Australian Government
Aged Care Quality and Safety Commission

GOVERNING FOR reform IN AGED CARE

Incident management & reporting

THE ASK:

Effective incident management is integral to the delivery of safe and quality consumer-centred care. The governing body is responsible for ensuring that incidents are responded to appropriately and that the incident management system supports accurate reporting of incidents so that incident learning can drive continuous improvement of the services being delivered.

Disclaimer: The new Aged Care Act 2024 (the Act) starts on 1 November 2025. The Act replaces existing aged care legislation. The Aged Care Rules (the Rules) are expected to be finalised before the Act starts. The Rules give more information about how the new Act will work. This resource is in draft. We will update it when both the Act and the Rules come into force.

Covered in this topic guide

- Elements for effective incident management.
- Reporting requirements and incident recording.
- Incident learning and continuous improvement.

Where are we now?

As a [governing body] we have developed over time, previously we only received information on finances and there was limited questioning of quality and safety. That has evolved over time. We look at what has changed and understanding why it has changed. Incidents are reported to the [governing body] and if there are any concerns about incidents, the [governing body] asks questions.

GOVERNING BODY MEMBER

Key concepts

- An **incident** is any act, omission, event or circumstance that occurs in connection with the provision of care or services that has, is suspected of having, or alleged to have (or could reasonably expect to have), caused harm to a consumer or another person. An incident can be clinical or non-clinical. Incidents can also relate to workers safety.
- A **near miss** is an incident that did not result in harm but had the potential to do so.
- An effective **incident management system** is a comprehensive approach to preventing, managing and learning from incidents (including near misses) that occur while delivering care and services to consumers and a critical part of a provider's overall governance systems.
- **Incident learning** is an approach to incidents that shifts the focus of incident management away from blame or punitive responses to something going wrong, towards a focus on incidents being a source of information that help an organisation to recognise areas requiring growth and improvement.
- A **reportable incident** is an incident (as set out under the *Aged Care Act 2024*) that is required to be reported to the Aged Care Quality and Safety Commission (the Commission) and, in some cases, must be reported to the police where there are reasonable grounds to do so.

Incident management in aged care

Incident prevention and management are integral to risk management, continuous improvement and the delivery of safe and high-quality, consumer-centred care. Providers of residential care, home and community care, and flexible aged care services are required to report certain incidents under the Serious Incident Response Scheme (SIRS). All providers must comply with Standard 2: outcome 2.5, Incident management of the strengthened Aged Care Quality Standards, which requires that providers use an incident management system to safeguard older people and acknowledge, respond to, effectively manage, mandatorily report (when required) and learn from incidents.

Story from the sector

Accurate reporting of incidents and near misses are critical for effective incident management

KEY TAKEAWAYS

- Governing bodies that understand good practice incident management are in a better position to oversee an effective incident management system that drives better outcomes.
- Identifying trends and patterns in incident data can assist the governing body and executives make systemic changes to improve the delivery of care to consumers.

The Acme Community Services' governing body includes several members with clinical experience. At their strategy meeting, the governing body reviewed the policies and procedures relating to incident management and reporting. Elaine, a registered nurse, noticed that the policies and procedures for reporting incidents were clearly set out, however there was no guidance on how to record near-miss events. Elaine suggested that this should be included in the next review of the incident management policy and additional training should be included for clinical care staff on how to record and manage near-miss incidents, together with all reportable incidents.

Six months later, an incident at another provider regarding incorrect medication that was given to a consumer received a large amount of media attention. It was decided that the governing body would review incidents relating to medication management at the next meeting. At that meeting, it appeared that the incident reporting relating to medication management was low. However, on closer review, it appeared that since the recent 'near-miss incident training', there was a 30% increase in the number of near-miss events recorded relating to medication management. As a result, the governing body was able to consider systemic and operational changes to improve the training regarding medication management to prevent or reduce the likelihood of an incident occurring in the future.

Tips for incident management

Older Australians at the centre

- Consumers have the right to safe and high-quality care, the right to be treated with dignity and respect and the right to live without abuse and neglect. Incident management systems should support these consumer rights.

Obligations and accountabilities

- Support workers and consumers to prevent, recognise, respond to and report incidents. Incidents can be clinical and non-clinical. Incidents can also relate to worker safety.
- Understand the incident management requirements and create systems and training that empower and educate staff about their obligations, including mandatory reporting requirements under SIRS.
- Acts swiftly to respond to and manage incidents.

