1. Purpose

This guideline has been developed to support the implementation of the Work Health & Safety Procedures, particularly the safety management standard for incident reporting.

2. WHS Staff Incident Reporting Process

Staff, contractor and visitor incident reporting includes near misses, personal injuries, security and personal threats, psychological injuries and building and equipment damage. In the event of a incident/injury the following steps are to be followed:

1. Respond to the immediate needs of the individual.

   Respond to the immediate needs of the individuals involved and follow standard emergency response procedures (as relevant), e.g. follow procedures for a medical emergency if someone is seriously injured.

2. Take any action to make the area safe. If the incident is a fatality, serious incident or illness, dangerous incident and serious electrical incident make the area safe, however do not disturb the scene. The WHSA or their delegate outside of business hours will report the incident to WorkSafe for external investigation.

3. Apply first aid or call emergency services.

4. Staff are not to escort injured personnel in private vehicles.

5. Advise senior staff members -notify relevant senior staff onsite including the Work Heath & Safety Advisor.

   NOTE: Prompt notification via phone/email is required for Moderate and High incident categories to the WHSA to ensure the appropriate investigation and reporting requirements are met.

6. Complete the staff incident report form (paper based form or online via Policy Connect.

   The incident report must be completed by the person involved and their Supervisor/RN and/or other witnesses present. All incidents must be reported promptly (same shift) to the Supervisor/Manager on duty.

   Include the immediate actions taken in response to the incident as well as any actions planned to prevent recurrence.

   Request witness statements (for high consequence incidents). A witness statement form is available in the document library.

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

   - Who was involved – include names of all parties including witnesses and residents
   - 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.

Inverted comma's if referring to any subjective statements from third part.

- Complete the PCS incident report form (where relevant)

3. Vehicle Related Incidents

1. In the event of a road traffic accident involving The Good Shepherd Home vehicle, the highest priority is to ensure the safety of passengers and staff. Minimizing risk to the general public and observing legal obligations are also important considerations.
2. Ensuring that the vehicle is not posing a traffic hazard come to a stop.
3. Where the accident damage is minor and involved no other person or damage to third party property, then the vehicle should be checked for damage and/or roadworthiness before proceeding back to the Good Shepherd Home.
4. Where the accident damage is significant: Check the welfare of passengers and ensure their safety.
5. Where necessary, contact the relevant emergency services: Fire/Ambulance
6. Report the accident to the Police
7. Get the names and addresses of all witnesses to the accident
8. **DO NOT ADMIT ANY LIABILITY.** No Good Shepherd Home staff member shall admit liability for an accident or make statements or comments, which may be interpreted as an admission of liability
9. If another vehicle is involved, a record of the following information should be obtained:
   - The owners name, address and telephone number
   - The drivers name, address and telephone number
   - The name of the owners insurance company
   - The make, model and registration number of the vehicle
10. Complete relevant paper work
    - A workplace incident form.
    - If a resident / client experiences injury complete a PCS incident report form

4. Internal Reporting timeframes Incident

- Injured staff are to report incidents as soon as reasonable practicable (within the shift that they occurred) to their Supervisor/Management on Duty.
- Department Managers are responsible for reporting Moderate / High risk incidents to the WHSA as soon as practicable of the incident being reported.
- SIRS related incidents are reported in accordance with priority 1 and priority 2 related timeframes. Priority 1 within 24hrs. Priority 2 within 30 days. Additional information related to the incident may be reported as obtained post event.

- Non-significant – Minor incident report forms must be received be the WHS department as soon as possible but not more than 2 business days of the incident occurring.
- WorkSafe Reportable Incidents as defined by https://www.worksafe.qld.gov.au/, which include fatalities, serious injuries or illnesses, dangerous incidents and serious electrical incidents are to be reported by the WHSA as soon as possible.

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.

3. Incident Report Review

The Work Health and Safety Advisor is responsible for reviewing all TGSH incident reports non clinical to ensure that the incident is subject to an appropriate level of response and that, where relevant, investigation, improvement strategies and follow-up actions are recorded.

