



NDIS Quality
and Safeguards
Commission

Incident Management Systems

Detailed Guidance for
Registered NDIS Providers

June 2019



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Key terms

Table 1: Key terms and definition

Term	Definition
Act	The National Disability Insurance Scheme Act 2013.
NDIS Commission	The NDIS Quality and Safeguards Commission.
Impacted person	A person with disability who has been affected by an incident that has occurred during the provision of NDIS supports and services.
Incident	<p>An incident is defined as an act, omission, event or circumstance.</p> <p>It may mean any of the following:</p> <ul style="list-style-type: none"> • Acts, omissions, events or circumstances that occur in connection with providing NDIS supports or services to a person with disability and have, or could have, caused harm to the person with disability • Acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person • Reportable incidents that have or are alleged to have occurred in connection with providing NDIS supports or services to a person with disability
Key personnel	A member of the group of persons who is responsible for the executive decisions of the registered NDIS provider and any other person who has authority or responsibility for (or significant influence over) planning, directing or controlling the activities of the registered NDIS provider. See s 11A of the Act.
NDIS	National Disability Insurance Scheme.
NDIS provider	<p>A person (other than the NDIA) who receives:</p> <ul style="list-style-type: none"> • funding under the arrangements set out in Chapter 2 of the Act; or • NDIS amounts (other than as a participant); or • a person or entity who provides supports or services to people with disability other than under the NDIS and who is prescribed by the NDIS rules as an NDIS provider. See s 9 of the Act.
NDIS (Incident Management and Reportable Incident) Rules 2018	The Rules require registered NDIS providers to establish an incident management system that meets minimum requirements and that is appropriate for the size of a registered NDIS provider and the supports or services they provide. The rules also set out the obligations on registered NDIS providers to notify, investigate and respond to reportable incidents.
NDIS Practice Standards	Consist of a core module and several supplementary modules that apply according to the types of supports and services NDIS providers deliver, and the corporate structure of the organisation. The NDIS Practice Standards are included in the NDIS (Provider Registration and Practice Standards) Rules and in the NDIS (Practice Standards – Worker Screening) Rules.

Term	Definition
Person with disability	A person with disability who is an NDIS participant and receives supports or services from an NDIS provider.
Registered NDIS provider	Means a person or entity registered under s 73E of the Act to provide supports and services to people with disability.
Relevant Personnel	<ul style="list-style-type: none"> • A member of the registered NDIS provider’s key personnel. • A supervisor or manager of the person • The person specified in the incident management system as being responsible for reporting incidents that are reportable incidents to the NDIS Commission (Specified personnel).¹
Reportable incidents	<p>Reportable incidents are serious incidents or alleged incidents which result in harm to an NDIS participant and occur in connection with NDIS supports and services. Specific types of reportable incidents include:</p> <ul style="list-style-type: none"> • The death of a person with disability. • Serious injury of a person with disability. • Abuse or neglect of a person with disability. • Unlawful sexual or physical contact with, or assault of, a person with disability (excluding, in the case of unlawful physical assault, contact with, and impact on, the person that is negligible). • Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity. • The use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person or a behaviour support plan for the person.
Specified personnel	Person named in the incident management system of a registered NDIS provider as being responsible for taking all reasonable steps to ensure that reportable incidents that occur in connection with the provision of supports or services are notified to the NDIS Commission.
Subject of the allegation	A worker, person with disability or any other person who has been accused of being involved with an incident that has occurred in connection with the provision of NDIS supports and services to a person with disability.
Trauma informed care	The provision of care that acknowledges how trauma affects people’s lives and their service needs. Awareness and sensitivity to the way in which people with disability may experience trauma differently.
Worker	Includes employees, contractors and people otherwise engaged for example, on a volunteer basis, by an NDIS provider.

¹ NDIS (Incident Management and Reportable Incidents) Rules 2018 s19.

Overview of incident management system requirements

Registered NDIS providers (you) require an incident management system to record and manage incidents that occur while providing supports or services to people with disability.

Your incident management system must cover:

- Acts, omissions, events or circumstances that occur in connection with providing NDIS supports or services to a person with disability and have, or could have, caused harm to the person with disability
- Acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person
- Reportable incidents that have or are alleged to have occurred in connection with providing NDIS supports or services to a person with disability

As a registered NDIS provider, you are responsible for preventing, responding to, and managing these incidents. Your incident management system needs to include procedures for identifying, assessing, recording, managing, resolving and reporting incidents. You must record all these incidents (not just reportable incidents), ensure you respond appropriately and take steps to prevent such incidents from happening again.

This guidance aims to assist you in developing or improving your incident management systems to meet the requirements.

You need to be prepared to make your incident records available to the NDIS Commission if required and to any approved quality auditor as part of the auditor's assessment of your compliance.

There is further guidance for registered NDIS providers on the NDIS Commission website (www.ndiscommission.gov.au), including detailed guidance about reportable incidents and the important role of workers providing services in responding to incidents.



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Part 1: Introduction

Part 1: Introduction

1.1 The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is one of the largest social and economic policy reforms in Australian history. The NDIS supports Australians who are born with, or acquire, a permanent and significant disability before the age of 65 to lead a more independent and inclusive life.

The NDIS represents a fundamental change to how supports for people with disability are funded and delivered across Australia. It is also a significant shift where people with disability are the purchasers and consumers of services from a diverse market.

1.2 The NDIS Commission

We are an independent government body that works to improve the quality and safety of NDIS services and supports, investigate and resolve problems relating to those services and supports, and strengthen the skills and knowledge of NDIS providers and people with disability.

We:

- Register and regulate NDIS providers and oversee NDIS provider quality
- Monitor compliance with the NDIS Practice Standards and NDIS Code of Conduct
- Respond to concerns, complaints and reportable incidents
- Advise NDIS providers on their own complaints management and support people with disability to make complaints
- Advise NDIS providers on incident management systems and how to report serious incidents to the NDIS Commission
- Work with people with disability, NDIS providers and their workers to improve their skills and knowledge
- Monitor providers' use of restrictive practices in relation to people with disability and educate providers and people with disability about behaviour support strategies
- Work with States and Territories to implement nationally consistent NDIS worker screening
- Provide NDIS market oversight by monitoring changes in the market that need attention
- Share information with other regulatory bodies

At full rollout, we will deliver a new, nationally consistent approach to quality and safeguards in the NDIS. This work is guided by the NDIS Quality and Safeguarding Framework

1.3 The foundations for our approach

Our approach is underpinned by the *UN Convention on the Rights of Persons with Disabilities* and the *National Disability Insurance Scheme Act 2013* (the Act). We support the rights of people with disability to:

- Realise their potential for physical, social, emotional and intellectual development
- Participate in and contribute to community life, including socially and economically

- Exercise choice and pursue their goals including taking reasonable risks and pursuing any grievance
- Be included in making decisions about their life
- Live a life of dignity, free from abuse, neglect and exploitation
- Have the roles of families, carers, and other significant persons in their lives recognised and respected
- Have the roles of advocates in representing the interests of people with disability acknowledged and respected

1.4 Our expectations of NDIS providers

There are incidents that can threaten the health, safety or wellbeing of people with disability. Incidents can have a significant impact on people with disability, workers, families, carers, community members and NDIS providers.

