2.6 Incident Management

Reportable Incident, Accident and Emergency Policy and Procedure

1.0 Purpose

La Vita Care will comply with the National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018 and state legislative requirements relating to mandatory reporting.

It is our objective to maintain an incident management system that covers incidents that consist of acts, omissions, events or circumstances that:

- occur in connection with the provision of supports or services to a person with a disability
- has, or could have caused harm to a person with a disability, child or young person.

Important note*:* Information on how La Vita Care reports harm, risk of harm, and abuse against children can be found in our Working with Children Policy and Procedure.

2.0 Scope

All staff members are responsible for ensuring the safety of all participants who access our services. All incidents must be reported as per this policy. Management is responsible for ensuring that staff are trained and undertake the NDIS Worker Orientation training module.

3.0 Definitions

Term	Definition
Incident	Acts, omissions, events or circumstances connected with providing support or services to a person with a disability have, or could have, caused harm to the participant.
Reportable incident	A reportable incident is any of the below: ● The death of a person with a disability. ● Serious injury of a person with a disability. ● 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 is committed against, or in the presence of, a person with a disability, including grooming the person with a disability for sexual activity. ● Use of restrictive practice to a person with a disability where the restrictive practice use is not following an authorisation (however described) of a state or territory concerning the person, or if it is used according to that authorisation but not following a behaviour support plan for the person with a disability.
Incident management system	Incorporates all items listed below: ● Acts, omissions, events or circumstances that connect with providing support or services to a person with a disability; and could have caused harm to the person with a disability. ● Incidents consist of acts by a person with a disability that occur in connection with providing support or services to the person with a disability and have caused serious harm or a risk of serious harm to another person. ● Reportable incidents allegedly occurred to provide support or services to a person with a disability.

4.0 Policy

La Vita Care recognises that many participants using La Vita Care services are at risk of incidents and accidents. Staff are required to encourage participants to report incidents to allow the organisation to improve practices and inform authorities following this policy.

La Vita Care's Reportable Incident, Accident and Emergency Policy and Procedure seeks to:

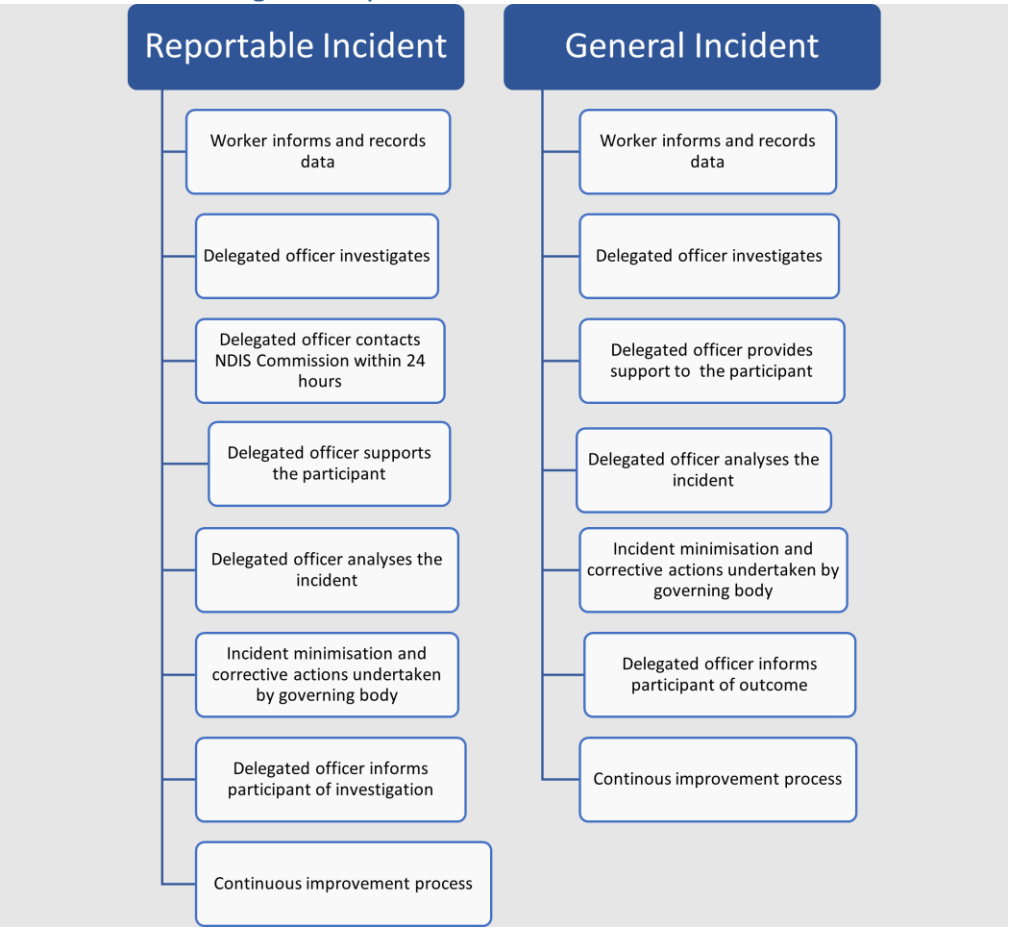
- minimise risk and prevent future incidents through the development of appropriate participant-centred plans, staff training, assessment and review
- ensure that there is immediate management of an incident, accident or emergency and that each of these events is prioritised, managed and investigated appropriately
- identify opportunities to improve participant support quality by ensuring that the incident system is planned, coordinated, and linked to the quality and risk management systems.

