Reporting for Aged Care Services

Summary This Policy Directive ensures specified NSW Health Aged Care services meet incident management and reporting requirements under the Aged Care Serious Incident Reporting Scheme (SIRS) and the National Disability Insurance Scheme (NDIS).

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Audience Chief Executives of LHDs;CEs, State Government Residential Aged Care managers, Aged Care and Transitional Aged Care Program managers;CEs, State Government Residential Aged Care managers, Aged Care and Transitional Aged Care Program managers;Multipurpose Service Managers

Secretary, NSW Health

NSW Health

POLICY DIRECTIVE

Reporting for Aged Care Services

POLICY STATEMENT

NSW Health is the Approved Provider of aged care services funded by the Australian Government, including State Government Residential Aged Care Facilities, Transitional Aged Care Programme services, Multi-Purpose Services and Commonwealth Home Support Programme services. Local Health Districts operate these aged care services, and the Australian Government has legal, regulatory, and funding responsibility for them.

To help protect aged care recipients, the *Aged Care Act 1997* (Commonwealth) and the *National Disability Insurance Scheme Act 2013* (Commonwealth) have compulsory reporting provisions through the Serious Incident Response Scheme (SIRS) and the National Disability Insurance Scheme (NDIS).

These Commonwealth incident management and reporting requirements are in addition to those required under the NSW Health Policy Directive *Incident Management* (PD2020_047).

SUMMARY OF POLICY REQUIREMENTS

NSW Health operated aged care services must report incidents in each system, when the reporting criteria are met for the Serious Incident Response Scheme (SIRS), the National Disability Insurance Scheme (NDIS) and NSW Health's Incident Management System.

Serious Incident Response Scheme reportable incidents are:

- Unreasonable use of force
- Unlawful sexual contact or inappropriate sexual conduct
- Neglect
- Psychological or emotional abuse
- Unexpected death
- Stealing or financial coercion by a staff member
- Inappropriate use of restrictive practices
- Unexplained absence from care

Priority 1 Serious Incident Response Scheme reportable incident (Aged Care) must be reported to the Aged Care Quality and Safety Commission within 24 hours.

Priority 2 Serious Incident Response Scheme reportable incident (Aged Care) must be reported to the Aged Care Quality and Safety Commission within 30 days of becoming aware of the incident.

These incidents must be reported in the My Aged Care Service Provider Portal.

National Disability Insurance Scheme reportable incidents are:

- Death
- Serious injury
- Abuse or neglect
- Unlawful sexual or physical contact with, or assault of, a person with disability
- Sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity.
- Use of restrictive practice not in accordance with authorisation/ behaviour support plan

All National Disability Insurance Scheme reportable incidents are to be reported in the National Disability Insurance Scheme Quality and Safeguards Commission Portal within 24 hours except for:

- use of restrictive practice not in accordance with a required state or territory authorisation and/or
- not in accordance with a behaviour support plan which must be reported within 5 business days.

Reportable incidents must be reported to NSW Police within 24 hours when there are reasonable grounds of facts or circumstances that could be of a criminal nature.

REVISION HISTORY

Version	Approved By	Amendment Notes
December 2023 (PD2023_042)	Deputy Secretary, Health System Strategy and Patient Experience	Updated to include extension of the Serious Incident Response Scheme to flexible care and in-home aged care services.
November 2022 (PD2022_054)	Deputy Secretary, Health System Strategy and Planning	Updated definition for Priority 1 SIRS incidents.
September 2022 (PD2022_045)	A/Deputy Secretary, Health System Strategy and Planning	Advises NSW Health residential aged care services of updated incident management and reporting requirements under the *Aged Care Act 1997* (Commonwealth) and the Serious Incident Response Scheme and the *National Disability Insurance Scheme Act 2013* (Commonwealth).
October 2019 (PD2019_049)	Deputy Secretary, Health System Strategy and Planning	Rescinds PD2017_024. Advises that MPSs must comply with compulsory reporting requirements under the Aged Care Act 1997.
July 2017 (PD2017_024)	Deputy Secretary, Strategy and Resources	Initial Document

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1. BACKGROUND

Local Health Districts operating State Government Residential Aged Care Facilities, Transitional Aged Care Program services, Commonwealth Home Support Programme services and Multi-Purpose Services must comply with incident management and compulsory reporting requirements under the Australian Government's Serious Incident Response Scheme (SIRS) and the National Disability Insurance Scheme (NDIS).

Since 2020, the Australian Government has made legislative changes under the *Aged Care Act 1997* (Commonwealth) and the *National Disability Insurance Scheme Act 2013* (Commonwealth). These changes related to the types of incidents that must be reported to the Commonwealth Department of Health and Aged Care and the National Disability Insurance Agency.

1.1. About this document

This document outlines incident management and compulsory reporting requirements for State Government Residential Aged Care Facilities, Transitional Aged Care Programme services, Commonwealth Home Support Programme services and Multi-Purpose Services to:

- the Aged Care Quality and Safety Commission and
- the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission where an incident involves an NDIS participant

These requirements are in addition to the NSW Health incident management and reporting requirements.

1.2. Key definitions

Approved Provider Aged Care	An approved provider is an organisation that has been approved by the Aged Care Quality and Safety Commission to deliver Australian Government subsidised home, residential or flexible care services to eligible older Australians. Note: The NSW Ministry of Health is the Approved Provider for State Government Residential Aged Care Facilities and Transitional Aged Care Programme services. Local Health Districts are the approved provider for the Commonwealth Home Support Programme and Multi-Purpose Services.
Approved Provider National Disability Insurance Scheme (NDIS)	An approved provider is an individual or organisation delivering a support or a product to a NDIS participant.
Behaviour Support Plan	Specifies a range of person-centred, proactive strategies that focus on individual needs to build on the resident's strengths, promote independence, improve functional ability, and reduce

	and potentially eliminate the use of restrictive practices.
Flexible Care	Defined under the Aged Care Act (1997) as the provision of any care provided in a residential or community setting by an approved aged care service that addresses care needs in alternate ways to the care provided by residential care or home care packages. The Transitional Aged Care Programme is a flexible care service provided by NSW Health.
ims+	NSW Health's incident management system used to record and manage incidents occurring in NSW Health services.
'In connection with' the provision of care	The meaning of 'in connection with' the provision of care is intentionally broad. It covers incidents occurring during the course of care being provided to a consumer and incidents that arise out of the provision of that care.
Key personnel	Persons responsible for the executive decisions of Australian Government funded Aged Care services, or any other person having authority or responsibility for (or significant influence over) planning, directing or controlling the activities of these services. In most cases this includes the State Government Residential Aged Care Facilities / Transitional Aged Care Programme / Multi- Purpose Service facility/service manager and/or Local Health District aged care contact.
National Disability Insurance Scheme (NDIS) Participant	A person with disability who meets the access requirements to become a participant in the NDIS. For the purposes of this Policy Directive, an NDIS Participant is a person with disability who is enrolled in the NDIS.
Priority 1 SIRS reportable incident (Aged Care)	All Priority 1 incidents need to be reported to the Aged Care Quality and Safety Commission within 24 hours of becoming aware of the reportable incident. Priority 1 reportable incidents include those that cause, or could reasonably have been expected to have caused, physical or psychological harm and/or discomfort that would usually require some form of medical or psychological treatment, or where there are reasonable grounds to report the incident to police. All reportable incidents involving instances of unexplained absence from care, unexpected death of a person who receives aged care, unlawful sexual contact, or inappropriate sexual conduct, are always Priority 1 reportable incidents.
Priority 2 SIRS reportable incident	An incident which must be reported to the Aged Care Quality and Safety Commission within 30 days of becoming aware of

(Aged Care)	the incident and are reportable incidents that do not meet the criteria for a 'Priority 1'.
'Reasonable grounds' to report to the police	'Reasonable grounds' may include scenarios where an Approved Provider is aware of facts or circumstances (alleged or known) that could be of a criminal nature and therefore must be reported to police (e.g. suspicion of indecent assault). If an Approved Provider becomes aware of reasonable grounds at a later time, the Approved Provider must notify the police within 24 hours of becoming aware of those grounds.
Reportable Incident (Aged Care)	Any of the eight specific incident types that have occurred or are alleged or suspected to have occurred involving an aged care recipient, in connection with the provision of residential care, flexible care or Commonwealth Home Support Programme services. See section 4.1 for definitions and examples.
Reportable Incidents (NDIS)	Are serious incidents or alleged incidents which result in harm to a resident of a State Government Residential Aged Care Facilities or Multi-Purpose Service who is a NDIS participant. See section 5.1 for definitions and examples.
Reportable Incidents Approver (NDIS)	The person with authority to review and is responsible for submitting a reportable incident to the NDIS Quality and Safeguards Commission. In most cases this is the State Government Residential Aged Care Facility or Multi-Purpose Service facility manager or on call manager.
Restrictive Practice	Any practice that results in any form of restriction on the freedom of movement or rights of a resident. Under the *Aged Care Act 1997* (Commonwealth) and the *National Disability Insurance Scheme Act 2013* (Commonwealth) there are five types of restrictive practices which include chemical restraint, environmental restraint, mechanical restraint, physical restraint, and seclusion.
Serious Incident Response Scheme (SIRS)	The Serious Incident Response Scheme is an initiative that helps prevent and reduce incidents of abuse and neglect in residential aged care services subsidised by the Australian Government. Approved providers must have an effective incident management system (IMS) in place and use this to continuously improve the management and prevention of incidents.
Worker	Anyone who is employed or otherwise engaged to provide supports and services to a care recipient within the Transitional

	Aged Care Programme, the Commonwealth Home Support Programme, a State Government Residential Aged Care Facility or Multi-Purpose Service. Workers can be paid or unpaid, and can be people who are self-employed, employees, contractors, consultants, and volunteers.

A note on terminology: *Care recipient, consumer*, and *resident* are used interchangeably by the Australian Department of Health and Aged Care, and NSW Health.

1.3. Legal and legislative framework

Compulsory reporting under the Aged Care Act 1997 (Commonwealth)

The *Aged Care Act 1997* (Commonwealth) requires providers of residential aged care flexible care services, Multi-Purpose Services and Commonwealth Home Support Programme services to comply with the requirements of the Serious Incident Response Scheme (SIRS).

The SIRS has two key components:

- compulsory reporting obligations for providers to report a range of serious incidents to the Aged Care Quality and Safety Commission.
- requirement for providers to have an effective incident management system in place to record, manage, resolve and report all serious incidents that occur or are alleged to or suspected to have occurred in an aged care service.

The *Aged Care Quality and Safety Commission Act 2018* (Commonwealth) provides the Aged Care Quality and Safety Commission with powers to administer and enforce the requirements of the SIRS and the responsibilities of Approved Providers.

The SIRS complements other regulations including the integrated expectations of the Charter of Aged Care Rights (the Charter), the Aged Care Quality Standards (the Quality Standards), the Code of Conduct for Aged Care and Open Disclosure requirements. Together, these regulations support providers to engage in risk management and continuous improvement activities to deliver safe, quality care to consumers.

Compulsory reporting under the National Disability Insurance Scheme Act 2013 (Commonwealth)

NSW Health State Government Residential Aged Care Facilities and Multi-Purpose Services that provide residential care for NDIS participants are automatically registered as NDIS providers with the NDIS Quality and Safeguards Commission (NDIS Commission).

The *National Disability Insurance Scheme Act 2013* (Commonwealth) provides the NDIS Commission with compliance and enforcement powers to encourage best practice among NDIS providers and manage risk to NDIS participants. As a condition of NDIS provider registration, State Government Residential Aged Care Facilities and Multi-Purpose Services with NDIS participants must record, manage and comply with NDIS reportable incident requirements.

These Commonwealth incident management and reporting requirements are in addition to those required under the NSW Health Policy Directive *Incident Management* (PD2020_047)

Other relevant legislation includes:

- *Health Administration Act 1982* (NSW)
- *Health Administration Amendment (Reportable Incidents) Regulation 2021* (NSW)
- *National Disability Insurance Scheme Act 2013* (NSW)
- *NDIS (Incident Management and Reportable Incidents) Rules 2018*
- *NSW Disability Inclusion Act 2014* (NSW)
- *Privacy Act 1988* (Commonwealth)
- *Work Health and Safety Act 2011* (Commonwealth)

2. ROLES AND RESPONSIBILITIES

NSW Ministry of Health

As the Approved Provider for aged care services in State Government Residential Aged Care Facilities and the Transitional Aged Care Programme, the NSW Ministry of Health is responsible for overseeing compliance with the Serious Incident Response Scheme (SIRS) reportable incident requirements. This includes having an effective incident management system in place and using this to continuously improve the management and prevention of incidents.

NSW Health has a Statewide incident management system (ims+) which is used to escalate and manage serious incidents.

Local Health Districts

As the Approved Provider of Aged Care Services in Multi-Purpose Services and the Commonwealth Home Support Programme, Local Health Districts are responsible for overseeing compliance with the SIRS and National Disability Insurance Scheme (NDIS) reportable incident requirements for Multi-Purpose Services.

This responsibility includes (but is not limited to) maintaining a central register for reportable incident notifications within each of these services to ensure appropriate and timely action is taken.

State Government Residential Aged Care Facilities, Multi-Purpose Services, Transitional Aged Care Programme and Commonwealth Home Support Programme services

All services must have a local compulsory reporting protocol outlining internal processes. Protocols must include the requirement for staff to submit a SIRS notification via the My Aged Care Service Provider Portal, as well as escalation processes for reporting Priority 1 SIRS notifications after hours and on weekends and Public Holidays.

In addition, State Government Residential Aged Care Facilities and Multi-Purpose Services with registered NDIS participants must also have internal reporting protocols for NDIS

reportable incidents via the NDIS Commission Portal (does not apply to Transitional Aged Care Programme and Commonwealth Home Support Programme services).

3. REPORTING REQUIREMENTS FOR AGED CARE SERVICES

NSW Health staff providing aged care services must report incidents in more than one system when incident reporting criteria are met, including:

- ims+ (NSW Health)
- My Aged Care (MAC) Service Provider portal
- National Disability Insurance Scheme (NDIS) portal (only if involving an NDIS participant)
- to police if appropriate.

Only the eight Serious Incident Response Scheme (SIRS) types of reportable incidents should be reported to the Aged Care Quality and Safety Commission (MAC portal),

However, all relevant incidents must be captured using the NSW Health ims+ system as per the NSW Health Policy Directive *Incident Management* (PD2020_047). If the incident involves people from Aboriginal or Torres Strait Islander background, please refer to sections

4.1.3 and 4.2.3 of the NSW Health Policy Directive *Incident Management* (PD2020_047). NSW Health staff must also follow any local protocols in place.

Complaints and concerns about clinicians are also to be managed via established processes under the NSW Health Policy Directive *Managing Complaints and Concerns about Clinicians Policy* (PD2018_032).

3.1. NSW Incident Management System

The SIRS and the NDIS require all residential, home based and flexible aged care services to have in place an effective incident management system, which includes a set of protocols, processes, and standard operating procedures that staff are trained to use.

NSW Health's ims+ meets the SIRS and NDIS requirements as outlined in NSW Health Policy Directive *Incident Management* (PD2020_047) and the *Health Administration Act 1982* (NSW). NSW Health services reporting notifications to SIRS and/or the NDIA must ensure they respond appropriately and take steps to prevent such incidents from happening again.

Additional information can be found in section 7.

3.2. Consequences of non-compliance

The Aged Care Quality and Safety Commission can sanction Approved Providers if they fail to appropriately report reportable incidents. Sanctions significantly impact individual facilities/services and NSW Health as an approved provider of l aged care services.

Registered NDIS providers must notify the NDIS Commission of all reportable incidents (including allegations), even when staff have acted and responded appropriately. A failure to comply with the requirement to notify, investigate and manage reportable incidents is a

breach of the approved provider's conditions of registration and may lead to regulatory action.

4. SERIOUS INCIDENT RESPONSE SCHEME REPORTING REQUIREMENTS

4.1. SIRS Reportable incidents

There are eight types of reportable incidents under Serious Incident Response Scheme (SIRS):

Incident type	Definition/examples
Unreasonable use of force	for example, hitting, pushing, shoving, or rough handling.
Unlawful sexual contact or inappropriate sexual contact	such as sexual threats or stalking, or sexual activities without consent.
Neglect of a consumer	for example, withholding personal care, untreated wounds, or insufficient assistance during meals.
Psychological or emotional abuse	such as yelling, name calling, ignoring a consumer, threatening gestures, racism or refusing a consumer access to care or services as a means of punishment.
Unexpected death	Residential Care: where poor quality clinical care is provided to a consumer resulting in their death, or where the actions of a consumer result in the death of another consumer. In Home Care: The circumstances in which home service providers are required to report unexpected deaths are more limited than in residential care. Providers are required to notify the Commission of any death where the provider, including staff and health professionals engaged by the provider: • made 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.
Stealing or financial coercion by a staff member	for example, coercing a consumer to change their Will to their advantage, or stealing valuables from a consumer.
Inappropriate use of restrictive practices	Residential Care: where physical or chemical restraint is used without prior consent or without notifying the consumer and/or their representative as soon as practicable; where physical restraint is used in a non-emergency situation; or when a provider issues a drug to a consumer to influence their behaviour as a form of chemical restraint. Home Care:

	The requirements for use of restrictive practice set out in the Quality of Care Principles are tailored to the residential care setting and do not currently apply to home service providers delivering care in a consumer's home. Use of a restrictive practice in an emergency situation will be a reportable incident in home services,
Unexplained absence from care	Unexplained Absence (Residential Care) where the consumer is absent from the service without explanation and there are reasonable grounds to report the absence to the police. Missing Consumers (Home Services): Where a consumer goes missing in the course of a home services provider delivering care and services to the consumer and there are reasonable grounds to report that fact to police, this is a reportable incident. This definition is intended to capture situations where a provider has the consumer in their physical care immediately prior to their absence. For example: • a staff member has taken a consumer to the shops and the consumer has gone missing during the outing • a consumer goes missing while in overnight respite, receiving care at a day therapy centre, receiving transport services or on a scheduled outing with the provider • a consumer goes missing while a staff member is delivering care and services in the consumer's home and there is reason for concern

4.2. Notifying the Aged Care Quality and Safety Commission of a Reportable Incident

Local Health Districts are required to notify the Aged Care Quality and Safety Commission of reportable incidents.

Under section 54-3 of the *Aged Care Act 1997* (Commonwealth), a reportable incident is any of the incidents listed in section 4.1 that have occurred, are alleged, or are suspected of having occurred to a care recipient (consumer), in connection with the provision of aged care in residential care, flexible care or home based care.

The period of time within which to report a reportable incident to the Aged Care Quality and Safety Commission will depend on the categorisation of the incident based on the assessment of the impact on the consumer.

Priority 1 SIRS reportable incident

Requires notifying to the Aged Care Quality and Safety Commission within 24 hours of the service becoming aware of the reportable incident.

Priority 2 SIRS reportable incident

Requires notifying the Aged Care Quality and Safety Commission within 30 calendar days of becoming aware of the reportable incident.

Section 7 provides further information about when to notify the Aged Care Quality and Safety Commission of a reportable incident. All SIRS notifications must be lodged electronically within the required timeframe using the form available through the SIRS tile on the My Aged Care Service and Support portal.

Reporting under SIRS does not replace any existing obligations to report particular incidents to other agencies, such as the police.

4.3. SIRS Procedure for Aged Care Services

The process for completing a SIRS report varies depending on the service type. If a staff member is informed of or suspects on reasonable grounds that a reportable incident has occurred, the staff member must follow Local Health District protocols, including the NSW Health Policy Directive *Incident Management Policy* (PD2020_047), and the process for submitting a SIRS notification form as outlined in section 7.

4.4. Aged Care Quality and Safety Commission risk management approach to incidents

As part of the Aged Care Quality and Safety Commission's risk-based approach to assess provider performance, they will monitor the requirement to have an incident management system and its usage. This may include requesting to view the incident management system, the procedures, incident management records and correspondence with affected persons and external agencies regarding incidents.

The Aged Care Quality and Safety Commission may also conduct interviews with affected persons, consumer representatives and staff, and may review incident management data and continuous improvement documentation.

5. NATIONAL DISABILITY INSURANCE SCHEME REPORTING REQUIREMENTS

Reporting requirements apply for incidents related to National Disability Insurance Scheme (NDIS) participants in State Government Residential Aged Care Facilities and Multi-Purpose Services.

5.1. NDIS Reportable Incidents

Reportable Incidents are serious incidents or alleged incidents which result in harm to a NDIS participant of a State Government Residential Aged Care Facility or Multi-Purpose Service.

This includes:

- Death of a person with disability
- Serious injury of a person with disability

- Abuse or neglect of a person with disability
- Unlawful sexual or physical contact or assault
- Sexual misconduct committed against, or in the presence of a person with disability, including grooming of the person for sexual activity
- Use of an unauthorised restrictive practice.

5.2. Reporting via the NDIS Commission Portal

Registered NDIS providers are required to use the NDIS Commission Portal 'My Reportable Incidents' tile to notify and manage all reportable incidents.

Reporting to the NDIS Commission does not replace any existing obligations to report particular events to other agencies, such as the police.

There are two set timeframes to notify the NDIS Commission:

- Within 24 hours of key personnel becoming aware of a reportable incident or allegation.

The only exception to this is that registered NDIS providers are required to notify the NDIS Commission within five business days of being made aware of an unauthorised restrictive practice incident that does not result in a serious injury. If the unauthorised use of restrictive practice has resulted in harm to an NDIS participant, it must be reported within 24 hours.

AND

- Any action taken and additional information must be provided in NDIS portal within five business days.

The detailed process for submitting a NDIS reportable incident is outlined in section 7.

6. RESOURCES

6.1. Additional NSW Resources

NSW Health Policy Directive *Open Disclosure Policy (*PD2023_034)

NSW Health Policy Directive *Managing Misconduct* (PD2018_031)

Victims Rights and Support Act 2013 (NSW)

NSW Ageing and Disability Commission

6.2. Aged Care Quality and Safety Commission Resources

SIRS provider resources

Effective incident management systems: Best practice guidance

Serious Incident Response Scheme – Guidelines for Residential Aged Care Providers

SIRS Guidelines for Providers of Home Services

SIRS Frequently asked questions

6.3. NDIS Resources

NDIS Reportable Incidents - Frequently Asked Questions Getting access to the NDIS Commission Portal

Incident Management System Guidance

Reference Card: 'Incident response: Is everyone safe?'

Poster: Identifying and responding to incidents, a 6 step guide for workers Incident management and RI: worker expectations

A range of other reportable incident resources are available at Guidance on the NDIS Commission's functions

Mandatory NDIS orientation training module NDIS: Quality, Safety and You.

7. INCIDENT MANAGEMENT REQUIREMENTS – IMPLEMENTATION

7.1. Incident Management Requirements under the Serious Incident Response Scheme

Requirements	NSW Health approach
Support services to understand risk and prevent incidents from occurring.	Mandatory training for all NSW Health staff is located on the NSW My Health Learning platform.
Focus on the health, safety, wellbeing and quality of life of consumers and anyone affected by an incident.	NSW Health Policy Directive *Incident Management* (PD2020_047) Section 1 Health services must seek to maintain the trust of the public when things go wrong. The principles of immediacy, accountability and kindness guide our interactions with patients, carers and families, staff and the broader community. Immediacy - We act immediately when people are harmed or at risk of harm. Accountability - We are open when things go wrong. We review to learn. We make changes to improve. We share what we find and learn. Kindness - We are caring. We are fair and just. We support all who are affected. NSW Health Policy Directive *Open Disclosure Policy* PD2023_034) Purpose This policy directive sets out the requirements for a consistent open disclosure process to ensure patients and their support person(s) and health service staff are: communicating effectively about a patient safety incident provided with an opportunity to recount their experiences, concerns and

	feelings and are listened to treated respectfully and provided with ongoing care and support for as long as is required.
Set out the actions and responsibilities of staff and others in relation to incident management.	NSW Health Policy Directive *Incident Management* (PD2020_047) This Policy Directive sets out the responsibilities and processes for managing incidents in NSW Health services. Section 1.4 *Responsibilities:* details responsibilities of all staff involved, including Managers, Heads of Departments, Chief Executives, Clinical Excellence Commission (CEC) and the NSW Ministry of Health (the Ministry). Section 2 *Incident Management Process*: describes the steps involved in the management of clinical and corporate incidents.
Include documented policies and procedures that are developed in consultation with consumers and staff to identify, manage and resolve incidents. These procedures should be easily understood by all who need to use them and support the organisation to: recognise incidents and near misses when they occur record and report incidents and near misses assess the impact of any incidents and respond to the needs of the people impacted review, analyse and if necessary, investigate incidents use the outcomes of the investigation and/or analysis (and incident and near miss related data more broadly) to inform service improvements and prevent future occurrence.	NSW Health Policy Directive Incident Management (PD2020_047) Section 2 Incident Management Process: describes the seven steps to managing clinical incidents: Step 1 - Identify incident Step 2 - Ensure safety of people and the environment Step 3 - Notify incident in ims+ Step 4 - Escalate incident Step 5 - Review incident Step 6 - Implement and monitor actions Step 7 - Feedback to staff and patients, carers and families Health services review incident management data and related data sets for action at all levels of the health service, share lessons learned across the health service and use the learnings to improve services. The Clinical Excellence Commission analyses clinical incident data to identify systems failings and emerging trends; disseminates lessons learned and develops and advises on strategies to minimise the occurrence of incidents.
Be well understood and used by staff through a staff training program and regular reinforcement about how the system operates.	NSW Health courses and training Clinical Excellence Commission Academy courses include: Healthcare Safety and Quality Capability Quality Improvement Tools Online training courses about incident management include: Introduction to Safety and Quality Post Incident Safety Huddles Open Disclosure Open Disclosure Advisor Clinician Disclosure

	Foundations of Healthcare Safety and Quality Online and classroom training courses about ims+ include: ims+ Searching, Reporting and Designing Reports ims+ Designing Reports ims+ How to Notify an Incident ims+ Reporting ims+ How to Manage and Review an Incident Record ims+ Managing Complaints and Consumer Feedback ims+ Searching ims+ Managing and Transferring Incidents ims+ Clinical Governance ims+ How to Manage and Review an Incident Record Survey ims+ range of training resources at https://imsplus.health.nsw.gov.au/training Aged Care Quality and Safety Commission webinars Reportable incidents under the Serious Incident Response Scheme Incident Management under the Serious Incident Response Scheme Reporting under the Serious Incident Response Scheme.
Include strong and open communication with consumers and their family/representatives, advocates and others regarding the operation of the system and opportunities to provide input to effective incident management and ongoing learning within the service (including the use of interpreters for consumers with limited English proficiency).	NSW Health Policy Directive *Incident Management* (PD2020_047) NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* (PD2017_044) Section 2.8 - *System wide learnings* Health services review incident management data and related data sets for action at an organisational level. The Clinical Excellence Commission analyses clinical incident data to understand whole of system harm and emerging trends, and communicates findings and coordinates state-wide action by Health services. The Clinical Risk Action Group (CRAG), CRAG subcommittees or other s23 committees can direct state-wide initiatives. The NSW Health Pillar organisations, under the coordination and leadership of the Clinical Excellence Commission, support system-based learning. They have a safety and quality role in areas such as training, models of care, technologies and specific clinical areas. Section 2.8.1 - *Driving continuous improvement* Incident data and feedback from staff and patients, carers and families can identify system vulnerabilities to inform quality improvement (QI) efforts. Local QI facilitators can advise QI methods (e.g., Practice Improvement, Model for Improvement, Clinical Redesign and rapid cycle testing) and evaluation measures. 2.8.2 - *ims+ Safety Learnings module*

	The ims+ Safety Learnings module enables sharing of lessons learned from incident management and other safety and quality processes. It is searchable by all staff.
Include a mechanism or tool for recording, storing and easily accessing information about specific incidents.	ims+ is a cloud-based state-wide incident management system which comprises five toolkits – capture, evaluate, strategy, implement and assess. Ims+ is accessed by all staff via a StaffLink ID.
Support effective governance and accountability to provide oversight of the system's operation and ensure its ongoing effectiveness in driving continuous quality improvement	NSW Health Policy Directive *Incident Management* (PD2020_047) This Policy Directive provides clear governance and information around driving continuous improvements.
Actively engage consumers and their representatives in the resolution of incidents and any remedial actions put in place to prevent incidents from reoccurring.	NSW Health Policy Directive *Incident Management* (PD2020_047) This Policy Directive requires 'Open disclosure', including an ongoing communication process with a patient, carer or family about an incident and its management. Formal open disclosure involves multidisciplinary discussion/s with the patient, carer or family and senior clinical leaders and/or hospital executive.

7.2. Incident Management Requirements under the National Disability Insurance Scheme

Requirements	NSW Health approach
Appropriate for your size and for the classes of supports or services you are delivering.	NSW Health recognises the importance of prevention to ensure the safety of National Disability Insurance Scheme (NDIS) participants and workers. Because every NSW Health staff member is a potential notifier of incidents, all NSW Health staff are required to complete the My Health Learning module called *ims+ How to notify an incident.* Anyone who has a role beyond notifying (e.g., who also reviews or manages incidents) must also complete the additional How to manage and review an incident eLearning module.
Documented in an accessible form, including having written procedures.	ims+ is a cloud-based state-wide incident management system which comprises five toolkits – capture, evaluate, strategy, implement and assess. ims+ is accessed by all staff via a StaffLink ID.
Is accessible to all workers employed or otherwise engaged by you and to residents who are NDIS participants.	ims+ is a cloud-based state-wide incident management system which comprises five toolkits – capture, evaluate, strategy, implement and assess. ims+ is accessed by all staff via a StaffLink ID. NSW Health Policy Directive *Incident Management* (PD2020_047) For reportable incidents (clinical Harm Score 1) or clinical incidents which may be due to serious systemic problems a staff member is designated a dedicated family contact (DFC). The DFC liaises between the patient, carer or family, open disclosure team and review team.

	Participants can provide feedback on complaints and compliments, refer to https://www.health.nsw.gov.au/patientconcerns/Pages/feedback.aspx.
Functional and able to appropriately capture all the required information.	ims+ is a cloud-based state-wide incident management system which comprises five toolkits – capture, evaluate, strategy, implement and assess.
Centred on residents who are NDIS participants - management of an incident is respectful of, and responsive to the NDIS participant's preferences, needs and values while supporting the person's safety and wellbeing.	NSW Health Policy Directive *Incident Management* (PD2020_047) Section 1 Health Services must seek to maintain the trust of the public when things go wrong. The principles of immediacy, accountability and kindness guide our interactions with patients, carers and families, staff and the broader community. Immediacy - We act immediately when people are harmed or at risk of harm. Accountability - We are open when things go wrong. We review to learn. We make changes to improve. We share what we find and learn. Kindness - We are caring. We are fair and just. We support all who are affected. NSW Health Policy Directive *Open Disclosure Policy* (PD2023_034) This Policy Directive sets out the requirements for a consistent open disclosure process to ensure patients and their support person(s) and health service staff are: Communicating effectively about a patient safety incident Provided with an opportunity to recount their experiences, concerns and feelings and are listened to Treated respectfully and provided with ongoing care and support for as long as is required.
Outcome focussed - Management of an incident should reveal the factors which contributed to the incident occurring and seek to prevent incidents from reoccurring.	NSW Health Policy Directive *Incident Management* (PD2020_047) Section 2.5 - *Step 5: Review* A review identifies what happened, why it happened and what could be done to improve safety. The type of review and level of oversight depends on the incident severity. Refer to "Review" sections in this Policy. Section 2.6 - *Step 6: Implement and monitor actions* Further actions are taken to improve safety following an incident review. Refer to "Implement and monitor actions" sections in this Policy.
Clear, simple and consistent- The process for dealing with incidents is easy to understand, accessible and consistently applied.	NSW Health Policy Directive *Incident Management* (PD2020_047) *Section 2 - Incident Management Process* Describes the seven steps to managing clinical incidents: *Step 1 - Identify incident* *Step 2 - Ensure safety of people and the environment*

	Step 3 - Notify incident in ims+ *Step 4 - Escalate incident* *Step 5 - Review incident* *Step 6 - Implement and monitor actions* *Step 7 - Feedback to staff and patients, carers and families*
Accountable - Providers are responsible for appropriately managing the response to incidents. Everyone involved in the management of an incident understands their role and responsibilities and will be accountable for decisions or actions taken regarding an incident.	NSW Health Policy Directive *Incident Management* (PD2020_047) Responsibilities of staff are set out in section 1.4. These cover responsibilities for all staff; managers; heads of departments, service managers and stream leaders; and chief executives.
Continual improvement - The incident management process facilitates the ongoing identification of issues and implementation of changes to improve the quality and safety of NDIS supports and services	NSW Health *Incident Management Policy* (PD2020_047) Section 2.6 - *Step 6: Implement and monitor actions* Further actions are taken to improve safety following an incident review. Refer to “Implement and monitor actions” sections in this Policy. For example, for Harm Score 1 incidents Section 4.6 - *Implement and monitor actions – clinical HS1 incidents* Managers are responsible for implementing recommendations arising from a Serious Adverse Event Review (SAER). Health Services are to: Monitor the implementation of recommendations Have escalation processes for recommendations that cannot be progressed Report to peak Health Services committees, Executive team and Board. Section 2.8 - *System wide learnings* Health services review incident management data and related data sets for action at an organisational level. The Clinical Excellence Commission analyses clinical incident data to understand whole of system harm and emerging trends and communicates findings and coordinates state-wide action by Health services. The Clinical Risk Action Group (CRAG), CRAG subcommittees or other s23 committees can direct state-wide initiatives. The NSW Health Pillar organisations, under the coordination and leadership of the Clinical Excellence Commission, support system-based learning. They have a safety and quality role in areas such as training, models of care, technologies and specific clinical areas. Section 2.8.1 - *Driving continuous improvement* Incident data and feedback from staff and patients, carers and families can identify system vulnerabilities to inform quality improvement (QI)

	efforts Local QI facilitators can advise QI methods (e.g., Practice Improvement, Model for Improvement, Clinical Redesign, and rapid cycle testing) and evaluation measures. Section 2.8.2 - *ims+ Safety Learnings module* The ims+ Safety Learnings module enables sharing of lessons learned from incident management and other safety and quality processes. It is searchable by all staff.
Proportionate - The nature of any investigation or actions following an incident will be proportionate to the harm caused and any risk of future harm to an NDIS participant.	NSW Health Policy Directive *Incident Management* (PD2020_047) A harm score from 1 to 4 is applied to clinical incidents based on the outcome and additional treatment and/or resources required. The requirements for each Harm Score are detailed in sections 4 to 6.

7.3. Detailed compulsory reporting procedure for aged care services

Below outlines the steps for NSW Health services when submitting a compulsory report to the Aged Care Quality and Safety Commission and/or the NDIS Commission.

The care and safety of residents/ care recipients must be prioritised. The first actions following identification of an incident are to provide immediate care to the residents and patients involved and to make the environment safe to prevent immediate recurrence. Residents/ care recipients are engaged with the health care team throughout the incident management process in keeping with their wishes.

Service Type	Step No.	Detail
State Government Residential Aged Care Facilities, Multi-Purpose Services, Transitional Aged Care Programme and Commonwealth Home Support Programme (SIRS)	1	**Reporting Priority 1 and 2 reportable incidents via the My Aged Care Provider Portal** State Government Residential Aged Care Facilities, Multi-Purpose Services, Transitional Aged Care Programme services and Commonwealth Home Support Programme services must report all SIRS reportable incidents, alleged or actual, to the Aged Care Quality and Safety Commission (the Commission) via the My Aged Care Provider Portal, including completion of all mandatory questions, within the required timeframes. Once a SIRS report has been submitted to the Commission, a confirmation email is automatically issued, which includes a SIRS notice number, the time and date of submission and a PDF copy of the notification received. When there are reasonable grounds to do so, services must also notify police of the incident within 24 hours of becoming aware of the incident.