All NDIS providers – registered or unregistered - of supports and services to people with disability are subject to the NDIS Code of Conduct. Registered NDIS providers are also subject to the NDIS Practice Standards. The Code of Conduct sets out the expectations for safe and ethical services and supports for both NDIS providers and workers. The NDIS Practice Standards create benchmarks by which registered providers can assess their performance and demonstrate how they provide quality and safe supports and services to people with disability. These rules that set out the NDIS Code of Conduct and NDIS Practice Standards are available on our website.

Even where you and your workers adhere to these frameworks, incidents may still occur in the course of service delivery. In these instances, you can learn and actively improve to prevent harm, abuse and neglect of people with disability.

It is good practice for all NDIS providers, even when unregistered, to have an appropriate and effective incident management system in place.

The Act and the NDIS (Incident Management and Reportable Incident) Rules require registered NDIS providers to have an incident management system that meets minimum requirements. The incident management system must be appropriate for the size of your organisation and the supports or services you provide. The Rules also set out your obligations to respond to, notify and investigate reportable incidents.

All incidents that happen in the delivery of NDIS supports and services will be recorded and managed in your incident management system. You will **identify** any incident and **respond**, including the activities undertaken to ensure the safety and wellbeing of people with disability and workers. You are required to appropriately assess and/or investigate all incidents.

If an incident is found to be a **reportable incident**, it must be notified to us by the relevant personnel using the required form. Registered NDIS providers may be required to **give information** to us in connection with any internal or external investigation or assessment that has been undertaken. You will need to respond to any **corrective and restorative measures** made by us following a reportable incident.

If an incident is deemed not to be a reportable incident, you are required to refer back to your **internal incident management** systems.

1.5 About this guidance

This guidance material provides information about the requirement to have an incident management system in place that meets the criteria set out in the *National Disability Insurance Scheme (Incident Management and Reportable Incidents) Rules 2018* (the Rules).



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Part 2: Your incident management system requirements

Part 2: Your incident management system requirements

It is a condition of registration² that you have an incident management system that includes the procedures for identifying, managing and resolving incidents.³ When you apply for, or seek to renew, your registration with us the auditor will check that you comply with incident management system requirements. If you don't have an incident management system, you may be in breach of your conditions of registration and penalties may apply.⁴

The following information sets out the core system requirements your incident management system must have. The key supporting practices to manage incidents and implement the system are described in Section 3.

2.1 The types of incidents your system must cover

Your incident management system must cover:⁵

- Acts, omissions, events or circumstances that occur in connection with providing NDIS supports or services to a person with disability and have, or could have, caused harm to the person with disability
- Acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person
- Reportable incidents that have or are alleged to have occurred in connection with providing NDIS supports or services to a person with disability

Some of these key terms are defined below.

2.1.1 Definition of incidents that occur in connection with providing NDIS supports or services to a person with disability and which have, or could have, caused harm to the person with disability.

Your incident management system must capture any acts, omissions, events that occur or particular circumstances that arise in connection with provision of NDIS supports or services to a person with disability, if they have, or could have caused harm to the person with disability. The subject of the allegation for these incidents may be anyone, including a worker, or a member of the general public, as long as the incident occurred in connection with the provision of NDIS supports and services to the impacted person with disability.

Harm is the resulting impact of the act, omission, event or circumstance that occurs, and can include physical, emotional or psychological impacts such as physical injuries, emotional impacts such as fear

² Subsection 73F(2) of the *National Disability Insurance Scheme Act 2013* provides that the registration of a person as a registered NDIS provider is subject to a number of conditions, including paragraph 73F(2)(g) which requires a registered NDIS provider to implement and maintain the applicable incident management system in accordance with section 73Y.

³ National Disability Insurance Scheme Act 2013 s 73Y; NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(1).

⁴ Section 73J makes it an offence for a person who is a registered NDIS provider not to comply with a condition of their registration.

⁵ NDIS (Incident Management and Reportable Incidents) Rules s 9.

or poor self-esteem, and psychological impacts such as depression or impacts on a person's learning and development.

2.1.2 Definition of 'in connection with'

A registered NDIS provider is only required to notify the Commission of reportable incidents which have occurred, or are alleged to have occurred, if those incidents happened **in connection with** the provision of supports or services by that provider.

This meaning of the phrase 'in connection with' is intended to be broad.

It covers incidents that:

- may have occurred during the course of supports or services being provided;
- arise out of the provision, alteration or withdrawal of supports or services; and/or
- may not have occurred during the provision of supports but are connected because it arose out of the provision of supports or services.

Reportable incidents could occur in a variety of settings but as long as there is a connection with the service delivery by a registered NDIS provider, then they must be notified to the Commission.

Examples of where these incidents might occur include:

- In the private home of a person with disability
- In a residential care setting
- In supported accommodation
- In the premises of the registered NDIS provider (for example, the rooms where therapy services are provided)
- In the community where the registered NDIS provider is supporting the person with disability to access the community

Although a reportable incident may happen to a person at the time they are receiving a service from a registered NDIS provider, this will not mean, on its own, that the incident occurred in connection with the service. If it was merely a coincidence that the incident happened at that time, then it is not 'in connection with' the service delivery and does not need to be notified to the Commission.

For example:

- An occupational therapist attends the home of a person with disability to conduct an assessment. While speaking with members of the person's family, the person with disability puts their hand on the stovetop and suffers a serious injury. The incident occurred at the time of service delivery, but was not directly linked with or caused by the service delivery. This is not a reportable incident and does not require notification to the NDIS Commission.
- A person with disability is accompanied by a worker to attend a physiotherapy appointment. As they leave the office building, a tile falls off the roof and hits the person who sustains a serious injury and needs hospitalisation. Although this happened at the time a person was receiving a service from the registered NDIS provider, the service delivery was coincidental to the injury caused. The incident did not occur in connection with the service provision and does not need to be reported to the Commission.

