RAC Care and Clinical Incident Management Procedure

Overview

This Procedure is designed to respond, report, resolve, and analyse incidents. Its purpose is to ensure safe and quality care for residents by promoting a culture of safety and reporting. The procedure supports residents, families, and staff during incidents, resolves issues, and improves internal incident management systems through ongoing review. It also provides staff with guidance on incident management and escalation and ensures compliance with regulatory requirements for notifiable incidents.

This Procedure is to be read in conjunction with the [CHL Care & Clinical Incident Management Framework](#).

Purpose

The purpose of this procedure is to:

- Provide safe, quality care and services for residents.

- Promote a culture of safety and reporting with a focus on understanding, learning, and improvement.

- Support residents, their families/representatives and staff appropriately should an incident occur.

- Resolve any incidents that may occur.

- Carry out ongoing reviews of internal incident management systems and processes with a view to learning and improvement.

- Ensure that the appropriate regulatory authorities are notified in instances where the criteria for a notifiable incident are met.

- Provide practical guidance for staff regarding incident management and escalation.

Scope

This procedure is applicable to all Residential Aged Care Staff, Volunteers, Contractors, and Students.

Contents

approver	owner	date approved	next review date	page
Clinical Governance and Safe Care (CGSC) Team	CGSC Team	28 August 2023	28 August 2026	**2 of 24**

RAC Care and Clinical Incident Management Procedure

Definitions

Critical Incident	Critical Incident that results in or has potential to result in **critical harm to an individual or the organisation.** Examples include: • Unexpected incident that results in or has the potential to cause critical physical or psychological Impairment. • Incidents that negatively impact on CHL's reputation or negative media attention. • Incidents that constitute malpractice and/or litigation. • Incidents to a resident, worker, or others that leads to fatality or severe permanent physical or psychological impairment.
Incident	Incidents are any acts, omissions, events, or circumstances that occur, are alleged to have occurred, or are suspected to have occurred in connection with the provision of care and services to a resident and have (or could reasonably be expected to have) caused harm to a resident or another person (such as a staff member or visitor to the service).
Natural Justice	Without Bias. Open and transparent.
Near Miss	A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness, or danger to health) to a resident or another person but had potential to do so.
Open Disclosure	An open discussion with a consumer about an incident or incidents that resulted in harm to that consumer while they were receiving aged care services. The elements of open disclosure are an apology or expression of regret (which must include the word sorry), a factual explanation of what happened, an opportunity for the consumer to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
Procedural Fairness	The right to be heard, equality and decisions based on the same set of established rules.

RAC Care and Clinical Incident Management Procedure

Abbreviations

RAC	Residential Aged Care
CM	Care Manager
RM	Residential Manager
CHL	Catholic Healthcare Limited
CGSC Team	Clinical Governance and Safe Care Team
Staff Member/ Employee	Anyone engaged by CHL to carry out any role within a CHL RAC Home. This includes CHL engaged staff, contractors, volunteers, and students.

RAC Care and Clinical Incident Management Procedure

ROLES AND RESPONSIBILITIES

1. Residents, Consumers, and their Representatives

a. Partner with CHL to provide feedback and advice on the quality and safety of services.

b. Report incidents and provide feedback about incidents, events, conditions that impact them.

c. Participate in investigations and reviews of incidents that they have witnessed and/or that have impacted them.

d. Engage in the resolution of the incident and contributing to service improvement as part of Continuous Quality Improvement (CQI).

2. CHL Chief Executive Officer (CEO)

a. Escalates CAS 1 (Extreme Risk) Incidents to the Board.

b. Briefs the Board on the progress of continuous improvement initiatives as provided by the Clinical Governance and Safe Care Team (CGSCT).

3. CHL Leadership Team (includes Executive and Management)

a. Develop and maintain policies, procedures, and templates to facilitate effective incident management across CHL, adhering to best practices.

b. Communicate incident management policies and procedures to staff, residents, representatives, advocates, and any other person significant to residents. It is CHL's responsibility to support people to understand how our incident management system operates.

c. Ensure staff undertake education and training on incident management.

d. Work with external providers (including contractors and volunteers) to ensure key elements of the Framework are articulated, understood, and adhered to by those working with CHL to provide care and services to CHL residents.

e. Escalate and report incidents according to policy requirements, and in case of serious incidents and organizational risks, escalate to the relevant business stream's General Manager, Legal Department, and Chief Executive Officer (CEO).

f. Co-ordinate Critical Incident Management activities within their area of responsibility including Residential Aged Care, Home & Community Services, Retirement Living, Head Office Support Services.

g. Undertake / Coordinate independent investigations of critical incidents (as determined by General Manager RAC (Residential Aged Care), General Manager HCS (Home and Communities) and General Manager, PQ (Practice and Quality).

h. Ensure serious and critical incidents are reported to relevant external regulatory bodies (ASQSC, NDIS Commission, Safe Work,) within the statutory timeframes.

i. Participate in and identify opportunities for Continuous Quality Improvement (CQI).

4. Clinical Governance and Safe Care Team (CGSC Team)

a. Develop and maintain policies, procedures, and templates to facilitate effective incident management across CHL, adhering to best practices.

b. Escalate and report incidents according to policy requirements, and in case of serious incidents and organizational risks, escalate to the relevant business stream's General Manager, Legal Department, and Chief Executive Officer (CEO).

c. Undertaking or coordinating independent investigations of critical incidents, as determined by the General Manager, RAC (Residential Aged Care), and General Manager, PQ (Practice and Quality). Additionally, provide support for the investigation of clinical incidents that result in critical harm or serious risk.

d. Analyse and provide insight in monthly clinical incident data, benchmarking, and trends.

e. Identify organisational continuous improvement opportunities based on clinical incident data.

f. Assist in developing and implementing clinical incident management education and training.

g. Assist in clarification, classification, and reporting requirements under the ASQSC, NDIS Commission, and other legislative bodies.

