Effective incident management systems:
Best practice guidance

December 2022

Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Acknowledgments

The Aged Care Quality and Safety Commission engaged mpconsulting to support development of external guidance relating to the introduction of requirements for the use of an incident management system to enhance practices for the effective prevention and management of incidents. This resource, together with the resources *Serious Incident Response Scheme: Guidelines for residential aged care providers* and *Serious Incident Response Scheme: Guidelines for providers of home services* enable the sector to be aware of and to meet their requirements. The Commission would like to acknowledge Andrea Matthews, Elsa Kennett, Ashleigh Kennedy and Riaza Rigby from mpconsulting for their central role and principal authorship of this resource.

Contents

Contents

Chapter 1:
Introduction

Context

All Commonwealth-funded providers of aged care ('you') have a responsibility to provide safe and quality care and services to support consumers to live the best lives they can.

As part of this responsibility, and as required by the Aged Care Quality Standards (the Quality Standards), you are expected to have effective risk management systems and practices to manage risks associated with the care of consumers. Guidance about the Quality Standards is available on the Commission's website.

Requirement 8(3)(d)(iv) of the Quality Standards specifically requires you to have effective risk management systems and practices for preventing and managing incidents, including the use of an incident management system. Effective incident management is a feature of safe and high-quality care and services, and an important element of quality improvement and a consumer-centred approach to aged care.

The Aged Care Quality and Safety Commission (the Commission) will monitor and assess your performance against this requirement. We will also provide guidance for providers to use in building their capability to prevent and manage incidents and to develop and implement an effective incident management system.

Purpose of this guide

The purpose of this guide is to help providers to develop and embed a best practice incident management system that enables them to determine, in relation to specific incidents and near misses:

- what happened
- how and why it happened
- what can be done to reduce the risk of recurrence and support safer care
- what was learned
- how the learning can be shared.

Adopting best practice incident management practices and systems will assist providers to:

- provide safe, quality care and services for consumers
- 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 consumers, their families/representatives and staff appropriately should an incident occur
- resolve any incidents that may occur
- take action to prevent incidents from recurring.

Chapter 2:
Responsibilities of aged care providers

The regulatory framework

Aged care consumers have the right to safe and quality care and services that support their health and wellbeing and promote their quality of life.

In support of this, all providers of Commonwealth-funded aged care operate in the context of the aged care legislative framework. The requirement to prevent and manage the risk and occurrence of incidents is one element of the framework that supports the provision of quality care and services and a safe environment.

The requirement for an incident management system complements and supports other regulatory settings including the integrated expectations of the Charter of Aged Care Rights (the Charter), the Quality Standards, open disclosure requirements, clinical governance requirements, and the Serious Incident Response Scheme (the SIRS). Together, these settings support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to consumers.

The Charter

Under the Charter, consumers have the right to safe and high-quality care and services, the right to be treated with dignity and respect, and the right to live without abuse and neglect. Providers are required to uphold these rights and ensure consumers in their care understand their rights under the Charter.

The Quality Standards

All providers must meet the requirements of the Quality Standards, which detail the standards of care all aged care consumers can expect.

The Quality Standards require providers to maintain effective organisation-wide governance and risk management systems and practices to prevent and manage incidents and to identify and respond to abuse and neglect of consumers.

Providers are also required to regularly review the care and services provided for effectiveness, including when incidents impact on the needs, goals or preferences of consumers, and to effectively manage the high impact and high-prevalence risks associated with the care of each consumer to ensure that each consumer gets safe and effective personal and clinical care.

Other requirements in the Quality Standards are also relevant to how providers prevent, assess and manage risks of and actual incidents. This includes requirements to provide consumers with choice, control and independence; to enable consumers to take risks to live the life they want; and to support consumers to maintain relationships of choice.

Open disclosure requirements

As outlined under the Quality Standards, providers must use an open disclosure process when things go wrong. This means that providers should facilitate an open discussion with consumers (and their representatives) when something goes wrong that has harmed or had the potential to cause harm to a consumer.

Providers are expected to practice open disclosure in their prevention and management of any incidents impacting consumers.

Clinical governance

The Aged Care Quality Standards require providers that provide clinical care to demonstrate the use of a clinical governance framework (Standard 8(3)(e)).

Clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms that are implemented to support safe, quality clinical care and good clinical outcomes for each consumer. An incident management system is an essential component of an effective clinical governance framework.

Code of Conduct for Aged Care

The Aged Care Code of Conduct is a set of behaviours that approved providers and their governing persons, workers, contractors and volunteers are expected to meet in the delivery of care and services.

The Code applies to approved providers of residential, home care and flexible care services and sets out standards of expected behaviours which apply equally to:

- approved aged care providers
- their governing persons (e.g. board members and Chief Executive Officers)
- aged care workers who are:
  - employed or otherwise engaged (including on a voluntary basis) by the provider
  - employed or otherwise engaged (including on a voluntary basis) by a contractor or subcontractor of the provider to provide care or other services to consumers.

The Code will not apply to the Commonwealth Home Support Programme (CHSP) and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) however CHSP and NATSIFACP providers will be required to provide care that is safe and respectful and to behave in a way that aligns with the Code.

The SIRS

The SIRS aims to prevent and reduce incidents of abuse and neglect in Australian Government subsidised aged care services.

It requires providers to have an effective incident management system in place and to identify, record, manage and resolve all incidents, and to notify all reportable incidents that occur, or are alleged or suspected to have occurred to the Commission (and the police where there are reasonable grounds).

Expectations of providers

Incident management is integral to risk management, continuous improvement, and the delivery of safe and quality care.

Requirements in relation to incident management complement existing requirements for services to undertake self-assessments against the Quality Standards and have plans for continuous improvement, including addressing areas of risk and where adverse outcomes for consumers are evident.

Requirement 8(3)(d)(iv) of the Quality Standards specifically requires you to have:

> *effective risk management systems and practices for managing and preventing incidents, including the use of an incident management system.*

Providers have responsibilities to prevent and manage incidents (focusing on the health, safety, wellbeing and quality of life of consumers), to notify reportable incidents to the Commission under the SIRS (and the police where there are reasonable grounds) and to use incident data to drive quality improvement.

For more information on SIRS requirements refer to *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.