Whether a reportable incident occurs in connection with the provision of services and supports also depends on the nature and extent of services being provided.

Where a person is living in supported accommodation, the registered NDIS provider involved usually has a responsibility for the supervision, health, safety and well-being of residents of the accommodation. This will often mean that reportable incidents which happen in the supported accommodation are in connection with the provision of services and supports and must be notified to the Commission. The exception to this would be where the reportable incident was entirely coincidental and unrelated to the provision of services, for example, a person suffers food poisoning after eating food delivered to the accommodation.

It is also not necessary for the registered NDIS provider to come to a conclusion about whether the service delivery 'caused' the reportable incident before deciding whether to notify the Commission. The phrase 'in connection with' does not mean that the registered NDIS provider directly caused the incident but simply there was some link between service provision and what happened to the person with disability.

An incident might also occur which is connected to the provision of supports or services but does not occur at the time those supports or services were provided. The connection to the service provision might be based in its role in contributing to the incident.

For example, a speech pathologist may develop an eating and drinking plan for a person with a disability who later chokes in their home when following this plan and requires hospitalisation (serious injury). While the incident did not occur at the time the plan was developed and provided by the speech pathologist, there may be connection between the injury and the plan if it did not adequately address choking risks to the person with disability.

2.1.3 Definition of acts by a person with disability that occur in connection with providing NDIS supports or services to the person with disability and which have caused serious harm, or a risk of serious harm, to another person

Your incident management system must also capture any acts by a person with disability that occur in connection with provision of NDIS supports and services to that person, that have caused *serious* harm or a risk of *serious* harm, to any other person, including a worker, other people with disability, or the general public.

Serious harm means that the harm is not minor or trivial. It involves a substantial physical, emotional or psychological impact on the impacted person such as a serious injury, or serious emotional or psychological distress.

Incidents that result in injuries to workers or others that do not consist of the act of a person with disability in connection with the provision of supports and services to the person with disability, do not need to be recorded in the incident management system.

For example, where a worker accidentally burns themselves when cooking a person's meal, or is involved in a traffic accident while providing services in the community, this should be managed through a registered NDIS provider's WH&S processes.

2.1.4 Definition of Reportable Incidents

You must notify us about reportable incidents. For an incident to become a reportable incident it must satisfy the following two requirements:

- The incident must be defined as a reportable incident in section 73Z(4) of the Act and section 16 of the NDIS (Incident Management and Reportable Incidents) Rules 2018

- The incident must have occurred or be alleged to have occurred in connection with the provision of supports or services you're providing

Subsection 73Z(4) of the NDIS Act states that reportable incident means:⁶

- a. the death of a person with disability; or
- b. serious injury of a person with disability; or
- c. abuse or neglect of a person with disability; or
- d. unlawful sexual or physical contact with, or assault of, a person with disability; or
- e. sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity; or
- f. the use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.

This list must be read with section 16 of the Rules, which says that:

- unlawful physical contact with a person with disability is *not* a reportable incident *if* the contact with, and impact on, the person with disability is negligible,
- the use of a restrictive practice in relation to a person with disability where the use is not in accordance with an authorisation (however described) of a State or Territory is *not* a reportable incident *if* the use is in accordance with a behaviour support plan for the person and the State or Territory in which the practice is used does not have an authorisation process in relation to the use of the practice, and
- the use of a restrictive practice in relation to a person with disability where the use is in accordance with an authorisation (however described) of a State or Territory *is* a reportable incident *if* the use is not in accordance with a behaviour support plan for the person⁷.

The definition of *reportable incident* captures not only **incidents** that have occurred, but also **allegations** of the incidents described above.⁸ It also **only includes incidents where the impacted person is a person with disability** – incidents that are recorded in an incident management system that relate to serious harm to workers or other people committed by a person with disability are not reportable. The only exception to this is where a person with disability is the impacted person of the incident.

Reportable incidents are one category of incident that must be captured by the registered NDIS provider's incident management system and practice.

A failure to comply with the requirement to notify, investigate and manage reportable incidents is a breach of a registered NDIS provider's conditions of registration and may lead to compliance and enforcement action.⁹

We have published separate guidance for you with more information about reportable incidents, which can be found on the NDIS Commission [website](#).

⁶ National Disability Insurance Scheme Act 2013 s 73Z(4); NDIS (Incident Management and Reportable Incident) Rules 2018 s 16

⁷ NDIS (Incident Management and Reportable Incident) Rules 2018 s 16(2)

⁸ National Disability Insurance Scheme Act 2013 s 73Z(1)

⁹ National Disability Insurance Scheme Act 2013, s 73F(2)(g) and s 73J

2.2 Your system requirements

Your incident management system must outline the approach and key actions to be taken in order to manage an incident when it occurs. The system should focus on the safety and wellbeing of people with disability, and set out the actions and responsibilities of workers, the registered NDIS provider and other stakeholders during the management of an incident.

Your incident management system must be:

- Appropriate for your size and for the classes of supports or services you are delivering.¹⁰
- Documented in an accessible form, including having written procedures.¹¹
- Accessible to, among others, all workers employed or otherwise engaged by you and to persons with disability receiving supports or services from you.¹²

Importantly, whatever form the incident management system takes, it must be functional and be able to appropriately capture all the required information.

2.2.1 Size of the system

All registered NDIS providers have the same minimum requirements for their incident management system. However, the type of system each registered NDIS provider maintains is likely to be different, depending on the registered NDIS provider's size and the types of supports or services they are delivering.

If you are a smaller registered NDIS provider (e.g. a sole trader) you may implement a simple system, such as a single spreadsheet or other software. You are still required to establish and document procedures. You are still required to train any workers in the system including their roles and responsibilities.

If you are a larger organisation employing many workers you will need to demonstrate that your incident management system is fit-for-purpose and meets the NDIS Commission's requirements, including procedures and training. This may require enhancements to existing ICT solutions.

If your organisation's structure changes over time, your incident management system may also need to change.

The complexity and risk associated with the supports and services that you deliver is also important. The incident management system should reflect the types of supports that are being provided. For example, if you offer Supported Independent Living services, where a person with disability requires 24 hour support including with tasks of daily living such as showering, you may require a more robust incident management system compared to a registered NDIS provider offering indirect services such as cleaning or gardening.

2.2.2 Documenting the system

Your incident management system must be documented. The documentation must include written procedures and may also include written policies and procedures. The documentation must communicate to all relevant parties about how the system will operate, and who is responsible for particular actions and processes. This will promote transparency about how an incident will be

¹⁰ National Disability Insurance Scheme Act 2013 s 73Y(a)

¹¹ NDIS (Incident Management and Reportable Incidents) Rules 2018 s12(1)

¹² NDIS (Incident Management and Reportable Incidents) Rules 2018 s 12(1)(b)

managed, and allows those involved in incident management to understand their roles and responsibilities throughout the process.

