Effective serious incident investigations
guidance for providers

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Australian Government
Aged Care Quality and Safety Commission

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Acknowledgements

The Aged Care Quality and Safety Commission (the Commission) acknowledges the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

The Commission engaged Demetrius Consulting to support development of external guidance relating to serious incident investigations for approved providers. The Commission would like to acknowledge Julianna Demetrius from Demetrius Consulting for her central role and principal authorship of this resource.

Disclaimer

The guidance material contained in this document is intended to provide general support. It does not constitute legal or other professional advice and should not be relied upon in that manner. You should seek legal or other professional advice on your legislative requirements, as appropriate. While every effort has been made to ensure the information is accurate and up to date at the time of the publication's release, the Commission does not guarantee the accuracy, completeness or currency of the information provided. The guidance material has been prepared without taking into account individual provider circumstances, objectives or needs. Organisations are also expected to evaluate other recognised guidance that might be specific to the services they deliver.

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About this guidance

Purpose

This publication is designed to assist providers of aged care services to conduct investigations into serious incidents. It is just one of many resources that may be used in the response to an actual, suspected or alleged serious incident.

It assumes that providers will:

- meet their primary responsibilities to ensure the safety, health, wellbeing and quality of life of care recipients, including providing emergency services and any required physical and psychological treatment. Meet their reporting obligations to the Commission under the Serious Incident Response Scheme (SIRS) by reporting Priority 1 notifications within 24 hours and Priority 2 notifications within 30 days
- report the matter to police where an incident may be criminal in nature e.g. actual, allegations and suspected fraud, assault, sexual assault, stealing, abuse. Consult with police and relevant oversight bodies when there are criminal allegations. This should happen before commencing an investigation to ensure evidence is not compromised
- in the case of alleged abuse by a staff member, ensure the affected consumer/s are not exposed to further risk.

This guidance focuses on the complex investigation process which can have significant consequences if not carried out appropriately. Providers should ensure investigations are undertaken by appropriately skilled and experienced staff or ensure they have access to external expertise.

The publication is not legal advice and does not replace legislation or a provider's investigations' policies and procedures as set out in their Incident Management System (IMS). The guidance promotes best practice approaches associated with conducting an investigation and outlines steps to take when responding to actual, alleged and suspected incidents.

Effective incident management systems

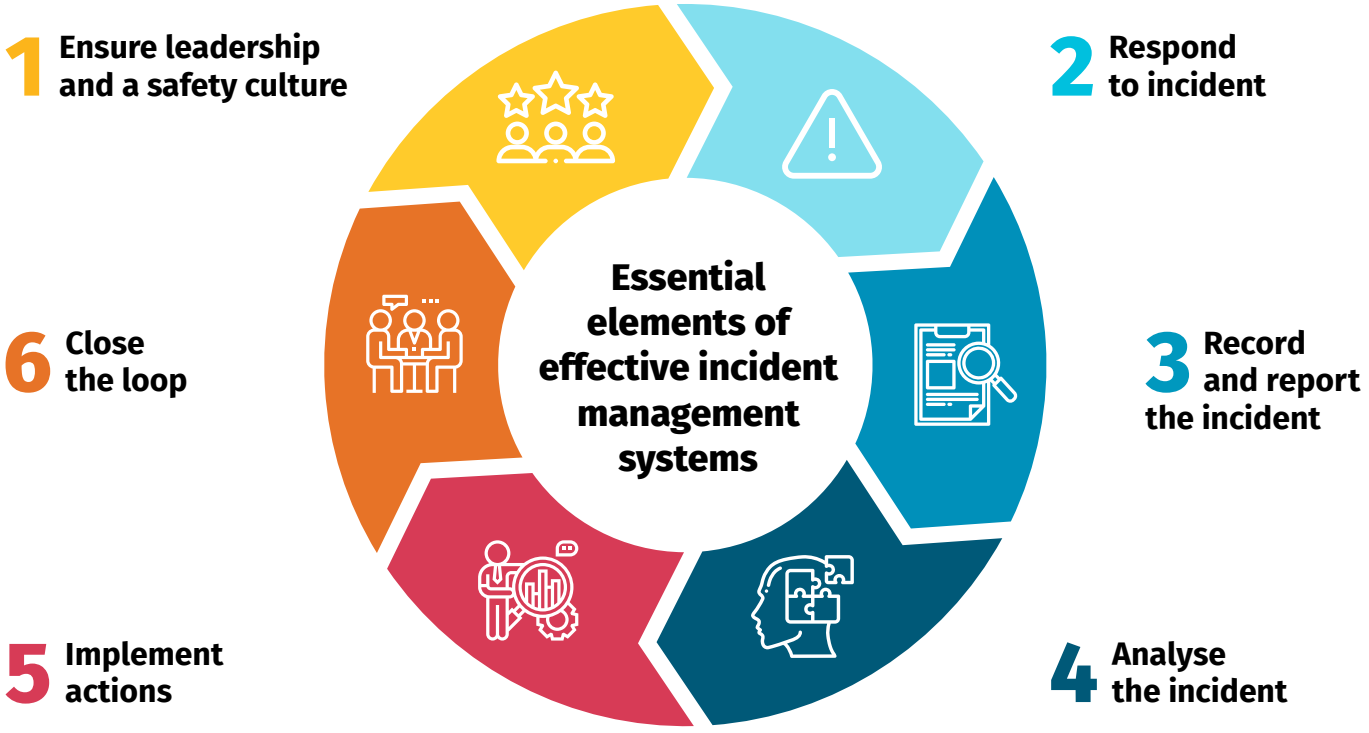
Effective incident management systems: Best practice guidance provides detailed information for providers to help develop and embed a best practice IMS. Having an effective IMS enables providers to respond to and manage specific incidents and near misses by assessing:

- what happened
- how and why it happened
- what can be done to reduce the risk of recurrence and support safer care
- what was learned
- how the learning can be shared.

Adopting best practice incident management practices and systems will assist providers to:

- provide safe, quality care and services for care recipients
- promote a culture of reporting, with a focus on understanding, learning and improvement
- take a systematic approach to minimising the risk of incidents occurring
- support care recipients, their families/representatives and staff appropriately should an incident occur
- resolve any incidents that may occur
- take action to prevent incidents from recurring.

This guidance highlights elements of an effective IMS.



1 Ensure leadership and a safety culture

Prepare for incidents by ensuring leadership around risk mitigation and incident management and creating a safety culture. Embed critical enablers through effective governance systems, with end-to-end policies and procedures that support staff to understand and use the incident management system.

2 Respond to incident

Respond to the immediate needs of those affected by the incident to ensure their health, safety and wellbeing. Assess the level of harm and mitigate any ongoing risk.

3 Record and report the incident

Record and report the incident to understand what occurred and the appropriate next steps (including any required notifications).

4 Analyse the incident

Understand underlying causes and how systems and practices could be improved to reduce the risk of similar incidents occurring in the future.

5 Implement actions

Implement remedial actions that help prevent future risk and improve incident response. Monitor actions for effectiveness.

6 Close the loop

Share lessons learned with management and leaders, staff, consumers and families. Continuously improve the quality and safety of aged care. Analyse incident trends and data and regularly review the incident management system.

Problem-solving approach

A problem-solving approach can assist providers to understand the causes of an incident more quickly by using shared, collaborative, and systematic techniques. Such an approach may be used to better understand the contributing causes of the incident, to develop solutions to prevent further incidents occurring and to evaluate the implementation of solutions. When using a problem-solving approach to understand the root cause of an incident, it may become apparent that the most appropriate course of action to address the current incident and improve incident management is to undertake an investigation.

Step 1 Understand the incident: what happened, who was involved?

Step 2 Root causes methodology; consider whether incident requires investigation — internal or external. Remember there may be many contributors.

Step 3 Identify a range of solutions.

Step 4 What will be effective? Prepare, plan, implement.

Step 5 What is different? Is the solution effective and sustained?

Expectations of providers

Incident management is integral to risk management, continuous improvement and the delivery of safe and quality care. Incident management requirements complement existing directives for services to undertake self-assessments against the Aged Care Quality Standards (Quality Standards) and have plans for continuous improvement. This includes addressing areas of risk and where adverse outcomes for care recipients are evident. Requirement 8(3)(d)(iv) of the Quality Standards specifically requires you to have effective risk management systems and practices for managing and preventing incidents, including the use of an IMS.

For providers delivering aged care services, or flexible care in an aged care setting, an IMS is also integral to your ability to meet your responsibilities under the SIRS. The SIRS establishes responsibilities for providers to:

- prevent and manage incidents, focusing on the health, safety, wellbeing and quality of life of the care recipient
- notify reportable incidents to the Commission and police where there are reasonable grounds
- use incident data to drive quality improvement.

For more information on SIRS requirements, refer to Serious Incident Response Scheme — Guidelines for residential aged care providers.

The role of the Commission

The Commission is the national regulator of aged care services and the primary point of contact for care recipients and providers in relation to quality and safety. Complaints or concerns about the quality of care and services can be made to the Commission. Both serious incident notifications and complaints play important roles in helping providers to improve the quality of care and services through a continuous improvement process.

The Commission accredits, monitors and assesses the performance of providers against the Quality Standards, and helps care recipients resolve complaints about a provider's responsibilities or actions. This is part of the Commission's function to protect and enhance the safety, health, wellbeing and quality of life of aged care recipients. Through the Commission's engagement and education work, it aims to build confidence and trust in aged care, empower care recipients, support providers to comply with the Quality Standards and promote best practice service provision. As part of the Commission's risk-based approach to monitoring and assessing provider performance, the Commission monitors provider performance in accordance with the requirement to have an incident management system.

This may include the Commission requesting to view your IMS and procedures, incident management records and correspondence with affected consumer/s and external agencies regarding incidents.

The Commission may also:

- refer the incident to police or another body with responsibility in relation to the incident (such as a relevant state or territory agency)
- require you to undertake specified remedial action in relation to the incident
- require you to carry out an internal investigation into the incident in the manner and within the period specified by the Commissioner
- require you to provide the Commissioner with an investigation report
- require you to engage an appropriately qualified and independent expert, at your expense, to carry out an investigation into the incident in the manner and within the period specified by the Commissioner, and to provide the Commissioner with a report on the investigation.

In cases where the Commission has requested an investigation be undertaken, the Commissioner may take any action to deal with the outcome of the investigation that the Commissioner considers appropriate.

The regulatory framework

Aged care recipients have the right to safe and quality care and services that support their health and wellbeing and promotes their quality of life. To help achieve this, all providers of Commonwealth-funded aged care operate in the context of the aged care legislative framework. The requirement to prevent and manage the risk and occurrence of incidents is one element of the framework that supports the provision of quality care and services and a safe environment.

The requirement for an IMS complements and supports other regulatory settings including the integrated requirements of the Charter of Aged Care Rights (the Charter), the Quality Standards, open disclosure requirements, clinical governance requirements, and the SIRS. Together, these settings support providers to engage in risk management and continuous improvement activities to deliver safe, quality care.

Glossary

Term/acronym	Meaning
Care recipient	A person approved under Part 2.3 of the *Aged Care Act 1997* as a recipient of aged care. A person is a care recipient of an approved provider if: (a) the person is receiving residential care, or flexible care provided in a residential setting, in respect of which the provider is approved; and (b) either: (i) subsidy is payable for provision of the care to the person; or (ii) the person is approved under Part 2.3 as the recipient of the care.
Care recipient representative	A nominated person given consent by an aged care recipient to speak and act on their behalf. Includes: · a person appointed under relevant legislation to act or make decisions on behalf of a care recipient · a person the care recipient nominates to be told about matters affecting the care recipient.
Incident	An event or set of circumstances that: · resulted or could have resulted in unintended or unnecessary harm, loss or damage to a person · caused, or could reasonably have been expected to have caused, a care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve · occurred, or was alleged to have occurred, or was suspected of having occurred.

