

Incident reporting protocol for the alcohol and drug sector

**Drugs Policy and Services Branch
Victorian Department of Human Services
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Prepared by the Drug Treatment and Health Protection unit, Department of Human Services

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List of acronyms

AOD	Alcohol and Other Drugs
CPR	Cardiopulmonary resuscitation
DHS	Department of Human Services
DP&S	Drugs Policy and Services Branch of DHS
MDSW	Mobile Drug Safety Workers
MORS	Mobile Overdose Response Service
NIDS	National Illicit Drug Strategy
NSP	Needle & Syringe Program
PHS	Primary Health Services

1. Aim

This operational protocol aims to clarify procedures for incident reporting practices in Victoria's alcohol and other drug (AOD) sector. It complements the Department of Human Services *Incident reporting departmental instruction*, which requires AOD services to report incidents to the department, including reporting of 'the apparently alcohol or drug related death of an Alcohol and Drug Services client irrespective of location of the incident'¹ as Category One incidents. The protocol also takes into account specific program issues and needs.

Incident reporting supports the provision of high quality services to clients through detailed and accurate reporting of adverse events and their subsequent analysis.

The aims of this protocol are to:

- protect the safety of clients and staff
- improve practice in the AOD sector.

¹ Department of Human Services, *Incident reporting Departmental instruction*, 2005, section 5.1, p15.

2. Principles

Recording and reporting incidents that occur in the AOD sector ensures the sector's commitment to:

- providing adequate standards and conditions of care and treatment for persons who suffer harm from use and misuse of licit and illicit drugs²
- minimising both individual and community harm related to problematic drug use
- providing common approaches to reporting and responding to incidents.

² Victoria's Alcohol and Drug Treatment Services, *The framework for service delivery*, March 1997, published by Victorian Government Department of Human Services.

3. Scope

This protocol contains a set of minimum standards for supporting clients and reporting incidents that occur to clients and/or staff in the AOD sector. It must be applied in conjunction with the department's incident reporting policy.

This protocol applies to all government-funded AOD services as well as to services that operate within an agency that has a funding and service agreement with the department, such as Needle Syringe Program (NSP), Primary Health Service (PHS), Mobile Drug Safety Worker (MDSW) and Mobile Overdose Response Service (MORS) services. Where the auspice agency is not directly funded by the department and, therefore, not bound by its incident reporting guidelines, services are advised to be aware of the reporting requirements of their respective auspicating bodies.

In the case of NSP services not auspiced by a department-funded agency, a brief incident reporting form is provided in the Victorian NSP *Operating policy and guidelines*³.

A separate incident reporting instruction for services funded under the National Illicit Drug Strategy (NIDS) grants programs will be issued by the Commonwealth Government.

³ Victorian Needle and Syringe Program, *Operating policy and guidelines*, December 2001, Published by Victorian Government Department of Human Services.

4. Definition of key terms

Alcohol and other drug (AOD) sector

For the purposes of this protocol, AOD sector refers collectively to drug-related treatment and harm reduction services. The AOD sector in Victoria is serviced by a drug treatment and health protection service system that provides a range of assessment, treatment and support services to adults and young people who have alcohol and/or drug use problems, and to their families and carers. The main aim of the AOD sector is to promote and protect the health and wellbeing of all Victorians by reducing death, disease and social harm caused by the use and misuse of licit and illicit drugs⁴.

Alcohol and other drug (AOD) sector agency

An AOD sector agency is an agency funded through the Department of Human Services to provide a variety of drug-related treatment, prevention, harm reduction and education programs and services. AOD sector agencies include those providing AOD treatment and rehabilitation, PHS, NSP, MDSW and MORS services. In the case of secondary NSP services, funding is in-kind, taking the form primarily of sterile injecting equipment and other resources provided for distribution to clients.

Active client

For the purposes of defining agency responsibility with respect to incident reporting, a key determinant in establishing client status lies in how certainly an agency could be expected to identify a person as a client. For anonymous clients, responsibility must be restricted to the time and place of an occasion of service delivery. This applies particularly to NSP (mobile, outreach and fixed-site), MDSW, MORS and unregistered PHS clients. Client anonymity necessarily reduces the extent to which incident documentation may be completed.

AOD treatment and rehabilitation services

An active client of an AOD treatment or rehabilitation services is a person undergoing alcohol and drug treatment and may sometimes be referred to as a 'direct client' by AOD workers. For the purposes of this protocol, active clients include persons who have been assessed, screened and registered, prior to entering treatment, and have an appointment with a worker. Persons who have completed an episode of care or have had an agency contact in the past month (30 days) should also be considered as active clients.