Your incident management system must establish procedures to be followed in identifying, managing and resolving incidents. As set out in the Rules, the minimum requirements for procedures include:

- How incidents are identified, recorded and reported
- Who incidents must be reported to
- The person who is responsible for notification of reportable incidents to us
- How you will provide support and assistance to the impacted person of an incident (including information about access to advocates and supports), to ensure their health, safety and wellbeing
- How the impacted person will be involved in the management and resolution of the incident
- Details of any investigations conducted to establish the causes of a particular incident, its effect and any operational issues that may have contributed to the incident occurring, and the nature of that investigation
- When corrective action is required and the nature of that action

Further description of the minimum requirements for each procedure are outlined below in Table 2: Minimum requirement for procedures and descriptions.

Table 2: Minimum requirement for procedures and descriptions

Procedure	Description
How incidents are identified, recorded and reported – paragraph 10(1)(a)	<p>These procedures should, at a minimum, address the following:</p> <ul style="list-style-type: none"> • Describing an incident. • How an incident is identified (for example, when a worker observes an incident or where a person with disability informs a worker of an incident). • The method and manner of recording an incident. • The timeframes for internal reports. • How incidents should be reported internally (for example, does it need to be in writing, on an internal form or orally). <p>There are minimum requirements for registered NDIS providers concerning the records they need to keep about incidents. The specific requirements are set out in section 10(1)(a).</p>
To whom incidents must be reported – paragraphs 10(1)(b) and (c)	<p>Registered NDIS providers should establish clear reporting lines when incidents occur, including specifying who must be notified when an incident occurs.</p> <p>The procedure may include:</p> <ul style="list-style-type: none"> • Guidance around when Police or emergency services should be notified. • Guidance around notifying guardians, family or carers. • Who must be notified internally when an incident occurs (for example, supervisors, managers or key personnel). <p>The system must also specify the person who is responsible for reporting incidents that are reportable incidents to the NDIS Commission.</p>

Procedure	Description
<p>How registered NDIS providers will support, assist and involve a person with disability affected by an incident to ensure their health, safety and wellbeing – paragraphs 10(1)(d) and (e)</p>	<p>The incident management system must specify:</p> <ul style="list-style-type: none"> • How the registered NDIS provider will provide support and assistance to a person with disability affected by an incident, to ensure the person’s health, safety and wellbeing.¹³ • How a person with disability affected by an incident will be involved in the management and resolution of the incident.¹⁴ <p>For example, the registered NDIS provider may specify that, in the event of an incident, it will keep the impacted person, or ask the impacted person to provide feedback and input into assessments, investigations and any corrective actions proposed or taken by the registered NDIS provider.</p>
<p>When an assessment or investigation into an incident is required – paragraph 10(1)(f) and subsection 10(3)</p>	<p>The incident management system must require all incidents to be assessed, considering the views of the impacted person, in relation to the following¹⁵:</p> <ul style="list-style-type: none"> • Whether the incident could have been prevented • How well the incident was managed and resolved • What, if any, regulatory action needs to be undertaken to prevent further similar incidents from occurring. • What, if any, regulatory action needs to be undertaken to minimise the impact of an incident. • Whether other persons or bodies need to be notified of the incident. <p>In some circumstances it may also be necessary to conduct an investigation to establish the cause of a particular incident, its effect and any operational issues that may have contributed to the incident occurring.</p> <p>Registered NDIS providers must have a process in place to identify when such an investigation is required, and the nature of that investigation.¹⁶ If Police are involved, an internal investigation must not interfere with Police inquiries. This could include delaying the internal investigation, if required.</p> <p>Registered NDIS providers should ensure that workers involved in conducting and responding to incidents receive appropriate training. Their incident management systems must require people to be afforded procedural fairness when an incident is being dealt with. Further guidance about how registered NDIS providers should respond to reportable incidents is contained in the NDIS Commission’s Reportable Incidents Detailed Guidance for Registered NDIS Providers document and additional guidance regarding investigations is provided in 3.5 Investigations.</p>
<p>When corrective action should be taken – paragraph 10(1)(g)</p>	<p>Corrective action aims to address identified systemic issues and drive improvements in the quality of the supports registered NDIS providers deliver. It also means registered NDIS providers are able to improve their system to prevent incidents from occurring, and minimise their impact on people with disability when they do occur.</p>

¹³ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(1)(c)

¹⁴ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(1)(e)

¹⁵ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(3)

¹⁶ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(1)(f)

Procedure	Description
	<p>A registered NDIS provider’s incident management system must specify when corrective action should be taken in response to an incident and the nature of such action.¹⁷ For example, it is expected that a registered NDIS provider would take corrective action in the following circumstances:</p> <ul style="list-style-type: none"> • Where an incident may have been prevented (or the severity lessened) by some action (or inaction) by a registered NDIS provider or worker. • Where there is an ongoing risk to people with disability. • Where action by the registered NDIS provider may prevent or minimise the risk of a reoccurrence. <p>Examples of corrective actions include:</p> <ul style="list-style-type: none"> • Re-training or further training of workers. • Practice improvements including developing or enhancing policies and procedures. • Changes to the environment in which supports or services are provided. • Changes to the way in which supports or services are provided.

The procedures may vary, depending on the seriousness of the incident.¹⁸ For example, procedures outlining the way in which support workers must report the death of a person with disability are likely to be more extensive and immediate compared to reporting a low risk medication error which did not result in harm to a person with disability.

The expected key practice to support these procedures is described the next sections.

2.2.3 Accessibility of the incident management system

You must ensure copies of the incident management system are available in an accessible form to key parties such as workers, and people with disability. This includes ensuring that clear communication about the system are provided in an accessible form to:

- People with disability receiving supports or services from you
- Each person employed or otherwise engaged by you
- The family members, carers, independent advocates and significant others of persons with disability receiving supports or services from you

In addition, you must assist each person employed, or otherwise engaged, to understand how the system operates.

¹⁷ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(1)(f)

¹⁸ NDIS (Incident Management and Reportable Incidents) Rules 2018 s10 (2)



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Part 3: Your key supporting practices

Part 3: Your key supporting practices

Your incident management system will be supported by key actions and good practice. Your supporting practice will be underpinned by the principles of good incident management and resolution that are outlined below.

