incidents.

Is this a criminal nature? X

✓

Report to the Police **within 24 hours**

Timeframe to report to the Commission

Priority 2 Incidents (From 1st Oct 2021)

1. Provide incident report to the Commission **within 30 days**
2. Final report (if required) to the Commission **within 84 days (12 calendar weeks)**

Priority 1 Incident (From 1st April 2021)

1. Initial notice to the Commission **within 24 hours** via My Aged Care Provider Portal.
   NB: **Regional Manager to review eCase Serious Incident Risk Register prior to entering incident into** My Aged Care Provider Portal.
2. Additional information to the Commission (if required) **within 5 days or by a date specified by the Commission.**
3. Final report (if required) to the Commission **within 84 days (12 calendar weeks).**

- We also encourage staff to use the Aged Care Quality and Safety Commission's SIRS Decision Tool.

13.eCase Documentation and Process Map for SIRS Incident

Steps	Alleged Victim (Resident)	Alleged Offender/Perpetrator (Resident)	Alleged Offender/Perpetrator (Staff/Family/Visitor)	Role Responsibility
1. Anyone becoming aware of an alleged, suspected or confirmed SIRS incident must report immediately to Residential Manager.	• Complete a head to toe assessment to identify any injuries and assess the impact to the resident affected by the incident. • If an allegation of sexual assault: ▪ The resident must be assessed by a Medical Practitioner (MP) immediately. If MP unavailable within 2 hours, transfer resident to hospital. ▪ Do not shower, remove clothing, or alter the resident and the environment in any way.	• For Care Worker, eCase Progress Notes – select *Incident - SIRS - Alleged Offender/Perpetrator (CW ONLY).* • For RN/EN, eCase Progress Notes – select *Incident - SIRS - Alleged Offender/Perpetrator (Mgr/RN/EN ONLY).* Notes: DO NOT DELETE TEMPLATE in eCase Progress Notes and Complete All Fields.	Report to RN/EN Residential Managers immediately.	Staff/RN/ Management
2. Immediate Action.	• Reduce risk and ensure safety. • Reassurance and emotional support.	• Reduce risk and ensure safety. • Reassurance and emotional support.	Reduce risk, ensure safety, and offer support.	Staff/RN/ Management
3. Residential Manager to determine whether it is a Priority 1 or 2 incident • Priority 1 - Contact Regional Manager Immediately • Priority 2 - Contact Regional Manager next business day.	• Initial investigation. • Complete of eCase Progress Notes - *select Incident – SIRS –* ▪ *Unreasonable use of force (victim)* ▪ *Unlawful/Inappropriate sexual contact (victim)* ▪ *Psychological/Emotional abuse (victim)* ▪ *Unexpected death (victim) P1* ▪ *Stealing/Financial Coercion by staff (victim)* ▪ *Neglect (victim)* ▪ *Inappropriate restrictive practice (victim)* ▪ *Unexplained absence from care (police involved) P1.* • DO NOT DELETE TEMPLATE and complete all fields in the eCase Progress Notes - *select Incident - SIRS* • Complete *eCase Serious Incident Risk Register.*	• Investigation incidents. • If not already completed, complete eCase Progress Notes – select *Incident - SIRS – Alleged Offender/Perpetrator (Mgr/RN/EN ONLY).* Notes: DO NOT DELETE TEMPLATE in eCase Progress Notes and Complete All Fields. • Complete *eCase Resident Incident Register – select type SIRS Incident - Alleged Perpetrator/Offender.*	SIRS incident Contact HR & Investigation.	RN/ Management/ Regional Manager
4. If incident is rated a. Priority 1 incident within 24 hours. b. Priority 2 within 30 days.	• Ensure ***eCase Serious Incident Risk Register*** has been completed correctly and notify Regional Manager for final approval. • Regional Manager to document final approval in ***eCase Serious Incident Risk Register – Manager Review Notes.***	• Rule out any medical causes. • eCase Progress Notes – select ***Post Incident Review.*** • Communication with residents and Authorised Representatives.	Provide information about EAP services.	RN consultation with Managers/ Management

Steps	Alleged Victim (Resident)	Alleged Offender/Perpetrator (Resident)	Alleged Offender/Perpetrator (Staff/Family/Visitor)	Role Responsibility
	• Once approval received from Regional Manager complete an **incident notification** in the My Aged Care Provider Portal. Note: ▪ **the SPARC number** according to Medicare is the resident's **Care Recipient ID in eCase.** ▪ **the ACMPS number** is for Community**, not required for RAC.** • If required to notify the Commission of any significant new information about the incident, complete a Notice of Significant New Information Form and send this notice and any supporting documents to SIRS@agedcarequality.gov.au • **Report to police** if incident is of a **criminal nature.** • Communication with residents and Authorised Representatives. • Complete eCase Progress Notes- ***select Incident – Review of SIRS Incident*** for any relevant update to the SIRS incident.	• **MUST** complete eCase behaviour care plan Fast Edit and Evaluation (refer to eCase QRG - Care Plan Evaluation). • **Evaluation MUST** critically assess appropriateness of any existing behaviour management strategies. If there are no existing strategies, then consideration must be given to any possible triggers for the behaviours and develop behaviour management strategies.		
5. Addition information (if required) for priority 1 incident, within 5 days or by date specified by the Commission (if required).	• Further investigation where required. • Complete a **Notice of Additional Information Form** (Priority 1) / (Priority 2) or a Final Report on Reportable Incident Form and send this notice and any supporting documents to SIRS@agedcarequality.gov.au • Communication with residents and Authorised Representatives. • Complete eCase Progress Notes- ***select Incident – Review of SIRS Incident*** for any relevant update to the SIRS incident.	• eCase Progress Notes – select ***Post Incident Review*** where required. • Communication with residents and Authorised Representatives.	Provide information about EAP services	RN / Management/ Regional Manager
6. Final Report (if required), within 84 days or 12 calendar weeks or by date specified by the Commission.				

