health

Department of Health

Incident reporting instruction

Updated May 2013

State Government Victoria

Incident reporting instruction

Updated May 2013

If you would like to receive this publication in an accessible format, please email: enquiries@health.vic.gov.au

This document is available as a PDF on the internet at: <www.dhs.vic.gov.au/funded-agency-channel>.

Authorised and published by the Victorian Government,
50 Lonsdale Street, Melbourne.

Contents

Contents (continued)

1. Introduction

The purpose of this policy is to outline the reporting requirements of incidents, or alleged incidents, that involve or impact on health funded organisations as defined in the scope, and on supported residential services.

A major objective of health service management is to assure service users of safe progress through all components of the service system. Efforts to minimise the risk of harm from care provided, and the environment in which it is provided, must encompass a systematic strategy to encourage the full and frank reporting of adverse events; understand the causes of adverse events; and improve the processes of care and training of staff on the basis of this analysis.

Compulsory reporting

Reporting of incidents as defined in the Department of Health incident reporting instruction is compulsory, to ensure the department complies with the requirements and expectations associated with public accountability, its legal obligations, and insurance requirements.

Further information

Incident report forms, supporting materials, and guidelines for particular program areas are available on the Funded Agency Channel <www.dhs.vic.gov.au/funded-agency-channel>.

2. Aims and overview

The aims of incident reporting are to:

- support the provision of high quality services to clients through the full and frank reporting of adverse events and subsequent analysis
- assure and enhance the quality of the department's programs, through monitoring and acting on trends identified through incident reports
- inform the appropriate ministers, the Secretary, executive directors, program directors and directors of health and aged care, of significant incidents affecting clients and staff, in a timely and accurate manner
- ensure due diligence and duty of care requirements are met and any identified deficits addressed
- support organisational consistency.

The department is a large and complex organisation, and within its operations, things sometimes go wrong. When this happens, the response should not be one of blame and retribution, but of learning, a determination to reduce risk for future clients and concern for staff who may suffer as a result of the incident.

The key reason for reporting incidents is to learn from them and if possible, prevent their recurrence. Without a detailed analysis of mishaps, incidents, and near misses, we may fail to uncover problems that are potential hazards to clients and staff. (Section 11 provides an overview on learning from incidents.)

It should be noted that incident reporting procedures represent a reactive response to critical incidents, and should be complemented by more proactive and systematic risk management activity aimed at minimising the risk of any new incidents, such as hazard identification. Both risk management and quality improvement are integral parts of good management practice. Further information about risk management can be found in the department's risk management framework.

The department has adopted a risk management policy and framework that is based on the *Australian and New Zealand Standard for Risk Management*. The framework promotes the consistent identification, evaluation, management, monitoring and recording of risks throughout the department. The incident reporting policy supports good risk management by ensuring that we record and learn from past incidents, have consistent processes in place for managing incidents and can monitor overall trends.

3. Scope of policy

This departmental instruction sets out the management and reporting requirements for incidents involving clients or staff in Department of Health-funded community service organisations (CSOs), registered community health centres and supported residential services (SRSs).

Funded organisations are required to comply with departmental incident reporting processes as part of their service agreement. Note: there is no current legislative requirement for proprietors of an SRS to report incidents directly to the department, however, regional Department of Health SRS program staff are required to report category one incidents in accordance with this instruction.

The following organisations are required to submit incident reports to the Department of Health.

3.1 Category one and two incidents

- CSOs providing psychiatric disability rehabilitation support (PDRS) services
- All providers of alcohol and other drug (AOD) services.

3.2 Category one incidents only

- CSOs providing home and community care (HACC) services
- CSOs providing aged care, carer's support programs
- registered community health centres providing community and women's health programs
- SRSs.

Table 1: Incidents to be reported to the department

Program or service	Category	
	1	2
AOD services	✔	✔
PDRS services	✔	✔
HACC services	✔	
Aged care, carer's support programs	✔	
SRSs	✔	
Community health centres	✔	

3.3 Services outside the scope of policy

This instruction does not apply to clients or employees in approved specialist clinical mental health services as defined by the *Mental Health Act 1986* that report via the hospital process.
This instruction does not apply to hospitals listed in Schedules 1-5 in the *Health Services Act 1988*:

- public hospitals, except those providing AOD services
- denominational hospitals
- metropolitan hospitals
- privately-operated hospitals
- metropolitan health services.

3.4 Additional guidelines

Divisions may issue additional guidelines for particular programs. Such guidelines must be formally endorsed by the program director or executive director of the program division, and the executive director of the Mental Health, Drugs and Regions Division. These guidelines can be accessed on the Funded Agency Channel <www.dhs.vic.gov.au/funded-agency-channel>.

3.4.1 Alcohol and other drugs services

Department-funded AOD services are obliged to report incidents involving unknown clients where the incident has a direct correlation to the nature of services that the agency is providing.

AOD services or programs managed by public health services are required to comply with the department's incident reporting instruction for category one and two incidents occurring in the department-funded service.

AOD services are required to keep a record of category one, two and three incidents, however only category one and two incident reports should be submitted to the department. AOD services should record category three incidents on an internal register/database and on the client file.

3.4.2 Supported Residential Services

The department is responsible for administering the *Supported Residential Services (Private Proprietors) Act 2010* (the Act) and *Supported Residential Services (Private Proprietors) Regulations 2012* (the Regulations).

The Act requires proprietors of SRS to notify the Secretary of any prescribed reportable incident that occurs on the premises, or in relation to the SRS, by the end of the next business day after the occurrence of the incident.

For the purposes of section 77(1) of the Act, regulation 50 specifies that prescribed incidents are:

(a) an unexpected death of a resident
(b) a serious injury of a resident
(c) a fire or other emergency event
(d) an alleged serious assault (sexual or physical).

Proprietors are not required to complete the department's incident report form. Reporting under this instruction is the responsibility of the department's SRS authorised officers only.

4. Roles and responsibilities

4.1 Service providers

The responsibility for the management of an incident rests at the local service level.
The responsibilities for managing incidents at the service provision level include:

- responding to the immediate needs of individuals involved, including staff
- taking any remedial action necessary to re-establish a safe environment (This is the first priority where there continues to be a threat)
- communicating with the client or staff member, relatives, carers, friends or advocates and other service providers as appropriate and in a timely manner
- communicating across the organisation through verbal and written incident reports in accordance with an approach of positive, non-punitive reporting
- reviewing incident information over time to identify lessons and practice implications and make recommendations for improvements
- generating and implementing improvement strategies and action plans, including those for incident prevention and minimisation, consulting with the department as appropriate
- monitoring and reviewing the effectiveness of actions taken
- supporting a reporting culture amongst clients and staff to encourage them to report incidents they experience
- communicating information on reportable incidents to the relevant external bodies in accordance with the instruction, including but not limited to, the police, the Coroner, the Chief Psychiatrist or WorkSafe
- undertaking compliance checks to assess the ongoing implementation of incident reporting policy. A compliance check will involve a review of documentation, data analysis from information systems and discussions with staff to determine the extent of compliance with the policy.