5. CHL Staff Members

a. Work in accordance with their position description and comply with all CHL policies and procedures including those related to incident management and Aged Care Code of Conduct.

b. Undertake education and training required to understand our incident management framework.

c. Identify, respond, and report incidents including allegations and near misses in accordance with policies and procedures.

d. Engage in continuous improvement activities to minimise and prevent the risk of incidents.
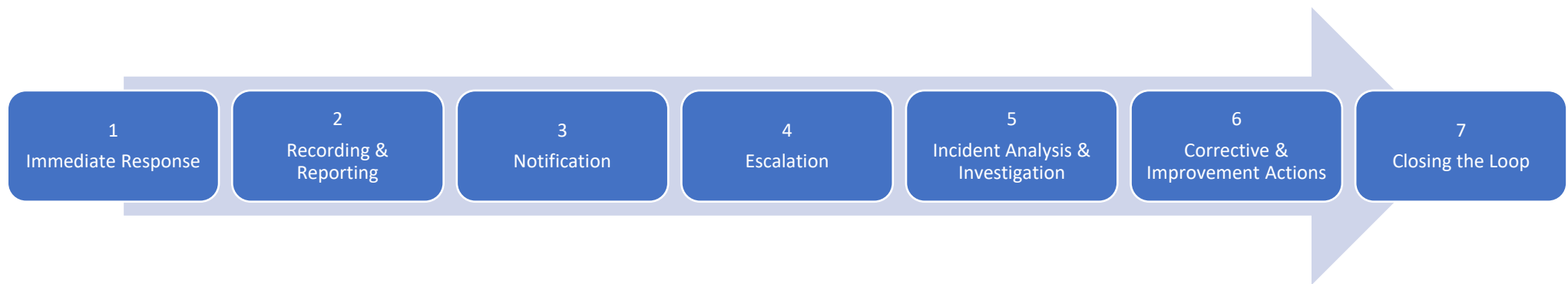
RAC Care and Clinical Incident Management Procedure

PROCEDURE

1. Incident Management in Residential Aged Care (RAC)

The procedure applies to all incidents, including substantiated incidents and unsubstantiated allegations. The response to the incident should be proportionate to the actual or potential harm caused by the incident or allegation.

Please note that an incident or allegation may lead to a complaint. For feedback and complaints, refer to the RAC_Feedback & Complaints Management Policy and Procedure.

1 Immediate Response	2 Recording & Reporting	3 Notification	4 Escalation	5 Incident Analysis & Investigation	6 Corrective & Improvement Actions	7 Closing the Loop

Steps	Instructions		Person Responsible	Time Frames
1. Immediate Response	a) Ensure immediate safety of the affected resident, assess for injuries (both physical and emotional), and provide necessary care to reduce harm. • For example: consider whether escalation pathways such as transfer to hospital, CPR etc are appropriate. b) Ensure the safety and well-being of others involved in the incident, addressing their immediate needs. c) Take immediate actions to mitigate ongoing harm and prevent recurrence of the incident. d) Conduct necessary clinical assessments on affected resident/s, such as delirium screen, UA, etc.		All Staff	Immediately after the incident occurs or immediately after staff become aware of the incident.

RAC Care and Clinical Incident Management Procedure

Steps	Instructions	Person Responsible	Time Frames

2. Recording & Reporting	a) Report the incident at the earliest opportunity to the Residential Manager or Care Manager or delegate.
	   • Refer to Section 2. Critical Assessment Scale (CAS) Rating.
	   • Refer to Section 3. Decision Matrix: Critical Assessment Scale (CAS) for CHL Escalation & Reporting Lines: Resident Events and Section 4. Incident/ Allegation/ Complaint Escalation Pathway.
	   • Refer to Section 5. Decision Matrix "SIRS" Incident Escalation Pathway.
	b) Notify at the earliest opportunity the Resident's family/Authorised Representatives (AR) and MP.
	c) Consider if there are reasonable grounds to report an incident to the police and coroners.
	   • This includes situations such as unexpected deaths, sexual assault (including allegations), the presence of potential or ongoing danger, etc.
	   • In the case of unexpected or suspicious deaths and sexual assault (including allegations), it is essential not to move the body or remove items from the body and room until authorities arrive and assess the situation.
	d) Assess whether the incident is considered reportable under the Serious Incident Response Scheme (SIRS) or under the NDIS Incident Management and Reportable Incident Rules (2018), if so, refer to notification and escalation rows below.
	e) Make a detailed record of the incident in eCase using the relevant progress note "sub type" and template.
	   • Ensure each question in the progress note entry is completed.
	   • Follow the worklog generated from the progress note, including documenting the incident in the relevant registers on eCase (e.g. resident incident register, SIRS Register, wound register, etc.).
		All Staff	Incidents must be reported & recorded immediately, or when it is safe to do so.

RAC Care and Clinical Incident Management Procedure

catholic healthcare

Steps	Instructions	Person Responsible	Time Frames
3. Notification	a) Initiate the report to ACQSC as a SIRS report if the incident is considered reportable • Refer to Section 5. Decision Matrix: SIRS Incident Escalation Pathway & Section 8. eCase Documentation and Process Map for SIRS Incident. b) Notify CHL's NDIS Coordinator if the incident is a reportable incident under NDIS • Refer to Section 6. NDIS Incident/ Allegation Escalation Pathway. c) Report the incident via MySafety if it involves a staff injury or near miss. d) For matters relating to Safeguarding matters: • Refer to Section 7. Safeguarding Disclosure Escalation Pathway, CHL Safeguarding Policy, and CHL Safeguarding Procedure. e) For matters relating to Voluntary Assisted Dying (VAD) • Refer to the CHL Responding to Requests for Voluntary Assisted Dying (VAD) Policy (QLD) and CHL Requests for Voluntary Assisted Dying Procedure – Queensland Only for information.	Care Manager/ RAC Manager	**SIRS Priority 1 - within 24 hours** of CHL becoming aware that the incident has occurred. **SIRS Priority 2 - within 14 days** as per CHL KPI. *Note: ACQSC SIRS reporting requirement is within 30 days. **NDIS incidents under the five reportable - within 24 hours,** except for unauthorised use of restrictive practices, which has a 5-day reporting timeframe. *Following the initial 24-hour report, a 5-day form must be completed through the NDIS Commission Portal, due 5 business days after the initial report.