The role of the Commission

The Commission is the national regulator of Commonwealth-funded aged care services, and the primary point of contact for consumers and providers in relation to quality and safety.

Through its engagement and education work, the Commission aims to build confidence and trust in aged care, empower consumers, provide information and guidance to the sector and promote best practice.

Complaints or concerns about the quality of care and services can be made to the Commission and, like notification of serious incidents, complaints also play an important part in helping providers to improve the quality of care and services.

The Commission accredits, monitors and assesses the performance of providers against the Quality Standards, and helps consumers resolve complaints about a provider's responsibilities or actions. This is part of the Commission's function to 'protect and enhance the safety, health, wellbeing and quality of life of aged care consumers'.

As part of the Commission's risk-based approach to monitoring and assessing provider performance, the Commission will monitor provider performance against the requirement to have an incident management system. This may include requesting to view your incident management system and procedures, incident management records and correspondence with affected persons and external agencies regarding incidents. The Commission may also undertake interviews with affected persons, consumer representatives and staff, and may review incident management data and continuous improvement documentation.

Chapter 3:
Incident management systems

What is an incident?

An incident is any act, omission, event or circumstance that occurs in connection with the provision of care or services that:

- has (or could reasonably be expected to have) caused harm to a consumer or another person (such as a staff member or visitor), or;
- is suspected or alleged to have (or could reasonably be expected to have) caused harm to a consumer or another person, or;
- the provider becomes aware of and that has caused harm to a consumer.

An incident management system should be used to identify, assess, respond to and record all incidents and near misses, regardless of whether they are known to have occurred or are alleged or suspected to have occurred.

Your incident management system should include any incidents that:

- occur, or are alleged to have or are suspected of having occurred in connection with the provision of aged care to a consumer, and
- have either caused harm, or could reasonably have expected to have caused harm, to the consumer or another person.

A subset of the incidents that should be recorded in your incident management system are reportable to the Commission under the SIRS. The incidents that must be reported to the Commission relate to:

- unreasonable use of force against a consumer
- unlawful sexual contact, or inappropriate sexual conduct, inflicted on a consumer
- psychological or emotional abuse of a consumer
- unexpected death of a consumer
- stealing from, or financial coercion of, a consumer by a staff member of the provider
- neglect of a consumer

- use of restrictive practices in relation to a consumer (other than in the circumstances set out in the Quality of Care Principles)
- unexplained absence of a consumer from the service (in residential care settings)
- missing consumer (in the course of provision of care in home and community settings)

For more information on the reporting requirements under SIRS refer to *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.

What is a 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 consumer or another person but had potential to do so.

Near misses in connection with the provision of care and services should also be captured by your incident management system, and you should consider the effect the near miss could reasonably have been expected to have had on a consumer. Examples of near misses includes when there is poor lighting that results in a staff member tripping and almost falling over an undetected extension cord, or equipment temporarily left at a blind spot in a corridor that could potentially have resulted in a collision involving staff members, consumers or visitors.

Being proactive about reporting near misses is an opportunity for your organisation to build a safety culture and assess and learn from events so that you can understand risks and prevent incidents from occurring. Staff should be supported to recognise and report near misses and be part of the learning and quality improvements that come out of near misses or close calls.

Case study: Near miss

While visiting his father in residential aged care, a consumer's son noticed that the packaging colour of the insulin medication his father was about to be given by the Registered Nurse was not the usual colour of the medication. On mentioning this difference in colour, the Registered Nurse realised that the medication was not the correct insulin medication prescribed for the consumer.

The Registered Nurse recognised that this event was a near miss and that it must be recorded in the service's incident management system to enable assessment, investigation and/or analysis. Systemic changes to improve practice and to prevent a similar event from happening in future were implemented and discussed with the consumer and his family.

What is an incident management system?

Incident management systems are used across a wide range of sectors to enable organisations to identify, assess and resolve incidents to quickly address risks and improve the safety and quality of services provided.

> *An incident management system is any system that helps an organisation to prevent incidents and to identify, respond to and manage any incidents and near misses that occur during the course of delivering care and services to consumers.*

An incident management system applies to all incidents that are known, suspected or alleged to have occurred in connection with the delivery of care and services, and should:

- support services to understand risk and prevent incidents from occurring
- focus on the health, safety, wellbeing and quality of life of consumers and anyone affected by an incident
- set out the actions and responsibilities of staff and others in relation to incident management
- include documented policies and procedures that are developed in consultation with consumers and staff to identify, manage and resolve incidents. These procedures should be easily understood by all who need to use them and support the organisation to:
  - recognise incidents and near misses when they occur
  - record and report incidents and near misses
  - assess the impact of any incidents and respond to the needs of the people impacted
  - review, analyse and if necessary investigate incidents

  - use the outcomes of the investigation and/or analysis (and incident and near miss related data more broadly) to inform service improvements and prevent future occurrence
- be well understood and used by staff through a staff training program and regular reinforcement about how the system operates
- include strong and open communication with consumers and their family/representatives, advocates and others regarding the operation of the system and opportunities to provide input to effective incident management and ongoing learning within the service (including the use of interpreters for consumers with limited English proficiency)
- include a mechanism or tool for recording, storing and easily accessing information about specific incidents
- support effective governance and accountability to provide oversight of the system's operation and ensure its ongoing effectiveness in driving continuous quality improvement.

The incident management system (and supporting policies and procedures) must also describe which incidents are reportable incidents under the SIRS (in accordance with the legislation and the relevant provider guidelines[1]) and identify who is responsible for reporting incidents that are notifiable under the SIRS to the Commission.

Tip: Engage with consumers

Requirements to communicate with consumers and their families and representatives regarding the operation and purpose of your incident management system are an opportunity to engage with consumers about how incident management systems support safe, quality care. Welcoming consumer interest, questions and reporting of incidents and near misses also strengthens your system by enhancing the focus on consumers and expanding the potential for learning and continuous improvement.

1 Relevant provider guidelines can be found on the Commission website – SIRS Guidelines for residential aged care providers and SIRS Guidelines for providers of home services

What form should an incident management system take?

Each provider's incident management system will include different elements and will look different. This is because an incident management system should be appropriate for the service size, location, type of services provided, and for the consumers at the service.

