Transcript

Aged Care Quality and Safety Commission

Reporting Under the Serious Incident Response Scheme

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 **Presented by:**

**moderator:**

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**Attendees:**

Janet Anderson PSM
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[The visuals during this webinar are of each speaker seated at a long table and speaking to camera]

**Nicola Dunbar:**

Hi. My name’s Nicola Dunbar from the Aged Care Quality and Safety Commission and I’d like to welcome you to the third in our series of webinars about the Serious Incident Response Scheme or SIRS.

I’d like to start by acknowledging the traditional owners of the lands on which we all meet around Australia today and pay my respects to Elders past, present and emerging.

In our last webinar we looked at incident management systems and the requirements around IMSs around SIRS. Today what we’re going to be focusing on is the reporting requirements for SIRS and go into detail about what incidents must be reported to the Commission, the timeframes for those reports and how the reports should be made.

We’ll also be focusing on particularly about reporting incidents and issues around people with cognitive impairment which is one of the new requirements under SIRS. Next week we’ll have our final webinar in this series where we’ll cover the Commission’s role around SIRS. I strongly encourage you to watch the other webinars that are on the Commission’s website if you missed them and to register for next week’s session so that you get an overview of SIRS as a whole. We will have some time for questions at the end of the webinar so please put your questions into the chat as we go along and we can deal with those at the end.

So I’ll introduce our speakers now. We have today Janet Anderson who’s the Commissioner of the Aged Care Quality and Safety Commission and also Maree McCabe, the CEO from Dementia Australia. And I’d like to hand to Janet for some introductory comments.

**Janet Anderson:**

Thanks Nicola. Hello everyone. As you know if you’ve watched the previous webinars or indeed done some of your own research SIRS is about so much more than just reporting on or gathering data about a set of incidents that need to be reported through to the Commission. It’s really a new way of looking at incidents that happen within an aged care setting, managing them well and learning from them to prevent any risk of recurrence or at least substantially reducing the opportunity for bad things to happen or go wrong in an aged care service.

The Aged Care Quality Standards have been amended through the SIRS legislation and now Standard 8 explicitly requires all approved providers of aged care to manage and prevent incidents including through the use of an incident management system. SIRS promotes an aged care system that does a number of things. It should promote a system that protects aged care consumers from harm, empowers consumers by reinforcing their right to safe care, and it also supports individual providers, you if you’re a provider of aged care, and the aged care sector as a whole to continuously improve the quality and safety of the care you provide and promote consumer wellbeing. Now I want to drill down on this goal of continuous improvement.

Please guard against any casual or perfunctory approach to the Serious Incident Response Scheme. It has so much more to offer you than that. I strongly recommend that you approach SIRS as a vital component of best practice aged care where you aspire to do so much more than keep older people safe and free from harm, you aspire to being the best provider you can be and enriching the lives of the older people to whom you are providing care.

There are two main aspects to SIRS and we will be talking about each of those this evening as well. The first is an obligation for providers to maintain an effective incident management system, and we talked about that in last week’s webinar, and the second aspect of SIRS is the obligation to report certain serious incidents to the Commission. Those two components are a logical expansion of the arrangements which currently exist under compulsory reporting. So for many of you – and this is an important point – it’s about building on and elaborating your existing incident management system and reporting procedures. You’re not starting from scratch. Thanks Nicola.

**Nicola Dunbar:**

People are not starting from scratch but nonetheless there are differences from the existing compulsory reporting. What are some of those key differences?

**Janet Anderson:**

There are arguably three principal differences between the new Serious Incident Response Scheme and the existing compulsory reporting arrangements and they are as follows. Firstly in SIRS there is an explicit requirement for providers to have and to use an incident management system. Secondly another new feature is the expansion in the range of incidents that need to be reported and when they need to be reported, and we will be talking about that. And a third key distinction between SIRS and compulsory reporting is that with SIRS reportable incidents include those involving perpetrators witnessed, alleged, suspected who are consumers with a cognitive impairment.

And as someone who knows a lot about older Australians receiving aged care who have or may develop a degree of cognitive impairment, Maree McCabe sitting on my left is well placed to offer a comment. And Maree welcome. I think it’s probably your turn for an introductory statement.

**Maree McCabe:**

Thank you very much Janet. I think perhaps some context around this would be really helpful. So in 2021 we have an estimated half a million Australians living with dementia and around 1.6 million people involved in their care. And we also know that of the 300,000 residents living in residential aged care almost 70% have a moderate to severe cognitive impairment. Not mild but moderate to severe. And the thing about that is dementia must be core business in aged care. And I have to say that with SIRS Dementia Australia is very supportive of that. We were very pleased to be involved in and be consulted on the scheme. And for this to fully succeed it’s got to be embedded in the processes and systems that already exist and the continuous improvement system in my mind actually. But also clear roles and responsibilities are absolutely key.