Steps	Instructions	Person Responsible	Time Frames
4. Escalation	**Immediate** a) Escalate the incident accordingly depending on the CAS Rating. • Refer to [Section 4. Incident/ Allegation/ Complaint Escalation Pathway](#).	All Staff	Refer to the [Decision Matrix: CAS](#).
	Further Escalation & Considerations a) The incident's nature and other factors determine the involvement of individuals in the analysis, the need for a formal investigation, and whether it should be conducted internally or independently by the GCSC Clinical Incidents & Complaints Investigation Team. • All CAS 1 – Extreme Risk incidents. • In certain situations, an independent investigation may be the best course of action, especially when the incident's facts are in dispute, it involves allegations of inappropriate staff behaviour, or if requested by the consumer or their family/representative. • If there are further risks and/or systemic issues identified during the service's investigation. b) **Media** • Only the CEO and the RAC General Manager of Catholic Healthcare or the delegate have the authority to communicate with the media.	RAC Managers must consult their Regional Managers before escalating to the GCSC GM & Investigation Team for an independent review. The GCSC GM may also initiate an independent review at their discretion.	

Steps	Instructions	Person Responsible	Time Frames

5. Incident Analysis & Investigation	General Guidelines
	
	a) CHL Investigation Principles:
	
	• Natural justice and procedural fairness.
	
	  o Information provided is accurate and factual. Avoid speculation and personal opinions.
	• Privacy and confidentiality, including disclosure to third parties.
	
	  o Names/details are not for release and matters under investigation cannot be discussed with individuals outside the investigation.
	• Openness and transparency in consultation with the RAC Executive & GCSC Team
	
	• Sound documentation management and preservation.
	
	b) Maintain accurate and timely records of the investigation, including documentation of meetings, file notes, statements with the resident/family or AR, and staff interviews. Additionally, ensure evidence to support the findings, including a written record of orally provided evidence, is properly documented.
	
	c) Documentation: CAS 2 to 5 incident investigations/review should be completed in eCase Resident Incident Register (CAS 2 to 5).
	
	d) Documentation: CAS 1 – Extreme Risk incidents should be escalated as discussed above. The Lead Investigator may utilise the form: Critical Incident - Comprehensive Investigation Report.
	
	e) All incidents must be promptly investigated, and the extent and type of investigation will vary based on factors such as:
	
	• the severity, impact on consumer confidence and safety, probability of recurrence, past occurrences, complexity, and any reportable incidents and considering affected individuals' views, including consumers and families/representatives.
		Care Manager/ RAC Manager	Investigation duration may vary based on incident severity and complexity, possibly extending up to 2 weeks or more.
			
			Clear communication of timelines to stakeholders, including the resident and AR, is essential to ensure alignment and achievable outcomes.

Steps	Instructions	Person Responsible	Time Frames

5. Incident Analysis & Investigation (cont.)	f) The investigator should establish the sequence and timing of events including how the individual/s are involved in the incident and identifying contributing factors by:
	• Evaluating the incident by analysing information from various sources such as but not limited to:
	   o Resident records such as progress notes, care plans, medication charts and staff reports.
	   o Local clinical process documentation such as Nursing Handover sheets, staff meeting minutes, Doctor's Communication Books.
	   o Information about the situation, environment, and conditions (staffing numbers, time of day).
	   o Policy & Procedures.
	   o Personnel records.
	   o Any physical evidence.
	• Conduct fact-finding meetings with involved staff and relevant individuals (involving HRBP if needed).
	• CAS 1 – Extreme Risk incidents – HRBP should be involved.
	• Obtaining factual and chronological statements from staff (and individuals involved if possible).
	• Observing environments and practices.
	g) During the investigation, various factors should be considered, including the underlying causes of the incident, actions needed to address the specific incident, and measures to prevent similar incidents in the future, which may involve systemic changes.
	• Seek to understand how the incident occurred and how the incident could have been prevented.
	• Initiate the process of implementing remedial actions to mitigate the risk of recurrence or similar incidents.
	• Involve and consult with the resident and/or AR in developing a plan for remedial actions and incident resolution, encouraging their feedback to contribute to continuous quality improvement strategies.
		Care Manager/
		
		RAC Manager
			Investigation duration may vary based on incident severity and complexity, possibly extending up to 2 weeks or more.
			
			Clear communication of timelines to stakeholders, including the resident and AR, is essential to ensure alignment and achievable outcomes.

Steps	Instructions	Person Responsible	Time Frames
5. Incident Analysis & Investigation (cont.)	**Trends Analysis** a) Review past incident trends for the resident and implement strategies to minimize ongoing risk and harm. • Assess whether the incident is an isolated occurrence or if there are emerging trends. • Develop individualized strategies to mitigate the resident's risk/s. b) Analyse incident trends across the Home, present them for thorough review at Monthly Clinical Risk Meetings, and develop additional strategies to enhance the delivery of safe care and services to residents. • Consider high impact and high prevalent risks across your residents' portfolio. • Develop strategies to mitigate identified risks at service and governance level. c) For CAS 1 – Extreme Risk incidents that utilized the Critical Incident - Comprehensive Investigation Report, a final report will be provided to the General Managers of RAC & GCSC for review, which may include recommendations for remedial action and dissemination of learning from the investigation.	Care Manager/Residential Manager with assistance from Regional Quality Manager and Regional Support Manager	Clear communication of timelines to stakeholders, including the resident and AR, is essential to ensure alignment and achievable outcomes.
6. Corrective & Improvement Actions	a) Implement corrective actions and recommendations should aim to reduce harm, prevent recurrence, and enhance future incident response and management. They should also be: • **S** – Specific **M** – Measurable **A** – Achievable **R** – Realistic **T** – Timely • Corrective actions may include (but not limited to) staff education, setting/realigning expectations or issuing warning letters, updating care plans, and implementing changes in care practices. b) Assess and evaluate the potential risk reduction of these actions for preventing similar incidents in the future. c) Assess and evaluate how these action/s can improve the response to a similar incident if they were to occur again. d) Monitor the effectiveness of these actions by measuring and tracking indicators such as a reduction in similar incidents, fewer complaints related to specific issues, or improved staff knowledge after educational sessions. e) Document the progress of relevant actions in a PCI entry in MOA.	Care Manger / Residential Manager with assistance from Regional Support Manager or Regional Quality Manager if needed.	Clear communication of timelines to stakeholders, including the resident and AR, ensures clear and achievable expectations.

Steps	Instructions	Person Responsible	Time Frames

7. Closing the Loop	a) Complete Manager Review for every incident, summarizing the actions taken in accordance with each step of this table.
	
	b) Discuss the incident, the response, and learnings in relevant meetings and forums to raise awareness.
	
	c) Involve resident/family/AR in incident resolution using open disclosure principles, encouraging their feedback for continuous quality improvement strategies.
	
