Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

SIRS notification example response

Neglect

February 2022

These case studies cover a range of examples to provide **general guidance** to assist approved providers on the content and form of information that may be included in a notification to the Commission. They are intended to be illustrative but not exhaustive of approved provider reporting requirements. Any similarities to an actual reportable incident or individual is purely coincidental. The case studies do not constitute legal advice or other professional advice. Approved providers should seek legal or other professional advice on their legislative requirements, as appropriate.

SIRS notification example response

Neglect

A good-quality incident notification requires more than simply transcribing the details taken from progress notes about the incident or copying text from the provider's incident management system. It is important that the person making the notification is familiar with what happened, has applied a problem-solving approach to understanding the causes and risks involved and has a good understanding of how the response to the incident will be managed.

Here is an example response to questions in the MyAgedCare portal for reportable neglect.

Web portal question	Answer scenario 1	Answer scenario 2
Type of incident	Neglect	Neglect
Victim first name	Rita	Ethel
Victim last name	Gonzales	Sloan
Select the most relevant incident type	Neglect	Neglect
Please select the appropriate level of cognition of the victim	Moderate cognitive impairment	Mild cognitive impairment
Does the care recipient reside within a secure unit?	No	No

Following are the MyAgedCare portal questions and examples of possible responses.
The blue numbers relate to the tips box on the pages following these questions on what details to include in your response.

Web portal question	Answer
Please provide a detailed description of the alleged incident. In your SIRS report please provide a detailed description of the incident that has occurred, is alleged, or suspected to have occurred.	**Example response scenario 1:** It was identified on 11 October 2021, at around 18:00 when Rita Gonzales was in the dining room for dinner, that she had soiled her pants. Staff did not become aware of the incident until PCW John Spencer identified the issue. PCW John asked Ms Gonzales if staff helped her to go to the toilet, but she was unable to recall. **1, 2, 3** PCW John assisted Ms Gonzales by quietly and discreetly removing her and assisting her to avoid embarrassment and public humiliation, in getting cleaned and changed before she had her meal. PCW John sent out a memo to staff on duty during the day to notify them of the incident and ask if any staff had noticed anything to suggest Ms Gonzales had soiled her pants. **1, 6, 7** It was reported by PCW Mia Lu that Ms Gonzales did not want to eat lunch, and that Ms Gonzales was observed to be very uncomfortable throughout the day as she was fidgety and appeared anxious. Other staff members stated her appetite has been lower than usual over the last couple of days. Ms Gonzales' assessed cognitive impairment is at a moderate level, and at times she has issues with her memory. **5, 9, 10** **Example response scenario 2:** It was reported on 4 November 2021 at around 06:30, by PCW Justin Reed to RN Kathy Long, that consumer Ethel Sloan was found on the floor. Ethel has a diagnosis of mild cognitive impairment. **1, 2, 3, 5** Upon further investigation of the incident, it appears that Ethel has attempted to mobilise without assistance from staff from her bedroom to the bathroom and back to her bedroom when she lost her balance and fell on the bathroom floor. **8** Ethel stated that she waited for a long time for staff to respond to her call bell. Upon reviewing the call bell records, it appears that Ethel may have been on the floor for 70 minutes before staff attended to her. **8, 9**