There will also be differing levels of maturity, with some providers using a broader quality management system or specialist risk management system to manage incidents, and others using Excel spreadsheets or paper-based systems. Paper-based systems must still ensure efficient reporting and trend analysis, through strategies such as the use of colour coding of entries or the use of designated incident type or near miss record books.

While the mechanism for managing incidents can be electronic or paper-based, providers utilising a paper-based incident management system may wish to consider the benefits of moving to an electronic system to support the effective and efficient recording, management and trend analysis of incidents, and to improve visibility as to the nature of incidents and near misses that are occurring, as well as empowering staff to provide real time reporting of incidents.

What are the principles of effective incident management?

The following principles are building blocks that form the foundation for effective incident management. Organisations are encouraged to develop, support and communicate these principles on an ongoing basis.

Principles	Description
Consumer-centred	Your approach to managing incidents and near misses should be based on consumer dignity and choice. In managing incidents and near misses, you must be respectful of, and responsive to, each consumer's individual identity, needs and preferences while supporting their safety and wellbeing. Consumers (and their representatives) should be actively engaged in the resolution of incidents and any remedial actions put in place to prevent incidents from recurring.

Principles	Description
Outcomes-focused	Your approach to managing incidents should focus on the health, safety and wellbeing of consumers, staff and others, with a view to understanding risk and preventing incidents from occurring, minimising harm if incidents do occur and taking action to prevent recurrence.
Open disclosure	You should use open disclosure when things go wrong, including apologising to, and facilitating an open discussion with those affected by an incident to address their immediate needs and determine the steps you will take to prevent any similar incidents from occurring again.
Accountable	You are responsible for the effective management of an incident. Everyone involved in the management of an incident must understand their role and responsibilities and be held accountable for decisions or actions taken in responding to an incident.
Clear, simple and consistent	Your incident management system policies and procedures should be easy for consumers and staff to understand. Your system should be documented, readily accessible and consistently applied.
Timely	You should respond to, and endeavour to resolve, all incidents in a timely manner, providing regular updates to those affected.
Continuous improvement	Your incident management system must enable you to identify trends, issues and areas for improvement. This will enable you to undertake ongoing continuous improvement to improve the quality of the care and services you provide.

What are the benefits of incident management systems?

There is a wide range of benefits associated with having an effective incident management system. An incident management system:

- supports you to provide safe, quality care and services for consumers
  - It gives you the tools to prevent incidents from occurring, which is the best way to keep consumers and others safe.
  - Effective incident management also helps you to continuously improve your delivery of care and services.
- supports you to understand and engage with risk, including to meet the needs and preferences of consumers
  - Incident management is not about eliminating risk but instead supporting you to understand risk and to make changes to practice as you better understand incidents and their impact.
  - Learning from incidents and near misses helps you to undertake risk assessment, in consultation with consumers (and their family/representative or other service providers as appropriate) to find ways to reduce risks whilst supporting the consumer's independence and choices, including to take some risks in life.
- empowers consumers (and their family/representative) and gives them confidence in the care and services you provide
  - People receiving aged care know that sometimes incidents can happen despite the best intentions of all.
  - What undermines confidence in aged care is if incidents and near misses are not acknowledged, if they are hidden, if actions are not taken to reduce the risk of the incident recurring and if incidents and near misses are not collectively understood and used to improve care.
  - Adopting a proactive and comprehensive approach to incident prevention and management in partnership with consumers and their representatives will help to foster trust and build confidence in your ability to provide the care and services that consumers need. Critical to this are open discussions with consumers and their family/representative about your approach to incident management and your commitment to learning from incidents and near misses, and continuously improving.
  - By involving consumers and their family/representative in identifying risks and developing strategies to mitigate risks and prevent harm, you also empower consumers and are more likely to meet their needs, goals and preferences while also keeping them safe.
- supports a 'blame free' culture, with a focus on understanding, learning and improvement
  - An organisational blame free culture makes it acceptable for individuals to report errors or near misses without fear of reprimand. It encourages staff to report incidents and to learn from them. It also supports staff, consumers and their families or representatives to collaborate and build solutions when things go wrong.

- informs care assessment and planning
  - Incident management can help inform strategies needed to manage risks to the health, safety or wellbeing of individual consumers, and equip you to more easily identify deterioration or change in a consumer's mental health, cognitive or physical function or capacity. For example, if a consumer has a fall, this may indicate decline in their physical function; if a consumer shouts at another consumer, this may indicate a change in their mental health and wellbeing or cognitive capacity.
- helps you to retain and develop staff
  - Effective incident management enables staff to feel confident in their practice, knowing that when they make mistakes, have near misses or incidents occur, they will be supported by the organisation to understand and learn from those incidents and near misses, to improve care delivery.
  - An incident management system empowers staff because it provides them with clarity about how to recognise and respond to risks, near misses and incidents. Incidents and near misses can then be used as a learning opportunity to support and develop staff to improve service delivery.
- helps you to identify ways to prevent or reduce future and potential incidents. Incident management is not only about immediately responding to each incident but also about taking the time to understand the underlying issues. These may be:
  - issues in organisational governance
  - staff knowledge or skill gaps
  - deficiencies in policies and practices
  - limitations in care planning and assessment
  - problems with the service environment or equipment.
- supports you to meet your broader responsibilities as an aged care provider. For example:
  - **Standard 8** of the Quality Standards requires you to have in place effective risk management systems and practices that enable you to manage high-impact risks associated with the care of consumers, and to identify and respond to abuse and neglect of consumers. An effective incident management system will help you to identify high-impact risks, put systems in place to prevent incidents from occurring and keep consumers safe, consistent with the requirement in **Standard 3**, which requires you to effectively manage high-impact and high-prevalent risks associated with the care of each consumer.
  - **Standard 6** of the Quality Standards requires you to demonstrate that an open disclosure process is used when things go wrong in providing care for consumers. Open disclosure is also an important part of incident management and can help you to build stronger, more transparent relationships with consumers and their representatives.
  - Applying effective incident management practices puts you in a better position to demonstrate your ongoing compliance with broader provider responsibilities.

- An incident management system will also assist you to meet your responsibilities under the SIRS.
  - An effective incident management system will enable you (and your staff) to identify incidents and near misses when they occur, assess the level of harm (or possible harm) to those affected, respond appropriately to limit the extent of harm and to notify the Commission and others where required.