Principles of good incident management and resolution

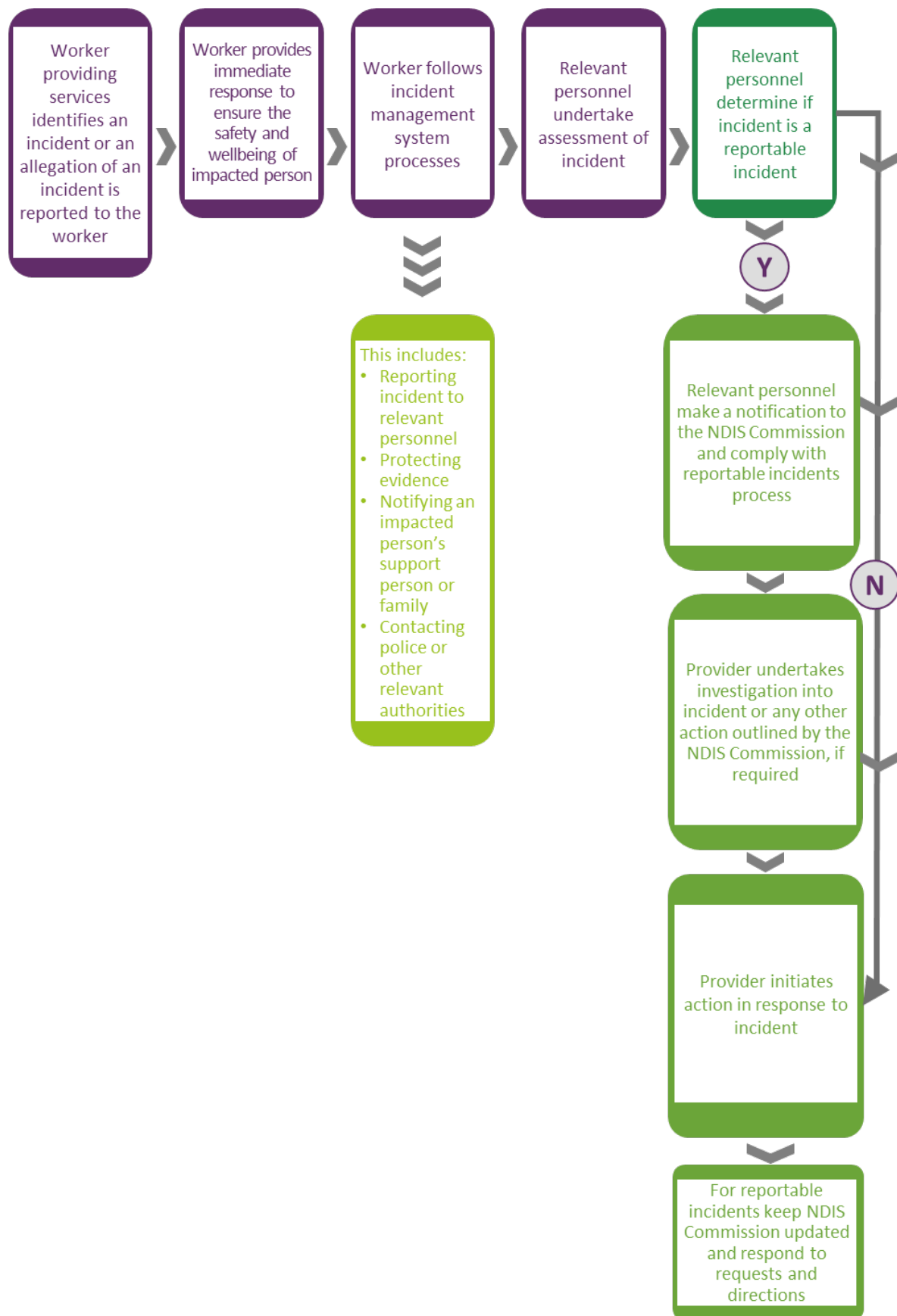
Figure 1: Principles of good incident management and resolution

Principle	Description
 Centred on people with disability	Management of an incident is respectful of, and responsive to, a person with disability's preferences, needs and values while supporting the person's safety and wellbeing.
 Outcome focussed	Management of an incident should reveal the factors which contributed to the incident occurring, and seek to prevent incidents from reoccurring.
 Clear, simple and consistent	The process for dealing with incidents is easy to understand, accessible and consistently applied.
 Accountable	Providers are responsible for appropriately managing the response to incidents. Everyone involved in the management of an incident understands their role and responsibilities, and will be accountable for decisions or actions taken in regard to an incident.
 Continual improvement	The incident management process facilitates the ongoing identification of issues and implementation of changes to improve the quality and safety of NDIS supports and services.
 Proportionate	The nature of any investigation or actions following an incident will be proportionate to the harm caused and any risk of future harm to a person with disability.

Source: NDIS Quality and Safeguards Commission

An overview of the steps in incident management, including notification to us, is provided in Figure 2: Steps in incident management and further explained in the information below.

Figure 2: Steps in incident management



3.1 Identification of incidents

Incidents may be identified in a number of ways, including where a worker or another person observes the incident, a person with disability makes a disclosure about the incident, or another party informs you that the incident occurred. An incident management system should outline what expectations you have of a worker’s response when incidents occur.

You should promote a culture where workers feel comfortable to identify incidents when they occur, report incidents to their relevant personnel, and record these incidents in the incident management system. A culture supportive of incident identification helps ensure that you’re aware of all incidents that occur, and are working towards continuous improvement in the safety of supports and services to people with disability.

Some incidents will be simple to identify, as a worker may witness the incident, or a person with disability may make a disclosure that can be recorded. However, other incidents may be harder to identify, especially where they involve abuse, neglect, or other types of reportable incidents.

In addition to incidents or allegations of incidents that are disclosed by an impacted person, or witnessed by someone, there are also additional signs that may indicate someone is an impacted person. These are indicators of potential incidents, especially where they involve abuse, neglect, sexual misconduct, or unauthorised use of restrictive practices.

Table 3: Indicators of incidents sets out the potential indicators and signs associated with particular types of incidents. It is important to note that these are only examples and not an exhaustive list.

