carers link		Date	31.1.12	Policy Title	P002 - Incident Management Policy
		Date	27.04.22	NDIS Practice Standards	1 ,2, 3 & 4
		Date	29.04.22	Aged Care Quality Standards	8

1. PURPOSE

The purpose of this Policy is to provide guidance to staff on their legislative and procedural responsibilities in the management of incidents involving customers, staff and visitors.

Through understanding their responsibilities, staff ensure that our customers are appropriately supported and incidents are managed and documented within a continuous improvement framework.

2. SCOPE

This Policy and its procedures apply to all Carers Link staff and contractors, including Host Home contractors.

3. POLICY PRINCIPLES

The Carers Link incident management system aims to maximise the safety and wellbeing of its customers and staff and ensures Carers Link's handling of incidents is transparent and accountable.

Carers Link recognises that incident prevention and management is a key element of effective risk management, continuous improvement and the delivery of safe and quality care.

Carers Link complies with the regulatory and legislative requirements of state and Commonwealth authorities, including in relation to the reporting of critical and reportable incidents or dangerous workplace incidents.

3.1 CARERS LINK'S DOCUMENTED INCIDENT MANAGEMENT SYSTEM

PREVENTING INCIDENTS - RISK MANAGEMENT

P016 - Risk Management Policy
F015 – Risk Assessment Tool for Host Homes
F035 – Lifestyle Support Worker Initial Risk Assessment of a New Customer's Home Environment
F091 – Venue Risk Assessment
F093 – Individual Risk Assessment
F113 – Host Home Individual Risk Assessment
R012 – Risk Assessment Form Log – New Customers
R035 – Risk Register
CH028 – Risk Rating Table

MANAGING AND REPORTING INCIDENTS

P002 – Incident Management Policy
P052 – Covid-19 Emergency Management Procedure
F003C – Incident Reporting Form - Incidents involving customers
F003W –Incident Reporting Form - Incidents involving workers

MONITORING AND EVALUATING OUR RISK AND INCIDENT MANAGEMENT SYSTEM

P023 – Internal Audit Policy
T061 – Monthly Internal Audit reports
R001 – Corrective and Preventative Action Register
T081 - Measuring Quality Objectives Report - compiled for:

- Quarterly Executive Management Committee meetings
- Quarterly Continuous Quality Improvement Team (CQIT) reports & meetings

INFORMING STAFF AND CUSTOMERS ABOUT OUR INCIDENT MANAGEMENT SYSTEM

Staff

- Staff are advised at Induction and provided with a **M004** – Induction Manual as a reference.
- Copies of our Risk Management and Incident Management Policies are included in their **F075** – New Support Worker Folder

Customers

- Key policies, including our Risk Management and Incident Management Policies, are available on our website
- New customers are advised that they can access these policies online or request hard copy versions

4. DEFINITIONS

4.1 General Definitions relating to Incident Management

Dignity of Risk - The concept that all adults have the right to make decisions that affect their lives and to have those decisions respected, even if there is some risk, perceived or actual, to themselves.

Carers Link will not automatically dissuade a customer from following through on a decision on the basis that it *may* result in an incident. Risk assessment will be undertaken and safer alternatives offering a similar experience should be discussed with customers.

Dignity of risk involves maintaining a balance between respect for an individual's autonomy and the protection of their other rights (such as safety, shelter). The concept of dignity of risk does not include activities which are unlawful or would unreasonably impact on the rights of others. Carers Link staff should not encourage potentially dangerous or harmful activities which may result in an incident.

Incident - An incident is any unplanned event, act, omission or circumstance which causes, or which has the potential to cause unnecessary harm, loss or damage to a person.

Examples may include:

- An injury sustained by a customer or employee during the provision of a Carers Link support service
- A workplace accident involving a Carers Link employee
- An accident or near miss
- The wrong medication being taken by a customer
- An incident that prevented an activity from occurring e.g. car breaks down on the way to an appointment with a customer.

