Policy 44 - Incident reporting and Investigation

PURPOSE

To describe the A24Group's requirements in relation to the reporting of all accidents and incidents, including critical incidents, and any subsequent investigation procedures.

SCOPE

This procedure covers all staff members whether permanent or temporary within the A24Group.

POLICY

A24Group intends to provide a safe and healthy working environment and safe practices at all times and wants to ensure the health and safety of its workers both permanent and temporary and others who may be affected by their actions, so far as is reasonably practicable. A robust and informative incident recording system and related database will be maintained and regularly interrogated to enable monitoring and learning to take place.

REFERENCES TO LEGAL, CENTRAL GOVERNMENT AND OTHER EXTERNAL DOCUMENTS, INCLUDING RESEARCH

Health and Safety at Work etc. Act 1974
Management of Health & Safety at Work Regulations 1999
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

DEFINITIONS

Various terms are commonly used to refer to different kinds of incidents and these include *events, incidents, accidents, untoward events, adverse incidents, critical incidents and serious untoward incidents.*

ROLES

Managers are responsible for implementing this procedure.

CONTENTS

1. DEFINITIONS

In order to provide consistency across the a24Group the following terms and definitions are recommended:

INCIDENT**:** We use the word incident here to cover anything that occurs in the workplace that could cause a situation that results in harm to people, damage to property or loss of service capacity, including accidents.

NEAR MISS: Describes an event that could have caused injury but narrowly missed doing so.

CRITICAL INCIDENT: The term 'critical' is used to reflect the actual or potential severity of the impact and the consequences of the event and would include the death or serious injury of a service user, visitor or staff member, serious assaults or serious medication incidents.

RIDDOR: The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) places a statutory duty upon the Agency to report and record all accidents, incidents, diseases and dangerous occurrences arising out of work activities.

DANGEROUS OCCURENCE**:** The term Dangerous Occurrence when applied to these guidelines, relates exclusively to the definition of Dangerous Occurrence contained in the RIDDOR Regulations 1995.

LOST TIME INCIDENT: Major or other accidents resulting in absence from duty for *over three days*, excluding the day of the accident. This is reportable under RIDDOR to the Health and Safety Executive (HSE).

MAJOR INJURY: Any injury included in the list under RIDDOR

CONTEMPORANEOUS: Contemporaneous records are those made during and immediately after the incident. This is essential for providing an accurate account of what happened. Failure to keep contemporaneous records could prejudice the validity of the evidence in court proceedings

2. INTRODUCTION

2.1 A24Group have a two tier system for the reporting of workplace incidents. This arises from the need to be informed both about the quality of the range of care services we provide and the health and safety of employees and temporary workers

2.2 To achieve a complete picture of our performance in delivering care services we intend to record all incidents that occur during the provision of care to service users,

employees and temporary workers alike. We will accomplish that by utilising an IT based recording system that stores the information gained on a database.

2.3 For all those employees who work in an office environment, and are not closely connected with service delivery, we use the corporate incident reporting system based upon use of the Accident Book. All of these incidents are similarly recorded on a database.

2.4 Trades Union representatives have a right to see all incident reports subject only to the permission of the persons involved.

2.5 The intention of both systems is twofold, firstly to gather data so that we can all learn from the experience and secondly to fulfil our legal obligation to report certain incidents under RIDDOR.

2.6 The details revealed in some incident reports will require the manager to carry out an investigation whilst others, of a minor nature, will only require that a detailed record is kept.

2.7 Incident reporting is mandatory and is an essential contributory factor in the update of risk assessments, maintaining quality of care provision and designing safe systems of work.

3. LEGAL REQUIREMENTS

3.1 Health & Safety at Work etc. Act 1974
Employers owe a duty of care for the health, safety and welfare of all employees and temporary workers whilst they are at work and to other people who may be affected by their activities. They must comply with the statutory duties contained within the Act, as amended, as well as those Regulations made under it.

3.2 Management of Health & Safety at Work Regulations 1999
Prominent among the requirements of these regulations is the duty to carry out suitable and sufficient risk assessments on all work activities.

3.3 Reporting of Incidents, Diseases & Dangerous Occurrences Regulations 1995 (RIDDOR)
Certain specified incidents must be reported to the Health & Safety Executive (HSE) within a given time period (see Appendices a & b)
http://www.riddor.gov.uk/reportanincident.html

4. INCIDENT REPORTING

4.1 It is imperative that all incidents and near misses are reported and all employees and temporary workers are required to inform their manager as soon as possible following an incident or near miss at work.

