SIRS notifications – top 5 key themes for incident notification

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This article reviews the recent release of example responses to providers regarding notifications for the Serious Incident Response Scheme (SIRS) and provides 5 tips to for incident management documentation for SIRS reporting.

Background

Residential Aged Care Providers are responsible for submitting notifications about serious incidents to the Aged Care Quality and Safety Commission (The Commission) via the Serious Incident Response Scheme.

The Commission has recently released example responses to assist Providers to understand what level of detail is required in their notifications for the Commission. This to assist the Commission to be able to appropriately assess and respond to it.

More information about these example responses can be found here.

I would encourage Providers to review these examples and consider opportunities that present in improving not only the way we document incident notifications but also what we can learn about the way we respond to incidents, the way we educate our teams about incident management in general, and the way we talk about them.

In reviewing these examples there are consistent themes to be found across all examples. I have consolidated these principles into 5 key themes that you may want to consider for future incident notification reporting, training on incident documentation and communication with stakeholders about incidents involving consumers.

Note – some incidents require protection of information

It is important to note that for some types of incidents (including those involving coronial referrals, allegations of theft and unlawful sexual contact) there will be constraints in what can be discussed and who can be identified in communications outside of the incident notification, management, and investigation process.

1. Be human

These examples place the consumer at the centre of the story and acts to humanise the incident itself. Names of those involved with the incident or allegation are used as well as those who respond, including the consumer's family. From a safety and quality perspective this is very important to do – framing the story about these human interactions helps to reinforce that quality and safety is all about keeping people safe from harm and a key part of this is how we interact with each other.

2. Be descriptive

The person notifying of the incident needs to know they who, what, how and whys of what occurred, when it occurred (or is alleged to have occurred). As noted in the example guide, we need to consider what we would need to know to describe the incident to a person who was not there, so they can understand what has happened. Creating a timeline of events (a key part of investigation processes) is a big help here. Narrating incidents like this also means they could be very useful case studies for peer review and training exercises down the track.

3. Be specific

If actual harm has occurred, the impact of this harm needs to be provided. This includes injuries or illness, symptoms observed, assessments, consumer self- reported issues, and clinical observations (where these are relevant to the incident reported) that support the assessment that harm has occurred. On the other hand, if harm is assessed as not having occurred, such information (how the consumer has been assessed for harm) are helpful to support the overall assessment of no harm.

4. Be objective

We want to humanise the account of the incident, but we still need to remain objective about what has happened. Statements or accounts provided from those involved should be provided in a concise way and provided without our own view or opinion of the merit of the statement or account. It may be a good idea to ask for a colleague not involved in the incident to read over what is being reported for peer feedback (and you can return the favour another day!).

5. Be responsive

Being responsive means that we are not just reporting what has happened, but what actions or immediate steps have been taken (and by who) to ensure the consumer is safe and that actual or potential harm to them is mitigated. Responsiveness also includes what will happen next – how will the matter be investigated and what will the investigation seek to determine. If the incident has already been investigated – what were the outcomes and what changes have been made.

I would also consider how was the incident escalated internally for notification and action taken where required. This may include how investigation findings have been or will be reported to governing bodies, and recommended process or system changes to quality and safety systems and who is responsible for seeing through any changes that need to occur. Of course, any such changes should be captured in your Plan for Continuous Improvement and linked both ways – by the event or incident number and the CI activity number in your SIRS report.

Further information

Review the example responses provided by the Aged Care Quality and Safety Commission here : --

https://www.agedcarequality.gov.au/sirs/submit-notifications