

Effective incident management systems: Best practice guidance

AGED CARE QUALITY AND SAFETY COMMISSION

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Safeguard

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1 Introduction

1.1 Context

All registered providers of Commonwealth-funded aged care have a responsibility to provide safe and quality care services to support older people to live the best lives they can.

As part of this responsibility and under the *Aged Care Act 2024* (Aged Care Act), providers in the following registration categories have conditions of registration relating to incident management:

- Home and community services (category 1)
- Advisory and support services (category 3)
- Personal and care support in the home or community (category 4)
- Nursing and transition care (category 5)
- Residential care (category 6).

The conditions of registration at s164 of the Aged Care Act are that relevant providers – also referred to as ‘you’ throughout this guidance – must:

- (a) implement and maintain an incident management system in accordance with any requirements prescribed by the Aged Care Rules 2025 (the Rules);
- (b) manage, and take reasonable steps to prevent, incidents in accordance with any requirements; and
- (c) not victimise or discriminate against anyone for reporting an incident.

There are also incident management obligations for responsible persons and operators of aged care digital platforms in the Aged Care Act. Your requirements for incident management are further detailed at Chapter 4, Part 10, Division 1 of in the Rules.

Registered providers in categories 4, 5 or 6 also need to conform with the Aged Care Quality Standards (the Standards), including Outcome 2.5 in Standard 2 where you must use an incident management system to:

- (a) safeguard individuals (i.e. older people); and
- (b) acknowledge, respond to, effectively manage and learn from incidents.

The Aged Care Quality and Safety Commission (the Commission) is the national rights-based regulator of Commonwealth funded aged care services. The Commission, our Commissioner and Complaints Commissioner all have functions under the Aged Care Act that give the Commissioners the authority to regulate the provision of aged care services and deliver government’s strategic priorities for the aged care system.

For more information see [1.3 The role of the Commission](#) below.

1.2 Purpose of this guide

The purpose of this guide is to help you as a provider to understand your responsibilities and obligations related to incident management, and for you to develop and embed a best practice incident management system.

A best practice incident management system enables you to determine for any incident:

- what happened
- how and why it happened
- what can be done to reduce risk of recurrence and support safer care
- what was learned, and
- how learnings can be shared to improve future practice.

Adopting best practice systems and responses in incident management assists you as a provider to:

- provide safe, quality care services for older people
- support older people, their families/representatives and aged care workers appropriately following any incident
- resolve any incidents that occur
- take action to prevent incidents from recurring
- use a systemic approach to minimising the risk of incidents occurring in the future, and
- promote a culture of reporting, with a focus on understanding, learning and improvement.

For more information about the regulatory framework and broader provider obligations, please refer to the [For providers](#) page of our website.

1.3 The role of the Commission

The Commission is the national regulator of funded aged care services. The Commission's primary purpose is to uphold rights, and protect and enhance the safety, health, wellbeing and quality of life of older people in Australia receiving funded aged care services.

The Commission also gives older people in Australia and their families a single point of contact to make a complaint or give feedback. A complaint can be about a registered provider, responsible person or aged care worker complying with the Aged Care Act, or about a registered provider acting in a way that is incompatible with the Statement of Rights (s358 of the Aged Care Act). A range of functions and powers available under the Aged Care Act and the Aged Care Rules enable the Commission to protect and enhance the safety, health wellbeing and quality of life of older people accessing funded aged care services, including by managing sector-wide risks and issues.

The functions and powers the Commission applies include:

- building the confidence and trust of older people in the delivery of funded aged care, including by promoting continuous improvement towards high quality care

- ensuring registered providers, responsible persons, aged care workers and operators of aged care digital platforms comply with their obligations under the Aged Care Act, including by using the Commission's information-gathering, compliance and enforcement powers
- educating the aged care sector on the rights of older people under the Statement of Rights, the role of the Commission, and the obligations that apply to registered providers, responsible persons, aged care workers and operators of aged care digital platforms
- promoting a culture for registered providers, responsible persons, and aged care workers of open disclosure and best-practice handling and resolution of complaints and feedback, including by building the capability of older people to engage in the complaints process.

For more information about the Commission, please refer to the [About us](#) page of our website.

2 Key terms and concepts

2.1 What is an incident?

Incidents (as indicated at s 164-10(1) of the Rules) consist of acts, omissions, events or circumstances:

- that occur, or are alleged to have occurred, or are suspected of having occurred in connection with the delivery of funded aged care services to an individual by a registered provider; and
- either:
 - have caused harm to the individual or another person; or
 - could reasonably have been expected to have caused harm to an individual or another person

Under s164 of the Aged Care Act, incident management obligations apply to registered providers of a kind prescribed by the Rules, being providers in registration categories 1, 3, 4, 5 and 6. If you are in one of these categories, any incident meeting this definition triggers your incident management obligations. Separately, providers in all registration categories (including category 2) must notify reportable incidents, a subset of incidents, to the Commission via the Serious Incident Response Scheme (SIRS). For more information about reportable incidents and the SIRS, please refer to the [SIRS Provider resources page](#) on the Commission's website, including the 'Reportable incidents and SIRS provider guidelines'.

2.2 'In connection with the delivery of' funded aged care services

2.2.1 In residential care home settings

For providers delivering funded aged care services in a residential care home, the phrase 'in connection with the delivery of' aged care services in the context of an 'incident' is intended to be broad.

Arising out of the 24 hour/7 day responsibility for care services in those settings, it covers incidents occurring while the care services are being provided to an older person in the residential care setting, and incidents when the older person is outside the care home under supervision of one or more workers (e.g. when on a social outing or to attend a specialist appointment). When you as a provider become aware of such an incident, your incident management obligations commence.

However, the phrase does not apply to incidents that occur when an older person is on leave from the residential care home, for example because they are in hospital or are visiting family without worker supervision.

This is different from an older person leaving the residential care home without the provider's knowledge. An unexplained absence from the residential care home, where there are reasonable grounds to report the absence to police, is a reportable incident. See the 'Reportable incidents and SIRS provider guidelines'.

If you as a provider or your residential care home workers become aware of incidents occurring while the older person is away from the residential care home (not in connection with your delivery of care services), these do not trigger incident management obligations under the Aged Care Act or the Aged Care Rules. However, you are still expected to act in the best interests of the older person to protect their wellbeing. Some actions you may take upon becoming aware of such incidents could be amending the older person's risk assessments, reporting matters to police or others as required, and if harm had been caused managing and resolving the incident via your incident management system.

2.2.2 In home and community settings

For providers in **home and community settings**, the phrase 'in connection with the delivery of care services in the context of an 'incident' is more limited, referring to the relationship or association between an incident and the provider.