Now the scheme is really important in helping to keep people living with dementia safe. And Janet mentioned there the two parts to the scheme, the incident management system and the compulsory reporting obligations. In 2020 – and what a year – restricted visitation was a real issue for so many people in residential aged care and particularly for people living with dementia on a couple of fronts. One the informal observation of people’s loved ones were not going on because they were unable to visit. And the second part of that was for people living with dementia where they were not getting the supported care from family members and loved ones that were often a very integral part of their care. And so incidents did occur and during that time I’m sure that incidents were missed in terms of reporting and also management of some of those incidents. And in situations that we have never been in before in a pandemic we were less supported and able to respond in ways that we would normally.

So I think that this is such a positive step towards meeting the needs of people living with dementia, reassuring families and loved ones, and also the scheme comes at a time when people living with dementia are some of the most vulnerable people in our community and this will certainly help safeguard and put safeguards into the future in relation to quality care.

**Nicola Dunbar:**

Thanks Maree. That’s a great start and a fantastic reminder of the context in which we’re doing this. I think it’s so important to have that broader view. So before we get into the details about what needs to be reported I think you’ve both mentioned incident management systems and it may be worthwhile just spending a little bit of time revisiting that because it’s such an important part. The reporting kind of comes second in many ways to the incident management system. So Janet can you maybe just take us through about incidents and incident management systems and then we can get onto the reporting?

**Janet Anderson:**

Okay. This might need to come with a warning. I’m about to read a definition. You can find this information in information which is available on our website and I know Nicola will refer you to that across the course of this webinar. So it is multi part and I will read it out. Let’s start with what we understand by the word ‘incident’. An incident is any act, omission, event or circumstance that occurs in connection with the provision of care or services that has or could reasonably be expected to have caused harm to a consumer or another person, or is suspected or alleged to have caused harm to a consumer or another person, or the provider becomes aware of and that has caused harm to a consumer.

Now again you probably need to see it in front of you and really study it to understand fully what that definition encompasses. Hopefully you’ve gleaned some impression of the construction of this notion of incident and the way it is related to the care provided to a consumer where there is an incident, some event that impacts on the consumer. Now it’s deliberately a very broad definition and it includes incidents that occur during the course of care as well as incidents that arise out of the provision of care. And that means that it includes incidents which may occur away from a residential service. For example if there is a social outing organised by the service and there is an incident which occurs on that social outing which impacts a consumer then it becomes a reportable incident.

**Nicola Dunbar:**

Thanks Janet. And so I think it’s useful to start with that because what is one of the requirements around SIRS is that everybody needs to have that incident management system and record all of those incidents in that system. What is the next step from that is about the things that need to be reported to the Commission. And so there is a subset of that broad range of incidents that need to be reported to the Commission. I think we should go through what those are now.

**Janet Anderson:**

Absolutely. Let me just reinforce the point Nicola just made. You have the full constellation of incidents within a residential aged care service and then a subset of incidents which are identified as subject to reporting to the Aged Care Quality and Safety Commission. And this subset is organised into eight incident types. Three of these types are already known to you through the compulsory reporting arrangements. So the first three are unreasonable use of force, for example hitting, pushing, shoving, rough handling of a resident. The second is unlawful sexual contact or inappropriate sexual conduct which can include things like sexual threats, stalking or sexual activities without consent. And the third also familiar to you is unexplained absence from care.

Now to that base of three five further incident types have been added through the SIRS legislation and they are as follows. Number four, neglect, for example withholding care, untreated wounds or insufficient help at mealtime. Five, psychological or emotional abuse, such as taunting, name calling, refusing access to care and services as a means of punishment. Six is unexpected death. Seven is stealing or financial coercion by a staff member such as coercing a consumer to change their will or stealing money or valuables from a consumer. And the eighth is inappropriate physical or chemical restraint. So there currently are three under compulsory reporting. There are eight types of reportable incident under the Serious Incident Response Scheme.

**Nicola Dunbar:**

Thanks Janet. We’ve already talked about how one of the big changes with SIRS is incidents that involve consumers with a cognitive impairment are now reportable. Maree can you tell us a bit about what impact you think this might have for consumers with cognitive impairment or dementia who are living in residential aged care?

**Maree McCabe:**

Nicola I think this is really important. All Australians have the right to live free from abuse and free from neglect. And this impact I think on people with a cognitive impairment and Australians living with dementia in residential aged care will be very positive. And I expect that initially we may see an increase in reporting and I see that as a very positive thing. Sometimes people think more incidents, not good. No. Not at all. Often more incidents, better reporting and better observation. And I see that as something that would be very positive to come out of that. And it will certainly help ensure that there are safeguards in place for people living with dementia and this framework is very clear about the compulsory reporting requirements. And the management of behavioural symptoms and changes in behaviour for people living with dementia is absolutely key as part of managing incidents and part of that is really about preventing escalation. It’s about keeping people safe from harm and it may be that the person is a danger to themselves or a danger to others. So I see that a person involved living with dementia and reporting can only bring about a raised awareness, better care, better reporting, better understanding and better protection for all involved.

**Nicola Dunbar:**

Okay. And one of the new types of incidents I know is particularly relevant and important for you is about physical and chemical restraint. What are the specific issues that providers might need to think about in terms of that reportable incident?