Chapter 4:
Key elements of an incident management system

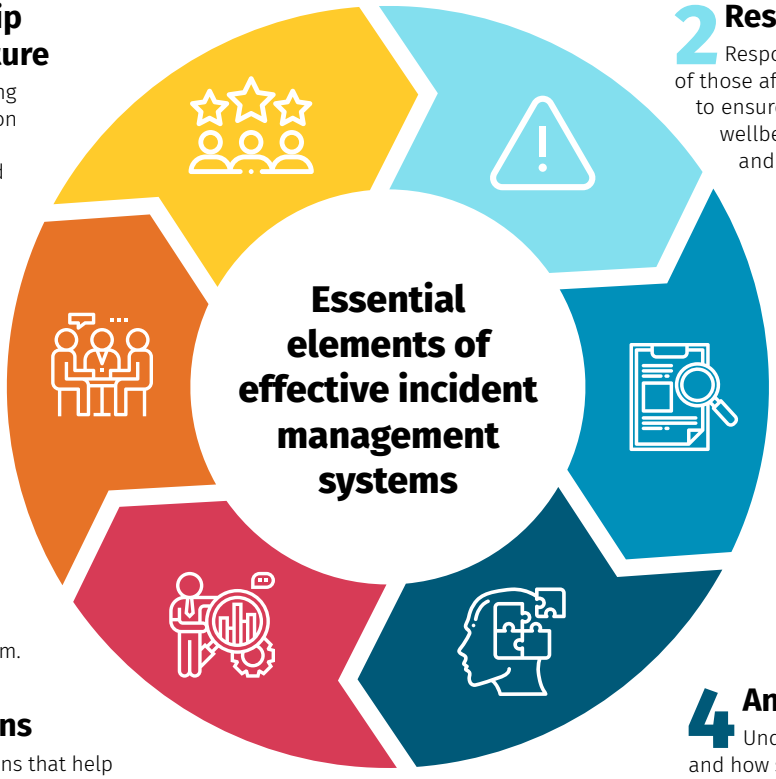
Overview

An incident management system is not a spreadsheet with a record of incidents. Rather, it is a comprehensive approach to preventing, managing and learning from incidents.

To be effective, an incident management system:

- requires **leadership commitment** and an organisational **culture** that values openness, accountability and continuous improvement in quality and safety
- must exist within a clear **governance** framework
- should include **comprehensive policies and procedures** relating to incidents and near misses, and their management
- should include a mechanism that enables incidents to be easily **recorded, safely and securely stored, and easily accessed**
- must be **well understood and utilised** by staff, as well as consumers, and their families and representatives
- must enable you to **respond to incidents** including to:
  - identify and respond to an incident including immediately supporting those affected
  - report the incident, make necessary notifications and record the incident appropriately
  - review, analyse and, if necessary, investigate how and why it happened
  - implement changes to reduce the risk of recurrence and to make aged care safer
- support you to **continuously improve, share learnings and analyse trends**
- should regularly be **reviewed**.

Each of these essential elements of an incident management system is discussed below.



1 Ensure leadership and a safety culture

Prepare for incidents by ensuring leadership around risk mitigation and incident management and creating a safety culture. Embed critical enablers through effective governance systems, with end-to-end policies and procedures that support staff to understand and use the incident management system.

2 Respond to incident

Respond to the immediate needs of those affected by the incident to ensure their health, safety and wellbeing. Assess the level of harm and mitigate any ongoing risk.

3 Record and report the incident

Report and record the incident to understand what occurred and the appropriate next steps (including any required notifications).

4 Analyse the incident

Understand underlying causes and how systems and practices could be improved to reduce the risk of similar incidents occurring in the future.

5 Implement actions

Implement remedial actions that help prevent future risk and improve incident response. Monitor actions for effectiveness.

6 Close the loop

Share lessons learned with management and leaders, staff, consumers and families. Continuously improve the quality and safety of aged care. Analyse incident trends and data and regularly review the incident management system.

Leadership commitment and organisational culture

Critical enablers for effective incident management include:

- **Leadership support and commitment**
  - — Effective incident management requires visible leadership support at all levels of the organisation.
  - — This starts with the board or the relevant governing body and must flow through the chief executive officer (CEO) (or similar role) and the entire leadership team.
  - — Consumers and staff need to be able to see that you are committed to incident management.
- **A culture of safe, inclusive and quality care delivery**
  - — The delivery of safe and quality aged care requires you to build and maintain a culture that values and focuses on quality and safety.
  - — This includes a culture that:
    - – places consumers at the centre of their care
    - – supports openness, honesty, fairness and accountability
    - – requires and encourages the reporting of incidents and near misses

  - supports staff to feel comfortable to identify incidents and near misses when they occur
  - supports opportunities for training and preparedness
  - promotes understanding, learning and improvement.

— Culture cannot be 'implemented' based on a set of policies and procedures; rather, an organisation's culture, encompassing the attitudes, understandings and behaviours of staff, needs to be consistently fostered over time and by example, at all levels in the organisation.

— Everyone in the organisation has a role in helping to build and maintain a culture that learns from incidents and near misses and strives to continuously improve the care and services provided to consumers.

— A culture of safe, inclusive and quality care and services is one that is embedded in all aspects of organisational life and owned by everyone. It is the organisation's governing body that enables this through its leadership, decisions and the directions it sets for the organisation. It will be reflected in how the organisation communicates its meaning and purpose to the workforce, consumers and those outside the service.

Tips for fostering cultural change

- Look for ways to promote a culture in which the organisation learns from its mistakes.
- Consider any cultural barriers staff or consumers may have for reporting and adapt communications and training to address these barriers.
- Discuss the benefits of effective incident management and prevention with staff and consumers.
- Ensure that the board routinely reviews incident and near miss data, trends, investigation outcomes and actions taken.
- Call out behaviours or actions that are not consistent with promoting a blame free culture and a commitment to learning from incidents and near misses.
- Talk to other organisations and learn how they have built leadership support for strong incident management and prevention and how they achieved cultural change.
- Review your internal documents – do your organisation's values reflect your focus on delivering safety and quality care, being open when things go wrong and continuously improving?

Effective organisation-wide governance

Organisation-wide governance is about how the organisation applies and controls authority below the level of the governing body. Authority flows from the governing body to the CEO (or similar role), then to the executive or management team and throughout the organisation.