It covers incidents that occur during times while care services are being provided, or that arise out of a failure to provide those services. It also includes incidents that may not have occurred while the care services were being provided, but occurred later because harm (or potential harm) arose from the delivery (or non-delivery) of services. Your incident management obligations commence when you as a provider (including through your workers) first become aware of such an incident.

For example, a worker providing domestic assistance leaves the kitchen floor slightly wet after hand washing dishes, which later results in a slip causing the older person injury. The injury/incident has occurred at a time care services were not being delivered but arose from the poor quality of the care service provided, and once you become aware the incident should be managed and resolved through your incident management system.

If you as provider or your workers in home and community settings become aware of incidents not in connection with the delivery of care services, these do not trigger incident management obligations under the Aged Care Act or the Aged Care Rules. For example, a worker may notice small injuries the older person sustained at home or during the hours they do not receive care services or worrying aspects about the older person's family or domestic dynamics. In such circumstances they are still expected to act in the best interests of the older person to protect their wellbeing.

If you or your workers become aware of harm to an older person that is not connected to the delivery of your services, this does not trigger incident management obligations. Examples include injuries the older person appears to have sustained outside service hours, or concerns about their family, supporters or home situation. Before reaching that view, consider whether the harm may be connected to the delivery (or non-delivery) of your services, such as a fall involving equipment you installed or following a missed visit. Workers may also have separate reporting obligations under their professional registration or state or territory laws. In all cases, you are still expected to act in the best interests of the older person to protect their wellbeing.

If the person is in immediate danger or there is an urgent threat to their safety, it is appropriate to call 000.

If there is no immediate danger, consider whether the older person is aware of, and able to access, services that may be able to support them.

Providers can play an important role in helping people connect with support and advice, drawing on their understanding of the person's circumstances. It is not uncommon for people experiencing abuse to seek advice from trusted sources such as friends, family members, health professionals or their GP. Other support options may include:

- 1800 ELDERHelp (1800 353 374), which can provide information and referrals to local support services.
- Older Persons Advocacy Network (OPAN), which provides advocacy and support for older people – <https://opan.org.au>.
- 1800RESPECT (1800 737 732), which is available 24 hours a day, 7 days a week for confidential advice and support relating to domestic, family and sexual violence.

If the older person is reluctant or unable to seek assistance themselves, providers may still wish to contact these services to discuss their observations and seek guidance on how best to support the person. For example, is it possible to adjust care arrangements in a way that helps maintain the person's privacy and enables connection to support services.

2.3 'Could reasonably have been expected to cause harm'

2.3.1 'Could reasonably have been expected to have caused harm'

The concept of 'harm' in the definition of incidents is broad, and involves injury, illness or danger to an older person's health. It is not limited to serious harm or injury or only to physical harm – it also includes emotional and psychological harm.

The phrase 'could reasonably have been expected to have caused harm' in the context of an 'incident' applies when acts, omissions, events or circumstances do not result in harm (such as injury, illness or danger to health) to an older person or another person in that specific instance – but had potential to, and would ordinarily do so.

For example, when:

- an older person is walking in a common area of a residential care home and slips on a wet floor but luckily grabs hold of a nearby cupboard and doesn't suffer any injury
- an older person with a significant cognitive impairment residing in the memory support unit leaves the residential care home and is found hours later crossing busy roads with reports of several near misses
- there is poor lighting that results in a worker tripping and almost falling over an undetected extension cord.

Ordinarily, harm could reasonably have been expected to have been caused in these circumstances. For example, where an older person slips but manages to catch themselves before falling, harm may not have occurred. However, if a reasonable person would expect the circumstances to result in injury or harm had the person not been able to regain their balance, the incident may still meet this threshold.

These incidents meet the definition of an incident and should be managed and resolved through your incident management system.

The phrase also includes circumstances where an incident involves conduct that is not acceptable and would ordinarily cause harm, even if it did not cause observable harm in that particular instance. For example:

- an older person is yelled at or threatened by another older person but does not display distress because their level of cognitive functioning prevents them from recognising or understanding what occurred. A reasonable person would ordinarily expect this conduct to cause harm.
- a worker takes photographs of an older person while they are showering and shares those photographs with other workers. A reasonable person would ordinarily expect this conduct to cause harm, even if the older person was unaware of the conduct or unable to communicate its impact.

In both examples, harm could reasonably have been expected to have been caused. These incidents meet the definition of an incident and should be managed and resolved through your incident management system.

Providers are responsible for assessing whether the threshold is met, having regard to the older person's individual vulnerabilities, needs and circumstances, and the nature of the conduct or event.

Providers should consider whether a reasonable person, with knowledge of the older person's circumstances, would expect the incident to cause harm.

2.3.2 'Consequence of harm'

When recording a description of an incident, providers are also required to include (if known) the consequences of harm caused (or that could reasonably have been expected to have been caused) to each affected person.

In an initial assessment of an incident, a provider should therefore turn its mind to the immediate and long-term consequences ranging across physical, emotional, and psychological impacts.

Financial impacts and cumulative harm arising from repeated incidents can also have consequences that should be considered.

Considering the consequences of harm should inform a provider's plan of actions to:

- respond to
- manage, and
- resolve; and
- prevent reoccurrence

2.3.3 Near misses

While not a legislative term, often these incidents that could reasonably have been expected to have caused harm are informally referred to as 'near misses'.

Near misses in connection with the delivery of care services trigger your incident management obligations and should be captured by – and managed and resolved through – your incident management system. You may see some references to “incidents (and near misses)” throughout this guidance and other resources produced by the Commission, but remember that near misses are considered incidents wherever the term “incidents” alone is used.

You should consider the effect the near miss could reasonably have been expected to have had on an older person, and as a result what steps you could put in place to reduce the risk of future harm. You should support your workers to recognise and report near misses, and to be part of the learning and quality improvements that come out of incidents including near misses.

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.

Case study: Near miss

While visiting his father in a residential care home, an older person's son noticed the packaging colour of the insulin medication that 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 older person.

Even though no harm was caused on this occasion, the Registered Nurse recognised that this event was a near miss that could reasonably have been expected to have caused harm, if the older person's father not been present and observant (or hadn't spoken up). They recorded this incident (near miss) in the provider's incident management system to enable assessment, investigation and/or further analysis. Systemic changes to improve practice and to prevent a similar event from happening in future were implemented and discussed with the older person and his family or supporters.

2.4 Other terms

For an explanation of other significant terms found in this guidance, please refer to the Commission's [Glossary](#).

