Procedure

# Incident Management – Consumer

## 1. Procedure Statement

CHL is dedicated to creating a safe and welcoming environment for older persons, employees, volunteers, students, visitors, contractors, and others in all service settings. CHL is committed to providing high-quality care and services through efficient systems and processes that facilitate proactive incident detection and management to prevent harm and minimise reoccurrence.

CHL promotes an open and transparent approach to incident management to ensure that all parties involved are treated with respect and given procedural fairness and natural justice. CHL utilises a continuous improvement approach to strengthen its culture of safety and minimise the risk of harm reoccurring.

This procedure establishes clear expectations for identifying, reporting and managing incidents ensuring prompt, fair and transparent processes, open communication and trust and operates within the context of Catholic Healthcare's Mission and Values underpinned by Catholic ethical standards.

## 2. Applicability / Scope

An **incident** is defined as an event that resulted or could have resulted in unintended or unnecessary harm to the older persons/s for whom we care or another person, caused by a breakdown in process, system, human error, or an external event.

This procedure applies to all incidents involving older persons and/ or those involving the delivery of care and services.

This procedure should be read in conjunction with the People - Health Safety and Wellbeing - Procedure and the guidelines listed below for employee-related incidents.

HSW.G.24 - MySafety Managers Guide - How to respond to a Safety Incident Report v1.0.pdf
HSW.G.24 - MySafety Managers Guide - How to respond to a Safety Incident Report v1.0.pdf

## 3. Index

# 3. Principles of Incident Management

CHL has adopted the Clinical Excellence Commissions principles of effective incident management.

- Transparency: CHL will provide older persons, carers, families and members of the workforce; where involved in an incident with an honest and open explanation of what happened, why it happened and what actions have and will be taken as a result.
- Accountability: CHL has a duty to take reasonable care to avoid harm to older persons, the workforce, contractors, visitors and volunteers. When a person is harmed, CHL will undertake an investigation and actions to remedy problems in a timely manner.
- Partnering with older people: CHL will facilitate and support older persons, carers and families as partners in incident investigations and reviews.
- Open fair and just culture: CHL will create a culture where the workforce, older persons, carers and families feel safe to report incidents. During an incident investigation, CHL will treat everyone fairly, according to just culture, using a system-based approach.
- Act in a timely manner: CHL will take action to remedy problems in a timely manner the allocation of responsibility for action is explicit. This includes meeting all regulatory reporting requirements.
- Take action: CHL will prioritise action to address problems and direct resources to the areas of highest risk and where the greatest improvements are possible
- Shared learning: CHL's will share the lessons learned from incidents across the organisation to prevent further harm and to take collective remedial actions

## 4.1 Open disclosure:

Open disclosure related to incidents involves open discussion with older persons, employees, visitors, or contractors when something goes wrong, causing or having the potential to cause harm. An apology or open disclosure is not an admission of guilt or fault by CHL. In the context of an incident, open disclosure must commence as soon as the incident is identified and continue throughout the incident management process until closure.

A transparent and honest discussion with the affected persons ( /employees /visitors /contractors) and/or their authorised representative must include the following:

I. a factual explanation of what occurred or could have occurred.
II. a discussion of the actual and/or potential consequences.
III. an opportunity for the affected persons (older persons/employees/visitors/contractors) and/or their authorised representative to recount their experiences, concerns, and feelings and ask further questions.
IV. an explanation of the steps taken to manage the event and prevent its recurrence; and
V. an apology to the affected persons (older persons/employees/visitors/contractors) and/or their authorised representative, without attribution of blame or speculation about the course of events.

Where necessary, legal, medical practitioners and/or allied health professionals should be involved in open disclosure discussions. Following an open disclosure process relevant staff should consult with the affected person/s and/or an authorised representative regarding ongoing plans of care, and consideration of any ongoing support that the affected person/s may require. Please refer to CHL Open Disclosure Procedure & Procedure for further details.