4.2 Regional office

Incident management and reporting is primarily a regional responsibility. The department's regional role includes:

- ensuring accuracy in categorising and investigating incidents to identify lessons and make recommendations for reducing risk to future clients and staff
- communicating with the ministers, Secretary, executive directors and other senior staff verbally and through written briefs and reports as appropriate
- a systematic approach to reviewing incidents and investigating where appropriate
- a focus on the root cause of the incident rather than the immediate event
- analysing and reviewing individual and aggregate incident information over time to identify lessons and practice implications and make recommendations for improvements
- generating and implementing improvement strategies and action plans, and consulting with central office programs as appropriate
- timely and periodic review of incident data for trends and the provision of feedback to services
- coordinating media interest with relevant programs, Media Unit, ministerial staff, and the Mental Health, Drugs and Regions Division

- undertaking compliance checks to assess the ongoing implementation of incident reporting policy. A compliance check will involve a review of documentation, data analysis from information systems and discussions with staff to determine the extent of compliance with the policy

The Director, Health and Aged Care in each region must ensure that all relevant regional departmental managers, authorised officers, and service providers comply with incident reporting and management requirements.

Regional departmental program and service advisers (PASAs) are responsible for ensuring that service providers, are aware of and comply with the department's incident reporting instruction and any other requirements established by the region or the program area. For incidents occurring in an SRS, departmental authorised officers are required to complete the incident report form.

4.3 Central office

Divisional program areas are responsible for reviewing incident data in consultation with regions, to inform policy development, practice and policy implementation.

The process of reviewing and managing incident data must include:

- a systematic approach to reviewing, and where appropriate, investigating incidents
- a focus on the root cause of the incident, as well as the immediate event
- analysing and reviewing aggregate incident information over time to identify lessons and practice implications and make recommendations for improvements
- generating and implementing improvement strategies and action plans, consulting with the regions, other programs and the Mental Health, Drugs and Regions Division as appropriate
- timely and periodic review (at least quarterly) of incident data for trends
- undertaking compliance checks to assess the ongoing implementation of incident reporting policy. A compliance check will involve a review of documentation, data analysis from information systems and discussions with staff to determine the extent of compliance with the policy.

The Mental Health, Drugs and Regions Division, through the regional coordination function, has overall responsibility for incident reporting process.

The Business Planning and Communications Branch is responsible for the aggregation of incident report data and trends through the Executive Performance Report coordination function.

5. Definition of key terms

5.1 ‘During service delivery’

All incidents occurring ‘during service delivery’ are required to be reported in accordance with the instruction for their category.

‘During service delivery’ relates to the:

- nature of the interaction or relationship with a client and the time an incident occurs
  - if a service provides 24-hour care, a report is required for all incidents involving clients of this service, regardless of the location
  - if a service is providing episodic care, a report is required when an incident occurs while the client is receiving that service, for example while a staff member is with a client
- location that an incident occurs
  - all incidents that occur on-site at the service or SRS are considered to have occurred ‘during service delivery’, including inside and around the building, and locations that are within view of staff
  - off-site /outreach services should report incidents that occur at the location of service delivery and the area directly surrounding that location.

Please note: A report may be required for incidents that occur off-premises or outside of service delivery where there is a direct and obvious relationship to, and impact on the delivery of service. For example, the apparent alcohol or drug related death of an active client of an AOD service must be reported, irrespective of the location.

Incidents that have potential to subject the service or the department to public scrutiny, or involve the relevant minister must also be reported regardless of the location.

5.2 Categorisation

Incidents are graded according to the actual impact on clients and staff, and the potential future risk to clients and the department.

There are three categories of incidents, and in grading them, consideration is given both to the actual impact or apparent outcome for client and staff, and to the likelihood of recurrence.

A category one incident is an incident that has resulted in a catastrophic outcome, such as death or severe trauma. Events that have the potential to involve the relevant minister, or high levels of public or legal scrutiny are also a category one.

A category three incident, in contrast, has minor impact on clients and staff with the significance of the incident not extending beyond the workplace or facility. **Note: the Department of Health does not require category three incident reports to be submitted to the department.**

5.2.1 Category one incidents

Category one incidents are the most serious; and such incidents occurring on-site or during service delivery must be reported.

Incidents at other times may also need to be reported where there is a direct and obvious relationship to, and impact on the delivery of service.

Category one incidents include:

- an unexpected death of a client or staff member (see note)
- the apparent alcohol or drug-related death of a client of AOD services irrespective of location of the incident
- a drug or alcohol overdose where the client is admitted to hospital as an inpatient and is unlikely to fully recover
- a serious injury to a client or staff member
- allegations of, or actual serious physical or sexual assault
- a fire involving death or serious injury
- a serious fire resulting in closure or significant damage to parts of a building or its contents which poses a threat to the health and safety of staff or clients
- serious property damage resulting in closure or significant damage to parts of a building or its contents, which poses a threat to the health and safety of staff or clients
- incidents in residential settings that have placed other residents at risk of harm
- a resident of an SRS missing for a significant period of time where there are concerns for their welfare, or where a missing persons report has been lodged with the police
- an event that has the potential to involve the relevant minister
- an event that has the potential to subject the department or service to high levels of public or legal scrutiny.

It is not feasible to list every possible type of category one incident, and it is expected that senior staff will use their judgement in considering the sensitivity and appropriate grading of individual incidents.

There is intense public and media interest in the operations of Victoria's health services, and it is essential that the department and ministers' offices are able to respond quickly to issues and events that may arise.

Note: As in the general population, people will pass away in an SRS, or while in receipt of services. The death of a resident or client of a service does not in itself constitute a category one incident. However, if the death involves circumstances that are out of the ordinary an incident report may be required, for example:

- the death occurred in unusual circumstances
- a resident of an SRS dies and the condition of the SRS or standard of care provided may have been a contributing factor
- the death has a direct and obvious correlation to the service the person was receiving
- the death is reportable – for example, to the Coroner (page 32) or to the Chief Psychiatrist.

5.2.2 Category two incidents

Category two incidents involve events that seriously threaten, clients or staff, but do not meet the category one definition. Incidents occurring at the service or during service delivery must be reported.

Category two incidents are only reported to the department by AOD service and PDRS services, however, all organisations should be aware of requirements to register and monitor these incidents internally for accreditation, insurance or service agreement compliance.

Category two incidents include:

- an injury for which a person attends and/or receives treatment by a medical practitioner but is not admitted to hospital as an inpatient
- a drug or alcohol overdose for which a person attends and/or receives treatment by a medical practitioner but is not admitted to hospital as an inpatient
- assaults that do not classify as category one incidents
- serious threats made against clients or staff
- unethical behaviour by staff, particularly if it involves taking advantage of clients
- client behaviour that could result in potential risk to client or others
- criminal behaviour resulting in police intervention*
- incidents that have the potential to escalate to a category one.

** Staff will need to use their judgement in relation to this incident type. Some clients or client groups may have more frequent involvement in the criminal justice system than others. Serious charges should always be reported.*

5.2.3 Category three incidents

Category three incidents occur where normal work and routine is interrupted, but the significance of the incident does not extend beyond the workplace or facility. Category three incidents include those which:

- can be dealt with adequately by the organisation
- have a minor impact on the client
- have no further implications for the department, region or the community.

Category three incidents do not need to be reported to the department, however, all organisations should be aware of any other requirements to register/record these incidents internally, for example, for accreditation, insurance, or legislative compliance.