**Maree McCabe:**

Look Nicola this has been an issue that we have talked about for a long time and there is a lot of evidence that shows that chemical and physical restraint are only effective in about 20% of instances and yet we continue to use it often as a mainstream way of managing severe behaviours. And it really is an issue about education. And we know that with physical restraint that actually it’s more likely to increase falls, it can cause injury and it causes a high risk of death. And with chemical restraint increasing heart attacks, increasing stroke, increasing death. The important part of this is actually giving people a suite of tools to use other than physical and chemical restraint, so being able to support people in other ways.

And some of the things too about chemical restraint is they’re powerful medications, psychotropics, and they come with very powerful side effects. And we don’t train staff in how to identify those side effects. So things like cogwheel rigidity, akathisia. Now what akathisia means is driven motor restlessness and if the person is being given psychotropic medication because they’re agitated what’s going to happen is that that agitation may actually be increased as a side effect. And so what we’re doing is exacerbating the very thing that we’re trying to prevent. And it’s really important that staff understand about side effects, that we understand about when it’s appropriate to use physical and chemical restraint in an emergency situation where a person is a danger to themselves or to others is a really good example. But it can’t be used as first line treatment and we need to educate staff in other ways of preventing some of these triggers.

But the other thing too is if you see changed behaviours please always think pain. So for people living with dementia they often can’t express that they’re in pain and if a staff member goes to move a person living with dementia and they’re in pain and they can’t communicate, the only thing they’ve got is to either hit out or push away. And that can be misinterpreted as aggressive behaviour when in fact the person’s in pain and trying to protect themselves from experiencing more pain. So this is something that we really need to get a grip on, that we need to work together as an industry, take a committed approach to reducing and minimising the use of physical and chemical restraint. It is an infringement on people’s human rights. There are instances where it’s appropriate and I think we’re all across what those incidents might be, but certainly in terms of using it as a first line treatment it’s absolutely unacceptable.

**Janet Anderson:**

Can I come in there? You’ve raised a really interesting point. There are some situations where restraint is necessary and then it would be subject to all of the very clear parameters that exist now and that are currently being looked at. And for the purposes of incident reporting we are now going to be expecting staff to identify inappropriate use of restraint. You mentioned staff training and I think that’s a really important point to underscore. Historically it may have been that staff have regarded restraint, to use your words, as the first line treatment and would not configure it as in any circumstance inappropriate. But what you’re drawing our attention to is you have to ensure that staff have a much clearer understanding of where the line must be drawn and what is appropriate in what circumstances when it comes to restraint, and the large majority of it being inappropriate or the last resort where other things have not yet been fully explored. Do you want to just elaborate on that a bit?

**Maree McCabe:**

Absolutely Janet. And look one of the issues may be that somebody may have a psychiatric illness. So they may have say chronic schizophrenia for example. And the use of anti-psychotics in that case is very – it’s completely appropriate. If they’re delusional and they have paranoid ideation they may be afraid for their life and their delusional system may be that the staff are the CIA and that they’re coming to get them. Now that is not unheard of and they will react. And it is really important that staff can protect themselves, they can protect other residents and that they can protect the resident who is experiencing the delusional situation. So there are times when this is appropriate. It may be that somebody is all of a sudden aggressive for no apparent reason and uncontrollable and they’re the kinds of situations where it is appropriate to use restraint. And staff need to be trained how to safely restrain somebody and to protect themselves and to protect all people involved.

**Nicola Dunbar:**

We’re going to move onto the timeframes for reporting incidents but before we do we’ve had a couple of questions and I just thought I’d quickly address them and then we can kind of move on, because they more relate to the things that we’ve just been talking about. Had a couple of questions about:

*Q: Is there a need to report incidents that occur when a family take a loved one out for an outing for lunch or something and if something happens?*

The answer to that is yes. This comes into the third of Janet’s points in her definition of an incident about any matters that the – sorry I need to go back to the words – the provider becomes aware of that have caused harm to a consumer. And so if somebody comes back from an outing with their family and there has been harm and there needs to be care provided by the service then this is something that should be reported even though it hasn’t happened with any staff member from the service. But if the service needs to provide care in response to that then yes you will need to report that as well. So I just wanted to clarify that and then we can move on.

**Maree McCabe:**

Nicola can I actually – because it may be that the service doesn’t need to provide care but they may actually notice bruising. They may notice an injury of some sort. It may not be that they’ve got to provide care but their observation shows that something has happened.

**Nicola Dunbar:**

And so as Maree says that is something that needs to be reported as well. So it is important to – you’re always going to be monitoring and looking out for people and seeing how they are but this is particularly important in this context as well.

**Janet Anderson:**

And if I may – and it’s not specific to the content for today’s webinar but I think it’s relevant in the context of that question. Reporting an incident isn’t the same thing as a regulatory response. The two are not equal or the one does not lead directly and inevitably to the other. Reporting an incident is a way of bringing it to the Commission’s attention. We expect you to have risk assessed it. We will also risk assess it. And for an incident where the impact is slight or immaterial and the circumstances of the incident were unavoidable and every step was taken immediately after it to support the consumer who was the victim of the incident and those who may have been surrounding them, and steps have also been taken to prevent any recurrence if that’s possible, then the Commission will reach a view that that has been an incident well managed. So please distinguish in your mind the reporting of an incident and any consequence from that reporting. Because as the regulator we have a job to do in understanding risk in the same way you do and that will guide any decisions we make subsequent to the receipt of the notification.