3 Incident management, systems and benefits

3.1 What are the principles of effective incident management?

The following principles are building blocks that form the foundation for effective incident management which are guided by the Statement of Rights and of principles under the Aged Care Act.

Person-centred

Your approach to managing incidents and near misses should be based on an older person's dignity and choice. In managing incidents and near misses, you must be respectful of, and responsive to, each older person's individual identity, needs and preferences while supporting their safety and wellbeing through trauma aware and healing informed care. Older people (and their representatives) should be actively engaged in the resolution of incidents and any remedial actions put in place to prevent incidents from recurring.

Outcomes-focused

Your approach to managing incidents should focus on the health, safety and wellbeing of older people, workers 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. Incidents should be managed with a focus on restoring the older persons trust, demonstrating the actions being taken to prevent recurrence, so it doesn't happen to someone else.

Open disclosure

You should use open disclosure when care services do not go to plan or when things go wrong.

Open disclosure is an open and transparent process that supports honest communication with older people, and where appropriate their supporters.

Open disclosure requires providers to:

- recognise and respond promptly when things go wrong
- address immediate needs
- acknowledge what has occurred and apologise or express regret
- find out and explain what happened
- partner with older people and their supporters throughout the process
- learn from the experience and make improvements to reduce the risk of recurrence.
- A provider using open disclosure in the transparent resolution of an incident promotes and fosters an environment and culture of learning and continuous improvement of care services in partnership with older people and their supporters.

For more information, please refer to [Open disclosure – rebuilding trust after something goes wrong](#) on the Commission website.

Accountable

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. Your approach should support a positive safety culture that encourages reporting, transparency, learning and continuous improvement, so incidents and near misses can be effectively addressed and prevented from recurring.

For more information, please refer to [Building a safety culture](#) on the Commission website.

Clear, simple and consistent

Your incident management system policies and procedures should be easy for older people and workers 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 services you provide.

Collecting incident-related data enables you to identify and address systemic issues in the quality of care provided, and provide feedback and training to workers about managing and preventing incidents (for example, building worker capability through awareness raising and education activities).

Regularly analysing and reviewing incident-related data to enable you to assess the effectiveness of your management and prevention of incidents, and what (if any) actions could be taken to improve your management and prevention of incidents. Analysis of incident-related data should inform reporting to relevant governance and advisory bodies, helping to identify systemic issues, monitor the effectiveness of improvement initiatives.

Tip: Engage with older people

Requirements to communicate with older people and their families and representatives about incidents (including while when managing resolving them) are an opportunity to engage with older people about how incident management systems support safe, quality care. Welcoming older person interest, questions and reporting of incidents and near misses also strengthens your system by enhancing the focus on older people and expanding the potential for learning and continuous improvement.

3.2 What is an incident management system?

An incident management system must 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.

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 services to older people.

In aged care, the use of an incident management system applies to all incidents that are known, suspected or alleged to have occurred in connection with the delivery of care services.,

Under the Aged Care Rules, your incident management system must:

- include procedures for managing incidents, improving how you manage and resolve them, and taking reasonable steps to prevent them

- be able to identify, record, assess, respond to and report on incidents
- specify the roles and responsibilities of your workers and responsible persons, including for escalating incidents and notifying reportable incidents to the Commission
- require appropriate support and assistance for people affected by an incident, including access to advocates and language services
- be documented, and those documents be available to workers, responsible persons, older people and their supporters, with help to understand how the system works
- be supported by training for workers and responsible persons.

As a matter of best practice, your incident management system should also:

- support you to understand risk and prevent incidents from occurring
- focus on the health, safety, wellbeing and quality of life of older people and anyone affected by an incident
- have policies and procedures developed in consultation with older people and workers
- include strong and open communication with older people, their supporters and advocates about how the system operates
- support effective governance and accountability so the system keeps driving continuous improvement.

The system and its procedures should be easily understood by all who need to use them, and must support your 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 as 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.

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

For more information about reportable incidents and the SIRS, please refer to the [SIRS Provider resources page](#) on the Commission's website, including the 'Reportable incidents and SIRS provider guidelines'.

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 provider size, location/s, type of services provided, and for the older people receiving care services.

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 workers to provide real time reporting of incidents.

3.3 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 services for older people

- It gives you the tools to prevent incidents from occurring, which is the best way to keep older people and others safe.
- Effective incident management also helps you to continuously improve your delivery of care services.

Supports you to understand and engage with risk, including to meet the needs and preferences of older people

- 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 older people (and their supporters or other providers as appropriate) to find ways to reduce risks whilst supporting the older person's independence and choices, including to take some risks in life.

Empowers older people (and their supporters) and gives them confidence in the care 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 older people and their representatives will help to foster trust and build confidence in your ability to provide the care services that older people need. Critical to this are open discussions with older people and their supporters about your approach to incident management and your commitment to learning from incidents and near misses, and continuously improving.
- By involving older people and their supporters in identifying risks and developing strategies to mitigate risks and prevent harm, you also empower older people 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 older people to report errors or near misses without fear of reprimand. It encourages workers to report incidents and to learn from them. It also supports workers, older people 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 older people, and equip you to more easily identify deterioration or change in an older person's mental health, cognitive or physical function or capacity. For example, if an older person has a fall, this may indicate decline in their physical function; if an older person shouts at another older person, this may indicate a change in their mental health and wellbeing or cognitive capacity.

Helps you to retain and develop workers

- Effective incident management enables workers to feel confident in their practice, knowing that when they make mistakes, have near misses or incidents occur, they will be supported by your organisation to understand and learn from those incidents and near misses, to improve care delivery.
- An incident management system empowers workers 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 workers 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
- workers knowledge or skill gaps
- deficiencies in policies and practices
- limitations in care planning and assessment
- problems with the care service environment or equipment.

Supports you to meet your broader obligations as an aged care provider.

Please refer to [4.3 Other obligations and requirements](#) below.

4 Expectations and requirements

4.1 Requirements relating to incident management under the Aged Care Act

There are a series of direct incident management obligations under the Aged Care Act and the Aged Care Rules and a further series of requirements that relate to how providers, responsible persons and aged care workers respond to incidents while providing aged care services. This includes a specific set of duties for registered providers and responsible persons and responsibilities under the Aged Care Code of Conduct. Additionally, there are requirements for Digital platform operators.

4.1.1 Incident management obligations

Incident management obligations under the Aged Care Act apply to registered providers.

As above, under s 164 of the Aged Care Act **providers** in registration categories 1, 3, 4, 5, and 6 must:

- implement and maintain an incident management system
- manage and take reasonable steps to prevent incidents, and
- not victimise or discriminate against anyone for reporting an incident.

