Incident Management System in Community Care

Note: This Policy and Procedure must be read in conjunction with Westmont Aged Care Services Ltd Occupational Health & Safety Policy & Procedure Manual.

POLICY

To protect the health, safety and wellbeing of all consumers with the aim to ensure incidents are minimised and appropriate actions are taken to improve systems, work practices and the working environment to reduce the possibility of an incident occurring.

REGULATORY FRAMEWORK

- The Charter of Aged Care Rights
- The Code of Conduct for Aged Care
- The Aged Care Quality Standards
- The Quality of Care Principles 2014
- Open disclosure requirements
- Serious Incident Response Scheme

DEFINITIONS

IMS	Incident Management System
SIRS	Serious Incident Response Scheme
The Commission	Aged Care Quality and Safety Commission (ACQSC)
Incident	A consumer incident is defined as 'an event or circumstance that occurred during service delivery and resulted in harm to the consumer'.

Reportable incidents	A reportable incident is:
	• An incident that has occurred, or is alleged or suspected of having occurred, in connections with the provision of care to a consumer
	• The incident has caused harm, or could reasonably have been expected to have caused harm, to the consumer, and
	• The incident is one of the following types of incidents:
	  ○ Unreasonable use of force
	  ○ Unlawful sexual contact or inappropriate sexual contact
	  ○ Psychological or emotional abuse
	  ○ Unexpected death
	  ○ Stealing or financial coercion
	  ○ Neglect
	  ○ Inappropriate use of restrictive practices, or
	  ○ Missing consumers
	For home services, this may include any incidents:
	• Resulting from the action (or inaction) of a staff member of Westmont. This includes contractors and volunteers

	• That occur while care and services are being delivered to a consumer (i.e. where the consumer is participating in an activity outside of the consumer's home organised by Westmont and is bullied or harassed by another consumer
Non-reportable incidents	Non-reportable incidents – incidents that occur during the delivery of care and services resulting in harm to staff members, the consumer's family members or others – where the consumer was not affected – are not required to be reported. Reportable incidents do not apply to suspected, alleged or witnessed incidents that do not occur in connection with the provision of care.
Priority 1 reportable incident	A Priority 1 reportable incident is a reportable incident: • That caused, or could reasonably have been expected to have caused, a consumer physical or psychological injury or discomfort that requires medical or psychological injury or discomfort that requires medical or psychological treatment to resolve • Where there are reasonable grounds to report the incident to police • Involving unlawful sexual contact or inappropriate sexual contact inflicted on the consumer • That is an unexpected death of a consumer, or • Where a consumer goes mission in the course of the provision of home services If Westmont become aware of a reportable incident and have reasonable grounds to believe that the incident is a Priority 1 reportable incident, Westmont must notify the Commission with 24 hours of becoming aware of the reportable incident.
Priority 2 reportable incident	A Priority 2 reportable incident includes any reportable incident that does not meet the Priority 1 criteria. For example, a Priority 2 reportable incident may include where the consumer is momentarily shaken or upset because of the incident or where the consumer experiences temporary redness or marks that do not bruise (or could not reasonably have been expected to cause an injury), and which do not (or could not reasonably have been expected to) require medical or psychological treatment to resolve. All Priority 2 reportable incidents must be notified to the Commission within 30 calendar day of Westmont becoming aware of the reportable incident.
Unreasonable use of force	Unreasonable use of force: • Includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force, such as shoving, pushing, hitting, punching, kicking or rough handling of a consumer • Does not include gently touching the consumer: o For the purpose of providing care o To attract the consumer's attention o To guide the consumer To comfort the consumer when they are distressed
Unlawful sexual contact or inappropriate sexual conduct	Unlawful sexual contact or inappropriate sexual conduct includes: • If the contact or conduct is inflicted by a person who is a staff member of Westmont or a person who provides care or services for Westmont and is providing care and services at the time of the incident:

	○ Any conduct or contact of a sexual nature inflicted on the consumer, including but not limited to sexual assault, an act of indecency or the taking and/or sharing of an intimate image of the consumer ○ Any toughing of the consumer's genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the consumer • Any non-consensual contact or conduct of a sexual nature, including but not limited to sexual assault, an act of indecency or the taking and/or sharing of an intimate image of the consumer • Engaging in conduct relating to the consumer with the intention of making it easier to procure the consumer to engage in sexual contact or conduct All incidents of unlawful sexual contact or inappropriate sexual conduct are Priority 1 reportable incidents and must be reported to the Commission within 24 hours of Westmont becoming aware of the incident. Incidents that are unlawful or considered to be of a criminal nature, must be reported to police within 24 hours of the provider becoming aware of the incident.
Psychological or emotional abuse	Psychological or emotional abuse of a consumer includes conduct that has caused, or that could have reasonably have been expected to have caused, psychological or emotional distress to a consumer, including actions such as: • Taunting, bullying, harassment or intimidation • Threats of maltreatment • Humiliation • Unreasonable refusal to interact with the consumer or acknowledge the consumer's presence • Unreasonable restriction of the consumer's ability to engage socially or otherwise interact with people Repetitive conduct or contact which does not constitute unreasonable use of force but the repetition of which has caused, or could reasonably have been expected to have caused, the consumer psychological or emotional distress
Unexpected death	Unexpected death is where the death is a result of care or services provided by the provider or a failure by the provider to provide care and services. Westmont are required to notify any death where Westmont, including staff and health professionals engaged by Westmont: • Make a mistake resulting in death • Did not deliver care and services in line with a consumer's assessed care needs, resulting in death • Provided care and services that were poorly managed or not in line with best practice, resulting in death All reportable unexpected deaths are Priority 1 reportable incidents and must be reported to the Commission within 24 hours of Westmont becoming aware of the incident.
Stealing or financial coercion	Stealing from, or financial coercion of, a consumer by a staff member includes: • Stealing from the consumer by a staff member of Westmont • Conduct by a staff member of Westmont that: ○ Is coercive or deceptive in relation to the consumer's financial affairs ○ Unreasonably controls the financial affairs of the consumer Westmont must notify the Commission if we have a reasonable belief that a staff member is, or is alleged or suspected to be, responsible for a consumer's missing or stolen item(s).

Neglect	Neglect of a consumer includes: • A breach of the duty of care owed by Westmont, or a staff member of Westmont, to the consumer • A gross breach of professional standards by a staff member Westmont in providing care or services to the consumer Neglect is not a reportable incident where: • The incident results from a choice made by the consumer about the care or services provided to them, or how the care or services are to be provided, and Before the incident occurred, is alleged to have occurred, or is suspected of having occurred, the choice had been communicated by the consumer to Westmont, and Westmont had recorded the choice in writing
Inappropriate use of restrictive practices	The inappropriate use of restrictive practices in relation to a consumer is a reportable incident. Restrictive practice includes any practice or intervention that has the effect of restricting the rights or freedom of movement of a consumer. The Quality of Care Principles describe that the use of a restrictive practice is not a reportable incident where: • The restrictive practice is used in the course of providing home services, and • Before the restrictive practice is used, the following matters were set out in the consumer's care and services plan: o The circumstances in which the restrictive may be used, including the consumer's behaviours of concern that are relevant to the need for the use o The manner in which the restrictive practice is to be used, including its duration, frequency and intended outcome, and • The restrictive practice is used: o In the circumstances set out in the plan, and o In the manner set out in the plan, and o In accordance with any other provisions of the plan that relate to the use, and Details of the use of the restrictive practice are documented as soon as practicable after the restrictive practice is used
Missing consumers	Missing consumers is a reportable incident. Where a consumer goes missing in the course of Westmont providing care and services to the consumer and there are reasonable grounds to report that fact to the police, this is a reportable incident. All reportable incidents of missing consumers are Priority 1 reportable incidents for the purposes of notifying the Commission.

OVERVIEW OF RESPONSIBILITIES

Westmont will demonstrate effective management systems and practices, including but not limited to:

- Managing high-impact or high-prevalence risks associated with the care of consumers
- Identifying and responding to abuse and neglect of consumers
- Supporting consumers to live the best life they can
- Managing and preventing incidents, including the use of an IMS

The SIRS introduces additional requirements for Westmont in relation to:

- Incident management and prevention
- Notifying the Commission of reportable incidents

Westmont will prevent, manage, respond effectively to, and minimise the risk of incidents, noting that this applies to all incidents, not just the subset of incident types reportable under the SIRS.

Westmont will prevent, minimise the risk of, and respond effectively to any incidents of abuse and neglect in connection with the care we provide. This includes:

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

PROCEDURES

Consumer incidents that occur during delivery of services and result in harm to a client must be reported to the Commission, the Department of Health and Aged Care or relevant Funding Body of the client according to the relevant reporting requirements and documented in Westmont Incident Management System (IMS).

Identifying and reporting incidents

Identification is when an incident is disclosed to, or observed by, Westmont staff at any service delivery setting. This includes disclosure by a consumer, family member or other professionals to Westmont.

When an incident occurs, staff must ensure the immediate safety, health and wellbeing of themselves, the consumer and other involved parties, providing or obtaining medical attention and notifying emergency services as required.

Staff will ring Westmont to advise that an incident has occurred immediately or as soon as possible after the incident. This is reported to the Director of Community Care, Supervisor – Community Care or Supervisor – Systems and Reporting. An Adverse Event Form is then completed within 24 hours of the incident occurring. Details of the incident are recorded on the consumers records in Carelink.