The Work Health and Safety Advisor may be consulted for Resident Care related incidents requiring further assessment . The Clinical Nurse Manager is assigned responsibility for oversight and management evaluation and review for all Incidents reported for individual Residents. The Clinical Nurse Manager may escalate incidents to the Director of Care or Chief Executive Officer dependent on the nature and severity of the incident. All SIRS related incidents are notifiable.

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 and timescales.
- Confirm that mandatory reporting requirements have been met

4. Learning from incidents

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

Incidents should be systematically analysed and change implemented in an ongoing way, to prevent similar events recurring. Many incidents involve human error. TGSH 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 resident 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 serious incident occurring in the future.

Evidence of an effective safety culture include:

- increasing focus on learning from incidents to enhance safety for residents and staff,
- serious failures of standards of care are uncommon
- serious failures of a similar kind do not recur
- 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.

5. Determining Level of Investigation

The level of investigation required is based on the *potential consequences* of an incident. Refer to the matrix below.

Potential consequences	Investigation methodology	Investigation by	Sign off by
Not significant Minor injuries or discomfort. No medical treatment	Basic root cause analysis E.g. five whys	• Person involved • Supervisor	Work Health & Safety Advisor
Low Injuries or illness requiring first aid treatment	Basic root cause analysis E.g. five whys	• Person involved • Supervisor	
Moderate Injury or illness requiring hospital treatment or ongoing medical review.	Simple investigation	• Person involved • Supervisor • Work Health & Safety Advisor	

High Injuries or illness resulting in permanent impairment Fatality	WHS Investigation or ICAM or PHIRES	• Supervisor • Work Health & Safety Advisor • Health Safety Representative • Relevant subject matter experts	Chief Executive Officer Director of Care

6. Basic Root Cause Analysis

Root cause analysis is a type of problem solving used to understand why something has happened. Their a various methodologies for conducting a root cause analysis, these are summarised below. When conducting an investigation select the method most suited to the level of incident.

7.1 Investigation Process

1. Form the investigation team
2. Gather information
3. Analyse the available information (root cause analysis)
4. Develop the investigation report
5. Communicate the key findings

7.2 The Five Why's Technique

The 'five whys' technique is a one of the simplest forms of root cause analysis. Asking 'why' multiple times helps us to move beyond the obvious and start to think about the underlying factors.

Five is just an arbitrary number, the theory is that if you don't ask enough '*whys*', you may end up focusing your attention on trying to prevent the '*symptoms*' rather than addressing the real '*causes'* of an incident.

1. Speak to the people involved in the incident. A five whys technique works best when there is active participation by people directly involved in the incident and/or experienced in the activities involved.
2. Define the problem with a clear statement, E.g. staff cut finger with knife. Be careful not to include any reference to the 'cause' within the problem statement.
3. Ask *why* the event occurred and write the reasons down. A 5-Whys' worksheet can be used for documenting the investigation. There are usually multiple causes (or conditions) that contribute to any single event. Start a new column in the 5-Whys worksheet for each cause.
4. For each of the initial causes identified, continue asking *why* until the question can no longer be sensibly answered. At this point you have either:
    - identified one of the root causes; or

- reached a point beyond which you have no control or require additional information.

5. Identify action(s) to address the identified root causes.

7.3 Fishbone Technique

Using the TGSH Cause & Effect Assessment template, agree on the problem statement (also referred to as the effect). This is written at the mouth of the "fish." Be as clear and specific as you can about the problem. Beware of defining the problem in terms of a solution (e.g., we need more of something).

Agree on the major categories of causes of the problem (written as branches from the main arrow). Major categories often include: equipment or supply factors, environmental factors, rules/policy/procedure factors, and people/staff factors.

Brainstorm all the possible causal factors of the problem. Ask "Why does this happen?" As each idea is given, the facilitator writes the causal factor as a branch from the appropriate category (places it on the fishbone diagram). Causes can be written in several places if they relate to several categories.

Again asks "Why does this happen?" about each cause. Write sub-causes branching off the cause branches.