4.1.2 Duties for registered providers and responsible persons

Under s 179 of the Aged Care Act, **registered providers** must ensure, so far as is reasonably practicable, that the conduct of the provider does not cause adverse effects to the safety, health and wellbeing of older people while delivering funded aged care services.

Reasonably practicable means taking the actions that are reasonably able to be done at the time to prevent or minimise an adverse effect, after carefully considering all relevant circumstances. This includes assessing how likely the adverse effect is to occur, the potential severity of any harm, what is known or should reasonably be known about effective control measures, whether those measures are available and suitable, and the rights of older people under the Statement of Rights.

Under s 180 of the Aged Care Act, **responsible persons** must take reasonable steps to ensure that the provider has appropriate processes for:

- receiving and considering information about incidents and risks, and
- responding to that information in a timely way.

Civil penalties may apply where registered providers and/or responsible persons are found to have breached their duties.

4.1.3 Requirements under the Code of conduct

Under ss145, 173 and 174 of the Aged Care Act, registered providers, aged care workers and responsible persons must comply with the Aged Care Code of Conduct, set out in Part 5 of Chapter 1 of the Rules. Registered providers must also take reasonable steps to ensure their aged care workers and responsible persons comply with the Aged Care Code of Conduct. The Aged Care Code of Conduct describes the behaviours and practices expected while delivering aged care services.

4.1.4 Requirements for Digital platform operators

Under s 189 of the Aged Care Act, **operators of aged care digital platforms** also have several incident management obligations. These include:

- implementing an incident management system to manage incidents
- display on the platform summary an explanation of the incident management system
- prescribed reporting requirements to the Commissioner about incidents reported, managed or referred through the incident management system

4.2 Incident management requirements under the Rules

These obligations under the Aged Care Act are further detailed as requirements under the Rules as follows:

- Managing incidents
- Improving and taking reasonable steps to prevent incidents
- Operating an incident management system
- Recording incident details
- Collecting and analysing data
- Making incident management system information available to workers and older people
- Complying with the Aged Care Quality Standards.

4.2.1 Managing incidents

Under s 164-40 of the Rules, providers must manage incidents through their incident management system by:

- assessing and providing required support and assistance to ensure safety, health, well-being and quality of life of people affected by the incident

- assessing how best to involve each person affected by the incident (or their supporter or advocate) in the management and resolution of the incident
- ensuring each person is involved in managing and resolving the incident in that way, and
- using an open disclosure process.

Providers must notify a police officer within 24 hours of becoming aware of the incident, if there are reasonable grounds to do so.

If a provider becomes aware of reasonable grounds later during their management and resolution of the incident, they must notify a police officer within 24 hours of becoming aware of those reasonable grounds.

For more information about reporting to police, please refer to [5.4.1 Reporting incidents](#).

4.2.2 Improving and taking reasonable steps to prevent incidents

Under s164-45 of the Rules, you must use your incident management system, taking into account the views of people affected by the incident, to assess:

- whether the incident could have been prevented
- what remedial action you need to take to prevent further similar incidents from occurring, or to minimise their harm
- how well the incident was managed and resolved
- what actions you could take to improve your management and resolution of similar incidents, and
- whether other persons or bodies should be notified of the incident.

You must then:

- notify any persons or bodies you identified
- take the remedial actions you identified to prevent further similar incidents or minimise their harm, and
- take the actions you identified to improve your management and resolution of similar incidents, including addressing any systemic issues in the quality of your care services.

4.2.3 Operating an incident management system

Under s164-20 of the Rules, your incident management system must include procedures for how you will:

- manage incidents
- improve your management and resolution of similar incidents, and
- take reasonable steps to prevent incidents.

Your incident management system must be able to identify, record, assess, respond to and report on incidents, and must set out procedures for each of these.

Your incident management system must require that appropriate support and assistance is given to people affected by an incident to ensure their safety, health, wellbeing and quality of life. This includes access to advocates and language services.

Your incident management system must also specify:

- how people affected by an incident will be appropriately involved in its management and resolution
- the roles and responsibilities of your aged care workers and responsible persons in managing and responding to incidents
- the roles, responsibilities, processes and timeframes for your workers and responsible persons to escalate incidents and notify reportable incidents to the Commission
- when you will investigate an incident to establish its causes, the harm caused, and any operational issues that may have contributed to it, and the nature of those investigations, and
- when remedial action is required, and the nature of that action.

4.2.4 Recording incident details

Under s 164-25 of the Rules, a provider's incident management system must record these details of each incident:

- a description of the incident, including:
 - harm that was caused, or could have been reasonably expected to have been caused, to each person affected
 - consequences of that harm if known
- whether the incident is a reportable incident
- the time, date and place at which the incident occurred, or was alleged or suspected to have occurred, if known
- the time and date the incident was identified
- the names and contact details of people directly involved in the incident
- the names and contact details of any witnesses to the incident
- details of assessments by the provider of the support and assistance required by people affected by the incident
- details of assessments by the provider, including the views of people affected by the incident, about:
 - whether the incident could be prevented
 - how well the incident was managed and resolved
 - any required remedial actions, improvement actions, preventative actions or notifications that need to be made
- actions taken in response to the incident, including support and assistance given, as well as remedial, improvement, prevention and notification actions
- any consultations undertaken with people affected by the incident

- whether people affected by the incident have been provided with reports or findings about the incident
- the details and outcomes of any investigation undertaken by the provider about the incident
- the name and contact details of the person recording details of the incident in the provider's incident management system, and
- the details included in the report to police, if a report was made about the incident.

A provider's incident management system may contain more than the above details for each incident.

Under s 154-150 of the Rules, details recorded in a provider's incident management system about an incident must be retained for 7 years starting on the day the record is made or received

4.2.5 Collecting and analysing data

Under s164-30 of the Rules, you must collect data through your incident management system that enables you to:

- identify similar incidents, including alleged or suspected incidents
- identify and address systemic issues in the quality of the funded aged care services you deliver
- give feedback and training to your workers and responsible persons about managing and preventing incidents
- give information to the Commissioner, if required or requested
- give information to your quality care advisory body and consumer advisory bodies (if any) to help them prepare reports or feedback about the quality of your funded aged care services, and
- continuously improve your management and prevention of incidents.

You must regularly analyse and review this data to assess:

- how effectively you are managing and preventing incidents, and
- what actions you could take to improve this.