**Nicola Dunbar:**

Thank you. I think that’s been a good discussion. Let’s move on. So let’s talk now about the timeframes for when incidents need to be reported to the Commission. Janet?

**Janet Anderson:**

Okay. More definitions. You hopefully would have heard about Priority 1 and Priority 2 incidents. This is material for the timetable for reporting. Priority 1 incidents are any reportable incidents that have caused or could reasonably have been expected to have caused a consumer physical or psychological injury that requires medical or psychological treatment to resolve. Now where medical and psychological treatment is required as I say those incidents are regarded as Priority 1 regardless of whether the impact on the consumer is temporary or permanent or whether the consequent treatment is provided on site or by some other person or provider.

So priority incidents also include any unexpected death, any unexplained absence of a consumer and any incident where there are reasonable grounds to report the matter to the police. And they would typically be a suspected criminal act. Examples of Priority 1 incidents which are reportable from the 1st of April include the following. And I’ll just give you a broad brush impression of the sorts of things that we consider to be in scope. It is illustrative, not exhaustive, because if you think of each of the eight reportable incident types we’d be here all evening.

So for example shoving, pushing, hitting, punching, kicking a consumer that results in bruises, cuts, abrasions, fractures or other physical injuries that require assessment and treatment by a health professional, a health practitioner who may be on site, who may be brought to the facility or who may be accessed away from the service. Taunting, bullying, harassment or intimidation of a consumer that causes anguish or distress for that consumer who then needs emotional support or counselling. Failure to monitor a consumer’s nutrition where missed or uneaten meals contribute to significant weight loss and clinical complications arise which need to be treated either in situ in the service or in a hospital setting for example. Failure to supervise a consumer in an environment that leaves them susceptible to injury and where they are in fact injured and require treatment. Now there are many, many other examples I could cite but hopefully that gives you a broad sense of the fairly wide domain of incidents which are included in reportable incidents for Priority 1.

Now Priority 1 is material because of the timetable for reporting. Priority 1 incidents are reportable from the 1st of April and they are reportable to the Commission within 24 hours of you the provider becoming aware of them.

I’ve mentioned Priority 2. Priority 2 incidents are all reportable incidents other than Priority 1. And I know it’s a bit circular but we wanted to cover the totality of reportable incidents. And I’ve explained to you what Priority 1 is. Priority 2 is all other reportable incidents. And Priority 2 incidents are reportable from the beginning of October. So Priority 1 incidents from the beginning of April and then allow maturation of your systems and processes. Priority 2 incidents, all other incidents which are reportable are to be notified from the beginning of October and they are to be notified within 30 days of the provider becoming aware of them.

So if I may just repeat. Priority 1 incidents reportable from the 1st of April within 24 hours of you becoming aware of them. Priority 2 incidents reportable from the beginning of October within 30 days of you the provider becoming aware of them. Now it’s important to note that your obligation to notify us the Commission of a reportable incident applies regardless of whether the consumer, their representative or family request or want a report to be made. So it’s an obligation which resides with the provider under the Act and you must report. You do need also to determine how to appropriately involve the resident and their representatives and family members who have been affected by the incident in managing and resolving it. And that’s key. That’s a separate issue. That doesn’t have to do with notification. That has to do with being a responsible, accountable provider and minimising impact and harm on a consumer who may have been affected by an incident. But it has nothing to do with whether you do or don’t report. You are obliged to report the incident if it is within that reportable incident category.

**Nicola Dunbar:**

Thanks Janet. One of the things that I think is important to note about the Priority 1 incidents is that it’s about things that have caused harm or could be reasonably expected to have caused harm. And part of the rationale for this definition was around ensuring that it captures incidents that people may not be in a position to report. So this is thinking about people with cognitive impairment who might not be able to articulate what has happened to them or display evidence of distress. And I think one of the aims of SIRS as you said at the beginning Maree is about ensuring that this is picked up, that people are empowered. Maree can you tell us about some of the approaches that providers can take to ensure that they identify incidents with consumers who may have dementia, a cognitive impairment? What might be some of the things that they would want to think about to make sure they really get the full array of things that are going on particularly when people are not in a position to articulate that themselves?

**Maree McCabe:**

I think communication and culture are key. And it may come to the attention of staff or management via another resident or a visitor and it may actually come to the attention because somebody is injured and something has obviously happened but they may not be able to communicate what’s happened. And I think communication here is really key. And because the resident with dementia may not be able to communicate we can. And we should still provide the reassurance, the explanation as far as we can as to what’s happened, the explanation as to what we’ll be doing about it, and if the resident has family and loved ones to communicate with them. Because family will be more – and I know that you know this but I think it’s still worth saying family will be more sensitive when they know that their loved one is more vulnerable because of their inability to communicate. So communicating with family, making sure that we’re transparent with family about what we know, what we don’t know and what we’re investigating, and also protecting confidentiality of staff is a really important component of this.