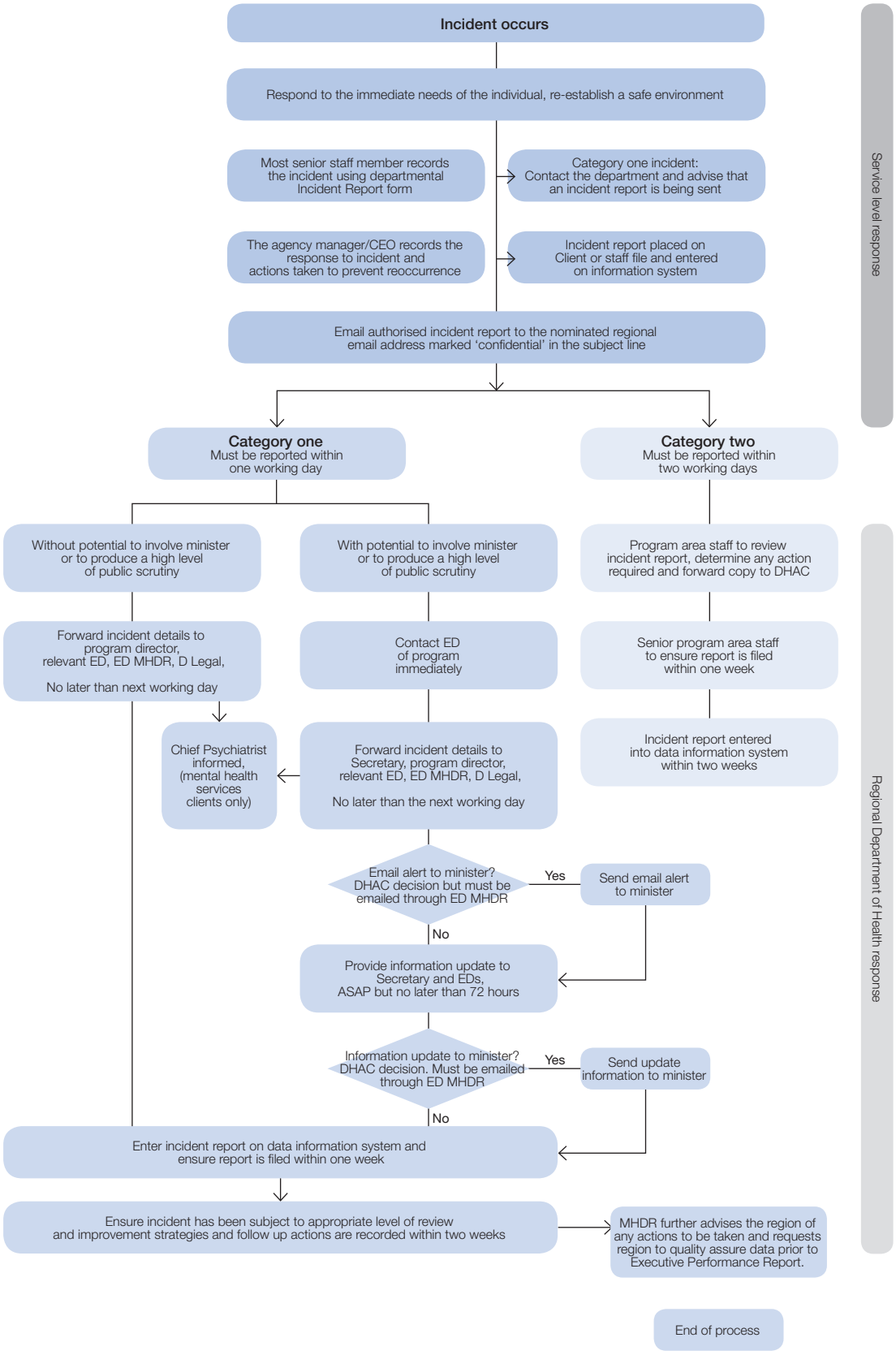
5.3 Reporting frequently recurring behaviour

For the purposes of the instruction, 'frequent behaviour' is reportable behaviours of the same incident type and subtype by a client that occurs more than once in a shift or workday. For example: incident type 'behaviour' and subtype 'disruptive'.

For category two incidents where a behaviour is clearly identified in a client care plan or support plan and occurs multiple times in a single work day or shift the incidents may be summarised in one incident report. A separate incident report for each occurrence is not required. The incident report must clearly report and outline the number of episodes of the behaviour.

Figure 1: Overview of incident reporting requirements for funded organisations

Note: the SRS incident report process is outlined in 6.2



6. Incident reporting requirements

6.1 Service provider reporting process

All service providers subject to a service agreement or contract should be provided with a service agreement information kit. Part of this kit sets out the procedures for recording and reporting incidents involving staff or clients in external funded services.

Service providers included in the scope of the policy and subject to a service agreement or contract are required to report incidents to the department in accordance with this instruction.

6.1.1 Respond to the immediate needs of the individual

The staff member responsible for the client at the time the incident occurred or when it was reported must respond to the immediate needs of the individuals involved and re-establish a safe environment.

6.1.2 Advise senior staff members

The most senior member of staff available at the time of the incident must report it immediately to their supervisor.

6.1.3 Contact the department and advise of the incident (category one incidents only)

The most senior member of staff available at the time should contact the department's regional office to advise them that an incident has occurred and that an incident report is being sent.

6.1.4 Submit the incident report form

The incident report form can be downloaded from the Funded Agency Channel <www.dhs.vic.gov.au/funded-agency-channel>.

The incident report must be completed by the most senior witness to the incident, or the person to whom the incident was reported, if there were no witnesses.

The reporting agency manager/CEO:

- records the local action in response to the incident and if appropriate, the action planned to prevent recurrence on the incident report
- must quality check the incident report ensuring the appropriate incident type, category, client and location details have been recorded
- submits the form to the relevant department regional office using the designated regional email address (see Section 9.5) in accordance with the set timelines, marking the subject line 'Confidential' only. Note: If the agency's service agreement is with the department's central office, the incident report should be sent directly to the central office program area that manages the service agreement.

Category one incident reports must be sent to the department as soon as possible, and within **one** working day

Category two incident reports must be sent to the department as soon as possible, and within **two** working days (AOD and PDRS services only)

6.1.5 Additional details

It is acknowledged that the need to quickly submit the incident report may conflict with the time required to develop long-term or complex responses. In this instance, the incident report must be submitted in accordance with the set timelines, noting on the form that a response is still being developed. That response must be completed within five working days and appended to the original incident report. This information should be sent to the department, with a copy retained by the reporting organisation.

6.1.6 Data management

The incident report form must be placed on the relevant client or staff file, and any follow up actions identified.

Each funded organisation must maintain an incident register or database to record incident reports. This register or database will be available for audit.

6.2 Supported Residential Services reporting process

Proprietors of SRS are not required to complete the department's incident report form.

As part of the category one reporting process, SRS authorised officers of the department will only report on incidents that have been received by the department as part of the prescribed reportable incident requirements of the SRS act.

6.2.1 Contact SRS and ensure incident has been responded to

When an authorised officer is advised of an incident they should contact the SRS to ensure:

- the proprietor has responded to the immediate needs of the resident(s) involved
- that the proprietor has taken any remedial action to re-establish a safe environment.

6.2.2 Contact SRS program manager

Following notification of the incident the authorised officer should contact the regional and central office SRS program managers to consult on the categorisation of the incident.

6.2.3 Submit the incident report form

For incidents occurring in an SRS, proprietors do not complete incident reports. The authorised officer, or SRS program manager must complete the incident report where it is not being completed by another program area.

The incident report form is then distributed through the relevant departmental regional office in accordance with the set timelines.

6.3 Regional office process following the receipt of an incident report

6.3.1 Receive, quality check of and review incident report

The appropriate regional office program area must quality check the incident report ensuring the appropriate incident type, category, client and location details have been recorded. In addition they will review the action taken in response and record any further action required.

If any changes are made to an incident report submitted by a service provider, the modified version must be returned to the reporting organisation for inclusion on the relevant client or staff file.

The regional program areas will verify the classification of category two incidents.

Once an incident report has been completed, the description of the incident must not be changed, amended or altered in any way or for any reason. Occasionally, other witnesses or individuals may disagree with the content of the report. Where this occurs, the alternative views must be put in writing on a separate piece of paper, and attached to the completed incident report.