	  • Documentation of meetings (including file notes) with the resident/family or AR demonstrating open disclosure should be retained.
	
	  • Refer to the [CHL Open Disclosure Policy and Procedure](#).
	
	d) Timely completion and closure of PCIs in MOA.
		Care Manger / Residential Manager with assistance from Regional Support Manager or Regional Quality Manager if needed.	Clear communication of timelines to stakeholders, including the resident and AR, ensures clear and achievable expectations.

2. Critical Assessment Scale (CAS) Rating

- The CHL CAS provides a prioritisation rating for each incident to ensure a standardised objective measure of severity is allocated to each incident to:

    o Inform the level of investigation.

    o Implement the required actions, and

    o Identify the appropriate reporting, including escalation and referral to relevant CHL Committees.

- Each Residential Manager will review every incident and with appropriate consultation prioritise them as either:

    o CAS 1 – Extreme Risk

    o CAS 2 – High Risk

    o CAS 3 – Moderate Risk

    o CAS 4 – Low Risk

    o CAS 5 – Negligible Risk

    (See Decision Matrix: Critical Assessment Scale contained within this Procedure for more details.)

- Any WHS incidents, near misses and or hazards must be referred to the CHL Corporate Human Resources Department for management by the Health, Safety and Wellbeing Management team as appropriate.

- Details of incidents are to be documented through the CHL Incident Management Systems.

3. Decision Matrix: Critical Assessment Scale (CAS)

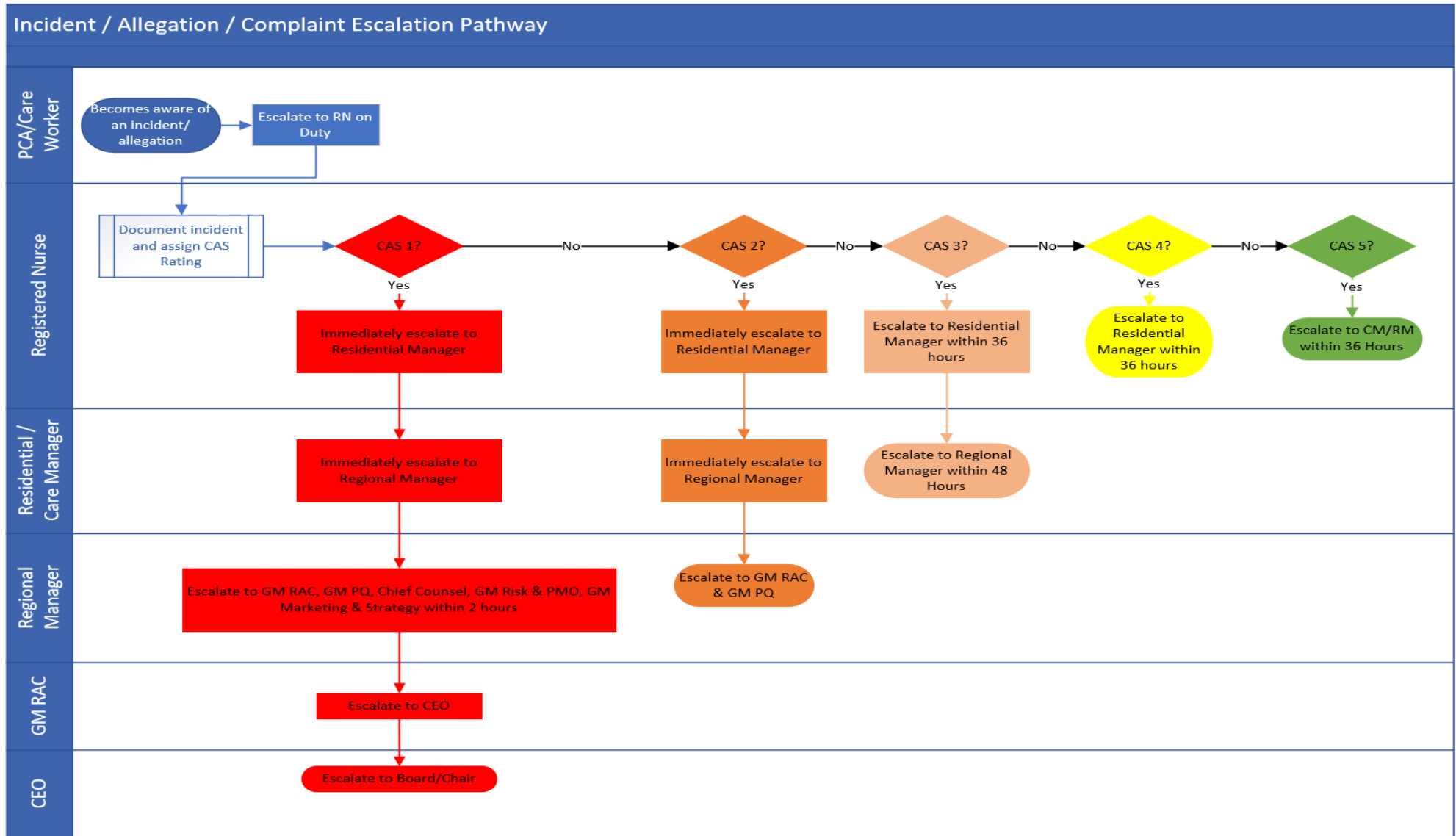| CAS1 Extreme Risk	CAS 2 High Risk	CAS 3 Moderate Risk	CAS 4 Low Risk	CAS 5 Negligible Risk
Definition				
A clinical event that results in or potential to cause **Critical Harm**. Critical event examples include: **Death** or that is thought to be **unrelated to the natural course** of a diagnosis / illness.	A clinical event that results in or potential to cause **Significant Harm**. An incident that causes a **consumer/ staff member to suffer** or has the **potential to suffer a major loss or reduction** in their usual level of function.	A clinical event that results in or potential to cause **Moderate Harm**. An incident that causes a consumer to **suffer injury or illness or psychological harm** unrelated to the natural course of their illness /diagnosis and differing from the expected outcome of care delivery requiring review by MP or Specialist.	A clinical event that results in or potential to cause **Minor Harm**. An incident or activity that results in consumers **temporary** increase in their level of care, monitoring, or emotional support.	A clinical event that results in **No Harm** or a **Near Miss**. No treatment or injury following an accident or incident or a near miss.
CHL Escalation & Reporting Lines: Consumer Events (RAC)				
Swift Reporting at the earliest opportunity (immediate ASAP) ➔ CM/ RM/ Reg. M/ GM RAC *GM RAC to consider escalation to:* ➔ *GM PQ/ Chief Legal Counsel/ CPO/ Chief Strategy Officer/ GM Risk & PMO/ CEO*	Reporting Within 24 hours ➔ CM/ RM/ Reg. M/ GM RAC *GM RAC/GM HCS to consider escalation to:* ➔ *GM PQ/ Chief Legal Counsel/ CPO/ Chief Strategy Officer/ GM Risk & PMO/ CEO*	Reporting / Actions: Within 36 hours ➔ Registered Nurse or Nurse In-Charge/ CM/ RM	Reporting / Actions: Within 36 hours ➔ Registered Nurse or Nurse In-Charge/ CM/ RM	Reporting / Actions: Within 36 hours ➔ Registered Nurse or Nurse In-Charge/ CM/ RM
• Chair- Chair of Board • CEO - Chief Executive Officer • GM Risk & PMO - General Manager Risk & Project Management Office • CPO – Chief People Officer • GM PQ - General Manager, Practice and Quality		• GM RAC - General Manager Residential Aged Care • Reg. M - Regional Manager • RM - Residential Manager • CM - Care Manager		

