Russell Kennedy and Pride Living Webinar: Serious Incident Response Scheme (**SIRS**) – Are you prepared?

Wednesday 17 March 2021

Presenters: Anita Courtney and Katrina Ong

Russell Kennedy Lawyers

Melbourne > Sydney

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- Attendees will be on mute and their cameras off for the entire webinar
- We have live BD technical support to assist with any technical issues
- Use the "Chat" function for any comments/technical issues
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- We will have a QR code linking to our Feedback Survey towards the end of the webinar so you can provide instant feedback
- We value attendee feedback
- Slides will be sent to attendees
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The information contained in this presentation is intended as **general commentary only** and should not be regarded as legal advice. Should you require specific advice on the topics or areas discussed, please contact the presenters directly.

Introducing Anita Courtney

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Anita is a Principal in Russell Kennedy's Aged Care Team who specialises in helping home care and residential care providers comply with their legal responsibilities.

Anita helps providers respond to the Aged Care Quality and Safety Commission. She also helps providers with their duty of care and in responding to complaints.

Anita drafts residential, respite and home care agreements and policies and provides training to home care workers on issues like consent and good record-keeping.

Anita has been recognised by *Best Lawyers in Australia* for her expertise in Health and Aged Care Law for their 2020 listing and was ranked as a Recommended Lawyer by *Doyle's Guide* in the area of Health and Aged Care.

Webinar overview

Anita:

Overview of the SIRS

Definitions of “serious incident” for mandatory reporting

Reporting and record-keeping requirements

Katrina:

Tips on implementing an incident management system

Concepts of preventive and reactive risk management

Concept of Root Cause Analysis in incident investigation

Live Q&A

Key takeaways and how we can help

What is the SIRS?

Incident management and reporting scheme

The SIRS has two key components:

- Incident management obligations
- Compulsory reporting obligations

According to the ACQSC, these are things you already do and it is about strengthening and modifying your existing systems

Aims of the SIRS

The aim of the SIRS is to reduce the risk of abuse and neglect of those in residential aged care by:

- building provider capacity to better identify and mitigate risks of potential harm
- building provider ability to respond to and manage serious incidents if and when they occur
- improving training to reduce the number of preventable serious incidents
- promoting accountability

SIRS also aims to:

- enable the ACQSC to assess and respond to risks at a service level and identify and act on opportunities for education and improvement across the sector
- increase consumer confidence in the system (OPAN)

ACQSC Guide

ACQSC Guide:

The effective management of incidents is critical to effective clinical governance and will enable you to manage risks to consumer and improve the quality of care and services you provide. By systematically recording and investigating incidents, you are better placed to identify trends and issues, and to pursue continuous improvement opportunities.

Timing of the SIRS: 1 April and 1 October

<u>First stage:</u> 1 April 2021:

- **System:** Providers must have an "*effective incident management system in place that enables their appropriate and timely prevention, identification, and response to all incidents*"
- **Reporting:** Providers will also be required to report all "Priority 1" "reportable incidents" to the Commission within 24 hours of becoming aware of the incident

<u>Second stage:</u> 1 October 2021 – increased reporting obligations:

- Providers must report **all** reportable incidents (Priority 1 and 2)
- Reportable incidents will still need to be assessed as "Priority 1" or "Priority 2" (which will determine the timeframe for reporting the incident)

Core IMS responsibilities

Providers must manage incidents and take reasonable steps to prevent incidents, including through implementing and maintaining an incident management system

Standard 8(3)(d) requires that providers have:

> "*Effective risk management systems and practices including:*
>
> - *Identifying and responding to abuse and neglect of consumers*
> - *Managing and preventing incidents, including the use of an incident management system*"

Core IMS responsibilities (continued)

The management of incidents must be focused on the safety, health, wellbeing and quality of life of the consumers (s 15LA *Quality of Care Principles*)

This means:

- Assessing and providing the support and assistance required by those affected
- Involving each person affected by the incident (or their representative) in the management and resolution
- Using an open disclosure process:

  - Have you got a documented *Open Disclosure Policy*?

