

St Marys Aged Care

TITLE:	Incident Management Policy	POLICY NO.	GOV-Incident Management-Policy
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EFFECTIVE DATE:	November 2025
REVIEW DATE:	November 2026
DISTRIBUTION:	All Staff
POLICY CONTEXT:	Quality Standard Outcomes/Actions: 2.5.1, 2.5.2, 2.5.3, 2.5.4, 2.5.5, 2.5.6
RELATED POLICIES:	GOV-Risk Man-Risk Man Policy: <i>Risk Management Policy</i>
RELATED PROCEDURES:	GOV-Incident Forms/Incident Response-Procedure-01: <i>Completing Incident Forms and Responding to Incidents</i> GOV-Incident Follow Up-Procedure-02: <i>Follow Up of Resident Incidents</i> GOV-SIRS Review-Procedure-04: <i>Reviewing and Investigating SIRS Incidents</i> GOV-Absence Reporting-Procedure-03: <i>Unexplained Absence Compulsory Reporting</i>
APPROVED BY:	DOC

PURPOSE

St Marys Aged Care (SMAC) is committed to the provision and maintenance of an effective incident management system to identify, document, respond to and manage incidents. This includes ensuring that responses to incidents and near misses are timely.

SMAC's aim is to create an environment which encourages accountability, transparency, trust and safety.

SMAC encourages and supports residents, family and carers, staff, volunteers, and any other stakeholders to recognise and report incidents, and facilitates their involvement in identifying ways to reduce incidents from occurring.

The incident management system will allow incident data to be collected, analysed and integrated into SMAC's quality system. This will enable issues and trends to be identified so that SMAC can strengthen risk mitigation strategies, improving the safety of services provided and driving continuous improvement.

SMAC's incident management policy includes the notification to the Aged Care Quality and Safety Commission (and the police where there are reasonable grounds), of all reportable incidents under the SIRS.

PRINCIPLES

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SMAC uses the Aged Care quality and Safety Commission best practice guidance for effective incident management systems to inform this policy and related procedures.

An incident is any act, omission, event or circumstance that occurs in connection with the provision of care or services that:

Has (or could reasonably be expected to have) caused harm to a resident or another person (such as a staff member or visitor),

or;

Is suspected or alleged to have (or could reasonably be expected to have) caused harm to a resident or another person,

or;

The provider becomes aware of and that has caused harm to a resident.

SMAC's incident management system is used to identify, assess, respond to and record all incidents and near misses, regardless of whether they are known to have occurred or are alleged or suspected to have occurred.

Incidents to be reported under the SIRS are:

- Unreasonable use of force against a resident.
- Unlawful sexual contact, or inappropriate sexual conduct, inflicted on a resident.
- Psychological or emotional abuse of a resident.
- Unexpected death of a resident.
- Stealing from, or financial coercion of, a resident by a staff member of the provider.
- Neglect of a resident.
- Use of restrictive practices in relation to a resident (other than in the circumstances set out in the Quality of Care Principles).
- Unexplained absence of a resident from the service.

Near misses:

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.

Near misses must also be captured by SMAC's incident management system as they provide an opportunity to build a safety culture and assess and learn from events, allowing for the understanding of risks and the prevention of incidents from occurring. Staff should be supported to recognise and report near misses and be part of the learning and quality improvements that come out of near misses or close calls

All SMAC incidents are documented on the Manad electronic information management system as an incident form.

All clinical incident forms (relevant to residents, staff, and any volunteers/visitors/contractors etc) are only to be completed by a registered nurse.

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SIRS incidents are reported and followed up by the CNs and NMs, with governance provided by the CM and DOC.

A member of the management team may complete non-clinical incident forms.

Manad incident forms for residents are found under the care tab, for staff under the workforce tab, and for everyone/everything else under the management tab.

Key information which should be included in incident forms

Details of the incident or allegation:

- The name and designation details of the person recording the incident or near miss.
- The name and designation details of the person making the allegation.
- The time and date the incident or near miss was identified/reported.
- The time, date and place at which the incident or near miss occurred (or was alleged or suspected to have occurred), where this is known.
- Whether a death has occurred as a result of the incident.
- Whether the incident is a reportable incident and if so, the type of incident (to assist in identifying patterns or common occurrences).
- A description of the incident or near miss, including the harm caused (or that could reasonably have been expected to have been caused) to each person affected by the incident and the consequences of that harm (if known).

People involved in the incident:

- Details of the persons directly involved, including names, contact details and cognitive status.
- Whether the subject of the allegation is a resident, and if not, their relationship to SMAC.
- Whether the affected resident or subject of the allegation have been involved in any prior incidents (if known).
- Whether the affected resident or subject of the allegation suffered any psychological or physical impact and if so, the level of impact.
- Whether the affected resident resides within a secure unit.
- The names and contact details of any witnesses.

Response to the incident:

Details of the actions undertaken in response to the incident, including:

- Whether the incident has been reported to the police and if so, when and how the police were contacted.
- The action taken by the police, including whether a person has been arrested or charged.
- Whether the affected resident or subject of the allegation's next of kin or enduring power of attorney has been notified.
- Whether the person's next of kin or enduring power of attorney has ongoing concerns about the management of the incident.