But if the person with dementia can communicate please don’t assume that because they’ve got dementia they can’t tell you what’s happened. And it may be that they have a short timeframe in which they can and then after that their recall is fuzzy. So it’s really important that we provide the opportunity for other residents and to reassure other residents too. Because they speak among themselves. If there’s an incident in the home they will be talking about it. They will need to be reassured and we need to be as transparent as possible. And also effective communication within the care team, so the GP, the pharmacist, other staff, and listening and responding to the concerns of families is a really important part of this ongoingly because that’s something that needs ongoing attention and support.

**Janet Anderson:**

Can I pick up that cue, listening to and responding to concerns raised by families? There is the possibility that an approved provider will understand a particular encounter and regard it as being outside scope for a reportable incident, and the resident themselves or possibly a family member would have a different perspective and would consider that it should be reported to the Commission. And I think those watching would understand that that scenario could emerge from time to time. I wonder whether you have a view on the way in which that might be managed by the provider or how that might unfold in a real life situation.

**Maree McCabe:**

It’s a great question Janet. We often have families call us where they are concerned where something like that has happened, that an incident has happened in the home, they don’t agree with the way management has responded and they will come to Dementia Australia if their loved one has got dementia. Now what we encourage is for people to go and speak to the management of the home and try and get it resolved there. And we’ll provide support for the family but we really do encourage them to go back and get it resolved at that level. And if it’s not resolvable in their mind then there is always the complaints opportunity. And that’s something that people can take up and people do take up.

And in fact recently we had an issue where a family came and said – and you can get divisions in families. Just because it’s a family doesn’t mean they’re aligned on how care should go. And one of these issues was around continence aids and the family were concerned that they were not changed frequently enough and the staff explained that you don’t need to change them every time somebody voids, that actually it’s fine to – depending on the type of aid that’s being used it can be changed – and I don’t know how often anymore but I think it’s twice a day or something like that. And so we tried to explain that these continence aids now the technology has evolved such that you don’t have to change a resident every time they void and that it’s completely fine to leave it on for a period of time. Now they were not happy with that and they said ‘No this is unacceptable. We want our mother changed every time she voids’. And so I said ‘Look we need to speak to the – it’s important to go back to the management, ask them about the type, get some education around this’. And they were still not satisfied and they did take up the avenue of complaint. So the process is there. It can be followed. People are not always going to agree and families will not always agree.

**Nicola Dunbar:**

So we’ve gone through kind of what the incidents are, what the timeframes are and the next step is really about how should reports be made to the Commission. And so can you tell us about that process Janet? What is the process that providers need to follow to make reports to the Commission?

**Janet Anderson:**

Okay. As approved providers you are already fully familiar with the My Aged Care portal and that is what you currently use and will use for the submission of reportable incidents, notifications to the Commission. That portal is managed by the Department of Health and if you want to access information about the provider portal I recommend you go to the Department of Health website where there is a lot of additional support and guidance available.

Now importantly we recommend that you have enough staff registered on the My Aged Care provider portal to meet the requirements of the reporting timeframes. Remember from the 1st of April Priority 1 within 24 hours of becoming aware of the incident. Let’s say you become aware of the incident having occurred some time early Saturday morning. 24 hours later sees you still in the weekend. If the only staff you have registered on the My Aged Care portal are those who work Monday to Friday business hours then you’re stuck. So I exhort you to look again at the number of staff you have registered on the My Aged Care portal and to ensure that you have sufficient staff and staff to cover a seven day working week in order that you can comply with the timeframes which are in the SIRS legislation.

Now that is entirely a matter for your discretion. You get to make choices about which of your staff are registered. But as I say we were expecting a significant increase in the number of staff who were registered. We haven’t seen that uptick yet and so I say again be clear on who among your staff currently is registered and make sure that you can cover your service in its operating hours or at least across seven days per week in order that you can comply with the schedule. We do expect to see an increase in the number of reports and that makes perfect sense. If we’re expanding the range of reportable incidents from three to eight types then we are expecting to see an increase in the volume of reports that come to the Commission and the volume therefore of reports that you as approved providers are having to make. So please make sure that you’re able to comply with that particular expectation by virtue of having sufficient staff who are registered to use the My Aged Care portal. Thanks.

**Nicola Dunbar:**

Thanks Janet. And I might just add a couple of points to Janet’s comments around that, is you can register in advance. So you can have all of your staff registered prior to go live and they will automatically then have access into the SIRS environment and be able to report after the 1st of April.

We’ve had a question that has asked about when the reporting icon, the new tile will appear on the My Aged Care portal. It isn’t there yet. It will appear at midnight on the 1st of April. And so that’s when you will be able to get in. So they’re still doing the user testing and all of that so it won’t appear until midnight on the 1st of April. So it’s all happening but you can go in and register now and you’ll automatically be able to have access after that point.

So we’ve talked about the reporting obligations around SIRS and the incidents that need to be reported to the Commission and the process of those. There are also obligations that providers have to other organisations, to the police and for some cases to the NDIS. Can you tell us about those kind of interactions between those different reporting obligations?

