Death Screening Policy and Procedure

Whiddon

Document Control

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Document Review

Date	Description of review	Initiated by	Version
19/05/2020	Transfer of policy from clinical positions statement to policy and procedure methodology	GMC&R	0.2
22/05/2020	Updates post consultation, additional detail of process, definition expanded.	GMC&R	1.1
3/06/2020	Revised sac matrix to clinical sac matrix. Hospital and community care added to application. QCCT oversee	GMC&R	2.0
16/06/20	Review by GMQCC	GMC&R	2.1
24-28/06/21	Review against Serious Incident Response Scheme (SIRS) and National Disability Insurance Scheme (NDIS) reporting requirements . Review by COO - Remove Community Care from Death Screen policy - Critical incident investigation instead. Approval of policy for re release	GMC&R/ DCEO	3.0
July 2024	VAD screening added. Time based review Definition update	GMCR&C	3.1
Nov 24	NDIS inclusion	GMCR&C	0.2

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Introduction

In the first national comprehensive Coronial study in Australian RACS looking into premature and potentially preventable deaths of residents. Deaths – from falls, choking, suicide and homicide – accounted for almost 3,300 deaths of residents. The study used coronial data to review the deaths by external (also known as injury-related) causes of all residents between 2000 and 2013. The study found that of the 21,672 deaths of nursing home residents reported to the Coroners' Court during the 13-year period, 3,289, or 15.2 %, were from external or preventable causes, almost all unintentional.[1]

Unintentional deaths: four (4) out of five (5) of those who died from external causes died from falls which was (81.5 %), and one (1) in twelve (12) died of choking (7.9 %). Complications of clinical care accounted for (1.2%) of these deaths. intentional Deaths: almost one in 18 people who died from preventable causes in aged care facilities were either from suicide (4.4 %) and resident-to-resident assault accounted for (1.0 %).[2]

Whiddon is committed to the screening of death events to inform and improve the quality of care to prevent potentially premature deaths and further, to improve the palliative pathway for residents.

In 2020 the Australian Department of Health published the Serious Incident Response Scheme requires Unexpected Deaths *"where poor quality clinical care is provided to a consumer resulting in their death, or where the actions of a consumer result in the death of another consumer"* .to be reported as a Priority 1 reportable events[3]

Unexpected death Subsection 15NA(8) of the Quality of Care Principles expands on the meaning of unexpected death of a consumer to provide that this includes death in circumstances where:

- Reasonable steps were not taken by the provider to prevent the death
- The death is the result of care or services provided by the provider or a failure by the provider to provide care and services. Providers are required to notify any death where the provider, including staff and health professionals engaged by the provider:
- Appropriate steps to prevent or mitigate an incident which resulted in the death of a consumer were not taken
- Appropriate action to assess and treat a consumer following an incident were not taken and the consumer died as a result of injuries related to the incident

[1] Premature deaths of nursing home residents: an epidemiological analysis Joseph E Ibrahim1 , Lyndal Bugeja1 , Melissa Willoughby1 , Marde Bevan1 , Chebiwot Kipsaina1 , Carmel Young1 , Tony Pham1 , David L Ranson. MJA online June 2017 accessed 26.11.2024 https://www.mja.com.au/journal/2017/206/10/premature-deaths-nursing-home-residents-epidemiological-analysis

[2] ibid

[3] Australian Government Aged Care Quality & Safety Commission Serious Incident Response Scheme Guidelines for residential aged care providers. Serious Incident Response Scheme – Guidelines for residential aged care providers | Aged Care Quality and Safety Commission accessed 26.11.24

- There was (or reasonably should have been) awareness of a consumer's condition and adequate steps to assess and treat the consumer were not taken
- A clinical mistake(s) occurred resulting in death
- The service did not deliver care and services in line with a consumer's assessed care needs or provided clinical care and services that were poorly managed or not in line with best practice, resulting in death.

and

- The death of a person receiving care under the National Disability Insurance Scheme

A death may occur immediately, or some time, after a 'mistake' was made or a 'failure' or incident occurred. Where the death could reasonably be considered to be related to a mistake, failure or incident, the obligation to notify the Commission is in addition to notifying the coroner in accordance with state/territory requirements and this applies even where a coroner has not yet determined the cause of death, or where the provider is advised of such a death which may not have occurred at the service.

You are not required to report all deaths where the cause of death is yet to be confirmed, only those that could reasonably be considered to be related to a mistake, failure, or incident.

If the cause of death does not include circumstances mentioned under section 15NA(8) of the Quality of Care Principles, you are not required to notify the Commission of the unexpected death.

All unexpected death reportable incidents are considered Priority 1 reportable incidents for the purposes of notifying the Commission.

Public reporting of SIRS information began in 2021 and will be expanded in coming months it is intended to increase transparency and information to the sector and consumers on performance.

Reporting will be informative and include quantitative and qualitative analysis and help the sector, policy makers and regulators understand current trends and emerging issues.

Information publicly reported on the operation of the SIRS may include annual and trend reporting on information on unexpected deaths :

The death of a person covered by the NDIS must be reported to the NDIS Quality and Safeguards Commission

Application of Policy

This Policy extends to all resident service areas, operations, and functions of Whiddon, and is expected to be followed by all senior clinicians and related key personnel.

A Death Screen must be undertaken for all permanent & respite residential deaths including deaths that occur in a hospital setting.

Death screening outcomes should be reported to the Quality Care and Compliance Team via the Clinical Governance Committee in general.

This policy applies to consumers in Residential Care and Community Care funded by the Department of Health and Aged Care and the National Disability Insurance Scheme (NDIS) .

To maintain clarity and consistency throughout the policy, the terms "consumers," "residents," "clients," "elders," and "NDIS participants" will collectively be referred to as "consumers," all such references encompass these groups equally.

Definition

Death Screening is a process where the circumstances of a consumer's death and events leading to a death in a service are systematically examined with the aim of identifying opportunities for improvement in the management of deaths and includes deaths occurring in hospital.

While most deaths are expected and unavoidable, some are not. It is therefore important that all deaths are reviewed, with lessons learned and shared to improve care and avoid untimely death. The screening process is designed to identify if a consumer suffered harm leading into the death and whether the death was associated with an intervention or incident.

Policy statement

Resident Death Screening is intended to ensure a comprehensive screening process of **all** resident deaths occurs within five (5) working days of the event, to facilitate identification and referral of cases requiring further/in-depth review.

All Whiddon residential care services will screen all resident deaths within five (5) working days of the event to identify cases that require further review by Critical Incident Investigation, or other mechanism as directed by the Executive and or Quality Care and Compliance team.

The screening process will be undertaken by a senior Registered Nurse or other suitably qualified person, who is assigned by the Director Care Services. They will conduct the screening using the resident Death Screening Tool within the eQstats Compliance and Governance Risk Management System .

The death is documented at the time of death on a Resident Incident form in AutumnCare which transfers to eQstats. The AutumnCare form must be used as eQstats facilitates the linkage of previous incident forms when this method of lodgement is used.

If a death is the result of misadventure or the result of a criminal act or suspicious this must be escalated to the DCEO immediately. The DCEO will notify the CEO.

Unexpected Deaths as defined by the Australian Government Department of Health Serious Incident Response Scheme for Commonwealth funded residential aged care and the death of a resident receiving care under the National Disability Insurance Scheme are treated as an unexpected death and will be reported as required to the relevant Department and within Whiddon Reporting requirements in eQstats

Unexpected deaths are a 'Death that is unexpected, where steps may not have been taken to prevent the death, or the death results from an intervention'[4].

The DCEO must also be notified for any death that:

- Meets the criteria for referral to the NSW or QLD Coroner outlined in NSW Department of Health Policy Directive 2010_054: Coroner's Cases, and the Coroners Act NSW 2009 and Queensland 2003.
- Any matters arising from screening or review of a resident death that relate to an event reportable under The Aged Care Quality and Safety Commission Serious

4 ibid

Incident Response Scheme(SIRS) and the National Disability Insurance Scheme(NDIS) Incident Reporting requirements.

- circumstances where the death could reasonably be considered to be related to a mistake, failure, or incident.
- Mandatory reporting of a clinician where it is identified that there may be significant performance or other matters, as required by their professional registration body.
- Suspected criminal activity of any type is identified in the course of screening or review.
- Death from an adverse event related to health care or service provision.
- The death of a resident receiving care under the National Disability Insurance Scheme

Death screen reviews will be conducted by the Quality Care and Compliance team as part of the quality review process and as required according to severity assessment

Death Screening Quick Snapshot

The screening process uses standardised questioning against known risk factors coupled with a Clinical Severity Assessment Classification/ Code (SAC) Matrix .

Death Screening follows a standardised screening process recommended by the Clinical Excellence Commission and Monash University against known Aged Care risk factors and the requirements of the Coroners notification.

The death is recorded in AutumnCare on the Resident Incident Form, the death is then screened and documented in Step 8 of eQstats Governance Risk Management and Compliance Advanced Incident Reporting Module.

Opportunities for improvement are addressed and acted on.

Deaths are assigned a Clinical Severity Assessment Code (SAC) rating according to predetermined definitions agreed by the Clinical Governance Committee which is detailed in Appendix 1 of this document.

Deaths in residential care are screened including deaths that occur in hospital from within Residential Care.

Deaths are screened initially at a service level by the senior clinician and are screened at a Governance level by the Quality Care and Compliance Team

External reporting to regulatory bodies does not preclude / rule out a death from being screened

Death Screen Process Overview

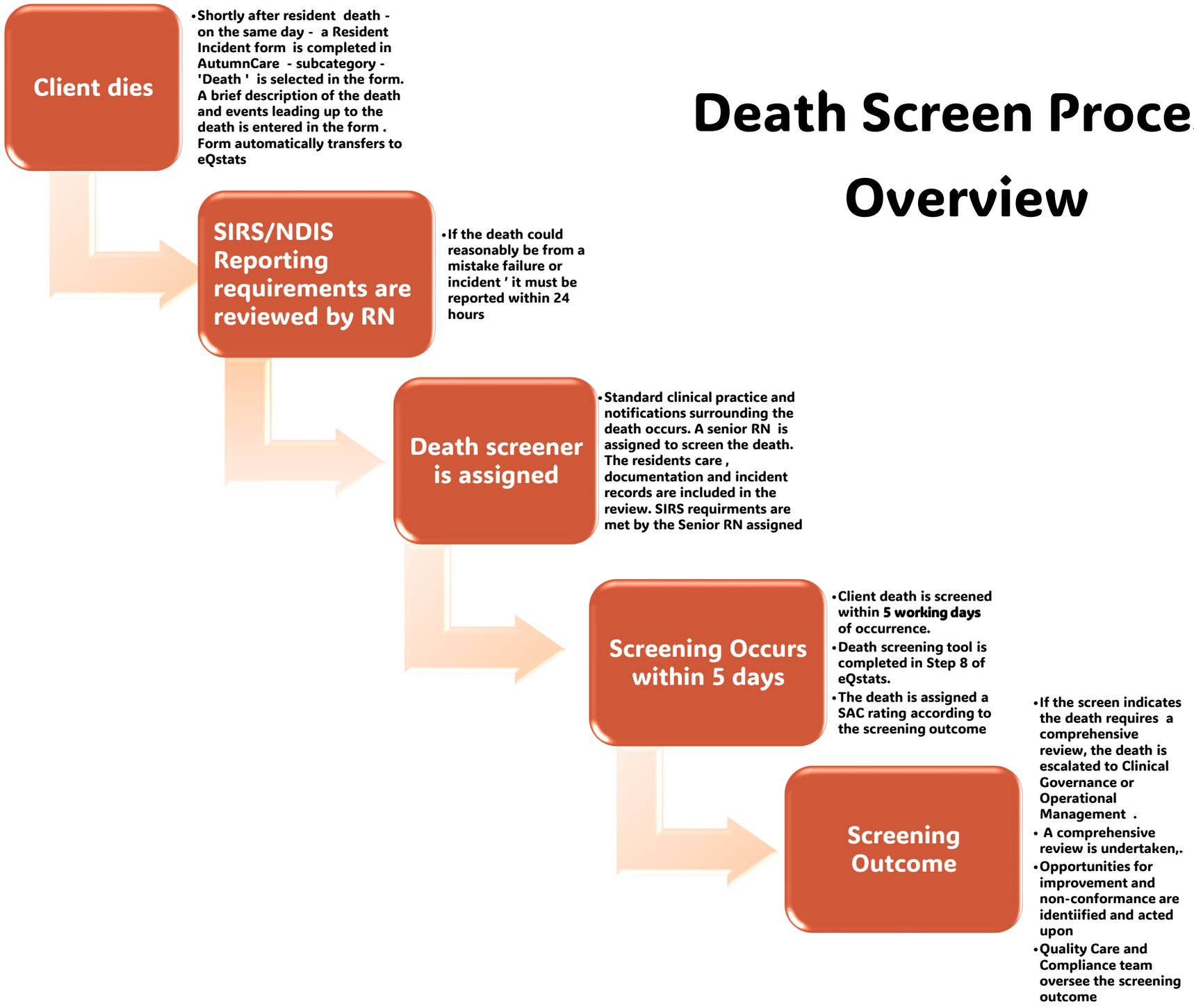

Figure 1 Death Screening Process Overview

Recording the death

The Resident's death is recorded via the AutumnCare - incident Form – Resident (eQstats) *See Figure 2 below* on the day of the resident's death or as soon as the death becomes known if the death occurs external to the service.

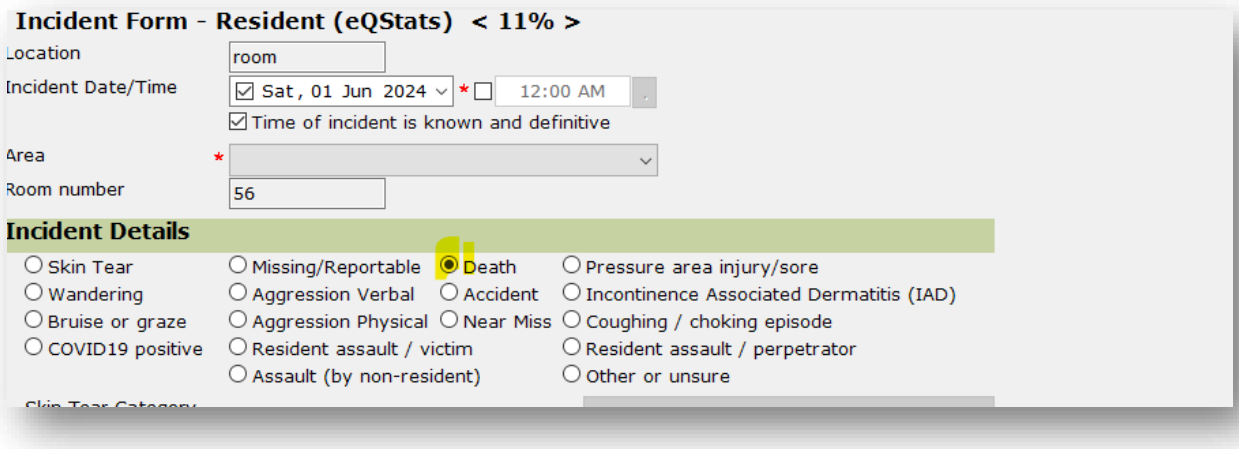

Figure 2 Incident Form - AutumnCare

1. The reporting requirements of the Serious Incident Response Scheme (SIRS) are reviewed with specific reference to Unexpected Death definition by the senior RN on duty.
   - Death "where poor quality clinical care is provided to a consumer resulting in their death, or where the actions of a consumer result in the death of another consumer"5
   - Death resulting from - examples include (but are not limited to) (extracted from DoH SIRS document)
     - A consumer falls while being moved or shifted, with the injuries sustained resulting in the consumer's death.
     - Untreated pressure injury left untreated that becomes infected, and appropriate medical assessment/treatment was delayed or not given resulting in the consumer's death.
     - A fall results in an unexpected death.
     - Where the actions of a consumer result in the death of another consumer, such as from an assault.
2. A brief overview of the death is recorded and any circumstances impacting the death are recorded in the AutumnCare Resident Incident Form relevant fields.
3. Notifications to the Residential Services Manager (RSM) and or Regional Manager are made if the death fits within the definition of the SIRS the definition.

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[5] Australian Government Aged Care Quality & Safety Commission Serious Incident Response Scheme Guidance June 2021 https://www.agedcarequality.gov.au/sirs#guidance%20material%20for%20aged%20care%20providers accessed 24.06.21

4. The required information is lodged the department via the SIRS / NDIS Portal
5. The AutumnCare form transfers to eQstats via the automated interface
6. The death is processed via eQstats through the Advanced Incident Management Module.
7. The required department notification number is recorded in Step 1 as an external identifier and other addendum forms are attached in step 7 of the eQstats incident.
8. Once the event has been acknowledged in eQstats the death becomes part of the register of deaths for the service and the register of reportable events if reportable
9. A SAC rating is assigned according to the Whiddon SIRS/ NDIS SAC Matrix (Appendix 1) and lodged by completing the pop-up questions in eQstats Step 7; The pop-up questions to rate the SAC are a guide to assist the severity rating and are not part of the incident. The actual risk and potential risk are given a SAC rating (Figure 3)

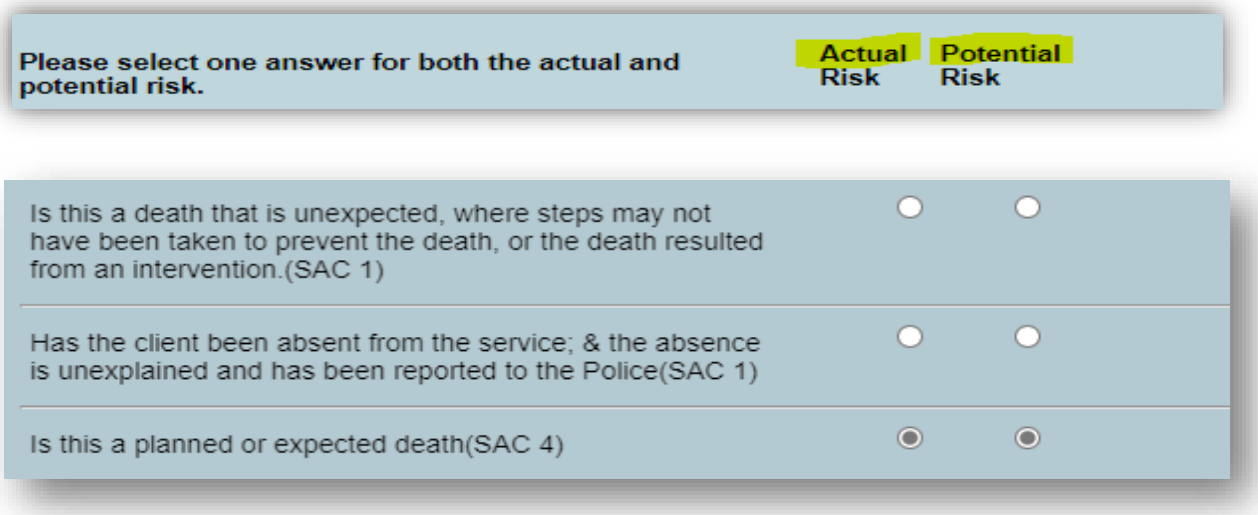

Figure 3 showing actual and potential risk - Step 7 eQstats pop up form.

Note - All SAC 1 events are required to be accompanied by a critical incident investigation form which is available in eQstats Step 8 as a pop-up form (see figure 4 below)

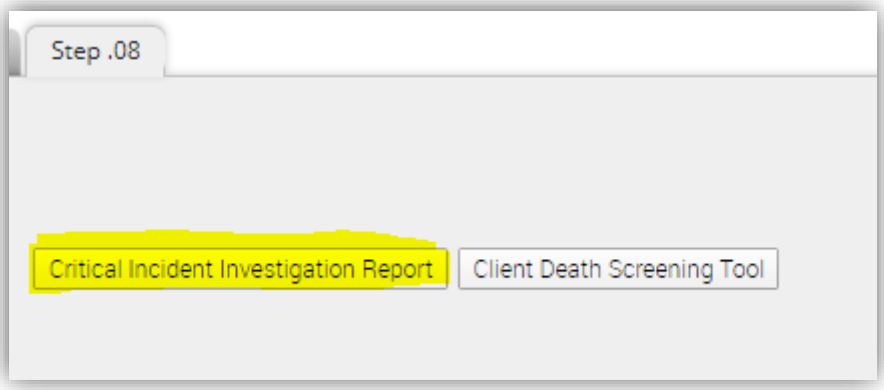

Figure 4 Critical Incident Investigation Report - Step 8 eQstats Pop up form.

The death informs the eQstats Clinical Activity Report and death Indicators are compiled for the service from this report.

Screening of the death

The questions in the pop-up form at step 8 (See Figure below) of eQstats Advanced Incident Module form the basis of the death screen process. The questions screen against known Aged Care risk factors.

The form should be answered in full by the screener.

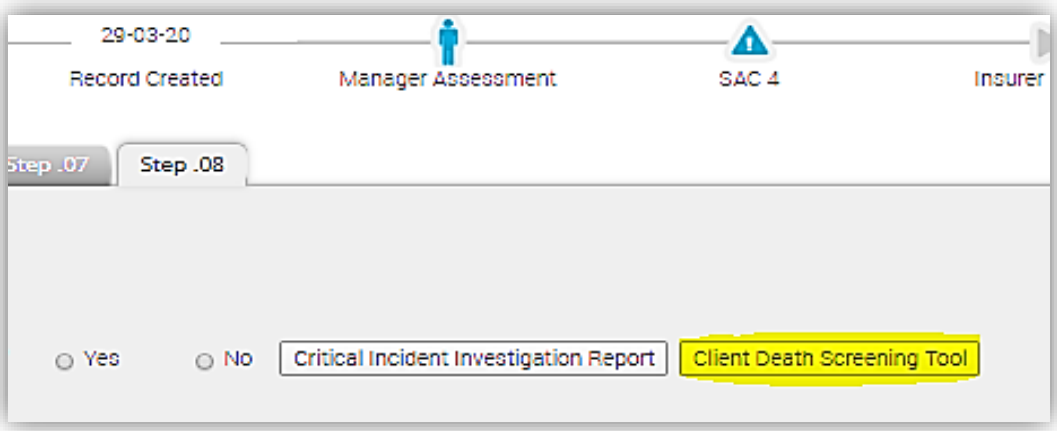

Figure 5 Death Screening Tool - Step 8 eQstats Pop up form.

Death Screen Tool Content – eQstats – Step 8

	Item	Reply
1.	**Admission Date**	**text**
2.	**Date of Death**	**text**
3.	**Gender**	**text**
4.	**Age**	**text**
5.	**Facility**	**text**
6.	**Was there an End of Life Care Directive in place?**	**yes no**
7.	**Was the death expected?**	**yes no**
8.	**Was a Palliative Care Plan in place?**	**yes no**
9.	**List Clinical Details/ Co-morbidities**	**text**
10.	**The following prompts may assist in the determination that the death requires further/ in-depth review**	

11.	1. Was there a Hospital/Acute Care transfer in the week before death?	yes no
12.	2. Was the transfer related to the resident's death?	yes no
13.	3. Is the death to be reviewed by the Coroner?	yes no
14.	4. Did an injurious fall, Traumatic Brain Injury (TBI) or other injury occur before death?	yes no
15.	5. Was the death as a result of equipment failure causing adverse event?	yes no
16.	6. Was there poor pain or symptom control noted in lead up to death?	yes no
17.	7. Did the death occur immediately after or as a result of a Medication Error?	yes no
18.	8. Was death certified by GP?	yes no
19.	9. Did the resident's family or friends express concerns over circumstances of the death?	yes no
20.	10. Did staff or other clinicians' express concerns over circumstances of the death	yes no
21.	11. Was there an incident report in the week before death?	yes no
22.	12. Was there a rapid onset deterioration evident where no review was undertaken, or where review did not occur in a timely manner?	yes no
23.	**Outcome of Screening (adapted from Clinical Excellence Commission admitted patient death screening tool 2016)**	
24.	Outcome 1. Was the death anticipated death due disease progression?	yes no
25.	Outcome 2. Was the death unexpected and not reasonably preventable with clinical intervention?	yes no
26.	Outcome 3. Was the death unexpected despite known preventative measures taken in a timely fashion?	yes no
27.	Outcome 4. Was the death as a result of an adverse event occurring in the Residential Aged Care Service*?	yes no
28.	Outcome 5. Death where consumer's family, clinicians or staff have expressed concerns, or is unrelated to and differs from the natural course of disease progression *	yes no
29.	**If there is a YES answer to Outcome 4* or Outcome 5* death event must be**	

	escalated to Quality Care and Compliance Team	
30.	**Have Quality Care and Compliance Team or Regional Manager have been notified?**	**yes no**
31.	**How were the Quality Care and Compliance Team or operational management notified?**	**text**
32.	**Has the DCEO been Notified?**	**yes no**
33.	**How was the DCEO notified? i.e. by phone, email, in person and date notified**	**text**
34.	**Name of Quality Care and Compliance Team member or operational manager notified**	**text**
35.	**How was the Quality Care and Compliance Team member or other manager notified? i.e. by phone, email, in person Please note the date notified**	**text**
36.	**Were other people notified ? please specify**	**text**
37.	**How were the other people notified? i.e. by phone, email, in person and date notified**	**text**
38.	**Person completing death screen name**	**text**
39.	**Person completing death screen designation**	**text**
40.	**Residential Service Managers Name**	**text**
41.	**Date**	**text**
42.	**If death is a SAC 1; a critical incident investigation must be completed.**	
43.	**For all SAC 1 deaths RSM please print and sign this form and place with medical file**	**text**
44.	**Was a Critical Incident Investigation undertaken**	**yes no**
45.	**Leader/Investigator name**	**text**
46.	**Was the death a Voluntary Assisted Dying death.**	**yes no**

Figure 6 Death Screen Tool Content – Questions

Post screen Severity Assessment

The SAC rating is altered to reflect the severity after the screening process if required.

A critical incident investigation is required to be conducted on all SAC 1 events. The Critical Incident Investigation form is appended as a pop-up form (see figure below) in step 8 of the eQstats Advanced incident Reporting module. The form should be opened, and investigation documented. Additional attachments are included in Step 7

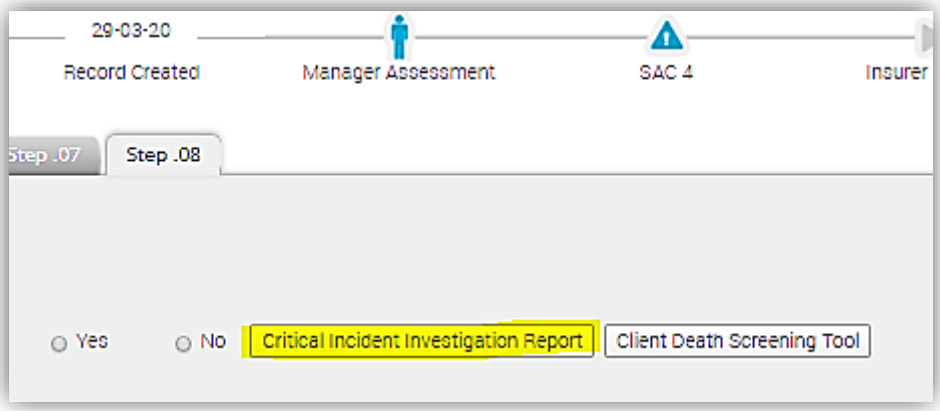

Figure 7 Critical Incident Investigation Form pop up - Step 8 eQstats.

Attach additional evidence if required

If additional documents are required to be attached this is done in Step 7

The documents uploaded will display listed when the Incident is viewed as a PDF.

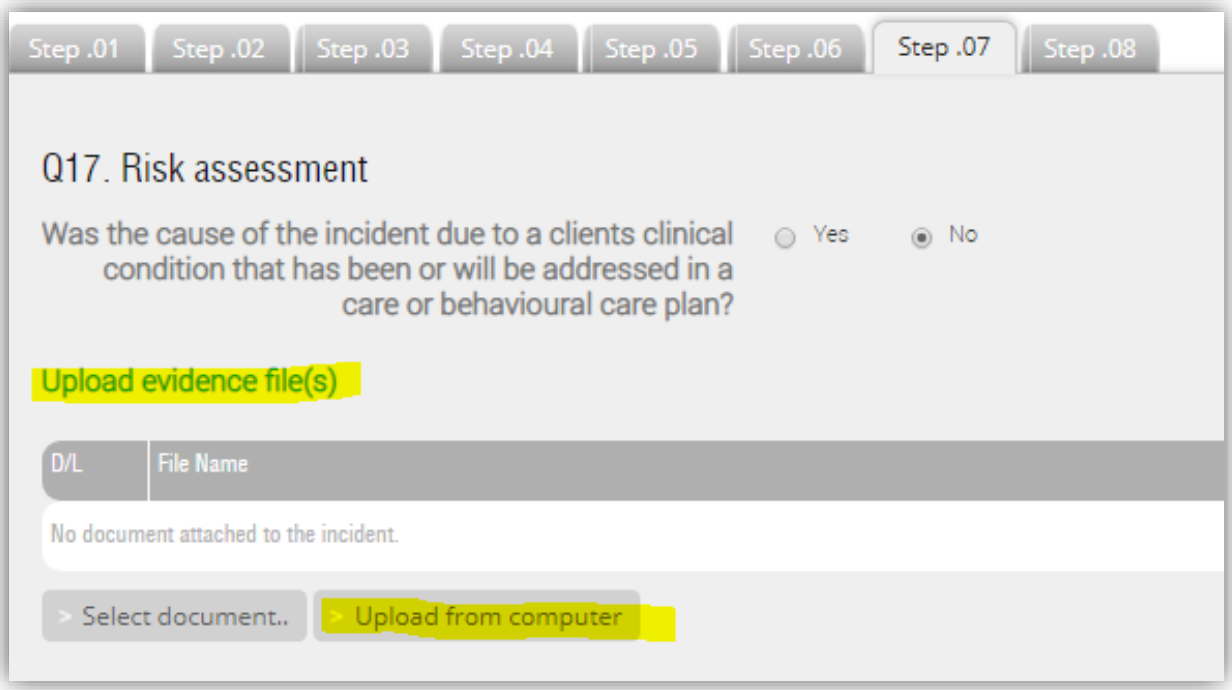

Figure 8 Additional evidence upload – Step 7 eQstats.

Escalation according to Severity

A death screen outcome that identifies that the resident died

- from an adverse event of any description

must be escalated to the Regional Manager or Chief Operating Officer and the Quality Care and Compliance Team in the first instance.

A death that has not been reported to the coroner but during screening is found to be reportable to the Coroner must be escalated to the Chief Operating Officer immediately.

A death screen that identifies that family, clinicians or staff have expressed concerns must be escalated to the Quality Care and Compliance Team.

A death screen that identifies that the death was unrelated to the natural course of disease progression must be escalated to the Quality Care and Compliance Team

The death of a person under the NDIS must be notified to the Quality Care and Compliance Team

A death reportable under the SIRS must be notified to the Quality Care and Compliance Team

Death screen review

Death screens that are escalated will be reviewed by Quality Care and Compliance Team oversight. The aim of the review is to.

- improve quality outcomes for residents leading up to death.
- reduce premature and preventable death; &
- identify and address non-conformance with best practice and Whiddon policy.

Death screen reviews will be undertaken by the Quality Care and Compliance Team as a component of standard governance review.

Where gaps are identified these will be addressed using an appropriate quality improvement and management methodology for the circumstances arising from the review.

Escalation of poor outcomes or unintended consequences of Voluntary Assisted Dying (VAD)

A Voluntary Assisted Dying death that has a poor outcome or other unintended consequences must be escalated immediately to the Regional or General Manager level in the first instance.

Examples of a poor outcome may be.

- A prolonged dying process that is painful or uncomfortable
- Respiratory distress / excessive secretions
- Anxiety
- An unsuccessful VAD process where the person does not die.

The Regional or General Manager will decide whether the death is reportable under the SIRS or NDIS reporting obligations.

VAD Death screen

VAD deaths will be screened using the Whiddon Death Screening Process, the aim being to

- Improve quality outcomes for residents who choose VAD.
- Identify and address non-conformance with best practice and Whiddon policy.

Death screen reviews will be undertaken by the Quality Care and Compliance Team as a component of standard governance review.

Where gaps are identified these will be addressed using an appropriate quality improvement and management methodology for the circumstances arising from the review.

Reportable Death Review

The Quality Care and Compliance Team will screen VAD deaths.

The Quality Care and Compliance Team will screen reportable deaths.

Grievance

Grievance in relation to this policy should be addressed to the Deputy Chief Executive Officer

A whistle blower policy is in place. This can be accessed on MyStaffroom.

Continuous Improvement and Review

This Policy is reviewed every three years, when improvements in practice require the policy to be updated or if regulatory requirements in relation to the Policy change. .

Appendix 1 SIRS NDIS Reportable Incidents (SAC) Matrix

	Serious Incident Response Scheme, National Disability Insurance Scheme Reportable Incidents SAC Matrix All events listed are SAC 1 Priority 1 unless there is a low level of harm, they are then SAC 2 Priority 2		
Where uncertainty exists as to the impact, or where the impact appears low, but the consumer (or their representative) expresses ongoing distress or concern, the incident should be treated as a Priority 1.	**Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Unreasonable use of force –**		
	Definition: Unreasonable use of force on a consumer, ranging from deliberate and violent physical attacks on consumers, to the use of unwarranted physical force.		
	Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
	Staff member. Family member/ visitor	**Consumer**	**The use of unwarranted or unjustified physical force against a consumer, including any rough handling of the consumer in the delivery of care and services. • Physical force including actions such as hitting, punching, pushing, shoving, kicking, spitting, throwing objects towards consumers, or making threats of physical harm. • Deliberate physical attacks or assaults on a consumer. • Any physical behaviour towards a consumer that is an offence under the law of a state or territory. • Incidents of physical contact that in isolation may not be significant but when they occur over an extended period of time, have an impact on the consumer. For example, a pattern of rough handling during the provision of care**
	Consumer	**Consumer**	**Hitting, Punching, Pushing, Shoving , Throwing objects, Kicking, Biting**
	Anyone	**NDIS consumer**	**Serious injury of a person with disability. Unlawful physical contact with, or assault of, a person with disability**
	Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Unlawful or inappropriate sexual contact		
	Definition: Unlawful sexual contact, or sexual misconduct committed against, with, to, or in the presence of a consumer		
	Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
	Staff member	**Consumer**	**Showing own genitals to a consumer, masturbating in front of a consumer, masturbating a consumer, Sexual innuendos, sexually explicit language, showing pornography to a consumer, Grooming, Stalking, or making sexual threats, touching consumer's genitals (or other private areas) without a care need, sexually penetrating a consumer with another part of their body or an object**
	Family member/visitor	**Consumer**	**Sexual threats or stalking, Activities without sexual consent: Showing own genitals to a consumer Masturbating in front of a consumer, Masturbating a consumer, Sexual innuendos, Sexually explicit language , Exposing a consumer to pornography or using a consumer in pornography, Sexually penetrating a consumer with another part of their body or an object, Touching consumer's genitals (or other private areas) without a care need**
	Consumer	**Consumer**	**Sexual threats or stalking Activities without sexual consent: Showing own genitals to a consumer, Masturbating in front of a consumer, Sexual innuendos , Sexually explicit language, Exposing a consumer to pornography, Sexually penetrating a consumer with another part of their body or an object**
	Anyone	**NDIS consumer**	**Unlawful sexual 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 for sexual activity**
	Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Psychological or emotional abuse		
	Definition: ***Verbal or non-verbal acts that cause significant emotional or psychological anguish, pain or distress including verbal taunts, threats of maltreatment, harassment, humiliation or intimidation, or a failure to interact with a person or acknowledge the person's presence.***		

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	Yelling, Name calling, Ignoring a consumer. Feigning violence. Threats to withhold care or services. Threatening gestures. Punishing a consumer by refusing access to care or services. Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity, or religious identity. Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional anguish, pain, or distress
Family member/visitor	Consumer	Yelling, Feigning violence, Name calling, Threatening gestures , Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity, or religious identity. Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional abuse
Consumer	Consumer	Yelling, Feigning violence, Name calling, Threatening gestures , Making disparaging comments about a person's gender, sexual orientation, sexual identity, cultural identity, or religious identity, Repeatedly flicking, tapping, bumping etc a resident, which of itself does not constitute physical assault, but the repetitive nature causes psychological or emotional anguish, pain, or distress.
Anyone	NDIS consumer	Abuse or neglect of a person with disability

Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Unexpected death

Definition: ***Death that is unexpected, where steps may not have been taken to prevent the death, or the death results from a mistake, failure, or incident***

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	A consumer falls while being moved or shifted, with the injuries sustained resulting in the consumer's death.
Provider	Consumer	Where poor quality clinical care is provided to a consumer resulting in their death. For example, a pressure injury or wound is untreated or not regularly tended to and becomes infected resulting in the consumer's death. • Where medical assessment or treatment is delayed, resulting in a consumer's death. For example, a consumer falls and is not assessed immediately afterwards and later dies as a result of injuries sustained from the fall.
Consumer	Consumer	Where the actions of a consumer result in the death of another consumer, such as from an assault.
Anyone	NDIS consumer	The death of a person with disability

Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Stealing or financial coercion by a staff member

Definition: Stealing from an aged care consumer or behaviour that is coercive, deceptive, or unreasonably controls the finances of an aged care consumer by a staff member.

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)
Staff member	Consumer	Coerces a consumer to change their will in favour of the staff member. Steals money or valuables from a resident.

Reportable Incident type: Neglect

Definition: ***Intentional or reckless failure in the duty of care for an aged care consumer that may also be a gross breach of professional standards resulting in significant harm or the potential to result in death or significant harm.***

Person who commits an incident	Person affected by an incident	Examples include (but are not limited to)

	Staff member	**Consumer**	**Withholding personal care such as showering or oral care. Untreated wounds . Maggots on/in the consumer. Leaving a resident outside unprotected in the sun resulting in significant burns**
	Provider	**Consumer**	**Serious injury sustained by a consumer that requires hospitalisation. Where a consumer's meals are not appropriately modified to account for their difficulty of swallowing (dysphagia) as recorded in their care plan, or insufficient assistance is given to the consumer to eat their food, resulting in the consumer either not being able to eat meals or the consumer choking.**
	Anyone	**NDIS consumer**	**Neglect of a person with disability**
	Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Inappropriate physical or chemical restraint		
	Definition: ***The use of physical or chemical restraint that does not meet the requirements of the Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019.***		
	Person who commits an incident	**Person affected by an incident**	**Examples include (but are not limited to)**
	Provider	**Consumer**	**Where physical restraint is used on a consumer, when it is not an emergency, and the provider does not seek prior informed consent.** **Where a provider uses physical restraint without consent and does not inform the consumer's representative as soon as practicable after the restraint starts to be used. A provider administers a drug to a consumer for the purpose of influencing their behaviour as chemical restraint. The consumer's representative was not informed before the drug was administered, or shortly afterwards.**
	Anyone	**NDIS consumer**	**The unauthorised use of a restrictive practice in relation to a person with disability**
	Reportable Incident type: Allegations of, suspicions of or if evidence is unambiguous of Unexplained absence from care		
	Definition: Reporting of unexplained absences will occur where the care recipient is absent from the service; and the absence is unexplained; and the absence has been reported to the police. **Consistent with current arrangements, we must report to the Commission as soon as reasonably practicable, but not later than 24 hours after the care recipient's absence was reported to the police.**		

Time Frame	**Distinguishing critical incidents and other serious incidents**			
	Impact category	**Degree of harm**	**Incident type**	**SAC / Priority**
SAC 2 **30 days**	**No impact**	**Low level of harm**	**Serious incident**	**SAC 2 Priority 2**
	Minor physical or psychological injury or discomfort which were resolved without medical or psychological interventions	**Low level of harm**	**Serious incident**	**SAC 2 Priority 2**
SAC 1 **24 hours**	**Physical or psychological injury or illness requiring onsite medical or psychological treatment**	**Higher level of harm**	**Critical incident**	**SAC 1 Priority 1**
	Physical or psychological injury or illness requiring a hospital admission (but not permanent)	**Higher level of harm**	**Critical incident**	**SAC 1 Priority 1**
	Permanent physical or psychological impairment	**Higher level of harm**	**Critical incident**	**SAC 1 Priority 1**
	Fatality or severe permanent physical or psychological impairment	**Higher level of harm**	**Critical incident**	**SAC 1 Priority 1**
24 hours	**NDIS: Reportable incident**	**SAC 1; regardless of type . Reportable within 24 hours**		
5 days	**NDIS: The unauthorised use of a restrictive practice in relation to a person with disability**	**SAC 1 event reportable within 5 business days**		

End of content

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