Service Management:

PROCEDURE 8.9
INCIDENT MANAGEMENT

Number	*Procedure*	*Related National Disability Insurance Scheme Quality Practice Standards*
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Definitions

Accident – an unforeseen event that causes damage to property, injury, or death.
Participant Incident – Acts, omissions, events or circumstances that occur in connection with providing supports or services to a person with disability who receives funding under the NDIS or the Commonwealth Continuity of Support Programme relating to Specialist Disability Services for Older People.

Near Miss – any incident that occurred during services with Better Together, which, although not resulting in any injury, illness, or damage, had the potential to do so.

Hazard – a situation that has the potential to harm a person (cause death, illness, or injury) or environment or damage property.

Hazard identification – A process that involves identifying all foreseeable hazards in the workplace and understanding the possible harm that each hazard may cause.

Hazard management – A structured process of hazard identification, risk assessment, and control, aimed at providing safe and healthy conditions for staff members, contractors, and visitors while on the premises.

Harm – Includes death, or injury, illness (physical or psychological), or disease that may be suffered by a person as a consequence of exposure to a hazard.
NDIS Quality and Safeguards Commission (the Commission) – The regulatory body established to oversee the registration of NDIS providers and monitor compliance, respond to complaints and reportable incidents, monitor behaviour support and restrictive practices, and undertake investigation and enforcement.

Notifiable Incident – Any extremely serious incident arising out of the conduct of a business or undertaking at a workplace, relating to any person — whether an employee, contractor, or member of the public.

Reportable incidents – incidents, or alleged incidents, that:

- arise from acts, omissions, events, or circumstances occurring in connection with providing supports or services to a person with disability AND resulted in, or could have resulted in, harm to the person with disability; OR which
- arise from acts by a person with disability that cause, or risk causing, serious harm to another person. Section 73Z(4) of the Act defines a reportable incident as:
- the death of a person with disability;
- serious injury of a person with disability including fractures, burns, deep cuts, extensive bruising, concussion, and any other injury requiring hospitalisation;
- abuse of a person with disability behaviour management including verbal, Incident
- neglect of a person with disability behaviour management that is seriously inappropriate or improper;
- unlawful sexual or physical contact with, or assault of, a person with disability by a worker or another NDIS participant;
- sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity;
- unauthorised use of a restrictive practice in relation to a person with disability.

