Saint Hilarion Aged Care is committed to collaborating closely with Clients and Representatives impacted or involved in a serious incident to identify:

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

The following steps will be taken to ensure the above requirements are met:

1. **The incident has been responded to and includes the following aspects to ensure the immediate safety, health and well-being of person(s) affected:**

   a. initial assessment of the support and assistance required, and

   b. implementation and provision of the support and assistance required**.**

2. **Commencement of incident investigation detailing that:**
   a. the victim has been interviewed and assessed by a senior Clinician to determine their account of the incident, and
   b. the alleged offender and witnesses have been interviewed and assessed by a senior Clinician, and where appropriate the Line Manager/People and Culture Manager to determine their account of the incident.

3. **An assessment of how all parties would like to be involved in the management and resolution of the incident has been completed and includes individual input into what actions shall be taken and expected outcomes for:**
   a. Client;
   b. Representatives;
   c. Advocacy services (such as ARAS), and
   d. Staff.

4. **Full and open disclosure with victim and representative has occurred and is documented in LeeCare. The elements of open disclosure include**:
   a. identify what has gone wrong;
   b. actions taken to immediately address and provide support;
   c. acknowledge and apologise, or express regret;
   d. find out and explain what happened, the root cause, and
   e. what will we do prevent from happening and other continuous improvement activities.

5. **All elements of the investigation will be recorded including:**
   a. description of the incident, including harm that was caused and impact;
   b. the date, time the incident was suspected, or confirmed to have occurred and when it was identified;
   c. Names and contacts of persons directly involved and witnessed in the incident;
   d. Details of assessments undertaken, *as per item 3*;
   e. Clear record and sequence of actions taken as a result of completed assessments, *as per item 4*, and
   f. Clear record of all consultations and notation as to whether any reports or findings regarding the incident have been provided.

6. **Determination as to whether other persons or bodies should be notified or the incident i.e. Police.**
   a. If yes, Police must be notified within 24hrs of becoming aware of incident.

7. **Aged Care Quality and Safety Commission will be notified of Incident via MAC Portal**
   a. Priority 1 incident reported within 24hrs, or
   b. Priority 2 incident reported within 30 days.

8. **Each incident will be reviewed and evaluated identifying:**
   a. The root cause of the incident;
   b. The harm caused by the incident;
   c. Any operational issues that may have contributed to the incident, and
   d. If remedial action has occurred and what this was.

9. **A review of the management of the incident will include:**
   a. Were immediate responses appropriate;
   b. Did Clients and Representatives feel they were appropriately included in the investigation process;
   c. Were all potential contributing factors considered, and
   d. Have appropriate strategies been identified and addressed to prevent similar incidents in the future.

10. **Continuous improvements which have been identified as part of the review and evaluation step, must then be:**
   a. Implemented at an individual level, and/or
   b. Added to the organisations Continuous Improvement Register and strategically rolled-out to resolve systemic issues