Certain types of incidents must be reported to external authorities, including those involving our customers with disability and employees who are injured are at work – (see Table at 5.1.1)

Incident Management System

The Aged Care Quality and Safety Commission provides a set of principles which should ensure an incident management system is effective – the principles state that the system should be:

1. Person-centred
2. Outcomes-focused
3. Open in disclosure
4. Accountable
5. Clear, simple and consistent
6. Timely
7. Driving continuous improvement

The NDIS Quality and Safeguards Commission states that an incident management system must:

1. Be documented, including in policies and procedures which indicate who is responsible for particular processes
2. Include procedures which indicate how incidents are identified, recorded and reported
3. Describe how the impacted person(s) will be supported to ensure their health, safety and wellbeing

4. Describe how the impacted person will be involved in the management and resolution of the incident
5. Provide details of any investigations conducted to establish the causes of a particular incident, its effect and any operational issues that may have contributed to the incident occurring
6. Describe whether corrective action is required and if so, the nature of that action.

Near Miss – An incident which did not result in harm or injury but had the potential to do so.

4.2 Regulatory Definitions relating to Incident Management

4.2.1 DEFINITION OF REPORTABLE INCIDENTS UNDER THE NDIS

As defined at Subsection 73Z (4) of the *NDIS Act 2013* reportable incidents are:

(a) The death of a person with disability ; or
(b) Serious injury of a person with disability ; or
(c) abuse or neglect of a person with disability; or
(d) unlawful sexual or physical contact with, or assault of, a person with disability ; or
(e) sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or
(f) the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.

In relation to (d), Section 16 (2) of the NDIS (Incident Management and Reportable Incidents) Rules 2018, allows that it is *not* a reportable incident if:

(a) the act is unlawful physical contact with a person with a disability: and
(b) the contact with, and impact on, the person with the disability is negligible.

4.2.2 Explanatory Information regarding the Definition of Reportable Incidents under the NDIS

- Section 17 of the NDIS (Incident Management and Reportable Incidents) Rules 2018 states that reportable incidents include ***alleged*** reportable incidents
- Reportable Incidents from an NDIS perspective only include incidents which negatively impact *customers with disability*. Incidents impacting staff and others which occurred as a result of a customer's actions must be recorded in our Incident Management System, but do not require reporting to the NDIS
- Incidents only have to be reported to the NDIS when they happen ***'in connection with the provision of supports or services'*** by Carers Link. So although an incident may involve one of our customers it may be unrelated to the provision of our support or services – for example, our customer might have a fall while visiting family on the weekend and suffer a serious injury – a reportable incident. While we may record this type of incident in our own system it does not require reporting to the NDIS.
- Records of reportable incidents must be kept for 7 years from the date of notification of the incident. (*Section 25 of the NDIS (Incident Management and Reportable Incidents) Rules 2018*

4.2.3 REPORTABLE INCIDENTS INVOLVING HOME CARE CUSTOMERS

Although section 54-3 of the *Aged Care Act 1997* sets out reportable incident obligations under the Aged Care *Serious Incident Response Scheme (SIRS*), these only apply to providers of residential aged care.

While there are no mandatory external incident reporting requirements in relation to Home Care customers, if a Carers Link staff member suspects incidents have occurred involving the abuse or neglect of a Home Care customer they are supporting, they should first discuss it discreetly with the customer. The customer should be advised about the *Reporting Elder Abuse in Qld* Hotline – 1300 651 192 if they wish to officially report incidents involving abuse / neglect themselves.

This conversation must be followed by a discussion with the Chief Services Executive during which the staff member's concerns and the customer's response will be considered. The suspicions and their investigation should be recorded in the customer's online file.

If on available information, the Chief Services Executive believes the customer's next of kin / carer may be abusing or neglecting them, other support services accessed by the customer can be contacted for their views.

If suspicions remain that the customer is being abused and / or neglected and the customer has not reported it, the Chief Services Executive should report the suspected abuse incidents to the Hotline.

The Chief Services Executive may also contact the Hotline for advice.

4.2.4 DEFINITION OF CRITICAL INCIDENTS INVOLVING CHILDREN AND YOUNG PEOPLE

The Qld Department of Children, Youth Justice and Multicultural Affairs defines two levels of critical incidents, with specified reporting timeframes for each level**. See Table at 5.1.1 for timeframes.**

LEVEL 1 CRITICAL INCIDENTS	
1.1 Death of a child or young person	• who was a child or young person known to Child Safety in the previous 12 months; or • where another client, foster or kinship carer or staff member is allegedly involved in the death; or • while attending or using department funded services*facilities or activities. ** Carers Link receives some Departmental funding for children and young people who are being cared for in Host Homes and who are known to Child Safety*
1.2 Life threatening injury to a child or young person	• where another child or young person who is a client, foster or kinship carer or staff member is allegedly involved in the injury; or • while attending or using departmental funded services, facilities or activities
1.3 Serious injury to a child or young person	• when a child or young person, currently known to Child Safety or known to Child Safety in the previous 12 months, is believed

that results in hospitalisation	to have an injury that meets the definition of physical abuse under the *Child Protection Act 1999*
1.4 Abduction	• abduction of a child or young person subject to departmental intervention from their carer/service provider
1.5 Alleged rape, sexual assault or serious assault of a child under 14 years	• with a disability while attending or using departmentally provided or funded services, facilities or activities; or • of or by a child or young person subject to departmental intervention; or

LEVEL 2 CRITICAL INCIDENTS	
2.3 Attempted suicide	• of a child or young person in care
2.4 Missing Child	• any child whose location is unknown and there are fears for the safety or concern for the welfare of that child

5. PROCEDURES

5.1 REPORTING INCIDENTS

Reporting certain incidents to Police or the Coroner

NDIS reporting requirements do not replace the need to also report certain events to the police or the Coroner – e.g. the death or sexual / physical assault of a customer – see Table at 5.1.1 below.

5.1.1 Carers Link Workforce Incident Reporting Responsibilities and Timetable

Report what	Report when	Report to	Carers Link Staff Member responsible for reporting incident
All incidents to be verbally reported.	Immediately	Chief Services Executive	Lifestyle Support Worker/ Cashmere House Supervisor
An incident in writing by using the Forms F003W Incident Report Form-Worker or F003C Incident Report Form-Customer	Within 24 hours of incident	Chief Services Executive	Lifestyle Support Worker / Cashmere House Supervisor
Any incident	Same day	Guardian / Carer	Lifestyle Planning & Support Coordinator / Cashmere House Supervisor (delegated by Chief Services Executive)

Report what	Report when	Report to	Carers Link Staff Member responsible for reporting incident
Any serious incident	Immediately	Guardian / Carer / Next of Kin / Service provider contracting Carers Link to provide a service	Chief Services Executive
Any alleged criminal acts	Immediately	Police / Commercial Manager	Chief Services Executive
All critical / reportable incidents, all incidents with a high risk rating and all incidents that resulted in injury	Immediately	Notify Director / Commercial Manager	Chief Services Executive
Reportable Incident: Death of a person with disability receiving supports /services from Carers Link (this is separate to a Death in Care. Reporting requirements for these deaths are included later in table)	Within 24 hours	NDIS Commission	Chief Services Executive
Reportable Incident: Serious injury of a person with disability	Within 24 hours ***See end of table for NDIS reporting forms***	NDIS Commission	Chief Services Executive
Reportable Incident Abuse or neglect of a person with disability	Within 24 hours ***See end of table for NDIS reporting forms***	NDIS Commission	Chief Services Executive
Reportable Incident Unlawful sexual or physical contact with, or assault of, a person with disability	Within 24 hours ***See end of table for NDIS reporting forms***	NDIS Commission	Chief Services Executive
Reportable Incident Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	Within 24 hours ***See end of table for NDIS reporting forms***	NDIS Commission	Chief Services Executive

Report what	Report when	Report to	Carers Link Staff Member responsible for reporting incident
Reportable Incident in relation to a person with disability, the use of an *unauthorised* restrictive practice / and /or a restrictive practice which is not in accordance with a behaviour support plan	*If there was harm to the person with disability,* within 24 hours. Otherwise, notification is required within 5 business days ***See end of table for NDIS reporting forms***	NDIS Commission	Chief Services Executive
Level 1 Critical Incidents involving children and young people with disability known to Child Safety	* Verbal notification immediately to Child Safety Officer responsible for the child or young person & Police in the case of abduction. * The timing of notification to next of kin is more likely to be a decision for Child Safety – advise them that Carers Link has not done so. Child Safety may request an incident report (our form +/- their form).	Child Safety Officer / Police in the case of abduction. Child Safety may prefer to notify Police in cases of alleged rape, sexual assault or serious assault.	Chief Services Executive