Continues to ask "Why?" and generate deeper levels of causes and continue organizing them under related causes or categories. This will help you to identify and then address root causes to prevent future problems.

Tips

- Use the fishbone diagram tool to keep the team focused on the causes of the problem, rather than the symptoms.
- Consider drawing your fish on a flip chart or large dry erase board.
- Make sure to leave enough space between the major categories on the diagram so that you can add minor detailed causes later.
- When you are brainstorming causes, consider going around the group asking each person for one cause. Continue going through the rounds, getting more causes, until all ideas are exhausted.
- Encourage each person to participate in the brainstorming activity and to voice their own opinions.
- Note that the "five-whys" technique is often used in conjunction with the fishbone diagram – keep asking why until you get to the root cause.
- To help identify the root causes from all the ideas generated, consider a multi-voting technique such as having each team member identify the top three root causes.

7.4 ICAM Investigation Process

ICAM is a widely used incident and investigation methodology. It provides a process to move beyond the idea of a single cause and identify a range of immediate causes, contributing factors and underlying causes. TGSH uses an adapted version of the ICAM process to investigate incidents that have serious potential consequences.

ICAM investigations are facilitated by the Work Health & Safety Advisor in partnership with relevant staff from the organisational unit/s involved in the incident. In the event of a fatality or serious injury, Executive staff will also be involved.

8.0 Corrective Actions

The objective of any incident investigation is to enable positive change.

Corrective actions must be based on the hierarchy of controls and, once accepted, recorded in Complispace action plan so that they can be tracked through to completion and periodically reviewed to monitor effectiveness.

9.0 Privacy

Incident investigations contain sensitive information and are not stored on resident clinical or HR files. Investigation reports are not released to residents or residents' representatives without the approval of the CEO. Investigations subject to external investigation e.g. WorkSafe, Coroners are released to the relevant governing bodies.

10.0 Conducting Interview

One of the primary methods of gathering information for an incident investigation is by interviewing people who were present at the time of the incident or in some way connected to the event.

It is important to interview people as soon as reasonably possible after the incident, acknowledging that this may not be straight way. Those involved in an incident may be under stress and require some time to process the events.

It is generally advisable to have another person present during an interview. Remember, the person being interviewed also has the right to have a support person present if they wish.

It is very important to make it clear to anyone being interviewed that the purpose of the investigation is not to establish blame. The purpose is to understand what happened, learn from the process and potentially prevent a similar event from occurring again in the future.

Interview plan

- Give an indication of how long the interview might take and offer to revisit at another time if needed.
- Explain why they are being interviewed (the purpose of the investigation).
- Start with open ended questions (*Tell me WHAT happened/WHEN that happened/WHERE*

that happened/HOW that happened/WHO was there)

- Use closed questions to confirm facts (*was it a black car?*)
- Take notes
- End on a positive by expressing appreciation for their time and input.
- Encourage them to contact you at a later date should they think of something else.
- Offer the Employee Assistance Program (EAP)

Avoid:

- Asking any leading questions (e.g. "*Didn't you think that...").*
- Intimidating the witness (e.g. "*Well that was a stupid thing to do*").
- Interrupting the witness.
- Conveying your judgements.

11.0 REFERENCED & ASSOCIATED DOCUMENTATION

Procedures & Polices	• Workplace Incident Report Form • Incident Statement Form • Incident report form PCS • TGSH form record of conversation • Vehicle Accident Work Instruction • SIRS flow chart. TGSH document • Responding to at Risk Behaviour • SIRS guidance resource for RAC providers • Forms **additional information forms** specific to SIRS ***ACQSC Home Page resource material refer to generic forms***
Legislative	• Work Health & Safety Act 2011 • Work Health & Safety Regulation 2011 • Aged Care Quality of Care Principles *monitor of updates* • Accountability Principles *monitor for updates* • Aged Care Act • Aged Care Quality Standards • Aged Care Code of Conduct
Further Resources	• https://www.worksafe.qld.gov.au/

	• https://www.agedcarequality.gov.au/sites/default/files/media/SIRS-guidelines-for-residential-aged-care-providers.pdf