Each of the elements of an effective organisation-wide governance system (described in Standard 8 of the Quality Standards) is critical for supporting effective incident management and prevention. For example:

- **Information management** – Effective information management systems and processes enable members of the workforce to get information that helps them in their roles. This includes information for each role about how they can prevent and manage incidents, and information to support incident management and continuous learning.
- **Continuous improvement** – Continuous improvement systems and processes support organisations to assess, monitor and improve the quality and safety of the care and services provided through the service. Incidents and near misses should directly inform the focus of continuous improvement and the actions that need to be taken. There should be clear linkages between the outcomes of incident management and your continuous improvement plans.
- **Financial governance** – Financial governance systems and processes manage the finances and resources that the organisation needs to deliver safe and quality care and services. Organisations are expected to ensure that if, as a result of the investigation of an incident (or analysis of incident and near miss trends), actions need to be taken to reduce the risk of recurrence, this is accommodated in financial planning.
- **Workforce governance** – All providers are required to ensure clear responsibility and accountabilities within the organisation. This includes responsibilities relating to incident identification, reporting, analysis and remedial action.
- **Regulatory compliance** – Regulatory compliance systems and processes ensure the organisation is complying with all relevant legislation, regulatory requirements, professional standards and guidelines. Effective incident management supports you to meet a wide range of regulatory obligations – these obligations are not specific to aged care but also apply to work, health and safety, food safety and to the conduct of aged care and health care professionals.
- **Feedback and complaints** – Your incident management system should also draw from the organisation's feedback and complaints. Often incidents and near misses are identified and reported by consumers and their families/representatives, which may mean it is first recorded through the feedback and complaints system and processes, and must subsequently be captured by your incident management system.

Establishing comprehensive policies and procedures

As part of your incident management system, you must establish policies and procedures to be followed in identifying, managing and resolving incidents.

Written policies and procedures regarding your incident management system must be made available to consumers and staff, and to family members, carers, representatives, advocates and any other person significant to consumers. It is your responsibility to support people to understand how your incident management system operates.

Your policies and procedures should describe matters including:

Procedure	Description
Roles and responsibilities	• Roles and responsibilities of staff in identifying, managing, resolving and preventing incidents and near misses • Roles and responsibilities of staff for notifying reportable incidents to the Commission • The role of each staff member in complying with the incident management system • Requirements of training for each staff member in the use of, and compliance with, the incident management system, noting that training needs will differ according to the roles of individual staff members (including any barriers to recognising and reporting incidents or near misses)
How incidents are identified, recorded and reported	• What incidents and near misses are and the types that should be covered by your incident management system • How incidents and near misses should be recorded, including: — the information to be recorded — how to record information to enable analysis of incident and near miss data that informs continuous improvement — the system for recording this information • How incidents and near misses should be reported internally, including: — identifying to whom incidents and near misses are to be reported — timeframes for internally reporting incidents and near misses

Procedure	Description
When others should be notified of incidents	· When and how to notify consumer representatives, or other emergency contacts · When police or emergency services should be notified · When government bodies (including the Aged Care Quality and Safety Commission, Australian Health Practitioner Regulation Agency (AHPRA) or state and territory health departments, or the NDIS Quality and Safeguards Commission where incidents relate to NDIS participants) should be notified
How you will provide support and assistance to those affected by an incident	· How you will provide support and assistance to those affected by an incident to ensure their health, safety and wellbeing · How you will involve people affected by an incident (and/or their representatives) in the management and resolution of an incident · The use of open disclosure processes when things go wrong · How to provide consumers and their representatives with information about access to advocates
Reviewing, analysing and investigating incidents	· A process for analysing all incidents to determine: — whether the incident could have been prevented — how well the incident was managed and resolved — what action (if any) needs to be undertaken to prevent similar incidents from occurring in the future — what action (if any) needs to be undertaken to minimise the impact of an incident — whether other bodies need to be notified of an incident · The circumstances in which you will undertake an investigation to establish: — the causes of an incident — the harm caused or effects of an incident — any operational issues that may have contributed to the incident occurring · The processes for undertaking an investigation

Procedure	Description
When remedial action might be required	• The circumstances in which remedial action may be required, including where: — an incident may have been prevented (or the severity of the impact lessened) by some action undertaken by you or a staff member — there is an ongoing risk to consumers, staff or others — action undertaken by you may prevent or minimise the risk of a recurrence • The different types and nature of remedial actions that may be required. For example: — changes to organisation/clinical governance — individual and/or service-wide staff training — educating consumers and/or visitors — changes to the service environment or equipment — changes to the care and services provided to consumers

For more information on SIRS requirements refer to *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.

Supporting and educating staff to understand and use the incident management system

Your incident management system will not be effective if staff:

- don't know what is required or expected of them
- are too scared to report incidents or near misses
- view incident management as a process disconnected from their role in delivering safe and quality care.

You need to ensure that staff who provide care and other services, including individuals who are employed, hired, retained or contracted by you (whether directly or through an employment or recruiting agency):

- know what their roles and responsibilities are in relation to incident management, including in relation to identifying, recording, managing and resolving incidents and in preventing incidents from occurring
- are comprehensively trained in the use of, and compliance with, your incident management system. It is your responsibility to ensure staff are appropriately trained and supported to identify, record, prevent and manage incidents in line with your incident management system
  - Ensuring staff at all levels of your organisation understand the system is critical. Staff that are not involved in direct care delivery may be the first on the scene after an incident occurs or may be the first to become aware of an incident occurring. Your incident management system will be more effective when all staff are consistently and appropriately trained in the requirements and use of the system.
- are constantly reminded about the importance of identifying, recording, responding to and reporting incidents and near misses. Reinforce that incident management is not just about reporting but about responding to incidents (supporting consumers) and learning from incidents to reduce risk. Encourage staff at all levels to be involved in the analysis of incidents and in identifying ways to improve care and services.

Encouraging consumers, their family and representatives to report incidents

Encouraging consumers, their family and representatives to actively report incidents creates an open and transparent environment in which consumers feel safe to make a report. This is particularly true where consumers may fear the consequences of making a report, or worry that the incident will reflect badly on a staff member who they like and who provides them with good care and services.