4 Department of Human Services Victoria, *Drug policy and services: an overview*, 2004.

Primary Health Service (PHS)

PHS clients may be registered, as are AOD treatment clients, or unregistered, where the client remains anonymous and no personal information is recorded. The distinction, however, mainly affects the amount of detail that may be recorded in an incident report. Otherwise, client status will be defined in much the same way as is that of an active client of AOD treatment and rehabilitation services. Clients currently accessing services at a PHS, however, may not be expected to be tracked in the way that AOD treatment and rehabilitation clients are (see 'Tracking clients off-premises' below).

NSP, MDSW and MORS

An active NSP, MORS or MDSW client is someone who receives, or has just received, NSP, MORS or MDSW services, whether in the field or at the worker's base agency. Since these clients are typically anonymous, the capacity to report an incident is usually restricted to the time and place of an occasion of service delivery. Incident reports should note the geographical location of the client at the time of the incident and identify how the worker responded to the incident, for example, by calling an ambulance or applying cardiopulmonary resuscitation (CPR).

Category One incident

As described in the departmental instructions summarised in **Attachment 1**, Category One concerns the most serious incidents that affect clients and/or staff of an AOD service. It is important to note that any incident or event that has the potential to involve the Minister, or the department, through media exposure, or to subject the department or funded agency to a high level of legal scrutiny or public interest, requires the completion of a Category One report.

Category Two incident

As per the departmental instructions summarised in Attachment 1, Category Two involves events that seriously threaten clients or staff but do not meet Category One criteria.

Category One and Category Two – Assault

An expanded definition of physical and sexual assault for Category One and Category Two, as contained in the *Responding to allegations of physical and sexual assault departmental instruction*, is included in Attachment 1.

Category Three incident

As per the departmental instruction, Category Three incidents must be recorded but are not forwarded to the department. Category Three incidents occur where normal work and routine is interrupted, but the significance of the incident does not extend beyond the workplace or facility.

Register

Agencies must maintain an incident register or database of Category One, Two and Three incidents. The register must be available for audit by the department.

Department

The Department of Human Services Victoria, as represented by the relevant Executive Officer, Regional Director or other nominated officer.

In-premises

In-premises means places within and around the building or property from which fixed-site services are officially being provided. This also includes locations that are within sight of agency workers, for example, where a client leaves the agency after a course of counselling, crosses the road and collapses.

- For **non-residential services** this includes the waiting room, counselling/ assessment room, toilet, corridors and car parking areas or any area within the facility, campus or site.
- For **residential services** this includes any area within or around the residential facility, campus or site, including corridors and car parking areas.

NSP, MORS and MDSW workers must report incidents if they occur on-site and/or within the proximity of their service and location at the time of the incident.

Off-premises

Off-premises means places that are outside the designated building/property where AOD treatment services are normally conducted. This may include the road, private houses, parks, bridges, alleyways, vehicles and other locations. A Category One incident that occurs off-premises and involves an active client must be reported.

Mobile Drug Safety Workers (MDSW)

MDSWs provide education on drug safety in areas of high drug use. MDSWs are typically attached to a NSP and often include NSP services among their duties. Workers are trained in resuscitation and refer drug users to treatment and rehabilitation.

Mobile Overdose Response Service (MORS)

Focusing on injecting drug users who have experienced a drug overdose, MORS workers offer support, information and access to treatment services. MORS may offer non-medical support to ambulance officers, where ambulance services have been called to attend at a drug overdose, and to emergency department staff in cases of drug overdose presentations.

Needle and Syringe Program (NSP)

NSP services prevent the spread of blood-borne viruses among injecting drug users and on to the broader community by providing sterile injecting equipment, safe disposal options, condoms, information and referral to health and other services. NSP services may operate from a fixed site, such as a community health service or emergency department; a vehicle, in the case of mobile services; or be provided by outreach workers on foot. NSPs are designated as primary, enhanced secondary and secondary NSPs. Primary and enhanced secondary NSPs receive funding for staffing, while secondary NSPs, accounting for over 90 per cent of NSP outlets, do not. Secondary NSPs operate from a range of agency types, including community health services, hospital emergency departments, AOD services, university campuses, pharmacies, local government offices, youth organisations and accommodation services.

Reporting of incidents involving an NSP client should be sensitive to the broader impact of the incident on service delivery, such as the impact on local traders or the community. Specific actions taken by the service provider, for example, calling an ambulance, applying CPR or calling police, should also be reported.