### 4.2. Risk Assessment

All incidents are categorised using CHL's Risk Escalation Matrix. Each incident is given a Critical Assessment Score, known as a CAS rating. The CAS score determines the level of escalation and informs the nature and appropriate level of investigation. For example, a CAS 1 or CAS 2 incident may be referred to the internal Incident, Investigation, and Complaints team. Refer to Residential - Serious Incident Escalation Protocol DEC 2023 - Form for more details.

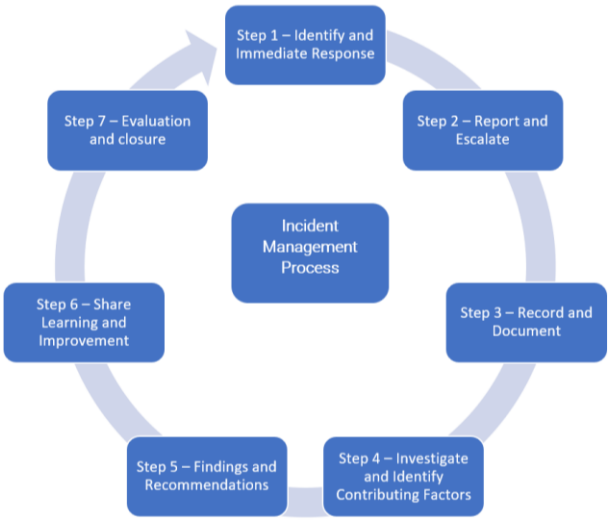
The table below outlines the escalation expectations in line with the Critical Assessment Score.

| Score | Escalations |
|---|---|
| Critical Assessment Score 1 (CAS 1) | ELT / CEO Board |
| Critical Assessment Score 2 (CAS 2) | Chief Residential/Chief Communities |
| Critical Assessment Score 3 (CAS 3) | Regional Manager |
| Critical Assessment Score 4 (CAS 4) | Business/Residential Manager |
| Critical Assessment Score 5 (CAS 5) | Business/Residential Manager |

## 5. Incident Management Process

CHL's incident management process provides employees, contractors and others to efficiently and effectively recognise and respond to incidents to mitigate risk and reduce harm.

There are 8 steps as shown in the diagram below.



# Incident Management – Consumer

The table below outlines the primary actions to be taken at each step in the incident management process:

| Process | Actions | Timeframe |
|---|---|---|
| Step 1 – Identify and Immediate Response | ▪ Provide immediate care and support to the individuals involved – this includes the older persons, clients, families, and members of the workforce<br>▪ Make the situation and immediate surroundings safe<br>▪ Contact 000 if Ambulance, Police or Fire are required<br>▪ Protect the scene and any evidence (as required) | Immediate |
| Step 2 – Report and Escalate | ▪ Notify your supervisor or the Residential Manager/Business Manager.<br>▪ Notify the authorised representative (AR)<br>▪ Allocate the level of harm and severity rating (CAS rating).<br>▪ Escalate in line with the Enterprise Risk Escalation matrix<br>▪ Confirm the level of harm and severity rating (CAS rating).<br>o For actual and potential CAS 1 incidents, the Incident Response Team convened to undertake assessment and determine management approach - refer to CAS 1playbook<br>▪ Establish a high-level sequence of events and known facts to complete a preliminary assessment of risk and additional actions for Legal, Media & Board escalation<br>▪ For employee involvement (conduct/safety), review the information and make a decision on whether a stand down is required<br>▪ Remove malfunctioning equipment or supplies<br>▪ Contact security and the police (if required) | Within first 4 to 6 hours |
| Step 3 – Record and Document | ▪ Gather and objectively document information about the chain of events<br>▪ Update and complete the incident record with objective, factual, and detailed information in the designated system.<br>▪ Hold briefings with employees and other stakeholders (if relevant) to maintain privacy and confidentiality.<br>▪ Deploy EAP/Counselling/Pastoral Care<br>▪ Issue Fact Finding letters to all interviewee(s)<br>▪ Complete Board Escalation if required<br>▪ Complete notifications of reportable incidents to regulatory bodies (i.e. SIRS/NDIS/Safework/Police) if required<br>▪ Consider notifications to the Insurer<br>▪ Prepare media statements if required | Within first 24 hours |