Term/acronym	Meaning
Other parties	People and organisations that the Commission consults with and keeps informed about a complaint process, but who are not the complainant or the service provider. Examples may include: · the person receiving aged care · an advocate nominated by the person receiving aged care · a legally appointed representative of the person receiving aged care · a person with a significant relationship to the person receiving aged care (such as a partner or close relative) · organisations such as police and hospitals.
Subject of allegation (SOA)	A staff member, care recipient or any other person who has been accused of being involved in a reportable incident that has occurred or was alleged or suspected to have occurred.
Staff member	An individual who is employed, hired, retained or contracted by the provider (whether directly or through an employment or recruiting agency) to provide care or other services.

Conducting an investigation

1 Initial and early response to a serious incident — the first 24 hours

Context: a serious incident has occurred, is suspected or alleged to have occurred — what do you do now?

This guidance summarises the factors you might consider and the actions you might take as soon as you become aware of a serious reportable incident or you have received information about an alleged or suspected incident.

Key considerations — first 24 hours

- ✓ Ensure the immediate health and safety of any affected consumer/s.
- ✓ Report the incident to police if there are reasonable grounds to do so.
- ✓ Provide support and assistance to any affected consumer/s to ensure their safety, health and wellbeing.
- ✓ If there has been an injury, assault or unlawful sexual contact, be mindful that there may be evidence which needs to be collected or protected. Seek advice from police.
- ✓ Where appropriate, communicate with the consumer's family, representative, or support person.
- ✓ Take immediate action relating to any ongoing risks posed by the subject of the allegation.
- ✓ Notify the Aged Care Quality and Safety Commission of all Priority 1 incidents (Priority 2 incidents must be notified within 30 calendar days).
- ✓ Identify if the incident needs to be reported to any other external agencies within the first 24hrs (e.g. State Coroner, APRHA).

For information about which incidents are reportable, refer to the SIRS reportable incidents fact sheets.

Providing support and assistance

When you become aware of an incident including a suspicion or allegation, you must support and assist any person affected by the incident to ensure their safety, health and wellbeing (s15LA(2)(a)-(b), *Quality of Care Principles*). This may be a care recipient who is the affected consumer of an incident but also includes a care recipient who is the subject of an allegation. **All care recipients should be treated with dignity and respect regardless of whether they are the affected consumer or subject of an allegation.**

'Safety and health' have both physical and psychological (emotional) aspects. 'Wellbeing' has many components including physical (the functioning of a person's body), psychological (how a person thinks and feels and their ability to cope), spiritual (experiencing a sense of meaning and purpose) and social (feeling a sense of connection and belonging).

When deciding what support and assistance to provide, you should consider the discomfort and the physical or psychological injury on the people affected by the incident. You should also think about whether they have specific needs due to a cognitive or communication impairment and/or their first language or cultural background.

It is good practice to openly communicate with and involve each affected consumer and/or their representative where appropriate, in decisions about support and assistance as early as possible. Doing this is an important way to involve each affected consumer (or their representative) in managing and resolving the incident (s15LA(2)(c)-(e), *Quality of Care Principles*) and making sure that as far as possible, their needs, preferences and values are respected and met.

Initial steps

Depending on the nature of the incident and when you became aware of it, the initial steps you take to provide support and assistance may include but are not limited to:

- arrange for a person to receive medical treatment, counselling, pastoral care, or support from a consumer advocate e.g. Older Persons Advocacy Network, Dementia Australia
- if the incident is of a criminal nature, or suspected to be of a criminal nature, report the incident to the police immediately.
- support the person when police arrive and/or arrange another appropriate support person.
- address immediate hazards in the physical environment e.g. trip hazards, faulty equipment
- ensure a person who is the alleged subject of an allegation does not have further contact with the affected consumer
- provide emotional comfort and support that meets the person's needs and preferences e.g. sitting quietly with them, making them a cup of tea, providing them with a favourite comfort item, distracting them with a calming activity
- organise for the person's preferred support person e.g. family member, friend, or carer to be with them/talk to them

- take other steps to ensure the person feels connected and supported in the care environment e.g. involving them in a favourite activity, involving a staff member or another care resident who they know well and like
- update the person about what actions the service is taking to respond to the incident, with their representative in attendance, when appropriate.

See also Aged Care Quality & Safety Commission, Effective incident management systems: Best practice` guidance, 2021, pp29-30.

When the subject of the allegation is another care recipient

The reasons for violence or other abuse by a care recipient in an aged care setting will vary and may be complex. Contributing factors that may impact their choices or behaviour include physical or mental health, cognitive capacity, medication effects, environmental suitability, and compatibility with other care recipients and staff who support them[1].

A person-centred approach to providing support and assistance to a care recipient who is the subject of an allegation is crucial. This approach should involve assessing the contributing factors and identifying strategies to prevent behaviours from reoccurring.

This may involve:

- asking the person to share their views about what happened
- communicating with the person's family/representative, with consent
- arranging for a health professional to assess the person
- making changes to the person's care plan/behaviour support plan
- arranging additional services/supports.

1 NSW Ombudsman, *A Quick Guide: Early response to abuse and neglect in disability services*, September 2017, p8.

Restrictive Practices

Restrictive practices in response to behaviours of concern must only be used as a last resort and in the least restrictive form, consistent with providers' requirements and responsibilities under the *Aged Care Act 1997* and *Quality of Care Principles 2014*.

Providers must consider the rights and protection of care recipients at all times.

When deciding to use a restrictive practice, providers must make sure:

- it is only as a last resort to prevent harm to a care recipient or others, and after consideration of the likely impact of the use of the restrictive practice on the care recipient
- to the extent possible, best practice alternative strategies are used before a restrictive practice is used, and they are recorded and documented in the care recipient's behaviour support plan if they are used or considered
- that the restrictive practice has been assessed as necessary by an approved health practitioner with day-to-day knowledge of the care recipient, or medical practitioner or nurse practitioner for chemical restraints the restrictive practice is only used to the extent necessary and in proportion to the risk of harm
- to use it in the least restrictive form, and for the shortest time necessary to prevent harm to the care recipient or other persons
- informed consent is given for the use of the practice by the care recipient, or where they lack capacity, their restrictive practices' substitute decision maker
- a behaviour support plan is in place which follows the requirements of the Quality of Care Principles for appropriate use of restrictive practices, and outlines all alternate strategies
- the use complies with the Quality Standards and the requirements (if any) of the state and territory law in which the restrictive practice is used
- the use is not inconsistent with the Charter of Aged Care Rights
- to monitor and regularly review use of the restrictive practice.

Please note that exemptions to some of these requirements apply in an emergency.

Any changes that are implemented should be monitored and assessed for effectiveness. While it is critical that care recipients who have caused harm to others are treated with care and sensitivity, it is important to remember that all care recipients have the right to be protected from mistreatment and abuse, and that serious incidents are reported to authorities when required.

Handling disclosures

You may become aware of an incident because someone discloses it to you. You must, as soon as you become aware, report the incident to key personnel, your manager or supervisor. Disclosures may consist of allegations or suspicions and can be made by the affected consumer/s, by another care recipient, a staff member or any another person e.g. family member. If you receive a disclosure of abuse or harm, you might consider the following steps:

- react calmly
- let the person use their own words and listen patiently
- provide comfort, support and assistance (see below)
- consult and involve the person's chosen or appointed representative
- let the person know that it was right to speak up and that you will do everything you can to keep them safe
- explain that you need to report the information to your manager who may need to share it with other agencies. Reassure the person that they will be informed if this needs to occur.
- write down what you were told as soon as possible afterwards, using the person's own words as much as you can
- follow your internal reporting procedures and keep a copy of your notes.

Reporting incidents to police

You must report incidents — actual, suspected or allegations — of a criminal nature to police. If you are in doubt about whether the incident is of a criminal nature you should seek guidance from the police. You must call police if there is any serious threat to any person's safety or other type of emergency. This includes a consumer's unexplained absence from the service when all reasonable attempts to locate them have been exhausted.

You must also report an incident to police within 24 hours of becoming aware of the incident if there are reasonable grounds (see below) to do so (s15LA(5), *Quality of Care Principles*). If you do not have reasonable grounds to report an incident to police within the first 24 hours of becoming aware of it, but you later identify reasonable grounds, you must report the incident as soon as possible or otherwise within 24 hours of becoming aware of these grounds.

'Reasonable grounds' include if you believe that an incident may involve a criminal offence or if you believe there is an ongoing danger[2]. Criminal offences are described differently in each state and territory but include homicide, physical assault, sexual offences, and stealing/theft/fraud. You should contact police for advice as soon as possible if you are in any doubt about whether an incident may involve a criminal offence.

2 Aged Care Quality & Safety Commission, Serious Incident Response Scheme: Guidelines for residential aged care providers, p15.

You must make a report to police if you have reasonable grounds to do so regardless of whether the care recipient and/or their family or representative want this to happen. You should always tell the care recipient when you have reported an incident to police[3].

When you make a report to police, tell them that the alleged person affected by the incident (and the subject of the allegation, if they are a consumer) is a vulnerable person. Explain any specific needs they have and let police know if they will need communication aides or other supports (e.g. an interpreter). Always ask for and make a record of the name of the police officer you spoke to and the police 'event number'. If you experience difficulties, ask to speak to the most senior police officer on duty.

Police may not initiate an investigation until they receive a complaint from the consumer or their representative. You should support them to report the matter to police if they wish to do so. You must not restrict their access to police or try to influence them not to seek police involvement.

Building a relationship with local police

It is a good idea to take a proactive approach to developing a positive relationship with your local police. Some jurisdictions, such as NSW, also have specialist Aged Crime Prevention Officers. Some ways you might do so include introducing yourself to senior officers, inviting police to attend a staff training session and/or other events (e.g. open day), and agreeing on a protocol for escalating any service issues that arise when you need to contact police about a serious incident.

Securing and protecting evidence

As soon as you become aware of an incident, you should be mindful that there could be evidence that needs to be secured and protected, particularly if a criminal offence may have occurred. You should report incidents — actual, suspected or allegations — of a criminal nature to police and follow their instructions.

3 Aged Care Quality & Safety Commission, Frequently Asked Questions, 'When does an incident need to be reported to Police?'

Following internal reporting procedures and recording the incident

You must follow your internal incident management procedures when an incident occurs. This includes reporting the incident to the responsible person nominated in your procedures and recording the incident in your IMS.

When you report an incident, record all the information you know. Do not include opinions or your interpretations — stick to the facts. Sign and date what you write. Provide a copy to the responsible person and keep a copy for yourself.

Providers must take reasonable measures to ensure that the identity of the person who reports a serious incident is not disclosed, except to key personnel, the Commission, police or as required by law or the requirements of procedural fairness. There are protections under the *Aged Care Act 1997* for people who report serious incidents, including protection from victimisation for making the report.

The record of the incident in your IMS must include certain information (s15MC(2), *Quality of Care Principles*). It's unlikely you'll have all this information when you first become aware of an incident, but you should record the details you do have and update the record as further information becomes available.

See also Aged Care Quality & Safety Commission, Effective incident management systems: Best practice guidance, 2021, pp31-34.

Incident records must include:

- a description of the incident, including:
  - the harm (discomfort or physical or psychological injury) that was caused, or that could reasonably have been expected to have been caused, to each person affected by the incident
  - the consequences of the harm (if known).
- whether the incident is a reportable incident
- when (time and date) and where the incident occurred or was alleged or suspected to have occurred, if known
- when (time and date) the incident was identified
- the names and contact details of the people directly involved in the incident
- the names and contact details of any witnesses to the incident
- details of the assessments undertaken in accordance with ss15LA(2) and (3) of the *Quality of Care Principles*

- the actions taken in response to the incident, including actions taken under ss 15LA(2), (4), (5) or (6) of the *Quality of Care Principles*
- any consultations undertaken with the people affected by the incident
- whether the people affected by the incident have been provided with any reports or findings regarding the incident
- if an investigation is undertaken by the provider in relation to the incident-the details and outcomes of the investigation
- the name and contact details of the person making the record of the incident.

Communicating with family/representatives

You must use an 'open disclosure' process when responding to incidents. (s15LA(e), Quality of Care Principles). This means openly discussing incidents with care recipients and if appropriate, their family/representative. If the affected consumer/s provides consent, you should contact their family/representative as soon as possible after you become aware of an incident, explaining what happened, the potential consequences, and what steps you are taking to manage the incident and prevent it from happening again[4]. If the person doesn't have sufficient decision-making capacity, you should contact their representative.