Table 3: Indicators of incidents

Incident types	Behavioural indicators and physical signs
Physical abuse, unlawful physical contact or physical assault	<ul style="list-style-type: none"> • Inconsistent, vague, unexpected or unlikely explanation for the injury. • Unexplained injuries – broken bones, fractures, sprains, bruises, burns, scalds, bite marks, scratches or welts. • Other bruising and marks that may suggest the shape of the object that caused it. • Avoiding or being fearful of a particular person or worker. • Being overly compliant with workers. • Frequent and overall drowsiness (associated with head injuries). • Out of character aggression.
Sexual contact, sexual assault or sexual misconduct	<ul style="list-style-type: none"> • Dropping hints that appear to be about abuse. • Bruises, pain, bleeding – including redness and swelling around breasts and genitals. • Torn, stained, or bloody underwear or bedding. • Repeating a word or sign, such as ‘bad’, ‘dirty’. • Presence of a sexually transmitted disease. • Pregnancy. • Sudden changes in behaviour or character, e.g.: depression, anxiety attacks (crying, sweating, trembling, withdrawal, agitations, anger, violence, absconding, sexually expressive behaviour, seeking comfort and security).

Incident types	Behavioural indicators and physical signs
	<ul style="list-style-type: none"> • Sleep disturbances, refusing to go to bed, and/or going to bed fully clothed. • Refusing to shower.
Psychological, emotional or verbal abuse	<ul style="list-style-type: none"> • Depression, withdrawal, crying or emotional behaviour • Being secretive, and trying to hide information and personal belongings. • Speech disorders. • Weight gain or loss. • Feelings of worthlessness about life and themselves; extremely low self-esteem, self-abuse, or self-destructive behaviour. • Extreme attention-seeking behaviour and other behavioural disorders (e.g.: disruptiveness, aggressiveness, bullying). • Being overly compliant.
Domestic violence	<ul style="list-style-type: none"> • Depression, withdrawal, crying or violence. • Feelings of worthlessness about life and themselves; extremely low self-esteem, self-abuse, or self-destructive behaviour. • Extreme attention-seeking behaviour and other behavioural disorders (e.g.: disruptiveness, aggressiveness, bullying). • Being overly compliant.
Neglect	<ul style="list-style-type: none"> • Inappropriate or inadequate shelter or accommodation, including unclean and unsanitary living conditions. • Weight loss. • Requesting, begging, scavenging, or stealing food. • Being very hungry or thirsty. • Inadequate supply of fresh food. • Constant fatigue, listlessness or falling asleep. • Dropping hints that appear to be about neglect. • Extreme longing for company. • Poor hygiene or poor grooming – overgrown fingernails and toenails, unclean hair, unshaven, unbathed, wearing dirty or damaged clothing. • Inappropriate or inadequate clothing for the weather. • Unattended physical problems, dental, and/or medical needs. • Social isolation. • Loss of social and communication skills. • Removal of means of communication. • Displaying inappropriate or excessive self-comforting behaviours.

Incident types	Behavioural indicators and physical signs
Financial abuse	<ul style="list-style-type: none"> • Sudden decrease in bank balances. • No financial records or incomplete records of payments and purchases. • Person controlling the finances does not have legal authority. • Sudden changes in banking practices. • Sudden changes in wills or other financial documents. • Unexplained disappearance of money or valuables. • Person does not have enough money to meet their budget. • Person is denied outings and activities due to lack of funds. • Borrowing, begging, stealing money or food.

3.2 Immediately supporting the impacted person

When an incident occurs – irrespective of whether it is reportable or not – you must take action to ensure the safety and wellbeing of people involved in the incident (including people with disability, and workers and other people where the incident involves an act by a person with disability). For example, if a person with disability suffers a serious injury and requires medical treatment, you must immediately contact appropriate emergency services.

It is good practice for you to have a *response plan* for when incidents occur, to ensure the health, safety and wellbeing of people with disability. A response plan for how to deal with incidents could include:

- Any actions to be taken immediately after an incident to ensure the health, safety and wellbeing of a person or persons with disability involved in an incident
- The assessment and mitigation of any immediate risks to other people with disability that could be impacted by the incident
- Where the incident is or may be a reportable incident, further action that must be taken

Where it is alleged or suspected that a criminal offence has occurred, or where there is ongoing danger, you should contact the Police and other relevant emergency services. To ensure safety immediately after an alleged or suspected criminal conduct toward a person with disability, or where there is ongoing danger the registered NDIS provider should:

- Ensure the impacted person is safe from harm
- Contact Police if there is a risk of immediate harm which requires their assistance
- Contact the ambulance if someone is injured
- Notify key personnel, and the NDIS Commission if required

An impacted person may decide not to participate in a victim interview or provide a witness statement regarding the alleged offence, and you should respect the impacted person's decisions





On the NDIS Commission [website](#) there is further information on the first response to an incident for workers delivering services.

3.3 Keeping records

You must keep records to improve accountability, promote transparent decision-making and ensure best practice. Good record keeping is also essential for the NDIS Commission to provide oversight and recommendations to you about your management, assessment and investigation of incidents.

The storage of information and records is a critical part of your incident management process. The records will be stored appropriately, acted on, underpin your assessment and inform your practice improvement. This is outlined further in Figure 3 below.

Figure 3: Expectations for your recordkeeping

Expectations	
	Store information and records relating to investigations of an allegation against an employee in a safe and secure place.
	Act on all reports including development of risk reduction plans and documenting the outcomes achieved.
	Reflect on whether a strategy was effective or ineffective and reflect the learning in other practice.
	Monitor the documented risk reduction action plans in a risk register or other tracking system.

3.3.1 Recording and storing information

Your incident management system should specify a place where information regarding incidents is to be recorded and stored. All incident records should be kept in this location.

Your incident management system should clearly outline who is responsible for collecting information regarding the circumstances of an incident. Examples of who may be responsible include, the most senior worker to witness the incident, or the senior worker to whom the incident is reported.

Workers delivering services have a key role in responding to incident disclosures made by people with disability, reporting incidents to relevant personnel and protecting evidence. For further detailed guidance relating to workers delivering services and their role, refer to the NDIS Commission's [website](#) for specific guidance

3.3.2 Privacy and confidentiality

You should maintain appropriate controls in relation to the privacy and confidentiality of information, particularly where it relates to people with disability receiving NDIS supports and services. This includes ensuring that personal and sensitive information, including incident reports, are securely stored and when transmitted (either within their organisation, to other parties such as Police, or in the case of reportable incidents, to the NDIS Commission), so that privacy and confidentiality is maintained.

You should maintain confidentiality in relation to incidents where required. Failure to do so could prejudice any subsequent investigation and legal processes and could cause unnecessary trauma to people with disability the impacted person or the subject of an allegation.

3.3.3 What information should be collected

Your incident management system must collect a range of information about each incident that occurs, including any Reportable Incidents.

Table 4: Information to be collected when an incident occurs outlines the key information that should be collected.

