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# Incident Learning

Flip Guides have been designed as supplementary supports for the learning modules. The Guides include key messages and insights for your continued reflection.

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# Need to Know: Incident Learning

The aged care sector requires governing bodies and executives to place greater emphasis on improving the quality of care and safety for consumers. A large element of improving safety and the quality of care can be associated with an organisation's capability for incident learning and management.

It is essential that governing body members ensure that the necessary mechanisms, policies and supports are in place for organisations to effectively engage in incident learning.

To achieve better practice incident learning, providers must educate their workforce, develop supporting policies and procedures, and ultimately ensure that continuous improvement of care and consumers are placed at the centre of all aspects of planning, delivery, and evaluation of care and services.

When viewed as important and effectively delivered, incident learning in an organisation be greatly benificial.

➔ *Read about the benefits on the following page.*

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# Need to Know: Incident Learning

**01**

Support the provision of safe, high quality care for consumers

**02**

Support organisations to understand and engage with risk, including meeting the needs and preferences of consumers

**03**

Empower consumers and their family/carers, giving them confidence in the care and services the organisation provides

**04**

Support an open, blame free culture, with a focus on understanding, learning and continuous improvement

**05**

Help support and retain staff

**06**

Support providers to meet their responsibilities as set out in the Aged Care Act 1997, the Quality of Care Principles 2014, and the Aged Care Quality Standards, such as those related to incident management systems, reportable incidents, open disclosure and the management of high-prevalence risks.

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# Incident Learning: Obligations and Accountabilities

All providers of residential aged care and home care services have a range of obligations in relation to incident management which are set out in the **Aged Care Act 1997**, the **Quality of Care Principles 2014**, and the **Aged Care Quality Standards**.

It's a provider's responsibility to prevent, manage, respond effectively to, and minimise the risk of incidents, noting that this applies to all incidents not just the incident types reportable under the SIRS. Incident management and prevention responsibilities apply to incidents that occur 'in connection with' the provision of care and services to consumers. This includes:

- any acts, omissions, events or circumstances that occur, are alleged to have occurred, or are suspected of having occurred in connection with the provision of care and services to a consumer, and
- that have, or could reasonably have been expected to have, caused harm to a consumer or another person.

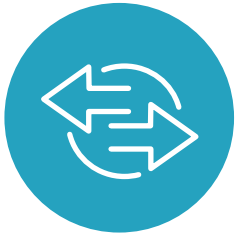
Outlined on the right are some of the key incident management obligations. The governing body and executives should be familiar with the detail of these obligations and be confident that their organisation is compliant with all of these requirements.

➔ *Find prompt statements on the following pages to assit you in understanding whether your provider is meeting it's obligations*

Incident Management System

Reportable Incidents

Open Disclosure



Protections for those providing information or reports on reporting incidents

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# Incident Learning: Obligations and Accountabilities

## Incident Management System

- My organisation has an incident management system for all types of incidents (both reportable and non-reportable).
- Our governing body has developed and established documented procedures to be followed in identifying, managing and resolving incidents.
- My provider's workforce, consumers and their families can easily access and understand the documented procedures to understand how the system operates.
- I am confident that our incident management system captures consistent data and information about incidents that occur, in keeping with the requirements of the Aged Care Act 1997.
- I am aware of how my provider's incident management system captures information about incidents in a form that allows for:
  - The identification of trends in incidents
  - The use of the information to drive quality improvement
  - Sharing of information to the Commissioner, if required.
- I'm confident that my organisation can effectively respond to an incident by:
  - Providing support and assistance to ensure the safety, health and well being of consumers affected by the incident
  - Appropriately involving each person (or their representative) affected by the incident in the management and resolution of the incident
  - Using an open disclosure process.
- I am aware of the process to assess incidents to enable greater understanding of:
  - Whether the incident could have been prevented
  - Any remedial action that needs to be undertaken to prevent further similar incidents from occurring
  - How well the incident was managed and resolved and actions that could be taken to improve the provider's management and resolution of similar incidents.

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# Incident Learning: Obligations and Accountabilities

## Reportable Incidents

- As a governing body we are confident our workforce is aware that reportable incidents occurring in residential, home and community settings must be reported within specified timeframes.