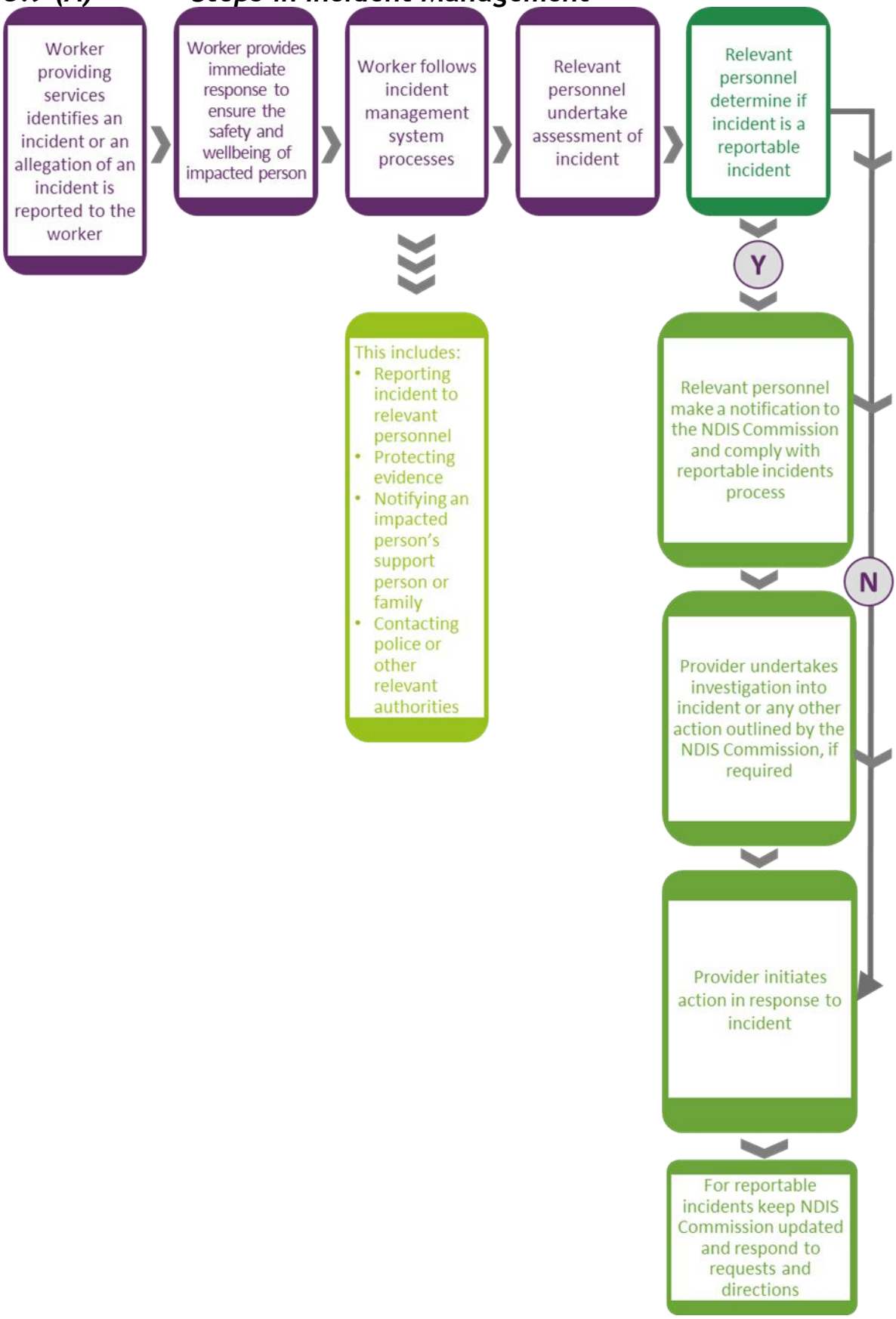
Incident

- Acts, omissions, events or circumstances that occur in connection with providing supports or services to a person with disability and have, or could have, caused harm to the person with disability.
- Acts by a person with disability that occur in connection with providing supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person.
- Reportable incidents that have or are alleged to have occurred in connection with providing supports or services to a person with Royal Institute for Deaf and Blind Children
- It covers incidents that:
    - May have occurred during supports or services being provided.
    - Arise from provision, alteration or withdrawal of supports or services.
    - May not have occurred during the provision of supports but are connected because it arose out of the provision of supports or services.

Procedural fairness - is a legal principle that ensures fair decision making and requires:

- decisions to be free from bias or appearance of bias by the decisionmaker
- decisions to be based on evidence that supports the facts
- people likely to be adversely affected by decisions have an opportunity to:
    - present their case and
    - have their response considered before the decision is made

8.9 (A) Steps in Incident Management



8.9 (B) Identifying Incidents or Allegations of Incidents

Rational

An incident can be;

- Acts, omissions, events or circumstances that occur in connection with providing NDIS supports or services to a person with disability and have, or could have, caused harm to the person with disability
- Acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person
- Reportable incidents that have or are alleged to have occurred in connection with providing NDIS supports or services to a person with disability an incident can be an act,

(types of incidents)

Minor Incident

- Minor injury to a service or their carer – First Aid not required;
- Minor injury to an employee – First Aid not required;
- Verbal abuse;
- Minor property damage.

Moderate Incident

- Injuries to employees requiring First Aid;
- Injuries to service users or carers requiring First Aid;
- Medication mismanagement that has minimal to no side effects
- Significant property damage.

Severe or Major (reportable) Incident

- Severe injury to employees requiring medical treatment or hospitalisation;
- Severe injury to service users and/or carers requiring medical treatment or hospitalisation;
- Any incident involving the Police, Fire or Ambulance service;
- Death of a client or person with a disability;
- The abuse or neglect of a person with a disability; unlawful sexual or physical contact with or assault of a person with a disability, sexual misconduct committed against, or in the presence of, a person with a disability, including grooming of the person for sexual activity;

8.9 (C) What to do in an Accident/Incident

Rationale

Knowing what to do when an accident occurs supports the staff in knowing how to proceed

Detailed Procedure

When an accident occurs employees must:

- Ensure the immediate safety of service users and other employees and render First Aid if required;

- Call 000 – if required (Police, Fire, Ambulance) – refer to WHS induction training;
- Immediately notify emergency contacts of a Severe or Major incident and if a client is injured;
- Mitigate any risks associated to other service users that could be impacted by the incident.
- Provide supportive conversations with the impacted person and gain as much information as possible
- Contact management and inform them of the incident
- Contact individuals emergency contacts if required.