RAC Care and Clinical Incident Management Procedure

CAS1 Extreme Risk	CAS 2 High Risk	CAS 3 Moderate Risk	CAS 4 Low Risk	CAS 5 Negligible Risk
Consumer Events (RAC)				
Consider SIRS P1/ NDIS Reportable Incident *Police/ Coroners Report Examples:* • Unexpected Death as a result of any accidental injury. • Death of a consumer due to faulty equipment in workplace. • Fall Causing Death. • Suspected Suicide. • Medication Error leading to Death. • Death as a result of an unexplained Absence. • Death as a result of Neglect. • Allegation of physical assault or criminal activity that leads to Critical Harm. • Alleged Sexual Assault that leads to Critical Harm. • Any Death of an NDIS Consumer. • Incidents that may contain reputational risk.	Consider SIRS P1 or P2/ NDIS Reportable Incident *Police Examples:* • Fall resulting in significant harm/ fracture / Admission to Hospital. • Accidental injury resulting in significant harm. • Accidental Injury of a consumer due to faulty equipment causing significant harm. • Consumer on restrictive practice at the time of the incident resulting in significant harm. • Sexual Assault - Elder Abuse/Sexual Misconduct. • Significant incident causing physical or psychological injury that requires immediate and acute medical intervention due to significant harm. (e.g. Choking, Fall, Burns) • All stage III, IV, unstageable and deep tissue pressure injuries. • Allegation of Criminal Nature by Consumer Reported to Police. • Missing Consumer Reported to Police • Infection Outbreaks (define) such as Acute Respiratory Outbreak, Gastroenteritis. • Medication Incident resulting in Admission to hospital. • Incidents that may contain or develop reputational risk.	Consider SIRS P2 / NDIS Reportable Incident *Examples:* • Consumer infection which requires a review by a Medical Practitioner. • An incident requiring hospital transfer for review – not resulting in significant harm e.g., Rx UTI. • Medication incident requiring review by a Medical Practitioner but not requiring immediate medical intervention or transfer to hospital. • Stage 1 or 2 pressure injuries. • Missing S8 medication. • Infections resulting in moderate harm, e.g. Antibiotic treatment may require hospital transfer.	Onsite Treatment (**Physical, Emotional, or Psychological**) by Staff Following an Accident or Incident. *Examples:* • Fall resulting in minor harm requiring review by a Medical Practitioner but not requiring treatment in hospital to resolve. • Incidents resulting in minor harm skin tears, bruises, and abrasions. • Infections resulting in minor harm, e.g., Covid managed in home, not requiring treatment. • Incidents that require an increased level of Supervision or Vital sign monitoring for < 4 hours. • Incidents that lead to a review of the Care Plan and/or additional assessments. • Incidents that lead a referral for Allied Health Assessment.	Should not meet SIRS or NDIS reporting criteria. *Examples:* • Near-miss incidents. • Falls that do not result in any apparent injury. • Medication error with no impact on consumer e.g. Administrative/ packaging errors.

approver	owner	date approved	next review date	page
Clinical Governance and Safe Care (CGSC) Team	CGSC Team	28 August 2023	28 August 2026	**17 of 24**

RAC Care and Clinical Incident Management Procedure

catholic healthcare

4. Incident/ Allegation/ Complaint Escalation Pathway

Incident / Allegation / Complaint Escalation Pathway

PCA/Care Worker
- Becomes aware of an incident/ allegation → Escalate to RN on Duty

Registered Nurse
- Document incident and assign CAS Rating →
- CAS 1? —No→ CAS 2? —No→ CAS 3? —No→ CAS 4? —No→ CAS 5?
  - CAS 1? Yes → Immediately escalate to Residential Manager
  - CAS 2? Yes → Immediately escalate to Residential Manager
  - CAS 3? Yes → Escalate to Residential Manager within 36 hours
  - CAS 4? Yes → Escalate to Residential Manager within 36 hours
  - CAS 5? Yes → Escalate to CM/RM within 36 Hours

Residential / Care Manager
- Immediately escalate to Regional Manager
- Immediately escalate to Regional Manager
- Escalate to Regional Manager within 48 Hours

Regional Manager
- Escalate to GM RAC, GM PQ, Chief Counsel, GM Risk & PMO, GM Marketing & Strategy within 2 hours
- Escalate to GM RAC & GM PQ

GM RAC
- Escalate to CEO

CEO
- Escalate to Board/Chair

RAC Care and Clinical Incident Management Procedure

5. Decision Matrix: 'SIRS Incident' Escalation Pathway

Alleged, Suspected or Actual SIRS Incidents include

1. Unreasonable Use of Force
2. Unlawful or Inappropriate Sexual Contact
3. Unexpected Death
4. Psychological or Emotional Abuse
5. Stealing or Coercion by a Staff Member
6. Neglect
7. Inappropriate Use of Restrictive Practice
8. Unexplained Absences

NB: There are **three categories** of incidents that can only be reported as a **Priority 1**:

1) Unlawful sexual contact or inappropriate sexual conduct inflicted on a consumer.
2) Unexpected death.
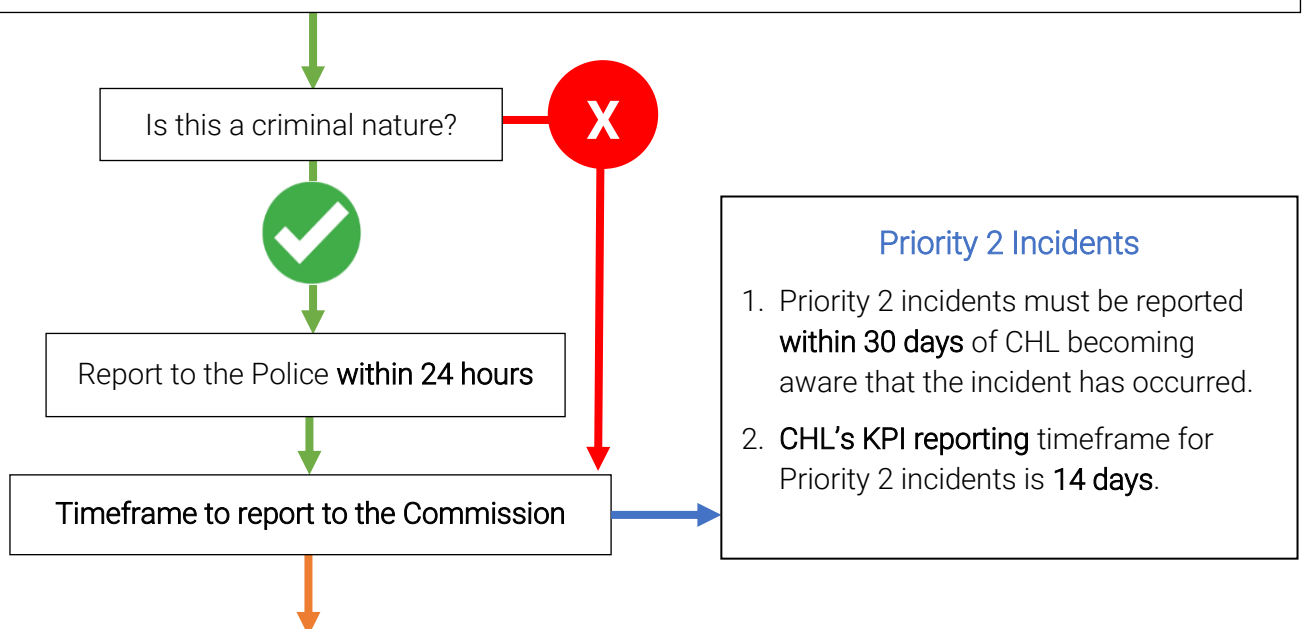3) Unexplained absence from care (RAC)

SIRS Incident

Residential Manager to determine whether it is a Priority 1 or 2 incident (**NB:** Encourage to use the Aged Care Quality and Safety Commission's <u>SIRS Decision Tool.</u>)

- Priority 1(P1) - Contact Regional Manager Immediately.
- Priority 2 (P2) - Contact Regional Manager next business day.

Residential manager to contact Regional Manager immediately for Priority 1 Incident and the next business day for Priority 2 Incidents.

Is this a criminal nature?

X

Report to the Police **within 24 hours**

Priority 2 Incidents

1. Priority 2 incidents must be reported **within 30 days** of CHL becoming aware that the incident has occurred.

2. **CHL's KPI reporting** timeframe for Priority 2 incidents is **14 days**.
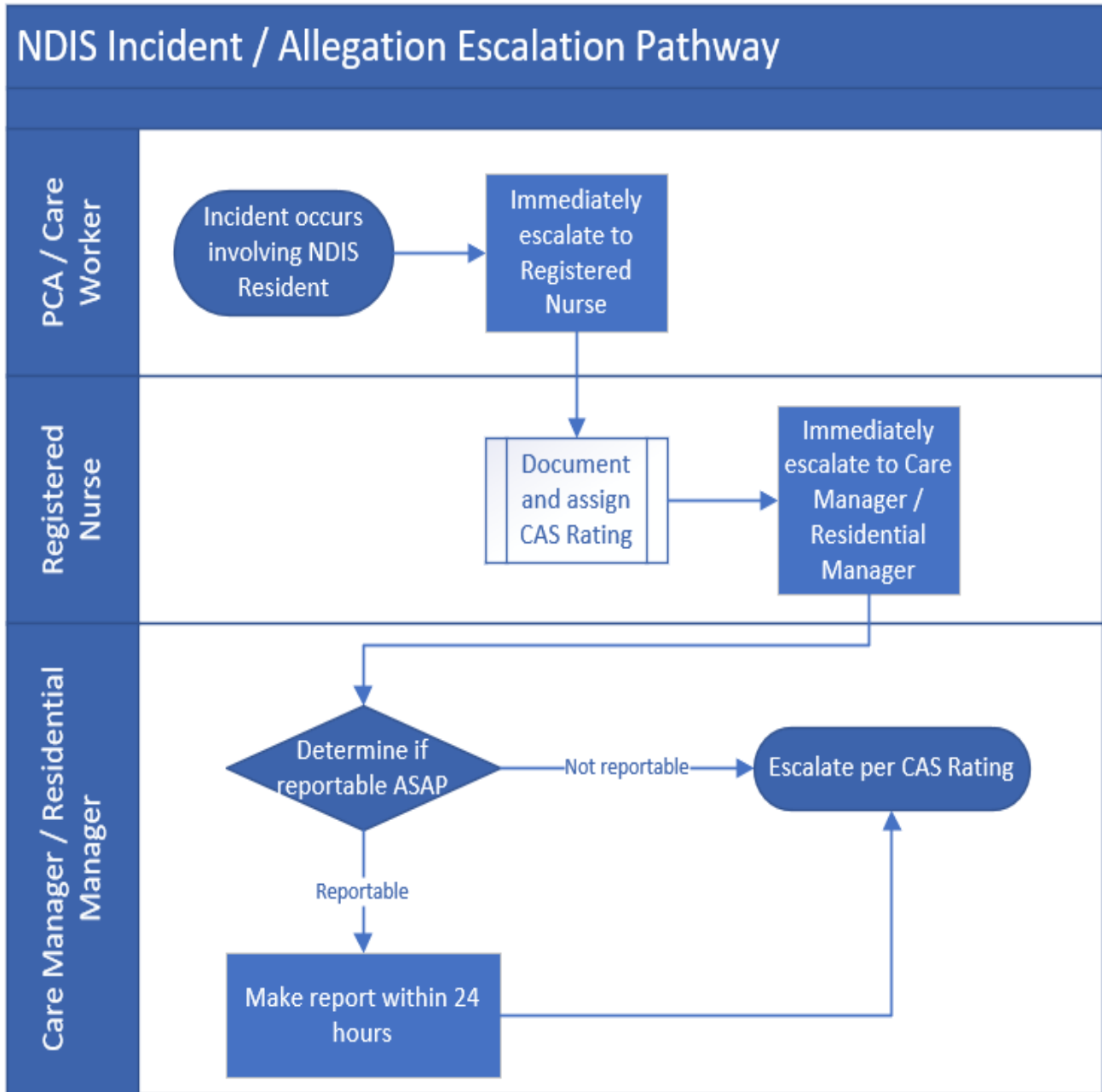
Timeframe to report to the Commission