Knowledge, skills and experience

- Understand incidents and near misses and gather the information required to get a holistic picture of incident management across the provider.
- Take an incident learning approach to continuously improve services.

Leadership and culture

- Encourage open disclosure, communication and a 'no blame' culture to drive improvements.
- The governing body demonstrates its commitment to incident management through organisational governance.

Reflecting on your practice

Think

Below are the top things you need to be **thinking** about:

- Do we have a clear incident management system, and is it widely understood and used by staff?
- Do staff understand the requirements and expectations around incident management?
- Do we provide training to ensure staff have the skills to manage incidents?

- How are we improving consumer outcomes and experiences as a result of changes driven by incident learning?
- How are we practising open disclosure with consumers and their families when managing incidents?

Ask and say...

Below are the top questions you need to be **asking**:

- How does the governing body hold executives and managers accountable for incident management and open disclosure?
- How does the governing body know that staff respond in the right way when things go wrong (i.e. with openness and transparency)?
- What evidence do you have that all staff feel comfortable reporting incidents and understand their mandatory reporting responsibilities?
- What do incidents at all risk levels, or trends in incidents, tell the governing body about strategic improvements or changes that need to be made?

Do...

These are the top **actions and behaviours** of leaders:

- Evaluate your incident management system to ensure it allows for the appropriate level of incident prevention, response, management, learning and improvement to occur.
- Ensure there are clear processes in place which identify when and how others should be notified of incidents, incident trends, and incident responses.
- Regularly review actions taken to resolve incidents, the implementation of solutions and whether the changes have led to positive outcomes for the organisation and the consumer.
- Regularly analyse the data for emerging risks and gaps in the quality of care and identify improvement opportunities such as adopting a system-wide approach to similar incidents.
- Regularly review reportable incidents to ensure reporting timeframes and information requirements under the SIRS are met.

What is an incident management system?

Effective incident management is a feature of safe and high-quality care and services and is an important element of quality improvement and consumer-centred care. Incident management systems set out processes that help an organisation prevent incidents, as well as identify, respond to and manage any incidents and near misses that occur while delivering care and services to consumers.

Incidents not only have the potential to threaten the safety and welfare of consumers and staff but can also impact visitors in a residential aged care setting and the broader community. An effective incident management system should be used to identify, assess, respond to and record all incidents and near misses that occur at a facility (e.g. residential aged care) or that occur during the delivery of care and services to consumers (e.g. in the home care setting). The information captured in an incident management system should be used by the governing body and the provider to drive improvements in service delivery. Incident management systems will take different shapes and forms based on a provider's service size, location, the services provided and the care needs of the consumers. However, all incident management systems should incorporate the following principles for effective incident management:

1. **Consumer and stakeholder engagement -** to ensure that the system is centred on consumer dignity and choice and focused on better health safety and well-being outcomes for consumers.
2. **Open disclosure** - to facilitate transparent communications with those affected by an incident.
3. **Accountability and responsibility** - to set clear roles and responsibilities for actions taken in responding to an incident.
4. **Accessible, simple and easy-to-understand policies and procedures** - to enable the timely and consistent response to incidents.
5. **Continuous improvement** - to prevent similar incidents from occurring in the future and to continuously improve the quality of care and services being provided.

Responsibilities of providers

All providers have obligations under the strengthened Aged Care Quality Standards. Standard 2: The organisation - outcome 2.4 Risk management, specifically requires providers to have effective risk management systems and practices for identifying, reviewing, preventing and managing incidents. Under this requirement, effective risk management systems and practices should:

- manage high-impact or high-prevalence risks associated with the care of consumers
- identify and respond to the abuse and neglect of consumers
- support consumers to live the best lives that they can, in consultation with the consumers
- manage and prevent incidents, including the use of an incident management system.

The role of the governing body

It is the role of the governing body to oversee risk and the delivery of safe and quality services. The governing body plays a key role in creating and sustaining a culture of openness and transparency when incidents occur or when things go wrong. It is important for the governing body to demonstrate and embed a culture that values quality, safety and reporting of incidents. It should also ensure that the incident management system is consistent with the providers' broader governance framework and risk management procedures. Governing bodies are encouraged to have oversight of the policies and procedures relating to incident management to ensure appropriate incident responses, share learnings, analyse trends, and manage risk effectively so that the quality of the services is improved.