4.2.6 Making incident management system information available

Under s164-35 of the Rules, you must prepare and keep up to date documents detailing your incident management system, including roles and responsibilities. You must make these documents available to:

- your workers and responsible persons, and
- the Commissioner, if required or requested.

You must also make these documents available in an accessible form to the older people you deliver care services to, their supporters, family members, carers and advocates, and any other

person significant to the older person. You must help these people understand how your incident management system works.

You must:

- ensure your workers and responsible persons are aware of and understand their roles and responsibilities under your incident management system
- train your workers and responsible persons on how your incident management system works, including how to recognise, respond to and report incidents, and on their roles and responsibilities
- require your workers and responsible persons to comply with your incident management system
- give this training at least annually, and when:
 - a person becomes a worker or responsible person
 - there is a change to how your incident management system works, or
 - there is a change to a person's role that affects their incident management system roles and responsibilities.

4.2.7 Complying with the Aged Care Standards

Under s 15-15 of the Rules, providers in registration categories 4, 5 and 6 must meet Aged Care Quality Standard 2, Outcome 2.5, which requires a provider to use an incident management system to:

- safeguard individuals (i.e. older people), and
- acknowledge, respond to, effectively manage and learn from incidents.

Additionally, providers may demonstrate compliance with this outcome of Quality Standard 2 by:

1. Implement an incident management system to record, investigate, respond to and manage incidents and near misses that occur in connection with the delivery of funded aged care services and reduces or prevents incidents from recurring.
2. Takes timely action to respond to and manage incidents.
3. Support older people and their supporters to report incidents and encourages their involvement in identifying ways to reduce incidents from occurring.
4. Support the workforce including through provision of tools, training and clear policies to prevent, recognise, respond to and report incidents.
5. Collect and analyse incident data and reports to the relevant regulator as required. All outcomes are reported to older people and aged care workers and feed into the provider's quality system to improve the quality of funded aged care services.
6. Regularly review and improve the effectiveness of your incident management system and communicates changes to aged care workers and older people.

4.3 Other obligations and requirements

Registered providers operate in the context of the aged care regulatory framework, to ensure that older people have the right to safe and quality care services that support their health and wellbeing and promote their quality of life.

Obligations and requirements about incident management are one element of an integrated framework, and complement and support other expectations to support providers to engage in risk management and continuous improvement activities around their delivery of funded aged care services.

4.3.1 The Statement of Rights

The Aged Care Act includes a Statement of Rights, outlining the rights that older people have when accessing aged care services.

It promotes quality and safe care for older persons accessing, or seeking to access, funded aged care services. It is also a reference for providers and workers so they can take steps to act in a way that promotes older people's rights when delivering care.

Under s144(1) of the Aged Care Act, it is a condition of registration that registered providers of a kind prescribed by the Rules must:

- demonstrate that they understand the rights of older people under the Statement of Rights, and
- have practices in place to ensure they act compatibly with the Statement of Rights, in accordance with s24(2) of the Aged Care Act.

Section 24(2) sets out Parliament's intention that registered providers take all reasonable and proportionate steps to act compatibly with the Statement of Rights when delivering funded aged care services. It also recognises that limits on rights may be necessary to balance:

- competing or conflicting rights
- the rights and freedoms of other people, including aged care workers and other older people accessing funded aged care services
- compliance with other Commonwealth, state or territory laws, including the *Work Health and Safety Act 2011*.

If an older person believes a provider is acting in a way that is incompatible with the Statement of Rights, they can make a complaint to the Complaints Commissioner (s358 of the Aged Care Act).

4.3.2 The Aged Care Code of Conduct

The Aged Care Code of Conduct describes how registered providers (providers), their responsible persons (for example, board members and Chief Executive Officers), and aged care workers (including volunteers) must behave and treat people accessing funded aged care services.

Providers must act in a way that's respectful, kind and consistent with the Code. You must also support, equip and prepare your workers and responsible persons to comply with the Code.

Providers must take reasonable steps to make sure all workers (including volunteers) and responsible persons you employ or otherwise engage, comply with the Code. This includes those workers employed or otherwise engaged (including as a volunteer) by an associated provider of the registered provider or engaged by the registered provider via an employment service.

Under s 14-5(f) of the Rules registered providers, aged care workers and responsible persons must promptly take steps to raise and act on concerns about matters that may impact the quality and safety of funded aged care services, which includes ensuring incidents are identified and responded to in accordance with incident management responsibilities.

For more information, please refer to the [Aged Care Code of Conduct](#) page on the Commission's website.

4.3.3 The Aged Care Quality Standards

Aged Care Quality Standard 2 Outcome 2.5 and its actions regarding incident management are just one aspect of the Standards, which are designed to make sure that older people receive quality care that is safe, meets their needs and preferences, and upholds their rights.

These outcomes (including for incident management) are just one aspect of the 7 Standards. The structure of each Standard includes:

- Intent – which describes the intended overall purpose of the Standard.
- Expectation statement – which describes what the older person can expect from their aged care provider related to that Standard.
- Outcomes – which describe what providers will be assessed against.

Actions – which describe what providers can do to meet the outcome.

For more information, please refer to the [Standards](#) page on the Commission's website.

4.3.4 Reportable incidents and the Serious Incident Response Scheme (SIRS)

The Serious Incident Response Scheme (SIRS) was introduced with the aim of reducing the risk of abuse and neglect of older Australians receiving aged care services.

During 2021 and 2022 the SIRS established responsibilities for all funded providers of aged care to:

- prevent and manage incidents, focusing on the safety, health and wellbeing of older people
- use incident data to drive quality improvement
- notify reportable incidents to the Commission.