Having a conversation with the affected consumer/s' family/representative at an early stage provides an opportunity for them to support the affected consumer/s and to participate in decisions about how the incident should be managed and resolved.

See also Aged Care Quality and Safety Commission, Aged Care Open Disclosure Framework and Guidance, 2019.

Managing issues relating to staff members subject to allegations

If the subject of the allegation is a staff member, you will need to consider any immediate risks and take appropriate action to ensure the safety, health and wellbeing of affected consumers.

- When considering what action to take in relation to the staff member you may consider the following factors:
  - the nature and seriousness of the allegation(s)
  - the vulnerability of the care recipients the staff member would be in contact with at work — considering, for example, their age, level of impairment and communication skills

4 Aged Care Quality & Safety Commission, Serious Incident Response Scheme: Guidelines for residential aged care providers, 2021, p76.

- the nature of the position occupied by the staff member — for example, the extent and nature of their interaction with care recipients
- the extent of the available supervision of the staff member
- the availability of support for the staff member on a day-to-day basis if their duties are not changed
  - for example, if they are working with care recipients who have behaviours of concern or high support needs.
- the staff member's disciplinary history
- any possible risks to the investigation of the incident.

- If the staff member remains in the workplace, decisions should be made about the duties they will undertake, and how the risks associated with the staff member having access to care recipients will be monitored and assessed and by whom.
- If police are involved, check with them to see if any action taken by you is likely to interfere with their investigation. It might also be appropriate to discuss any proposed changes to the staff member's duties.
- Appropriate support for the staff member who has had the allegation made against them should also be provided and their privacy maintained.

Notifying the Commission

If an incident is an actual, suspected, or alleged 'reportable incident' under the SIRS, you must notify the Commission via the My Aged Care service provider portal. Priority 1 reportable incidents must be notified to the Commission within 24 hours of the incident. Priority 2 reportable incidents must be notified to the Commission within 30 days of the incident.

Priority 1 reportable incident

A reportable incident:

- that caused, or could reasonably have been expected to have caused, a care recipient physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or
- where there are reasonable grounds to report the incident to police, or
- when there is the unexpected death of a care recipient or the care recipient's unexplained absence from the service (s15NE(2), Quality of Care Principles 2014).

Priority 2 reportable incident

Any reportable incident that does not meet the criteria for a Priority 1 incident.

See also Aged Care Quality & Safety Commission, *Serious Incident Response Scheme: Guidelines for residential aged care providers*, 2021, pp54-56; SIRS decision making tool

Notifying other agencies

Depending on the nature of the incident, in addition to notifying the Commission and in some circumstances police, you may need to make further notifications to other agencies within specific timeframes. For example, you may need to notify a death to the Coroner[5]; notify Safe Work Australia or the equivalent in your respective state, if an incident has occurred as a result of a workplace incident; AHPRA where the incident has been caused by the professional conduct of a registered health practitioner; local public health units where the incident triggers a requirement to report a notifiable disease or condition; or the NDIS Quality and Safeguards Commission where an incident relates to a NDIS participant[6]. This is not a comprehensive list of possible obligations and providers should seek further guidance from relevant authorities.

5 Deaths may be referred to a coroner for a range of reasons including if a person dies unexpectedly, or from an accident or injury, if the death is unnatural or violent, or a doctor has not been able to sign a death certificate because the cause of death is unknown. Each state and territory has specific requirements in relation to the obligations to notify a death to the coroner

6 Aged Care Quality & Safety Commission, Effective incident management systems: Best practice guidance, 2021, p32.

Final checklist for initial and early response to incidents

Have you	Yes/NA	Actions/comments	Who	Date
Called Triple Zero (000) if an emergency?	◯ Yes ◯ No			
Made sure you and others are safe?	◯ Yes ◯ No			
Reported the incident to police if necessary?	◯ Yes ◯ No			
Provided initial support and assistance to any affected consumer/s?	◯ Yes ◯ No			
Secured and protected any potential evidence?	◯ Yes ◯ No			

Have you	Yes/NA	Actions/comments	Who	Date
Followed internal reporting procedures?	◉ Yes ◯ No			
Notified the affected consumer/s' family/ representative	◯ Yes ◯ No			
Taken necessary action to manage any risks posed by the subject of the allegation (staff member or other care recipient)	◯ Yes ◯ No			
Notified the incident to the Commission, if necessary?	◯ Yes ◯ No			
Notified the incident to other external agencies, if necessary?	◯ Yes ◯ No			
Recorded the incident on your IMS?	◯ Yes ◯ No			

2 Deciding to conduct an investigation

At times you will need to conduct an investigation in order to meet your responsibility to effectively manage an incident. This guidance explains what conducting an investigation means and provides factors to consider when deciding if an investigation is necessary.

Factors to consider when deciding to conduct an investigation

- ✓ Have you taken necessary action to support and assist any person affected by the incident?
- ✓ What do your incident management system procedures say about when an investigation is required?
- ✓ What type of investigation is most appropriate?
- ✓ Can the investigation be conducted internally, or should an external investigator be engaged?
- ✓ Does the incident involve a criminal allegation and should it be reported to police?

In circumstances where a report is made to police:

- ✓ Have you sought advice from police about communicating with parties involved in the incident?
- ✓ Have you received clearance from police to investigate?

'Assessing' incidents

Providers are responsible for managing and taking reasonable action to prevent incidents with a focus on the safety, health, wellbeing, and quality of life of care recipients. In addition to assessing and providing support and assistance to individuals affected by an incident, section 15LA(3) of the *Quality of Care Principles 2014* (Quality of Care Principles) require providers to 'assess' the incident to identify:

- if it could have been prevented
- if any remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their harm
- how well the incident was managed and resolved
- what, if any, actions could be taken to improve the provider's management and resolution of similar incidents
- whether other persons or bodies should be notified of the incident.

The Quality of Care Principles are not prescriptive about how providers should assess incidents, except to the extent that they must take into account the views of people affected by the incident (s15LA(3)).

The circumstances of every incident are unique, and providers are in the best position to perform an appropriate assessment, having regard to their knowledge of the people involved and their own incident management policies and procedures.

When is an investigation required?

The Quality of Care Principles do not require every incident to be investigated. However, they do require, under section 15MB(1)(f) of the Quality of Care Principles, that a provider's IMS be supported by procedures that specify:

- when an investigation is required to establish:
  - the causes of a particular incident, or
  - the harm caused by the incident,
  - or any operational issues that may have contributed to the incident occurring, and
- the nature of the investigation.

After receiving a notification of a reportable incident, the Commission may also require, under section 95G(1)(c) of the Aged care Quality and Safety Commission Rules 2018 (Commission Rules), a provider to conduct an investigation (or appoint an external investigator to do so (section 95G(1)(d) of the Commission Rules).

What does an investigation involve?

An investigation is a process of inquiry to gather and document facts and information about a matter. The scope and extent of the process should be in proportion to the circumstances and seriousness of the matter being investigated.

Sometimes, the facts and information that are needed to support a fair and informed judgement about a matter are readily available or can be quickly obtained. For example:

- initial enquiries may reveal that an allegation has arisen from a simple misunderstanding or miscommunication, or

- the cause of an incident may be straightforward, immediately apparent and able to be resolved without the need for further enquiries, for example, by checking records.

After documenting the enquiries and their outcome, the investigation can be quickly concluded. This type of investigation is often referred to as 'outcomes-focused'.

In other circumstances, it may be clear from the initial assessment of an incident that a more formal process of gathering facts and information is required. For example, in the case of an allegation that a staff member engaged in inappropriate conduct on a particular date, and your initial enquiries reveal they were on duty at that time, further evidence will need to be gathered and assessed to substantiate whether or not the conduct occurred. As an investigation of this type has the potential to result in disciplinary action, the evidence needs to be gathered and documented in a way that meets all legal and procedural requirements (and the investigation needs to be recorded in the provider's IMS). This type of investigation is usually referred to as 'evidence-focused'.

Depending on how the investigation unfolds, it may be appropriate to switch from one type of investigation to another. In general, it is easier to move from an evidence-focused investigation to an outcomes-focused investigation. For this reason, if you are unsure how to proceed following the initial assessment of an incident, it is best to err on the side of a more formal investigation process to begin with.

When an incident is reported to police

In certain circumstances you must report an incident to police. If an incident is criminal in nature, police will make inquiries and may decide to investigate it. In these circumstances, you must make sure you do not take any actions that could put the police investigation at risk.

You should get advice from police about what you can say to the person who is the subject of the allegation and other involved parties, including potential witnesses. Beyond establishing basic details needed to report the matter to police, do not undertake any investigation unless you receive clearance from police to do so.

Is an investigation necessary?

Consider the following factors when deciding if an incident needs to be investigated, and if so, the scope and extent of the investigation process that's required. This includes:

- any direction from the Commission about the need to conduct an investigation or engage an external investigator
- the severity of the incident and its impact on any affected consumer/s (e.g. death or serious injury or trauma)
- whether it has been alleged that a staff member has engaged in inappropriate conduct e.g. sexual misconduct, or an incident may have resulted from the conduct of a staff member (e.g. neglect)
- whether the incident may be the result of service gaps or failures in your systems, policies, procedures or practices

- the seriousness of the potential consequences for any person that is the subject of an allegation
- the views of the affected consumer/s and their family/representative, where appropriate
- the extent to which the facts of the incident are immediately clear and agreed to by those involved
- the extent to which the underlying causes of the incident and/or the appropriate actions to prevent a similar incident from reoccurring, or minimising harm, are immediately clear
- whether a similar incident has occurred in the past and/or involves a person or people who have been involved in other incidents in the past
- if an allegation has been criminally investigated, the outcome of that investigation
- whether there is substantial public interest in the matter.

When the subject of an allegation is a care recipient

When an incident involves another care recipient as the subject of an allegation, your management of the incident should focus on:

- notifying police if there are reasonable grounds to do so
- providing support and assistance to both care recipients (i.e. the alleged affected consumer/s and the subject of the allegation) to ensure their safety, health and wellbeing. When seeking to establish the causes of the incident and any actions that can be taken to prevent a similar incident from occurring in future, the actions and responsibilities of the service, rather than the care recipient, should be the focus of any investigation.

See also Aged Care Quality & Safety Commission, Effective incident management systems: Best practice guidance, 2021, p35.

Who should conduct the investigation?

You will need to select an appropriate person to conduct the investigation. The investigator must have adequate knowledge of key investigation principles and methods as well as policies, procedures and legislation that are relevant to the issues being considered.

If the investigation is being internally conducted, the investigator must have sufficient authority and not be subject (or perceived to be subject) to undue influence or direction by others. It is also essential that the investigator does not have a conflict of interest.

The investigator must be able to:

- plan and conduct the investigation without undue delay and in a way that is proportionate to the issues being investigated
- observe any legal or procedural requirements
- act fairly and without bias
- maintain confidentiality
- make adequate inquiries
- communicate with people affected by the investigation
- gather and document relevant evidence using appropriate methods
- consider the available evidence and make logical findings and recommendations supported by the evidence
- make a full record of the investigation including documenting the findings in an investigation report and providing it to the Commission, if required.

When should an external investigation be conducted?

After receiving a notification about a reportable incident, the Commission may direct you to engage an external investigator (under section 95G(1)(d) of the Commission rules. Otherwise, there are a range of factors you should consider in deciding whether it is appropriate to organise an external investigation. They include:

- whether your service has the necessary knowledge, skills and capacity to conduct the investigation
- whether specialist or technical expertise is likely to be needed e.g. to determine the underlying causes of the incident
- whether there are any conflicts of interest or perceived conflicts of interest that could lead to a perception of bias if the investigation is conducted internally. For example, does the incident involve an allegation against a very senior staff member? Does the person at your service who would usually investigate a matter of this type have a personal relationship with a person involved in the incident?
- the views of any person affected by the incident and their family/representative, where appropriate
- whether there is a high level of public interest in the incident and the outcome of the investigation e.g. has it been covered by the media?