| | | |
|---|---|---|
| Step 4 – Investigate and Identify Contributing Factors | ▪ Explore and confirm the need for privacy and legal privileges (as required)<br>▪ Determine the scope of the investigation and appropriate methodology based on the severity and nature of the incident (Comprehensive Incident analysis/Concise Incident analysis/5 Why's)<br>▪ Identify the investigation lead (based on the nature of the incident)<br>▪ For CAS 1 incidents, the Incident Response Team will appoint an Investigation Lead and decide on the need for an external investigator.<br>▪ Identify the investigation team (based on the nature of the incident); the response team will meet regularly to track actions and respond to new and emerging information and risk.<br>▪ Gather information, including re-enactments, interviews, and supporting documents, to create a detailed incident chronology.<br>▪ For reportable incidents to regulatory bodies (i.e. SIRS/NDIS/Safework/Police) commence report preparation<br>▪ Commence Open Disclosure and hold Older Person/employee briefings<br>▪ Review preliminary findings and consider if stood-down employees can return to duties with risk mitigation (as/if required)<br>▪ Determine the need to adjust investigation timeframes<br>▪ If not made earlier, consider notifications to the Insurer post-preliminary investigation.<br>▪ Consider any requests by external bodies for information/meetings<br>▪ Complete preliminary findings and make recommendations to the decision-makers on actions and the next steps. | Within 1 to 2 business days |
| Step 5 – Findings and Recommendations | ▪ The Investigation team and/or the Incident Response Team meet to finalise the findings and the recommendations<br>▪ Complete the Investigation Report and provide the report to the decision-makers<br>▪ Provide additional updates / final notifications of reportable incidents to regulatory bodies (i.e. SIRS/NDIS/Safework/Police)<br>▪ Communicate findings and outcomes to stakeholders internally and externally<br>▪ Identify any additional risk/factors and escalate to the decision-makers<br>▪ If not directed, consider notifications to external regulatory bodies (AHPRA, NDIS/ACQSC - Banning Orders Register etc.)<br>▪ Determine closure criteria for the incident | Within 10 to 14 working days |

| | | |
|---|---|---|
| Step 6 – Share Learning and Improvement | ▪ Communicate investigation outcomes to stakeholders internally and externally<br>▪ Schedule and complete Formal Open Disclosure with those directly affected.<br>▪ Determine incident de-brief and trauma informed conversation with the individuals directly/indirectly affected<br>▪ Develop case study and lessons learnt to share at the service level and network level.<br>▪ Develop Plans of Continuous Improvement (PCI) to capture and track recommendations at service and network level<br>▪ Identify improvement actions and resources locally/centrally. | Within 28 days |
| Step 7 – Evaluation and closure | ▪ Evaluate the effectiveness of the improvement actions and strategies to validate that improvements have been effective.<br>▪ Once all recommendations are implemented and evaluated the incident is considered closed.<br>▪ Make a follow up with all individuals directly or indirectly affected by the incident. | Within 3 months |

The steps are contained in the Incident Management Process – Checklist which can be printed to record the completed actions of the procedure.

## 6. Documentation Systems:

All incidents must be documented in the designated system. The table below outlines the specific requirements.

| Incident Type | Designated system |
|---|---|
| Consumer related | Connect Incident Register |
| Workforce Incidents | MySafety |
| Service delivery impact incidents | MySafety |

## 6. Roles and Responsibilities

### Consumers and their Representatives

- Inform the Residential Manager/Care Advisor of any incidents, events, or conditions that occur or that you learn about in a timely manner.
- Where applicable, participate in the incident management process.
- Contribute to service improvements as part of Continuous Quality Improvement (CQI).