Note, ACQSC says Standard 8 to be modified to reflect SIRS

What an IMS must address

According to ACQSC, there are **four elements** to an effective IMS:

- Documented policies and procedures – staff must report incidents to management/key personnel OR to police or the Commission if concerned
- Reporting tools
- Staff training
- Governance and accountability by the provider for what happens in relation to an incident

What an IMS must address (continued)

Your IMS must **at a minimum** address:

- How incidents are identified, recorded and reported
- The person within the organization to whom incidents must be reported and who is responsible for reporting to ACQSC
- How reportable incidents are notified and managed (in accordance with the SIRS and other requirements (eg NDIS) and open disclosure requirements
- How you will provide support and assistance to those affected by an incident to ensure their safety, health and wellbeing (including information about accessing advocates)
- How people affected by an incident will be involved in the management and resolution
- When an investigation is required to establish the cause, harm etc
- Processes for investigating
- When remedial action is required

Note: May be different levels of investigation depending on seriousness of type of incident

Reporting obligations – what's changing

What is new about the SIRS?

- Much broader definition of what you need to report
- No longer need to report to the police every time – only if:

  - you suspect, or it is alleged to you, that the incident involves a criminal offence

  - there are reasonable grounds to report the incident to police – eg where you are aware an incident is likely to be of a criminal nature (eg indecent assault)

- No longer an exception where the incident is perpetrated by a resident with a cognitive impairment
- No longer need to have a suspicion "on reasonable grounds" – *any* suspicion will do
- Must confirm you have provided a notice of collection to any person you are talking about in the report

Reporting obligations – what isn't changing

What hasn't changed?

- Timeframe for reporting to the Commission is still 24 hours for priority
- Still need to report any allegation (even if unreasonable/delusional) or suspicions
- Still report assault type allegations to the police
- Still only applies to residential care
- No discretion to report even if consumer doesn't want you to
- Other than stealing or coercion, it doesn't matter who perpetrated the incident against the consumer

When is an incident NOT reportable?

If the incident has **not** occurred "*in connection with the provision of residential care*".

- Does **not** include incidents that occur while the consumer is:

  - on leave

  - in hospital

NOTE, the phrase "in connection with the provision of residential care or flexible care in a residential setting" is intended to be broad, eg it covers incidents that occur outside the facility if under staff supervision.

When is an incident NOT reportable? (Continued)

Also does **NOT** include the incident if it results from the consumer choosing to refuse care and services offered by the provider, or not acting on their advice eg:

- decides to decline health or medical advice – eg eating food that is inconsistent with their dietary needs
- consumer with liver disease chooses to drink alcohol
- consumer chooses not to shower/brush their teeth or hair

BUT, will need to consider whether you supported the consumer through a dignity of risk process. SO… would the following be reportable?

- Consumer refuses to go into the secure dementia unit absconds from the facility?
- Consumer tells you their son hit them while on the way to the doctor?

Definition of Priority 1 reportable incidents

Priority 1 reportable incidents:

- an incident that causes or could have caused a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve; or
- an incident that involves an unexpected death or a consumer's unexplained absence from the service,

where there are reasonable grounds to report the incident to police.

Initial notice of these incidents must be reported to the Commission within 24 hours.

The Commission will then determine other reporting requirements.

Definition of Priority 2 reporting incidents

Priority 2 reportable incidents:

- All other “reportable incidents” that don’t fit the definition of Priority 1

NOTE, the ACQSC says Priority 2 incidents are any reportable incidents that result in a low level of harm

BUT, legislation just says any reportable incident that is **not** a Priority 1 is a Priority 2

KEY TIPS:

- Any reportable incident where the consumer is hospitalized is a Priority 1
- Remember the test is whether it *could reasonably have caused* injury – the fact a consumer does not show any signs of trauma or discomfort does not mean it is not Priority 1
- If not sure if Priority 1 or 2, be guided by consumer or representative reaction

What incidents are reportable?

The first three are as per **current** arrangements:

- unreasonable use of force
- unlawful sexual contact or inappropriate sexual conduct
- unexplained absence from care

New reportable incidents:

- psychological or emotional abuse
- unexpected death
- stealing or financial coercion by a staff member
- neglect
- inappropriate physical or chemical restraint

Unreasonable use of force

Unreasonable use of force against a care recipient includes conduct ranging from a deliberate and violent physical attack to use of unwarranted physical force

Includes (according to the ACQSC):

- Shoving, hitting etc
- Throwing things at a consumer
- Making threats of physical harm (?)
- Spitting at a consumer (?)
- A pattern of rough handling (?)

Does not matter if harm was actually caused

Unreasonable use of force (continued)

What does it **not** include?

- Gently touching a care recipient for the purposes of providing care, to attract their attention, to guide them or comfort them
- Unless it is careless or negligent, accidental contact will not be considered unreasonable use of force
- Physical contact with lawful justification (eg pushing a consumer out of the way of a car)
- Reasonable management of a consumer – eg where a staff member is trying to assist a consumer and, despite best intention, they get a small scratch
- Minor disagreements between consumers

Unlawful sexual contact or inappropriate sexual conduct

This is any conduct or contact of a sexual nature inflicted on the consumer and includes:

- any sexual contact with a staff member
- staff member touching resident's anal or genital area or breast when not necessary to provide care and services to the consumer
- any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency or sharing of an intimidate image of the resident
- conduct relating to the resident with the intention of making it easier to procure the resident to engage in sexual contact

NOT consensual contact or conduct of a sexual nature between the resident and person who is not a staff member.

VOLUNTEERS: Consensual contact with a volunteer is ok if they are not working at the time.

QUERY: Do you need to report contact between two residents where neither have capacity to consent?

Unexplained absences from care

- This will need to be reported if:

  - the absence is unexplained

  - there are reasonable grounds for reporting the absence to the police

- You will be required to report this absence to the police within a reasonable timeframe
- You must also report this to the Commission within 24 hours of becoming aware that the consumer is missing
- DON’T need to report it if the consumer comes back before you noticed they were missing

NOTE: All unexplained absences are Priority 1 incidents

Psychological or emotional abuse

Conduct that has caused, or that could reasonably have caused, the consumer psychological or emotional distress, such as:

- Threats
- Taunting
- Bullying
- Harassment
- Intimidation
- Humiliation
- Repetitive contact after they have asked you to stop
- Silent treatment or unreasonable refusal to interact with the resident or acknowledge their presence

Psychological or emotional abuse – specific examples

Specific examples:

- Staff member yelling at a consumer
- Staff member giving “abrupt, terse or brusque” orders to a consumer
- Family member making inappropriate or cruel comments or jokes to or within earshot of a consumer
- Repeated actions such as flicks, taps and bumps to a consumer
- Threatening or aggressive gestures towards a consumer

Unexpected death

A death where:

- reasonable steps were not taken by the provider to prevent the death
- it is the result of care or services provided by the approved provider
- it is the result of a failure of the approved provider to provide care or services

Can be a death that happens straight away or one that happens a while later

What is **not** an unexpected death?

- death resulting from an ongoing illness, disease or condition

If you are unsure whether to report the death, err on the side of caution, particularly where it is unclear what caused the death

All unexpected deaths are considered Priority 1 reportable incidents

Unexpected death – specific examples

Specific examples:

- Clinical mistakes resulting in death
- Wound not treated – becomes infected – resulting in death
- Medication error resulting in death
- Consumer has a fall – not assessed immediately – dies from injuries

Stealing or financial coercion by a staff member

Includes:

- Stealing from a consumer
- Conduct by a staff member of the provider that:
  - is coercive or deceptive in relation to financial affairs
  - unreasonably controls the financial affairs of the consumer

Theft:

- Not required to report every missing item, only if you think a staff member is responsible
- BUT, ACQSC says to report if a consumer is concerned about a missing item

Stealing or financial coercion by a staff member

Examples:

- Encouraging a consumer to give them gifts
- Advising a consumer to change their will
- Using POA to inappropriately control a consumer's finances

What is **not** reportable (ACQSC):

- Accepting a small gift (unsolicited)
- Items go missing "but are quickly found"

Neglect

Includes:

- breach of duty of care owed to the consumer
- gross breach of professional standards in providing care or services

This is a very broad category
Examples:

- vital medication or treatment has not been provided which would have prevented an adverse incident
- assistance to a consumer has been withheld without a lawful reason and leads to harm to the consumer
- failure to properly supervise a resident
- failing to dress a resident appropriately for the weather
- withholding personal care, such as showering, toileting or oral care
- failing to treat injuries, wounds, pain, etc
- failing to call an ambulance when required

Inappropriate physical or chemical restraint

Unauthorised use of restraint, ie outside the rules in the QoC Principles is reportable

Other than in an emergency, use of physical restraint will be reportable unless:

- recommended by a health practitioner who had day-to-day knowledge of the resident's care
- alternatives have been tried and this is the least restrictive option
- consent has been provided by an appropriately authorized representative

Use of chemical restraint will be reportable unless:

- a medical practitioner has prescribed it and obtained consent
- this decision has been recorded in the consumer's care and services plan
- the consumer's representative is informed *before* the restraint is used if practicable to do so

NOTE: Secure units/keypads can be a form of physical restraint. Do you have the appropriate authorization?

Reporting and record-keeping requirements

You must record the following in your IMS:

- Incident details
- Whether the incident was reportable
- Person reporting the incident
- Contact details of all people involved including witnesses
- Details of consultation with the consumer/s and representative/s involved
- Details of initial assessment and investigation (if you did an investigation)
- What was the response to the incident, including supporting the consumers involved and improvements

These records must be kept for **7 years** after 30 June of the year in which the incident was identified

Note, this is different to other record-keeping obligations in the Aged Care Act which only requires information be recorded for 3 years

The SIRS and NDIS

If a serious incident involves an NDIS participate, you will be required to notify both the Commission and the NDIS Quality and Safeguards Commission

The SIRS reporting requirements are more onerous than that of NDIS

Serious injury is also a reportable incident under the NDIS

Consequences of not complying with the SIRS

Civil penalties of up to a maximum of 500 penalty units will apply in circumstances where victimisation is apparent following a protected disclosure

SIRS will also expand the Commissioner's powers to enforce the requirements of the SIRS and the responsibilities of approved providers and related offences more generally eg:

- non-compliance and sanctions
- civil penalties
- infringement notices
- enforceable undertakings
- injunctions

Summary and take home points

The SIRS has two elements:

- IMS
- mandatory reporting

More serious incidents require an internal investigation

MUCH broader reporting obligations

Be aware of signs that a resident has been subject to a reportable incident

Need to report reportable incidents that have occurred OR are alleged or suspected to have occurred

Timeframes for reporting to Commission depending on whether the incident is a Priority 1 or 2

No exceptions for incidents perpetrated by those with a cognitive impairment

Only need to report to police if you suspect a crime OR the resident is missing

Introducing Katrina Ong

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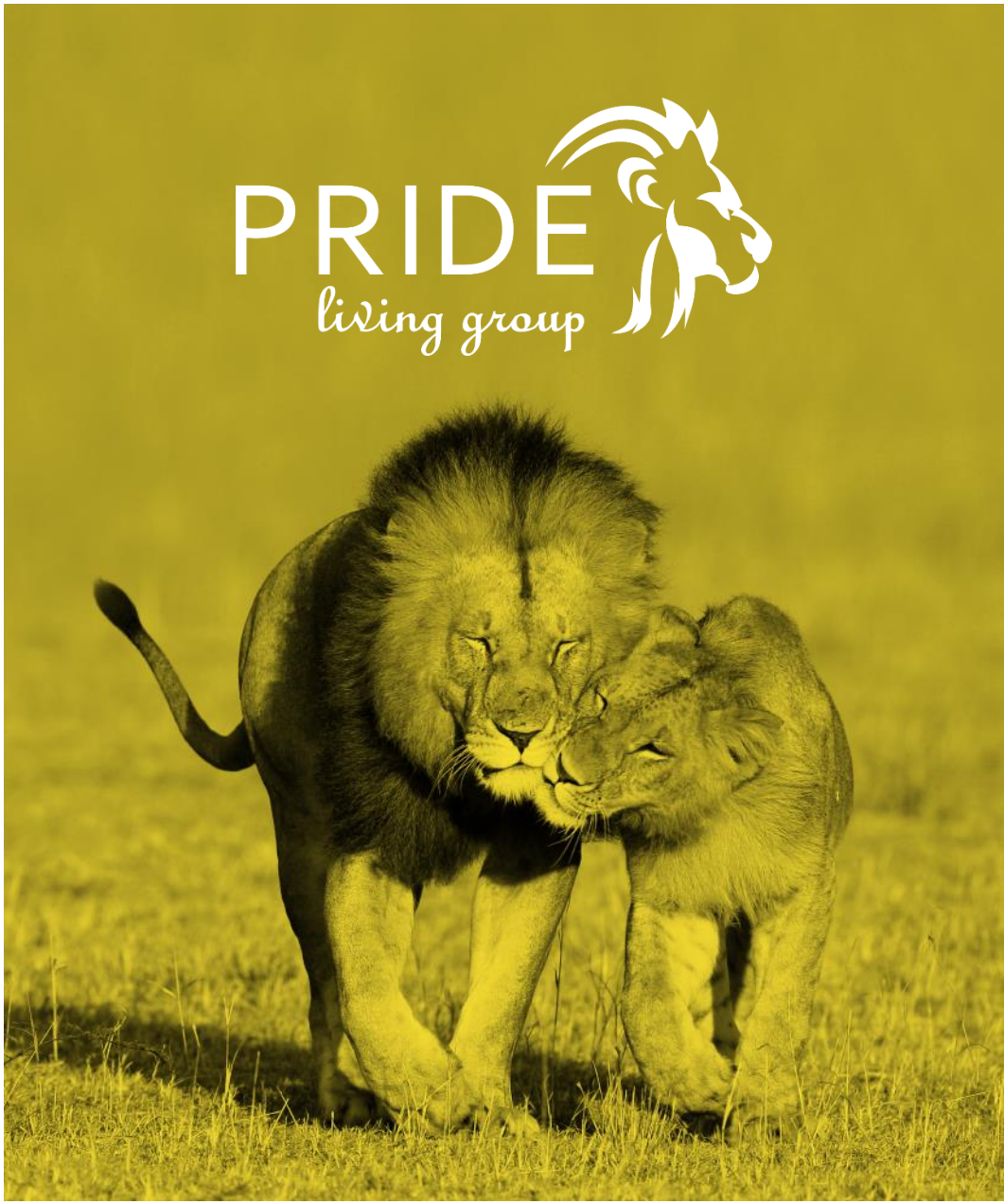
With substantial experience in clinical practice within aged care as registered nurse, Katrina has worked to transform the way in which resident care is delivered in aged care services. She has a particular interest in supporting providers, large and small, to develop effective quality management systems as well as to ensure their systems respond to the new aged care quality standards.

As someone who has worked ‘hands on’ in the aged care industry, she offers an authentic understanding of the challenges providers face in delivering exceptional resident care in an ever more complex and consumer driven environment.

Practical Tips
Proactive and Reactive Risk Management
Root Cause Analysis

Katrina Ong

Partner - Quality Management and Clinical Governance



Practical tips

Incident Management System- already exists

How to improve?

Review/ Implement organizational frameworks:

- Clinical Governance
- Risk Management
- Quality Management

- ✓ Consultation and engagement
- ✓ Policies, procedures, position descriptions, audit tools
- ✓ Education and training
- ✓ Compliance mapping (staff journey, experience and understanding)
- ✓ Reporting framework and CULTURE incl. tools, forms
- ✓ Communication pathways – Internal and External (each personnel understands escalation process)

Journey of Risk Mitigation

PRIDE living group

Proactive and Reactive Risk Management

Risk Management Activities	Functions
Proactive	Repeatable activities A systemic approach involving scheduled quality control activities Example: investigate hazards and near misses
Reactive	Triggered by a specific event Analytical- may result in a deep dive

- Risk Management and Continuous Improvement go hand in hand
- Organizations may focus on risk management without quality improvement
- Must break the cycle of reporting due to implementation of sustained improvements

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Swiss Cheese

Holes represent unaddressed systemic issues

Examples

- Systems and processes in place but ineffective
- No testing arrangements
- Lack of reporting/ governance oversight
- Lack of staff awareness/ confidence in system and process