3 Planning and conducting an investigation

This guidance provides information about planning and conducting an investigation of an incident. It is focused on meeting the requirements of formal evidence-based investigations but it is also relevant to less formal investigations.

Checklist for planning and conducting an investigation

- ✓ Be clear about the purpose of the investigation and the issues it will and won't consider.
- ✓ Provide the investigator with terms of reference that establishes the focus and defines the scope of the investigation.
- ✓ Identify the sources of evidence available to the investigator.
- ✓ Identify the key actions that need to be completed and the order in which they should be undertaken.
- ✓ Develop a strategy for managing the people who are affected by the investigation including identifying risks and communicating the strategies to stakeholders.
- ✓ Prepare an investigation plan.
- ✓ Gather the necessary evidence, ensuring each piece of evidence is logged and securely stored.

Planning the investigation

Effective planning is key to the overall success of the investigation. You will need to be involved in planning the investigation even if you have decided to engage an external investigator.

Defining the scope

Defining the 'scope' of an investigation involves clarifying its purpose and the issues the investigation will and won't consider. This includes identifying whether the investigation is about systemic issues (policies, procedures and practices), and/or the conduct of individuals, and deciding the 'lines of enquiry' that will be pursued.

The investigator should be provided with terms of reference that establishes the focus and sets limits on the investigation, i.e. clearly explain what the investigation is required to cover and anything that does not need to be covered. The terms of reference for the investigation should also identify which legislation, policies, procedures and practices are relevant to the issues being examined.

Identifying sources of evidence

Once the scope of the investigation has been established, it is necessary to identify sources of evidence available to the investigator. Ideally, potential evidence will have been identified and if necessary, secured as part of the initial response to the incident. Relevant sources of evidence will depend on the nature and circumstances of the incident but may include:

- oral evidence (recollections)
- documentary evidence (records)
- electronic evidence (images and communications)
- forensic evidence (e.g. results of medical examinations)
- expert evidence (technical advice/ professional opinion)
- site inspection (to identify, say, where an incident occurred).

While only one source of evidence may be needed to make a finding, it is best practice to provide corroboration with additional sources of evidence.

Planning key actions and timeframes

The investigator should plan the key actions they need to undertake and the order in which they should be undertaken. This will depend on the unique circumstances of the investigation, but the following factors should be considered:

- It is critical to explain the need for confidentiality early on to people involved in the investigation.
- As people's recollections of events can quickly fade, interviews should be conducted as soon as possible, allowing time for the investigator to prepare and adequate notice to be given to individuals being interviewed.
- The person who is the subject of an allegation is generally interviewed last, once you've collected and analysed as much evidence as you can, so that all relevant issues identified can be put to them.
- If there are multiple witnesses in a matter, you should try to interview them within as short a timeframe as possible to manage the risk of collusion i.e. witnesses agreeing to provide or conceal particular evidence. Carefully weigh up the order of witness interviews — consider first interviewing witnesses who are likely to have a more independent perspective.
- If it is likely that you will need to obtain expert evidence, request it early to allow sufficient time to receive a response.

Identifying people affected by the investigation and developing a communication plan

An important part of early investigation planning is identifying the people affected by the investigation (stakeholders) and developing a plan for communicating with them. Stakeholders include the affected consumer/s of the incident, the subject of the allegation, witnesses and any external agencies you may need to notify, liaise with or consult e.g. police, the Commission, AHPRA. Your stakeholders are also likely to include the family/representatives of affected consumer/s, other care recipients and staff.

Your communication strategy should identify who is responsible for liaising with different stakeholders as well as what information should/should not be shared with them.

When planning how you will communicate with care recipients, one size doesn't fit all — you should identify and take into account each person's circumstances, needs, and preferences. You must ensure your actions are consistent with the Charter of Aged Care Rights. This includes the right of care recipients to be treated with dignity and respect; to access all information about themselves; to make choices about their care; to be listened to and understood; and to have a person of their choice support them or speak on their behalf.

Identifying risks

At an early stage you should identify risks that may arise during the investigation and put in place strategies to manage them. Risk management means identifying the potential for a negative event to occur and taking steps to reduce the likelihood that it will occur or minimising its impact. The nature of the incident will influence the actual and possible risks you will need to manage but in general, you should consider the following:

- The need to manage any ongoing risks to the safety, health or wellbeing of any affected consumer/s by the incident, or any other care recipient, as well as anyone involved in the investigation, i.e. subject of the allegation, witnesses.
- Issues that could affect the integrity of the investigation, e.g. breach of confidentiality, loss or contamination of evidence, failure to provide procedural fairness
- The need to avoid compromising any investigation by an external agency e.g. police, the Commission.
- The potential for damage to your service through breach of trust with care recipients/ families, loss of reputation, regulatory sanctions etc.

Preparing an investigation plan

A formal investigation should be guided by an investigation plan which documents the purpose and scope of the investigation, sources of evidence, key actions and timeframes (planned and completed), communication plan and risk management strategies. The investigation plan should be systematic but flexible so that it can be adjusted as needed during the investigation. An investigation plan and summary template is provided at **Annexure A** and can be adapted to meet your needs.

Gathering evidence

During the investigation planning stage, you will have identified the evidence you need to gather and assessed the order of priority. Allow sufficient time to obtain all the required evidence. Ensure each separate piece of evidence is carefully logged, recording all relevant details including how and when you obtained it. All evidence must be securely stored.

Conducting interviews

Oral evidence obtained from interviews is usually a key source of evidence. The PEACE model of investigative interviewing is considered best practice and is suitable for any type of interviewee. PEACE stands for:

Preparation and planning
Engage and explain
Account, clarify and challenge
Closure
Evaluation

Preparation and planning are the foundations of success for any investigative interview. You should have a clear understanding of what you need to establish from the interview. You should also identify whether the person you're interviewing has any communication support needs including language or other barriers and plan any necessary adjustments such as providing an interpreter or other communication aides. Choose an interview location that is neutral, private, convenient and accessible for the interviewee and their support person.

If you wish to record the interview, explain this to the person before the interview and obtain consent. If the person chooses to have a support person, make sure that the proposed support person does not have a potential conflict of interest e.g. that they are also a witness. Explain that the support person's role is limited to providing emotional support to the interviewee. They should not control the process, provide answers on behalf of the interviewee, or influence the interviewee's responses in any way.

Make an effort to establish rapport at the start of the interview — the accuracy and amount of information that a person provides during an interview generally decreases if rapport is absent. You should encourage the person to give their evidence in a 'free narrative' without interruption. Where necessary, you can prompt them to continue and expand their account. Do not reveal too much about what you already know before seeking their version of events. For further guidance about conducting interviews see **Annexure B**.

Record all relevant details about interviews. This may include:

- any pre-interview planning e.g. contact with the person being interviewed, planning to provide communication supports/adjustments
- the date and location of the interview
- who was present including any support person
- the start and finish times of the interview
- the questions that were put to the person and their responses (verbatim)
- observed behaviour of the person at the time of interview. Be mindful that your interpretation of a person's behaviour is highly subjective and should not be treated as objective evidence.

After the interview, you should provide the person with an opportunity to verify the accuracy of your record of the evidence they provided.

Obtaining information from other agencies

Make sure that you request information from any other agencies that would help to inform the investigation, obtaining consent from relevant individuals or their representative/substitute decision-maker, where required. For example, you may request information from police if they had any involvement in investigating the incident and/or a treating doctor or hospital if medical attention was sought.

4 Providing support and fairness to people during an investigation

This guidance provides advice about how to meet your duty of care to provide support and fairness to people when investigating an incident.

What does 'fairness and support' mean and why does it matter?

When you are investigating an incident, you have a duty of care to be fair and provide support to people involved in the investigation.

Being fair: Being fair means providing people who are involved in the investigation with an adequate opportunity to participate and be heard. Under section 15LA(2)(c)-(e) of the Quality of Care Principles 2014 (Quality of Care Principles), you have a specific obligation to involve each affected consumer (or their representative) in managing and resolving the incident. Fairness also involves being objective and unbiased and providing the subject of an allegation with an adequate opportunity to respond to the allegations and any proposed findings/actions that will affect them 'procedural fairness' (see below).

Providing support: Providing support includes giving people timely and appropriate information about the investigation, providing any assistance they need to participate in the investigation process (e.g. interpreter, communication aide), acknowledging trauma and stress, and facilitating access to appropriate support.

Being fair and providing support during an investigation matters because:

- The *Quality of Care Principles* require your management of incidents to be focused on the safety, health, wellbeing and quality of life of people receiving aged care. You have a specific obligation to support and assist any person affected by an incident.
- As an employer, you have a duty of care to your staff, including under work health and safety laws. This duty of care extends to ensuring, as far as is reasonably practicable, that staff members are not exposed to psychological health and safety risks[6]. Action can be taken against you if you fail to meet your duty of care to a staff member, including during an investigation.

6 Aged Care Quality & Safety Commission, Effective incident management systems: Best practice guidance, 2021, p32. (National guidance material), January 2019. Work related psychological health and safety - A systematic approach to meeting your duties.pdf

- Providing fairness and support can lead to a better investigation by improving the quality of evidence you are able to gather.
- The integrity of your investigation, and any actions you take based on the investigation, can be challenged and action taken against you if you do not provide fairness and/or you cannot demonstrate this.

How you plan to provide support and fairness should be outlined in the investigation plan and any related decisions you make during the investigation should be adequately recorded.

Providing support

The guidance below is about providing support during an investigation.

Who should be supported?

You must support any person involved in the investigation. This includes:

- the alleged affected consumer/s of the incident
- the subject of an allegation
- witnesses
- family/representative of people affected by the incident
- other care recipients or staff affected by the incident.

What kind of support should be offered?

You should tailor the support you offer to the circumstances of the incident and investigation and the people involved. Different kinds of support may be needed at different stages of the investigation, for example, during an interview and when receiving information about the progress and outcome of the investigation. As a guide, consider the following steps:

- **Acknowledge trauma:** Depending on the nature and circumstances of the incident, one or more people involved in the investigation may be experiencing trauma. The alleged affected consumer/s of the incident is most likely to experience trauma but witnesses to an incident and the person's family may also be traumatised. If the subject of the allegation is a care recipient, they may also experience trauma. Acknowledging trauma means being aware of the possibility of trauma, anticipating and asking questions about people's support needs, taking appropriate steps to meet these needs, and where possible, not doing anything that could re-traumatise the person.
- **Appoint a liaison person:** Where possible, one person should be identified to be responsible for liaising with the alleged affected consumer/s and if appropriate, their family/representative throughout the entire process. This person may or may not be the investigator, but it should be someone appropriate and trusted by the affected consumer/s. The same approach should be used when a care recipient is the subject of the allegation. Ideally, to avoid a conflict of interest, the same person should not be responsible for liaising with the affected consumer/s and the subject of the allegation.

- **Communicate effectively:** Communicating with people involved in the investigation is part of providing support and fairness. Ensure you communicate appropriately with all relevant parties, not just the affected consumers and the subject of the allegation. Communicate in ways that are respectful and that people can understand. If a person does not have sufficient decision-making capacity, you must communicate with their representative. See 'Ensuring fairness' below.
- **Uphold duty of care for staff member:** If a staff member is the subject of the allegation or a witness to an incident, you should refer them to your employee assistance scheme or another appropriate and independent source of support. You may also consider appointing someone within your service to act as a liaison/support person. This person should not be involved in the investigation or the incident leading to the investigation. You should consider the views and preferences of the staff member who is the subject of the allegation before appointing a support person.
- **Arrange additional services/supports:** Find out whether any person involved in the investigation needs access to additional services or supports to help them participate and/or to manage any stress associated with the investigation process. This may include offering to arrange a support person or advocate and/or other supports a person needs to participate in the investigation process e.g. an interpreter, other communicate aide or cultural support worker. See 'Ensuring fairness' below.

Remember: A person's support needs may be different at different stages of the investigation process and may also change over time. If someone turns down an offer of support, you should let them know that support is always available to them if they change their mind.