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- The actions (support or assistance) taken to ensure the health, safety and wellbeing of the residents involved.
- Details of any actions undertaken to prevent further similar incidents from occurring, or to minimise their harm.
- Any consultation with those affected by the incident (and/or their representatives) in the management and resolution of the issue and any findings/outcomes they have been provided.
- Any notifications made to the Commission, police, and other relevant organisations.

Investigation and analysis:

An investigation and/or analysis may consider/include:

- The underlying causes of the incident.
- Additional actions required to address the incident that occurred.
- Additional actions that reduce the occurrence of a similar incident in the future, including any systemic changes.
- Details of investigation/analysis undertaken to identify the cause or source of an incident.
- The outcomes of any investigation or analysis undertaken (including whether the incident could have been prevented).

Initial actions to reduce the risk of harm and potential for recurrence

Local actions to reduce the risk of harm and potential for recurrence should be taken immediately where possible. Residents, families/representatives and staff should be informed of immediate actions.

The nature of the incident will inform the extent and type of analysis (or investigation, where warranted):

- The severity of the incident.
- The impact of the incident on resident (and family/representative) confidence and safety.
- The probability of recurrence.
- Whether the same or similar incident has occurred in the past.
- Whether the incident involves a similar underlying cause to an incident that has occurred in the past.
- Whether it involves people who have been involved in other incidents in the past.
- The complexity of the incident (for example, where the facts are in question or the underlying cause is unclear).
- If the incident is a reportable incident under the SIRS.
- The views of the affected people (including any residents, families/representatives).

Implementing changes to mitigate risk and improve safety

Whenever an incident occurs, SMAC will consider whether:

- It may have been prevented (or the severity of the impact lessened) by some action taken by SMAC.
- There is an ongoing risk to residents, visitors, staff or others following the incident.
- There are actions SMAC could undertake or cease, to prevent or minimise the risk of a recurrence.

Remedial actions may include:

- Providing or mandating individual and/or service-wide staff training or re-training.
- Making changes to SMAC's organisational or clinical governance frameworks.

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- Reviewing and updating SMAC's policies and procedures or developing new procedures to support staff to manage emerging risks and issues.
- Making changes to the service environment or equipment used to provide care and services.
- Taking actions to promote a safe culture of care (for example, making incident management a key focus when inducting new staff).
- Making additional staff available to assist residents with certain activities.
- Seeking specialist assistance and/or implementing alternate strategies to manage resident behaviours.
- Updating care planning documentation to address the cause or impacts of the incident.

It may also be appropriate to take disciplinary actions with respect to staff (including, for example, undertaking ongoing performance management, implementing a probationary period, standing down a staff member pending the outcomes of any investigation or terminating a staff member's employment).

Closing the loop

SMAC's incident management system must enable the collection of data and other information relating to incidents to enable SMAC to:

- Identify and address systemic issues in the quality of care provided.
- Identify repeated occurrences (including alleged/suspected occurrences) of similar incidents or near misses.
- Analyse trends and identify patterns of incidents (e.g. behaviours).
- Provide feedback and training to staff about preventing and managing incidents.
- Provide information to the Commission as requested.

SMAC will undertake regular review and analyses of incident data to inform the consideration of where any organisational improvements may be made.

As part of the broader risk management process, SMAC will consider incident trends, common or repeated incidents (and causes of incidents) and feedback from residents, staff and others to identify risks.

SMAC will use this information for organisational learning to improve the quality of care and services provided; reduce risks to the health, safety and wellbeing of residents, staff and others, and continuously improve the management and prevention of incidents.

Quality improvement –

The NMs review incidents in real time and on a daily basis. This is to ensure that all relevant information is captured, all necessary action has been taken, and all stakeholders notified as required.

The NMs prepare a monthly report on all incidents to present to the clinical meeting. This enables tracking and trending and the identification of any systemic issues and the planning and instituting of remedial action. The DOC presents incident data as a standing agenda item at the monthly quality assurance meetings and the governing body meetings. This further allows for the identification of any systemic issues and for incidents data to be fed into SMAC's continuous improvement plan.

SMAC will continuously monitor its incident management system to ensure that it is effective and reliable, this will allow for areas for further improvement to be identified.

SMAC will share incident data with those affected by the incident, staff, and the governing body.

Related education –

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- Strengthened quality standards.
- Manad documentation.
- SIRS.
- Incident reports.

End of Document

RELATED DOCUMENTS/EVIDENCE-BASE

Australian Commission on Safety and quality in Health care (2021). *Incident Management Guide*.

https://www.safetyandquality.gov.au/sites/default/files/2021-12/incident_management_guide_november_2021.pdf

Australian Government. Aged Care Quality and Safety Commission (2022). *Effective incident management systems: Best practice guidance*.

<https://www.agedcarequality.gov.au/sites/default/files/media/effective-ims-guidance-august-2021.pdf>

Australian Government. Aged Care Quality and Safety Commission (2024). *Strengthened Quality Standards*.

<https://www.agedcarequality.gov.au/providers/quality-standards/strengthened-quality-standards>

Australian Government. Aged Care Quality and Safety Commission (2024). *Strengthened Quality Standards. Provider Guidance*.

<https://www.agedcarequality.gov.au/sites/default/files/media/strengthened-quality-standards-provider-guidance.pdf>

Australian Government. Department of Health, Disability and Ageing (2024). *Serious Incident Response Scheme*.

<https://www.health.gov.au/our-work/serious-incident-response-scheme-sirs?language=en>