8.9 (D) Recording and Reporting Incidents

Rational

Clear accurate accounts of incidents need to recorded and kept to improve accountability, promote transparent decision making and ensure best practice. Anyone can identify and report an incident and there are no negative consequences for doing so.

Detailed Procedure:
NDIS Incident Management requirements, for each incident, registered NDIS providers must record, at a minimum, the following details:

- a description of the incident, including the impact on, or harm caused to, any person with disability;
- whether the incident is a reportable incident;
- if known, the time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified;
- the names and contact details of the persons involved in the incident and any witnesses to it;
- the actions taken in response to the incident, including action taken to support or assist a person with disability impacted by an incident;
- if an investigation is undertaken by the provider in relation to the incident – the details and outcomes of the investigation; and
- the name, position and contact details of the person making the record of the incident
- any risk management strategies put in place and follow up actions

A Better Together staff member will;
Recording Process

- Report the incident to management as soon as practicable ideally within 2 hours of the incident via phone call to either the Manager, service delivery coordinator or compliance coordinator.
- Written Incident reports will be completed in flow logic under the name of the person who experienced the incident found under:correspondence and reports.
- Reports will be written as soon as practice and a max 24hrs.

- If a carer, family member or community member is reporting the incident to the organisation the person who the incident is being reported to will complete an incident report form for family, carers and or community member. And will be handed to the manager/assistant manager within the same timeframes for the same types of incidents.
- When recording the accounts of what happened the staff member filling the form must remember to keep the information factual, objective and give as much detail as possible before the incident (if relevant) and the incident.
- record what actions they took during the incident and who they informed and when.
- if possible collect information from other witnesses to the incident and their names and contact information in case a follow up is required.

Record Access

- All incident records are kept under the file of the service users or staff member who the incident was regarding. Access to completed reports is limited to delegated staff who are assessing and resolving incidents.
- Records of information relating to assessments and investigations will be kept in the files with the incidents and on a staff members file if pertinent

Correspondence relating to the assessment, or potential investigation, of an incident should also be documented and retained. This includes any statements, phone calls, dates, responses:

- For correspondence between Better Together, the service use or their family
- For correspondence from the subject of the allegation following the incident
- For records of correspondence between Better Together, the service user or advocates

8.9 (E) Initiating and Conducting Investigations

Rational

In some circumstances it may be necessary to conduct a more formal investigation to establish the cause of a particular incident, its effect and any operational issues that may have contributed to the incident occurring.

No further investigation Required

This may be appropriate where it can be clearly established that the report of the incident is inaccurate or there is no basis for concerns about the safety of the client or the quality of care the client is receiving. If the decision is not to undertake an investigation, the grounds for this decision must be supported and recorded with persuasive reasoning backed up by evidence.

Investigation:

The manager/assistant manager will;

An incident investigation is required when the incident is more serious and/or complex and management and subject matter experts need to be involved to provide their advice and expertise. Whether an investigation needs to be conducted will depend on factors such as:

- The nature of the incident and its impact

- The significance of the impact of the incident for the organisation and
- those involved
- The time that has lapsed since the incident
- The clarity regarding the facts and circumstances that led to the incident
- Whether the incident indicates the presence of systemic issues or patterns of conduct within the organisation.

At a minimum incident investigation will always be undertaken for actual or alleged:

- Physical abuse
- Sexual abuse
- Financial abuse
- Emotional/psychological abuse
- Injury – major unexplained injury e.g. requiring hospital cases if an investigation needs to occurs,

Internal investigation: Internal investigations may be undertaken where Better Together considers it has the capability to undertake the investigation required.

External investigation: An external investigation may be commissioned to ensure the investigation is robust, objective and expert. Better Together may commission an investigator, or a person from another organisation with relevant expertise.
Depending on the nature of the incident and the organisation, one of the following may be appropriate to conduct the investigation:

- An area of the organisation that is sufficiently independent from staff who are the subject of any allegations, such as another division or an independent investigative function
- An external investigative body.

An investigation involves the planned and systematic gathering and analysis of all relevant facts by interviewing witnesses, examining documentation, skilled observation and obtaining expert opinion where appropriate.

The outcome of an investigation may differ depending on whether an allegation has been made against a person and if so, whether that person is a staff member or another client.