Being fair

Providing fairness is essential to the integrity of the investigation. It involves ensuring people affected by the investigation have an adequate opportunity to participate and have reasonable assistance, if needed, to participate. An 'open disclosure' process is used to communicate with them during the investigation, complying with the principle of 'procedural fairness'.

Promoting participation

You should make it as easy as possible for people to participate in the investigation. In practice, this means:

- assessing a person's decision-making capacity. If a person does not have sufficient capacity to make decisions, you must engage with their representative to do so on their behalf

- listening to the alleged affected consumer/s and their family/representative, where relevant and considering their views when planning and conducting the investigation. You should be respectful of what the person needs to feel safe and able to participate. Acknowledge their dependency and vulnerability as a consumer of aged care services and provide appropriate reassurance about protecting their safety and wellbeing. The same considerations should also apply where the subject of the allegation is a care recipient
- providing adequate information about the investigation, including the investigation process, to all involved people. Information should be provided in a way that each person can understand. If a person has a cognitive or communication impairment, this may mean tailoring the information e.g. using simple language or enlisting someone e.g. advocate or family member who can help them to understand it
- where possible, being flexible and providing choices e.g. offering an alternative interview date or location if necessary
- helping people to give their best evidence by identifying and planning how you will meet any communication support needs, ensuring you have regard to both expressive and receptive communication needs[7]. This may involve adjusting the way you communicate during an interview and/or providing the person with any equipment or other supports they need.

While you must always consider how to facilitate participation, it's important to remember that not all care recipients may be able to participate in an investigation in a similar way, particularly (but not only) if they have a cognitive impairment. You should assess this on a case-by-case basis as part of the planning process and if necessary, throughout the investigation. If the person consents to you doing so, it may be appropriate to involve their chosen family/representative. If they do not have sufficient decision-making capacity, you should consult their representative. Always record the steps you have taken to achieve participation and related decisions.

Ensuring communication

You must use an 'open disclosure' process when responding to incidents (s15LA(e), Quality of Care Principles). This includes communicating effectively with all parties involved in the investigation. Effective communication involves providing sufficient information at an appropriate time, in a way people can understand. You should consider people's needs and preferences when deciding how to provide information e.g. in person or in writing. Where the subject of the allegation is a staff member, certain information should be provided in writing — see 'Providing procedural fairness').

7 Expressive communication refers to a person's ability to express information in speech, writing, sign language or gesture. Receptive communication refers to a person's ability to receive, process and interpret verbal or written information.

At the start of an investigation, you should inform the people involved:

- that an investigation is being conducted
- who is responsible for carrying out the investigation
- what the investigation process involves
- their rights and responsibilities
- how long the investigation is expected to take
- who they should contact if they have questions.

When communicating with a staff member who is the subject of an allegation, you should be mindful of managing risks and the appropriate stage of the investigation to provide them with certain information — see 'Procedural fairness' below.

Although you may be limited in what you can say at various stages of the process, during the investigation you could consider providing regular updates to the people involved. This includes communicating about and providing reasons for any delays. At the end of the investigation, you should consider communicating the outcome. The type and amount of information you provide at this stage will depend on the nature of the outcome and the person's involvement in the matter.

Explaining rights and responsibilities

You should inform people of their rights and responsibilities in relation to participating in the investigation. Rights include obtaining independent advice from a legal representative or an advocate and having a support person present during any interview. Responsibilities include maintaining confidentiality and not take any retaliatory action against a person.

Providing procedural fairness

Procedural fairness is a safeguard that applies to an individual whose rights or interests are affected by an investigation. It applies to the process and procedures that are followed during the investigation. The main rules of procedural fairness are:

- **Provide enough information to the person who is the subject of the allegation** to allow them to understand the nature of the allegation. Provide them with an adequate opportunity (and timeframe) to respond and be heard before making any finding or decision that adversely affects them.
- **Ensure the investigation is fair and unbiased.** The investigator must act in a way that is impartial. This includes not having a conflict of interest or favouring one person or version of events over another. All evidence should be considered.
- **Make reasonable enquiries and base decisions on evidence.** This means the investigator must make sufficient enquiries to gather all relevant evidence, whether it is favourable or unfavourable to the subject of the allegation, and only make decisions that are based on this evidence. Reasons for decisions must be given.

- **Maintain confidentiality to the extent possible.** Information about and obtained during an investigation should only be disclosed if required by law or where it is otherwise appropriate in the circumstances for it to be shared. However, this must be balanced with the obligation to act fairly to a person whose interests may be adversely affected by a decision arising from the investigation. In certain circumstances, the obligation to be fair to the subject of the allegation may completely or partially override confidentiality.
- **Avoid unnecessary delay.** The length of time required to conduct and finalise an investigation will vary depending on the nature and complexity of the issues being investigated and the amount of evidence that needs to be gathered and assessed. You should be proactive about communicating likely timeframes as well as delays, and the reasons for delays, to people involved in the investigation. Unreasonable delays may breach procedural fairness and can result in the integrity of the investigation, and any action taken as a result, being challenged.

How you provide procedural fairness to the subject of the allegation will look different depending on whether they are a staff member or a care recipient.

When the person is a staff member, you should consider any state and Commonwealth laws that might impact how you conduct an administrative investigation. This might include providing written advice to the person or their supporter about the allegations, providing a support person, providing them with information about the investigation process, any proposed adverse findings/ decisions, and the final outcome of the investigation. If you are in doubt about the appropriate process, you should seek specialist legal advice.

When the subject of the allegation is a care recipient, you will need to decide the most appropriate way of providing them with an opportunity to respond to the allegation and any proposed findings/actions that will affect them. These opportunities should be given before any substantiation of an allegation occurs. What is appropriate will depend on the person's circumstances, including whether they have a cognitive impairment (and if so, its severity), the nature of any communication support needs, and if they have decision making capacity.

You should always avoid unnecessarily traumatising the person. Where the person does not have sufficient decision-making capacity or they are particularly frail, you should communicate with their representative about the investigation. In other circumstances, if the person provides consent, it may be appropriate to also communicate with their chosen family member/representative about the investigation. Regardless, of the approach you take in meeting your obligation to provide procedural fairness, you should clearly record your decision and reasons.

See Annexure A for a list of steps to follow to provide procedural fairness.

5 Protecting personal information and providing confidentiality

This guidance explains the important steps you should consider to protect personal information and ensure confidentiality (to the extent possible) when investigating an incident.

Checklist for managing privacy and confidentiality

- ✓ Familiarise yourself with your organisation's policies and procedures about protecting and disclosing personal information.
- ✓ Manage and investigate incidents in a confidential manner that is considerate and respectful of the interests of all parties and care recipients' right to privacy.
- ✓ Explain the need to maintain confidentiality to all involved parties at the start of the investigation, as well as the limits on confidentiality associated with legal requirements and procedural fairness.
- ✓ Make informed decisions, based on a risk assessment, of what information can be shared with involved parties during the investigation and at what stage.
- ✓ Only disclose information on a 'need to know' basis and limit the information to the extent that is necessary to meet the purpose of sharing it.
- ✓ Record decisions to disclose information and the reasons for decisions.
- ✓ Take steps to protect personal information from loss, unauthorised access, use, disclosure, or any other misuse during the investigation process.

Protecting personal information and providing confidentiality

You must take steps to protect personal information and provide confidentiality when conducting an investigation. Protecting personal information means lawfully collecting, using and disclosing it, and preventing its loss or misuse.

Ensuring confidentiality means keeping information private i.e. not sharing it with other people, to the extent that is possible. Legal requirements and/or procedural fairness considerations may partly or completely over-ride confidentiality in some circumstances unless consent is given. See 'During the investigation'.

What are your obligations to protect personal information?

Your service should have relevant policies and procedures which outline obligations in relation to protecting personal information

The *Aged Care Act 1997* requires providers to protect the personal information of care recipients. Personal information means 'information or an opinion, whether true or not, and whether recorded in a material form or not, about an identified individual, or an individual who is reasonably identifiable' [8]. Examples of personal information include an individual's name, signature, date of birth, medical records, financial details and commentary or opinion about them.

The Division 62 of the Act says that providers:

- Must **not use** a care recipient's personal information, other than for a purpose connected with the provision of aged care to the care recipient by the provider, or a purpose for which the personal information was given to the provider by or on behalf of the care recipient.
- Must **not disclose** a care recipient's information to any other person (unless with the care recipient's written consent) except for:
  - a purpose connected with the provision of aged care to the care recipient by the approved provider, or in the limited circumstances outlined in Div. 62 (1)(b)(ii) and (iia) of the Act, another approved provider
  - a purpose for which the personal information was given by or on behalf of the care recipient
  - the purpose of complying with an obligation under the Act or the *Aged Care (Transitional Provisions) Act 1997* or any of the Principles made under section 96 1 of the Act or the *Aged Care (Transitional Provisions) Act 1997.*
- Must **have** reasonable security safeguards in place to protect against the loss or misuse of personal information.

The Act does not prevent personal information being given to a court, tribunal, authority, or person which has the power to require the production of documents or the answering of questions. This includes the Commission.

The Charter of Aged Care Rights recognises that care recipients have the right to personal privacy and to have their personal information protected.

8 Office of the Australian Information Commissioner, 'Privacy Act'

The above obligations apply alongside regulatory requirements in relation to privacy contained in relevant state, territory or Commonwealth legislation, such as the Privacy Act 1988 and the Australian Privacy Principles (APPs).

Providing confidentiality

Your service's policies and procedures should also address the need to manage and investigate incidents in a confidential manner that is considerate and respectful of the interests of all parties, including the person who reported the incident, the alleged affected consumer/s, the subject of the allegation and any witnesses. This is important to protect people's right to privacy, dignity and safety; to protect the integrity of the investigation; and to limit unnecessary disruption in the workplace.

In general, confidentiality may be necessary or appropriate in relation to the following:

- the fact that an incident (including a disclosure/allegation) has occurred
- the nature of the incident
- the identity of the person who reported the incident, the alleged affected consumer/s, the subject of the allegation and any witnesses
- any evidence gathered by the investigator.

However, it is important to be aware that there is no absolute right to privacy and confidentiality as legal requirements and/or procedural fairness considerations may partly or completely over-ride these in some circumstances, as outlined below.

Factors to consider at different stages of an investigation

At the start of an investigation, you should inform all parties — including the alleged affected consumer/s, subject of the allegation, witnesses and support people — that they need to maintain confidentiality. They should not discuss or share any details with anyone else unless they are obtaining legal/industrial advice or support for their wellbeing e.g. from a counsellor or family member.

You should also explain that while confidentiality will be protected as far as possible, there are limits on confidentiality that mean certain information gathered during the investigation may need to be shared. Explain why this is the case.

When planning and during the investigation, you will need to make decisions about what information you can and should share with involved parties, and when it is appropriate to share it. You must consider what is lawful as well as what is appropriate, having regard to factors including:

- care recipients' right to personal privacy. This right applies to a care recipient regardless of whether they are an alleged affected consumer/s or the subject of an allegation
- what you need to do to continue to be able to provide appropriate services to affected consumer/s
- the need to treat the alleged subject of the allegation fairly
- not prejudicing the investigation or an external investigation by another agency
- the need to protect the person who reported the incident from victimization, if relevant
- the legitimate interests of other parties such as care recipients' families and staff
- minimising workplace disruption and morale.

During the investigation

Throughout the investigation you should take reasonable steps to protect personal information from loss, unauthorised access, use, disclosure or any other misuse during the investigation process. For example, interviews should be conducted in private, registered post should be used to send correspondence, care should be taken to limit responsibility for retrieving, copying and filing documents, and investigation documents should be separately stored where access can be restricted.

Information about the investigation, obtained during the investigation, should only be used and disclosed on a 'need to know' and measured basis, limiting the information to the extent that is necessary to meet the purpose of sharing it.

Legal requirements and the principles of procedural fairness mean there is no absolute right to privacy or confidentiality. For this reason, you should never suggest or promise otherwise to any person involved in an investigation. For example, you have a responsibility to notify the Commission of reportable incidents and provide relevant information about how you have managed and resolved them. Where there are reasonable grounds to do so, you also have an obligation to report incidents to police. Depending on the nature of the incident, you may also be required to provide relevant information to another external agency, e.g. Coroner, Safe Work Australia, AHPRA.