**Janet Anderson:**

Let me deal specifically with the mutual obligations between the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission. There will be occasions where a consumer in a residential aged care service is an NDIS participant. If you as a provider are looking after such a consumer then you’re actually required to notify both the Aged Care Quality and Safety Commission and the NDIS Commission of the incident. Now as I say that I ask you to look closely at the respective rules governing those notifications to the respective Commissions because it is up to you to ensure that you’re complying with the expectations within each of those different service systems. We’re being clear about the rules that apply within the aged care sector. You need to be equally clear about the rules that apply within the disability services sector in order that you can ensure that the notification you submit has the right content, is submitted in the right timeframe and to the extent that there is further work required of you that you are also fulfilling that commitment as well.

So there may even be differences in definition of what constitutes a reportable incident between the SIRS scheme in aged care and the notification scheme in the disability support sector. So please do your homework. Make sure that you understand with equal clarity the requirements in disability services and can fulfil those requirements as you are also fulfilling your obligations under the SIRS in aged care.

**Nicola Dunbar:**

Thanks Janet. We’ve talked quite a bit about the involvement of families, the importance of families in these processes. And Maree can you talk a bit more about this, about what the importance is of the role of families, carers, representatives of consumers particularly for people with cognitive impairment or dementia in this kind of environment and how I guess – we’re talking about a whole range of different incidents here and issues that might be considered but it’s important for providers to think about how they involve families in resolving those incidents potentially in reporting.

**Maree McCabe:**

One of the challenges of course is that people will respond differently to incidents. And for people living with dementia, I remember somebody saying to me once when you’ve met somebody living with dementia you’ve met one person living with dementia. And we all have our own background, our own experiences, and for people living with dementia it is exactly the same. And while somebody may seem to react in a particular way that people think is an overreaction we don’t know necessarily what has happened in the background but families often will. So residents may have been subject to traumatic experiences and what they’re reacting to is what’s being triggered in that incident. And I think speaking with families and having the opportunity for families to share with us about that is really important in terms of being in a person-centred way and being able to respond in a way that reassures the person.

And I think the more we know about people the better equipped we are to be able to support them when incidents occur. And families are very valuable sources of information especially when it comes to past traumatic events and the way that people may respond. Now not everybody in aged care has a family or a loved one where we can get that information but I think the thing to remember is that it’s not always what’s happening in front of us that the person’s responding to. And if we can manage the environment in a way that it’s supportive for the person living with dementia, if we can remove any things that are confusing to the person, if we can minimise the stimulus, the noise – and one of the challenges for people living with dementia is stimulus is a very sensitive balance. Too much is confusing. It can cause agitation and upset. And too little can exacerbate cognitive decline.

So somebody explained it to me once, especially with noise, people with a hearing aid I understand have difficulty tuning out. They hear everything at the same level. And that’s often what happens for people living with dementia. So if we want to ensure if somebody’s upset and agitated, one of the first things we can do is address the noise in the environment and take away the conflicting sounds and take people to somewhere where it’s quiet and have somebody be able to sit and be with the person. And they’re the sorts of things that can make a massive difference to somebody in the face of an incident where they’re finding it to be extremely distressing. And families give us great information but where people don’t have families it’s really important to understand the other part of this.

And the other thing I think about incidents too is that it’s really important we have boundaries around the management. And I think this is one of the really great things about the incident management framework. And we also need to have boundaries around families’ contact with staff about incidents. And if something has happened where family members feel aggrieved it isn’t up to them to speak to the staff member. That’s for management to manage. And we need to take a very proactive approach in protecting the staff member from advances from family, verbal abuse from family. That is not okay and I think we need to draw a very clear line in the sand about that and support our staff and ensure that they are well supported and protected in the process.

**Nicola Dunbar:**

Thank you Maree. We’ve got about 15 minutes left and so we’ll go now to some of the questions that have been coming through. We won’t have time to go through all of the questions in the time we have remaining but keep sending the questions in anyway because what they help us to do is to formulate for FAQs. So we’ll be using those to put FAQs on our website. So we’ll go through some of the questions now but the others we will be taking and providing answers through FAQs.

So I want to go to one that kind of comes to the conversation that we had earlier about complaints and incidents. And so if Janet for example we may receive a complaint from a family member at the Commission and the complaints officer looks at that and says ‘There’s something here that really I think should have been reported’ and contacts the team who are dealing with reports but it hasn’t been, what would be the process there? Would they be going back to the provider saying ‘You need to report this’? What kind of approach?

**Janet Anderson:**

A couple of streams to the answer. First and foremost we must understand a complaint as a concern registered by an individual who deserves a response to that issue. So we never turn away entirely from a complaint. We actually do deal with the complaint because we respect the complainant and the fact that they have brought this to our attention. That means they deserve an action and a response from the Commission to that individual situation. Meanwhile there are also other things that we understand about that provider. We have risk intelligence. We have other means of engaging with that provider and appreciating the extent to which that provider understands and manages risk in their service for example.