### All employees

- Proactively identify and report incidents, issues and risks to the supervisor/on duty as soon as safe and practical.
- Document and record incidents in the designated incident management systems.
- Participate in investigations maintaining privacy and confidentiality.
- Participate in open disclosure, lessons learnt and continuous improvement activities.
- Undertake annual training in incident management.

### Registered Nurses

- Proactively identify and report incidents, issues and risks to the supervisor/on duty, escalating to management in accordance with the Enterprise Escalation Matrix.
- Proactively respond to incidents to ensure the safety of all affected, providing first aid, preserving the scene, removing or managing the malfunctioning equipment contacting 000 etc.
- Document and record incidents in the designated incident management systems.
- Prepare and contribute to reports to regulators in accordance with timeframes.
- Participate in investigations and maintain privacy and confidentiality.
- Participate in open disclosure, lessons learnt and continuous improvement activities
- Undertake annual training in incident management and open disclosure.

### Care Managers (RAC only)

- Proactively identify and report incidents, issues and risks to the supervisor/on duty, escalating to management in accordance with the Enterprise Escalation Matrix.
- Document, record and review incidents in the designated incident management systems.
- Participate/lead investigations maintain privacy and confidentiality
- Proactively review clinical incidents, identifying contributing factors, and implementing strategies to prevent re-occurrence and minimise harm to the older person.
- Prepare and contribute to reports to regulators in accordance with timeframes.
- Clinical governance processes proactively detect and prevent incidents from reoccurring through review of incident trends.
- Undertake relevant annual training in incident management and open disclosure.

### People Leaders (Residential and Business Managers)

- All employees are aware of incident management procedure and processes and have attended training in accordance with CHL's education program.
- Ensure that all supervisors are aware of and comply with the incident and escalation protocols with the service.

- Communicate regularly with the victim, carer or family during the incident investigation.
- Ensure all incidents are documented in the designated organisational incident management system.
- Undertake relevant incident management training.
- Monitor incident notifications in the incident management system and ensure all steps of the incident management process are adhered to prevent re-occurrence.
- Support staff involved in incidents
- All incidents are promptly reviewed and analyzed to minimize harm, prevent reoccurrence, and provide a timely response in accordance with CHL protocols.
- Monitor timelines and execution of remedial works and improvement actions.
- Monitor staff practice to ensure compliance with this procedure and related policies and procedures.
- Monitor and review hazards to take proactive steps to mitigate risk
- Support and/or undertake open disclosure

### Regional Managers

- All incidents are reported, categorised and escalated correctly
- All incidents are investigated, and corrective/improvement actions implemented
- Incident trends are monitored, and improvement actions are implemented as part of effective governance.
- Partner with PQR/HR on serious incidents to support timely investigation and reporting.
- Participate/lead investigations and open disclosure to maintain privacy and confidentiality.
- Ensure all service level recommendations from the incident analysis and investigations are implemented, monitored and evaluated for effectiveness.

### Chief Residential Officer/Chief Communities Officer

- Receive and respond to all CAS 1 and CAS 2 incident escalations.
- Escalate incidents according to procedure requirements, and in case of serious incidents (CAS 1 and CAS 2) escalate to the relevant business stream's Chief Officers and the Chief Legal Counsel.
- Lead/Contribute to investigations of CAS 1 incidents (or other Incidents that may be due to serious system problems).
- In partnership with the Chief Quality Officer, convene the Incident Response Team to triage and conduct a preliminary assessment, and risk mitigation (for CAS 1 incidents).
- Sign-off on the scope of investigation for the CAS 1 incidents (or other Incidents which may be due to serious system problems)
- Notify the Chief Legal Counsel of incidents with the potential to become legal claims.

### Chief Quality Officer

- Ensure CHL has systems in place to report, review and take action to prevent incidents, protect people in healthcare settings, and improve the delivery of safe, high-quality care and services.
- Ensure that CHL meets its regulatory obligations for incident management.
- All reportable incidents are reported to the external regulatory bodies (ACQSC, NDIS Commission, Safework, Emergency Services etc.) in line with prescribed timeframes.
- Ensure policies and strategies are in-place to improve the delivery of safe and high-quality care and services.