You may also need to disclose certain information to provide the subject of an allegation with procedural fairness during the investigation. For example, in order to allow the person to fully respond to the allegations, you may need to share identifying names and details. While the subject of the allegation may not necessarily need to know who made the allegation, they will generally need to be informed of the identity of the alleged affected consumer/s to have a fair chance of responding to the allegation. The person managing the investigation should seek to balance fairness and confidentiality requirements and, as far as possible, safeguard the interests of all parties.

Decisions to disclose information about an incident or investigation should be made by a person with appropriate authority and clearly recorded, together with the reason for the disclosure.

At the end of the investigation

When the investigation has finished, you will need to decide what information to share about the outcomes and with whom. You should only share information with people who need to know and/or have a legitimate interest in the details. You must be careful not to breach any other person's right to privacy and confidentiality. If you make adverse findings about a staff member who is the subject of allegation, you must have regard to their privacy rights when determining what information about the outcome/decision is shared with others, including the affected consumer/s.

6 Finalising an investigation and deciding outcomes

This guidance provides information about finalising an evidence-based investigation and deciding what should happen next.

Checklist for finalising an investigation

- ✓ Evaluate the strength and weight of all the evidence that has been gathered.
- ✓ Consider whether you need to obtain or assess additional evidence.
- ✓ Based on your assessment of the evidence, you must make a finding regarding each allegation by applying the standard of proof — the balance of probabilities.
- ✓ Give the subject of the allegation an opportunity to respond to any proposed adverse findings against them and any recommendations that will adversely affect them if implemented.
- ✓ Identify and recommend actions to address the safety, health and wellbeing of any person affected by the incident. This will help prevent further similar incidents from occurring or minimising harm and will improve the management and resolution of similar incidents.
- ✓ Prepare an investigation report that outlines the process that was followed, the evidence that was gathered and assessed, and the findings and recommendations made by the investigator.
- ✓ Provide the investigation report to the appointed decision-maker to accept or reject.

Assessing the evidence

Once all the evidence has been gathered, the investigator needs to assess it to evaluate its strength. The investigator should consider the source and reliability of the evidence; whether it is relevant to the alleged incident; whether accounts are consistent (over time, with other evidence, and more or less plausible); and whether there is any other evidence to support or contradict an allegation[9].

Making evidence-based findings

Once the evidence has been assessed, the investigator should make a recommended finding. If the investigation has examined more than one allegation about a person, a finding must be made for each allegation. It is up to the decision-maker (see 'Making decisions') to confirm the recommended findings and any additional recommendations made by the investigator.

If for any reason, the investigator does not believe a finding can be made, they must provide clear reasons to the decision-maker. This should rarely occur. For example, it is not appropriate for an investigator to conclude that they couldn't reach a finding because there was evidence which both supported and did not support a sustained finding, as this is really about the proper application of the standard of proof — discussed below. It is, however, legitimate for an investigator not to make a finding against any person if they were unable to identify the person involved in an incident after reasonable inquiries had been made.

Applying the standard of proof

Investigators do not need to apply the criminal standard of proof i.e. beyond reasonable doubt, when making findings. However, they must be able to show their findings are based on clear and persuasive evidence — not guesswork, suspicion or rumour. The more serious the allegation or incident, the more care must be taken when making a finding. If a finding in relation to an allegation could result in disciplinary action against a staff member or have a significant impact on a care recipient, the evidence to support the finding must be clear and convincing.

Providing procedural fairness

You must make sure the subject of the allegation is given a proper opportunity to respond to any proposed adverse findings against them as well as recommendations that, if implemented, will adversely affect them. You should give them enough information to allow them to respond to the allegations against them and the reasons for any proposed adverse findings.

9 NSW Ombudsman, *Making a finding in Disability Reportable Incident investigations*, Factsheet, July 2018.

Using findings to recommend actions

Once the investigator has reached their recommended findings, they should also identify and recommend any actions. Actions should be aligned with the requirements for managing incidents contained in the *Quality of Care Principles 2014*, i.e. focused on:

- the safety, health, wellbeing and quality of life of any affected consumer/s (s15LA(1))
- remedial action to prevent further similar incidents from occurring, or to minimise their harm (s15LA(3)(b)), and
- actions that could be taken to improve the management and resolution of similar incidents (s15LA(3)(d)).

Factors to consider when recommending actions:

- Are there any ongoing risks to the safety, health and wellbeing of the affected consumer/s or any other care recipient? What strategies can be implemented to remove or minimise these risks?
- Have any systems' issues been identified, e.g. deficiencies in policies, procedures, training or practices? How can these deficiencies be corrected?
- Is there evidence that the incident could have been prevented and/or harm minimised? What could be done to prevent similar incidents/minimise harm in future? e.g. consider how services/supports are provided, development or amendment of a policy or procedure, training for staff.
- How well was the allegation/incident managed and resolved from the outset? Could the future management/resolution of incidents be improved? What would need to be in place for this to happen?
- Has a staff member breached the Code of Conduct and/or other policies or procedures? Does their ongoing employment present an unacceptable risk? Is disciplinary action e.g. probation, performance management, dismissal appropriate?
- Are there additional actions that can be taken to address the physical and/or psychological impact of the incident on any affected consumer/s or their family? e.g. counselling, practical support, an apology, other actions that may be considered appropriate by your service on a case-by-case basis.
- Having regard to the principle of open disclosure, relevant legislative obligations (including the protection of personal information requirements under the *Aged Care Act 1997* and the Australian Privacy Principles) and safety risks, which people or agencies should be provided with information about the outcome of the investigation and what information should be provided to them?

Writing an investigation report

Best practice investigation reports outline the process that was followed, the evidence that was gathered and assessed, and the findings and recommendations made by the investigator. They will also have a logical structure, be factual and unbiased.

An investigation report will be concise while containing enough information to support the findings and recommendations and be understood by someone not familiar with the case. Information relied on in the report should be sourced i.e. when you refer to a piece of information, it should be clear where/how you obtained it (e.g. review of record A, interview with witness B). You should attach any relevant documents as annexures to the report e.g. statements by witnesses, photographs, incident reports. An investigation report template is provided at **Annexure A**.

Making decisions

Ideally, the person who makes decisions based on the findings of the investigation should not be the investigator. They should also have sufficient decision-making authority.

Once the investigator has finalised their report, the decision maker should read it and make their own assessment of the evidence and the investigator's findings. The decision maker should then make a finding for each allegation, applying the required standard of proof. They should also decide whether to accept any additional recommendations made by the investigator.

The decision maker should not depart from the investigator's findings and/or recommendations unless they can demonstrate good reasons for doing so. If the decision maker decides not to accept the investigator's findings and/or recommendations, this should be clearly documented together with reasons.

The decision maker is responsible for making the final decision about what action should be taken as a result of the investigation including, but not limited to, possible disciplinary action against the subject of the allegation if they are a staff member.

7 Communicating investigation outcomes and taking follow-up actions

This guidance provides steps to consider once the investigation of an incident has been finalised. It provides information about how and to whom you should consider communicating the investigation outcomes, as well as the types of follow-up actions you may need to implement.

Checklist for communicating investigation outcomes and follow-up actions

- ✓ Ensure the decision-maker has considered the investigation report and made final decisions.
- ✓ Identify who needs to be provided with advice about the investigation outcomes. In addition to the affected consumer/s of the incident and any staff member or other care recipient who is the subject of an allegation, you should consider:
  - family/representative of the affected consumer/s
  - internal stakeholders, as required by your service's policies or procedures, e.g. Board/committees
  - external agencies, e.g. the Commission, Coroner, AHPRA, Safe Work Australia
  - other people with a legitimate interest in the outcome of the investigation.
- ✓ Identify the type of information that should be provided to each of the above parties. Ensure you have regard to privacy obligations in relation to sharing information about individuals e.g. details of disciplinary action against a staff member or actions taken to support a care recipient's safety, health or wellbeing.
- ✓ Consider the needs and preferences of people affected by the incident when determining the most appropriate way of communicating investigation outcomes. Identify whether you need to involve other people to assist.
- ✓ Keep a record of who is provided with information about the investigation outcome.
- ✓ Assign responsibility for implementing any recommendations arising from the investigation. Once completed, ensure the IMS and relevant internal/external stakeholders are updated and the investigation is closed.

What are 'investigation outcomes'?

At the end of an investigation, the decision-maker decides whether to accept the findings and recommendations put forward by the investigator. The decision-maker may also decide on any further actions they consider necessary based on the evidence available to them. At this stage, the 'investigation outcomes' are known, and the final stage of the investigation process begins.

Providing advice about outcomes

Providing advice about the outcomes of an investigation involves two steps — identifying who should receive advice and deciding what information should be provided.

Who should receive advice?

You should communicate the investigation outcomes to:

- the affected consumer/s of the incident and, if appropriate, where the affected consumer/s has consented, their family/representative. If the person does not have sufficient decision-making capacity, their representative should be informed and involved in deciding how to communicate the outcome.
- the subject of the allegation
- internal stakeholders as required by your policies or procedures, e.g. Board, Risk Committee
- the Commission and any other external agencies that need to be notified, e.g. AHPRA, Safe Work Australia.

* If the subject of the allegation is a care recipient, consider whether it is appropriate to also inform them and/or their family/representative, with consent, about the outcome of the investigation.

Depending on the nature of the incident, for example, if it was witnessed by a number of people and/or has caused significant concern on the part of other care recipients, their families and/or other staff, it may also be appropriate to provide **some** information to indirectly affected people with a legitimate interest in the outcome of the investigation — as outlined below.

What information should be given?

The information that should be given will depend on who you are providing it to.

Affected consumer/s of the incident

The advice you provide should include:

- the actions taken to properly investigate the matter and the investigation findings, including the reasons for the findings
- actions taken or planned to prevent further similar incidents from occurring or to minimise their harm and to improve their management and resolution in future
- actions taken to provide support and assistance to ensure the person's safety, health and wellbeing. This may include providing high-level advice about risk management actions taken in relation to a person who is the subject of the allegation

* Aged Care Quality & Safety Commission, Aged Care Open Disclosure Framework and Guidance, 2022, p34-35.
Aged Care Quality & Safety Commission, Effective incident management systems: Best practice guidance, 2021, p38.

- review options if the alleged affected consumer/s or their family are not satisfied with the outcome of the investigation.

Subject of allegation

The advice you provide may include:

- the actions taken to properly investigate the matter and the investigation findings, including the reasons for the findings
- where the subject of the allegation is a staff member, any management or disciplinary action taken against the person, the reasons for the decision to take the action, and the consequences of the action
- where the subject of the allegation is a care recipient, any decisions that will affect the person, such as changes to the way services and supports will be provided
- review options if the subject of the allegation is not satisfied with the outcome of the investigation.

Internal stakeholders

An important component of good governance involves boards and/or executives having direct line of sight over serious incidents and staff conduct. This should include regularly reviewing data about incident trends, in a way that doesn't compromise privacy or jeopardise ongoing investigations. This will help to continuously improve the management and prevention of incidents (s15LB, Quality of Care Principles 2014). Your service's policies and procedures should identify which internal stakeholders should be provided with information about investigation outcomes and what type of information they should receive.

External agencies

If you need to tell any external agencies about the investigation outcome, you should be guided by their requirements. Ask them for advice if you're unsure.

When you notify a reportable incident to the Commission, we will tell you what further information we need you to provide. If the Commission has required you to conduct an internal investigation or engage an external expert to conduct an investigation, you will need to provide us with a copy of the investigation report and advice about the final outcomes of the investigation once complete.

Other people with a legitimate interest in the outcome of the investigation

If, because of the nature of the incident, you decide it is appropriate to communicate with other people with a legitimate interest in the outcome of the investigation, you must be cautious about the information you provide. The type and amount of information provided should be limited to what is necessary to convey the steps taken by your service to appropriately respond to the incident. The privacy of individuals affected by the incident, as well as any witnesses, must be protected.

How should information be provided?