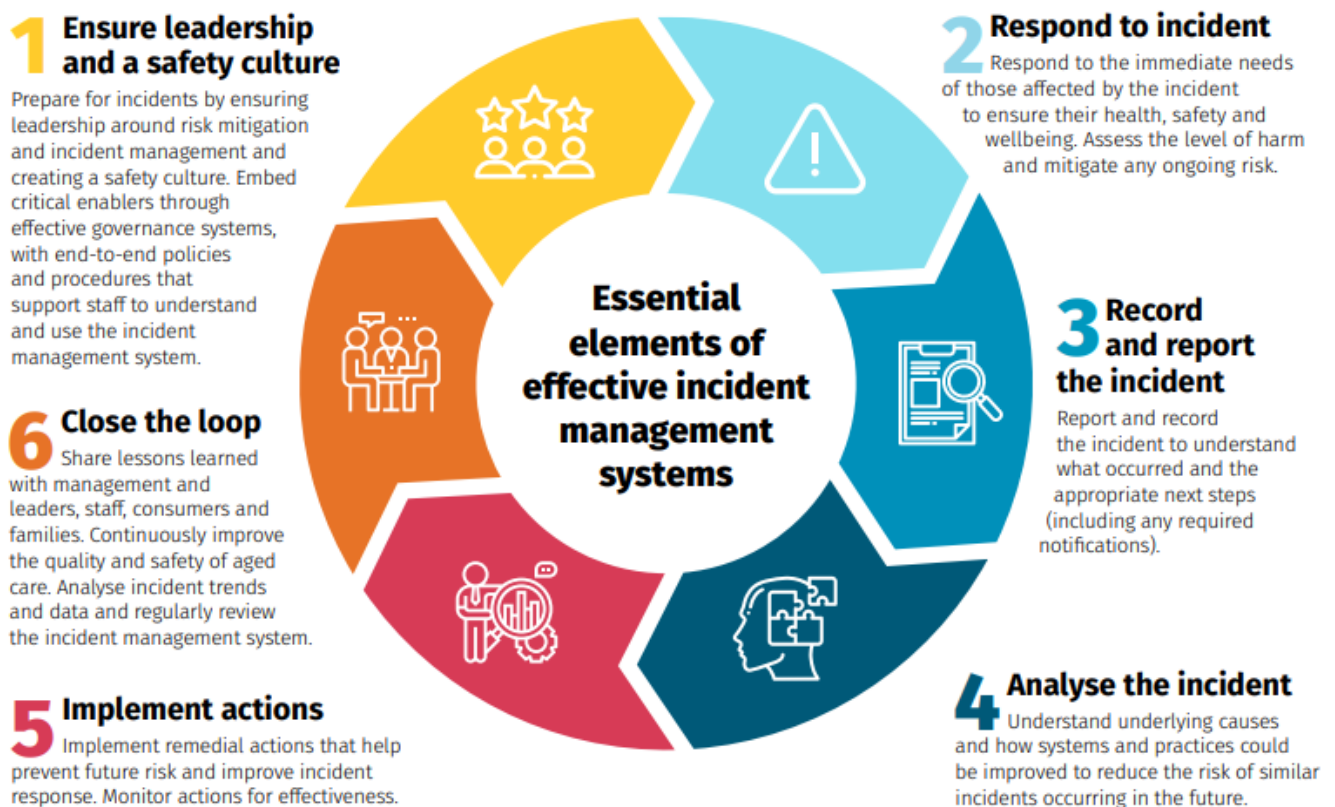
Under the Aged Care Act and the Aged Care Rules registered providers of aged care services continue to have obligations and responsibilities to notify a subset of all incidents ('reportable incidents') to the Commission, via the SIRS.

For more information about reportable incidents and the SIRS, please refer to the [SIRS Provider resources page](#) on the Commission's website, including the 'Reportable incidents and SIRS provider guidelines'.

5 Key elements of an incident management system

5.1 Effective incident management systems

An incident management system is more than 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 **governance** framework
- should include **comprehensive policies and procedures** relating to incidents and near misses
- should include a mechanism that enables information about incidents to be easily **recorded, safely and securely stored and easily accessed**
- must be **well understood and utilised** by workers, as well as older people receiving care services and their families and supporters
- 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 care services safer
- support you to **continuously improve, share learnings and analyse trends**
- should regularly be **reviewed**.

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

5.2 Ensuring 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 workers to understand and use your incident management system.

5.2.1 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 your organisation.

This starts with the board or relevant governing body and must flow through the chief executive officer (CEO) or similar role and the entire leadership team.

Older people receiving care services, their families and supporters, and your workers need to be able to see that you are committed to incident management.

A culture of safe, inclusive and quality care service delivery

The delivery of high quality care services requires you to build and maintain a culture that values and focuses on safety and inclusion.

This includes a culture that:

- places older people receiving care services at the centre of their care
- supports openness, honesty, fairness and accountability
- requires and encourages the reporting of incidents and near misses
- supports workers 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 needs to encompass the attitudes, understandings and behaviours of workers, and be consistently fostered over time and by example at all levels of your organisation.

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

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

Tips for fostering cultural change

- Look for ways to promote a culture in which your organisation learns from its mistakes.
- Consider any cultural barriers that workers, older people receiving care services or their families and supporters may have for reporting and adapt your communications and training to address these barriers.
- Discuss the benefits of effective incident management and prevention with workers, older people receiving care services and their families and supporters.
- Ensure that the board routine reviews your 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, or with 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 their 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?

5.2.2 Effective organisation-wide governance

Organisation-wide governance is about how your 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 of management team and throughout your organisation.

Each of these elements of an effective organisation-wide governance system is critical for supporting effective incident management and prevention. For example:

Information Management

Effective information systems and processes enable your workers to get information that helps them in their roles. This includes information specific for each role and how they can prevent and manage incidents, as well as information to support your incident management and continuous learning generally.

Continuous improvement

Continuous improvement systems and processes support organisations to assess, monitor and improve the quality and safety of the care services provided across your service locations. 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 your organisation needs to deliver safe and quality care services. Organisations are expected to ensure that any actions needed to be taken to reduce the risk of recurrence following the investigation of an incident (or analysis of incident and near miss trends) are accommodated in financial planning.

Workforce governance

All providers are required to ensure responsibility and accountabilities within your organisation are clear. This includes responsibilities relating to incident identification, reporting, analysis and remedial action.

Regulatory compliance

Regulatory compliances systems and processes ensure your 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 your organisation's feedback and complaints. Often incidents and near misses are identified and reported by older people receiving care services or their families and supporters, which may mean it is first recorded through your feedback and complaints system and processes, and must subsequently be captured by your incident management system for response and next steps.

5.2.3 Establishing comprehensive policies and procedures

As part of your incident management system, you must establish and maintain 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 older people receiving care services, their families and supporters (and any other people significant to the older person), and your workers. It is your responsibility to support people to understand how your incident management system operates.