- Provide advice and seek regular reports from Management on quality and safety issues, trends and lessons learned from incident management.
- Analyse systems failings and human factors contributing to incident trends and develop organisational improvement plans and strategies to eliminate and reduce the potential for harmful events to occur.

CEO

- Notify the Governing Body if urgent attention is required for a CAS 1 incident or a CAS 2 that has potential risk (or other Incidents that may be due to serious system problems)
- Advise the Board on strategies to minimise organisation-wide incident system errors.
- Ensure an organisation-wide approach to recognizing and responding to actual, potential or emerging risks as they are identified.

Chief Counsel

- Lead/Contribute to investigations of serious incidents (or other Incidents that may be due to serious system problems).
- Facilitate communication with Insurers where required.
- Facilitate obtaining legal advice where required and ensure processes are in place to protect privileged information and documents
- Provide Legal Advice on matters

Investigation, Incident and Complaints Team (PQR)

- Lead/Contribute to investigations of CAS 1 incidents (or other Incidents that may be due to serious system problems).
- Ensure the incident investigation findings, reports and recommendations report are submitted within timeframes.
- Assist in clarification, classification, and reporting requirements under the ASQSC, NDIS Commission, and other legislative bodies.
- Develop and maintain policies, procedures, and templates to facilitate effective incident management across CHL, adhering to best practices.
- Disseminate incident learnings to the appropriate staff, CHL Departments and other stakeholders as required.
- Analyse and provide insight for monthly incident data, benchmarking, and trends, identifying organisational continuous improvement opportunities.
- Report trended incident data and outcomes of CAS 1 incident (or other Incidents which may be due to serious system problems) reviews to peak safety and quality committees, the Board and relevant groups within CHL.

Incident Response Team (Mixed) – led by CQO or their delegate.

- Appoint the Lead Investigator to undertake a PRA (preliminary risk assessment) for CAS 1 incidents.
- Consider the need to refer to the investigation externally.
- Appoint safety check teams to undertake safety checks of safety-associated CAS 1 incidents

- Assign a dedicated family contact for CAS 1 incidents (or incidents that may be due to serious systemic problems).
- Consider notifications to other external regulatory bodies under statutory provider obligations.
- Ensure the incident investigation findings report and recommendations report are submitted within timeframes.

Investigation Lead – as appointed by the Incident Response Team.

- The investigation lead can be a CHL employee from operational or non-operation streams or can be referred externally.
- Lead and coordinate the investigations
- Undertake information gathering and develop incident chronology. Present preliminary findings to the panel to confirm and advise on the next steps
- Finalise the findings and recommendations and complete the final report.
- Develop the case study and lessons learnt for organisational learning.

## 7. Definitions

| | |
|---|---|
| ACQSC | Aged Care Quality and Safety Commission |
| Apology | An expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, whether or not the apology admits or implies an admission of fault in connection with the matter. |
| Authorised Representative | An Older person's or Client's authorised representative includes:<br>• A person appointed under relevant legislation to act or make decisions on behalf of the Older person or Client<br>• A person the Older person or Client nominates to be told about matters affecting the Older person or Client. |
| Client | Client refers to an individual accessing services through CHL Home & Community |
| Older Person/Resident | Older person/resident refers to any individual that is accessing the services within CHL for Residential Aged Care (RAC) |
| Continuous Improvement | A systematic, ongoing effort to raise Catholic Healthcare's performance in achieving outcomes for Older persons. |
| Incident | An incident is defined as an event that resulted or could have resulted in unintended or unnecessary harm to the older persons/s for whom we care or another person, caused by a breakdown in process, system, human error, or an external event. |
| NDIS | National Disability Insurance Scheme |

| | |
|---|---|
| Open Disclosure | Open disclosure related to complaints is the open discussion with consumers when something goes wrong where harm, or the potential to cause harm to a consumer has occurred. It involves an expression of regret and a factual explanation of what happened, the potential consequences, and what steps are being taken to manage the issue and prevent it happening again. Even if something has gone wrong or we have not met their expectation, but it has not resulted in harm, the general principles of open disclosure (e.g. apologise, explain what happened, learnings) should still be applied. |
| Privacy Laws | Includes the Privacy Act 1988 (Cth), the Privacy and Personal Information Protection Act 1998 (NSW), the Health Records and Information Privacy Act 2002 (NSW) and any other applicable legislation. |
| Resident | A person who CHL provides, or is to provide, Residential Aged Care. |
| SIRS | Serious Incident Response Scheme |
| Workforce | All CHL employees, volunteers, students, visiting medical practitioners, allied health professionals, and contractors (including all staff employed, hired, retained, or contracted to provide services under the control of CHL). |
| Event | An event refers to something that happens or takes place |
| CAS | Critical assessment Score |
| Safework Australia | Safe Work Australia is a national procedure body representing the interests of the Commonwealth, states and territories, as well as workers and employers. |
| AHPRA | Australian Health Practitioners Register |
| ACQSC | Aged Care Quality and Safety Commission |
| Banning Order | A ban can be permanent or for a specific period. It can be general or only apply to specific types of aged care, or specific activities the person does. It can also have conditions applied. Banning orders are published on the Aged Care Banning Orders Register, which is public. |
| Insurer | A company engaged by CHL that underwrites an insurance risk |
| Workforce | All CHL employees, volunteers, students, visiting medical practitioners, allied health professionals, and contractors (including all staff employed, hired, retained, or contracted to provide services under the control of CHL). |
| | |

# 8. Related Documents and Resources

## 8.1 Legislation/Standards

This procedure is guided by the following legislation:

- Aged Care Quality and Safety Standards 2019
- National Disability Insurance Scheme Act 2013
- Federal Register of Legislation - Quality of Care Principles 2014
- Aged Care Act 1997
- Quality of Care Principles 2014
- User Rights Principles 2014
- Coroners Act 2003, QLD Legislation
- Coroners Act 2009 No 41, NSW Legislation
- Work Health and Safety Act 2011, Australian Government

  Work Health and Safety Regulation 2017, NSW Legislation

## 8.2 Related Documents and Resources

- CHL Incident Management Procedure
- CHL's Risk Escalation Matrix
- Residential - Serious Incident Escalation Protocol DEC 2023 - Form
- Incident Management Tool Kit
- Incident Management RACI Matrix
- CAS 1 Playbook
- Crisis Management Procedure
- Risk Management – Enterprise-Wide Risk Management Procedure and Framework
- Incident Management Process - Checklist

## 8.2 References


- Effective incident management systems: best practice guidance (agedcarequality.gov.au)
- Incident Management Guide (safetyandquality.gov.au)
- Incident Management (nsw.gov.au)
- National Disability Insurance Scheme Act 2013
- National Disability Insurance Scheme (Code of Conduct) Rules 2018
- National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018
- National Disability Insurance Scheme (Protection and Disclosure of Information—Commissioner) Rules 2018
- National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018
- National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018
- NDIS Quality and Safeguarding Framework
- Effective incident management systems: Best practice guidance, Aged Care Quality and Safety Commission
- Effective serious incident investigations guidance for providers, Aged Care Quality and Safety Commission
- Incident Management Procedure, NSW Health
- Notice of collection, Aged Care Quality and Safety Commission

- Open disclosure Framework and guidance, Aged Care Quality and Safety Commission
- Recording incidents in an incident management system, Aged Care Quality and Safety Commission
- Register of injuries, NSW Safe Work
- Reportable incidents, NDIS Quality and Safeguards Commission
- SIRS decision support tool, Aged Care Quality and Safety Commission
- Serious Incident Response Scheme - Guidelines for residential aged care providers, Aged Care Quality and Safety Commission