So where we reach through further analysis the view that something happened to a consumer which on our look suggests it should have been reported and wasn’t, we will then reach out to the provider and have that conversation with them. That could go in a number of directions. Depending on the seriousness of the omission we could find ourselves in regulatory territory, or it might have been inadvertent, it might have been a systems failure, a slip up by somebody who was expected to make a report and ended up not doing so. By whatever means the report didn’t come to us that needs to be determined. And then we will consider the information which is available to us and make a judgment about a proportionate response to that which may be ‘Gosh you really do need to try harder because that was one you overlooked. And we understand there were circumstances extenuating in that instance which prevented you from reporting in a timely way but you should have done so’. Or more towards the other end of the spectrum where a provider’s made a judgment to exclude that incident from notification and we think on all the evidence it should have been, then there may be some more serious consequences.

But I do want to assure people we will look at each circumstance on its own merits and on a case by case basis make a decision about any further action we would take. Typically it would involve some engagement with the provider to understand better what has happened or hasn’t happened as a result of a particular event occurring for a consumer.

**Nicola Dunbar:**

Thanks Janet. We’ve got a question here that I might just quickly – we can give a quite straightforward answer to about:

*Q: If an incident is reported to the Commission does it need to be reported within the internal IMS?*

I think what we’re actually thinking is it needs to be flipped around. Everything should be in your IMS and then a subset of those actually is what’s reported to the Commission.

**Janet Anderson:**

Can I come in on the back of that? Let me underscore that point. The incident management system should become your new business as usual. If you don’t have one yet or if it’s slightly underdeveloped and is a little bit ad hoc then it needs to be strengthened and systematised. And the four elements if I may of an incident management system – and this was something covered in an earlier webinar – are as follows. Documented policies and procedures, a recording tool, so a means by which you capture information about the incident and you store it and you can retrieve it and then you can report it, a recording tool. Third is staff training. There’s no point in having policies and procedures and a recording tool if staff are unfamiliar or unaware of their responsibilities in delivering care, identifying incidents, capturing that information and potentially reporting them. And fourth and most importantly of all a governance and accountability framework within which you operate this system. So who’s watching to ensure that the staff are aware of what they need to do and are doing it, that there is quality in the capturing of information, in the reporting of incidents, and that there is a really strong feedback loop so that you are building into your incident management a quality improvement cycle, learn from the data, put into place remedial action, prevent recurrence, improve the quality and safety of care.

So those are the four key features of any incident management system. Chances are you have a version of that already. So check. How would you rate yourself against those four features? What parts of that do you need to do further work on to ensure that you have a robust, reliable system which is going to operate at every stage of the delivery of care? But it should capture all incidents as Nicola said and then a subset of those which are captured would fall within one of those eight reportable incident categories which would then become either a Priority 1 incident for reporting from the 1st of April or a Priority 2 incident for reporting from the beginning of October.

**Nicola Dunbar:**

Thanks Janet. We’ve had quite a few questions, and I’m not surprised about this, about restraint, about issues around physical and chemical restraint. And I know there is a lot of material that exists already to help providers around restraint and what I think is interesting is SIRS is kind of I guess bringing renewed emphasis on that which I think is a great thing and obviously part of the intent. Maree can you give us a bit of guidance? I’m not saying we kind of go into detail here but people are asking ‘What do I do about this? How do I deal with this?’ So it might be worthwhile perhaps just to spend a few minutes kind of giving people a bit of background about what’s out there that they can go to to bring in the help that they need.

**Maree McCabe:**

Absolutely. Thank you. And I’m really glad that it’s generated so many questions. It’s fantastic. So Professor Joe Ibrahim has done a lot of work in the area of physical restraint particularly. He’s also done some in the area of chemical restraint. Professor Henry Brodaty, there’s a lot of references and resources that Henry has worked on and I really encourage you to have a look at his work particularly around chemical restraint. Professor Sube Banerjee from the UK is another really rich source of information around restraint and he’s done some fantastic work in the area of dementia and physical and chemical restraint as well. So if you Google any of those they will come up with the information that you need, and failing that please contact us at Dementia Australia, 1800 100 500, and we will direct you to some of the best resources. And thank you for asking.

**Nicola Dunbar:**

It’s several people. I’m sure there’s more but quite a few questions. And I think building on that there’s a specific question here of somebody who has a particular population within their service where they use a lot of alternative mechanisms but in some cases they need to use restraint because they have a particular population with high mental health needs. And I guess coming to one of the things we touched on right at the beginning, are concerned about if they’re going to need to report every use of restraint then what does that mean for their service? That kind of looks like that could be a really bad thing but it may not be given the population within the service.

**Janet Anderson:**

Maree in an earlier comment made a similar reflection. And you could say the same thing broadly about complaints as well. More is not equated in every instance with worse. More may be as you’ve outlined it a feature of a particularly challenging group of individuals where deployment of alternative strategies isn’t going to do the job every time. So if you find yourself submitting numbers of incidents for fairly similar circumstances relating to the same or different individuals then we will understand that. We will see that. We will engage with you. We will have the conversation and give you the opportunity of explaining your take on that profile. How do we understand seven incidents across the course of three days. They all appear to be remarkably similar. What say you as a provider? You get to explain your side of the story. So this is what we’re trying to do. We deploy all these alternative strategies. In these particular circumstances we had to resort to restraint for the following reasons but we understand the principles under which we are restraining that individual. Limited time, clinical supervision, ready review, all of those rules which apply to the use of restraint in order that it is minimised and released as quickly as at all possible. Maree is there anything further you want to say?

