Reporting serious incidents

Using a problem solving approach to enhance effective incident management

December 2021

Australian Government
Aged Care Quality and Safety Commission

Engage
Empower
Safeguard

Effective incident management systems

The Effective incident management systems: best practice guidance provides detailed information for providers to help develop and embed a best practice incident management system. Having an effective incident management system in place will enable providers to respond to and manage specific incidents and near misses by assessing:

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

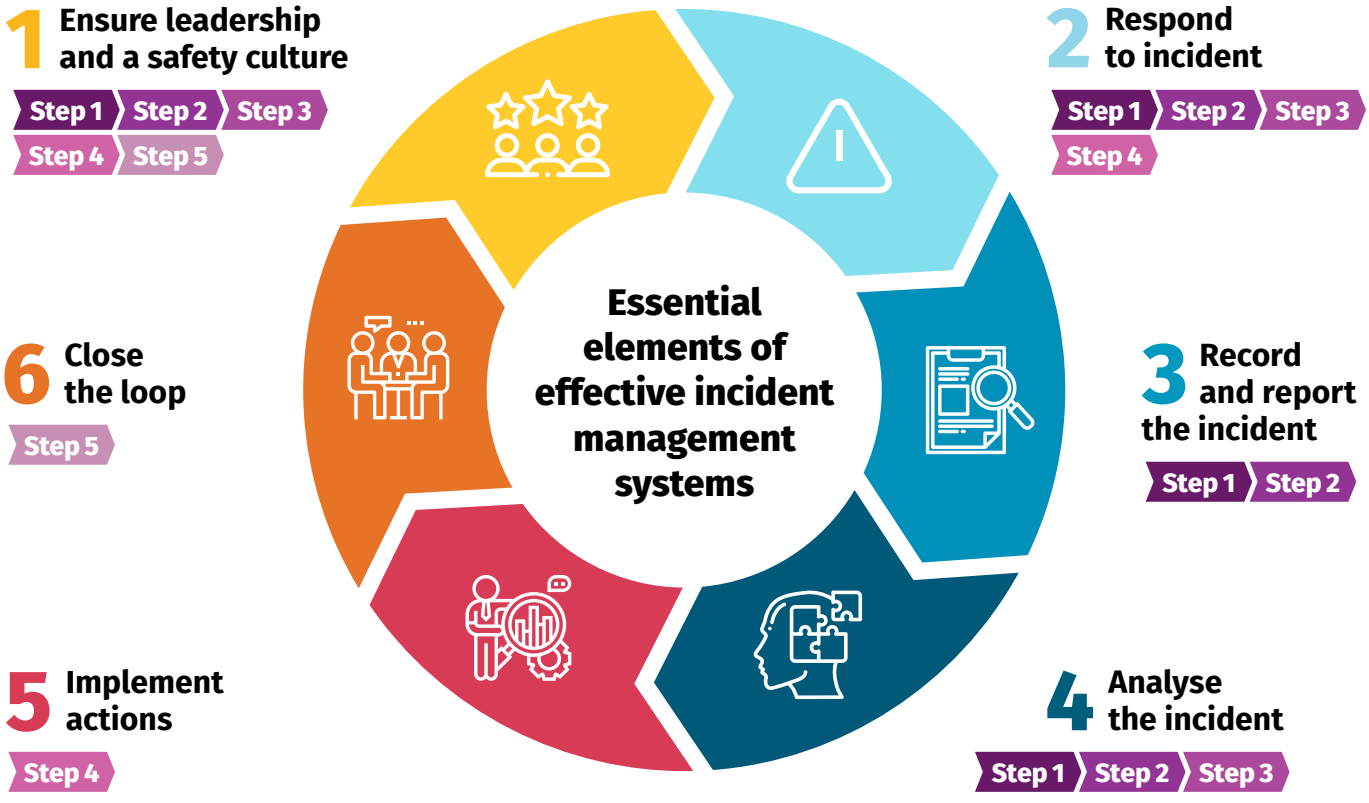
Problem solving approach

A problem solving approach can assist to understand the causes of an incident more quickly by using shared, collaborative, and systematic techniques. Such an approach may be used to better understand the contributing causes of the incident, to develop solutions to prevent further incidents occurring and to evaluate the implementation of solutions.