6.3.2 Verify the incident category and follow procedure for that category

The Director, Health and Aged Care will verify the category one classification and follow the process outlined in section 7.

If the Director, Health and Aged Care determines that a report submitted by a service provider as category one is in fact category two (or vice versa) the reporting organisation will be advised of the re-categorisation.

Section 7 outlines the departmental procedure for responding to category one incident reports.

Section 8 outlines the departmental procedure for responding to category two incident reports.

6.3.3 Endorse and file report

Once the incident report is verified and endorsed, copies must be placed on the relevant file.

6.4 Completing the incident report form

6.4.1 Incident details

The incident report form should record all necessary factual details. It must include:

- who was involved
- how, where and when the incident occurred
- who was injured and the nature and extent of injuries (if applicable)
- what action is being taken in response to the incident.

Objective language must be used.

6.4.2 Security and privacy

Consistent with the department's privacy policy, appropriate security safeguards must be in place when collecting information necessary for the aims of incident reporting (see section 9). It may not be necessary to name witnesses. All reports must be legible and presented in the specified report format.

An incident report may include personal information from a third party to an incident, that is, someone who is not a client or staff member but witnessed or was involved in an incident. Where this occurs, the privacy policy in relation to collecting information from third parties applies. The person should be notified that the information is being collected by the department for the purpose of incident reporting, and in particular, to prevent the repetition of a similar incident. Further information is available at <www.health.vic.gov.au/privacy>.

6.5 Clients involved with a number of programs or activities

An incident may occur that involves a client who is also involved with a number of other programs or organisations, or who resides in an SRS.

In this case, the organisation or program which first becomes aware of the incident must complete the incident report, unless a more appropriate program or organisation takes responsibility for reporting the incident.

If the organisation or program that first becomes aware of the incident is not the lead program or organisation with prime responsibility for the client, then they must ensure the lead program or prime organisation is informed.

7. Departmental procedures for category one incidents

7.1 Procedures for category one incidents without the potential to involve the minister or produce a high level of public or legal scrutiny

7.1.1 Following receipt of incident report by Director, Health and Aged Care

The Director, Health and Aged Care will verify the category one classification and determine whether the incident has the potential to involve the relevant minister or is likely to subject the department or reporting agency to high levels of public or legal scrutiny.

If the incident does not have the potential to involve the relevant minister and is not likely to be subject to high levels of public or legal scrutiny, the Director, Health and Aged Care will ensure that the incident details are forwarded to the:

- Executive Director, Mental Health, Drugs and Regions Division
- relevant executive director
- relevant program director
- Director, Legal Services
- Chief Psychiatrist (mental health service clients only).

These people must receive the incident details no later than the next working day.

If the incident involves a fire or serious property damage, Capital Projects and Service Planning Branch may also need to be informed (refer to section 13.4).

If the incident has the potential to involve the relevant minister and is likely to subject the department to high levels of public or legal scrutiny, refer to section 7.2.

7.1.2 Incident review

The Director, Health and Aged Care will ensure that the incident is subject to an appropriate level of review and that, where relevant, improvement strategies and follow-up actions are recorded. Incident reviews should:

- identify reasons that the incident occurred
- identify opportunities for improvement in systems or processes
- make recommendations for improvement strategies in order to prevent or minimise recurrences. Improvement strategies should define prioritised actions, responsibilities, timescales and strategies for measuring the effectiveness of actions
- confirm that mandatory reporting requirements have been met (for example reporting to WorkCover, the Coroner, the Chief Psychiatrist).

Where the Director, Health and Aged Care considers it appropriate, or at the specific request of the relevant executive director, the Director, Health and Aged Care will provide the executive director with a comprehensive report within two weeks of the incident.

7.1.3 Data management

The Director, Health and Aged Care must ensure that category one incident reports are entered on the department's data management system within one week of the incident. Departmental staff members are required to file copies of all incident reports and review incidents as part of quality assurance.

Table 2: Category one incidents without the potential to involve the minister or produce a high level of public or legal scrutiny – actions by Director, Health and Aged Care

Action	Timeline
Forward incident details to program director, relevant executive director, Executive Director Mental Health, Drugs and Regions, Director Legal Services	No later than next working day
If mental health service client, forward incident report to the Chief Psychiatrist	No later than next working day
Enter incident report on information system and ensure report is placed on file	Within one week
Ensure incident has been subject to appropriate level of review, and improvement strategies and follow up actions are recorded	Within two weeks

7.2 Additional procedures for category one incidents with the potential to involve the minister or produce a high level of public or legal scrutiny

The Director, Health and Aged Care or their nominee will immediately contact the relevant executive director to advise of the incident.

The Director, Health and Aged Care will ensure that the incident details are sent to:

- the Secretary
- the relevant executive director
- the Executive Director Mental Health, Drugs and Regions Division
- the relevant program director
- Director, Legal Services
- Chief Psychiatrist (mental health service clients only).

These people must receive the incident details no later than the next working day. The Director, Health and Aged Care has discretion to submit an email alert to the minister.

For incidents that have media interest the Director Health and Aged Care should coordinate media interest with the relevant programs, the Media Unit and ministerial staff.

If the incident involves a fire or serious property damage, Capital Projects and Service Planning Branch may also need to be informed (refer to section 13.4).

7.2.1 Information Update

The Director, Health and Aged Care will provide an Information Update to the Secretary and executive directors, and minister where appropriate, as soon as possible, but no later than 72 hours after a category one incident has been determined to have the potential to involve the minister, or is likely to subject the department or reporting organisation to high levels of public or legal scrutiny.

The Director, Health and Aged Care (or if applicable, the program director) will ensure that the minister and Secretary are kept informed of events and issues as appropriate.

Table 3: Category one incidents with the potential to involve the minister or produce a high level of public or legal scrutiny – actions by Director, Health and Aged Care

Action	Timeline
Contact program executive director	Immediately
Forward incident details to the Secretary, program director, relevant executive director, Executive Director Mental Health, Drugs and Regions Division, Director, Legal Services	No later than next working day
Send email alert to the minister where appropriate	No later than next working day
Provide Information Update to the Secretary and executive directors, and minister where appropriate	ASAP no later than 72 hours
Enter incident report on information system and ensure report is placed on file	Within one week
Ensure incident has been subject to appropriate level of review, and improvement strategies and follow-up actions are recorded	Within two weeks

8. Departmental procedures for category two incidents

Only AOD and PDRS services are required to report category two incidents to the department.

The PASA should initially review and quality check the incident report, and then forward the report to the most senior program area staff member within one day of receipt of the report.

The most senior staff member in the regional program area will review the incident report and where appropriate, provide advice on any action required in response to the incident.

The incident report should be provided to the Director, Health and Aged Care for endorsement and placed on the file within one week.

Each regional departmental program area must ensure that incident reports are recorded on the data information system within two weeks.

Table 4: Category two incidents

Action	Responsibility	Timeline
Forward report to program manager	PASA	Within one day
Review incident report, determine any action required and ensure report is endorsed by Director, Health and Aged Care and filed	Senior program area staff	Within one week
Enter incident report on information system	IR administrator	Within two weeks

9. Privacy

Respecting the privacy of individuals who are involved in, or witness to, an incident is an important consideration in dealing with incident reports, which often contain personal and other sensitive information.

9.1 Departmental staff

Department of Health staff must comply with the department's privacy policy whenever personal and/or health information about clients, staff or others is collected, stored, transmitted, used or disclosed.