Participants will be provided information in Easy Read format, as required.

The Executive Service Manager is the delegated officer listed in this policy and will manage, investigate and report all incidents as required. Within this process, the Executive Service Manager will ensure procedural fairness when dealing with an incident. Our organisation will follow all procedural fairness guidelines as required by the Commissioner.

5.0 Procedure

5.1 Incident management procedure



La Vita Care will establish a procedure that identifies, manages and resolves incidents, as follows:

Step 1. Record incident

1. The worker to report the incident to the Executive Service Manager. (child-related incident - the worker, as mandatory reporter must report to the state statutory reporting body refer to Working with Children Policy and Procedure for process)
2. The worker completes an Incident Report via ClickUp that identifies and records details relating to the incident, i.e. people, place, time and date.

Step 2. Review and investigation

1. The Executive Service Manager or delegated authority will determine, from the information provided, if the incident is classified as a reportable incident by the NDIS Quality and Safeguards Commissioner or a different type of incident:
    - A reportable incident must comply with the reportable incident reporting process, including child and young person's mandatory reporting requirements
    - La Vita Care will comply with the National Disability Insurance Scheme (Incident Management and Reportable) Rules 2018.
    - A general incident is an accident with non-reportable injuries.
2. The Executive Service Manager or delegated authority will review the details of the incident:
    - People involved.
    - Location.
    - Circumstances.
    - The outcome, e.g. injury.
3. The Executive Service Manager or delegated authority will investigate the incident/accident to determine the required information:
    - Primary reasons for the event.
    - Underlying reasons for the event.
    - Immediate actions are required to fix the cause of the event.
    - Preventative actions are required for the future.
    - Note: do not investigate children and young people suspicion of real or potential harm and follow state authority requirements
4. Any information learned from incidents/accidents will be incorporated into our continuous improvement cycle to prevent the same incident/accident from recurring.
    - The analysis and investigation of each incident will vary based on the seriousness.

Step 3. Support participant

1. The Executive Service Manager or delegated authority ensures that the affected participant is supported and assisted:
    - informing them that they have access to an advocate; if the participant does not have an advocate, the Executive Service Manager or delegated authority can help access an independent advocate
    - reviewing their health status to assist and support
    - assessing the environment to ensure their safety and to prevent any recurrence
    - ensuring their well-being and assisting in developing the participant's confidence and competence so they do not lose any function/s
    - provide support to their family or relevant others, if relevant to the participant.
2. The Executive Service Manager or their delegated authority will review the incident with the participant and collaborate with the person/s involved to manage and resolve the incident.