  **Note:** There has been an update to include the requirement of home care services to report incidents. View the Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022 for more information, and view the What is SIRS? Information for home services care recipients page for guidance for home care service providers.

  – Priority 1 incidents are required to be reported within 24 hours. Priority 1 incidents are reportable incidents that cause, or could reasonably have been expected to have caused, physical or psychological injury or discomfort requiring some form of medical or psychological treatment, or where there are reasonable grounds to report the incident to police. View the Serious Incident Response Scheme page for more information.

  – Priority 2 incidents are required to be reported within 30 days. Priority 2 incidents are reportable incidents that do not meet the criteria for Priority 1. View the Serious Incident Response Scheme page for more information.

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# Incident Learning: Obligations and Accountabilities

## Open Disclosure

- Our provider utilises open disclosure in response to incidents and incident management.
- Our governing body regularly reviews and refreshes our clinical governance framework ensuring it includes open disclosure and matches the strategic priorities of our provider.

## Protections for those providing information or reports on reporting incidents

Our provider workforce are aware that if certain reporting requirements are met the following protections apply to any person making a disclosure:

- Will be protected from any civil or criminal liability for making the disclosure
- Will have qualified privilege in proceedings for defamation relating to the disclosure
- Is not liable to an action for defamation relating to the disclosure
- Is protected from someone enforcing a contractual or other remedy against that person based on the disclosure.

Further information on reporting requirements and protections can be found at on the Serious Incident Response Scheme for Providers page.

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# SIRS

## What is a reportable incident under the SIRS?

Serious incidents include those examples where consumers experience:

- Unreasonable use of force hitting, pushing, shoving or rough handling.
- Unlawful sexual contact sexual threats or stalking, or sexual activities or inappropriate sexual conduct without consent.
- Neglect withholding personal care, untreated wounds, or insufficient assistance during meals.
- Psychological or emotional abuse yelling, name calling, ignoring a consumer, threatening gestures or refusing a consumer access to care or services as a means of punishment.
- Unexpected death in the event of a fall, untreated pressure injury, or when the actions of a consumer result in the death of another consumer.
- Stealing or financial coercion if a staff member coerces a consumer by a staff member to change their will to their advantage, or steals valuables from the resident.
- Inappropriate use of restrictive practices where restrictive practices are used other than in the circumstances set out in Part 4A of the Quality of Care Principles, such as without prior consent or without notifying the consumer's restrictive practices substitute decision-maker as soon as practicable, where restrictive practices are used in a non-emergency situation, or when a provider issues a drug to a consumer to influence their behaviour as a form of chemical restraint.
- Unexplained absence from care this occurs when the consumer is absent from the service, it is unexplained and has been reported to the police. Under the SIRS, an allegation, suspicion or witness account of any of the above serious incidents must be reported to the Commission.