Web portal questions	Answer
Harm **Did the consumer suffer physical impacts?** **Level of physical impact.** **Did the consumer suffer psychological impacts?** **Level of psychological impact.**	**Example response scenario 1:** Ms Gonzales was assessed after dinner to ensure the incident did not cause any infections. RN David Mayo and GP assessed Ms Gonzales and found that Ms Gonzales may be suffering from adult encopresis, which appears to be a new condition for Ms Gonzales. **8, 11** An assessment for impact and distress was conducted on Ms Gonzales and found that she is experiencing mild stress after the incident, as she is displaying agitation and unusual behaviours when it comes to attending the dining room for her meals. **8, 9, 10, 11** Ms Gonzales has always dressed and presented herself well. A well-being assessment will help to address her heightened level of stress. We are currently trying to identify the cause of this by reviewing her care plans, medications, and meals, and having open discussions with her representative. **10, 11** **Example response scenario 2:** Ethel's fall was unwitnessed, and after a head-to-toe assessment and vital signs check were conducted it was established that she did not sustain any injuries; however, as the fall was not witnessed, Ethel required neurological observations post fall every 30 minutes. **8, 11** Ethel has been assessed for pain and rated her pain 1/10 at the time of the fall and when she was found on the floor by staff. Ethel declined the offer of analgesia, and pain charting is to be conducted every two hours post fall. **8, 11** Ethel was anxious post fall and was distressed that she had been on the floor waiting for staff to come to assist her, as she was teary when recalling her fall. **8, 9, 10**

In response to the above questions, you should consider the following:

1. Who was directly involved in the incident (include full names)?
2. What time and date the incident occurred (or was alleged or suspected to have occurred)?
3. Where at the service did the incident occur (or was alleged or suspected to have occurred)?
4. Who else saw the incident (include their name, position, and contact details)?
5. What is the level of cognitive impairment of the consumers directly involved in the reportable incident? (e.g., Dementia substance-induce cognitive impairment, developmental disorders).
6. What was happening immediately before the incident occurred?
7. What occurred immediately after the incident? (your answer to this question must describe any actual harm that was caused to the consumer AND any harm that could reasonably have been expected to have been caused to the consumer).
8. Details of actual harm caused (type of seriousness of injury/illness, symptom and/or clinical observations.
9. Describe the consumer's response (This could include any observed behaviours such as crying, shaking, throwing things, not speaking, not wanting to be around other people, or doing usual activities).
10. Explain how and why any behaviour identified is different from the person's usual behaviour.
11. Describe any medical and/or psychological treatment provided.
12. Include enough information so that a person who wasn't there can understand what happened.

When assessing and describing what harm an incident 'could reasonably have been expected to have caused'.

(When considering whether an incident could reasonably have been 'expected to have caused' discomfort, physical or psychological injury, it is important to think about the general vulnerability of aged care consumers. Would it be reasonable to expect the incident would have caused discomfort, physical or psychological injury to other consumers in your service, such as instances where a consumer has medical or psychological limitations.)

Note: when you provide clear and comprehensive information early on, it is less likely that the Commission will need to ask for further details, or require you to conduct an investigation, or in some cases, directly investigate the matter itself.

Web portal question	Answer
What specific action(s) has and will be taken in response to the incident to ensure the immediate AND ongoing safety, health, well-being, and quality of life of the consumer affected by the incident?	**Example response scenario 1:** The incident was not reported to any authority. Ms Gonzales was supported immediately by PCW John and the relevant medical assessments were conducted after the incident by RN David. **1, 2** Ms Gonzales' family representative, sister Emilia, was contacted on 12 October 2021, at around 16:30, and was updated of her diagnosis and the actions taken to identify the issue, as well as her care plan being updated with the new diagnosis. Emilia was satisfied with the outcome but was concerned about how long it took for the issue to be addressed. **2, 3** Ms Gonzales' sister Emilia was assured that this would not happen again. It has been identified that PCW Mia got caught up with another consumer when she identified the unusual behaviour that Ms Gonzales was displaying, and then forgot to follow it up as Ms Gonzales is usually self-sufficient with her own daily cares. **6** Ms Gonzales' personal GP was notified of the incident and the relevant documentation was sent. An appointment was set for 13 October 2021 to address her new diagnosis. Bowel monitoring was commenced. **1, 4** GP assessment found that Ms Gonzales' diet needs to consist of increased levels of fibre, well-being assessments are to be conducted more frequently, and adding incontinence aids to Ms Gonzales' care plan should be considered. **4** All staff were made aware of the incident and its severity. It has now been directed that staff need to be vigilant with monitoring consumers in line with the frequency identified in their continence management care plan and documenting and following up any change in behaviour. **5, 6, 7**