Your policies and procedures should include and describe matters such as:

Roles and responsibilities

- Roles and responsibilities of workers in identifying, managing, resolving and preventing incidents and near misses
- The role of each worker in complying with your incident management system
- Requirements of training for each worker in the use of and compliance with your incident management system, noting that training needs will differ according to their individual roles (including any barriers for that role recognising and reporting incidents or near misses)
- Roles and responsibilities of your workers and responsible persons for notifying reportable incidents to the Commission

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 used in your organisation for recording this information
- How incidents and near misses should be reported and escalated internally, including:
 - identifying to whom incidents and near misses are to be reported or escalated
 - timeframes for internally reporting or escalating incidents and near misses

When others should be notified of incidents

- When and how to notify family or supporters of older people receiving care services, or other representatives and emergency contacts
- When police or emergency services should be notified
- When government bodies including the Commission, the Australian Health Practitioner Regulation Agency (Ahpra), or state and territory health departments should be notified (or the NDIS Quality and Safeguards Commission where incidents relate to NDIS participants)

How you will provide support and assistance to those effected 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 family or supporters) in the management and resolution of an incident
- The use of open disclosure processes when things go wrong
- How to provide older people receiving care services and their family or supporters 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 process for undertaking an investigation

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 worker
 - there is an ongoing risk to older people receiving care services, your workers or others
 - an 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 your organisational/clinical governance
 - individual and/or service-wide worker training
 - educating older people receiving care services and/or visitors
 - changes to the care service environment or equipment
 - changes to the care services provided to older people

5.2.4 Supporting and educating workers to understand and use your system

Ensuring workers at all levels of your organisation understand your incident management system is critical. Your workers 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 workers are consistently and appropriately trained in the requirements and use of the system.

Your incident management system will not be effective if your workers and responsible persons:

- 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 services.

You need to ensure that your workers who provide care services, your responsible persons and other relevant workers, 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 those for 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
- are constantly reminded about the importance of identifying, recording, responding to reporting incidents and near misses.

It is your responsibility to ensure workers and responsible persons are appropriately trained and supported to identify, record, prevent and manage incidents in line with your incident management system. Reinforce that incident management is not just about reporting but about responding to incidents (supporting older people) and learning from incidents to reduce risk. Encourage workers at all levels to be involved in the analysis of incidents and in identifying ways to improve your care services.

5.2.5 Encouraging older people and their supporters to report incidents

Encouraging older people receiving care services, their family or supporters to actively report incidents and near misses creates an open and transparent environment in which they feel safe to make a report.

This is particularly true where older people or their supporters may fear the consequences of making a report or worry that the incident will reflect badly on a worker who they like and who provides them with good care services.

Engaging to communicate the benefits of an effective incident management system to older people receiving care services and to explain how they or their supporters can make reports, and be involved in solutions and improvements is critical to encouraging an active information sharing and reporting culture.

5.3 Responding to incidents

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.

5.3.1 Identifying incidents

Incidents (and near misses) may be identified in several ways, including where a worker or another older person receiving care services observes the incident, an older person makes a disclosure about the incident, or another person informs a worker that an incident occurred (or is alleged or suspected to have occurred).

An incident management system should outline your expectations for workers who identify that an incident has (or may have) occurred. Some incidents may be simple to identify, for example, where a worker witnesses an incident, or an older person notifies a worker 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 workers are trained and equipped to identify and report incidents and near misses when they occur.

Older people may disclose information to workers regarding an incident that has occurred to them, an incident they were involved in, an incident they were told about by another older person or worker 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.

Older people 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 an older person with cognitive impairment continues to report incidents that (following investigation) you find did not occur, you should still provide appropriate support to the affected older person and record these in your incident management system.

Some older people may be uncomfortable or concerned about reporting for fear of the subject of allegation finding out, of being hurt or having care services taken from them. All workers 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 'Reportable incidents and SIRS provider guidelines' available via the [SIRS Provider resources page](#) on the Commission's website.*

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 potential abuse.

Workers and responsible persons 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 an older person. Examples of these behaviours may include repeated flicking or poking, regular name calling or several occasions of speaking to an older person (or more than one older person) in an abrupt or brusque manner.

5.3.2 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 the following types of responses:

Taking immediate actions following an incident to ensure the health, safety and wellbeing of those involved in an incidentExamples:

- Checking on those affected to ensure their health, safety and wellbeing
- 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 incidentExamples:

- Notifying an older person's representatives about an incident as soon as practicable after it occurred (or was first notified to a worker)
- 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
- Checking in and providing ongoing updates to those affected by an incident, including about the reason for/cause of the incident and what is being done to address it, as well as 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

Examples:

- Engaging with older people and others who witnessed an incident to provide support and reassurance
- Providing updates to those who could be affected by an incident about 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

Further action that must be taken where the incident is (or may be) a reportable incident

Examples:

- Notifying relevant authorities, for example the Commission, police, the coroner or Ahpra
- Undertaking internal investigations to determine the cause of an incident and the events that led to an incident occurring

5.4 Reporting and recording incidents (including notifications)

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

5.4.1 Reporting incidents

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

Internal reporting of incidents 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 worker(s) assigned to receive incident reports in your organisation 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.

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

People receiving care services

You should start speaking with the older person and their supporters as soon as possible about the incident or near miss. Disclosure is an ongoing process in which multiple conversations may occur over time. Often practical support is needed, and people affected by the incident should be provided with appropriate contacts 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 older people, their families and supporters and your workers in healing and in restoring trusting relationships. For more information, please refer to [Open disclosure – rebuilding trust after something goes wrong](#) on the Commission’s website

Reporting to police

Reasonable grounds to report an incident to police include where a provider is aware of facts or circumstances (known or alleged) that lead you to believe or suspect that:

- the incident is likely to be criminal in nature, or
- unlawful activity has occurred (or is suspected).

Where there are reasonable grounds to report an incident to police, you must contact police and any other relevant emergency services. Police should be notified within 24 hours of becoming aware of the incident, or of becoming aware of the reasonable grounds that mean the incident should be reported to police. Some states and territories will also require you to contact the police if a death (including an unexpected death) has occurred.

Notifying the Commission

If the incident is a ‘reportable incident’ under the Aged Care Act and the Aged Care Rules, you must notify the Commission via the SIRS within the relevant timeframes. Priority 1 reportable incidents must be notified to the Commission within 24 hours of you (the provider) becoming aware of the incident. Priority 2 reportable incidents must be notified to the Commission within 30 days of becoming aware of the incident.

For more information about reportable incidents and the SIRS, please refer to the [SIRS Provider resources page](#) on the Commission’s website, including the ‘Reportable incidents and SIRS provider guidelines’.

Reporting to the coroner

Each state and territory has specific requirements in relation to the obligations to notify a death to the coroner. Deaths may need to be referred to a coroner for a range of reasons including if an older 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.

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 about incident and near misses can result in increased trust of all stakeholders, including the public.

5.4.2 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.