Priority 1 Incident

1. Initial notice to the Commission **within 24 hours** via <u>My Aged Care Provider Portal.</u>
   <u>NB: Regional Manager to review eCase Serious Incident Risk Register prior to entering incident into</u> <u>My Aged Care Provider Portal.</u>
2. Additional information to the Commission (if required) **within 5 days or by a date specified by the Commission.**
3. Final report (if required) to the Commission **within 84 days (12 calendar weeks).**

---

6. NDIS Incident/ Allegation Escalation Pathway

NDIS Incident / Allegation Escalation Pathway

PCA / Care Worker

Incident occurs involving NDIS Resident → Immediately escalate to Registered Nurse

Registered Nurse

Document and assign CAS Rating → Immediately escalate to Care Manager / Residential Manager

Care Manager / Residential Manager

Determine if reportable ASAP → Not reportable → Escalate per CAS Rating

Reportable → Make report within 24 hours → Escalate per CAS Rating
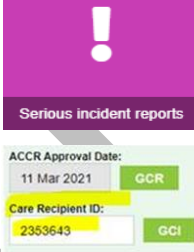
7. Safeguarding Disclosure Escalation Pathway
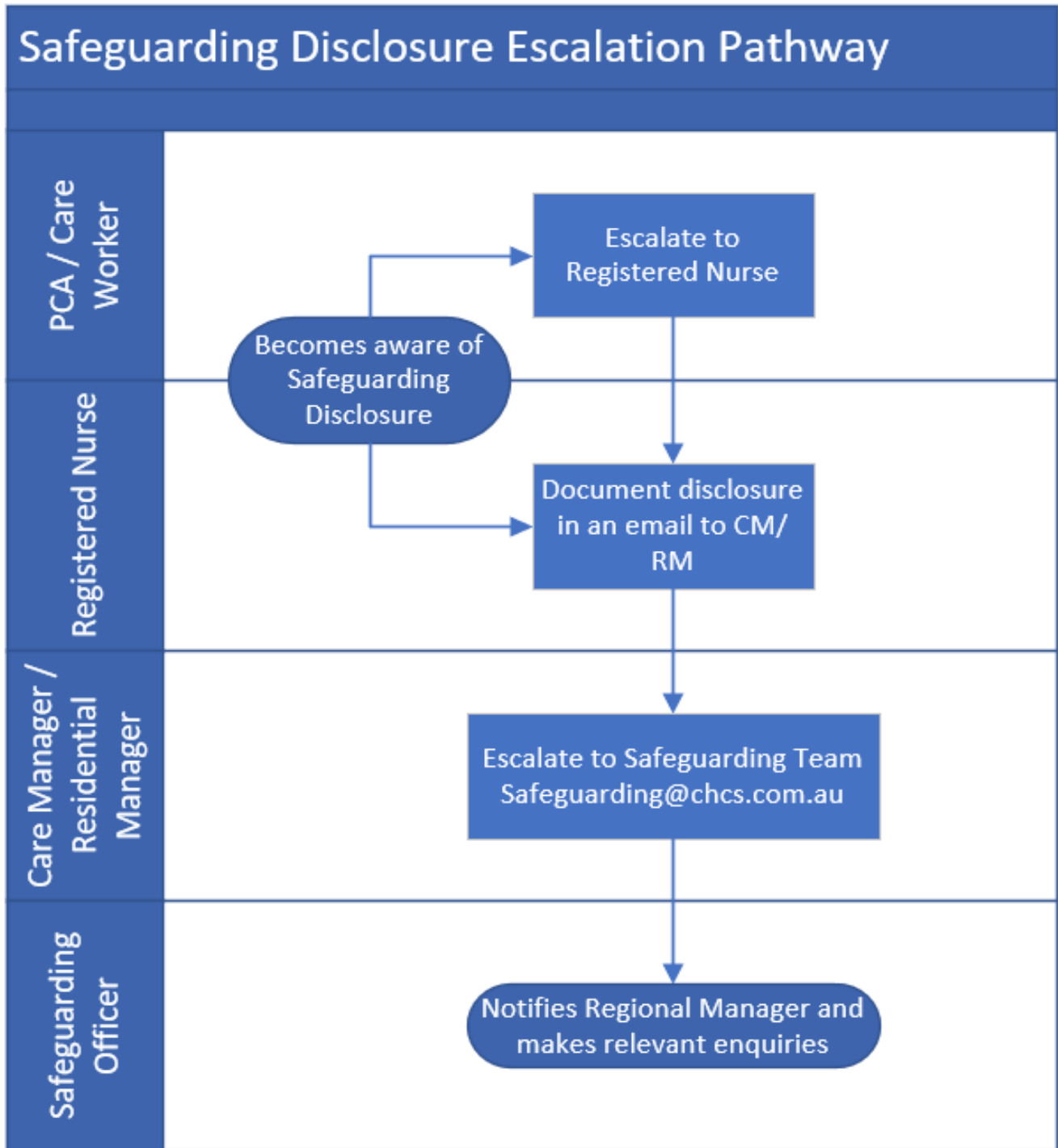
RAC Care and Clinical Incident Management Procedure