When the subject of an allegation is a staff member, information about investigation outcomes should be provided in writing. When providing information to care recipients, whether they are the alleged affected consumer/s or the subject of the allegation, you should consider their individual needs and preferences, including whether they have a cognitive or communication impairment which may affect the way they receive and understand information. It may be preferable to directly meet with the person and/or their family/representative to communicate the outcome, before or at the same time as providing written advice. You may also need to engage an interpreter or another person e.g. a social worker, to assist. You should keep a written record of any meetings or conversations during which investigation outcomes are discussed.

In situations where it is necessary to communicate information to indirectly affected people with a legitimate interest in the outcomes of an investigation, you should also think about the best way of doing this. For example, it may be appropriate to provide direct verbal advice or send a standard letter to relevant individuals.

Taking follow-up actions

As part of your incident management system, you should have processes in place to make sure that investigation outcomes are effectively implemented and tracked.

Implementing recommendations

The decision-maker should nominate who is responsible for implementing any recommendations arising from the investigation and the timeframe for implementation. Depending on the scope and complexity of the recommendations, one or more people may be responsible.

Once the recommendations have been implemented, the relevant record in the IMS should be updated to reflect this and internal stakeholders should be informed. In some cases, it may also be necessary to update external stakeholders or other agencies about relevant actions that have been completed, particularly if they relate to systemic improvements.

The investigation should only be officially 'closed' once all outstanding actions have been fully implemented or, in the case of significant systemic reforms, adequately progressed.

Providing ongoing support to affected consumer/s

It is essential to ensure that support for people affected by an incident does not suddenly stop once the investigation is finalised. If an outcome of the investigation is that changes are made to the services/supports provided to a care recipient, it is particularly important that these changes are actively monitored to make sure they are well-targeted and effective.

Services should also be aware that when a person has been affected by a serious incident, trauma can be episodic, ongoing or only surface much later. Sometimes, other events or circumstances can unexpectedly trigger trauma symptoms. There should be strategies in place so that staff know what to do if this occurs.

8 Keeping investigation records

This guidance summarises your responsibilities to make and keep records of the investigation of incidents.

Checklist for keeping investigation records

- ✓ During an investigation, keep records that thoroughly and accurately document the investigation process and evidence relied on to make findings and recommendations.
- ✓ Ensure your incident management system captures information about whether affected people have been provided with reports or findings regarding the incident and the details and outcomes of investigations undertaken.
- ✓ Securely store investigation records to protect them from accidental or deliberate loss, damage, destruction or misuse.
- ✓ For each investigation, identify who can and cannot access the investigation records. Ensure adequate controls are in place to prevent unauthorised access to records.
- ✓ Comply with relevant legislative and policy requirements for the retention of records.
- ✓ Regularly review and analyse incident data, including data drawn from.

Why record-keeping is important

Keeping good records is critical to organisational governance, accountability and integrity. It allows you to:

- demonstrate compliance with legislative and policy requirements (including the *Records Principles 2014*, *Quality of Care Principles 2014 (Quality of Care Principles)* and *Aged Care Quality Standards*)
- produce evidence, when required, of decisions made and actions taken by your service
- undertake quality assurance, monitor trends and plan for continuous improvement.

What records about investigations should be made?

During an investigation, the following types of records should be made to document the investigation process and evidence relied on to make findings and recommendations:

- investigation plan documenting the scope of the investigation, sources of evidence, communication plan, risk management strategy and key investigation actions
- copies of correspondence and file notes of conversations related to the investigation
- records of interviews with the affected consumer/s, the subject of allegation and any witnesses
- capacity assessment
- records of any other evidence obtained by the investigator e.g. incident reports, medical reports, rosters, progress notes, behaviour support/care plan, photographs, CCTV footage, training records
- records of liaison with other agencies during the investigation e.g. police, the Commission, Coroner, APHRA, Safe Work Australia
- decisions made during the investigation and the reasons for decisions
- final investigation report including the findings and recommendations proposed by the investigator
- record of final decisions, and reasons, by the decision-maker
- whether the affected consumers/their family/representative were satisfied with the investigation process.

The ability to produce the above information is particularly important if you are required to account for the adequacy of your management and resolution of an incident and/or if an investigation process or findings are challenged e.g. by the subject of an allegation who is affected by adverse findings.

Recording information about investigations in your IMS

The SIRS requires providers to implement and maintain an IMS which records a minimum set of details about incidents (s15MC(2) of the Quality of Care Principles 2014). This includes whether affected people have been provided with reports or findings regarding the incident and the details and outcomes of any investigation of undertaken in accordance with s15MC(2)(j)-(k) of the Quality of Care Principles.

While the Quality of Care Principles do not specify the form that the above information should take, it is good practice to record key details about investigations, including:

- the name and contact details of the investigator
- the date the investigation started and was finalised
- the investigator's findings and recommendations
- the name and contact details of the decision-maker
- if the decision-maker did not agree with the investigator's findings and recommendations and the reasons for this

- all evidence obtained and considered during the investigation
- any action taken as a result of the investigation, including systemic changes e.g. staff training or policy changes; and individualised action such as management/disciplinary action against a staff member, review of accommodation arrangements, change to behaviour support, updated risk management plan, change in psychological support to care recipient
- which people and agencies were provided with information about the outcomes of the investigation and what information they were given.

Storing records

Providers should have adequate information management systems in place to protect against the accidental or deliberate loss, damage, destruction or misuse of records. These systems and associated processes should be documented in relevant policies and procedures. Investigation records should be kept together in a file that is securely stored during and at the conclusion of the investigation.

Restricting access to investigation records

Confidentiality is critical during an investigation. This includes protecting investigation records to make sure that only authorised people can access them for a legitimate purpose.

The investigation plan should clearly identify who can and cannot access investigation records. This is particularly critical when the subject of an allegation is a staff member and/or there are staff who are witnesses to an incident. Additionally, you have an obligation to ensure that the identity of the person who reports a serious incident is not disclosed, except to key personnel, the Commission, police or as required by law. Any unauthorised access to information in these situations could compromise the integrity of the investigation and/or place a person who has reported an incident at risk of victimisation.

Your service's policies and procedures should specify processes for limiting access to different types of records, including investigation records. These processes should cover security controls for electronic as well as hard copy records.

Timeframe for retaining records

A record of an incident, details of the investigation and the outcome of the investigation for the purposes of satisfying the IMS requirements contained in s15MC(2) of the *Quality of Care Principles*, must be retained for 7 years after the date the incident was identified. This requirement only relates to the information recorded in the IMS.

Your service should have a record retention policy which clarifies how long more detailed records of individual investigations should be retained. The policy should take into account any legislative requirements in addition to those outlined above, as well as relevant risk management considerations e.g. the potential likelihood that records of certain investigations may need to be retrieved and provided in future.

Monitoring, analysing and reporting records

Keeping good investigation records will assist you to meet your obligations under the Quality of Care Principles (s15LB and s15MC(4)) to collect incident data that enables you to:

- identity and address systemic issues in the quality of care you provide
- assess and improve the effectiveness of your management and prevention of incidents
- provide feedback and training to staff about managing and preventing incidents
- give quality information to the Commission, if required.

You should regularly review and analyse incident data, including data drawn from investigation records. Your policies and procedures should specify who at your service is responsible for monitoring, analysing and reporting incident data, as well as how, to whom and at what frequency it will be reported.

See Aged Care Quality and Safety Commission, Effective incident management systems: Best practice guidance, August 20

Illustrative purposes only. This template is available in the Approved forms section of the SIRS provider resources page.

Annexure A – Investigation plan template

This template can be adjusted to reflect your specific IMS and needs.

Investigation plan – incident/subject of allegation:

Incident #	*Record **your internal incident number***
SIRS notification #	*Record the number issued to you by the Commission after receiving your notification of the incident*
Access controls	
Information access controls	*Specify who will/will not have access to information about the allegation/incident and investigation and list actions to restrict access.*
Details of incident to be investigated	
Alleged affected consumer/s (AAC)	**Full name and DOB:** **SPARC/ACMPS ID:** **Nature of any support needs:** **Known physical/psychological impact of incident:**
Subject of allegation if care recipient	**Full name and DOB:** **SPARC/ACMPS ID:** **Nature of any support needs:** **Known physical/psychological impact of incident:**

Subject of allegation if staff member	**Full name and DOB:** **Role:** **Nature of any support needs:**
Summary of allegation/incident	*Include only facts and circumstances leading up to the incident if known*
Reportable incident type/form of conduct	*Specify the reportable incident type. If the incident involves an allegation of inappropriate conduct by a staff member, also provide details here e.g, breach of relevant provision of Code of Conduct*
Date and time of allegation/incident	*State if unknown or uncertain*
Location where allegation/incident occurred	*State if unknown or uncertain*
Name and role of the first staff member who became aware of the incident/allegation	
Date and time the first staff member became aware of the incident/allegation	
How the first staff member became aware of the incident/allegation	*Example: Observation, disclosure, verbal complaint, written complaint. Include the name of any person who reported the matter to the first staff member, including relationship to AAC/SOA*

Date and time the incident/allegation was reported by the first staff member to key personnel			
Name and role of key personnel who received the report			
Witnesses to the incident	**Name**	**Contact details**	**Relationship to SOA/AAC**
External agencies involved e.g.: • Police • Aged Care Quality and Safety Commission • Coroner • Safe Work Australia • AHPRA • Health practitioner	**Agency**	**Contact person & details**	**Nature of involvement**

• Other			

Investigation overview		
Investigation purpose	The purpose of the investigation is [*tailor as appropriate*]: 1. *Ensure all appropriate external authorities are notified of the allegation and related investigation.* 2. *Gather all relevant evidence to inform the investigation of the alleged conduct.* 3. *Determine whether, on the available evidence (applying the requisite standard of proof), what has been alleged to have occurred and if so, make a finding in relation to the conduct.* 4. *Identify any risks that may impact on the process or individuals involved if such risks arise during the investigation and provide appropriate advice.* 5. *Provide appropriate advice on any risks that should be managed following on from the completion of the investigation.* 6. *Ensure appropriate individuals and authorities are notified of the outcome of the investigation.* NB: Include any aspect of the incident or allegation that will NOT form a part of the investigation and the reasoning for this.	
Details of investigator	**Name:** **Contact details:** **Date engaged:**	
Details of manager responsible for investigation		
Investigation commencement and approval	**Date commenced:**	**Approved by:**

Investigation key activities			
External notifications			
Police report	• Date and event number for report		
SIRS notification	• Date and notification number		
Other			
Initial risk assessment and management			
• Risks to AV • Risks to SOA • Risks to other affected parties (e.g. other care recipients, witnesses, staff) • Risks to integrity of investigation • Organisational risks	**Risk Type**	**Risk Level**	**Mitigation strategy**

Support, welfare and procedural fairness			
Support for AAC	• *Steps taken to ensure the AAC has immediate and ongoing support and is informed during the investigation* • *Include details of any further action that has been considered or is being considered* • *Include details of how family/representative/support person/s will be involved and informed (if appropriate) during the investigation, including details of consent given by AAC.*		
Support for SOA (care recipient)	• *Steps taken to ensure the SOA has immediate and ongoing support and is informed during the investigation, if appropriate* • *Include details of any further action that has been considered or is being considered* • *Include details of how family/representative/support person/s will be involved and informed, if appropriate, during the investigation, including details of consent given by SOA.*		
Procedural fairness, welfare and support for SOA (staff member)	• *Steps taken to ensure the SOA will be provided with procedural fairness throughout the investigation, including:* - *informing them of the allegations (initial and detailed letters of allegation)* - *explaining the investigation process* - *providing the opportunity to respond to the allegations (via an interview or in writing)* - *providing the opportunity (post interview/written submission) to comment on any proposed adverse information.* *Referrals or support arrangements made e.g. referral to employee assistance program or other counselling; nomination of liaison officer/support person for duration of investigation.*		