Web portal question	Answer
What specific action(s) has and will be taken in response to the incident to ensure the immediate AND ongoing safety, health, well-being, and quality of life of the consumer affected by the incident? (continued)	**Example response scenario 2:** Ethel has consented to have the Chaplain come and provide her with further support. Ethel's family representative, son Michael, was contacted on 4 November 2021, at around 10:00, and was notified of the incident. Michael was given reassurance that she did not sustain any physical injury but was upset due to the time she waited for her call bell to be answered. **1, 3** Ethel's son has raised concerns regarding his mother being on the floor for 70 minutes and how this occurred. Michael has been given reassurance that an investigation would be conducted into the incident, and he would be notified of the outcome. **3, 6** Michael has been advised that the locum GP would be assessing Ethel that afternoon around 14:00 for injuries, vital signs, medication review, and general well-being check. **1, 2** Ethel has a bed sensor, pendant alarm, and call bell in place. Staff remind Ethel to utilise her call bell when requiring assistance, but at times she will forget to request assistance. **4** Ethel also likes to maintain her independence and therefore she will attempt to mobilise without the assistance of staff. Staff assist Ethel to the toilet at regular intervals throughout the day such as upon rising, before and after meals, and upon retiring or as otherwise required. **4, 5** Staff ensure that Ethel's room is clean and clutter free, and they ensure that there is a clear pathway from Ethel's chair and bed to the bathroom. Staff ensure that Ethel's mobility aid is always within reach. **4, 5** Staff ensure that Ethel's room is well lit during the day, and they ensure there is a clear path from the bed and chair to her bathroom. **4, 5** Ethel's care plan has been updated for staff to continue to provide reassurance and check her pain levels or any change in behaviour or vitals. Staff are to have individual conversations with her, asking if she needs assistance to go the bathroom, and spend time with her regularly. **4, 5**

In response to the above question, you should include the following:

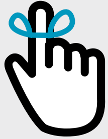
1. Whether the incident was reported to a relevant authority (e.g., coroner, AHPRA).
2. How the consumer was treated and supported immediately after the incident (consider both physical and psychological treatment and/or support). This could include whether external health advice was sought such as onsite or offsite counselling session.
3. Whether the consumer's representative was immediately contacted regarding the incident; for e.g., to discuss and review support needs or to be involved in the management and resolution of the incident.
4. Any assessment or planning changes; for e.g., development or update to a risk management plan for the consumer and subject of allegation (if also a consumer).
5. Any immediate or planned changes to the duties/supervision of any staff members.
6. Whether you assessed immediate risk to other consumers affected or who could have been affected by the incident.
7. Whether you have used the outcome of any incident assessment, analysis, or investigation to identify/implement actions to improve the safety, health, well-being, and quality of life to all consumers.

Web portal question	Answer
What specific action(s) has been taken or is planned to manage or minimise the risk of re-occurrence of this or a similar incident in the future?	**Example response scenario 1:** A physical examination and discussion were conducted with Ms Gonzales regarding her symptoms, bowel movements, and eating habits, and review of her care and meal plans was conducted identifying the possible cause of the incident. **1** The head RN, Care Manager, and Ms Gonzales' representative are all satisfied with the adjustments made to Ms Gonzales' care plan, in relation to her diet and including more fibre, as well as her follow-up appointment with her GP. **3** The Incident Management System has been updated to remind all staff of the importance of adhering to consumers' continence management plans and following up on any change in behaviour, as doing these things ensures reo-ccurrence of this incident is minimised for all consumers in the facility. **4, 5, 6** All staff are to complete training modules and education on continence management, with a reminder to staff of their responsibilities to monitor all consumers in line with their care needs. An informal discussion was conducted with PCW Mia, and it was communicated to her the importance of adhering to our protocols and policies. **6, 7** Staff and consumers' representatives will be made aware of these changes as the Incident Management System will reflect the changes that have been made and the preventive measures that have since been implemented Staff will work to limit the possibility of occurrence of a similar incident. Audits will be conducted by the DON to ensure the correct practices are occurring and are being measured. **6, 7, 8**

