Incident Management System & SIRS

Version: 4
Published: 20 Sep 2022, 1:49 PM
Approved: 20 Sep 2022, Sharon Wilkinson
Last edited: 20 Sep 2022, 1:47 PM
Next review: 5 Aug 2024

INCIDENT MANAGEMENT PRINCIPLES

Peninsula Palms acknowledges a responsibility to provide a safe and secure environment for Residents, employees, contractors, volunteers, visitors, and others. All parties are encouraged to raise any concerns regarding risk, incidents, or safety.

Peninsula Palms is also committed to a culture of continuous quality improvement which includes undertaking a planned and systematic approach to Incident Management to inform future systems and practice.

This Policy provides practical advice and resources to support an Incident Management process which:

- Recognises that all parties involved in an incident need to be treated with respect.
- Provides for natural justice and procedural fairness.
- Meets our statutory obligations regarding risk management and safeguarding of residents, employees, volunteers, visitors, contractors, and other assets and Peninsula Palms' functions, operations and objectives against losses or injury.

This Policy will be made available to:

- Residential Care Recipients (a summary will be added to the Resident Handbook and reference to website for full policy.
- All Staff Members (on Centro Assist) with a copy given out at Orientation; and

Family members, carers, representatives, advocates, and any other person significant to a Residential Care Recipient on the Peninsula Palms website.

Peninsula Palms will assist the abovementioned people understand how the summary version operates.

Peninsula Palms manages incidents based on the following principles:

- Consumer-Centred
- Outcomes-Focused,
- Open Disclosure,
- Accountable,
- Clear, simple and consistent,
- Timely,
- Continuous Improvement.

SERIOUS INCIDENT RESPONSE SCHEME (SIRS) FOR RESIDENTIAL AGED CARE

What is SIRS?

The Serious Incident Response Scheme (SIRS) is a Government initiative that commenced on 1st April 2021 to help prevent and reduce the risk and occurrence of incidents of ***abuse and neglect*** in residential aged care homes subsidised by the Australian Government. The SIRS establish:

- The obligations of approved providers to manage all incidents, focusing on the safety and well-being of the impacted resident/s and to use incident date to drive quality improvement.

- The mandatory reporting of alleged, suspected, or actual serious incidents.

Policy Commitment

The purpose of this policy is to ensure Peninsula Palms

- provides safe, quality care and services for residents.
- promotes a culture of reporting, with a focus on understanding, learning and improvement.
- takes a systematic approach to minimising the risk of incidents occurring.
- supports residents, their families/representatives and staff appropriately should an incident occur.
- The Care Manager or delegate should commence an investigation of any critical incident. A critical incident is defined as a major incident that places residents, visitors and staff at significant risk related to their health, safety or well-being. Critical incidents also include incidents that place the operation of the facility or the organisation at significant risk.
- resolves any incidents that may occur.
- takes action to prevent incidents from recurring.
- Carries out ongoing reviews of internal incident management systems and processes with a view to learning and improvement.

In relation to incidents and near misses, including acts or omissions, the Peninsula Palms Incident Management System will determine,

- what happened.
- how and why, it happened?
- who was involved?
- who was affected (directly or indirectly)?
- what support was offered to all affected persons?
- was open disclosure practised?
- were all affected persons consulted and involved in the review practice?
- what can be done to reduce the risk of recurrence and support safer care?
- was the incident management and investigation process reviewed as a whole for effectiveness?
- what were the learnings and how can they be shared?

Process Guidance

SCOPE

This policy applies to the Facility, Employees, Residents, Volunteers, Students, Contractors and Visitors of Peninsula Palms.

PRINCIPLES OF CONSULTATION

- Peninsula Palms recognises:
  - Consumer engagement necessitates a two-way stream of required communication.
  - The facility is considered the home of each resident.
  - Each resident and/or their authorised representative has the right to participate in decision-making processes concerning their life and the formulation of their care planning.
- Residents and/or their authorised representatives will be a partner in consultation in matters concerning both their care and the overall management of the facility.

INCIDENT MANAGEMENT SYSTEMS

The Peninsula Palms Incident Management System contains the following:

- Governance and Incident Management Responsibilities
- Responding and Reporting
- Critical Assessment Scale (CAS) and Incident Escalation,
- Investigation and Recommendations,
- Documentation,
- Evaluation and feedback,
- Support for Stakeholders,
- Stakeholder consultation and involvement,
- Education and training,
- Data Collection

The Quality Team

- Oversees the Incident Management System including monitoring, reviewing, and reporting on its effectiveness.
- Reviews the policies and procedures to be followed in identifying, managing, and resolving incidents.
- Writes policies and procedures regarding Peninsula Palms' Incident Management system which must be made available to residents and staff, and to family members, carers, representatives, advocates, and any other person significant to residents. It is Peninsula Palms' responsibility to support people to understand how Peninsula Palms Incident Management System operates.