**Maree McCabe:**

There is actually. And one of the things I want to say is look incidents are a part of life. When we are dealing with people and caring for people incidents are going to happen. And challenging things happen in very good places. It’s how we manage them that counts and what we do afterwards in terms of building the capacity of staff to do better, to understand more and to be able to improve our practice. So challenging things happen in very good places.

**Nicola Dunbar:**

And I think we might start to wrap up. As I say we haven’t gone through all of the questions but we’ll take the questions and they’ll be part of our FAQs. Maree are there any final remarks that you would like to make to wrap up the session?

**Maree McCabe:**

Look I’m really pleased that the scheme includes now people living with dementia and a cognitive impairment and I think that it’s something that will really build our quality of life and care and our understanding. And this data is really rich and it’s something that we can use for education, for better understanding what happens in services and how to best prevent some of these challenges occurring in the first place. So thank you. Thank you for the opportunity to share this tonight.

**Nicola Dunbar:**

Thanks Maree. Janet?

**Janet Anderson:**

I’m going to try to recap some of the headlines if that’s possible. I want to start by reminding you of something I said earlier, that this is not starting from scratch. You are familiar with the compulsory reporting arrangements that exist now and this is an extension and expansion on those. So chances are you have aspects of this already in place and you need to understand what you already have in order to ensure that you are fit for purpose from the beginning of April. There are some key differences. You are now required legally to have an incident management system. There is an expanded number of reportable incidents and we went through those. There are now eight. There will be eight I beg your pardon from the 1st of April, where there are currently three. And you need to familiarise yourselves with each of those incident types in order that you can provide the training to your staff to ensure that as and when they occur they are recorded in the incident management system that you have in place and they are also reported in accordance with the timetable that I’ve also outlined. Priority 1 incidents reportable from the 1st of April and then all other reportable incidents including Priority 2 from the beginning of October.

Let me circle back to where I started. If you’re wondering where to start because this sounds like a lot of information a tip for you, start with where you are. Understand what you need to build, understand what an incident management system looks like in its fullest form. Figure out where you are and then understand that journey. What do you need to do? Do you have an incident management system now? Does it need to be further developed? Do you have documented policies and procedures? Do you have staff training and how does that need to be expanded or re-run because you now have an increasing number of incidents that are within scope for reporting. What is your governance arrangement? How often does your board get to hear about incidents in your service? If they’re not asking, you should be telling. There should be briefs which go regularly to your board to let them know what’s happening and what you’re doing about it and indeed what is being reported to the Commission under the new Serious Incident Response legislation.

You’re actually further advanced than you may even understand but I counsel you to look carefully at what you have now, understand the distance you still have to travel and that’s what you should be focusing on between now and the beginning of April and then beyond April as you move further into the year and mature your systems.

**Nicola Dunbar:**

Thank you Janet. And thank you everybody for joining us today and for the questions that you’ve submitted throughout the session. As I say we have not been able to answer all of them but we will take them and we will have them as FAQs.

I just want to highlight to finish up some of the resources that we have. We have published over the last few weeks detailed guidance around SIRS and particularly about the reporting. So some of the questions that have come through that we haven’t got to the details of those about specific things about what’s reportable and what’s not and some of the issues around that you’ll find in the SIRS guidance that’s on our website. You’ll also find detailed guidance about incident management systems. So there’s a best practice guide around incident management systems that’s on our website. So I encourage you to go to the specific SIRS section of the Commission’s website where you’ll find those guidance documents. You’ll also find fact sheets and including one – no. Not including one. One that will be published in the next couple of days that is about the information to be recorded. So I’ve had a couple of questions about what information do we need to have in our system and this fact sheet – the information is in the incident management system guidance and we’re also going to have a specific fact sheet that will come out in the next day or so around that.

We have a SIRS queries email address. So SIRSqueries@agedcarequality.gov.au. I don’t even know our email address. Sorry about that. So if you do have questions about what’s reportable and what’s not, what’s Priority 1, what’s Priority 2, all of those kinds of questions, please email them through and we have a team who will be able to answer them for you.

The other thing that is really important here that I want to point out is our online education. We have online modules that you can use for training with your staff. The first one of these is live in our ALIS platform and there will be more that will follow over the coming weeks. You can now extend your free ALIS licence through to October. So if you haven’t joined ALIS now is the time. You can access it for free to October and you’ll find not only the modules about SIRS but a whole lot of stuff about the standards and other things that you can use for training for your staff.

In addition the webinars, the first two webinars are on our website. You can go and watch those. And this one will be loaded as with the one that will follow next week. So next week 25th of March we will have a webinar that is about focusing specifically about the role of the Commission, how we will be approaching dealing with incidents and the responses that we will make. So I encourage you to join that. You will receive an invitation about that soon. And please join in and join in the discussion and we look forward to seeing you then. Thanks very much.

[End of Transcript]