Document Control Summary

14.Review History

Version Number	Date of update	Version Number	Date of update
		Version 5	01 July 2021
Version 9	29 April 2022	Version 4	03 May 2021
Version 8	18 March 2022	Version 3	08 April 2021
Version 7	29 November 2021	Version 2	01 April 2021
Version 6	08 October 2021	Version 1	05 March 2021

15.Reference & Related Documents

References

- Effective incident management systems: Best practice guidance, 16 August 2021, Available from: https://www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance
- Government of Western Australia (2011). Clinical Incident Management Toolkit
- Guidance and Resources for Providers to support the Aged Care Quality Standards, March 2021, Aged Care Quality and Safety Commission, Available from: https://www.agedcarequality.gov.au/resources/guidance-and-resources-providers-support-aged-care-quality-standards
- Health Quality & Safety Commission New Zealand (2012). Root cause analysis for clinical incidents. A practical guide. National District Health Board Quality and Risk Managers Group
- Incident Notification Information Sheet, Safe Work Australia, Available from: https://www.safeworkaustralia.gov.au/system/files/documents/1702/incident-notification-fact-sheet-2015.pdf
- Manser, T (2011). Managing the aftermath of critical incidents; Meeting the needs of health care providers and patients. Best Practice & Research Clinical Anaesthesiology (25) p.169-179
- Mental Health Coordinating Council www.mhcc.org.au
- NSW Health Incident Management Policy 2020, Available from: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_047.pdf
- QLD Best practice guide to clinical incident management, June 2014, Available from: https://clinicalexcellence.qld.gov.au/sites/default/files/2018-01/clinicalincidentguide.pdf
- Serious Incident Response Scheme – Guidelines for residential aged care providers, October 2021, Available from: https://www.agedcarequality.gov.au/resources/serious-incident-response-scheme-guidelines-residential-aged-care-providers
- Wolshynowych, M. et al. (2005) The Investigation and analysis of critical incidents and adverse events in healthcare. Health Technol Assess: 9 (19)
- Aged Care Quality and Safety Commission's SIRS Decision Tool.

Related Policies & Procedures:

- CHL Human Resources Systems
- CHL Legal and Mission Systems
- CHL Open Disclosure Policy and Procedure
- Guide_RAC Agency Staff
- Incident Definitions – SharePoint Incident Management System
- RAC_Behaviours of Concern Management Policy
- RAC_Clinical Risk Management Policy
- RAC_Continuous Quality Improvement (CQI) Policy

- RAC Critical Assessment Scale (CAS)_A3 Poster
- RAC_Feedback & Complaints Management Policy
- RAC – Flipbook - SIRS Incident Reporting Guide
- RAC Incident Management Flow Process
- RAC National Disability Insurance Scheme (NDIS) Policy Guideline
- RAC_Resident Information Management Policy

Related Documents & Forms:

Documents:

- Corporate Human Resource Documentation
- RAC_Critical Incident Investigation Data Collection Tool (Word File)
- RAC_Critical Incident Report Template (Word File)
- eCase Assessment, Care Plan, Chart, Register & Progress Note
- eCase Maintenance Log
- eCase Plan for Continuous Improvement
- RAC Auditing Document
- RAC Critical Incident Brief (Word File)
- Record of Conversation Form (Word File)
- Resident Identification Form

The Aged Care Quality and Safety Commission-Approved Forms:

- SIRS – Notice of additional information form (Priority 1)
- SIRS – Notice of additional information form (Priority 2)
- SIRS – Notice of significant new information form
- SIRS – Final report on reportable incident form

Legislation & Rules:

This policy is guided by the following legislation and rules:

- Aged Care Act 1997
- National Disability Insurance Scheme Act 2013
- National Disability Insurance Scheme (Code of Conduct) Rules 2018
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018
- National Disability Insurance Scheme (Protection and Disclosure of Information—Commissioner) Rules 2018
- National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018
- National Disability Insurance Scheme (Quality and Safeguards Commission) Rules
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS Quality and Safeguarding Framework
- Quality of Care Principles 2014
- User Rights Principles 2014 - Charter of Care Recipients' Rights and Responsibilities

16.Key Words for Search

Elder Abuse, Abuse, Unlawful Sexual Contact, Unreasonable use of force, Missing Resident, Unexpected Death, Psychological Abuse, Emotional Abuse, Financial Abuse, Neglect, Chemical Restraint, Physical Restraint, Unexplained Absence, SIRS, Reportable Incident, Incident, Management, Reporting, Investigation, Governance, Feedback, Complaints, Critical Assessment Scale (CAS); CAS Rating, Critical Incident, Risk, Continuous Improvement, Near Miss, Natural Justice, Procedural Fairness, Triangulation, Media, Notifiable; Restrictive Practice