Report what	Report when	Report to	Carers Link Staff Member responsible for reporting incident
Level 2 Critical Incidents involving children and young people with disability known to Child Safety	* Immediate verbal notification to Child Safety Officer responsible for the child or young person, & Police in the case of a missing child. * The timing of notification to next of kin is more likely to be a decision for Child Safety – advise them that Carers Link has not done so. Child Safety may request an incident report (our form +/- their form).	Child Safety Officer / Police in the case of a missing child.	Chief Services Executive
Death in Care (that is, death of a person with a disability who received funded accommodation or respite support). 'Person' includes children and young people with disability	***Immediately*** in terms of Police or Coroner, ***within 4 hours*** of the CSE being notified in terms of advising the young person's Child Safety Officer. ***Within 24 hrs*** in the case of the NDIS Commission.	Police or Coroner. NDIS Quality and Safeguards Commission and Qld Dept of Child Safety, Youth and Women if a child or young person known to Child Safety and supported by Carers Link dies	Chief Services Executive
Death of a Home Care customer discovered by Home Care support worker or while support worker present	Immediately that notification is received from the support worker.	Police or Coroner / Next of Kin **NOTE:** There are no *mandatory* incident reporting requirements relating to Home Care customers	Chief Services Executive

Report what	Report when	Report to	Carers Link Staff Member responsible for reporting incident
Any incident that arises out of the conduct of a Carers Link business or undertaking that results in the death, serious injury or serious illness of a person or involves a dangerous incident	Immediately Carers Link becomes aware of the incident.	Workplace Health and Safety Queensland	Chief Services Executive
Any injuries sustained by an employee which may lead to a compensation claim	Immediately Carers Link becomes aware of the incident. It is an offence if Carers Link does not advise Work Cover within 8 business days of becoming aware of an employee's work related injury which may result in a workers' compensation claim.	WorkCover Queensland	Chief Services Executive
Details of incident in the R001-Corrective and Preventative Actions Register	Within 24 hours.	Management	Chief Services Executive or delegate
Trends/ outstanding incident issues in R001 Register	Next CQIT meeting.	Continuous Quality Improvement Team (CQIT)	Chief Service Services Executive / Quality Officer
Quarterly on incident issues, trends and strategic remedial actions	Quarterly CQIT and EMC meetings	CQIT group and Executive Management Committee	Chief Services Executive / Quality Officer

5.1.2 NDIS Commission Reporting forms

The immediate notification and 5 business day notification forms for reporting to the NDIS Quality and Safeguards Commission are available at:
https://www.ndiscommission.gov.au/providers/reportable-incidents

Completed forms can be emailed directly to the NDIS Commission at:
reportableincidents@ndiscommission.gov.au or uploaded to the NDIS Commission providers' Portal.

5.1.3 REPORTING A DEATH IN CARE

If a person who has died had a disability, their death is considered to be a ***death in care*** if the person received accommodation or respite support delivered by a funded service provider (such as Carers Link).

Carers Link must always immediately report a death in care to the Police or the Coroner, even if:

- the customer died somewhere other than where they ordinarily lived, or where they received respite support (even if it is in a hospital)
- you think the customer died of natural causes.

Although it may seem unnecessary to report a death when it is known that someone else has already done so or will report the death (for example if a customer dies in hospital of natural causes and the nurse may say they will arrange for it to be reported), it is best practice for Carers Link to report the death to the Police or the Coroner in **every case.**

To clarify, if the customer has received accommodation or respite support from Carers Link, the reporting obligation applies irrespective of:

- whether or not the customer was receiving accommodation or respite support at the time of death
- the amount/level of accommodation or respite support the customer was receiving at the time of death
- where the customer was at the time of death.

When reporting to the Coroner, Carers Link should email Coroner Brisbane at

(State.Coroner@justice.qld.gov.au) with the:

- time and place of death
- background to the incident that led to hospitalisation
- if any Carers Link employees were present at incident
- funded supports that were provided to the person
- confirmation that Carers Link was **OR** was not providing support at time of death
- and if any Carers Link employees were present at the death of the person (rostered on or not).

5.1.4 ENSURING IMMEDIATE SAFETY DURING AND IMMEDIATELY AFTER AN INCIDENT

- Supervising staff should ensure the safety of themselves and customers / colleagues immediately following an incident
- Call '000' if someone needs *urgent* medical care or there is ongoing danger and / or an immediate risk of harm to anyone
- Any Carers Link customers involved in or witness to a distressing incident should be provided with comfort and reassurance at the scene
- Apply first aid if required
- Clear any hazard area
- Call doctor or ambulance if required
- Advise the Chief Services Executive immediately.