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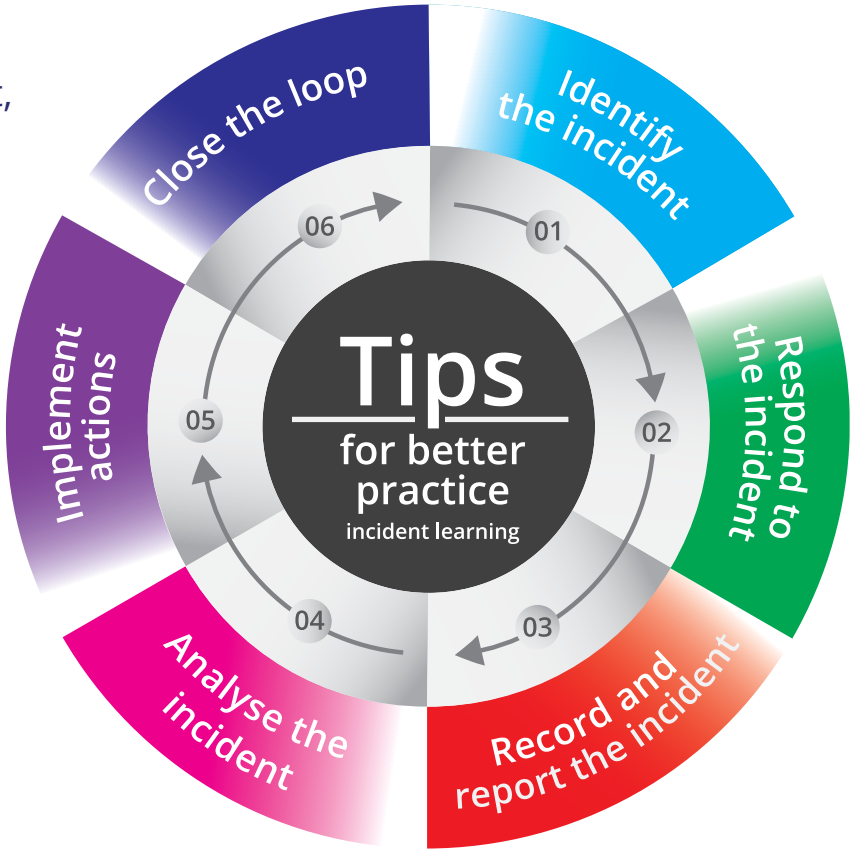
# Tips for Better Practice Incident Learning

Better practice incident learning is not only a responsibility of a provider's workforce and management, but also of a provider's governing body and executives. The governing body must have confidence that when an incident occurs, it is identified and managed correctly, with lessons from the incident used to inform ongoing quality of care practices.

There are six steps to effective incident learning.

➔ Read more about each step on the following page




Understanding and developing processes that enable the organisation to follow all six of these steps will assist your organisation in delivering effective incident learning.

As a governing body member, ask yourselves:

- Am I confident that our management can effectively lead the workforce through the incident learning cycle above to improve our provider's quality of care and services?
- Am I aware of the types of incidents regularly occurring within our organisation?
- Are there sufficient feedback mechanisms in place to ensure the governing body has the appropriate information to support decision making and incident learning?

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# Tips for Better Practice Incident Learning

## 01. Identify the incident

a. Understand how to recognise an incident.

b. All stakeholders of an aged care provider should understand their role in identifying incidents.

## 02. Respond to the incident

a. Provide immediate care or comfort.

b. Share incident information with the appropriate people. i.e. direct supervisors, management, or where necessary escalated to executive or governing body.

## 03. Record and report the incident

a. All incidents must be reported in a clear and structured way.

b. Use agreed governance structures and legislated requirements for reporting.

## 04. Analyse the incident

a. Investigate what contributed to the incident occurring, whether it could have been prevented and what action needs to occur to prevent it in the future.

b. Share incident analysis with relevant people . i.e. direct supervisors, management, or where necessary escalated to executive or governing body.

c. Look for links between the incident and other incidents.

## 05. Implement actions

a. Implement actions and assign roles and responsibilities for actions.

b. Monitor, document and report on progress of actions.

## 06. Close the loop

a. Identify trends as shown in aggregated incident data.

b. Share findings and lessons learned through managing an incident.

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# When did you last undertake the following?

## 01

### Re-assess:

Appraise your incident management system to ensure it allows for the appropriate level of incident prevention, response, management, learning and improvement to occur.

## 02

### Clarify:

Ensure there are clear processes in place which identify when and how others should be notified of incidents, incident trends, and incident responses. It is essential that all staff understand their own roles in incident learning, and are supported in building the skills and capabilities to carry these out.

## 03

### Review:

Regularly review the actions taken to resolve incidents, ensuring the changes made have led to positive outcomes for consumers.

## 04

### Risk & Gap Analysis:

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.

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# Additional Resources

- Incident Management and Reporting Topic Guide
- Aged Care Act 1997
- Aged Care Quality Standards
- Quality of Care Principles 2014
- Serious Incident Response Scheme for Providers
- Open disclosure framework and guidance
- Unreasonable use of force: Notifications of resident to resident
- Serious Incident Response Scheme for Consumers
- Canadian Incident Analysis Framework
- Aged Care and Other Legislation Amendment (Royal Commission Response) Bill 2022