5. Managing issues

The Department of Human Services will ensure that AOD sector agencies are aware of this protocol and that directly funded agencies are aware of the departmental incident reporting policy.

Communication – see **Attachment 2**.

Further questions from Department of Human Services staff

When Department of Human Services staff are notified of an incident, they may ask additional questions to ascertain the category of the incident. For example, when a client has been found dead in their own home while receiving outreach/community support from an AOD agency, a number of questions may need to be asked to correctly determine the incident category. A summary checklist of these questions is in **Attachment 3**.

Reporting timelines – as per the *Incident reporting Departmental instruction*, see **Attachment 4**.

Resources – the department will provide staff training to raise awareness of its Incident Reporting Policy. Printed resources, such as a copy of the departmental instruction, will be available to all staff.

Agencies should develop their own resources, such as a practice protocol, to address issues including assertive follow-up for managers and staff after an incident, internal review and recommendations for improved practice.

Strategies

Tracking clients off-premises – agencies are required to have operational policies/guidelines to keep track of clients who are still active in treatment should they change address.

All agencies are required to have assertive follow-up protocols/policies/guidelines where clients who miss an appointment are contacted, whether by letter, telephone or both. The purpose of these contacts is to offer further appointments or support. Most agencies implement three assertive follow-ups before closing the episode of treatment. (See definition of active client, section 4.)

Preventing or reducing the occurrence of incidents – agencies should have documented policy, guidelines, operational procedures and protocols. Prevention strategies may range in scope from the preparation of practice guidelines to the review of physical facilities, from entry to exit points. Periodic practice reviews should be conducted to update prevention strategies.

As incidents cannot be totally prevented, the first step in identifying the problem is to record and report all incidents. At the absolute minimum, an incident report should include:

- who was involved (details of clients or staff)
- how, where and when the incident occurred
- who is injured and the nature and extent of injuries (if applicable)
- a brief narrative of events
- what action is being taken in response to the incident.

Every service must increase the profile of incidents by reporting on them as an agenda item in management or board meetings.

Risk assessment/risk management – a risk assessment of agency practices, including equipment, work methods and premises, is a useful tool for staff, as it assists with identifying and possibly reducing the occurrence of critical incidents. An example of risk assessment matrix tables is in Attachment 5.

Debriefing of staff – this is the process of supporting staff, clients and others who are affected by the trauma post incident. Debriefing responsibilities should rest with management. All possible steps must be undertaken to minimise post incident trauma for all parties involved.

A popular approach in helping victims cope in the immediate aftermath of an incident is known as **Psychological First Aid**. It aims to mollify the painful range of emotions and physical responses experienced by people exposed to traumatic incidents⁵. Attachment 3 provides some common debriefing strategies.

5 Uniformed Services University of the Health Sciences, Bethesda, *Helping victims in the immediate aftermath of disaster*, 2005. <http://www.usuhs.mil/psy/CTCPsychologicalFirstAid.pdf>

6. Roles and responsibilities

An incident may occur that involves a client of a number of programs or agencies. In this case, the agency or program that first becomes aware of the incident must complete the incident report, unless a more appropriate program or agency takes responsibility for reporting the incident.⁶

Issues relating to client confidentiality and client consent are dealt with in section 10.2 of the *Incident reporting departmental instruction*.

As a general rule, when reporting incidents:

- the agency that takes responsibility for the client is the one that reports
- workers must report immediately as much information as is available (see Incident reporting timelines, Attachment 4)
- additional relevant information should be sent through as a follow-up report when determined.

Responsibilities

AOD sector agency

AOD sector worker

- Inform the most senior supervisor available at the time of the incident. This could be a team leader, supervisor or manager.
- Complete an incident report with assistance from the most senior supervisor to whom you have reported the incident.

Supervisor/manager/team leader/director/executive officer

- Assist AOD worker to complete the incident report.
- Inform the program manager.
- Ensure that the other questions, as listed in Attachment 3, have been answered.
- Forward the incident report to the Department of Human Services Regional Director within the required timeline (as per the Incident reporting Departmental instruction).
- The most senior agency supervisor must ensure the incident report is completed and forwarded to Department of Human Services Regional Director or other nominated regional officer.

⁶ Department of Human Services, *Incident reporting Departmental instruction*, 2005, section 5.4.2 p21.

Department of Human Services

AOD Regional Coordinator

- First point of contact via telephone and/or email.
- Ensure copy of the incident report is sent to the Director, Drugs Policy and Services Branch.

Regional Director

- Verify Category One incidents and determine whether the incident has potential to involve the Minister or produce a high level of public or legal scrutiny.
- Ensure incident is entered on TRIM database and a copy forwarded to Head Office.