Overlap between IMS effective systems and 5-step problem solving approach

Step 1	Step 2	Step 3	Step 4	Step 5
Define the problem	Determine the root causes of the problem	Develop possible solutions	Select and implement a solution	Evaluate the outcome
Understand the incident: what happened, who was involved.	Root causes methodology, consider whether incident requires investigation — internal or external. Remember there may be many contributors.	Identify a range of solutions.	What will be effective, prepare, plan, implement.	What is different? Is the solution effective and sustained.

These **5-steps** will be demonstrated by applying a practical example to an incident.



How the 5-step problem solving model and incident management system work together

The problem solving model supports the key elements of an effective incident management system to promote the health, safety, wellbeing and quality of life of older people.

Each step within the 5-step problem solving approach has been aligned with the corresponding element in the Best Practice Guide: Effective management systems.

Applying the problem solving approach to the management and reporting of serious incidents

The 5-step problem solving model can inform and enhance management of the eight reportable serious incident types under the Serious Incident Response Scheme (SIRS). These reportable incident types are:

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

Further details on these incident types and SIRS reporting requirements can be found 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

An example for how the problem solving approach can be applied to one of the reportable serious incident types — Unexplained absence of a consumer — is provided on the following pages.

Using a problem solving approach to enhance effective incident management — SIRS notification: unexplained absence of a consumer

Here is an example of an unexplained absence which is a reportable incident. Following is an example response to four questions in the MyAgedCare portal, how they relate to the 5-step model, and what to consider.

Details of the incident

MyAgedCare portal question: Please provide a detailed description of an incident.

5-step problem solving steps

Step 1: Understand the incident, what happened, who was involved.

Effective incident management

- respond to incident
- record and report the incident.

Consider the following

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 consumer(s) directly involved in the reportable incident?
7. **What** was happening immediately before the incident occurred?
8. **What** occurred immediately after the incident?

Example response

On 15 August 2021 at 13.07 Arthur Menzies (consumer) was reported missing by Personal Care Worker (PCW) Rachel Watson.
The absence was reported to the Facility Supervisor, Wendy Robinson, when Arthur could not be located for lunch.

Arthur has a moderate cognitive impairment and has been previously reported missing on three other occasions. When unable to locate Arthur, a full facility search was conducted, and the police were notified.

During the facility search it was noted that the gate in the back fence was left open, and the lock was broken. A phone call was received at 13.48 by a good Samaritan who located Arthur about 900m from the facility at the local shops wandering around. PCW Rebecca drove to pick up Arthur and return him to the facility.

Upon return Arthur was assessed by Amy Smith (Registered Nurse) where no physical injuries were noted and his clinical observations were normal. Arthur's family was contacted to notify them about the incident, and then a phone call to the police was made to inform them that Arthur has now been located and returned to the facility.

MyAgedCare portal question: If there was psychological and/or physical impact to the victim/and or subject of the allegation, select the appropriate level of impact.

Answers to this question must describe any actual harm that was caused to the person AND any harm that could reasonably have been expected to have been caused to the person.

When assessing what harm an incident 'could reasonably have been expected to have caused', consider the harm (psychological or physical) that you would expect to result from the same incident occurring outside of the context of aged care, and without regard to cognitive impairment or other qualities unique to the individual consumer.

5-step problem solving steps

Step 1: Understand the incident, what happened, who was involved.

Effective incident management

- respond to incident
- record and report the incident
- analyse the incident.

Consider the following

1. **Details** of actual harm caused (type and seriousness of injury/illness, symptoms and/or clinical observations).
2. **Describe** the person's response; this could include any observed behaviour such as crying, shaking, throwing things, not speaking, not wanting to be around other people or not 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.

Example response

When first located by PCW Rebecca, it was observed that Arthur was agitated and disorientated and did not want to get into the car.

Upon arrival back at the service, Arthur was assessed by the RN, with nil physical injuries reported. All clinical observations were performed. Arthur did not want to eat lunch when he returned and went to his room and was quieter than usual.

The Chaplain went to check on Arthur and stayed with him until his son arrived at 17.00 to encourage Arthur to eat supper.

MyAgedCare portal question: What specific action(s) have and will be taken in response to the incident to ensure the immediate AND ongoing safety, health, wellbeing and quality of life of people affected by the incident?

5-step problem solving steps

Step 2: Determine the root causes of the problem — root causes methodology, consider whether incident requires investigation — internal or external.