Identifying and responding to incidents: 6 step guide for workers

It is your responsibility to prevent, respond to, and report incidents that may occur when providing supports or services to people with disability.

1 Identify, prevent and mitigate

- You must take all reasonable steps to prevent all forms of harm.
- If you identify any risks of harm to people with disability talk to your employer.
- Ask your manager or supervisor if you are unsure about how to identify, reduce, and prevent risks to people with disability

When an incident does occur

2 Ensure immediate safety

- Call '000' if someone needs urgent medical care and/or if there is an immediate and serious risk of harm to you or others.
- Make sure you and the people around you are safe from harm.
- Notify your manager or supervisor.
- Follow your incident management procedures.

3 Respond to a disclosure

Sometimes you will not see an incident, but a person with disability will tell you ('make a disclosure') about it. In these circumstances:

- record and report this information as per your incident management procedures and tell your supervisor or manager as soon as possible
- reassure and support the person with disability by staying calm and explaining what will happen next
- listen to the person, writing down the details using their exact words. If you need more information to form a general understanding of the allegation, ask open questions, and avoid leading questions
- tell the person with disability that you have to report the incident.

4 Protect evidence

If it is your job to gather the initial information about a reportable incident, you must protect any evidence. For example, depending on the incident:

- do not disturb any evidence that may be required for an investigation
- if there is an alleged sexual assault, try to delay the victim bathing or showering until police arrive
- do not wash the person's clothing or bedlinen, but keep these things safe.

5 Record and report

If you become aware of a reportable incident you must notify your manager or supervisor as soon as possible. Do not rely on someone else to do this. Follow your workplace incident management procedures, including:

- record what you have seen and heard, including the details of any witnesses
- give your manager or supervisor any notes you have taken
- do not interview the person who is allegedly responsible for the incident.

6 Report to Police

Any allegation of a criminal offence against a person with disability must be reported to the police. Follow your incident management procedures, and:

- if appropriate, report the alleged offence as soon as possible
- tell the police that the impacted person is a vulnerable person and let them know if they will need communication aides or other supports
- support the person with disability when they are dealing with the police so that their wishes are made known.

NDIS providers must notify the NDIS Commission about a reportable incident that occurs, or is alleged to have occurred,in connection with the NDIS supports or services you deliver.

Reportable incidents are:

- The death of a person with disability
- Serious injury of a person with disability
- Abuse or neglect of a person with disability
- Unlawful sexual or physical contact with, or assault of, a person with disability
- Sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity
- Unauthorised use of restrictive practices in relation to a person with disability.

NDIS Quality and Safeguards Commission

Contact Us | Call: 1800 035 544 (free call from landlines).
Our contact centre is open 9.00am to 4.30pm in the NT, 9.00am to 5.00pm in the ACT, NSW, QLD, SA, TAS and VIC Monday to Friday, excluding public holidays.
Email: reportableincidents@ndiscommission.gov.au | **Website:** www.ndiscommission.gov.au

Responding to incidents at your service (who to contact, etc):

5.2 COMPLETING A WRITTEN INTERNAL INCIDENT REPORT

Staff are required to complete a Carers Link Incident Report Form (F003C) or Incident Report Form (F003W) - and possibly an external agency's incident report if applicable. The staff member making the report should:

- do so immediately while events are fresh in their memory. If there is no immediate access to the form details should be written or typed immediately onto plain paper and copied over to the form as soon as possible
- keep the report factual - do not provide a personal interpretation of why something may have happened - just explain what you witnessed
- describe factually any events/ activities that were happening at the time or in the lead up to the incident
- sign and date the report
- attach another staff member's report if further information is required
- verbally notify your supervisor / the Chief Services Executive that the report has been made and
- ensure the relevant sections of the Incident Report Form are completed by the Chief Services Executive, who then reports back either verbally or in writing (depending on severity) to parties involved with the incident.

5.3 COMPLETING A WRITTEN MEDICATION INCIDENT REPORT

An incident may involve issues relating to a customer's medication and if this is the case, the Medication Incident Report Form F046 must be completed. Initial input to the form is provided by the Support Worker, followed by Incident Analysis Conclusions and recommended actions by the Chief Services Executive.