Director, Drugs Policy and Services

- Notify the Executive Director, Rural and Regional Health and Aged Care Services Division.

NSP

Primary providers – most are attached to an AOD agency, a community health centre and/or a hospital. In these cases, the NSP will follow the reporting procedures of the relevant auspicing organisation using the department's incident report form.

Secondary NSPs – these are unfunded programs operating within existing organisations. As they are not funded by the department, reporting is not required to be sent to the department. Secondary NSP services are advised to be aware of the reporting requirements of their respective auspicing bodies.

MDSW and MORS

Critical incident reporting will be done through the auspicing agency.

7. Implementing the protocol

Drugs Policy and Services Branch and Department of Human Services regional offices will jointly implement the protocol. They will:

- conduct initial awareness training in each region (including Commonwealth funded organisations)
- ensure that a copy of the protocol is available online
- assist agencies to incorporate the protocol into staff training resources.

An audit will be conducted by the department to assess the benefits of this protocol.

This protocol will be an evolving document and will be reviewed and updated, as required, after the first 12 months. Any comments on this protocol should be forwarded to your AOD Regional Contact (**Attachment 6**) or Head Office contact listed below.

Contacts:

- Department of Human Services Incident Reporting Policy – contact Penny Tolhurst on: (03) 9616 8375
- Region – contact your respective AOD Regional Coordinator (see Attachment 6)
- Drugs Policy and Services Branch – contact Luz Bland on: (03) 9637 5235

8. Resources

The Department of Human Services *Incident reporting departmental instruction* is available from:

- <https://fac.dhs.vic.gov.au/home.aspx>
- <http://www.dhs.vic.gov.au/dhsforms.htm>

The following guidelines and instructions are also available on this site:

- Guidelines for Office of Housing
- *Responding to allegation of physical and sexual assault*, departmental instruction, August 2005.

Service Agreement information kit for agencies 2003-06 is available from <https://fac.dhs.vic.gov.au/>

Attachments

Attachment 1: Definition of incidents^{7*}

Category One incident

- The death of, or serious injury to, a client or staff member.
- Allegation of, or actual serious sexual or physical assault of or by a client or a staff member as specified below.
- A serious fire involving death or serious injury.
- A serious fire in programs (other than Housing) resulting in closure or significant damage to parts of a building or its contents and/or which poses a threat to the health and safety of staff or clients
- Serious property damage in programs other than Housing (closure or significant damage to parts of a building or its contents), which poses a threat to the health and safety of staff or clients.
- The escape of a person in custody in a Juvenile Justice Centre, and absconding from temporary leave.
- Unauthorised absenteeism from secure welfare services.
- The apparent alcohol or drug related death of an alcohol and drug services client, irrespective of location of the incident.
- An event that has the potential to involve the Minister. (Reporting and management of incidents that are directly related to or result from emergencies are covered under the Department of Human Services State Level Emergency Management Plan.)
- An event that has the potential to subject the department or funded agency to high levels of public or legal scrutiny.

Examples of Category One incidents in the AOD sector

Incidents that occur in premises are easier to classify and report than incidents that occur off premises. Some examples of incidents occurring off premises are as follows:

- Motor vehicle accident immediately following direct contact with a service, where an AOD affected client insisted on driving.
- Sexual assault of a client perpetrated by another client while both were at residential withdrawal treatment.
- Death of a supported accommodation active client.
- Fatal overdose of an active client.
- Apparent suicide of an active client.

⁷ Department of Human Services: *Incident reporting Departmental instruction*, 2005, pages 15-18.

Category Two incident

- Incidents that result in injuries requiring medical attention, and assaults that do not classify as Category One incidents.
- Serious threats made against clients or staff.
- Unethical behaviour by staff, particularly if it involves taking advantage of clients (such as the alleged trafficking or provision of illicit substances to clients by staff, or staff in receipt of stolen goods from clients, inappropriate relationships between staff and clients).
- Criminal behaviour resulting in police intervention.

Note: Staff will need to use their judgment in relation to this incident type. Some clients or client groups may have more frequent involvement in the criminal justice system than others. Serious charges should always be reported.⁸

- Unauthorised absenteeism resulting in a warrant being sought, or a missing persons report filed for a client from a placement and support agency.
- Unauthorised absenteeism from Disability Services Statewide Forensic Services.
- Incidents that may have lead to significant client or staff injury or death (near misses).
- Incidents that have the potential to escalate to Category One.

Note: Once there is media or ministerial involvement, or escalating seriousness, an incident automatically becomes a Category One.