## 9. Fundamental Knowledge and Education

Incident management, investigation, incident management process, risk assessment

## 10. Version history

| Version number | Risk rating | Edits | Approval Date |
|---|---|---|---|
| Version 1 | 3 (med) | Amendments, new document, replacement | 30/07/2024 |

**End of Document**

# Incident Management Process and Timeline

This process is to be used for all consumer related incidents across CHL.

| | | Action | Person/s Responsible (RAC) | Timeline |
|---|---|---|---|---|
| Step 1 – Identify and Immediate Response | | **Identification of the alleged or actual incident** | **First Responder** | **Immediate** |
| | | ■ Providing immediate care to the individuals involved – this includes the residents, carers, families, and members of the workforce | **All employees** | |
| | | ■ Make the situation and immediate surroundings safe | **All employees** | |
| | | ■ Contact 000 if Ambulance, Police or Fire are required (if required) | **Most Senior Person on duty** | |
| | | ■ Protect the scene and any evidence (if required) | **Most Senior Person on duty** | |
| Step 2 – Report and Escalate | | ■ Notifying the residential manager/business manager | **Registered Nurse** | **Within first 4 to 6 hours** |
| | | ■ Notify the AR | **Registered Nurse/Most Senior Person on duty** | |
| | | ■ Confirm the level of harm and risk or severity rating (CAS rating). | **Residential Manager in consultation with the Regional Manager > CRO** | |
| | | ■ Escalate inline with the Enterprise Risk escalation matrix | **Residential Manager > Regional Manager** | |
| | * | *CAS 1 and CAS 2 incidents escalated to respective Chief* | **Regional Manager > CRO** | |
| | | *CAS 1 and/or CAS 2 to Chief Quality Officer* (CQO to convene **Incident Response Team** to triage)* | **CRO > CQO** | |
| | | If CAS 1, Incident Response Team convened and undertake assessment and determined management approach - **refer to CAS 1playbook** | | |
| | | *Consider the appointment of a Family Liason Officer to liaise with the authorised representative of the individual/s involved* | **CRO with CQO & CPO** | |
| | * | ■ Establish high-level sequence of events and known facts to complete a preliminary assessment of risk and confirm the next steps | **Residential Manager>Regional Manager > CRO** | |
| | | ■ For employee involvement, review the information and make the decision to stand down | **Regional Manager/HR Business Partner** | |
| | | ■ Removing or managing malfunctioning equipment or supplies | **Registered Nurse/MMost Senior Person on duty** | |
| | | ■ Determine need for onsite security (if required) | **Regional Manager** | |
| Step 3 – Record and Document | | ■ Gathering information about the chain of events and objectively document these | **Residential Manager** | **Within first 24 hours** |
| | | ■ Update/complete the incident record (objective, factual and detailed information) in the designated system | **Residential Manager with Regional Manager** | |
| | | ■ Hold briefings with employees (and other stakeholders as/if relevant) to maintain privacy and confidentiality | **Residential Manager** | |
| | | ■ Deploy EAP/Counselling/Pastoral Care | **Residential Manager & HRBP** | |
| | | ■ Issue Fact Finding letters to all interviee(s) | **HR Business Partner** | |
| | * | ■ Complete Board Escalation if required | **CRO>CEO** | |
| | | ■ Complete notifications of reportable incidents to regulatory bodies (i.e. SIRS/NDIS/Safework/Police) | **Residential Manager with Regional Manager** | |
| | * | ■ Prepare media statements if required | **Media** | |
| | * | ■ Determine if Insurer needs to be notified | **CQO>Chief Counsel** | |
| Step 4 – Investigate and Identify Contributing Factors | * | ■ Explore and confirm the need for privacy and legal privileges (as required) | **Incident Response Team &/or Chief Counsel** | **Commence within 1 to 2 business days and complete within 10 working days** |
| | * | ■ Determine scope of investigation and appropriate methodology based on severity and nature of incident (Comprehensive Incident analysis/Concise Incident analysis/5 Why's) | **Regional Manager with CRO** | |