The privacy policy is an integrated policy, which supports the protection and management of personal information and seeks to meet the legislative requirements of the Information Privacy Act 2000 and Health Records Act 2001. Information relating to privacy is available at www.health.vic.gov.au/privacy

9.2 Funded organisations

Funded organisations are required by the standard clause in their service agreement to comply with the *Information Privacy Act 2000* and *Health Records Act 2001*. Funded organisations may also be subject to the Health Records Act in their own right if handling health information.

The information handling procedures outlined in this document have been developed in consultation with the Corporate Integrity, Information and Resolutions Unit and Legal Branch.

9.3 Privacy policy requirements

The privacy policy requires that individuals be advised of why information about them is being collected and how it will be handled. This means that clients and other individuals, about whom information is being collected, should be advised that the purpose of the collection is to report on and investigate an incident and that it will only be used for this purpose and to improve the service system.

If an incident report includes information collected from a client prior to the incident and/or outside the context of the incident, such as background information commonly collected at the point of entry into the service system, the following principles apply:

- use and disclosure of that information in the incident report must be for the primary purpose for which the information was collected, or must be directly related to that primary purpose; and
- use and disclosure of the information in the incident report must be within the person's reasonable expectations.

In the event of a serious incident, in most cases clients and staff both from within the department and external agencies would reasonably expect that a report and investigation would occur.

The personal information to be disclosed in an incident report in these circumstances should only be information which is directly related to the specific circumstance and which is clearly necessary for the purpose of reporting and investigating the incident.

If the information in an incident report is highly sensitive or there are doubts about whether its use and disclosure would be within the person's reasonable expectations, the person should be advised of the intended use and disclosure through the reporting process.

Personal identifiable information should only be collected, used and disclosed to the extent necessary for the investigation and reporting of the incident. For example, where staff of a funded organisation are bystanders at an incident, with no other involvement, the organisation should keep

a record of their presence but need not advise the department of staff names. The organisation must retain the information for possible future use.

It is recommended that at the time of the incident witnesses should be asked to provide their consent to the collection of their personal information and use of their information for the purposes of reporting and investigation of the incident. This will also facilitate easy identification and contacting of witnesses in the future.

Both the *Information Privacy Act 2000* and *Health Records Act 2001* contain some key limited exemptions when information can be used or disclosed without the consent of the person to which it relates. These exemptions mean that consent may not be required if:

- the use or disclosure is for the primary purpose for which the information was collected
- the use or disclosure is for a purpose that is not the primary purpose for which the information was collected, but is related to that primary purpose, and is a purpose for which the person concerned would reasonably expect his/her information to be used and disclosed
- the use or disclosure is to lessen or prevent a serious and imminent threat to individual's life, health, safety or welfare
- the use or disclosure is to lessen or prevent a serious threat to public health, public safety or public welfare
- the use and disclosure is necessary as part of investigation where there is a suspicion of unlawful activity
- the use or disclosure is required or authorised under law.

If there are uncertainties in relation to the use or disclosure of personal information collected, please consult with the privacy team in the Corporate Integrity, Information and Resolution Unit.
Email privacy@health.vic.gov.au or phone 9096 0888.

9.4 Secure transmission and storing of information

Consistent with the department's privacy policy, appropriate security safeguards must be in place when transmitting and storing information.

Incident reports should be stored in a secure electronic file, in locked cabinets or cupboards, and copies that are no longer required should be destroyed. Only authorised personnel should be able to access these files.

Incident reports must be completed by the most senior witness to an incident. Per section 6.1.4, the funded agency manager or CEO must quality check the incident report, paying particular attention to incident type, category, client and location details. The report should then be submitted by the funded agency manager or CEO via email to the relevant dedicated DH regional account. (See section 9.5 for details.)

Reports should be attached as a PDF document with the subject line marked *"Confidential"* only. When using email addresses, care should be taken with the list of addressees and in particular no personal email addresses should be used for departmental communications. Communications must be via the dedicated Department of Health regional account.

There are particular risks in relation to messages sent via the Internet, which apply to funded organisations. The confidentiality of Internet traffic can be difficult to assure, as it may pass through, and be scanned and copied by nodes in many different places.

Similarly, there are risks to privacy in sending information via fax. These include misdialling a number, people other than the intended recipient reading the information, or the transmission not being authorised.

On balance, lodgement via email, limited only to traffic between the funded agency manager or CEO and the dedicated DH accounts is the best way to limit privacy breaches within the current technological environment.

9.5 Step-by-step instructions

1. Complete the electronic incident report form including all necessary details.
2. Obtain the funded agency manager or CEO's signature.
3. Email the approved document marked 'confidential' to the dedicated regional email account (see below).
4. The Regional Office will contact the funded agency to clarify issues and request any additional information where necessary and provide a full report to the central office where necessary.
5. The Central Office will review the incident and take any action as necessary, monitor overall trends and implement systems improvements.

If the incident has a potential to attract media attention, the regional office and subsequently the central office should be contacted immediately, prior to the incident report being submitted.

Nominated email addresses for regions and central office:

Southern	SouthernDH.Incidents@health.vic.gov.au
Eastern	EasternDH.Incidents@health.vic.gov.au
North and West	NorthWestDH.Incidents@health.vic.gov.au
Grampians	GrampiansDH.Incidents@health.vic.gov.au
Hume	HumeDH.Incidents@health.vic.gov.au
Loddon Mallee	LoddonDH.Incidents@health.vic.gov.au
Gippsland	GippslandDH.Incidents@health.vic.gov.au
Barwon South Western	BarwonDH.Incidents@health.vic.gov.au
Central	MHDR.Incidents@health.vic.gov.au
Central	SRS.Incidents@health.vic.gov.au
Central	HACC.Incidents@health.vic.gov.au
Central	Aged.Incidents@health.vic.gov.au

See Figure 1 (page 11) for an overview of the incident reporting requirements.

9.6 Privacy principles

For more information on privacy you can visit the following websites:

Office of the Victorian Privacy Commissioner
http://www.privacy.vic.gov.au

Office of the Australian Information Commissioner
http://www.privacy.gov.au

National Privacy Principles
http://www.privacy.gov.au/materials/types/infosheets/view/6583

Other information and guidelines
http://www.privacy.gov.au/law/apply/guidance

10. Reporting physical or sexual assault

10.1 Physical assault

For the purposes of this instruction, physical assault consists of any non-accidental form of injury or serious harm caused by the direct or indirect application of force.

Physical injury is defined to include, but is not limited to, internal injuries, dislocated or broken bones, cuts, bruising, welts or burns. These may be caused by hitting, throwing, shaking, suffocation, strangulation, poisoning, mutilation, or assault with a weapon. Assault may also include other actions such as spitting or serious threatened or attempted assault (for example, involving a weapon) that results in discomfort or pain.

Assaultive behaviour of any type is unacceptable, regardless of the intent of the person committing the violence.

10.2 Sexual assault

Sexual assault includes rape, assault with intent to rape and indecent assault. Indecent assaults are assaults that are accompanied by circumstances of indecency. Examples are unwelcome kissing or touching in the area of a person's breasts, buttocks or genitals. Indecent assault can also include behaviour that does not involve actual touching such as forcing someone to watch pornography or masturbation.

Consent is not a defence to some sexual offences. For example a person who takes part in an act of sexual penetration with a child under the age of 16 is guilty of an indictable offence, unless the child is aged between 10 and 16 and the two people taking part in the act are married to each other. If the two people are not married, and the child is aged more than 10 years, then consent is not a defence unless the accused:

- believed on reasonable grounds that the child was aged 16 or older
- was not more than two years older than the child
- believed on reasonable grounds that they were married to the child.