Engaging with consumers to communicate the benefits of an effective incident management system and how they can make reports, share information and be involved in solutions and improvements is critical to encouraging consumer reporting.

Responding to incidents

Identifying incidents

Incidents (and near misses) may be identified in a number of ways, including where a staff member or another consumer observes the incident, a consumer makes a disclosure about the incident, or another person informs a staff member that an incident occurred (or may have occurred). An incident management system should outline your expectations for staff members who identify that an incident has (or may have) occurred.

Some incidents may be simple to identify, for example, where a staff member witnesses an incident, or a consumer notifies a staff member of an incident that occurred. However, other incidents may be harder to identify, especially where they involve abuse, neglect or other types of reportable incidents.

Near misses may also be difficult to identify, given that there is no resulting harm by virtue of being a potential 'incident'. You may recognise a near miss where an error, omission or hazard is identified that, without intervention, could have resulted in injury, illness or damage. The occurrence of a near miss may not be evident on first reflection, but it is vital to consider after an event whether the effect could have been harmful. Understanding what prevented the harm from occurring is vital for learning and continuous improvement.

It is your responsibility to ensure that all your staff are trained and equipped to identify and report incidents and near misses when they occur.

Consumers may disclose information to staff regarding an incident that has occurred to them, an incident they were involved in, an incident they were told about by another consumer or staff member or where they suspect an incident might have occurred. All disclosures relating to an incident must be taken seriously and appropriately investigated to determine whether an incident occurred.

Consumers with cognitive impairment may allege that an incident has occurred based on a delusion. Where this occurs, you must ensure the incident is appropriately investigated to determine whether an incident did or did not occur. Where a consumer with cognitive impairment continues to report incidents that (following investigation) you find did not occur, you should still provide appropriate support to the affected consumer and record these in your incident management system.

Some consumers may be uncomfortable or concerned about reporting for fear of the subject of allegation finding out, of being hurt or having care and services taken from them. All staff should be aware of, and alert to, indicators or signs that may indicate someone has been affected by an incident. Potential indicators of reportable incidents are further discussed in the *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.

Tip: Collecting information to identify trends

In addition to being able to record individual incidents and near misses, your incident management system must enable you to collect information in a way that supports you to link related incidents and identify patterns of abuse.

Staff should be supported to recognise repeated minor instances of behaviours or incidents and to record these in your incident management system. While these types of incidents may not cause significant harm or suffering in each instance, the repetitive nature of the behaviour (over time) may have a cumulative effect which intensifies the level of harm to the person(s). This may include, for example, repeated flicking or poking, name calling or speaking to a person in an abrupt, terse or brusque manner.

Immediately supporting those affected

When an incident occurs, you must take immediate action to ensure the health, safety and wellbeing of those involved in the incident.

You should assess the support and assistance required for those affected by the incident. As part of your assessment, you should consider the level of harm or the impact on anyone involved in the incident and what actions can be taken to reduce this harm and ensure each person's health, safety and physical and psychological wellbeing.

It is good practice for you to have a response plan for when incidents occur. A response plan for how to deal with incidents could include:

Response	Examples
Taking action immediately following an incident to ensure the health, safety and wellbeing of those involved in an incident	· Checking on those affected to ensure their health, safety and wellbeing and assessing the level of psychological or physical harm caused by the incident (including by engaging with a clinician where necessary) · Ensuring those affected by an incident are provided with timely and appropriate (physical or psychological) treatment or support that is proportionate and appropriate to the level of harm
Engaging with those affected to determine an appropriate response to an incident	· Notifying consumer representatives of an incident as soon as practicable after it occurred or was notified to the provider · Facilitating access to advocates, the Older Persons Advocacy Network (OPAN) or other external support services · Facilitating meetings and discussions with those affected by an incident (and their representatives as appropriate) using open disclosure, to apologise and determine an appropriate response to the incident · Providing ongoing updates to those affected by an incident, including in relation to the reason for/cause of the incident, what is being done to address it and what is being done to prevent or mitigate the risk of such incidents in the future
Assessing and mitigating any immediate risks to others who could be affected by the incident	· Engaging with consumers and others who witnessed an incident to provide support and reassurance · Checking in and providing updates to those who could be affected by an incident regarding the reason/cause of the incident, what is being done to address it and what is being done to prevent or mitigate the risk of such incidents in the future
Where the incident is (or may be) a reportable incident, further action that must be taken	· Notifying relevant authorities, for example the Aged Care Quality and Safety Commission, police, the coroner or the AHPRA · Undertaking internal investigations to determine the cause of an incident and the events that led to an incident occurring

Reporting and recording incidents (including notifications)

Reporting incidents

Organisations will have different approaches and practices for incident and near miss reporting. This usually involves completion of an incident report form (whether paper or electronic). Incidents with a high potential for harm can also be reported verbally as part of the immediate response.

Reporting assists in understanding the next steps, such as whether further investigation and/or analysis is needed and whether additional resources and other actions, such as further notifications, are required. At a minimum, the staff member(s) assigned to receive incident reports should review and analyse the facts of the incident and gather any additional information needed to gain a preliminary understanding of what happened. Any contributing factors identifiable at this point should also be documented.

Reporting is the trigger for a chain of notifications that, depending on the nature of the incident, may involve:

- **Consumers** – You should start speaking with the consumer and their family/representative as soon as possible. Disclosure is an ongoing process in which multiple conversations may occur over time. Often practical support is needed, and contacts should be provided to the persons affected by the incident so that those who may have suffered emotionally and/or physically can receive early assistance. Open disclosure, expressions of compassion and offering an apology are important elements of communication, helping both consumers and staff in healing and in restoring trusting relationships.
- **Notifying the Commission** – If the incident is a 'reportable incident' under the SIRS, you must notify the Commission within the relevant timeframes. Priority 1 reportable incidents must be notified to the Commission within 24 hours of the incident. Priority 2 reportable incidents must be notified to the Commission within 30 days of the incident. Requirements for notifying a reportable incident are detailed in the *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.
- **Reporting to the coroner** – Deaths may be referred to a coroner for a range of reasons including if a person dies unexpectedly, or from an accident or injury, if the death is unnatural or violent, or a doctor has not been able to sign a death certificate because the cause of death is unknown. Each state and territory has specific requirements in relation to the obligations to notify a death to the coroner.
- **Reporting to police** – Where there are reasonable grounds to report an incident to police (where there is ongoing danger), you should contact police and other relevant emergency services within 24 hours of becoming aware of the incident (or within 24 hours of becoming aware that there are reasonable grounds to report the incident). Some states and territories will also require you to contact the police if there has been a death (including an unexpected death).