Table 4: Information to be collected when an incident occurs

Subject	Details
Details of the incident or allegation	<ul style="list-style-type: none"> • Description of the incident • The impact on, or harm caused to, any person with disability • Note as to whether the incident is reportable, if known • The time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified • The names and contact details of the persons involved in the incident and any witnesses to it • The name and contact details of the person making the record of the incident or alleged incident
Initial response	<ul style="list-style-type: none"> • The registered NDIS provider’s initial response to the person making the allegation, the impacted person and the worker who is the subject of the allegation. This must include actions taken to support or assist persons with disability affected by the incident
Reporting to other bodies	<ul style="list-style-type: none"> • Note whether the registered NDIS provider considered the need to notify the Police about a suspected criminal offence or a child protection agency if the incident relates to a child or young person, and the outcome of any reports made
Assessment and Investigation	<ul style="list-style-type: none"> • Details of the assessment undertaken for each incident or allegation in accordance with minimum requirements set out in Table 2 above • Where and investigation is undertaken, the details for how the investigation was conducted, as well as the outcomes of the investigation. This could include the following information: <ul style="list-style-type: none"> ○ Describe a plan detailing how an investigation into the allegation is to be conducted ○ Details of all interviews conducted as part of the investigation, including details of the questions and responses ○ Any decisions made, both during and at the conclusion of the investigation, including their rationale, the position and name of the person making the decision and the date the decision was made
Risk	<ul style="list-style-type: none"> • The registered NDIS provider’s initial risk assessment following identification of the incident or receipt of the allegation, including identified risks, arrangements for managing those risks, and decisions made about the worker and the action taken in relation to the person with disability person with disability or worker (e.g. change in duties, support or counselling)

Subject	Details
Consultation	<ul style="list-style-type: none"> • Any consultations undertaken with the impacted person. This might include the following information: <ul style="list-style-type: none"> ○ Note the details of the discussions – questions, advice and outcome ○ Note the name of the person making the contact ○ Note the date of the correspondence • As good practice, the incident management system may also cover other personal contact, discussions or emails with others about the matter, including witnesses and other parties. In these cases, the system should note the details of corresponding individual's position and organisation and where appropriate, the reason for the contact
Statistical and other information	<ul style="list-style-type: none"> • Provide for the collection of statistical and other information that will allow the registered NDIS provider to review issues raised by occurrence of incidents, identify and address systemic issues, and report information relating to complaints to the Commissioner, if requested to do so
Follow up actions	<ul style="list-style-type: none"> • Record whether persons with disability affected by the incident have been provided with any reports or findings regarding the incident • Record changes to services provided • Establishment or review of policy and/or procedures • Training of the organisation's personnel

You are expected to store the information and records (both paper and electronic) relating to an allegation or incident in a safe and secure place. Records should not be removed from your location e.g. records should not be taken to a worker's home.

The information must be kept for a minimum of 7 years from the date the record is made. You may also have additional state and territory laws to comply with for the retention of records.

In addition:

- Records relating to the worker who is the subject of the allegation should be kept on a file that is separate to their personnel file, to ensure no privacy or confidentiality requirements are breached
- Information, relating to the assessment, or investigation if one is conducted, that is pertinent to supporting a person with disability (including where they are the impacted person, or the subject of the allegation) or management of the worker, could be copied to their respective personnel or participant files for future reference
- All files relating to a specific incident should be kept together to ensure all information relating to a reportable incident is readily accessible
- You need documented policies in relation to the access of records. Access to records should be limited to appropriate workers who have a business purpose for doing so e.g. accessing information that is directly related to the provision of person with disability care

3.3.4 Record management of correspondence

Correspondence relating to the assessment, or potential investigation, of an incident should also be documented and retained. This includes:

- For correspondence between you, the person with disability or their family:
 - All correspondence following any incident should be retained
 - Any statements made by the impacted person to deny or correct remarks, statements or claims should be recorded
 - Date all statements and enter the dates mailed or delivered to the person with disability.
 - If there has been a reply from the person with disability or their representative, attach to the record and date
 - If there is no reply or response from the person with disability, this should also be recorded
- For correspondence from the subject of the allegation following the incident:
 - All correspondence should be retained
 - Any statements made by the subject of the allegation to deny or correct remarks, statements or claims made by the impacted person should be recorded
 - Date all statements
- For records of correspondence between you, the person with disability or advocates
 - Meetings between a registered NDIS provider and person with disability should be recorded with the date, items discussed and names of those present
 - Paper and electronic correspondence should be dated and copies filed
 - Oral discussion notes, including telephone discussions (date, time, people involved) should be dated and filed

3.4 Reporting incidents

3.4.1 Internal reporting of any incident

Your workers need to understand that they are supported to report incidents and that there are no negative consequences for doing so. Each organisation should have a policy for worker disclosure. All workers should be advised that they can make a complaint on behalf of a person with disability to the registered NDIS provider or to the NDIS Commission. All workers must comply with your incident management system, and be aware of their roles and responsibilities in identifying, managing and resolving incidents and in preventing incidents from reoccurring.¹⁹

3.4.2 Assessment of incidents

When it is identified or disclosed that an allegation or incident has occurred, and you have taken steps to ensure the safety of people with disability, you must undertake an assessment to determine:

- Why the incident occurred
- Whether the incident could have been prevented

¹⁹ NDIS (Incident Management and Reportable Incident) Rules 2018 s 12(1) and 12(2)

- How well the incident was managed and resolved
- What, if any, regulatory action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact
- Whether other persons or bodies need to be notified of the incident

A post-incident assessment is a requirement your incident management system, and must be undertaken for all incidents, including for reportable incidents. You should have documented procedures to support relevant personnel to undertake these assessments when incidents occur. When you apply for renewal of your registration, you may be audited to determine if you're complying with this registration requirement.

The detailed assessment that includes the cause of the incident, its effect on the person with disability and any operational issues that may have contributed to its occurrence must also be stored in your incident management system.

If you cannot establish these factors in your assessment, further investigation may be required for any incident. In the case of reportable incidents, you:

- may opt to undertake an investigation
- may be directed by the NDIS Commission to undertake an internal investigation; or,
- engage an external party to undertake an investigation.

3.4.3 Notifying the NDIS Commission of Reportable Incidents

If a worker of a registered NDIS provider becomes aware of a possible reportable incident that has occurred, or is alleged to have occurred, in connection with the provision of supports or services by the registered NDIS provider, they have a duty to notify one of the following as soon as possible:

- A member of the registered NDIS provider's key personnel
- A supervisor or manager
- The person specified in the incident management system as being responsible for reporting incidents that are reportable incidents to the NDIS Commission (Specified Personnel)²⁰

Your incident management system must clearly specify who is to notify the NDIS Commission of a reportable incident. The specified personnel are responsible for identifying whether the incident is a reportable incident that occurred in connection with the provision of supports or services and, if it is, taking all reasonable steps to ensure that it is notified to the NDIS Commission.