10.3 Categorising assault incidents

Assaultive behaviour can vary in nature from life-threatening events to minor incidents. An example of a minor incident is one client or resident shoving another with no injury. Further advice is provided below to assist with the categorisation of allegations of assault.

10.3.1 Category one assaults

Category one assaults include rape, the production of child pornography and physical assault of or by a client which results in medical attention being required for the victim, or involves use of a weapon. Medical attention means attendance or treatment by a medical practitioner.

Any form of assault of a client by a staff member, proprietor or volunteer is category one, this includes indecent assault and physical assault not requiring medical intervention.

10.3.2 Category two assaults

Physical assaults not requiring medical attention are usually category two incidents (unless the alleged perpetrator is a staff member, proprietor or volunteer, in which case the assault would be considered category one). A physical assault between clients that requires first aid only, for example, is a category two incident.

10.3.3 Indecent assault of or by a client

Indecent assault includes forcible touching on breasts or genitals, or unwelcome exposure of breasts of genitals to others. Indecent assault of or by a client may be categorised as a category one or two incident depending on the circumstances of the event. Some of the factors that should be considered in categorising this type of assault include:

- The level of distress caused to the victim. Note: Continuous, low level, inappropriate touching may not be thought of by staff as indecent assault, but may feel like that to the victim, and in some circumstances may be regarded as such by the law. Where a minor is the victim, cumulative behaviour may also attract sexual assault charges regardless of individual incidences being low level.
- The individual client's behaviour or disability. Categorising inappropriate touching or exposure will also depend on the clients understanding of the behaviour. For example, if they are unable to distinguish between the significance of touching someone on the arm as opposed to the breast, then it may be most appropriate to categorise the incident as category three. However, a client with a disability may have the cognitive capacity to understand inappropriate touching is unacceptable, and hence an incident will be category one or two depending on the circumstances. If the behaviour is such that criminal charges are likely, or the client has previously been charged with sexual offences, then the incident must be categorised as category one.

Staff should be mindful that sex-offending develops via a progression of behaviours that increase in severity over time. Accurate categorising and reporting of inappropriate sexual behaviour will help identify the need to intervene and assist the client to develop appropriate behaviour.

10.3.4 Categorising assault incidents – minimum requirements

Categorising of incident reports must follow the table below as a minimum requirement. It is not possible to stipulate every possible variety of incident, and judgement by senior staff will be required.

Table 5: Categorising assault incident types

Category	Type of alleged assault
Category one	Rape of or by a client/resident
	Rape or indecent assault by a staff member, proprietor, or volunteer
	Production of child pornography by a client / resident, staff member, or volunteer
	Physical assault of a client/resident by a staff member, proprietor, volunteer
	Physical assault of or by a client/resident resulting in medical attention being required for the victim (for example stitches, surgery, setting of a fracture)
	Physical assault of or by a client/resident involving a weapon such as a knife, hammer, or other object
Category two	Physical assault of or by a client resulting in first aid being required for the victim. (This does not include the assault of a client by a staff member)
Category three	Shoving or pushing between clients/residents that does not cause injury

10.4 Reporting allegations of physical and sexual assault to the police

It is expected practice that all physical and sexual assaults occurring on-site, during service delivery, or where there is direct involvement of the service or its staff, will be reported to the police.

If the alleged incident involves a child, reporters of the incident should be aware of any mandatory reporting responsibilities as outlined in the *Children, Youth and Families Act 2005*. This includes reporting child welfare concerns to child protection.

Further information on supporting victims and reporting allegations of sexual assault can be found in the *Responding to allegations of physical and sexual assault instruction.*

11. Reviewing and learning from incidents

Without organisational learning and change, the safety and quality of services to clients will not improve.

Incidents should be systematically analysed and change implemented in an ongoing way, to prevent similar events recurring. This may include processes such as local regional reviews, Chief Psychiatrist reviews, or regulation reviews of a SRS.

Many incidents involve human error. The department supports a systems approach to human error, recognising that these will occur even in the best organisations. A systems approach concentrates on the conditions under which individuals work, as the root cause of an incident may lie in organisational and management systems. For instance, the root cause of an incident involving injury to a client may be a staff-training deficit or equipment failure. The focus must be on trying to build defences and to prevent errors or reduce their effects.

It may be appropriate to use root cause analysis for unexpected occurrences or incidents involving death or serious physical or psychological injury, or the risk thereof. Root cause analysis both probes the source of a problem and suggests solutions in the form of preventive system changes.
Root cause analysis:

- focuses primarily on systems and processes, not individual performance
- progresses from special causes in care processes to common causes in organisational processes
- repeatedly digs deeper by asking 'why?' until no additional logical answer can be identified
- identifies changes that could be made in systems and processes, through either redesign or development of new systems or processes, to improve the level of performance and reduce the risk of a particular serious incident occurring in the future.

Root cause analysis is founded on the belief that people make mistakes and that errors are inevitable, but that organisational improvement is always possible and the ever-present goal.

The department supports a culture of safety in the organisation and its funded services. With the development of systems to aggregate incident data, there will be an increasing focus on learning from incidents to enhance safety for clients and staff, and for residents living in an SRS.

A service working well should expect that:

- serious failures of standards of care are uncommon
- serious failures of a similar kind do not recur
- incidents where services have failed in one region are not repeated in other regions
- systems are in place to reduce, to a minimum, the likelihood of serious failure in standards of care
- attention is paid to monitoring and reducing levels of less serious incidents.

12. Incident report records management and data analysis

12.1 Incident report register and files

Every Department of Health region must ensure that all category one and two incident reports within the region are entered on TRIM, the department's record management system. The incident reports must be entered in the system according to TRIM guidelines on KnowledgeNet.

This enables a review of policy and practice issues and development and implementation of appropriate changes.

The region must ensure that hard copies of all incident reports are filed appropriately and can be readily accessed. The region must ensure that all hard copies are filed while the original is forwarded through the appropriate channels. Copies should remain on file until replaced by the final signed copy. This procedure will ensure that information is up to date at all times. The original copy must be placed on the file.

12.2 Funded organisation obligations and requirements

Funded organisations must maintain an incident register or database. The register or database must be available for audit by the PASA.

Where allegations are made against a staff member or client, the incident report and any subsequent reports retained by the department and the funded organisation are to be cross-referenced to the staff or client file.

Paper incident reports and related electronic data must be stored securely and accessed only by staff that have a business purpose for doing so. Paper reports should be stored in locked filing cabinets, and electronic access limited to appropriate staff.

12.3 Trend analysis

Aggregate reviews of reported incidents can show patterns or trends that may not be noticeable from individual incident analysis, and provide additional valuable information for learning.
Every division and region must maintain an active overview of category one, and where relevant category two, incident reports related to its area of responsibilities. This will entail analysis from aggregate data retrieved from TRIM, as well as the review of individual incidents. Aggregate reviews can be carried out on all or selected types and categories of incident using the following approaches:

- Frequency analysis – how many incidents happen?
- Cross-tabulation analysis – how many incidents happen by type of program?
- Trend analysis – what happened over time?

13. Other departmental reporting processes or requirements

The incident reporting instruction is one of several departmental processes for dealing with a range of incidents or events. All have a common theme in risk management, and the desire to learn from and prevent repetition of adverse events. Some are purely internal to the department, and others apply to the Victorian community. To assist in understanding the web of processes, a brief outline is given of each. Some incidents will require a number of reports for different purposes.

13.1 The Chief Psychiatrist

The Chief Psychiatrist has responsibility under the *Mental Health Act 1986* for the medical care and welfare of persons receiving treatment or care for a mental illness.