Examples of Category Two incidents in the AOD sector

- Any on-site non-fatal client overdose that required medical attention.
- Sexual misconduct in residential facility (as opposed to sexual assault).
- Break in or significant damage of agency premises or vehicles and neighbouring properties, involving an active client or staff member.

Physical and sexual assault

The following are expanded definitions of physical and sexual assault which could fall as Category One and/or Two incidents as per the new Responding to allegations of physical or sexual assault instruction.

⁸ Department of Human Services: *Incident reporting Departmental instruction*, 2005, page 23.

Physical assault

Physical assault is generally defined as the application of force, which causes physical injury requiring medical attention. Medical attention means treatment by a medical practitioner.

Physical injury is defined to include (but is not limited to) internal injuries, dislocated or broken bones, cuts, bruising, welts or burns. These may be caused by hitting, throwing, shaking, suffocation, strangulation, sexual assault, poisoning, mutilation, or assault with a weapon. Assault may also include other actions, including spitting or serious threatened or attempted assault (for example, involving a weapon) that results in discomfort or pain.

Assaultive behaviour of any type is unacceptable, regardless of the intent of the person committing the violence.

Sexual assault

Sexual assault includes rape, assault with intent to rape and indecent assault. Indecent assaults are assaults that are accompanied by circumstances of indecency. Examples are unwelcome kissing or touching in the area of a person's breasts, buttocks or genitals. Indecent assault can also include behaviour that does not involve actual touching, such as forcing someone to watch pornography or masturbation. This definition is consistent with the Victorian Crimes Act 1958 (ss. 35–60A).

Consent is not a defence to some sexual offences. A person who takes part in an act of sexual penetration with a child under the age of 16 is guilty of an indictable offence, unless the child is aged between 10 and 16 and the two people taking part in the act are married to each other. If the two people are not married, and the child is aged more than ten years, then consent is not a defence unless:

- the accused believed on reasonable grounds that the child was aged 16 or older
- the accused was not more than two years older than the child
- the accused believed on reasonable grounds that they were married to the child.

Categorising assault incidents

Assaultive behaviour can vary in nature from life-threatening events to minor incidents. An example of a minor incident is one client shoving another with no injury. To assist staff and agencies with accurate categorisation of reports, further advice is provided below regarding allegations of physical and sexual assault.

Category One assaults

The assault of a client by a staff member or volunteer carer is Category One regardless of the need for medical attention and regardless of the type of sexual assault alleged (for example, rape or indecent assault). Rape and production of child pornography are always a Category One incident. Physical assault of or by a client that either results in medical attention being required for the victim, or involves use of a weapon, is a Category One incident. Medical attention means treatment by a medical practitioner.

Category Two assaults

Physical assaults not requiring medical attention are usually Category Two incidents (unless the alleged perpetrator is a staff member or volunteer carer). A physical assault between clients that requires first aid only, for example, is a Category Two incident.

Indecent assault of or by a client

Indecent assault of or by a client will usually be categorised as a Category One or Two incident depending on the circumstances of the event. An event such as forcible touching of a client on the breasts or genitals is likely to be Category One. The level of distress caused to the victim is a factor in categorising the incident.

Classifying incidents

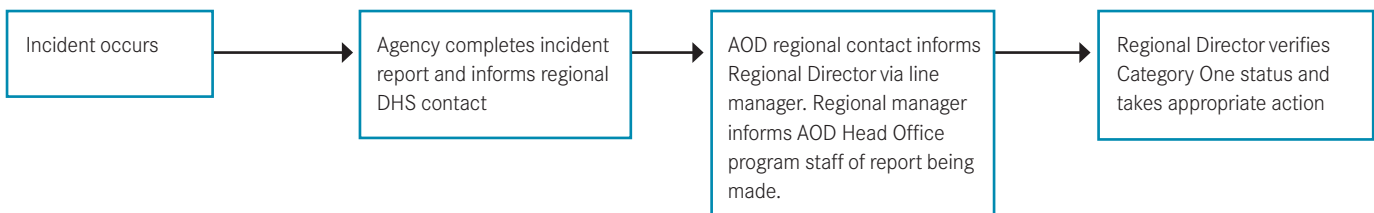
Classifying of incident reports must follow the table below as a minimum requirement. It is not possible to stipulate every possible variety of incident and judgement by senior staff will be required.