Action and Reporting

- Employees, residents, contractors, volunteers, family members, visitors, and others are informed of emergency procedures through orientation, induction, handbooks, meetings and emergency management.
- The facility has a risk management, hazard, incident and reporting system in place.
- Fire officers are trained and available.
- Peninsula Palms has a Fire Emergency and Disaster Management Folder
- Daily logs of residents, staff, contractors, and visitors' movements are maintained.
- A current list of all resident and their individual evacuation requirements/information is maintained in the event of facility evacuation.
- In any situation involving an incident and or a near miss; employees and management will act in a timely and comprehensive manner to ensure the ongoing safety and security of all persons involved both directly and indirectly.

Notification

After the Occurrence of a notifiable incident, the Care Manager, Care Co-ordinator or Manager is to contact the following (depending on the circumstances):

- Workplace Health & Safety Qld by telephone or in writing, by fax or email (depending on circumstances)
- Qld Coroner
- The local Police
- The Aged Care Quality and Safety Commission
- AHPRA

The notification must provide the information required by the respective regulator.

CRITICAL ASSESSMENT SCALE (CAS) AND INCIDENT ESCALATION

- Peninsula Palms' CAS provides a priority rating for each incident to ensure a standardised objective measure of severity is allocated to each incident to:
    - Inform the level of investigation
    - Implement the required actions and
    - Identify the appropriate reporting, including escalation and referral to the relevant Governing body.
- The Manager will review every incident and with appropriate consultation prioritise them as either:
    - CAS 1 - Extreme Risk
    - CAS 2 - High Risk
    - CAS 3 - Moderate Risk
    - CAS 4 - Low Risk
    - CAS 5 - Negligible Risk
    - (see Decision Matrix Critical Assessment Scale contained within this Policy for more details)
- Any WHS incidents, near misses and or hazards, must be referred to the Manager
- Details of incidents are to be documented through the Peninsula Palms' Incident Management Systems.

Investigation and Recommendations

- The Quality Team will ensure that each incident is investigated with an appropriate investigation methodology and that corrective management processes are implemented and evaluated.
- The Care Manager is associated with the Manager is responsible for coordinating incident management activities within the area of their responsibility including the development of recommendations and their implementation and evaluation.
- In the case of a criminal act or breach of legislation, the relevant authorities will be notified according to the applicable regulatory requirements. In these circumstances, a Critical Incident Investigation may be required and conducted as directed by the Manager.
- Findings from incident investigations will be documented and discussed at relevant meetings as appropriate.
- Each investigation should establish, at a minimum:
    - The causes of the particular incident.
    - The harm caused by the incident.
    - Factors (operational and non-operational issues) that have contributed to the incident occurring; and
    - The nature of the investigation.
- If an external investigator is engaged, they should be provided with the Critical Incident Report Template.
- The investigation results should be shared with the persons affected by the incident and recorded that this has occurred.

Documentation

- All information is gathered with due regard to privacy and confidentiality and is recorded factually and comprehensively and stored securely.
- All clinical incidents should be documented in the **eCase Residents' Incident Register** and **Progress Notes (including the post-incident review progress note)**, and the **SIRS Register** in eCase if necessary. If the incident has been identified because of a complaint, the complaint details should be recorded in the **Compliment and Complaint Register.**
- Facility Incidents should be documented in the eCase Incident Register

- Staff incidents are reported on a staff incident form and added to the Staff Incident Register, once complete the form is placed in the staff member file.
- All incident records must be retained for a period of 7 years after the incident was identified.
- Incident reports are to include at a minimum:
    - A description of the incident includes the harm that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident' and
    - If known, the consequences of that harm.
    - Whether the incident is a reportable incident in accordance with Peninsula Palms' Serious Incident Response Scheme Policy.
    - the time, date and place at which the incident occurred or was alleged or suspected to have occurred.
    - the time and date the incident was identified.
    - the names and contact details of the persons directly involved in the incident.
    - the names and contact details of any witnesses to the incident.
    - the names and contact details of all other persons directly or indirectly affected by the incident.
    - details of the assessments undertaken in accordance with Peninsula Palms' Support for Stakeholder Requirements and Stakeholder Involvement Requirements in this policy
    - and the actions taken in response to the incident, including:
        - actions are taken in accordance with Peninsula Palms' Support for Stakeholder Requirements in this policy.
        - Remedial actions to prevent further similar incidents from occurring, or to minimise the harm arising from similar incidents.
        - Notifying the Police of the incident where required.
        - any consultations were undertaken with the persons affected (directly or indirectly) by the incident in accordance with Peninsula Palms' Support for Stakeholder Requirements and Stakeholder Involvement Requirements in this policy.
        - whether persons (directly or indirectly affected) by the incident have been provided with any reports or findings regarding the incident.
    - if an investigation is undertaken by the provider in relation to the incident - the details and outcomes of the investigation; and
    - the name and contact details of the person making the record of the incident.

Evaluation and Feedback

- Residents, employees, and other stakeholders involved in the incident should be advised of the findings and recommendations of the incident investigation (this must be recorded in progress notes).
- Openness about failures is acknowledged and Residents and their families/support persons are offered an apology and told what went wrong and why (this must be recorded in progress notes)
- Information may be reported through the meeting system or to individuals.
- Review incident reports monthly and identify trends and areas for improvement.
- Reviews of policy, procedure and equipment may occur because of the incident.

Support for Stakeholders

- An assessment must be made and documented of how to appropriately provide support and assistance to persons affected to ensure their safety, health, and wellbeing (this must be recorded in progress notes).
- Any employees, Residents, volunteers, visitors, contractors, and others involved in or affected by an incident **(person/s affected by the incident)** must be assessed to determine the support they require to ensure their safety, health and well-being (this must be recorded in progress notes).
- Once the required support has been determined, this must be deployed to the person/s affected by the incident and documented (this must be recorded in progress notes).

- Throughout the incident process, you must seek feedback from the person/s affected by the incident to determine that the support deployed remains effective and suitable (this must be recorded in progress notes).
- At all times an open disclosure process must be followed see Peninsula Palms' Disclosure Policy for more information (this must be recorded in progress notes).
- Support must be provided to the Residents affected by an incident (including information about access to advocates), to ensure their health, safety and wellbeing (this must be recorded in progress notes).

Stakeholder Involvement

- An assessment must be made and documented of how to appropriately involve each person/s affected by the incident or their representative, in the management and resolution of the incident. Each person should also be consulted to determine how they would like to be involved (this must be recorded in progress notes).
- Following this assessment, each person or representative must be involved in the process as determined by the assessment (this must be recorded in progress notes).
- The views of each person/s involved in the incident should be ascertained and recorded in the progress notes in respect of:
    - Whether the incident could have been prevented.
    - What remedial action needs to be undertaken to prevent further similar incidents?
    - How well the incident was managed and resolved.
    - Any suggestions as to how Peninsula Palms could improve its management and resolution of similar incidents?
    - Whether other persons or bodies need to be notified of the incident.
- At all times, an open disclosure process must be followed see Peninsula Palms' Open Disclosure Policy for more information.

Education and Training

- The Quality Team will facilitate employee and volunteer education and training as appropriate.

Data Collection

- All information gathered in the Documentation process must be stored securely on eCase with due regard to privacy and confidentiality.
- The data collected on eCase will be regularly reviewed by the Care Manager and Manager to:
    - Identify occurrences of similar incidents.
    - Identify and address systemic issues in the quality of care provided by Peninsula Palms.
    - Provide feedback and training to staff about managing and preventing incidents; and
    - Provide to the Aged Care Quality and Safety Commission as required.
- Data Collected in accordance with this section will be regularly reviewed and analysed by the Peninsula Palms to assess:
    - The effectiveness of Peninsula Palms' management and prevention of incidents; and
    - To identify actions that can be taken to improve Peninsula Palms' management and prevention of incidents.

CRITICAL INCIDENT MANAGEMENT

Critical incidents include but are not limited to incidents to a resident, worker, or others where the resulting damage leads to fatality or severe permanent physical or psychological impairment.

Resident:

- Priority 1 SIRS incident, and
- Notifiable Illness Outbreak - COVID-19 only

Complaints:

- Issues regarding serious events or grossly substandard care, or death of a resident as a result of receiving care in a manner that is unrelated to the natural course of the illness and differing from the expected outcome of management of resident care.

Staff, Volunteer, Contractor or Visitor:

- The accidental or unexpected death of a Staff Member, Volunteer, Contractor or Visitor
- Incidents instigating a visit by Safe Work.
- The incident led to a permanent injury to a staff member.

Service Impact:

- Complete Loss of Service Due to Natural Disasters / Fire or Widespread Equipment Failure.
- Evacuation of Service
- Bomb Threat, Armed Hold Up.
- Improvement or Penalty Notice Issued by Safe Work.

SERIOUS INCIDENT RESPONSE

What is a SIRS Incident?

A SIR's incident is any of the following incidents that **have occurred**, are **alleged** to have occurred, or are **suspected** of having occurred to a resident in residential aged care. These incidents **must be** reported to the Commission.

1. Unreasonable use of force against a resident - refers to unreasonable use of force fact sheet

2. Unlawful sexual contact, or inappropriate sexual conduct, inflicted on a resident - refer to unlawful sexual contact or inappropriate sexual conduct fact sheet.

3. Psychological or emotional abuse of a resident - refers to the psychological or emotional abuse fact sheet.

4. Unexpected death of a resident - refers to the unexpected death fact sheet.

5. Stealing from, or financial coercion of, a resident by a staff member of the provider - refer to stealing or financial coercion fact sheet.

6. Neglect of a resident - refer to neglect fact sheet.

7. Inappropriate use of restrictive practices of a resident (other than in the circumstances set out in the Quality of Care Principles_ - refers to inappropriate use of restrictive practice fact sheet.

8. Unexplained absence of a resident from the Facility - refer to unexplained absence from the care fact sheet.

SIR's incidents involving another resident at the facility must be reported irrespective of whether that resident has an assessed cognitive impairment. For example, if a staff member witnesses an incident involving unreasonable use of force on a resident by another resident with a diagnosis of dementia, this maybe be notified. The exemption from reporting under the previous compulsory reporting scheme no longer applies.

The facility MUST notify the Commission of all SIRS incidents, even where the facility believe that have acted and responded appropriately, or where an internal or police investigation is underway.

It is the facility's responsibility to notify the Commission of a SIRS incident applies regardless of whether the resident and/or their representative or family wish the incident to be notified.

The Facility is required to determine how to appropriately involve people affected by the incident (or their representatives) in managing and resolving the incident, but this does not mean they can decide whether the incident is reported to the Commission or not.

UNREASONABLE USE OF FORCE AGAINST A RESIDENT

The definition of unreasonable use of force for the SIRS is:

Unreasonable use of force on a resident, ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force.

This category of SIRS incidents **does not include** touching an aged care resident to attract their attention, guide them, or comfort them if they are distressed. It is recognised that in the aged care environment, there may be circumstances where a staff member could be genuinely trying to assist a resident, and despite their best intentions the resident is injured because the person bruises easily or has fragile skin. Injury alone therefore may not provide evidence of either the use of unreasonable force or the seriousness of an assault.

The below examples are illustrative only.

Please refer to the Unreasonable Use of Force Fact Sheet

What is not unreasonable use of force?	What is unreasonable use of force?

• Gently touching a resident to attract their attention or to guide them • Gently touching a resident to comfort them if they are distressed. • Accidental contact (unless it is careless or negligent). • Physical contact that has lawful justification. For example, pushing a resident out of harm's way (such as out of the way of an oncoming car that would otherwise hit them or out of the way of a falling item. • Reasonable management or care of a resident considering any relevant code of conduct or professional standard. For example, where a staff member is genuinely trying to assist a resident and is acting in accordance with applicable professional standards and, despite the staff member's best intentions, the resident receives a small scratch that causes them no discomfort. • Minor disagreements between residents. For example, where one resident taps another resident on the hand as the result of a disagreement over a card game. • Potential incidents. For example, where a resident is prevented from harming another resident through the intervention of a staff member or other person.	• The use of unwarranted or unjustified physical force against a resident, including any rough handling of the resident in the delivery care and services. • Physical force includes actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards residents, or making threats of physical harm. • Deliberate physical attacks or assaults on a resident. • Any physical behaviour towards a resident that is an offence under the law of a state or territory. • Incidents of physical contact that in isolation may not be significant but when they occur over an extended period of time, have an impact on the resident. For example, a pattern of rough handling during the provision of care.

UNLAWFUL OR INAPPROPRIATE SEXUAL CONTACT INFLICTED ON A RESIDENT

The definition of unlawful or inappropriate sexual contact for the SIRS is:

***Unlawful sexual contact, or sexual misconduct committed against, with, to, or in the presence of a resident*.**

It is important to note that residents of aged care homes have the right to sexual freedom and to give and receive affection. In the Charter of Aged Care Rights, residents have the right to:

"have control over and make choice about by care and personal and social life, including where the choices involve personal risk"

This category does not include consenting sexual relations between aged care residents or between an aged care resident and a partner that is not a resident at the facility (e.g. that may visit or volunteer at the facility).

Understanding the Capacity to Consent

When considering the nature of sexual contact, it can be useful for providers to consider the following questions:

- Does the resident have the capacity to consent to this particular activity, at this time?
- Does the resident have the capacity to participate in the activity?
- Does the resident have the capacity to agree to participate in the activity?
- Does the resident show sign of distress?

Determining a resident's capacity to consent to sexual activity is a decision that may also be informed by an assessment by a health professional, which should be considered on a case-by-case basis. If it is determined that the resident has the capacity to consent to the particular activity at that particular time, and the resident's family and/or carer disagree with that assessment, providers should manage that through careful and sensitive discussion.

The capacity to consent should be reviewed on a regular basis. If you have doubt about a resident's capacity to consent to an incidence of sexual contact, then the incident should be notified. Any incident of sexual contact that results in a resident being distressed or upset should also be notified.

Notes:

Any allegation or suspicion of unlawful sexual contact **must be assessed by the Medical Practitioner immediately. If MP is unavailable within 2 hours, transfer the resident to the hospital.** Do not shower, remove clothing, or alter the Resident and environment in any way. DNA evidence may be required for investigation. To get this evidence, a MP or the emergency department will need to take samples of the Resident's saliva, urine, blood, clothing and public hair, and swabs from the Resident's mouth, rectum and genitals.

The below examples are illustrative only.

Please refer to the Unreasonable Sexual Contact or Inappropriate Sexual Conduct Fact Sheet

What is not unlawful sexual contact or inappropriate sexual conduct?	What is unlawful sexual contact or inappropriate sexual conduct?

• Consensual acts of affection such as greeting someone with a kiss on the cheek or a hug • Consensual sexual relations between residents, or between a resident and their partner who is not a resident at the Facility. • Gestures of comfort, for example, a carer rubbing a resident's back or patting a resident on the knee where this aligns with the resident's personal preferences. • Helping a resident to wash and dry themselves, where the carer is acting in accordance with applicable professional standards.	• Any conduct or contact of a sexual nature inflicted on the resident by a staff member of a person who provides care or services for the provider, while that person is providing such services (e.g. while volunteering) • Sexual contact without the resident's consent, against their will or where the consent is negated for other reasons such as lack of capacity to consent. • Having sexual intercourse or sexually penetrating a resident (with a body part or an object) without consent. • Touching resident's genitals (or other private areas) without a care need. • A person masturbating, showing their genitals to a resident, or exposing themselves in the presence of a resident. • Undressing in front of a resident or watching residents undress in circumstances where supervision is not required. • Inappropriate exposure of residents to the sexual behaviour of others. • Sexual innuendos, sexually explicit language or showing pornography to a resident or using a resident in pornography. • Grooming, stalking, or making sexual threats to or in the presence of a resident. • Forcing, threatening, coercing, or tricking a resident into sexual acts. • Unlawful sexual contact encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory, or the Commonwealth

PSYCHOLOGICAL OR EMOTIONAL ABUSE OF A RESIDENT

The definition of psychological or emotional abuse of a resident for the SIRS is:

Verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person or acknowledge the person's presence.

In addition to single event incidents such as a staff member yelling at an aged care resident, this category includes incidents that are part of a pattern of abuse. While the behaviour may not cause significant harm or suffering to the individual in each instance, the repetitive nature of the behaviour (over time) has a cumulative effect that intensifies the level of harm to the individual or in some circumstances individuals.

Approved providers' incident management systems must be able to record incidents in a way that allows for repeated minor instances of these types of behaviour to be identified easily so that any pattern of abuse can be identified and reported as a single SIRS incident.

The below examples are illustrative only.

Please refer to the Psychological or Emotional Abuse Fact Sheet

What is not psychological or emotional abuse?	What is psychological or emotional abuse?
• A person raising their voice to attract attention or speak with a resident who has hearing difficulties. • Minor disagreements between residents • Making reasonable requests of a resident to enable the safe and effective delivery of care and services (for example, asking a resident to cooperate or encouraging a resident to eat their dinner?	• Yelling, name-calling, bullying or harassing a resident. • Humiliating or intimidating a resident. • Making threatening or aggressive gestures towards a resident or feigning violence. • Unreasonable ignoring a resident, threatening to withhold care or services from a resident or threatening to mistreat a resident. • Unreasonably refusing resident access to care or services (including as a punishment) • Taunting, making disparaging comments about a resident's gender, sexual orientation, sexual identity, cultural identify, or religious identity or constantly criticizing a resident. • Making repeated actions such as flicks, taps and bumps to a resident (which of itself does not constitute physical assault but the repetitive nature causes psychological or emotional anguish, pain, or distress). Any action inflicted on a resident where the individual is knowingly causing anguish or distress to a resident (for example, calling a resident by the wrong name or ignoring a resident's expressed (and reasonable) preferences).

UNEXPECTED DEATH OF A RESIDENT

The definition of unexpected death for the SIRS is:

***Death is unexpected, where steps may not have been taken to prevent death or the death results from an intervention*.**

Death may occur immediately, or sometimes after a 'mistake' was made or a 'failure' or incident occurred. Where the death could reasonably be considered to be related to a mistake, failure, or incident, this should be notified to the Commission, even where a coroner has not yet determined the cause of death, or where the provider is advised of such a death which may not have occurred at the Facility.

The Facility is not required to notify the Commission of all deaths where the cause of death is yet to be confirmed, **only those that could reasonably be considered to be related to a mistake, failure, or incident.**

All unexpected deaths are considered Priority 1 SIRS incidents for the purpose of notifying the Commission.

The below examples are illustrative only.

Please refer to the Unexpected Death Fact Sheet

What is not an unexpected death?	What is an unexpected death?
• Where a resident dies because of an ongoing illness, disease or condition that was appropriately assessed, monitored and managed (including where the resident was receiving palliative care and appropriate end-of-life medications) • Where a resident is involved in an incident and later dies because of an unrelated condition or illness. • Deaths resulting from outbreaks of disease (for example, separate reporting processes have been established in relation to outbreaks of COVID-19)	• Where a resident falls while being moved or shifted, with the injuries sustained contributing to or resulting in the resident's death. • Where poor quality clinical care is provided to a resident contributing to or resulting in their death. For example, a pressure injury or wound is untreated or not regularly tended to and becomes infected resulting in the resident's death. • Where medical assessment or treatment is delayed, contributing to or resulting in a resident's death. For example, a resident falls and is not assessed immediately afterwards and later dies because of injuries sustained from the fall

STEALING FROM, OR FINANCIAL COERCION OF A RESIDENT BY A STAFF MEMBER

The definition of stealing from or financial coercion of a resident by a staff member is:

Stealing from an aged care resident or behaviour that is coercive, deceptive, or unreasonable controls the finances of an aged care resident by a staff member.

Incidents of stealing or financial coercion notifiable under the SIRS are limited to the actions of a staff member of the facility. A staff member is defined in the legislation to include an individual who is employed, hired, retained, or contracted by the provider (whether directly or through an agency) to provide care or other services.

When assessing where the facility is required to report an incident, suspicion, or allegation of stealing by a staff member, not every missing item must be notified to the Commission. However, the facility is required under the SIRS to notify the Commission if there is a reasonable belief that a staff member is responsible for a missing or stolen item or items.

Missing items and Unknown offenders

Where a resident's money or valuables go missing without explanation, the facility should try to help the resident to locate the item(s). **If they cannot be found and the resident believes that a staff member is responsible and appears concerned or distressed about the loss, this should be notified to the Commission.** If the item is subsequently located, the facility should provide an update to the Commission.

It is acknowledged that the facility may not always be able to identify the subject of the allegation at the time of reporting an incident of stealing. However, it is expected that the facility will conduct an investigation to try to locate the item and/or to identify who stole the item or how it came to be missing / reported stolen.

The below examples are illustrative only.

Please refer to Stealing or Financial Coercion by a Staff Member Fact Sheet

What is not stealing or financial coercion?	What is stealing or financial coercion?
• Where a resident willingly, of their own volition, buys a staff member a coffee while out for an appointment. • Where a resident of their family gives a carer a gift to thank them for their support. • Where items go missing but are quickly found to have been misplaced.	• Where a staff member coerces a resident to change their will in favour of the staff member. • Where a staff member steals money or valuables from a resident. • Where a staff member asks or coerces a resident to buy something for them or another person. • Where a staff member uses power of attorney to steal money from a resident. • Where an item goes missing and the resident (or their family) have alleged or suspected that a staff member is involved.

NEGLECT OF A RESIDENT

The definition of neglect for the SIRS is:

Intentional or reckless failure in the duty of care for an aged care resident may also be a gross breach of professional standards resulting in significant harm or the potential to result in death or significant harm.

Neglect may be because of systemic issues within an aged care facility, for example, lack of appropriate policies, procedures and/or practice resulting in poor quality care for aged care residents. Neglect may also be the deliberate and negligent conduct of one individual either as a one-off incident or repeated incidents.

Noting residents have the right to have control over and make choices about their care. This category **is not** intended to capture situations where a resident chooses not to shower, or a resident with diabetes refuses to eat a diabetic diet and as a result, has a wound with a poor healing prognosis.

The below examples are illustrative only.

Please refer to Neglect Fact Sheet

What is not neglect?	What is neglect?

• An isolated incident of late or missed administration of medications where there is no significant impact on the resident. • Rapid weight loss because of disease, where all reasonable efforts are made to ensure the resident is receiving adequate nutrition. • Where a resident chooses not to receive care and services in line with their assessed care need, for example: • Where a resident with dysphagia chooses not to eat a liquified diet and is appropriately supervised while eating. • Where a resident with diabetes chooses not to eat a diabetic diet. • Where a resident with liver disease chooses to drink alcohol. • Where a resident chooses not to shower, brush their teeth, or brush their hair. • When a resident with a chronic condition or disease chooses not to undergo clinical treatment • Where a resident chooses to smoke despite having a chronic respiratory condition or other conditions exacerbated by smoking	• Depriving a resident of basic necessities, including food, drink, or clothing. • Withholding personal care, such as showering, toileting or oral care. • Regular late or missed administration of medications, or failure to administer time-critical medications. • Failing to supervise a resident in an environment that leaves them susceptible to injury. For example: • Leaving a resident outside unprotected in the sun resulting in significant burns. • Leaving a resident enclosed in a vehicle on a hot day where the temperature in the vehicle is likely to increase rapidly and cause significant harm to the resident. • Failing to supervise residents where they may wander into unsafe environments such as busy roads, construction sites or bodies of water. • Failing to monitor a resident's nutrition and hydration results in rapid weight loss and clinical complications. • Failing to seek appropriate medical assessment and treatment for a resident who appears unwell or is injured. For example: • Failure to treat injuries or wounds. • Failure to assess and manage pain. • Failure to seek medical diagnosis or treatment when a resident shows signs of illness. • Failure to call an ambulance when the resident's injuries or illness require treatment in the hospital. • Failing to ensure a resident is reviewed regularly by a health professional or specialist in line with their documented care needs. • Failing to appropriately modify a resident's meals to account for their difficulty of swallowing as recorded in their care plan or failure to give sufficient assistance to a resident to eat their food, resulting in the resident not being able to eat meals or choking. • Lack of consistent clinical oversight exacerbates conditions requiring acute care, such as lymphedema, contractures, catheter care and infections.

INAPPROPRIATE USE OF RESTRICTIVE PRACTICES OF A RESIDENT

The definition of inappropriate physical or chemical restrictive practice for the SIRS is:

The use of restrictive practice that does not meet the requirements of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*. Note: From 1 July 2021, the term physical and chemical restraint will be replaced with the term restrictive practice to align with the NDIS approach.*

From 1 July 2019, the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019 requirements apply to approved providers of residential care to minimise the use of physical and chemical restrictive practices. Only when providers

have explored alternatives to restrictive practice, and satisfied a number of conditions, can restrictive practice be used as a last resort. The requirements were amended on 1 July 2021.

Any use of restrictive practice that is inconsistent with the requirements in the Quality of Care Principles must be notified to the Commission.

The below examples are illustrative only.