If an incident is deemed to be a reportable incident, it must be notified to the NDIS Commission by the specified personnel using the approved forms that are available on the NDIS Commission Portal. There are set timeframes for notification and providing further information. These timeframes are critical to ensuring an incident is effectively managed.

All reportable incidents, except for the unauthorised use of a restrictive practice, must be notified to the NDIS Commission within 24 hours of you becoming aware of the incident. Any unauthorised use of restrictive practices must be notified within 5 days.

You are only required to notify the NDIS Commission of reportable incidents that occur in connection with the service you are providing. If a registered NDIS provider (such as a support coordinator or allied health professional) witnesses an incident or conduct, by another registered

²⁰ NDIS (Incident Management and Reportable Incidents) Rules 2018 s19.

NDIS provider, that is reportable, this should be raised by that registered NDIS provider as a concern to the NDIS Commission. This should only happen when:

- They witness or become aware of an incident that is not in connection with the services they themselves are providing; and,
- They believe the registered NDIS provider linked to the incident hasn't notified the NDIS Commission.

Contact us on 1800 035 544 and ask to speak to the Complaints Team who will follow up with the relevant registered NDIS provider. **There is further guidance on reportable incidents and NDIS Commission oversight available on the NDIS Commission [website](#).**

3.5 Investigations

The purpose of an investigation is to establish the causes of a particular incident, its effect on the impacted person, and any operational issues that may have contributed to the incident occurring.

An investigation may be the most appropriate response for the following examples of incidents, however this list is not exhaustive:

- The cause of the incident is unknown, or could have been one of a number of factors or a combination of factors
- The nature and the impact of the incident was significant, and requires investigation to support the safety and wellbeing of people with disability
- The incident may involve an allegation against a worker, and an investigation is required to determine what actions are required to manage the potential risk associated with the subject of allegation

You will need a documented process for nominating a particular person to manage or oversee the investigation. This person will be the investigator.

An investigation will include the following phases, or steps:

- Establishing the cause of the incident
- Determining its impact
- Identifying operational issues that may have contributed to its occurrence

3.5.1 The role of the investigator

An investigation is usually conducted internally but you also choose to involve other external organisations to undertake the investigation when you do not have the required expertise within your organisation, or there is a conflict of interest present.

You might engage an external expert to conduct the investigation, this may be required at the instruction of the NDIS Commission. It is important for the appointed investigator to be impartial and objective, and maintain independence throughout the investigation (see *Maintaining Independence* below).

The investigator will have appropriate decision-making authority and overall responsibility for coordinating and directing the investigation.

The investigator must be appropriately trained and have the experience required for conducting incident investigations. The investigator is responsible for overseeing the investigation process, and gathering the relevant evidence and facts to ensure that there is an in-depth understanding of the

incident. The investigator may recommend seeking internal or external experts to advise on matters relating to the investigation.

You must ensure that the appointed investigator is objective and impartial to the incident and investigation. To maintain independence, the investigator should have had no involvement in the incident and could be:

- Someone from a different part of your organisation
- Someone from another registered NDIS provider
- An external party with the skills and experience to conduct the investigation

To ensure that investigations are fair, it is very important for you to manage any actual or perceived conflict of interest in relation to the incident investigation.

A conflict of interest refers to a situation where the personal or professional interests of an investigator could influence the performance of their official duties or responsibilities in the investigation.

A conflict of interest can be actual or perceived. An actual conflict of interest relates to any personal, professional or financial interest that may compromise the investigator's objectivity and impartiality. A perceived conflict of interest occurs where it could reasonably be perceived, or appears, that a competing interest could influence the investigator's decisions.

3.6 Learning from incidents

Your incident management system provides a tool that can be learnt from, as it will assist you to identify patterns of behaviour or systemic issues that can be continuously improved in providing support to people with disability. You must have a procedure in place to identify when corrective action should be taken in response to an incident and the nature of such action. For example, it is expected that you would take corrective action in the following circumstances:

- Where an incident may have been prevented (or the severity lessened) by some action (or inaction) by you or your workers
- Where there is an ongoing risk to people with disability
- Where action by you may prevent or minimise the risk of a reoccurrence

Like complaints and other feedback, incidents provide an opportunity to review practices and procedures and identify where improvements in service quality and safety can be made. Your assessment or investigation of an incident must consider the range of issues listed in Section 3.4.2 above, as well as:

- The views of people with disability impacted by the incident
- What you have learnt and could improve on

You are expected to consider the outcome of such assessments and investigations to determine what action should be taken in order to continually improve your services quality and delivery of supports. Examples of what this action may include are as follows:

- Corrective actions aimed at reducing the likelihood of the same type of incident occurring in the future may include:
 1. Training and education of workers

2. Modification of the environment
 3. Development or amendment of a policy or procedure
 4. Changes in the way in which support or services are provided
 5. Other practice improvements
 6. Disciplinary action for the worker involved in the incident including ongoing performance reviews, imposing a probationary period, or termination of employment
- Restorative actions that aim to repair the relationship with the person with disability may include:
 1. Providing ongoing support to the person with disability impacted by the incident
 2. Giving an apology to the person with disability involved in the incident

In addition, an assessment or investigation may result in you determining that no further action is necessary.

The incident management system must also provide for periodic review of the system²¹, and the identification and resolution of systemic issues in relation to incidents.²²

Following an incident and any assessment or investigation that may take place, the findings and recommendations should inform the mitigation of risks that could result in the same type of incident occurring again, and the management any new risks that may emerge during the investigation. It is good practice for you to document and consider all relevant risks that may arise in the course of delivering supports and services to NDIS people with disability, and how these can be mitigated. As such, good risk management should be considered as being aimed at improving the overall quality of the supports and services delivered to NDIS people with disability, and preventing the likelihood of incidents occurring.

It may be useful in this process to consider documentation relating to repetitive issues and organisational feedback in order to identify risks, and relating to reports made to management and your executive board.

²¹ NDIS (Incident Management and Reportable Incidents) Rules 2018 s 10(6)

²² NDIS (Incident Management and Reportable Incidents) Rules 2018 s 12(5)(b)



NDIS Quality
and Safeguards
Commission

Part 4: Further information

Part 4: Further information

You can find out more information and access to resources on the NDIS Commission [website](#)

You can contact the NDIS Commission on 1800 035 544 or the Reportable Incident Team on reportableincidents@ndiscommission.gov.au