

## A new incidents reporting and complaints system in Queensland

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent government body that works to improve the quality and safety of NDIS services and supports, investigates and resolves problems, and strengthens the skills and knowledge of providers and participants.

The NDIS Commission will commence in Queensland on 1 July 2019 and will progressively roll out across Australia.

When it is operational in all states and territories, the NDIS Commission will provide a single, national registration and regulatory system for providers that will set a consistent approach to quality and safety across Australia.

## What has changed?

Under the NDIS Commission, registered providers must have an incidents management system in place to record and manage incidents (including allegations) that occur while providing supports or services to people with disability.

All providers, registered and unregistered, must also have an in-house complaints management and resolution system and support participants to make a complaint.

The following table provides guidance on the reporting of incidents and complaints in Queensland prior to, and from 1 July 2019 noting that Queensland has also safeguards in relation to the operation of NDIS provided services.

Incidents	Prior to the NDIS Commission	Under the NDIS Commission
Supports or services concerned	Services funded by the Department of Communities, Disability Services and Seniors (DCDSS) NDIS registered providers with state-based approvals under the Human Services Quality Framework (HSQF)	NDIS providers delivering funded services or supports to participants
Incident Management System	In Queensland, providers were required, under their service agreements, to maintain and apply their own internal critical incident policy, as well as have processes for reporting and responding to potential or actual harm, abuse and/or neglect that may occur for people using services.  This was audited as part of the QLD Human Services Quality Framework.	As outlined in the NDIS (Incident Management and Reportable Incidents) Rules 2018, incidents that must be recorded and managed include incidents where harm, or potential harm, is caused to or by a person with disability while they are receiving NDIS supports or services.  The incident management system must include procedures for identifying, assessing, recording, managing, resolving and reporting incidents.

		NDIS providers must keep records about incidents, and must document their incident management system and make it available to workers and participants.
What must be reported	<ul> <li>Services funded by the DCDSS were required to report:</li> <li>an incident that affected or was likely to affect the delivery of any of the Services; and/or</li> <li>an incident that related to any of the Services or Service Users and that required an emergency response including fire, natural disaster, bomb threat, hostage situation, death or serious injury, or threat of death or serious injury, of any person or any criminal activity.</li> <li>There was no requirement for NDIS-registered providers registered in Queensland to report critical incidents relating to an NDIS participant to the DCDSS.</li> <li>However, providers of NDIS supports registered in Queensland were required to immediately report specific incidents to relevant authorities, such as Police, the Coroner and/or Child Safety.</li> <li>In Queensland, from 1 July 2019, a death in care under the Coroner's Act 2003 (QLD) must be reported immediately to the Coroner or Police.</li> </ul>	Reportable Incidents are serious incidents or allegations, which result in harm to an NDIS participant, which happened in connection with the provision of supports or services by registered NDIS providers.
What types of incidents to report	<ul> <li>Deaths in care under the Coroner's Act 2003 (QLD).</li> <li>Includes a person with disability receiving accommodation services, funded or provided by the department; and</li> <li>An NDIS participant living in accommodation for people with disability, or residential service that was not a private dwelling or aged care facility, receiving services funded under the NDIS.</li> <li>Specific incidents requiring reporting to:         <ul> <li>Police</li> <li>The Coroner</li> <li>Child Safety.</li> </ul> </li> </ul>	The following reportable incidents (including allegations) arising in the context of NDIS supports or services must be reported to the NDIS Commission:  • the death of a participant; • serious injury of a participant; • abuse or neglect of a participant; • unlawful sexual or physical contact with, or assault of, a participant; • sexual misconduct committed against, or in the presence of, a participant, including grooming of the participant for sexual activity; • the use of a restrictive practice in relation to a participant, other than where the practice is authorised and used in accordance with the participants approved behaviour support plan.
How you report	DCDSS funded providers were required, under their service agreements, to have, maintain, implement and act in accordance with policies consistent with the department's Critical Incident Reporting Policy.	From 1 July 2019 providers will be able to report through the NDIS Commission's website
When to report an incident	DCDSS funded providers were required to notify the department immediately, or within 1 business day after they became aware of an incident.	Most reportable incidents must be notified to the NDIS Commission within 24 hours of a provider's key personnel being made aware of the incident. A more detailed report about the incident and actions

	Criminal acts or deaths were required to be immediately reported to the police and, in the case of a reportable death, to the coroner.	taken in response to it is required within five working days.  The NDIS Commission must be notified of the use of unauthorised restrictive practices within five business days of a provider's key personnel being made aware of the incident. If there is harm to a participant, it must be reported within 24 hours as the relevant reportable incident category, such as serious injury or abuse.  A final report may also be required within 60 business days of submitting the five-day report. The NDIS Commission will advise providers if a final
	Staff and managers in DCDSS funded associates and	report is required.  In addition to incident reporting requirements under the NDIS Commission, in Queensland, a death in care under the <i>Coroner's Act 2003</i> (QLD) must be reported immediately to the Coroner or Police.
Who is responsible for reporting an incident	Staff and managers in DCDSS funded providers, and DCDSS staff and managers were required to report incidents/complaints immediately to an appropriate person within their organisation; and to immediately report criminal acts or deaths to the police.	All registered providers, regardless of their service type, are required to notify the NDIS Commission of reportable incidents that occur in connection with the delivery of NDIS supports and services.
Corrective action	DCDSS could report outcomes achieved from a complaints perspective and provide further detail on each complaint managed, if required.	The NDIS Commission may take action in response to a reportable incident, where required. This may include requiring the provider to undertake specified remedial action, carry out an internal investigation about the incident, refer the incident to another body, or engage an independent expert to investigate and report on the incident.  Upon review of specified actions undertaken by a provider a determination may be made to refer a matter on to another function within the NDIS Commission.
Record keeping	Complaints were recorded in the department's Resolve Complaints Management System. Critical Incidents were recorded in the department's Critical Incident Recording system.	Registered NDIS providers must keep records of each reportable incident that occurs, or is alleged to have occurred, for a period of seven years from the date of notifying the NDIS Commission of the incident.
Additional reporting obligations	Criminal acts or deaths were required to be immediately reported to the police and, in the case of a reportable death, to the coroner.	Registered providers are required to report serious incidents to the NDIS Commission.  This does not replace existing obligations to report suspected crimes to the police and other relevant authorities.

Complaints	Prior to the NDIS Commission	Under the NDIS Commission
How a participant can make a complaint	NDIS participants could make complaints about the quality of NDIS services to the DCDSS.  Complaints about the NDIA, decisions made by NDIA, conduct of NDIA staff and market capacity were referred to the NDIA to manage.  Registered NDIS providers were required to have effective and proportionate complaint management and resolution system in place.	Complaints about the quality or safety of NDIS supports and services can be made to the NDIS Commission by calling 1800 035 544. Complaints about the NDIA or participant plans continue to be made to the NDIA or to the Commonwealth Ombudsman.  Registered providers are required to have effective and proportionate internal complaint management and resolution arrangements in place. Registered providers must afford procedural fairness to people when managing complaints.

## Find out more

You can find more information and resources on the NDIS Quality and Safeguards Commission website at <a href="www.ndiscommission.gov.au">www.ndiscommission.gov.au</a> or you can call the NDIS Commission on **1800 035 544** during business hours.