Reporting serious incidents:

Practical tips for providers when making a notification

December 2021

Purpose

The purpose of this fact sheet 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 priority 1 (P1) notification.

Why quality notifications are important

Notifying reportable incidents via the SIRS supports providers to identify trends and issues and pursue continuous improvement in service quality and safety. It also supports the Commission to assess and respond to risk at a service level, and to identify where improvements are needed across the sector.

Key considerations

When a provider supplies clear and comprehensive information early on, it is less likely that the Commission will need to ask for further details, or require the provider to conduct an investigation, or in some cases, directly investigate the matter itself.

We understand that you won't always have all the necessary information available to you within 24 hours when submitting a P1 notice, but your notification should still include as much detail as possible about what steps you've taken to ensure the immediate safety, health and wellbeing of the affected consumer; and what else you plan to do to assess the causes of, and plan your overall response to, the incident.

Once further details become available, they should be provided to the Commission (within five days for a P1 incident), including whether you plan to conduct any further investigation into the incident and/or how you intend to prevent future similar incidents from occurring (if not already reported in the initial notification).

Providers must also tell the Commission as soon as possible if they become aware of any significant new information after making the notification.

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 (see Resource 2) to understanding the causes and risks involved and has a good understanding of how the response to the incident will be managed.

You should also attach relevant records to the notification which demonstrate the steps you've already taken.

Remember!

If the Commission decides to further assess an incident or conduct an investigation, it will look for evidence of the actions taken by providers to manage the incident.

Practical Tips

Consider providing sufficient detail in response to the questions below when completing a notice. No answer should be recorded as 'not applicable'.

Please provide a detailed description of the alleged incident

Questions to think about

1. Who was directly involved in the incident (include full names)?
2. What time and date did the incident occur (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?
5. Who reported the incident (include their name, position and contact details)?
6. What is the level of cognitive impairment of the consumers directly involved in the reportable incident?
7. What was happening immediately before the incident occurred?
8. What occurred immediately after the incident?

Further considerations

- Include enough information so that a person who wasn't there can understand what happened.
- Describe the situation at the time the incident happened (e.g. how and when a person was found injured/deceased and who found them).
- This will often require you to interview the relevant people as clinical notes often don't give a clear enough picture.
- Clinical observations and their meaning may be relevant (e.g. "O2 sat 87%, very low", or "BP was 105/65, which is outside the consumer's normal range").

What specific actions have been taken to ensure the health, safety and wellbeing of the care recipient(s) involved?

Questions to think about

1. Whether the incident was also reported to a relevant authority (e.g. police, coroner, AHPRA).
2. How the person 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 counselling.
3. Whether the person's representative (ensuring appropriate consent and confidentiality arrangements are observed) was immediately contacted regarding the incident; for example, 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 example, development or update to a risk management plan for the affected consumer and subject of the allegation (if also a consumer).
5. Any immediate or planned changes to the duties/supervision of any staff members involved in the incident.
6. Whether you assessed immediate risks 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 health, safety, wellbeing and quality of life of all consumers.

Further considerations

- Think about 'health, safety and wellbeing' in terms of physical AND psychological/emotional/cultural factors.
- Think about the person's immediate AND ongoing health, safety, and wellbeing.
- Identify immediately if authorities (e.g. police, ambulance) need to be contacted.
- Remember, you must involve each person affected by the incident (or their representative if desired and appropriate) in managing and resolving the incident.
- Ask the affected person and other people who know them well (e.g. family, health professionals, other staff) what help or support they need to be healthy, safe, and well.
- Be clear about how the specific actions taken are relevant to ensuring the health, safety and wellbeing of the person following the incident.
- Explain what you have done to help the person feel safer.

If there was psychological and/or physical impact to the victim and/or subject of the allegation, select the appropriate level of impact

When considering whether an incident could reasonably have been 'expected to have caused' discomfort or physical or psychological injury, it is important to think about the additional vulnerabilities associated with age and health condition. Would it be reasonable to expect the incident would have caused them the same discomfort or physical or psychological injury, even if they are not showing signs of distress? If other consumers would have reported distress, anxiety or appeared upset, it is likely that this type of incident would cause that same type of distress to any person.

Questions to think about

1. Details of actual harm caused, consequences of the harm, or harm that could have been caused (type and seriousness of injury/illness, symptoms and/or clinical observations).
2. Describe the person's response; this could include any observed behaviour. For example, crying, shaking, throwing things, not speaking, not wanting to be around other people or doing usual activities.
3. Explain how and why any behaviour identified is different from the person's usual behaviour.
4. Describe any medical and/or psychological treatment provided in response to the incident.

Further considerations

- People with dementia, mental health diagnoses or intellectual disabilities may need extra support and consideration to determine level of impact and appropriate responses.
- Think about the type of harm that could have occurred due to the incident no matter who it happened to (e.g. fall may have caused a broken limb; medication error may have caused unconsciousness or death).
- Remember that psychological distress may not be obvious. Consider what things are important to the person's usual wellbeing and whether the incident has had an impact on these things (e.g. resident used to enjoy bingo and craft for social contact but is now anxious leaving their room).
- Consider the views of the affected person, as well as their representative and other people who know them well (e.g. staff and health professionals).
- Consider attaching relevant supporting documents, such as your internal incident form.

What specific actions have been taken to manage or minimise the risk of recurrence of this or a similar incident in future?

Questions to think about

1. The actions you have taken or plan to take to identify the cause of the incident (e.g. assessments, root cause analysis, internal/external investigation, other methods).
2. Have you conducted an investigation to understand the cause of the incident?
3. Describe what further actions are proposed to be taken in response to the incident. Include any disclosures or consultations with family or substitute decision makers.
4. Describe what actions have been taken or are being taken to reduce the occurrence of a similar incident in the future.
5. Whether the incident has been assessed to determine whether it could have been prevented or caused less harm; and the outcome of that assessment.
6. 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.

Further considerations

- Think about what caused the incident and consider the views of the person affected.
- Remember an incident will often have many contributary factors and as many of these as possible need to be identified. *For example, a fall might result from a rush to the toilet at night time, poor lighting, loose rails, got up quickly with postural hypotension issues.*
- What was happening at the time of the incident and in the time leading up to it? Think about the affected consumer, involved staff member(s), care environment, care plan, procedures etc.
- Could the incident have been prevented or caused less harm? If yes, how? *For example, a fall may be prevented by installing a night light, reviewing a prioritising call button responses, offering a commode near the consumer's bed overnight, or reviewing blood pressure medications.*
- Have the care plans of affected people been updated?

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7. Describe how you are embedding changes within the service and how you are measuring the effectiveness of the changes.

8. Describe the observable differences that the Commission, consumers, family members and staff may be able to see as a result of changes made?

9. Describe how you have 'closed the loop' by analysing any incident trends to identify and address any systemic issues.

- Could a similar incident be prevented from happening in the future? If yes, what preventative measures have been put in place to identify and manage similar risks? (Think about anyone who could be affected in future, not just the person who was impacted by the incident you're reporting.)
- How will you document and implement any changes to processes or policies? *For example, in the case of a fall, evidence of night lighting installed in all toilets and regular monthly checks of rails.*
- Is there a plan to further investigate the incident?

Further detailed guidance for providers is contained in the *Serious Incident Response Scheme Guidelines for Residential Aged Care Providers* agedcarequality.gov.au/resources/serious-incident-response-scheme-guidelines-residential-aged-care-providers.

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