Governing body members also play a role in taking an innovative approach to incident learning. Governing bodies with an understanding of new or contemporary incident management systems and models are better placed to implement effective systems for the provider that best meet the needs of consumers.

Taking an incident learning approach

Incident management systems play an important role in identifying harm (or potential harm) that has occurred and ensuring there is a response that is appropriate in supporting those involved. They provide critical information to help organisations learn where they need to improve. Providers that embrace this information and analysis are best placed to ensure they continue to improve the outcomes, safety and quality of life for their consumers.

An incident learning approach is important as it shifts the focus of incident management away from a response that is blame-based or punitive toward one focused on incidents being a source of information that help a provider to recognise areas requiring growth

and improvement. Incident learning is important to the organisational governance of a provider for the following reasons:

- It supports the provision of safe, high-quality care for consumers.
- It supports organisations in understanding and engaging with risk, including meeting the needs and preferences of consumers.
- It helps support and retain staff.
- It supports an open, blame-free culture, with a focus on understanding, learning and continuous improvement.
- It empowers consumers and their families/carers, giving them confidence in the care and services the organisation provides.
- It supports providers meet their regulatory and compliance responsibilities.

Supporting a culture of incident learning

An incident management system is not designed to eliminate all risks and incidents. Rather, it provides a system to reduce the likelihood and occurrence of risks by ensuring that incidents are appropriately responded to and recorded and that agreed actions for change following an incident are implemented and drive improvements.

An effective incident management system requires staff to know what their roles and responsibilities are regarding incident reporting so that they know what is expected of them. This can help to promote incident learning and reporting as an integral part of delivering safe and quality care (rather than being disconnected from it). All staff, including clinical and non-clinical staff, must understand the incident management system and be encouraged to take an incident learning approach. Incident learning encourages reporting that is transparent and supports a 'blame-free' culture without fear of reprimand and promotes collaboration on solutions to improve service delivery.

A culture of incident learning can empower consumers and staff to respond to incidents appropriately with a focus on the safety of consumers. It can also increase consumer and community confidence in the provider's ability to deliver safe, high-quality, consumer-centred services sustainably and in line with community expectations. Encouraging staff to report and record incidents accurately and to learn from previous experiences can drive a strong culture of incident learning.

Elements to effective incident management

An incident management system should set out clear policies and procedures about how to identify, respond to and reduce the reoccurrence of incidents.

Identify the incident

Respond to the incident

Record and report the incident

Analyse the incident

Implement actions to reduce risks

Close the loop

Identify and respond to the incident

Incidents can be identified in several ways by a number of different people, including workers, consumers or visitors. Some incidents are simpler to identify in nature, while other incidents or near misses can be more difficult to identify, particularly where they may not have resulted in direct harm to a consumer.

From an organisational perspective, it is important that all staff understand what incidents are and how to respond appropriately. It is important that staff undergo training about how to identify and respond to incidents that they witness, experience or that have been reported to them by consumers, family members or visitors. Importantly, once an incident has been identified, staff should be trained to be able to respond appropriately, with the immediate health, safety and well-being of the person affected by the incident at the forefront of any actions taken.

Record and report the incident

Information about all incidents must be recorded in a clear and structured way, which is compliant with legislative requirements and is in a form that allows for tracking and analysis. Such information should be reported through agreed governance structures with the speed and specificity appropriate to the seriousness of the incident. Recording of incidents in the incident management system should include:

- details and a description of the incident, including the time, date and place
- the people involved in the incident, including the details of the person recording the incident and any near misses
- details of the actions taken in response to the incident, including the actions of any third parties such as the police

- details of the outcome of the investigation undertaken in relation to the incident.

Accurate and thorough recording of incidents is critical for effective incident management, as it forms the basis of any data analysis about the occurrence of incidents or any patterns of incidents that need to be addressed by the management team or the governing body.

Reporting and recording

Recording and reporting incidents is an important step in responding to incidents. An incident management system should include procedures and guidance about the process for reporting incidents, including examples of incident report forms and any subsequent triggers or notification chains that need to be followed once a report has been made.