Volunteers and contractors will ring Westmont or advise in person that an incident has occurred. This is reported to the Director of Community Care, Supervisor – Community Care, Supervisor – Systems and Reporting or the Social Connections Coordinator. Volunteers and contractors will be assisted to complete an Adverse Event Form within 24 hours of the incident occurring. Details of the incident are recorded on the consumers records in Carelink.

Responding to incidents

Response covers the immediate activities undertaken to ensure the safety and wellbeing of consumers, staff and visitors, preserve evidence and notify emergency services and family or other support people.

Management of incidents will focus on the safety, health, well-being, and quality of life of the consumers that receive our care and services.

Westmont will respond to an incident by:

- Assessing the support and assistance required to ensure the safety, health, and well-being of those affected by the incident and then providing that support and assistance
- Appropriately involving each person affected by the incident (or a representative of the person) in the management and resolution of the incident
- Using an open disclosure process with those affected by an incident
- Engaging the person or people in the management and resolution of the incident

Investigating and assessing incidents

An incident investigation is defined as ‘a formal process of collecting information to ascertain the facts, which may inform any subsequent criminal, civil, disciplinary or administrative sanctions.

The purpose of an incident investigation is to determine whether there has been a reportable incident of a consumer by a staff member or other consumer.

Westmont will assess all incidents that have occurred, are alleged to have occurred, or are suspected of having occurred, to determine the support we need to provide to the people affected.

Westmont will assess:

- Whether the incident could have been prevented
- What, if any, remedial actions need to be undertaken to further prevent similar incidents from occurring, or to minimise their harm
- How well the incident was managed and resolved
- What, if any, actions could be taken to improve our management and resolution of similar incidents
- Whether other persons or bodies should be notified of the incident

Westmont will take any actions identified through the assessment, including to notify the relevant persons identified, minimise risks, prevent future incidents from occurring and improve our approach to managing incidents. Westmont is responsible for deciding:

- Whether an internal investigation is required to be undertaken to determine:
    - The causes of the particular incident
    - The harm caused by the incident
    - Any operational issues that may have contributed to the incident occurring
- The nature of any such investigation

Notification of incident

The Director of Community Care, Supervisor – Community Care or Supervisor – Systems and Reporting are responsible for notifying reportable incidents to the Commission.

Incident review

A review is the analysis of an incident to identify what happened, determine whether an incident was managed appropriately, and to identify the causes of the incident and any subsequent learnings to apply to reduce the risk of future harm. Such reviews may be carried out by Westmont or external bodies.

Incident reviews are distinguished from accident investigations, which have a focus on determining whether there has been a reportable incident of a consumer by a staff member or other consumer.

The Director of Community Care will review the details of the incident to determine the type of incident that occurred, how it occurred and what action was taken to support or assist the consumer or person involved. Where required, the Director of Community Care will phone the consumer and/or their nominated emergency contact and provide support and assistance to the consumer to ensure their health, safety and wellbeing and involve them in the management and resolution of the incident.
The incident will be assessed and consider the views of the consumer affected by the incident to determine:

a) Whether the incident could have been prevented.
b) How well the incident was managed and resolved.
c) What, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact.
d) Whether other persons or bodies need to be notified of the incident.

Analysing and learning

Analysis and learning include monitoring and acting on trends identified through the analysis of consumer incident information to enhance the quality of services and supports to consumers.

Westmont will collect data relating to incidents to enable us to continuously improve our prevention and management of incidents, including to:

- Identify and address systematic issues in the quality of care we provide
- Provide feedback and training to staff about preventing and managing incidents

We will regularly review this information to assess the effectiveness of our prevention and management of incidents and determine what, if any, actions can be taken to improve our approach. We will take any actions identified to ensure the continuous improvement of our approach to managing incidents.

IMS requirements

Our IMS will enable us to collect data relating to incidents in a way that assists us to:

- Identify occurrences (or alleged or suspected occurrences) of similar incidents
- Identify and address systematic issues in the quality of care we provide
- Continuously improve your management and prevention of incidents
- Provide information relating to certain incidents to the Commission and other authorities (as required)

Informing the consumer of the incident management system

Westmont will ensure information about our incident management system is up to date and maintained in easily accessible formats for staff and consumers. Consumers will be informed of the incident management system prior to services commencing through communication with the Client Care Coordinator and our Client Information Booklet.

Training

Staff will receive information and training on our incident management processes at induction, at meetings and refresher training and is a requirement of all staff position descriptions.

Date approved:	January 2021	By Department:	DCC		
To be reviewed:	January 2024	By Department:		Key changes:	