Step 4. Analyse incident

1. As part of our continuous improvement process, the information gained from an incident is used to amend or implement new practices:
    - we will establish the incident cause/s and the effects and any operational issues that may have contributed to the incident occurring and the nature of the investigation
    - if an incident requires corrective action, an appropriate plan will be developed to adjust practices according to the required action.

2. The Executive Service Manager or their delegated authority will undertake an appropriate analytical process to:
    - determine the cause of the incident
    - ascertain if the incident was an operational issue
    - consider the participant's perspective, including:
        - whether the incident was preventable
        - how the incident was managed and reviewed
        - determining any remedial action required to minimise future impacts and prevent a recurrence.
    - identify why the incident occurred, e.g. environmental factors, participant health, age factors that may impinge
    - ascertain if current strategies or processes require review and improvement
    - devise new strategies or procedures, if required
    - plan staff training for any new strategies
    - implement new strategies
    - evaluate the success of new strategies.

Step 5. Incident/accident minimisation and corrective action

1. La Vita Care will risk-assess all participants in conjunction with our Risk Management Policy and Procedure.
2. During staff orientation and ongoing training sessions, incidents, emergency minimisation, mandatory reporting and procedures are taught.
3. Risks will be identified, and control mechanisms agreed upon with participants.
4. La Vita Care will consult with participants, and relevant stakeholders, to design specific risk control mechanisms to reduce risk to participants and their environment.
5. The effectiveness of mechanisms will be evaluated via:
    - participant review processes, including support plan review
    - participant feedback
    - case conferencing.
6. Internal and external risk audits.
7. Reviews of policies and procedures.

<u>Corrective actions</u>

Upon completing the incident analysis procedure, any corrective action will be implemented. Each corrective action identified will be evaluated to ascertain the action's effectiveness, as per our Continuous Improvement Policy and Procedure, i.e. Plan, Do, Check, Act.

Step 6. Informing participants

1. La Vita Care will inform participants or their advocate of the incident outcome/s, either in writing or verbally, dependent on the participant and the situation. Collaborative practice will ensure the participant and their advocate are involved in the incident's management and resolution.

5.2 Staff training

La Vita Care recognises the importance of prevention to ensure our staff and participants' safety. Our orientation process includes training in risk and safety practices, including manual handling, infection control, mandatory reporting, safe environments, and risk and hazard reduction.

Upon commencing employment with La Vita Care, all staff are trained in organisational incident management processes, including how to report an incident and who to report an incident to. Quality

5.3 Reportable incidents

Staff must report any reportable incident immediately that it becomes evident.

The Quality Manager is responsible for reporting all reportable incidents to the NDIS Quality and Safeguards Commission. Reportable incidents are serious incidents or allegations that harm any NDIS participant.

As a registered provider, La Vita Care is required to report serious incidents (including allegations) arising from the organisation's service provision to the NDIS Quality and Safeguards Commission.

5.3.1 Reporting roles

The organisation will establish the following roles and ensure that allocated staff are aware of their responsibilities:

1. Approved Reportable Incident Approver responsibilities:
    - Authority to review reports before submission to the NDIS Commission.
    - Views previous reportable incidents submitted by their organisation.
2. Authorised Reportable Incident Notifier responsibilities:
    - Supports the Authorised Reportable Incident Approver to collate and report the required information.
    - Creates new reportable incident notifications to be saved as a draft for review and submission by the authorised Approver.
3. Mandatory reporters – children and young people
    - Staff identifying or having suspicion of real or potential risks of harm must report via state legislative process
    - Provide information as per Working with Children Policy and Procedure

5.3.2.1 Timeframes for notifying the NDIS Commission about reportable incidents

When a reportable incident occurs or is alleged in connection with the NDIS supports or services you deliver, you must notify us using the NDIS Commission Portal within the required timeframes (set out below). The timeframes are calculated from when a registered NDIS provider became aware that the incident occurred or was alleged to have occurred.