The Chief Psychiatrist's responsibilities include monitoring the clinical standards of psychiatric practice and treatment provided by public mental health services, and responding to complaints from consumers, carers and others.

Under the Act an authorised psychiatrist of an approved mental health service or a person in charge of any other 'psychiatric service' must report the death of any person receiving treatment or care for a mental disorder, which is a reportable death within the meaning of the *Coroners Act 2008*.

The Chief Psychiatrist's reportable deaths guideline also requires that services report the death of any currently registered mental health consumer if it is unnatural or unexpected, and where they become aware of the unexpected death of a consumer who was a registered client within the preceding six months. The Chief Psychiatrist reviews the report to identify any clinical, service or system issues of concern.

Further information about the role of the Chief Psychiatrist, and guidelines to inform mental health practitioners and services about the operation and clinical issues in relation to the Mental Health Act can be accessed at <www.health.vic.gov.au/chiefpsychiatrist>.

13.2 Victorian Health Incident Management System (VHIMS)

This statewide incident management system is built on a standardised (standards based) incident data set. All Victorian publically-funded health services are within VHIMS scope and include:

- public health services (and all services auspiced from these services)
- registered community health centres
- Ambulance Victoria
- Royal District Nursing Service
- Ballarat District Nursing and Healthcare
- bush nursing centres
- Forensicare
- five Incorporated residential aged care services.

VHIMS has been designed to cater for all incident types whether clinical (patient/client) occupational health and safety or non-clinical incidents.

VHIMS has the capacity to capture and report information on a broad range of clinical and non-clinical incidents occurring across all health care settings. The VHIMS data collection combines a number of existing Department of Health administrative data collections into one, these include:

- sentinel events
- radiation safety incidents
- allegations of suspected physical or sexual assault in aged care residential care facility
- absconds and unexplained absences from residential aged care services that have been reported to the police
- serious transfusion incidents
- pressure ulcer indicator program.

Further information on the implementation of VHIMS can be accessed at <www.health.vic.gov.au/clinrisk/vhims>.

13.3 Health and Human Services Emergency Management: Shared services arrangements

This policy provides a framework for Department of Health and Department of Human Services staff in relation to emergency classification and reporting. It applies across all regions, divisions and program areas with emergency management responsibilities within the departments. The policy is available from the Emergency Management Branch intranet site on human services hub.

13.4 Fire risk management

The department has developed a series of guidelines to provide a consistent approach to fire risk management. *The Capital Development Guidelines: Series 7—Fire Risk Management (2008)*, published by the Capital Management Branch (now Capital Projects & Service Planning Branch), outlines the department's expectations with respect to fire risk management for services where sleeping accommodation is provided along with care, support or supervision by staff at all times that occupants are present. These guidelines are available at <www.capital.dhs.vic.gov.au/TechnicalGuidelines/FireRiskManagement/>.

Under the guidelines; for each facility, building or house, and funded organisation providing residential care, a nominated member of staff must have fire risk management responsibilities. These responsibilities include:

- ensuring all facility staff participate regularly in fire safety training and fire drills
- receiving or preparing reports of all fire incidents and false alarms occurring in the facility or houses, informing the nominated senior staff member of their contents, and arranging for appropriate action
- providing reports of fire incidents and false alarms, including corresponding reports issued by the fire brigades, to the department through the region and program, with a copy to the Capital Projects & Service Planning Branch for information and monitoring.

This reporting of fire incidents must follow the procedures outlined in Appendix 6 to Guideline 7.1 (2008).

All organisations should be aware of fire risk management strategies, including the recommended actions of the Victorian Fire Danger Rating scale.

A serious fire is a category one incident and as such the normal category one procedures apply. A serious fire is defined as involving death or serious injury, and includes fires resulting in the closure or significant damage to parts of a building or its contents, or which poses a threat to the health and safety of staff, clients, or residents. Copies of incident reports for serious fires or property damage in all Department of Health funded organisations are required to be sent to Capital Projects & Service Planning Branch for information and monitoring.

13.5 Incidents involving the health, safety and wellbeing of staff

13.5.1 Incidents involving staff

Many incidents involve or affect staff. The health, safety and wellbeing of employees are core management responsibilities. Prevention of workplace risks to health, safety and wellbeing is the most effective way to reduce occupational illness and injury.

Where workplace prevention fails and injury or illness occurs, circumstances will be investigated and action taken to prevent a recurrence. Some incidents involving departmental staff will thus require the completion of a Disease/Injury/Near Miss/Accident (DINMA) form for staff involved, or possibly notification to WorkSafe. The Health Safety & Wellbeing Unit of the People Services Branch manages the DINMA process.

Where a staff member is injured or becomes ill in the workplace, supervisors must provide appropriate support. This will include discussing with the staff member the factors leading to the incident or injury and any assistance the staff member may need, such as debriefing or the Employee Assistance Program.

In addition to internal incident reporting procedures, regional offices and program areas are also required to notify the department's insurer, the Victorian Managed Insurance Authority (VMIA), promptly. Financial Services Branch can provide advice on insurance related matters.

In relation to incidents that may result in general insurance loss and additional to reporting incidents through the departmental incident reporting process, CSOs are required to report all incidents that may lead to a claim against the organisation, to the insurer, VMIA, as detailed in its insurance manual for CSOs.

13.5.2 Disease injury near miss accident (DINMA) reporting

A departmental employee must register an injury, near miss or illness using the DINMA form within 30 days of the incident. Failure to do so can, under the *Accident Compensation Act 1985*, compromise the worker's access to WorkCover compensation.

Under the Act all Victorian employers are required to have a register of injury, as specified by the Victorian WorkCover Authority. This register must be readily accessible in all work places. DINMA reporting ensures that the department complies with the requirements of the Act.

Some incidents may fall within the reporting parameters of both DINMA and this departmental incident reporting instruction. The DINMA form must be completed in addition to the reporting requirements of this departmental instruction for any incident involving worker injury, near miss, illness or accident.

13.5.3 External reporting requirements

Under the *Occupational Health and Safety Act 2004* the employer must notify WorkSafe immediately after the employer becomes aware of a serious incident at a workplace. Refer to s37(2) of the Act and seek assistance from the Work Health Unit for clarification. Note that notification to WorkSafe is required where any person (not just an employee) is involved in a serious incident of a workplace under the control of that employer.

13.6 Residential aged care services

Residential aged care services are funded and regulated by the Commonwealth under the provisions of the *Aged Care Act 1997*. These services are operated by Commonwealth approved providers, which include private for profit, not for profit and government organisations. Most Victorian public health services and a small number of CSOs are approved providers in their own right and receive top-up funding from the Victorian Government to assist in the provision of these services. These providers, referred to as public sector residential aged care service (PSRACS) providers are required to, in addition to complying with Commonwealth requirements, report certain incidents to the Victorian Department of Health.

The Commonwealth Aged Care Act and the Aged Care (Investigation) Principles provide for the establishment and operation of the Aged Care Complaints Investigation Scheme and the Aged Care Commissioner. The responsibilities of approved providers, the powers of the Commonwealth Department of Health and Ageing (DoHA) to impose sanctions in the case of non-compliance with the accreditation standards, and the power of the Aged Care Commissioner to make determinations, are set out in the legislation. The accreditation standards require that approved providers have incident reporting processes and complaints recording and resolution mechanisms for residents in place.

Related Commonwealth requirements include:

- compulsory national police checks for aged care staff and volunteers
- compulsory reporting of alleged and suspect sexual and serious physical assault
- compulsory reporting of missing residents (unexplained absences).