	2	**Investigate the incident** Investigate the incident in line with NSW Health processes and identify and implement required actions. This includes any action directed or requested from NSW Police and the Aged Care Quality and Safety Commission. NSW Health requires that the focus must be on the safety of the consumer. State Government Residential Aged Care Facilities and Transitional Aged Care Programme services must inform the Aged Care Unit, NSW Ministry of Health about decisions, actions or reforms and responses that the Commission advises.
	3	**Providing additional information to the Aged Care Quality and Safety Commission (the Commission)** In the instance where additional information needs to be submitted to the Commission or when the Commission requests additional information, services must use the approved forms: To provide any information required and not provided in a Priority 1 notice; and/or any further information specified by the Commission under subsection 95C(1) of the *Aged Care Quality and Safety Commission Rules 2018* - Notice of additional information form To provide the Commission with significant new information - Notice of significant new information form To provide a final report about a reportable incident under section 15NI of the Quality of Care Principles 2014 SIRS – Final report on reportable incident.
State Government Residential Aged Care Facility residents & Multi-Purpose Services (NDIS Commission)	1	**Reporting via the NDIS Commission Portal State Government Residential Aged Care Facilities and Multi-Purpose Services must report all incidents, alleged or actual via the NDIS Commission Portal, including completion of all mandatory questions, within the required timeframes.** Once a NDIS report has been submitted to the NDIS Commission, a confirmation email is automatically issued to the NDIS provider Primary Contact, which includes an NDIS notice number, the time and date of submission and a PDF copy of the notification received. When there are reasonable grounds to do so, services must also notify police of the incident within 24 hours of becoming aware of the incident.
	2	**Investigate the incident** Investigate the incident in line with NSW Health processes and identify what action, if any, is needed. This includes any action directed or requested from NSW Police and the NDIS Commission. NSW Health requires that the focus must be on the safety of the resident. State Government Residential Aged Care Facilities must inform the Aged Care Unit, NSW Ministry of Health about decisions, actions or reforms and responses that the NDIS Commission advises.

	3	**Completing a final report** Following the submission of a reportable incident, the State Government Residential Aged Care Facility or Multi-Purpose Service may be required to provide a final report at the request of the NDIS Commission. When this is the case, the NDIS Commission will provide this form and detail the requirements via email.
SIRS Reporting for NSW Health sub-contracted providers:	1	**Reporting Priority 1 and 2 reportable incidents subcontracted providers via the My Aged Care Provider Portal:** <u>Transitional Aged Care Programme:</u> Transitional Aged Care Programme services must ensure all incidents, alleged or actual, are reported under the correct Approved Provider (NSW Ministry of Health) within the My Aged Care Provider Portal. For NSW Transitional Aged Care Programme services, the 'Outlet' selected when completing the SIRS submission must be linked to the Ministry of Health ABN 92697899630, meaning the outlet must be the Transitional Aged Care Program service and not asub-contracted provider. <u>Commonwealth Home Support Programme:</u> Commonwealth Home Support Programme services must ensure all incidents reported, alleged or actual are linked to the Local Health District as the approved provider. For this to occur, the 'Outlet' completing the SIRS submission must be linked to the Local Health District ABN and not the sub-contracted service provider. When reporting an incident that has occurred within a sub-contracted provider the name of the sub-contracted provider should be entered in the sub-contractor field. Recommended wording: "The incident occurred in XXXXX and involved a staff member of the contracted providerand/orcare recipient." Transitional Aged Care Programme and Commonwealth Home Support Programme services are responsible for developing local processes with all contracted providers to ensure local reporting and escalation processes meet the SIRS requirements and timeframes. Once a SIRS report has been submitted to the Aged Care Quality and Safety Commission, a confirmation email is automatically issued, which includes a SIRS notice number, the time and date of submission and a PDF copy of the notification received. Where there are reasonable grounds to do so, services must also notify police within 24 hours of becoming aware of the incident.
	2	**Investigate the incident** Local Health Districts are responsible for ensuring the sub-contracted provider investigates the incident in line with NSW Health processes and identifies what action, if any, is needed. This includes any action directed or requested from NSW Police and the Aged Care Quality and Safety Commission. NSW Health requires that the focus must be on the safety of the consumer. For incidents occurring under subcontracted providers of the

		Transitional Aged Care Programme, Local Health Districts must update the Aged Care Unit, NSW Ministry of Health about any decisions, actions or reforms and responses that Aged Care Quality and Safety Commission advises.
	3	**Providing additional information to the Aged Care Safety and Quality Commission (the Commission)** In the instance where additional information needs to be submitted to the Commission or when the Commission requests additional information, services must use the approved forms below: To provide any information required and not provided in a Priority 1 notice; and/or any further information specified by the Commission under subsection 95C(1) of the *Aged Care Quality and Safety Commission Rules 2018* - Notice of additional information form To provide the Commission with significant new information - Notice of significant new information form To provide a final report about a reportable incident under section 15NI of the *Quality of Care Principles 2014* SIRS – Final report on reportable incident.