Reportable Incident	Timeframe
Death of a person with disability	24 hours
Serious injury of a person with disability	24 hours
Abuse or neglect of a person with disability	24 hours
Unlawful sexual or physical contact with, or assault of, a person with disability	24 hours
Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity	24 hours
The use of restrictive practice concerning a person with disability if the use is not following a required state or territory authorisation and/or not under a behaviour support plan.	5 business days

5.3.2 Reportable incident procedure

The Quality Manager will review the information and contact the police immediately to inform them of any suspected abuse.

The Approver submits reportable incidents via the NDIS Commission Portal's My Reportable Incidents page. https://www.ndiscommission.gov.au/providers/ndis-commission-portal:

1. Complete an **Immediate Notification Form** and submit it within 24 hours:
    - Approved Reportable Incident Notifier will create for approval.
    - Approved Reportable Incident Approver will approve the report and submit it.
      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.
2. **5-day form** to be completed within five days of key stakeholders being informed:
    - Approved Reportable Incident Notifier will create a form for approval.
    - Approved Reportable Incident Approver will approve and submit the form.
      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.
3. **Final Report** will be submitted on the due date if requested by the NDIS Commission:
    - Approved Reportable Incident Notifier will create a report for approval.
    - Approved Reportable Incident Approver will approve the report and submit it.
      Note: Approved Reportable Incident Notifier may create and submit as required by the incident's circumstance.

Assessment of the incident by the Executive Service Manager, or their delegated authority, will involve:

- assessing the incident's impact on the NDIS participant
- analysing and identifying if the incident could have been prevented
- reviewing the management of the incident
- determining what, if any, changes are required to prevent further similar events from occurring
- recording all incidents and responsive actions taken.

5.4 Documentation

- All reportable incident reports and registers must be maintained for seven (7) years.
- This policy is to be reviewed annually or when legislation changes occur.
- All participants, families and advocates are informed of this policy.
- All staff are trained in the procedures outlined in this policy.

6.0 Related documents

- Continuous Improvement Policy and Procedure
- Final Report (NDIS form)
- 5-day form (NDIS form)
- Incident Report – ClickUp link or paper based
- Incident Register
- Immediate Notification Form (NDIS form)
- Participant Handbook
- Participant Information in Easy English
- Reportable Incident, Accident and Emergency Policy and Procedure
- Client Risk Assessment and Management Plan
- Risk Management Plan Register
- Risk Management Policy and Procedure
- Staff Training Record

7.0 References

- NDIS (Incident Management and Reportable Incidents) Rules 2018
- NDIS Practice Standards and Quality Indicators 2021
- Privacy Act 1988 (Commonwealth)
- Disability Services Act 1986 (Commonwealth)
- Work Health and Safety Act 2011 (Commonwealth)

Reportable deaths (coroner) – Victoria

Not all deaths must be reported to the Coroner's Court of Victoria. Reportable deaths include deaths:

- that are unexpected, unnatural or violent or resulted after an accident or injury
- that unexpectedly occur during or after a medical procedure
- where the identity of the person or their cause of death is not known
- where the person was in custody or care.

A person who can report a death to the Coronial Admissions and Enquiries

- Persons who must advise the coroner of a reportable or reviewable death include *any person who had care or custody of a person placed in care.*
- Anyone who thinks a reportable death has occurred and that the court has not been advised should report the death without delay.
- The immediate family of a person who has died might report the death to the coroner if the person who died was discharged from an approved mental health service within three months of the death.

Procedure to report a death

In the event of a reportable death, the Quality Manager will undertake the following steps:

1. Contact Coronial Admissions and Enquiries on phone number: 1300 309 519.
2. Complete a Medical Deposition online, if requested by Coronial Admissions and Enquiries.
3. Advise the participant's family that they can request access to coronial documents by contacting the Registry on 1300 309 519

References

- Coroners Act 2008 (VIC)
- Coroners Court of Victoria (information sighted - 9:12 am on 17/11/20)