Australian Government
Aged Care Quality and Safety Commission

Engage
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SIRS notification example response

Unexpected death

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These case studies cover a range of examples to provide **general guidance** to assist approved providers on the content and form of information that may be included in a notification to the Commission. They are intended to be illustrative but not exhaustive of approved provider reporting requirements. Any similarities to an actual reportable incident or individual is purely coincidental. The case studies do not constitute legal advice or other professional advice. Approved providers should seek legal or other professional advice on their legislative requirements, as appropriate.

SIRS notification example response

Unexpected death

A good-quality incident notification requires more than simply transcribing the details taken from progress notes about the incident or copying text from the provider's incident management system. It is important that the person making the notification is familiar with what happened, has applied a problem-solving approach to understanding the causes and risks involved and has a good understanding of how the response to the incident will be managed.

Here is an example response to questions in the MyAgedCare portal for reportable unexpected death.

Web portal question	Answer
Type of incident	Unexpected death
Victim first name	Albert
Victim last name	Johnson
Select the most relevant incident type	Unexpected death
Please select the appropriate level of cognition of the victim	Moderate cognitive impairment
Does the care recipient reside within a secure unit?	No

Following are the MyAgedCare portal questions and examples of possible responses.
The blue numbers relate to the tips box on the pages following these questions on what details to include in your response.

Web portal question	Answer
Please provide a detailed description of the incident. In your SIRS report please provide a detailed description of the incident that has occurred or is alleged or suspected to have occurred.	**Example response:** Albert Johnson (consumer) was being helped in the shower by staff member Tien Li at approximately 08:00 on 8 September 2021. Albert's care plan states he is to be assisted in the shower by two staff members; however, a medical emergency in the adjacent wing had meant that Mr Johnson's wing was temporarily short-staffed, and so staff member Tien was showering Albert alone. **1, 2, 3** When staff member Tien turned to reach for the shampoo, Albert slipped off the shower chair and hit the left side of his head on the floor tiles. Albert appeared to be unconscious, and the emergency buzzer was pressed. **1, 2, 3, 8** RN Michelle Long arrived in the shower around 08:05 to assist staff member Tien to place Albert in the recovery position to keep his airways clear. RN Michelle then called the ambulance to assist. **1, 2, 11** RN Michelle and staff member Tien made Albert comfortable by placing a pillow under his head and covering him with a robe and providing oxygen. **6, 7, 11** The ambulance arrived at approximately 08:45 and assessed Albert and identified that his vital signs were unstable and took Albert to St Bernadette's Hospital for further investigation. **7, 8, 11** RN Michelle contacted Albert's family representative, son John, and notified him of the incident on the same day at approximately 09:00. John was advised that Albert was being transported to St Bernadette's Hospital. John told RN Michelle that he was on his way to the hospital. **11** RN Michelle contacted the St Bernadette's Hospital on the same day at around 15:30 to check on Albert's condition and was advised by the hospital that Albert passed away earlier in the day due to an intracranial haematoma complication, and Albert was high risk candidate for surgery due to his age and co-morbidities. **11**

Web portal question	Answer
Harm **Did the consumer suffer physical impacts?** **Level of physical impact.** **Did the consumer suffer psychological impacts?** **Level of psychological impact.**	**Example response:** Upon falling, Albert became unconscious, and staff member Tien and RN Michelle placed Albert in the recovery position to keep airways clear and placed robes onto Albert to keep him warm. **8** According to Albert's son John, upon arrival to the hospital it was assessed that Albert had concussion and a brain bleed. The concussion caused a considerable state of delirium for Albert. Albert was being consistently monitored by hospital staff from his arrival until his death on 8 September 2021, at around 12:30. The cause of death was intracranial haematoma. **2**

In response to the above questions, you should consider the following:

1. Who was directly involved in the incident (include full names)?
2. What time and date the incident occurred (or was alleged or suspected to have occurred)?
3. Where at the service did the incident occur (or was alleged or suspected to have occurred)?
4. Who else saw the incident (include their name, position, and contact details)?
5. What is the level of cognitive impairment of the consumers directly involved in the reportable incident? (e.g., Dementia substance-induce cognitive impairment, developmental disorders).
6. What was happening immediately before the incident occurred?
7. What occurred immediately after the incident? (your answer to this question must describe any actual harm that was caused to the consumer AND any harm that could reasonably have been expected to have been caused to the consumer).
8. Details of actual harm caused (type of seriousness of injury/illness, symptom and/or clinical observations.
9. Describe the consumer's response (This could include any observed behaviours such as crying, shaking, throwing things, not speaking, not wanting to be around other people, or doing usual activities).
10. Explain how and why any behaviour identified is different from the person's usual behaviour.
11. Describe any medical and/or psychological treatment provided.
12. Include enough information so that a person who wasn't there can understand what happened.

When assessing and describing what harm an incident 'could reasonably have been expected to have caused'.

(When considering whether an incident could reasonably have been 'expected to have caused' discomfort, physical or psychological injury, it is important to think about the general vulnerability of aged care consumers. Would it be reasonable to expect the incident would have caused discomfort, physical or psychological injury to other consumers in your service, such as instances where a consumer has medical or psychological limitations.)