8. eCase Documentation and Process Map for SIRS Incident

Steps	Alleged Victim (Resident)	Alleged Offender/Perpetrator (Resident)	Alleged Offender/Perpetrator (Staff/Family/Visitor)	Role Responsibility
1. Anyone becoming aware of an alleged, suspected or confirmed SIRS incident must report immediately to Residential Manager.	• Complete a head to toe assessment to identify any injuries and assess the impact on the resident affected by the incident. • **If an allegation of sexual assault:** ▪ The resident must be assessed by a Medical Practitioner (MP) immediately. If the MP is unavailable within 2 hours, transfer the resident to hospital. ▪ Do not shower, remove clothing, or alter the resident and the environment in any way.	• For Care Worker, eCase Progress Notes – select *Incident - SIRS - Alleged Offender/Perpetrator (CW ONLY).* • For RN/EN, eCase Progress Notes – select *Incident - SIRS - Alleged Offender/Perpetrator (Mgr/RN/EN ONLY).* Notes: DO NOT DELETE TEMPLATE in eCase Progress Notes and Complete All Fields.	Report to RN/EN Residential Managers immediately.	Staff/RN/ Management
2. Immediate Action.	• Reduce risk and ensure safety. • **Reassurance and emotional support.**	• Reduce risk and ensure safety. • **Reassurance and emotional support.**	Reduce risk, ensure safety, and offer support.	Staff/RN/ Management
3. Residential Manager to determine whether it is a Priority 1 or 2 incident • Priority 1 - Contact Regional Manager Immediately • Priority 2 - Contact Regional Manager next business day.	• Initial investigation. • Complete of eCase Progress Notes - *select Incident – SIRS –* ▪ *Unreasonable use of force (victim)* ▪ *Unlawful/Inappropriate sexual contact (victim)* ▪ *Psychological/Emotional abuse (victim)* ▪ *Unexpected death (victim) P1* ▪ *Stealing/Financial Coercion by staff (victim)* ▪ *Neglect (victim)* ▪ *Inappropriate restrictive practice (victim)* ▪ *Unexplained absence from care (police involved) P1.* • DO NOT DELETE TEMPLATE and complete all fields in the eCase Progress Notes - *select Incident - SIRS* • Complete *eCase Serious Incident Risk Register.*	• Investigation incidents. • If not already completed, complete eCase Progress Notes – select *Incident - SIRS – Alleged Offender/Perpetrator (Mgr/RN/EN ONLY).* Notes: DO NOT DELETE TEMPLATE in eCase Progress Notes and Complete All Fields. • Complete *eCase Resident Incident Register – select type SIRS Incident - Alleged Perpetrator/Offender.*	SIRS incident Contact HR & Investigation.	RN/ Management/ Regional Manager

Steps	Alleged Victim (Resident)	Alleged Offender/Perpetrator (Resident)	Alleged Offender/Perpetrator (Staff/Family/Visitor)	Role Responsibility

4. If incident is rated
  a. Priority 1 incident within 24 hours.
  b. Priority 2 within 30 days.
	• Ensure *eCase Serious Incident Risk Register* has been completed correctly and notify Regional Manager for final approval.
	• Regional Manager to document final approval in *eCase Serious Incident Risk Register – Manager Review Notes*.
	• Once approval received from Regional Manager complete an **incident notification** in the My Aged Care Provider Portal.
	Note:
	  ▪ the SPARC number according to Medicare is the resident's **Care Recipient ID in eCase.**
	  ▪ the ACMPS number is for Community, **not required for RAC.**
	• If required to notify the Commission of any significant new information about the incident, complete a Notice of Significant New Information Form and send this notice and any supporting documents to SIRS@agedcarequality.gov.au
	• **Report to the police** if the incident is of a **criminal nature.**
	• Communication with residents and Authorised Representatives.
	• Complete eCase Progress Notes- *select Incident – Review of SIRS Incident* for any relevant update to the SIRS incident.
		• Rule out any medical causes.
		• eCase Progress Notes – select *Post Incident Review.*
		• Communication with residents and Authorised Representatives.
		• **MUST** complete eCase behaviour care plan Fast Edit and Evaluation (refer to eCase QRG - Care Plan Evaluation).
		• **Evaluation MUST** critically assess the appropriateness of any existing behaviour management strategies. If there are no existing strategies, then consideration must be given to any possible triggers for the behaviours and develop behaviour management strategies.
			Provide information about EAP services.	RN consultation with Managers/ Management

5. Addition information (if required) for priority 1 incident, within 5 days or by date specified by the Commission (if required). 6. Final Report (if required), within 84 days or 12 calendar weeks or by date specified by the Commission.	• Further investigation where required. • Complete a **Notice of Additional Information Form** (Priority 1) / (Priority 2) or a Final Report on Reportable Incident Form and send this notice and any supporting documents to SIRS@agedcarequality.gov.au • Communication with residents and Authorised Representatives. • Complete eCase Progress Notes- *select Incident – Review of SIRS Incident* for any relevant update to the SIRS incident.	• eCase Progress Notes – select *Post Incident Review* where required. • Communication with residents and Authorised Representatives.	Provide information about EAP services	RN / Management/ Regional Manager

approver	owner	date approved	next review date	page
Clinical Governance and Safe Care (CGSC) Team	CGSC Team	28 August 2023	28 August 2026	**23 of 24**

Version History:

Version Number	Date of update	Version Number	Date of update
Version 1	28 August 2023		

References:

1. CHL Care and Clinical Incident Management Framework
2. CHL Clinical Governance Framework
3. CHL Open Disclosure Policy and Procedure
4. RAC National Disability Insurance Scheme (NDIS) Policy Guideline

Forms:

- Critical Incident - Comprehensive Investigation Report (Word File)
- Record of Conversation Form (Word File)
- The Aged Care Quality and Safety Commission-Approved Forms:
  - SIRS – Notice of additional information form (Priority 1)
  - SIRS – Notice of additional information form (Priority 2)
  - SIRS – Notice of significant new information form
  - SIRS – Final report on reportable incident form

Keywords:

Elder Abuse, Abuse, Unlawful Sexual Contact, Unreasonable use of force, Missing Resident, Unexpected Death, Psychological Abuse, Emotional Abuse, Financial Abuse, Neglect, Chemical Restraint, Physical Restraint, Unexplained Absence, SIRS, Reportable Incident, Incident, Management, Reporting, Investigation, Governance, Feedback, Critical Assessment Scale (CAS); CAS Rating, Critical Incident, Risk, Continuous Improvement, Near Miss, Natural Justice, Procedural Fairness, Triangulation, Media, Notifiable; Restrictive Practice