Category	Type of alleged assault
Category One	<p>Rape of or by a client.</p> <p>Rape or indecent assault by a staff member or volunteer carer.</p> <p>Production of child pornography by a client, staff member or volunteer</p> <p>Physical assault of a client by a staff member or volunteer carer.</p> <p>Physical assault of or by a client resulting in medical attention being required for the victim (for example, stitches, surgery, setting of a fracture).</p> <p>Physical assault of or by a client involving a weapon (such as a knife, hammer or other object).</p>
Category Two	Physical assault of or by a client resulting in first aid being required for the victim. (This does not include the assault of a client by a staff member.)
Category Three	Shoving or pushing between clients that does not cause injury.

Attachment 2: Reporting Category One incidents

Step 1

For AOD workers



Step 1 – Ascertain:

- The client is an ‘active’ client of the service.
- Who has responsibility for client at the time of the incident. If client is a shared client, who has prime responsibility? The agency in contact with the client during an incident should report the incident.

Step 2 – Agency must report on DHS incident report form all information available **immediately and no later than the next working day** (Category One).

Download the most recent incident report form from <http://www.dhs.vic.gov.au/dhsforms.htm> each time a report is required.

Step 3 – DHS staff may ask questions as listed in Attachment 3. This is a guide as to whether a briefing to the Minister is required.

Agencies also need to ensure agency level reporting has been completed for the incident, either in a log book or spreadsheet.

Step 4 – appropriate action may include:

- Briefing the Minister and Communications Unit (Media).
- Consider further practice implications.
- Enter incident report on information system and ensure report is in client’s file.
- Ensure appropriate level of local investigation and causal analysis, and, where appropriate, develop improvement strategy.

For NSP/MORS workers



All incidents that occur on-site or within the proximity of the outlet and/or worker, which resulted in the worker taking direct action in response to the incident, **must** be reported.

Auspecting agency (community health centre, hospital, community service organisation) must include incident reports from NSP/MDSW/MORS when doing impact analysis. Workers **must** use the most recent incident report form from <http://www.dhs.vic.gov.au/dhsforms.htm>

As a general rule, **all** Category One incidents need to be reported to the Department of Human Services.

Attachment 3: Debriefing

Questions that Department of Human Services regional staff may ask agencies

To assist departmental staff with briefings for the Minister, regional staff may ask some clarifying questions. These questions are AOD specific and are included here to assist staff with accurate and timely reporting.

- If reporting death, was the death directly due to alcohol and drug use?
- Are children involved? If so, has Child Protection been involved?
- Is the person living in an Office of Housing property?
- What other services have been involved, for example, mental health? Is this agency aware of any risk assessment that the mental health services have undertaken in recent times?
- Does the agency consider that there is reason for the cause of death to be treated with suspicion?
- Have the Police been involved?

Common debriefing strategies

Psychological First Aid⁹ has the primary aim of creating and sustaining an environment of safety, calmness, connectedness to others, self-efficacy or empowerment and hope. It is fundamental that debriefings do not attach any 'blame'.

Do

Promote safety

- Help people meet their needs for food and shelter, and obtain emergency medical attention.
- Provide repeated, simple and accurate information on how to obtain these.

Promote connectedness

- Help people contact friends or loved ones.
- Keep families together. Keep children with parents or other close relatives whenever possible.

Promote calm

- Listen to people who wish to share their stories and emotions and remember there is no wrong or right way to feel.
- Be friendly and compassionate even if people are being difficult.
- Offer accurate information about the incident or trauma and the relief efforts underway to help victims understand the situation.

Promote self-efficacy

- Give practical suggestions that steer people towards helping themselves.
- Engage people in meeting their own needs.

⁹ Uniformed Services University of the Health Sciences, Bethesda, *Helping victims in the immediate aftermath of disaster*, 2005. <http://www.usuhs.mil/psy/CTCPsychologicalFirstAid.pdf>

Promote hope

- Find out the types and locations of government and non-government services and direct people to those services that are available.
- Remind people (if you know) that more help and services are on the way when they express fear or worry.

Don't

- Force people to share their stories with you, especially very personal details (this may decrease calmness in people who are not ready to share their experiences).
- Give simple reassurances like 'everything will be OK' or 'at least you survived' (statements like these tend to diminish calmness).
- Tell people what you think they should be feeling, thinking or doing now or how they should have acted earlier (this decreases self-efficacy).
- Make promises that may not be kept (broken promises decrease hope).
- Criticise existing services or relief activities in front of people in need of these services (this undermines an environment of hope and calm).