Details of the incident (or alleged or suspected incident)	
<u>Record:</u>	• The name and contact details of the worker recording the incident or near miss • The name and contact details of the person making reporting the incident • 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)
People involved in the incident	
<u>Record:</u>	• Details of the people directly involved, including names, dates of birth (where available), contact details and cognitive status • Whether the subject of the allegation is an aged care recipient, and if not, their relationship to the care service, such as worker/employee, volunteer. • 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 memory support or specialist dementia care area • The names and contact details of any witnesses
Response to the incident	

<u>Record:</u>	Details of the actions undertaken in response to the incident, including: • Whether the affected older person, their registered supporter or other authorised person has been informed about the incident and involved in decisions about its management • The actions (support or assistance) taken to ensure the health, safety and wellbeing of the older person involved • Whether the older person, their registered supporter or other authorised person has ongoing concerns about the management of the incident • Any consultation with the older person, their registered supporter or other authorised person in the management and resolution of the issue and any findings/outcomes they have been provided • Details of any actions undertaken to prevent further similar incidents from occurring, or to minimise their harm • 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 • Any notifications made to the Commission, police, and other relevant organisations
Investigation and analysis	
<u>Record:</u>	• Details of investigation/analysis undertaken to identify the cause or source of an incident • The outcomes of any investigation or analysis undertaken including what the older person was told about the findings, including whether the incident could have been prevented, whether the older person is satisfied that all reasonable steps have been taken to address the incident and any actions taken to restore and maintain their trust and confidence in their care and services.

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

5.4.3 System considerations

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 worker'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.

Under s154-150 of the Rules, you must retain records of incidents for 7 years starting on the day the record is made or received. You should also maintain appropriate controls in relation to the privacy and confidentiality of information, particularly where it relates to the personal information of older people. 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 people affected by an incident (e.g. for incident records or to notify a reportable incident to the Commission).

Section s 154 of the Aged Care Act sets out your responsibilities in relation to the protection of personal information of older people, which apply alongside regulatory requirements in relation to privacy contained in relevant Commonwealth, state or territory legislation, such as the *Privacy Act 1988* and the Australian Privacy Principles (APPs).

5.5 Investigating and/or analysing how and why it happened

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

Local actions to reduce the risk of harm and potential for recurrence may need to be taken immediately. Older people, families/representatives and workers 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 or investigation may depend on:

- the severity of the incident
- the impact of the incident on older person (and family or supporters) 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 to the Commission via the SIRS
- the views of the affected people (including any older people, families/representatives).

The nature of the incident and other factors may also influence who is involved in the analysis, and whether a formal investigation is necessary and whether that 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 worker has acted in an inappropriate manner or if requested by an older person, or the older person's supporters (as 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.

For more information, please refer to [Effective serious incident investigations guidance for providers](#) on the Commission's website.

5.6 Implementing changes to reduce risk of recurrence

Implement remedial actions that help prevent future risk, improve incident response and make care services safer. Monitor actions for effectiveness.

Whenever an incident occurs, you must assess and consider:

- whether it could have been prevented (or the severity of its impact lessened) in any way
- how well the incident was managed and resolved, and whether there is an ongoing risk to people receiving care services, workers or others following the incident
- what (if any) remedial actions you (or your workers) could take to improve your organisation's management and resolution of the incident
- what (if any) remedial actions you (or your workers) could take to prevent or reduce the risk of further similar incidents from occurring, or to minimise their harm
- whether other persons or bodies should be notified of the incident.

When assessing incidents or near misses there is often an aspect relating to either your people, processes or systems (or all three) that could be improved prevent or lessen the risk or impact of similar incidents occurring in the future. In many circumstances, you should undertake remedial action to prevent similar incidents from recurring in the future – and for incidents reportable to the Commission, you may even be required to demonstrate that you have effectively controlled the evident risks.

Tip: Appropriate remedial actions

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

- Have we addressed the immediate impacts of the incident on the older person and anyone else affected?
- Do the actions address the underlying causes and contributing factors?
- Will the actions help restore safety, wellbeing and trust in care?
- How will we know whether the actions have been effective in reducing the risk of recurrence?

Remedial actions may include actions relating to people, processes, systems and the environment, such as:

People

- taking actions to promote a safe culture of care (for example, making incident management a key focus when inducting new workers)
- providing or mandating individual and/or service-wide worker training or re-training
- making additional workers available to assist older people receiving care services with certain activities
- seeking specialist assistance and/or implementing alternate strategies to manage behaviours of older people receiving care services.

Process

- reviewing and updating your organisation's practices and procedures or developing new procedures to support workers to manage emerging risks and issues
- updating care planning documentation to address the cause or impacts of the incident
- improving reporting, escalation or communication processes

Systems

- making changes to the provider's organisational or clinical governance frameworks
- processes are interconnected and work together effectively

Environment

- making changes to the physical environment, equipment or technology used to provide care services to reduce risks and improve safety for older people and workers.

You should ensure that any organisational changes made in response to an incident are well communicated to older people receiving care services and their representatives, your workers and any associate providers who you contract as appropriate.

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

5.7 Closing the loop

Analyse incident trends and data and regularly review your incident management system. Share lessons learned with management and leaders, workers, older people receiving care services and families. Continuously improve the quality and safety of aged care.

5.7.1 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 workers 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 older people, workers and others to identify risks.

You should use this information for organisational learning to:

- improve the quality of care services provided
- reduce risks to the health safety and wellbeing of older people receiving care services, your workers and others; and
- continuously improve your management and prevention of incidents.

5.7.2 Continuously improving and sharing learnings

Sharing what was learned both within your organisation – with older people receiving care services and their families and supporters, those involved in the incident and others as needed – and outside your organisation is key to preventing additional harm and making care services safer. Without learning and sharing, the same or similar incidents could simply 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, your leadership team, workers, those affected by the incident and even publicly. You should also consider the value in sharing learnings and opportunities with other providers and with peak bodies, in the interests of quality and safe aged care.

5.7.3 Reflecting on and improving your 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, make effective use of resources, are efficient for your workers, and contribute to improving your care services. In addition, the learning can assist in developing other resources that can help your workers 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 your 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 completed in reducing the recurrence of harm
- feedback from those affected by the incident, and
- sharing what was learned.

6 Resources

6.1 Legislation

This document is underpinned by:

- Latest [Aged Care Act 2024](#) and the [Originating Bill and Explanatory Memoranda](#)
- Latest [Aged Care Rules 2025](#) and the [Explanatory Statements](#)

6.2 Reference material

This guidance must be read in conjunction with and is supported by the following:

- Our [Regulatory Strategy](#)
- Our [Compliance and Enforcement Policy](#)
- The Commission's [Glossary](#)
- Relevant [resources for providers about incident management](#) on the Commission's website
- [Open disclosure – rebuilding trust after something goes wrong](#) on the Commission's website



Phone
1800 951 822



Web
agedcarequality.gov.au



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