| | | ■ Identify the Investigation Lead (based on the severity and nature of the incident) | **Leads maybe any one of thefollwoing: Manager/ Regional Manager/Business Manager/Regional Support Manager/Quality Improvement Specialists/Investigation, Incident and Complaints** | |
| | * | *For CAS 1, the incident response team will appoint an Investigation Lead, this may be referred to an external consultant* | **Incident Response Team** | |
| | | ■ Identify the investigation team (based on the nature of the incident); response team meet regularly to track actions and respond to new and emerging information and risk | **Investigation Lead** | |
| | | ■ Undertake information gathering inc. re-enactments, interviews, fact finding meetings, review medical records and other supporting documents and construct a timeline (detailed incident chronology) | **Investigation Team** | |
| | | ■ For reportable incidents to regulatory bodies (i.e. SIRS/NDIS/Safework/Police) commence report preparation | **Residential Manager and Regional Manager** | |
| | | ■ Commence Open disclosure process and hold Consumer/Employee briefings | **Residential Manager/Regional Manager & HR Business Partner (if required)** | |
| | | ■ Review preliminary findings to consider if stood-down employees can return to duties with Risk Mitigation (as/if required) | **Residential manager/Regional Manager & HR Business Partner (if required) & Investigation Lead** | |
| | | ■ Determine need to adjust investigation timeframes | **Investigation team** | |
| | * | ■ If not made earlier, consider notifications to the Insurer post preliminary investigation. | **Chief Counsel** | |
| | | ■ Consider any requests by external bodies for information/meetings | **CRO/CPO/Chief Counsel** | |
| | * | ■ Present preliminary findings to the decision-makers to confirm and advise on the next steps. | **Investigation Lead** | |
| Step 5 – Findings and Recommendations | * | ■ Investigation and/or Incident Response team meet to finalise the findings and recommendations | **Residential manager/Regional Manager & HR Business Partner (if required) & Investigation Lead** | **Within 10 to 14 working days** |
| | | ■ Complete the Investigation Report and provide the report to the decision makers | **Investigation lead/team** | |
| | | ■ Provide additional updates / final notifications of reportable incidents to regulatory bodies (i.e.SIRS/NDIS/Safework/Police) | **Residential Manager/Regional Manager** | |
| | | ■ Communicate findings and outcomes to stakeholders internally and externally | **Investigation lead/team** | |
| | | ■ Identify any additional risk/factors and escalate to decision makers | **Residential Manager and Regional Manager** | |
| | | ■ If not directed, consider notifications to external regulatory bodies (AHPRA, NDIS/ACQSC - Banning Orders Register etc.) | **CPO/Chief Counsel** | |
| | | ■ Determine closure criteria for Incident | **Investigation lead/team** | |
| Step 6 – Share Learnings and Improvement | | ■ Communicate investigation outcomes to stakeholders internally and externally | **Investigation Lead** | **Within 28 days** |
| | | ■ Schedule and complete Formal Open Disclosure with those directly affected. | **Residential Manager/CRO with CQO** | |
| | | ■ Determine incident de-brief and trauma informed conversation with the individuals directly/indirectly affected | **Residential Manager/CRO with CPO/Mission** | |
| | | ■ Develop case study and lessons learnt to share at the service level and network level. | **Investigation Lead** | |
| | | ■ PCI developed to capture and track recommendations at service and network level | **Investigation Lead** | |
| | | ■ Improvement actions and resources identified locally/centrally. | **Investigation Lead** | |
| Step 7 – Evaluation and closure | | ■ Evaluate the effectiveness of the improvement actions and strategies to validate that improvements have been effective. | **Residential Manager/Regional Manager** | **Within 3 months** |
| | | ■ Once all recommendations are implemented and evaluated the incident is considered closed. | **Residential Manager/Regional Manager** | |
| | | ■ Follow-up with the individuals affected by the incident . | **Residential Manager/Regional Managaer** | |

* *Indicates Compulsory for CAS 1*