Step 3: Develop possible solutions — create a variety of solutions.

Step 4: Select and implement a solution — what will be effective, prepare, plan, implement.

Effective incident management — good practice

- analyse the incident
- implement the actions
- close the loop.

Consider the following

1. Whether the incident was reported to a relevant authority (e.g. 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 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 person and subject of the allegation (if also a consumer).
5. Any immediate or planned changes to the duties/supervision of any staff members.
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.

Example response

The police were notified when Arthur could not be found (Police Report Number #QI573672) and later informed that Arthur has been located and returned to the facility.

Arthur's Next of Kin (NOK) was notified, and his son Brendon informed staff that he would come in at 17.00 to check on his father, and to encourage him to eat dinner. Brendon spoke to Arthur on the phone to reassure him and ask him how he felt.

When Brendan visited the manager met with Brendan and Arthur. They discussed what happened and it was agreed that 30 minute sight checks were appropriate.

Upon his return Arthur was assessed by the RN with nil physical injuries reported. The Chaplain stayed with Arthur until his son arrived.

A working group with personal care workers, care workers and RNs was formed to discuss the incident. The group decided a maintenance audit was required to systematically identify any issues and sort out more timely responses to infrastructure issues that may put residents at risk.

An email was recently sent to all staff about keeping the back fence locked and reporting any broken or faulty locks to the maintenance team, and 30 minute sight checks are now in place for Arthur.

A staff meeting was held to reinforce these instructions and to reflect on the lessons from this incident, so that the chance of recurrence for Arthur (or any other residents) is reduced.

The open fence has been reported to the maintenance supervisor and will be replaced.

Dementia Support Australia has been contacted to assist in providing support to Arthur.

Staff will consider why Arthur leaves and how to better support him.

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?

5-step problem solving steps

Step 2: Determine the root causes of the problem — root causes methodology, consider whether incident requires investigation — internal or external.

Step 3: Develop possible solutions — create a variety of solutions.

Step 4: Select and implement a solution — what will be effective, prepare, plan, implement.

Step 5: Evaluate the outcome — what is different, is the solution effective.

Effective incident management — good practice

- analyse the incident
- implement the actions
- close the loop.

Consider the following:

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. Have you investigated to understand the causes of the incident?
3. Describe what further actions are proposed in response to the incident. Include any open disclosure actions taken or proposed.
4. Describe what actions have been taken or are being taken to reduce the risk of a similar incident occurring 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.
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 the Commission, consumers, family members and staff will 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.

Example response (update provided to the Commission as further significant information came to light)

Arthur has wandered from the facility on three occasions prior to the present incident. 30 minute sight checks are now in place. An email was sent to all staff about the importance of keeping the premises secure and locking the back fence, and in addition, a sign was placed on the fence reading 'please lock gate'.

Automatic gate closers have been installed.

An email was sent to all staff to remind them to report any faulty locks to maintenance for urgent repairs. A referral was made to Dementia Support Australia, and they recommended a GPS tracker. This will be discussed with Arthur and his son Brendon, and if Brendon supports the proposal, a tracker will be ordered.

To 'close the loop' the working group has diarised a one month review of the effectiveness of all actions and interventions and will provide a report to the manager about the outcome.

Quotes are being sought to update the facility's surveillance system so that in the event of re-occurrence, footage can be viewed. Upon receipt of the quotes, management will decide whether upgrading the surveillance system is an appropriate and proportionate strategy.

The service's Incident Management System has been updated regarding the fence to ensure that all consumers' representatives have been notified of the updated safety protocols.

Arrangements have been made for Arthur to join a resident walking group twice a week to enable him to access the community and have some exercise.

If you have a Serious Incident Response Scheme (SIRS) enquiry, you can:

call free on **1800 081 549**
9am to 5pm, Monday to Friday;
8am to 6pm Saturday to Sunday **or**

email sirs@agedcarequality.gov.au

Please refer to the SIRS resources on the Aged Care Quality and Safety Commission website: agedcarequality.gov.au/sirs/provider-resources for additonal resources including:

Approved forms
Fact sheets
Frequently asked questions
Guidance documents
Poster
Webinars
Videos

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

Phone
1800 951 822

Web
agedcarequality.gov.au

Write
Aged Care Quality and Safety Commission
GPO Box 9819, In Your Capital City