Web portal question	Answer
What specific action(s) has been taken or is planned to manage or minimise the risk of re-occurrence of this or a similar incident in the future? (continued)	**Example response scenario 2:** It was identified upon review of the incident and questioning staff that were rostered on night shift on 4 November 2021, that PCW Andrew Dell did not attend to Ethel as required on her care plan. PCW Andrew recalls seeing the call bell but was attending to another consumer and he assumed that Ethel had been attended to by another staff member. **1** Performance management has started with PCW Andrew to address performance concerns and he has been issued with a warning letter. PCW Andrew will be required to report to the RN during his shifts for the next two weeks to show that he has adhered to consumers' care plans and attended call bells in a timely manner. This will then be reviewed at the end of the two weeks. **3, 4** Staff have been advised of the incident, and it has been communicated to all staff through memos and during staff meetings that staff are to always adhere to a consumer's care plan and must attend a call bell within the required call bell response times and be aware of the need for prompt attendance to call bells. Staff levels and call bell response times will be assessed to ensure they are sufficient. **5, 6, 7, 8** It was identified that Ethel was wearing her slippers at the time of her mobilising to the bathroom, and this could have been a contributing factor to the fall due to Ethel shuffling whilst mobilising. This has been updated in Ethel's falls risk assessment and care plan in consultation with the physiotherapist. **4, 6** Our Incident Management System has been updated with the details of the incident and strategies taken to minimise the risk of re-occurrence, including which measures have taken place such as staff education on clinical documentation, the completion of assessments, and care planning. Weekly meetings are to take place with the physiotherapist and management team relating to pain management and falls prevention. Daily call bell reports continue to be provided to management to ensure that any call bells outside of the benchmark are followed up with performance management and education. **7, 8** Case studies are to be built as a discussion point for nursing staff for weekly meetings to improve knowledge and understanding of different incident types and the preventative measures that are put into place to prevent re-occurrence. **7, 8, 9**

In response to the above question, you should consider the following which may refer to the relevant aspects from your Incident Management System:

1. The actions you have taken or plan to take to identify the causes of the incident (e.g., assessment, used problem solving methodology, root causes analysis, internal/external investigation, other methods).
2. Describe what further actions are proposed in response to the incident. Include any open disclosure actions taken or proposed.
3. Describe what actions have been taken or are being taken to reduce the risk of a similar incident occurring in the future.
4. Whether the incident has been assessed to determine whether it could have been prevented or caused less harm, and the outcome of that assessment.
5. The preventative measures, including remedial actions that have been put in place to identify and manage similar risks. For example, details on planned updates to your processes and procedures to ensure the risk of re-occurrence of this or a similar incident, including near misses, in the future is minimised.
6. Describe the observable differences the Commission, consumers, family members and staff will be able to see as a result of changes made.
7. Describe how you are embedding changes within the service and how you are measuring the effectiveness of the changes.
8. Describe how you have ‘closed the loop’ by analysing any incident trends to identify and address any systemic issues.



Reminder:

If further information is available to you, then please ensure any Priority 1 notifications are updated within five days with the further relevant information once incident analysis or investigation is complete.

The information is to be provided in the form located on the Commission website:

agedcarequality.gov.au/sirs/provider-resources#approved-forms

The purpose of this document is to give practical guidance to providers when making reports about serious incidents via the SIRS tile on the My Aged Care Provider Portal.

We have chosen four of the most important questions from the portal to help demonstrate the type of information that should be included in a notification.

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

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