Interaction with Police and Other Investigating Agencies
It may be necessary to refer the incident to another party for their own investigation. In particular, allegations of criminal conduct may be investigated by Police and allegations of breaches of professional standards may be investigated by professional standards bodies. Different investigations may have different processes and purposes. Multiple investigations may operate on different timeframes, including in parallel with one another. To the extent possible, investigations should avoid unnecessary duplication and overlap. Importantly, where Police decide to conduct an investigation, they may request the Better Together to put investigative processes on hold. Better Together should not interview staff or service users without direction from Police that it is safe to proceed, or without undertaking screening of the incident as described below

- The approach, process undertaken, findings and recommendations of the internal investigation will be documented in a way that is proportionate to the severity of the incident.

- If police are involved, an internal investigation should not commence until the police have completed their inquiries.

Principles in Undertaking and Investigation
The investigation should adopt a person-centred and rights-based approach (client focus), taking into account what is important to the client. Service users should be invited to participate in the investigation process and obtain the support they need to do so. The investigation must, however, remain impartial and independent at all times.

The investigation should abide by the standard principles of good investigations:

- Principles of procedural fairness – hear all parties involved in the incident, consider all relevant
- submissions, act fairly and without bias, and conduct the investigation without undue delay
- Confidentiality and privacy – keep information provided by a witness confidential (unless required to be disclosed by law, in which case the witness should be informed of the potential need to disclose), obtain consent from the person being interviewed to record the interview, provide people with the opportunity to review their statements, and check to make sure their statements are accurate
- Appropriate interview techniques to obtain objective and reliable evidence. Interviews should be professional, planned and sensitive to the interviewee
- Weighing the evidence according to how persuasive and probative it is
- Recording interviews and obtaining witness statements.

8.9 (F) Reportable Incidents

Rational
Some incidents require reporting to other authorities and regulatory bodies outside of Better Together. As a registered provider Better Together has legal requirements to notify the NDIS commission of certain incidents and keep them informed of any investigations or actions arising from the incident the NDIS commission will oversight Better Together's responses to reportable incidents

Detailed Procedure

Better Together will;

- Report reportable incidents to the NDIS Commission by the Better Together Manager within 24 hours of a provider's key personnel being made aware of it
- Provide a more detailed report about the incident and actions taken in response to it to be provided within 5 business days.

The report will assess:

- The impact on the NDIS participant
- Whether the incident could have been prevented
- How the incident was managed
- What, if any, changes are required to prevent similar events occurring

If a death has occurred or the incident has breached legal or human rights, the proper authorities will be advised (see Policy 9.0 Protection from Abuse, Neglect, Exploitation and Discrimination).

8.9 (G) Assessing, Preventing and Reviewing Incidents

Rational

Incidents need to be assessed to ensure the organizations is meeting our requirements with safety, training, education and management we also need to be actively. Assessing how an incident occurred and was handled is a risk management strategy and continuous improvement strategy.

Detailed Procedure;

Better Together Manager/Assistant Manager will assess all incidents to determine;

- Why the incident occurred
- Whether the incident could have been prevented
- How well the incident was managed and resolved
- Future prevention measure by adding improvement to the continuous improvement register
- Who else needs to be notified about the incident
- We will also look at the effect of the incident on the person with the disability and any operational issues that may have contributed to the incident occurring

- Review and audit the process from time to time (see policy service management risk management)
- review systemic issues in the WHS meeting mins with actions and improvements.

WHS Meeting incident Reviews;
Better Together WHS meetings the WHS team review all of our incidents (since the last meeting) by reading out each incident and actions/outcomes for each. The purpose of service users incident review is to foster continuous improvement to ensure that client safety and wellbeing are maintained, and that key learnings from client incidents are captured to prevent the same type of incident from happening again.

The purpose of an incident review is to answer the following questions:

- What are the key learnings from the incident? (trends in the volume and type of incidents – risk areas)
- Why did the incident happen (what might have caused it e.g. human, process and system errors), document lessons, and what can be changed to reduce the likelihood of similar or related incidents happening again? (Focus on continuous improvement)
- Did the service provider respond with appropriate actions to manage the incident? (Focus on quality assurance, accountability and client outcomes)

This reviewing process in our meetings assists us in identifying patters of behaviour or systemic issues that can be continuously improved. These identified issues and improvements are minutes in our WHS meetings which can include but not limited to;

1. Training and education of workers

2. Modification of the environment
3. Development or amendment of a policy or procedure
4. Changes in the way in which support or services are provided
5. Other practice improvements
6. Disciplinary action for the worker involved in the incident including ongoing performance reviews, imposing a probationary period, or termination of employment (see policy human resource management)

Related Policy and Procedure

Preventing and responding to Abuse, Neglect, exploitation and discrimination
Service management risk management
Human resource Management
Service management continuous improvement