The information management system should also provide a system of recording near misses or other non-reportable incidents, which can ultimately help the governing body identify and address systemic issues in the quality of care provided to consumers. Recording the details of the incident, the people involved in the response and the investigation of the incident is critical as it allows the governing body to review and analyse issues raised, identify and address systemic issues and ensure mandatory reporting requirements are being complied with.

Reportable incidents

Aged care providers are required to prevent and manage risk and the occurrence of incidents as part of the provision of safe and high-quality consumer-centred care. Therefore, it is important for governing bodies to be aware of their responsibilities for mandatory reporting, ensure that an appropriate response has been taken, and ensure that the right data is being reported to understand the trends in that reported data.

The governing body and executives should have responsibility for the oversight of the incident management and learning system and be confident that it's operating as intended. Close attention is needed when reportable incidents occur (i.e. serious incidents reported to the Commission as part of the Serious Incident Response Scheme (SIRS)) and where there are trends in incidents that don't meet the criteria of SIRS but show a pattern of harm occurring to consumers.

The Serious Incident Response Scheme (SIRS)

In addition to the requirements outlined in the strengthened Aged Care Quality Standards for systems that support risk and incident management, residential and home-based aged care service providers are required to comply with the SIRS.

The SIRS seeks to reduce the risk of abuse and neglect of consumers of aged care services and establishes the responsibilities of providers to prevent, manage and report serious incidents. It is important that governing bodies are aware of and understand the mandatory reporting requirements under SIRS to effectively oversee the quality of the services being provided by the provider and to ensure that those involved have responded appropriately to incidents of a serious nature.

Analyse and implement actions

Incident management systems should include an analysis of how and why an incident occurred. The depth and detail of this analysis will depend on the severity, complexity and impact of the incident. However, generally, all incidents should be analysed to determine:

- what factors contributed to the incident occurring
- whether it could have been prevented
- what action needs to occur to prevent a similar incident from occurring again (for example if the incident relates to a consumer, ensuring that a review of their care and services plan has been completed and changes understood by workers.)

An incident management system that encourages incidents and outcomes to be shared transparently and frequently can facilitate deeper analysis and better ways to respond to those incidents.

Actions should reduce risks

Actions identified should be implemented, with roles and responsibilities clearly detailed to drive accountability and reduce the occurrence and risk of the incident. The governing body has a role in ensuring that the processes in place ensure that incidents are actioned appropriately and in line with the organisation's strategic objectives and risk policies. It is important that incident management procedures are transparent and communicated openly with staff, the management team and the governing body to ensure that the actions taken in response to any serious incident are appropriate and reduce future risks to consumers.

Close the loop

Effective incident management systems facilitate the collection of data relating to incidents that enable the governing body to understand:

- What types of incidents are occurring?
- What are the common factors driving incidents?

- What is being done in response to these incidents?
- How do we know we are improving?

An important part of closing the loop is to consider what post-incident management activities need to be undertaken. Activities, such as staff debriefs, follow-ups and check-ins with consumers and their families or providing access to external support services to staff and consumers, are important factors in effective incident management.

Closing the loop is not only a responsibility of management but also of the governing body. The governing body must have confidence that learning and change have occurred in response to the incident and that incident trends have been identified, which can help drive continuous improvement in the delivery of quality care.

Review and continuously improve

Findings and lessons learned should be shared – both in relation to individual incidents and trends in incidents. Often the way to prevent incidents from reoccurring requires open disclosure and communication both within the provider and with any affected parties.

Governing body members are encouraged to ask questions and critically evaluate the information being provided to ensure that the data is appropriate, accurate and reliable. Regular review of incident data can assist in informing considerations of whether any organisational improvements need to be made and if any actions relating to incident management need to be accommodated in the financial planning of the provider.

Ultimately, it is the role of the governing body to have oversight over the policies and procedures relating to incident management and to have insight into all levels of the incident management system. It is important that governing bodies are confident that incidents are being identified, responded to appropriately, recorded into the system, and the agreed actions and learnings are implemented.

Useful references and links

Aged Care Act 2024 | Australian Government Federal Register of Legislation

Strengthened Quality Standards | Aged Care Quality and Safety Commission

Serious Incident Response Scheme | Aged Care Quality and Safety Commission

SIRS decision support tool | Aged Care Quality and Safety Commission

Incident Management Systems | Aged Care Quality and Safety Commission

Open disclosure framework and guidance | Aged Care Quality and Safety Commission