13.6.1 Compulsory reporting of alleged and suspected sexual and serious physical assaults and unexplained absences of residents of residential aged care services

Residential aged care service providers must report allegations or suspicions of unlawful sexual contact, or unreasonable use of force, on a resident of a Commonwealth Government-subsidised aged care home. Providers must also report incidents of unexplained absence of a resident from a residential aged care service. Reports must be made to the police and DoHA within 24 hours of the allegation, or when the approved provider suspects a reportable assault or when the unexplained absence is noted (when the approved provider has decided that a person is unaccountably missing and is sufficiently concerned to notify police).

Compulsory reports are to be made to DoHA via the Aged Care Complaints Investigation Scheme, telephone 1800 550 552.

Residential aged care service providers are required to have systems and protocols in place to enable compulsory reporting and provide protection for staff reporting incidents. Approved providers must also keep consolidated records of all incidents involving allegations or suspicions of reportable assaults and the unexplained absence of residents. These records will be subject to monitoring by DoHA and the Aged Care Standards and Accreditation Agency.

Further information on Commonwealth requirements in relation to allegations of unlawful sexual contact and/or unreasonable use of force, and incidents of unexplained absences can be found in DoHA's Compulsory reporting guidelines for approved providers of residential aged care, available from <www.health.gov.au>.

13.6.2 Parallel reporting requirement for Victorian public sector residential aged care providers

The Department of Health requires Victorian public sector residential aged care service providers to report all Commonwealth compulsory reporting incidents to the Department of Health at the same time as they are reported to DoHA and Victoria Police.

This parallel reporting requirement ensures the department is informed of all such alleged or suspected incidents and unexplained absences of residents in the services. The department has developed a report form based on the information compulsorily required by DoHA and contains no resident identifying information. The form is available at <www.health.vic.gov.au/agedcare/services/psracs.htm.>.

Information and further detail of the above reporting processes are set out in the hospital circular 18/2007 (August 2007) and hospital circular 3/2010 which have been provided to chief executive officers of all public health services, Department of Health divisions and regions.
Refer: <www.health.vic.gov.au/hospitalcirculars/>

13.7 Reporting to the Coroner

In addition to reporting client deaths through departmental incident reporting processes, a statutory obligation to report deaths to the Coroner may also apply. A 'reportable death' to the Coroner includes (but is not limited to) deaths:

- that appear to be unexpected, unnatural or violent, or to have resulted, directly or indirectly, from accident or injury
- of a person whose identity is unknown
- of a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986**.

The Coroner's Act 2008 is available at <www.coronerscourt.vic.gov.au>.

**A member of the immediate family of a deceased person may report the death to the coroner if the person was a person discharged from an approved mental health service within the meaning of the Mental Health Act within three months immediately before the person's death.*

Glossary

Aggregate data – Data collected and reported by organisations as a sum or total over a given time period, for example, monthly or quarterly.

Client – Children, young people or adults who receive services delivered or funded by the department.

Drug/s – For the purpose of the instruction a drug is a chemical substance, natural or synthetic, that alters the functions or structure of the body.

Departmental contact – The first point of contact/liaison officer between the department and organisation, this could be a PASA or SRS authorised officer.

Error of commission – An error that occurs as a result of an action taken. An example is the wrong dose of a drug being given to a client.

Errors of omission – An error that occurs as a result of action not taken. An example is a client suicide associated with a lapse in carrying out frequent client checks where there are significant mental health concerns.

Hazard – A source of potential harm or a situation with a potential to cause loss.

Incident report – Documentation, via a departmental form, of any unusual or concerning problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established policies and procedures or practices.

Medical attention – The attendance and/or treatment by a medical practitioner.

Mental health service – Includes mental health services providing local and statewide specialist treatment and support for people with mental illness and associated psychiatric disability. They include child and adolescent mental health services, adult mental health services, aged persons mental health services and specialist statewide services.

Monitor – To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify change.

Overdose – A drug and/or alcohol overdose occurs when a drug and/or alcohol is used in quantities and/or concentration that cause severe illness. It is a type of poisoning.

Resident – Refers to a person paying a fee to a proprietor of a Supported Residential Service for accommodation and personal or special care (or support).

Risk management – Strategies, structures and processes that are directed towards the effective management of potential opportunities and adverse effects.

Root cause analysis – Process for identifying the basic or causal factor(s) that underlie variation in performance, and which can assist with learning from serious incidents.

Serious injury/harm – Refers to an injury for which a person is admitted to hospital as an inpatient OR any of the following injuries: fractures, concussion, internal injuries, crushings, burns, severe cuts requiring stitches, lacerations, or severe shock.

Sexual penetration – Introduction (to any extent) by a person of his penis into the vagina, anus or mouth of another person. Introduction (to any extent) by a person of an object, or another part of his or her body (other than the penis) into the vagina or anus of another person, other than in the course of a procedure.

Weapon – Thing designed or used or useable for inflicting bodily harm, for example, a knife or brick.

Definitions of commonly used incident types

Assault physical	The incident involves the application of force that caused, or had the potential to cause, serious harm to others.
Assault physical, actual	Actions, or attempted actions, that involve the use of physical force against a person that results in, or had the realistic potential to cause, serious harm.
Assault physical, threatened	Explicit language and/or actions that threaten serious harm.
Assault sexual	Assault sexual involves actions or attempted action of a sexual nature that has caused, or has the realistic potential to cause serious harm.
Assault sexual, indecent	Actions of a sexual nature carried out against a person's will through the use of physical force, intimidation and/or coercion.
Assault sexual, rape	Actual or attempted sexual penetration (anal, oral, vaginal) and/or forcible sexual acts through the use of physical force, intimidation and/or coercion without that person's consent (always categorised as category one).
Assault sexual, rape threatened	Explicit language and/or action that threatens rape. Behaviour, manner, actions, style of conduct or treatment of others that is, or has the potential to be, a serious threat to the health or safety of self or others.
Behaviour, dangerous	Action that leads to, or places self or others, at risk of harm.
Behaviour, disruptive	Actions that cause disorder, are offensive to others or intrusive.
Behaviour, sexual	Sexually orientated actions in an inappropriate circumstance (that do not meet the 'assault sexual' definition).
Behaviour, verbal abuse	Maltreatment through the use of hostile or culturally inappropriate words.
Drug/alcohol	Involves the use or misuse of drugs and/or alcohol.
Possible overdose	An incident that involves the severe illness of the client of undetermined intent by the probable consumption of drugs and/or alcohol.
Injury	Involves actions or behaviours that unintentionally cause harm that requires first aid or medical attention.
Medication error	The incident involves an error in the administration of medication.
Medication error incorrect dose/drug	The wrong medication has been administered by staff.
Medication error missed/delayed	Medication has not been administered as directed by staff.
Medication error pharmacy error	There was an error in the written instruction or medication provided by a pharmacist that results in the administration of incorrect medication.
Medication error refused by client	Client has refused prescribed or authorised medication.
Medication error other	A factor other than listed above caused the incorrect administration of, or access to medication.
Self-harm	The incident involves actions that intentionally cause harm or injury to self. Note: a suicide is recorded as a death.
Death	The incident involves the death of person, including suicide.

Incident reporting instruction feedback form

The department is committed to continually improving the clarity and accessibility of the incident reporting instruction. Your feedback is important to assist in identifying opportunities for improvement.

Please complete the form below and return to:

Department of Health
Incident reporting instruction
Regional Strategy
Level 17/50 Lonsdale Street
Melbourne VIC 3000

Date:
Policy area:
Clause/page number:
Describe the problem or issue?
Suggestion for improvement to the Department of Health *Incident reporting instruction:*
If you would like to be contacted regarding your suggestions please provide your name and contact details: