Safety Learning System

Topic Guide

Aged Care SIRS Reporting

Government of South Australia

SA Health

Aged Care Serious Incident Response Scheme (SIRS) Reporting

Subject to decisions by the Federal Parliament, from 1 April 2021 it is expected that current compulsory reporting legislative requirements will be repealed. From that date, approved providers will be subject to the legislative requirements of the new Serious Incident Response Scheme (SIRS).

The Serious Incident Response Scheme (SIRS) is designed to help prevent and reduce the risk and occurrence of incidents of abuse and neglect in residential aged care services subsidised by the Australian Government.

SIRS requires providers to;

- Make mandatory reports of serious incidents
- Have in place an effective incident management system that enables the appropriate and timely prevention, identification, and response to all incidents.

  In SA Health this is covered by the use of the Safety Learning System (SLS) and the systems and practices described in the SA Health Patient Incident Management and Open Disclosure Policy Directive. These are also required by the National Safety and Quality Health Services Standards.

Reporting into the Safety Learning System (SLS)

Appendix 1 includes the recommended classifications for each category of reportable incident.

Staff should notify a suspected reportable incident immediately to their Nurse Unit Manager, Director of Nursing or person who is responsible for notifying reportable incidents to the Commission. This will ensure reporting timeframes are met, noting that some preliminary investigation may be required to confirm if the incident meets the definition of a reportable incident.

The Notifier must:

- Report the incident as soon as practicable into the SLS, but within 24 hours.
- Select ‘Aged Care’ within the ‘Primary Person Affected – Demographics’ section of SLS, and also select the appropriate identifier / commonwealth funding source (eg. RAC)
- Refer to Appendix 1 – Aged Care SIRS Reportable Incident Classifications table to ensure the correct Level 1, Level 2 and Level 3 classifications are selected

The Incident Manager must:

- Confirm the incident is a reportable incident and make the appropriate report to the Aged Care Quality and Safety Commission through the My Aged Care service provider portal according to the required timeframes for Priority 1 and Priority 2 incidents
- Complete the Aged Care Mandatory Reporting Details on the Structured Review tab (refer Appendix 2)
- Complete a Clinical Incident Briefing (CIB) where applicable and upload into SLS

Investigation

The approach to managing incidents must focus on the safety, health, wellbeing and quality of life of consumers and meet the requirements of the aged care legislation and the *Aged Care Quality and Safety Commission, Effective incident management systems: Best practice guidance*. The legislation and guidance describe your responsibilities in identifying, responding to, managing and recording all incidents, and preventing the recurrence of similar incidents in future. All incident management (including investigation and actions taken) and correspondence generated must be recorded in SLS in accordance with SA Health Patient Incident Management and Open Disclosure Policy Directive.

Open Disclosure

Open disclosure is the open discussion that an aged care provider has with residents, and their families if appropriate, when something goes wrong that has harmed or had the potential to cause harm. Ensure the appropriate level of Open Disclosure is conducted, and noted in SLS. Refer to the Patient Incident Management and Open Disclosure Policy Directive and Open Disclosure toolkit for further information and resources.

Additional reporting that may be required

Use the Linked records function in the SLS to connect additional reporting and investigations for that incident (see below).

Coroners Notification

Professional Indemnity Notification - Notifications Module (formerly known as Medical Malpractice)

A report to other third party, for example SAPOL, AHPRA, NDIS, Adult Safeguarding Unit (ASU)

Further information is available:

- Safety Learning System (SLS) Guide - How to Report a patient incident
- Safety Learning System (SLS) Guide - How to Manage a patient incident

For more information

Official Use Only I1-A1
SA Health
Safety and Quality Unit
11 Hindmarsh Square
Email: safetylearningsystem@sa.gov.au
Telephone: 08 8226 6539
www.sahealth.sa.gov.au/safetylearningsystem

www.ausgoal.gov.au/creative-commons

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APPENDIX 1 – Aged Care SIRS Reportable Incidents Classifications

Under section 54-3 of the *Aged Care Act*, a reportable incident is any of the incidents listed within the table below that have occurred, are alleged to have occurred, or are suspected of having occurred to a residential care recipient (consumer), in connection with the provision of residential care, or flexible care provided in a residential setting.

You must notify the Aged Care Quality and Safety Commission of all reportable incidents, even where you believe that you have acted and responded appropriately, or where an internal or police investigation is underway. Your legislated responsibility to notify the Commission of a reportable incident applies regardless of whether the consumer and/or their representative or family wish the incident to be notified.

A reportable incident includes any of the following:	Classification guide options for reporting the incident within the Patient Incident Module of SLS		
	Level 1	Level 2	Level 3
Unreasonable use of force Example: hitting, pushing, shoving or rough handling.	Challenging Behaviour	Patient behaviour to other persons	Physical abuse, or violence
	Challenging Behaviour	Patient behaviour to patient	Physical abuse, or violence
	Challenging Behaviour	Staff behaviour to patient	Physical abuse, or violence
	Treatment, procedure	Connected with the management of operations / treatment	Inappropriate handling of the patient
	Treatment, procedure	Connected with the management of operations / treatment	Inappropriate use of control and restraint
Unlawful sexual contact or inappropriate sexual conduct Example: sexual threats or stalking, or sexual activities without consent	Challenging Behaviour	Patient behaviour to other persons	Physical abuse, or violence
			Verbal abuse or disruption
	Challenging Behaviour	Patient behaviour to patient	Physical abuse, or violence
			Verbal abuse or disruption
	Challenging Behaviour	Staff behaviour to patient	Physical abuse, or violence
			Verbal abuse or disruption
Neglect Example: deliberately withholding medication, deliberately withholding personal care, deliberate untreated wounds, or deliberately insufficient assistance during meals.	Deliberate Neglect could fit under numerous classifications, including but not limited to:		
	Clinical Assessment	Administration of assessment	Failure to follow up
	Medication	Administration of medication	Omitted medication
	Implementation of care	Several level 2	Delay or failure to follow up
	Pressure injury / Ulcer / Sore	Worsening of existing	Select from applicable level 3

<table>
<tr><td rowspan="3">Psychological or emotional abuse

Example: yelling, name calling, ignoring a consumer, threatening gestures or refusing a consumer access to care or services as a means of punishment.</td><td>Challenging Behaviour</td><td>Patient behaviour to other persons</td><td>Verbal abuse or disruption</td></tr>
<tr><td>Challenging Behaviour</td><td>Patient behaviour to patient</td><td>Verbal abuse or disruption</td></tr>
<tr><td>Challenging Behaviour</td><td>Staff behaviour to patient</td><td>Verbal abuse or disruption</td></tr>
<tr><td rowspan="10">Unexpected death

Example: in the event of a fall, untreated pressure injury, or when the actions of a consumer result in the death of another consumer</td><td colspan="3">Unexpected death could fit under numerous classifications, including but not limited to:</td></tr>
<tr><td>Patient Falls and other injuries</td><td>Falls</td><td>Fall</td></tr>
<tr><td rowspan="3">Pressure Injury</td><td>New</td><td rowspan="3">Select from applicable level 3</td></tr>
<tr><td>Worsening of existing/observed after internal transfer</td></tr>
<tr><td>Present on admission from home or external service provider</td></tr>
<tr><td>Challenging Behaviour</td><td>Patient behaviour to patient</td><td>Physical abuse, or violence</td></tr>
<tr><td>Challenging Behaviour</td><td>Self harm</td><td>Select from applicable level 3</td></tr>
<tr><td rowspan="2">Clinical Assessment</td><td rowspan="2">Administration of assessment</td><td>Delay / difficulty in obtaining clinical assistance</td></tr>
<tr><td>Failure to follow up</td></tr>
<tr><td>Implementation of care</td><td>MH care, assessment, review, admission, transfer</td><td>Death of a MH consumer – due to physical illness</td></tr>
<tr><td>Stealing or financial coercion by a staff member

Example: if a staff member coerces a consumer to change their will to their advantage, or steals valuables from the consumer.</td><td>Challenging Behaviour</td><td>Staff behaviour to patient</td><td>Financial abuse, coercion or stealing</td></tr>
<tr><td rowspan="8">Inappropriate physical or chemical restraint

Examples include: where physical or chemical restraint is used

• without prior consent or without notifying the consumer’s representative as soon as practicable;
• where physical restraint is used in a non-emergency situation; or
• when a provider issues a drug to a consumer to influence their behaviour as a form of chemical restraint.</td><td rowspan="8">Restraint / Seclusion</td><td rowspan="2">Chemical Restraint (administered medications)</td><td>Intubation not required</td></tr>
<tr><td>Intubation required</td></tr>
<tr><td rowspan="6">Mechanical Restraint (applied by devices)</td><td>Hard shackles</td></tr>
<tr><td>Soft shackles</td></tr>
<tr><td>Posey vest</td></tr>
<tr><td>Chair (eg. Pelvic belt/holder or tray table)</td></tr>
<tr><td>Bed rails</td></tr>
<tr><td>Net</td></tr>
</table>

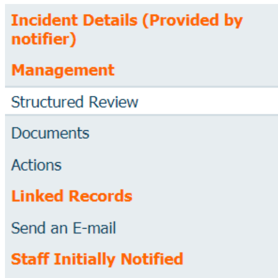
			Other
		Physical Restraint (applied by people)	Physical restraint
Unexplained absence from care Example: this occurs when the consumer is absent from the service, it is unexplained and has been reported to the police.	Challenging Behaviour	Absconded	Unaccountable Absence

Detailed information and examples of reportable incidents can be found in the Aged Care Quality and Safety Commission Guidelines for residential aged care providers: 'Chapter 3 Types of incidents to be notified'

APPENDIX 2 – Aged Care Mandatory Reporting Details on the Structured Review tab

This is NOT the report to the Aged Care Quality and Safety Commission, this is the process of using the SLS to record that the mandatory report has been successfully made to the Commission.

> Login to SLS and locate the incident, select the ‘Structured Review’ tab from the left hand menu



> Scroll to the bottom of the ‘Structured Review’ tab to ‘Reporting to External Agencies’ where you will find ‘Aged Care Mandatory Reporting – Serious Incident Response Scheme (SIRS) Details’ field

> Select the category of the report made from the drop down list
> Select the date the report was made to the Commission
> Enter the SIRS report number automatically issued at the time of report and/or Commission case number provided
> Save the record
> Any investigation that occurs as a result of the notification must be recorded and/or uploaded into SLS