Please refer to the Inappropriate use of Restrictive Practice Fact Sheet

What is not an inappropriate use of restrictive practice?	What is an inappropriate use of restrictive practice?
• Where a RAC facility uses restrictive practices consistent with the requirements in the Quality of Care Principles. • Where a RAC facility uses restrictive practices without consent in an emergency situation and the restrictive practices substitute decision-maker is informed as soon as practicable after the restrictive practice starts to be used. • Where a RAC facility administers a drug to a resident as prescribed for the treatment of a diagnosed health condition and this is documented.	• Restricting a resident's movements other than in line with the appropriate use of restrictive practices. For example, inappropriate use of bed rails or a lowered bed that makes it difficult for a resident to get out; placing a table or something in front of a resident in order to limit their ability to move; using vortex illusions (such as floor rugs) that prevent the resident from moving because of their fear of the illusion. • Seclusion or confinement of a resident where the voluntary exit is prevented or not facilitated. • Use of a bed belt or lap-sash restraint. • Physically blocking a resident's path, holding on to a resident to prevent their movement, or holding a resident down. • Removing the batter out of a resident's electric wheelchair or putting mobility aids out of a resident's reach to limit their movement. • Restrictive practices used in an emergency do not comply with the requirements in the Quality of Care Principles. • Any drug that is used to control, sedate, or restrict the movement or behaviour of a resident instead of for the treatment of a diagnosed health condition.

UNEXPLAINED ABSENCE OF A RESIDENT FROM THE FACILITY

A SIRS report of an unexplained absence from the facility will occur where the:

- The resident is absent from the facility; and
- the absence is unexplained (i.e. the resident is missing from the facility and you are unaware of any reason for their absence); and
- there are reasonable grounds for reporting the absence to the Police (whether or not the absence has been reported to the police)

It is expected that the facility will report an unexplained absence to the police within a reasonable timeframe so an appropriate response and actions can be taken to locate the resident. The facility is also required to report eh absence to the Commission as soon as reasonably practicable, and within 24 hours after becoming aware of the incident.

All incidences of the unexplained absence of a resident are considered to be Priority 1 SIRS incidents for the purposes of notifying the Commission.

Absent Residents who Return

If a resident returned to the facility before the facility became aware that they were missing, there is no requirement to notify the Commission. However, the facility must notify the absence of the Commission if the police are aware of the resident's absence where the resident has been returned to the facility by the police.

All unexplained absences of a resident should be recorded in the facility incident management system, and the resident's care plan, so that resident behaviours or wandering patterns can be understood and properly managed.

WHAT IS ELDER ABUSE?

The definition of elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

Abuse of older people may take different forms and can include financial, psychological, physical, sexual abuse or neglect. These forms of abuse may occur at the same time. The definition of abuse **does not include self-neglect or self-harm.**

All elder abuse must be reported immediately to the most senior staff member on duty at the facility who will report to the Manage. This means you must make a report if you suspect that elder abuse may have occurred or if you have witnessed or been informed of elder abuse.

The manager will determine whether the elder abuse incident is a Priority 1 or Priority 2 SIRS reportable incident and follow the attached **10 Decision Matrix: 'SIRS Incident'** to report to **the police and the Commission.**

DISTINGUISHING TYPES OF INCIDENTS AS PRIORITY 1 OR PRIORITY 2

When determining if an incident is a SIRS reportable incident, we encourage staff to use the Aged Care Quality ad Safety Commission's SIRS Decision Tool.

Distinguishing types of incidents as Priority 1 or Priority 2

The period of time within which to report a reportable incident to the Commission will depend on your categorisation of the incident based on your assessment of the harm and/or discomfort caused to the consumer.

A reportable incident can be categorised as either:

• a Priority 1 reportable incident, or

• a Priority 2 reportable incident.

Subsection 15NE(2) defines a Priority 1 reportable incident as a reportable incident:

• that caused, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or

• where there are reasonable grounds to report the incident to the police, or

• that is a consumer’s unexpected death or a consumer’s unexplained absence from the service.

Categorisation of the incident as Priority 1 or Priority 2 determines the relevant timeframe for reporting the incident to the Commission and the information required to be reported.

When will a reportable incident be a Priority 1 reportable incident?

If you become aware of a reportable incident and have reasonable grounds to believe that the incident is a Priority 1 reportable incident, you must notify the Commission within 24 hours of becoming aware of the reportable incident.

A Priority 1 reportable incident is a reportable incident:

• that caused, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or

• where there are reasonable grounds to report the incident to the police, or

• that is an unexplained absence of a consumer from the service where there are reasonable grounds to report the absence to the police, or

• that is an unexpected death of a consumer; this includes death in circumstances where:

— the death is a result of care or services provided by the approved provider, or a failure of the approved provider to provide care or services; or

— reasonable steps were not taken by the approved provider to prevent the death.

The Commission considers all incidents of unlawful sexual contact or inappropriate sexual conduct to be Priority 1 reportable incidents.

Physical or psychological injury or discomfort

Reportable incidents that cause, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological

treatment to resolve will be Priority 1 reportable incidents regardless of whether:

• the injury or discomfort caused to the consumer is temporary or permanent

• the medical or psychological treatment is provided to the consumer at the service or elsewhere.

Physical or psychological injury or discomfort includes but is not limited to:

• consumer distress requiring support or counselling

• cuts, abrasions, burns, fractures or other physical injuries to a consumer requiring assessment and/ or treatment by a nurse, doctor or allied health professional

• bruising, including large individual bruises or a number of small bruises over the consumer that requires medical or psychological treatment to resolve

• head or brain injuries which might be indicated by concussion or loss of consciousness

• injury or impairment requiring the consumer's attendance at or admission to a hospital

• the death of a consumer.