Support for other involved parties (e.g. witnesses, other care recipients, staff member)	• *Steps taken to ensure other involved parties have immediate and ongoing support and are informed, where appropriate, during the investigation. This includes steps taken to protect the person who reported the incident from victimisation/reprisal.* • *Include details of any further action that has been considered or is being considered.* • *Include details of how family/representative/support person/s will be involved and informed, if appropriate, during the investigation, including details of consent given by involved person.*
Communication strategy	
Stakeholders and responsibilities	• *Identify who is responsible for liaising with different stakeholders as well as what information should/should not be shared with them.*
Sources of evidence	
Internal evidence	*Relevant internal evidence may include:* • *Policies and procedures* • *Incident report/s* • *Medical records* • *Behaviour support plans* • *Staff rosters* • *Shift notes* • *Care recipient records* • *SOA's employment, induction/training and disciplinary records* • *Photographs, CCTV/video footage.*
Other evidence	*List any other sources of evidence to be obtained*

Interviews ***When planning interviews, you should consider and separately record the key lines of enquiry for each interview***	**Who**	**Interviewer**	**Date**	**Support person**
Investigation outcome				
Outcome	**Allegation**	**Finding**		**Reason**
Have any systems or practice issues been identified? Are there areas for improvement?	*Consider:* • *whether the incident could have been prevented* • *how well the incident was managed and resolved at all stages of the process, from the first staff member becoming aware of the matter through to finalising the investigation* • *what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise harm.*			

Recommendations: • Systems/practice issues identified • Restorative action that can be taken to address impact/ harms to the AAC • Who (individuals or other agencies) should be provided with information about the outcome of the investigation	**Action**	**Person responsible**	**Timeframe**
Decision-maker's comments	*If the decision-maker does not agree with the investigator's proposed findings and recommendations, this should be recorded together with reasons and the decision-maker's final decisions about the outcome of the investigation.*		
Notification of outcome	**Agency/person notified**	**Form of notification & date**	**Comment** *Include any feedback received*

Closure		
Investigator	**Name and signature**	**Date**
Decision-maker	**Name and signature**	**Date**

Annexure B — Tips for interviewing template

General tips

- Adopt an open, relaxed posture. Be aware of your body language and gestures.
- Use simple, short questions that are, as far as possible, non-leading and open-ended e.g. *'Tell me more about that.' 'What happened next?' 'What did you do then?'*
- Avoid leading or suggestive questions or comments e.g. *'You were very angry, weren't you?'*
- Avoid forced choice and multiple-choice questions e.g. *'Was it Monday or Tuesday?'*; *'Was there anyone in the bathroom or was no one there or don't you know?'*
- Avoid using the present tense when asking about past events e.g. *'So, you are in bed and he comes up to you...and then what...?'*. A better choice would be *'What happened when you were in bed? What happened next?'*
- Avoid complicated words and phrases.
- Avoid non-literal language e.g. *'Did you keep an eye out for him?'*
- Use names in preference to pronouns e.g. ask *'What did Jim tell you?'* rather than *'What did he tell you?'*
- Match the interviewee's vocabulary e.g. if the interviewee refers to Monday as *'bingo day'*, ask *'What else happened on bingo day?'*
- Be flexible and respond to the evidence provided. Use prompts and open questions which reflect back on what the interviewee has said. Pause frequently and allow for silence.
- Avoid showing facial expressions or making comments that may indicate your views about particular evidence given (e.g. disbelief, disapproval or approval).
- Ask about inconsistencies only if they are relevant and only after open questioning has ended.
- Be open about misunderstandings and mistakes. Don't pretend to understand something if you don't.

Interviewing a care recipient

- Before you interview a care recipient, find out about their communication abilities and needs e.g. interpreter/communication assistant and/or communication aids. You can do this by speaking to the person or, with their consent, others who know them well.
- Consider their gender, language preferences, cultural and religious background. For example, cultural norms may mean that a care recipient may be more comfortable speaking to a person of the same gender or cultural background. While this might not always be possible, a support person of their choosing may help to make them feel more at ease.

- Consider preferable days/times to conduct the interview. A person may be more alert or settled at a particular time, especially if they have a cognitive impairment.
- Consult the NSW Elder Abuse Toolkit for communication advice and tips[10]:
  - Tool 3.1: Recommendations for communicating with older adults
  - Tool 3.2: Checklist — triggers that might indicate a need for a capacity assessment
  - Tool 3.3: Communication tips — talking to a person with dementia
  - Tool 3.4: Responding with compassion — talking to a person who has been sexually assaulted
  - Tool 3.5: Communicating with older people from a CALD background
  - Tool 3.6 Communicating effectively with Aboriginal and Torres Strait Islander people.

10 NSW Government, Elder Abuse Helpline and Resource Unit, *NSW Elder Abuse Toolkit — Identifying and Responding to the Abuse of Older People: the 5—step Approach,* 2016.

Annexure C — Procedural fairness template

Follow these steps to provide fairness to the subject of the allegation.

- Consider how confidentiality can be maintained while still being as fair as possible to the subject of the allegation.
- Select a person to investigate the incident who does not have any real or perceived conflicts of interest and avoid any reasonable perception of bias.
- If the subject of the allegation is a staff member, identify the training, policies, procedures, communications and any other relevant systems made available to them that are relevant to the alleged incident.
- Advise the subject of the allegation of the investigation, and the allegation(s) against them. Do not provide too much information early on e.g. detailed information about the nature of the allegation if it could potentially prejudice the investigation or put another person's safety at risk.
- Tell the subject of the allegation how the allegation will be investigated; who will be conducting the investigation; how long it is expected to take; and how the investigation will be reported.
- Ensure that the investigation is conducted in a fair and unbiased manner.
- At an appropriate stage, give the subject of the allegation enough details of the allegation to enable them to respond. The right time to share these details will depend on the nature of the allegation. It is generally sufficient to give the person a summary of all relevant information that may be relied on in reaching a decision. Sometimes it might be necessary to allow a person to inspect a document or other evidence (e.g. CCTV footage). It may also be necessary to re-interview the subject of the allegation or give them a final opportunity to provide a response to any preliminary findings.
- Inform the subject of the allegation of any potential decision/action that may result from the investigation of a staff member.
- Wherever possible, allow the subject of the allegation to choose how they respond to the allegation. You may need to consider reinterviewing the subject of the allegation after all the information has been collected to ensure the investigator can assess all credible, relevant and significant information. They may wish to bring along a support person/advocate or make a written submission. Consider any communication support needs such as providing an interpreter or communication aides if the person has a cognitive impairment or some other communication support requirement.

- Inform the subject of the allegation of any proposed adverse findings/decisions and provide them with an adequate opportunity and timeframe to respond. The timeframe will depend on the circumstances, the volume and the complexity of any material the person may need to review and respond to.
- Once the investigation concludes, inform the subject of the allegation of the final outcome of the investigation. If they have a right to challenge or review the outcome, they should be advised of this and the process for doing so.
- If management or disciplinary action is taken against a staff member, the nature of the action taken should be clearly recorded (e.g. an adverse finding recorded on their personnel file).

Annexure D — Evidence-focused template

This template provides a structure and guidance for completing an evidence-focused investigation report.

Investigation report — incident/subject of allegation:

1. Instructions and objectives

Outline the scope/terms of reference/ objectives for the investigation and any other instructions provided to the investigator.

2. Case summary

- Provide a summary of the parties involved in the matter. Include the following information:
  - name of approved aged care provider
  - details of alleged affected consumer/s: name, DOB, gender, SPARC or ACMPS ID, nature of identified support needs e.g. requires translator, hearing/vision impaired, cognitive impairment
  - name of affected consumer/s' family/ representative
  - details of subject of allegation: name, DOB, gender, role and date employment commenced (if staff member), SPARC or ACMPS ID (if care recipient), nature of identified support needs
  - name of subject of allegation's family/representative
  - nature of relationship between affected consumer/s and subject of allegation e.g. staff member and care recipient; both care recipients.

3. Overview of the allegation/incident

- Provide a narrative overview of the allegation/incident which includes the following information:
  - date, time and location of the allegation/ incident (specify if unknown)
  - type of allegation/incident e.g. criminal offence (state type), SIRS reportable incident (state type and whether Priority 1 or 2), Code of Conduct breach
  - circumstances leading up to the incident (if known)
  - known psychological and physical impact on the affected consumer/s, e.g. death, hospitalisation, injury, trauma
  - names and details of witnesses (e.g. staff, other care recipient, family member).
- If the allegation/incident has been assessed as notifiable to an external authority e.g. police, the Commission, Coroner, AHPRA. Provide any further details necessary to clarify why.

- Summarise how and when the allegations arose and became known to the service including:
  - name and role of the first staff member who became aware of the incident/allegation
  - date and time the first staff member became aware of the incident/allegation
  - how the first staff member became aware of the incident/allegation, including the name of the person who reported the matter to the first staff member
  - date and time the incident/allegation was reported by the first staff member to key personnel
  - name and role of key personnel who received the report.

4. External notifications and reporting

- Specify if there was a requirement to notify the allegations to an external authority/s e.g. police, the Commission, Coroner, AHPRA, and state the relevant legislative provision/s.
- Provide key notification and reporting dates and receipts e.g.:
  - for the Commission — 24-hour notification and SIRS notice number, submission/s of missing, further or significant new information
  - for police — date, event number and Officer-in-Charge.
- Summarise any liaison with/feedback from external authorities e.g. police clearance to investigate, decision by the Commission to commence direct investigation (etc).

5. Initial and ongoing risk assessment and management

- Summarise the steps taken to assess and manage immediate and ongoing risks:
  - to the alleged affected consumer/s, the subject of the allegation and anyone else impacted e.g. other care recipients, witnesses
  - to the integrity of the investigation e.g. securing evidence, managing conflicts of interest, initiating information access controls
  - to the service e.g. media interest, concerns of other care recipients/families.
- Include external notifications/reports.
- Include any risk management action taken in relation to the subject of the allegation.

6. Support for alleged affected consumer/s and other involved parties

- Summarise the steps taken to ensure the alleged affected consumer/s and any parties involved in the investigation e.g. witnesses, other care recipients, staff, family/representative of alleged affected consumer/s, receive immediate and ongoing support and are kept informed, where appropriate, during the investigation.
- Include details of any further action that has been considered or is being considered.
- If any affected consumer/s has a representative, include details of how the representative has been involved and informed, if appropriate, during the investigation.

7. Procedural fairness/welfare for SOA

- Summarise the steps taken to ensure the subject of the allegation has been provided with procedural fairness throughout the investigation, including when and how they were:
  - informed of the allegations
  - provided with an explanation of the investigation process
  - given the opportunity to respond to the allegations
  - given the opportunity to comment on any proposed adverse findings/actions.
- Include any referrals or support arrangements made e.g. for staff members, referral to employee assistance program or other counselling and/or nomination of liaison officer/support person for duration of investigation. For care recipients, include any immediate and ongoing supports provided or arranged. If they have a representative, include details of how the representative has been involved and informed, if appropriate.

8. The evidence

- Outline, in appropriate detail, all evidence relied on during the investigation, including:
  - information/documents/records internally sourced
  - information requested from or provided by other agencies
  - interviews with the affected consumer/s, witnesses and subject of allegation
  - any other sources of evidence e.g. photographs.
- Include details of all information sought/reviewed, even if it did not produce relevant evidence.
- Include references to any evidence that is attached to the report as appendices e.g. transcripts, emails, photographs.

9. Observations and findings

- Explain, in appropriate detail, the approach taken by the investigator in assessing the evidence.
- Record the observations made during and at the conclusion of assessing the evidence.
- Specify a finding for each allegation and the reason for the finding, ensuring you provide reasons for each recommended finding.
- Identify the specific evidence relied on in making each finding.

10. Recommendations

- Outline any additional recommendations identified by the investigation. For each recommendation, explain the reason for making it. Examples of actions might include but are not limited to:
  - update incident management procedures
  - review staffing levels
  - increase supervision
  - review and/or change accommodation arrangements
  - review and/or change behaviour support needs
  - review medical/health needs
  - change health support provided
  - Review psychological/mental health needs
  - change psychological/mental health support provided
  - provide education for the client/s
  - provide training for staff
  - review legal/decision-making capacity
  - referral/assistance to access legal support.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

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