Note: when you provide clear and comprehensive information early on, it is less likely that the Commission will need to ask for further details, or require you to conduct an investigation, or in some cases, directly investigate the matter itself.

Web portal question	Answer
What specific action(s) has been and will be taken in response to the incident to ensure the immediate AND ongoing safety, health, well-being, and quality of life of the consumer affected by the incident?	**Example response:** The incident was initially reported to the ambulance so Albert could receive the proper care. We considered reporting the incident to the Commission under the incident type "Neglect", but due to Albert having died believed it was best to report under "Unexpected death". **1** HR were notified of the incident once Albert was picked up by the ambulance and advised to stand down staff member Tien pending an investigation. Tien was advised to go home after the incident. HR were supportive of Tien knowing it was certainly not deliberate and being aware that he felt terrible. EAP was also offered to Tien. **1, 5** Tien will not be rostered whilst the investigation is taking place and coroner investigation conducted. An internal review of staffing levels, policies in relation to dealing with emergencies, and training for staff on how to deal with similar situations will be scheduled for all staff. **5, 6, 7** Albert's representative, son John, was notified immediately after the incident occurred and was advised to meet Albert at St Bernadette's Hospital. **3**

In response to the above question, you should consider the following:

1. Whether the incident was reported to a relevant authority (e.g., coroner, AHPRA).
2. How the consumer was treated and supported immediately after the incident (consider both physical and psychological treatment and/or support). This could include whether external health advice was sought such as onsite or offsite counselling session.
3. Whether the consumer's representative was immediately contacted regarding the incident; for e.g., to discuss and review support needs or to be involved in the management and resolution of the incident.
4. Any assessment or planning changes; for e.g., development or update to a risk management plan for the consumer and subject of allegation (if also a consumer).
5. Any immediate or planned changes to the duties/supervision of any staff members.
6. Whether you assessed immediate risk to other consumers affected or who could have been affected by the incident.
7. Whether you have used the outcome of any incident assessment, analysis, or investigation to identify/implement actions to improve the safety, health, well-being, and quality of life to all consumers.

Web portal question	Answer
What specific action(s) has been taken or is planned to manage or minimise the risk of re-occurrence of this or a similar incident in the future?	**Example response:** The nature of the incident warrants an investigation into our practices when showering consumers, and when emergencies arise. **1, 2** The incident occurred due to understaffing in the facility. Management has engaged an agency to provide additional care workers during staff shortages. It has been identified that another contributing factor included staff not following set protocols when understaffed, and when an emergency arises. **1, 3** Care management have directed care staff to limit the number of showers occurring simultaneously during the times of staff shortages, to make sure that the service can always maintain two staff members per consumer when showering if required or stated in their care plan. **4, 5, 6** The incident management system has been updated with the details of the incident, our findings regarding staff shortages, and staff learning needs regarding emergency protocols. **6, 7** These changes have now been embedded into our service through the Incident Management System, as well as notifying staff through email and staff meetings of the new showering requirements. All staff are required to undertake a shower safety refresher course, including our emergency protocols best practices, and to reaffirm that staff are following the consumers' care plans. **7** Care management will also conduct spot checks and further audits to ensure all staff are following the correct protocols. **4, 6, 7, 8** Collecting data, such as spot checks and audits, will enable us to continuously improve the management and prevention of incidents. We will analyse and review the information to assess the effectiveness of our management and review of incidents and what actions could be taken to improve. **4, 7**

Web portal question	Answer
What specific action(s) has been taken or is planned to manage or minimise the risk of re-occurrence of this or a similar incident in the future? (continued)	It has been communicated to Albert's family how devastated staff are about Albert's death, and how sorry they are that this happened. Reassurance has been given to the family that we have put in place changes attempting to prevent similar incidents happening to other residents. We will keep Albert's family involved in the management and resolution of the incident. **9**

In response to the above question, you should consider the following which may refer to the relevant aspects from your Incident Management System:

1. The actions you have taken or plan to take to identify the causes of the incident (e.g., assessment, used problem solving methodology, root causes analysis, internal/external investigation, other methods).
2. Describe what further actions are proposed in response to the incident. Include any open disclosure actions taken or proposed.
3. Describe what actions have been taken or are being taken to reduce the risk of a similar incident occurring in the future.
4. Whether the incident has been assessed to determine whether it could have been prevented or caused less harm, and the outcome of that assessment.
5. The preventative measures, including remedial actions that have been put in place to identify and manage similar risks. For example, details on planned updates to your processes and procedures to ensure the risk of re-occurrence of this or a similar incident, including near misses, in the future is minimised.
6. Describe the observable differences the Commission, consumers, family members and staff will be able to see as a result of changes made.
7. Describe how you are embedding changes within the service and how you are measuring the effectiveness of the changes.
8. Describe how you have 'closed the loop' by analysing any incident trends to identify and address any systemic issues.

Reminder:

If further information is available to you, then please ensure any Priority 1 notifications are updated within five days with the further relevant information once incident analysis or investigation is complete.

The information is to be provided in the form located on the Commission website:

agedcarequality.gov.au/sirs/provider-resources#approved-forms

The purpose of this document is to give practical guidance to providers when making reports about serious incidents via the SIRS tile on the My Aged Care Provider Portal.

We have chosen four of the most important questions from the portal to help demonstrate the type of information that should be included in a notification.

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

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