NOTE: If somebody was injured or adversely affected as a result of the medication incident, a standard Incident Report (F003C or F003W) will also need to be completed.

5.4 LOGGING INCIDENTS IN THE CORRECTIVE & PREVENTATIVE ACTIONS REGISTER

Once details of an incident are submitted, the Chief Services Executive or their delegate must allocate an incident code (beginning with the letter I (for Incident) and numbered following on from the last report logged in the R001 Register e.g. I026). This code should be recorded on the Incident Report Form.

The incident must then be written up by the Chief Services Executive or delegate under the 'Incidents' tab in the R001 Corrective and Preventative Actions Register, including the allocation of an appropriate risk rating utilising the categories set out in the table below – low risk, medium risk, high risk or extreme risk. When writing up the incident any actions taken should be recorded, including any further preventative action required.

5.5 RISK RATINGS TABLE

RISK RATING	TYPES OF INCIDENTS
LOW	• **One-off** incident - not recurring • Incidents where nobody **was or was potentially** physically or psychologically harmed • Any **injuries / illnesses which were very minor** – band aid or Panadol was enough to remedy • There was **no significant damage to property** e.g. perhaps a glass was broken when it slipped out of somebody's hand or a window was broken by a badly aimed cricket ball
MEDIUM	• A **one-off incident** which identified **an ongoing hazard needing urgent remedy** – client injured by incident with wheelchair needing repair / broken shower chair • A **recurring incident** involving the same client or the same LSW (even if at the lower end of seriousness). Needs closer monitoring and better management • An **illness** which may have required medical attention / hospitalisation but was not life threatening • **Accident resulting in an injury which did not require medical attention / hospitalisation**– client may slip in the shower and bruise their arm against the glass screen; a worker might trip a client up because they hadn't been watching where they were walking; a client might accidentally bruise an LSW's leg while practising with a cricket bat; client might accidentally run over an LSW's foot with their wheelchair; or hit a worker's face with their arm when they had an involuntary spasm; • **Deliberate acts of aggression** which did **not** result in an injury requiring medical attention / hospitalisation • **An incident involving psychological trauma** which was dealt with effectively through comforting / counselling & was not ongoing
HIGH	• Would **potentially** have required an extreme rating if intervention had not occurred – that is an Incident so serious it had the potential to result in death / serious injury /serious injury requiring hospitalisation / abuse or neglect etc
EXTREME	**1. Reportable Incidents under the NDIS** Note: Incidents are reportable under the NDIS even if they are only being alleged • Death of a person with disability • Serious injury of a person with disability • Abuse or neglect of a person with disability • Unlawful sexual or physical contact with, or assault of, a person with disability; or • Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or

RISK RATING	TYPES OF INCIDENTS
EXTREME (cont.)	• The use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person. Under the NDIS Act 2013 it is not necessary to report unlawful physical contact with a person with disability if the contact with / impact on, the person with the disability **is negligible**. Given the difficulty of assessing the level of impact on a customer, Carers Link should report all incidents involving unlawful physical contact with a person with disability. **2. Critical Incidents** Any incident which qualifies as **critical** by the Qld Department of Child Safety, Youth and Women – i.e. • Involving Death; • Life threatening injuries; • Serious injury resulting in hospitalisation; • abduction; • Alleged rape, sexual assault or serious assault of a child under 14; • attempted suicide of a child or young person in care; • missing child whose location is unknown & there are fears for their safety or welfare.

5.6 TIMEFRAMES FOR RESOLVING / CLOSING OUT INCIDENTS

None of the timeframes below alter the requirement for the CSE to be notified immediately when an incident occurs.

LOW Within 5 business days

MEDIUM Within 48 hours

HIGH Immediately / within 24 hours depending on the severity

EXTREME Whatever the NDIS Commission or Department of Child Safety etc stipulate – ranges from immediate notification to police and coroner to within 24 hours to notify a reportable incident. See table at 5.1.1 of this Policy.

5.7 SAVING INCIDENT RECORDS

All incident forms including attachments need to be saved in V:\inhouse documents\Carers link docs\Business Management System\Risk Management & Corrective Actions\Incidents file:

- Where the incident is still under investigation it should be saved in the *Open for Investigation* folder.
- Where an incident has been addressed and closed out in the R001 Register and signed off by the supervisor it can be saved in to the *Closed Out* folder
- Once the incident has been closed out, a copy should be placed on the client's electronic file under 'Incidents'
- The supervisor will ensure that only one version of the Incident Report is saved on the system and that it is the registered version signed off by the Chief Services Executive.