If a consumer is hospitalised in relation to a reportable incident, the incident should be treated as a Priority 1 reportable incident. There will be instances in which consumers are hospitalised for reasons unrelated to injury or harm resulting from

an incident, and these instances are not reportable incidents. Hospitalisation includes a consumer's presentation or admission to an emergency or other ward within a hospital facility (including short-stay admissions) where this is related to an injury acquired from an incident.

A Priority 1 reportable incident also includes incidents that could have reasonably caused a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve. This ensures that incidents that a reasonable person would consider could have caused a consumer harm or distress are also captured, particularly where a consumer has a cognitive impairment, memory deficit or such other condition that prevents them from articulating or displaying evidence of harm and/or discomfort.

When will a reportable incident be a Priority 2 reportable incident?

A Priority 2 reportable incident includes any reportable incident that does not meet the Priority 1 criteria as outlined above.

Examples of a Priority 2 reportable incident may include where the consumer is momentarily shaken or upset or where the consumer experiences temporary redness or marks that do not bruise.

In these cases, where medical or psychological treatment for the consumer is not required, the reportable incident will be a Priority 2.

Documentation and Process Map for Managing CAS 1 Incident

SIRS Decision Matrix - Critical Assessment Scale

Decision Matrix Flowchart

Roles and Responsibilities

EMPLOYEES OF PENINSULA PALMS

- Comply with all requirements of the Incident Management System; and
- Report all identified incidents (clinical and non-clinical) including allegations, critical incidents, near misses and complaints and document appropriately.
- Identify and engage in the minimisation of clinical, non-clinical and corporate risks that may exist in their area of employment.
- Demonstrate knowledge of:
    - The required initial response to an incident and or a near miss, including the provision of appropriate initial treatment.
    - The reporting process is required to escalate an incident or a near miss to the relevant people.
- Follow Incident Escalation procedures (i.e. Report a Critical Incident immediately to the Facility Manager or Care Manager and ensure affected/injured parties are provided with appropriate emergency responses and care).
- In the case of the death of a person, adhere to the legislative requirements for a potential Coroner's Case by **not touching the body or any equipment.**

- Preserve the area involved in the Critical Incident in accordance with regulatory requirements including and as appropriate:
    - Isolating the area and surroundings in which the Critical Incident occurred.
    - Isolating any equipment that was being used in the events preceding the Critical Incident.
    - Identifying and actioning any remaining danger.
- Complete training and assessment on induction, and at regular intervals as requested by Peninsula Palms, in relation to:
    - The use of Peninsula Palms' Incident Management System Policy.

ROLES AND RESPONSIBILITIES

All Staff

- Complete mandatory training in incident management and SIRS.
- Inform their supervisor if any aspects of Incident Management or SIRS are unclear to them.
- Report all critical incidents to their supervisor, Care Coordinator, Care Manager or Manager immediately after ensuring that any resident impacted by the incident is attended to.
- Update resident progress notes as required.
- Report all other incidents to their supervisor, RN Co-ordinator, or Manager as soon as possible.
- Follow the instructions of the RN Co-ordinator or Manager within 2 hours.

The Quality Team:

- Will meet the obligations under the Serious Incident Response Scheme, reporting SIRS incidents to the ACSQC within the statutory timeframes.
- Will provide appropriate responses and resolutions to Critical Incidents.
- Is to incorporate the learning from Critical Incident Investigations into Peninsula Palms' Quality Improvement System.
- This is to ensure that all Clinical Critical Incidents are recorded and reported.
- This is to ensure that all Non-Clinical Critical Incidents are recorded and escalated appropriately through the Board and their system for reviewing Quality and WHS matters.

The Manager (or Delegate) is required to:

- Provide timely Board Reporting of relevant results and analysis of incidents investigations.
- Coordinate incident management activities including the development of recommendations and actions for the facility.
- Ensure that all Residents, Staff, authorised representatives, and visitors to the facility have access to incident reporting mechanisms.
- Ensure that all residents, staff, authorised representatives, and visitors to the Facility have been orientated to incident management processes.
- Provide education and counselling for staff where required.
- Provide support to all persons affected (directly and or indirectly).
- Escalate and report any Critical Incident to the Executive Director by telephone as soon as possible of the incident occurring.
- Work with the Quality Team
- Record Critical Incidents through Peninsula Palms' Incident Management and Quality Systems.
- Ensure serious and critical incidents are reported to relevant external regulatory bodies (ASQSC, Safe Work) within the statutory timeframes.

The Lead Investigator (Care Manager, Care Coordinator or Manager) is responsible for:

- Collecting the documentation to support the investigation
- Undertaking interviews in line with the investigation plan
- Escalating any identified, ongoing risk to the manager and CEO immediately.
- Providing a preliminary report to the manager within 48 hours
- Compiling a full report within 3 - 5 days as determined by the Manager.
- Providing the manager with all documents
- the Lead Investigator must abide by the following principles when investigating
    - Natural justice and procedural fairness
    - Privacy and confidently including disclosure of information to third party
    - Openness and transparency in consultation with the quality team
    - The process relating to recording interviews
    - Follow processes when dealing with external agencies
    - procedures relating to conflict of interest and defamation
    - Procedures relating to protecting information and legal privilege
    - Sound documentation management/preservation and recording

Glossary

SIRS Glossary