Other strategies

For staff

- Provide short break from counter/current duties.
- Remove from public contact entirely for a specified time.
- Relieve from duties temporarily (by providing different role, but ensure staff remain within the social network of normal work group).
- If hospitalised, arrange visits, provide amenities (for example, television, telephone), send flowers/chocolates.
- Offer counselling with option to use either in-house counsellors or local professionals.
- Involve family members of staff by, for example, providing copy of a videotape, provide explanation of incident to help them understand what trauma their family member is going through.
- Ban clients possessing a record of aggression toward staff by directing them to leave the premises if appropriate.
- Issue injunction prohibiting client from entering the service.

For clients

- Talk to family members and offer support through, for example, contacting next of kin, organising medical, participating in the investigation of the case and other arrangements.
- Offer counselling with option to use either an in-house counsellor or local professionals.
- If hospitalised, arrange visits, provide amenities (for example, television, telephone), send flowers/chocolates.
- If client died, offer condolences to the family and attend funeral, if possible.

Attachment 4: Incident reporting timelines

(as per the *Incident reporting Departmental instruction*)

Category One

Category One incidents without the potential to involve the Minister or produce a high level of public or legal scrutiny	
Action	Timeline
Consider possible practice implications.	Immediately
Forward incident report to Program Director, E/D Operations, E/D, Director Legal Services.	No later than next working day
Enter incident report on information system and ensure report is placed on client's file.	Within one week
Ensure appropriate level of local investigation and causal analysis and, where appropriate, develop improvement strategy.	Within two weeks

Category One

Category One incidents with the potential to involve the Minister or produce a high level of public or legal scrutiny	
Action	Timeline
Contact Executive Director of program.	Immediately
Consider possible practice implications.	Immediately
Forward incident report to Minister, Secretary, Program Director, E/D Operations, E/D, Director Legal Services.	No later than next working day
Provide Ministerial Brief to Minister, Secretary, E/Ds,	ASAP, no later than 72 hours
Enter incident report on information system and ensure report is placed on client's file.	Within one week
Ensure appropriate level of local investigation and causal analysis and, where appropriate, develop improvement strategy.	Within two weeks

AOD agencies must report what they can immediately and then send a follow up with additional information at a later date.

Category Two incidents

Action	Responsibility	Timeline
Forward incident report to Program and Service Adviser (PASA) of if out-of-home care client, to Child Protection Unit Manager and Placement and Support Manager	Funded Agency	Within 2 days
Forward report to Program Manager	PASA or DHS direct service staff	Within 1 day
If quality of care/neglect concern in home-based care, forward incident report to E/D Ops and E/D, Office for Children	Placement and Support Manger	Immediately
If juvenile justice custodial client, forward incident report to Director, Juvenile Justice Custodial Services	Juvenile Justice Centre CEO	Immediately
Review incident report, determine any action to be taken and ensure report filed on client's file	Senior Regional Program Manager/ JJ CEO	Within 1 week
Enter incident report on information system	Regional officer or JJ Officer	Within 2 weeks

Attachment 5: Risk assessment matrix

A risk assessment matrix can be a useful tool to rank and assess risks. A good appreciation of risks in your workplace helps to correctly direct resources for improvement and form strategies around workplace safety.

This generic matrix plots consequences with likelihood. Consequences are based on imagined scenarios, or what 'could happen'. Likelihood is estimated on an understanding of what has happened in the past or in similar circumstances. This matrix can be adapted to your workplace, and there are many resources on risk assessment and risk management in business publications or on the Internet.

For more information, refer to the Australian and New Zealand Standard for Risk Management, AS/NZS 4360:2004 at www.standards.com.au

Step One:

Consider a list of possible incidents and risks. A risk is the possibility of something occurring that may impact on service objectives.

Asking the following questions is an excellent place to start:

- What can happen?
- When and why can it happen?

Use your analysis of previous incident reports to support your identification of possible risks.

Consider the range of possible sources for critical incident risks: facilities, staff, equipment, materials, work practices, systems or clients.

Consider the possible sources and identify a list of possible risks.

Step Two:

Evaluate the risks by estimating their likelihood and consequences. Past incident reports can be a useful source of data for this evaluation.

Consider the possible consequences of each incident.

Consider the likelihood of the identified consequences occurring.

