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Health, aged care and retirement living briefing

Serious Incident Response Scheme: If a resident falls, is it reportable?

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We understand the expansion of the type of incidents reportable to the Aged Care Quality and Safety Commission under the new Serious Incident Response Scheme has caused some confusion as to whether or not falls need to be reported to the Commission.

Background

On 1 April 2021 the Serious Incident Response Scheme (**SIRS** or **Scheme**) commenced. The Aged Care Quality and Safety Commission (**Commission**) has reported that in the first weeks of the SIRS a key issue has been the reporting of incidents that do not fall within any of the eight categories of reportable incident. Falls is an example given by the Commission as a type of incident that is being reported when it does not fit within a reportable incident category. In this article we consider when a fall by a resident will be reportable to the Commission.

Are falls 'incidents'?

Under the SIRS there are 'incidents' and 'reportable incidents'. An 'incident' includes an act, omission, event or circumstance that has occurred, or is suspected or alleged to have occurred, in connection with the provision of care in a residential care setting and has caused, or could reasonably have been expected to have caused, harm to a resident.

Generally, if a resident has a fall it would be an 'incident' and the provider would need to comply with its incident management requirements, including recording the fall on its incident management system. However, a fall will not necessarily be reportable to the Commission.

Are falls 'reportable incidents'?

A fall is reportable to the Commission depending on whether the fall fits within one of the eight categories of 'reportable incident'. There are some categories of reportable incident that are irrelevant to falls, for example, stealing or financial coercion. However, there are a number of categories into which falls may fit, depending on the circumstances. We discuss three of these categories below.

If a fall does not fit within any of the categories of 'reportable incident' it will not be reportable to the Commission. An example given by the Commission of when a fall does not fit within a reportable incident category, and therefore does not need to be reported, is where a resident with osteoporosis has a fall due to a collapsed hip, not because of any action or inaction by the provider.

Unreasonable use of force

The most obvious category that a fall could fit within is the unreasonable use of force. This may arise where a person (eg, resident, staff member or visitor) uses unreasonable force against a resident, causing the resident to fall. For example, a resident may shove another resident, causing that resident to lose balance and fall. The use of unreasonable force will result in the fall being a reportable incident.

Relevant to this, under the SIRS incidents by a resident who has a cognitive impairment are now reportable. Therefore, if in the example above, the resident who used unreasonable force has dementia, this incident would now be reportable to the Commission regardless of the resident's cognitive impairment.

Neglect

A more complex category of reportable incident that falls may fit within is neglect. Neglect arises where there has been a gross breach of professional standards or a breach of duty of care. In considering if there has been a breach of the duty of care, the provider should consider:

(a) if a reasonable provider/staff member would have reasonably foreseen the harm; and

(b) if the provider/staff member took reasonable steps to prevent the harm.

If the harm was reasonably foreseeable and the provider or staff member failed to take reasonable steps to prevent the harm, the provider may have breached its duty of care.

An example of where a fall may arise from neglect is where a personal care worker moves a resident without the use of a hoist, against care directives, and the resident falls during the move and suffers injury.

Unexpected death

Unexpected death is another category of reportable incident that may capture falls. If a fall results in a resident's death and:

- reasonable steps were not taken by the provider to prevent the death; or
- the death is a result of:
    - care or services provided by the provider; or
    - a failure of the provider to provide care or services

the fall will likely be a reportable incident under the category of unexpected death.

Examples of when a fall results in the unexpected death of a resident are:

- where a resident falls while being moved or shifted and sustains injuries that contribute to, or result in, the resident's death; or
- where the resident has a fall and the resident is not assessed immediately afterwards and later dies as a result of the injuries sustained from the fall.

Where a fall results in an unexpected death, it may be that the fall has already been reported to the Commission as, for example, an unreasonable use of force or neglect prior to the unexpected death occurring. In this situation it is Parliament's intention that the unexpected death should be reported as new significant information relating to the initial reportable incident.

Falls while on outings from the facility

The reporting obligations to the Commission only apply where an incident occurs 'in connection with' the provision of care. Therefore, where a resident has a fall while on an outing from the facility and the outing is not facilitated by the provider (for example, family have taken the resident out for the day) the fall will generally not be reportable to the Commission, even if it fits within a reportable incident category. However, the provider will still need to comply with the incident management requirements, which apply regardless of whether or not the incident occurred in connection with the provision of care.

If the resident is on an outing that is facilitated by the provider and the resident falls, the provider should consider if the fall fits within a category of reportable incident because it will have likely occurred in connection with the provision of care. For example, if a staff member is taking a resident to an appointment and the resident falls during that outing it may be reportable to the Commission if it fits within a category of reportable incident.

Is the fall priority 1 or priority 2?

If a fall occurs in connection with the provision of care and fits within a reportable incident category, a provider will need to consider if the fall is a priority 1 or priority 2 reportable incident. This is relevant not only in relation to the time frame within which the report is to be made (ie, priority 1 within 24 hours and priority 2 within 30 days) but that presently only priority 1 incidents are reportable (until 1 October, from which priority 2 reporting also commences).

The fall will be a priority 1 reportable incident if:

- it caused, or could reasonably have been expected to have caused, physical or psychological injury or discomfort that requires medical or psychological treatment to resolve;
- there are reasonable grounds to report the incident to the police; or
- the fall resulted in an unexpected death.

The fall will be a priority 2 reportable incident if it does not fit within priority 1.

Summary

This briefing provides a high level overview of the SIRS. It is the fourth in our series on the Scheme. If you require any legal advice in relation to the effect the legislation has upon you or your organisation we would be happy to assist you.

> "Whether a fall needs to be reported to the Commission depends on if the fall fits within a category of 'reportable incident'."

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