- **Notification to others** – There may be circumstances in which you will need to make further notifications depending on the nature of the incident. For example, you may need to notify Safe Work Australia (or the equivalent in your respective state) if an incident has occurred as a result of a workplace incident; AHPRA where the incident has been caused by the professional conduct of a registered health practitioner; local public health units where the incident triggers a requirement to report a notifiable disease or condition; or the NDIS Quality and Safeguards Commission where an incident relates to a NDIS participant.

Effective, timely and respectful internal and external communication can result in increased trust of all stakeholders, including the public.

Recording incidents

While each provider's system for recording incidents and near misses will be different, all incident management systems should be able to comprehensively record key details in relation to any incident and near miss. Key details are provided in the following table.

By collecting all the information in this table, providers will also have all the details required to notify the Commission about a reportable incident.

Subject	Details
Details of the incident or allegation	· The name and contact details of the person recording the incident or near miss · The name and contact details of the person making the allegation · The time and date the incident or near miss was identified/reported · The time, date and place at which the incident or near miss occurred (or was alleged or suspected to have occurred), where this is known · Whether a death has occurred as a result of the incident · Whether the incident is a reportable incident and if so, the type of incident (to assist in identifying patterns or common occurrences) · A description of the incident or near miss, including the harm caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and the consequences of that harm (if known)

Subject	Details
People involved in the incident	· Details of the persons directly involved, including names, contact details and cognitive status · Whether the subject of the allegation is an aged care recipient, and if not, their relationship to the service · Whether the affected care recipient or subject of the allegation have been involved in any prior incidents · Whether the affected care recipient or subject of the allegation suffered any psychological or physical impact and if so, the level of impact · Whether the affected (residential) care recipient resides within a secure unit · The names and contact details of any witnesses
Response to the incident	Details of the actions undertaken in response to the incident, including: · Whether the incident has been reported to the police and if so, when and how the police were contacted · The action taken by the police, including whether a person has been arrested or charged · Whether the affected care recipient or subject of the allegation's next of kin or enduring power of attorney has been notified · Whether the person's next of kin or enduring power of attorney has ongoing concerns about the management of the incident · The actions (support or assistance) taken to ensure the health, safety and wellbeing of the care recipients involved · Details of any actions undertaken to prevent further similar incidents from occurring, or to minimise their harm · Any consultation with those affected by the incident (and/or their representatives) in the management and resolution of the issue and any findings/outcomes they have been provided · Any notifications made to the Commission, police, and other relevant organisations
Investigation and analysis	· Details of investigation/analysis undertaken to identify the cause or source of an incident · The outcomes of any investigation or analysis undertaken (including whether the incident could have been prevented)

Your system for recording incidents should:

- provide for the collection of data and other information that will allow you to review and analyse issues raised by occurrence of incidents, identify and address systemic issues, and report incident information to the Commission, if required and/or requested to do so
- enable you to record and identify recurring incidents and patterns of abuse, including to support you to notify reportable incidents to the Commission
- record and store incident records safely and securely (for example, electronic systems should have protection to prevent inappropriate access and files and paper records should not be taken to a staff member's home)
- clearly outline who is responsible for collecting information regarding the circumstances of an incident. Records relating to incidents (for example, correspondence regarding incidents) should be kept together with incident records.

In line with best practice records management, records of incidents should be retained for 7 years after the date the incident was identified.

You should also maintain appropriate controls in relation to the privacy and confidentiality of information, particularly where it relates to the personal information of consumers. This includes ensuring that personal and sensitive information, including incident reports, are securely stored and when transmitted (either within your organisation, to other parties such as police, or in the case of reportable incidents, to the Commission), so that privacy and confidentiality is maintained.

You will also need to consider requirements to use a notice of collection when gathering and recording personal or sensitive information from, or about, any persons affected by an incident (e.g. for incident records or to notify a reportable incident to the Commission).

Section 62-1 of the Aged Care Act sets out your responsibilities in relation to the protection of personal information of consumers, which apply alongside regulatory requirements in relation to privacy contained in relevant state, territory or Commonwealth legislation, such as the Privacy Act 1988 and the Australian Privacy Principles (APPs).

For more information on SIRS requirements refer to *Serious Incident Response Scheme Guidelines for residential aged care providers* and *Serious Incident Response Scheme Guidelines for providers of home services*.

Investigating and/or analysing how and why it happened

Local actions to reduce the risk of harm and potential for recurrence may need to be taken immediately. Consumers, families/representatives and staff should be informed of immediate actions.

Additional actions typically follow after a more thorough analysis has been undertaken.

The nature of the incident will inform the extent and type of analysis (or investigation, where warranted). For example, the extent and type of analysis may depend on:

- the severity of the incident
- the impact of the incident on consumer (and family/representative) confidence and safety
- the probability of recurrence
- whether the same or similar incident has occurred in the past
- whether the incident involves a similar underlying cause to an incident that has occurred in the past
- whether it involves people who have been involved in other incidents in the past
- the complexity of the incident (for example, where the facts are in question or the underlying cause is unclear)
- if the incident is a reportable incident under the SIRS
- the views of the affected people (including any consumers, families/representatives).

The nature of the incident and other factors may also influence who is involved in the analysis, whether a formal investigation is necessary and whether an investigation is to be undertaken internally or independently.

There may be circumstances in which an independent investigation is the most appropriate response following an incident. This may be relevant where the facts of the incident are in dispute, where it involves an allegation that a staff member has acted in an inappropriate manner or if requested by a consumer, or the consumer's family/representative (where appropriate).

An investigation and/or analysis may consider:

- the underlying causes of the incident
- additional actions required to address the incident that occurred
- additional actions that reduce the occurrence of a similar incident in the future, including any systemic changes.

Implementing changes to reduce the risk of recurrence and to make aged care safer

In some circumstances, you will be required to undertake remedial action to prevent similar incidents from recurring in the future. Whenever an incident occurs, you should consider whether:

- it may have been prevented (or the severity of the impact lessened) by some action taken by you or a staff member
- there is an ongoing risk to consumers, visitors, staff or others following the incident
- there are actions you (or your staff) could undertake or cease to prevent or minimise the risk of a recurrence.

Remedial actions may include:

- providing or mandating individual and/or service-wide staff training or re-training
- making changes to the provider's organisational or clinical governance frameworks
- reviewing and updating the service's practices and procedures or developing new procedures to support staff to manage emerging risks and issues
- making changes to the service environment or equipment used to provide care and services
- taking actions to promote a safe culture of care (for example, making incident management a key focus when inducting new staff)
- making additional staff available to assist consumers with certain activities
- seeking specialist assistance and/or implementing alternate strategies to manage consumer behaviours
- updating care planning documentation to address the cause or impacts of the incident.

In parallel with other actions, it may also be appropriate to take disciplinary actions with respect to staff (including, for example, undertaking ongoing performance management, implementing a probationary period, standing down a staff member pending the outcomes of any investigation or terminating a staff member's employment).

You are responsible for ensuring any necessary remedial actions are taken and for updating those affected by an incident on the outcomes or progress of any remedial actions undertaken.

You should ensure that any organisational changes made in response to an incident are well communicated to consumers and their representatives, staff and service providers who you contract as appropriate.

Tip: Appropriate remedial actions

In considering what remedial actions are appropriate, try asking three fundamental questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in sustained improvement?

Closing the loop

Analysing incident trends and data

Your incident management system must enable the collection of data and other information relating to incidents to enable you to:

- identify and address systemic issues in the quality of care provided
- identify repeated occurrences (including alleged/suspected occurrences) of similar incidents or near misses
- analyse trends and identify patterns of incidents (e.g. behaviours)
- provide feedback and training to staff about preventing and managing incidents
- provide information to the Commission as requested.

You should undertake regular review and analyses of incident data to inform your consideration of where any organisational improvements may be made.

As part of your broader risk management process, consider incident trends, common or repeated incidents (and causes of incidents) and feedback from consumers, staff and others to identify risks.

You should use this information for organisational learning to improve the quality of care and services provided; reduce risks to the health, safety and wellbeing of consumers, staff and others and continuously improve your management and prevention of incidents.

Continuously improving and sharing learnings

Sharing what was learned both within the organisation (with consumers and family/representatives, those involved in the incident and others as needed) and outside the organisation is key to preventing additional harm and making aged care safer. Without learning and sharing, the same or similar incidents could happen again.

Learning from incidents and near misses, understanding and articulating what can be done to prevent them from occurring, and building trust are key aims of the incident management process.

Results of incident investigation and/or analyses should form part of organisation-wide reporting and be shared with the board, the leadership team, staff, those affected by the incident and the public. You should also consider the value in sharing learnings and opportunities with other providers and with peak bodies.

Reflecting on and improving the incident management system

Your incident management system needs to be continuously monitored to ensure that it is effective and reliable. Consistent monitoring helps to identify areas for further improvement.

You are encouraged to routinely dedicate time and resources to review and evaluate how your incident management processes are working. This ensures the processes are appropriate, reliable, effectively use resources and staff, and strive to improve care and services. In addition, the learning can assist in developing other resources that can help staff prevent and manage incidents.

The effectiveness of incident management is underpinned by the quality of incident analysis, which is extremely important in restoring trust and rebuilding relationships among those involved in an incident, and in building a safe culture in your organisation. Relevant factors to consider when reflecting on the quality of incident analysis and remedial actions include:

- timeliness of completing the analysis
- implementation of remedial actions (e.g. were actions completed?)
- effectiveness of the remedial actions implemented in reducing the recurrence of harm
- feedback from those affected by the incident
- sharing what was learned.

Glossary

Term / acronym	Meaning
***Aged Care Act 1997* (Aged Care Act)**	The Aged Care Act is the overarching legislation which outlines the obligations and responsibilities that aged care providers must follow to receive subsidies from the Australian Government.
aged care consumer/ consumer	A person who is receiving Australian Government-subsidised aged care services.
Aged Care Quality and Safety Commission (Commission)	The national regulator of aged care services, and the primary point of contact for consumers 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 consumers; to promote aged care consumers' confidence and trust in the provision of aged care services; and to promote engagement with aged care consumers about the quality of their care and services.
Aged Care Quality Standards (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.
Australian Health Practitioner Regulation Agency (AHPRA)	AHPRA is the national organisation responsible for working with various National Health Practitioner Boards to implement the National Registration and Accreditation Scheme for a range of health professions across Australia.
Charter of Aged Care Rights (Charter)	Describes the rights of consumers of Commonwealth-funded aged care services to be consulted and respected. Provides the same rights to all consumers, regardless of the type of subsidised care and services they receive. The Charter is made under the Aged Care Act.

Term / acronym	Meaning
Older Persons Advocacy Network (OPAN)	OPAN organisations support consumers and their families and representatives to effectively access and interact with Commonwealth-funded aged care services and have their rights protected.
provider (also referred to as 'you' in this document)	Provider approved under the Aged Care Act (or funded through funding agreements) to provide Commonwealth-funded aged care services with responsibilities in relation to incidents. In many cases this will include management and staff but where separate requirements rest with certain staff or management, this has been identified.
***Quality of Care Principles 2014* (Quality of Care Principles)**	The Quality of Care Principles specify the care and services that a provider must provide and the quality standards to which that care must be delivered.
reportable incident	An incident described in section 54-3 of the Aged Care Act (and section 15NA of the Quality of Care Principles).
Serious Incident Response Scheme (SIRS)	The scheme established to prevent, and reduce the risk of, incidents of abuse and neglect in Australian Government-subsidised aged care services. It requires providers to have an effective incident management system in place and to identify, record, manage, resolve and report all serious incidents that occur, or are alleged or suspected to have occurred.
service	The business run by a provider through which Commonwealth-funded aged care services are provided.
staff member	Individual who is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruiting agency) to provide care or other services.
you	Approved provider or service provider with responsibilities in relation to incidents. In many cases this will include management and staff but where separate requirements rest with certain staff or management, this has been identified.

The Aged Care Quality and Safety Commission acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, in your capital city