Step Three:

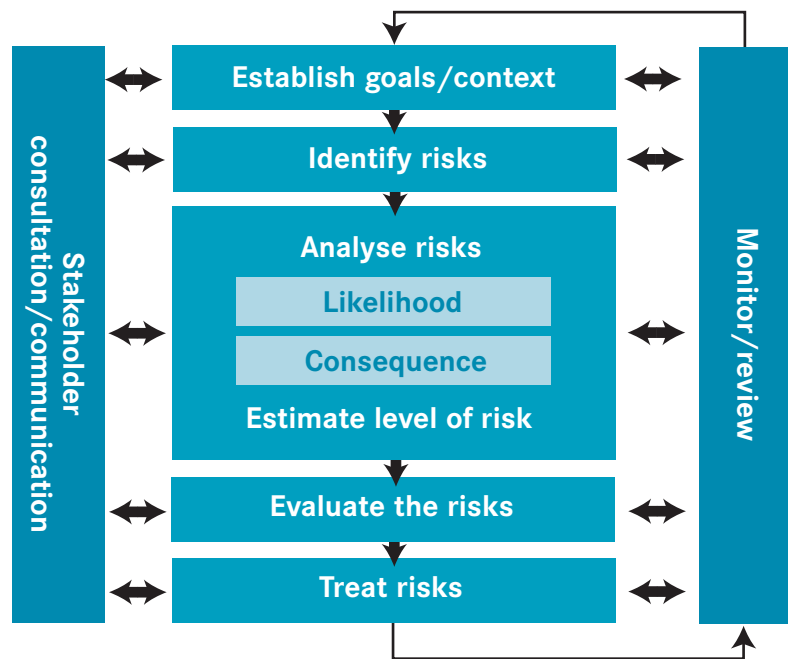
Calculate the risk by mapping the consequence against the likelihood. This clarifies how serious or likely it is that any particular incident may occur.

Step Four:

Depending on the seriousness and likelihood of the risk, determine the action you need to take.

The following risk management ready reckoner is consistent with the Australian Standard, which the department has adopted for risk management.

The Australian Standard risk management process



Source: Standards Australia, AS/NZS 4360:1999 Risk management

Risk exposure

	Consequence				
Likelihood	<i>Negligible</i>	<i>Low</i>	<i>Moderate</i>	<i>Major</i>	<i>Extreme</i>
<i>Almost certain</i>	High	High	Critical	Critical	Critical
<i>Likely</i>	Medium	High	High	Critical	Critical
<i>Possible</i>	Low	Medium	High	Critical	Critical
<i>Unlikely</i>	Low	Low	Medium	High	Critical
<i>Rare</i>	Low	Low	Medium	High	High

Likelihood of risk

Level	Description
Almost certain	Is expected to occur in most circumstances – say, more than once a month
Likely	Will probably occur in most circumstances – say, once or more a year
Possible	Should occur at some time – say, once or more in three years
Unlikely	May occur at some time – say, once or more in ten years
Rare	May occur in exceptional circumstances – say, less than once in ten years

Consequence

Level	Description						
	Services	Human	Financial	Reputation	Liability	Regulatory	Department outlook
Extreme	Total cessation of multiple services for several months.	Multiple deaths or disabling injuries of clients and/or employees.	Loss of more than 0.5% of DHS operating budget	Media event, immediate broad concern. Royal Commission or Parliamentary inquiry	Potential liability of more than 0.5% of DHS operating budget.	Shutdown of multiple services for non-compliance	Department may not survive.
Major	Disruption of multiple services over several months.	Death or disabling injury of a client or employee.	Loss of between 0.25% and 0.5% of DHS operating budget.	Melbourne papers, radio and/or TV. External inquiry – for example, Coroner’s request.	Potential liability of between 0.25% and 0.5% of DHS operating budget.	Shutdown of services for non-compliance. Offence punishable by imprisonment.	Program, activity or project may not survive.
Moderate	Total service cessation for a week and subsequent disruption.	Multiple injuries to clients and/or employees.	Loss of between 0.1% and 0.25% of DHS operating budget.	Local media concern. Internal inquiry.	Potential liability of between 0.1% and 0.25% of DHS operating budget.	Immediate action needed to achieve compliance. Offence punishable by major fine.	Program, activity or project would be subject to significant review or changed ways of operating.
Low	Minimal service disruption.	Injury to a client or employee.	Loss of between 0.05% and 0.1% of DHS operating budget.	Minimal media interest. Explicit or specific internal reporting.	Potential liability of between 0.05% and 0.1% of DHS operating budget.	Short to medium term action needed to achieve compliance. Offence punishable by moderate fine.	Efficiency or effectiveness of program, activity or project would be affected but would be managed internally.
Negligible	No service disruption.	Minor injury.	Loss of less than 0.05% of DHS operating budget.	No public concern. Routine internal reporting.	Potential liability of less than 0.05% of DHS operating budget.	Minor compliance issues. Offence punishable by low fine.	Consequences would be resolved in routine operations.

Attachment 6: Alcohol and drug regional coordinators, Department of Human Services

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