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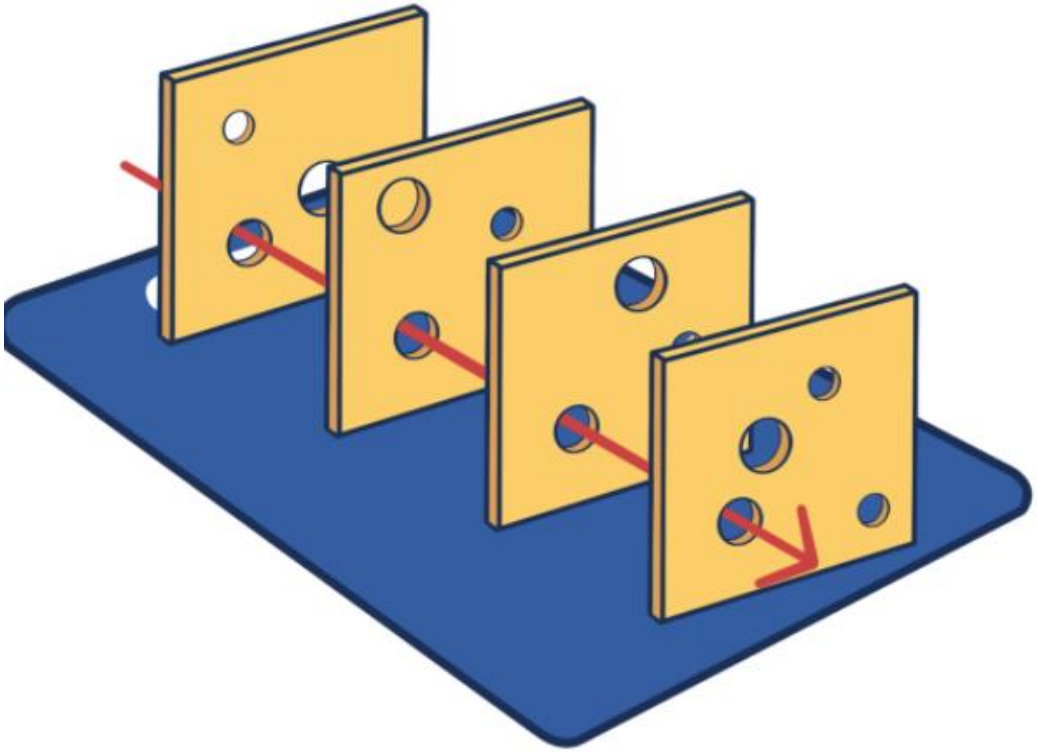
Inaction of the “holes” causes catastrophic event/ incident

Speed may be too fast to mitigate catastrophe



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Root Cause Analysis in incident investigation

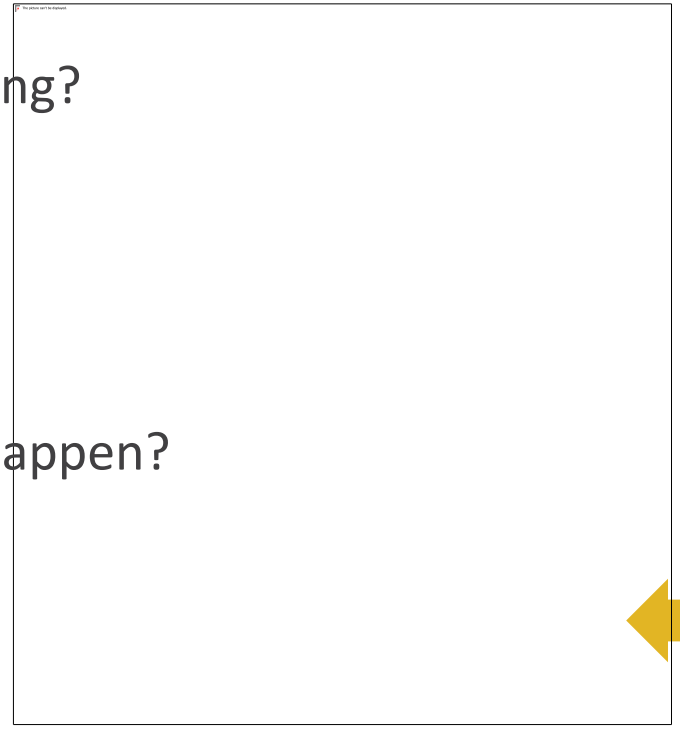
3 W's and H

What went wrong?

Who was responsible?

Why did that happen?

How can we prevent this from recurring?



Symptom

- Result of the problem

Problem

- Above the surface, obvious
- The gap between reality
- and the goal

Source

- Below the surface, obscured

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