5.8 INCIDENTS RESULTING IN COMPLAINTS

If an incident results in a complaint being lodged, the complaint should be handled in a respectful, responsive and timely manner. The response to any complaints will rely heavily on the details contained in the Incident Reports and this emphasises the need for accurate, complete documenting of incidents.

For guidance on dealing with complaints made to Carers Link, please see P003 *Complaints and Feedback Policy.*

5.9 CASHMERE HOUSE INCIDENTS

- Incidents that occur at Cashmere House, including those involving Cashmere residents, should be recorded as per 5.2
- The incident forms are to be saved in V:\inhouse documents\Carers link docs\Business Management System\Cashmere House Directory\Incident Reports in the 'Open for Investigation' Folder – the House Supervisor should insert links before forwarding them on to the Chief Services Executive
- Once the incident has been addressed and signed off by the Chief Services Executive, the House Supervisor should :
  - Replace the original incident report saved in V:\inhouse documents\Carers Link docs\Business Management System\Cashmere House Directory\INCIDENT REPORTS in *the Open for Investigation Folder* with the registered, completed incident report (including any attachments)
  - Move the Incident Report to the 'Closed Out' folder
  - Place a copy of the Incident Report on the individual resident's file

- If an incident occurs at Cashmere House which has had a negative impact on a resident's emotional health, an early appointment with their GP or psychiatrist should be organised by the House Supervisor, in addition to the notification to their guardian / next of kin by the Chief Services Executive

  Discussions will be held with residents(s) involved in the incident about future strategies and more effective ways of managing the particular situation which led to the incident. The resident(s) should be encouraged to be positive contributors to 'brainstorming' solutions.

6. EVALUATION AND CONTINUOUS IMPROVEMENT

Incident reporting provides opportunities to make positive changes to the way we provide our services and inform the continuous improvement cycle at Carers Link:

- Incidents will be reported by the Chief Services Executive at the next CQIT and EMC meetings following the incident.
- Incidents will be assessed for the likelihood of recurrence
- Consideration of whether new training or re-training of employees and contractors needs to be provided.
- Lifestyle Planning and Support Coordinators must ensure that customers with disability / Home Care customers involved in an incident participate in the development of strategies to avoid a repeat of the incident
- Are any updates required to Carers Link Policies and Procedures, to better inform staff about managing the risk of incidents?
- Discussions should be held about whether changes to the environment in which supports or services are provided would prevent a recurrence of particular incidents
- Changing the way supports and services are provided may be necessary
- A summary report on improvements, trends and concerns should be reported by the Chief Services Executive and the Quality Officer to management at EMC meetings
- Incidents will be monitored and closed out through the R001 Corrective and Preventative Actions Register
- The R001 register and Chief Services Executive CQIT & EMC reports will form part of the annual management review. For more information on using the R001 Register see the P010 – *Quality Policy.*

7. REFERENCES

https://www.legislation.gov.au/Details/F2018L01837Aged Care Quality and Safety Commission Rules 2018
NDIS Factsheet Incident Reporting, Management and Prevention
Reporting Child Abuse (Child Safety Website)
Workplace Health and Safety Queensland Incident Reporting
F003C - Incident report form for incidents affecting customers
F003W-Incident report form for incidents affecting workers
F046 – Medication Incident report form
P001 – Abuse, Neglect and Exploitation Policy and Procedure
P016 – Risk Management Policy and Procedure
P027- Workplace Health and Safety Policy and Procedure
P031 – Reporting Missing or Absent Children
P052 – Covid19 Emergency Management Procedure

8. LEGISLATION

Aged Care Act 1997 (C'wlth)
Aged Care Quality and Safety Commission Act 2018 (C'wlth)
Child Protection Act 1999 (Qld)
Disability Services Act 2006 (Qld)
Disability Services Regulation 2017 (Qld)
Human Rights Act 2019 (Qld)
NDIS Act 2013 (C'wlth)
NDIS (Incident Management and Reportable Incidents) Rules 2018
Work Health and Safety Act 2011 (Qld)
Work Health and Safety Regulations 2011 (Qld)