4.2 The reporting process should operate as follows:

4.2.1 The employee or temporary worker ensures that a record is made in the Accident Book. (In any event a record should be made as soon as possible even if it is properly transferred later)

4.2.2 The employee, or their representative, informs their manager about the Incident or near miss and gives any additional information that may be required.

4.2.3 The manager then decides whether the information supplied by the employee indicates that a full investigation may be necessary.

4.2.4 Some incidents will not need detailed investigation.

4.2.5 If the manager decides that a detailed investigation is needed, they should keep a record of their findings with the incident report or complete the appropriate section on the IT system.

4.2.6 All incident details received are entered onto a centrally managed database.

4.2.7 The A24Group complaints team read all Incident report forms and decide whether a formal investigation or further follow-up action is necessary in any cases. They will then contact relevant managers and other parties in order to prepare their own additional report.

4.3 Remember that the "potential" of the incident is the factor not necessarily the actual outcome. So for example a minor injury, but one where the person realistically could have been seriously injured or killed, could still be considered serious despite the minor outcome on the occasion being considered.

5 INCIDENT INVESTIGATION

5.1 Thorough investigation is fundamental to determining all the facts and root causes of incidents and remember, the information gained may be used as evidence in any future litigation.

5.2 Any investigation can only be as good as the method used to carry it out. It should always involve the systematic collection and evaluation of the facts, even those that may initially seem irrelevant or unimportant.

5.3 Start collecting information and evidence, including statements, for submission to any subsequent investigations. Take clear, contemporaneous records of the

circumstances, including written statements and for critical incidents these will need to be kept secure.

5.4 Where necessary preserve the site of the incident, and/or equipment involved, until the investigation is completed. Take photographs where possible.

5.5 Incident prevention can only be effective if the diagnosis arrived at during any investigative process is then used to suggest solutions and put corrective measures and action plans into practice to prevent reoccurrences.

5.6 In summary, effective investigations require that managers:

- Collect full details of the incident and establish all the facts surrounding it
- Learn from the experience and take steps to prevent a repeat occurrence
- Determine what action may be appropriate in the circumstances, that may include:
  - changes to a system of work
  - extra training courses
  - more information and/or instruction
  - closer supervision and/or monitoring

5.7 If an investigation reveals a failure of work equipment, personal protective equipment or a safe system of work, a risk assessment should be carried out to determine the levels of hazard and risk involved in the actions being taken at the time of the accident and appropriate measures that need to be introduced to control risks identified.

6. INCIDENT CATEGORIES

6.1 **MINOR**

6.2 On the IT based system, those incidents that get classified as Minor (no harm) will still need to be reviewed by the Complaints team. They should confirm first that the classification is correct (consider the potential for more serious harm occurring next time) and that no investigation needs to be carried out and whether there are any learning points that can be communicated to staff. Characteristics of minor incidents are:

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- No injuries or obvious harm
- Most incidents of harm to a person requiring simple first aid on-site
- No loss of property or minimal value loss only
- No significant likelihood of service issues arising from incident

6.3 **SERIOUS**

6.3.1 Incidents that get a serious classification will automatically go to the complaints team for monitoring and review. Managers have a responsibility to investigate and report back on all serious incidents but there may be a need for the Complaints team to carry out their own investigation as well. Examples of serious incidents are:

- Significant harm to any individual requiring more than simple first aid on-site.
- Small fires which are readily controlled by staff on duty
- Disruption to normal service activity
- Significant damage or loss of property
- Likelihood of wider service issues arising from incident

6.4 **CRITICAL**

6.4.1 Those incidents classified as critical will automatically generate action from senior management who will put into action the Critical Incident process (see section 7 below).

7. CRITICAL INCIDENTS

7.1 Critical incidents, such as an unexpected death or serious injury, are rare events but when they do occur it is vital that they are reported systematically, fully investigated to establish the facts, and that lessons are learned to prevent a recurrence. It is also important to provide support to staff, victims, their families and carers, and demonstrate appropriate accountability.

7.2 The aim of reporting incidents is to identify systems and processes which could be improved to promote safety and the reduction of risk to permanent and temporary staff, service users and other members of the public – not to apportion blame to individuals or teams. Given this aim, disciplinary action will not normally result from reporting incidents or near misses of any kind.

7.3 Where an investigation does suggest the need for disciplinary action this will be dealt with separately and will not form part of the critical incident investigation process. Such issues which could lead to disciplinary action will include:

i) criminal or malicious activities;
i) acts of misconduct;
ii) repeated errors or violations of written procedures;

iii) where, in the view of the A24group or the relevant professional body, the action(s) causing the incident were far removed from acceptable practice;
iv) there is evidence of an attempt to conceal the fact that an incident occurred or to tamper with any material evidence relating to the incident.

In such cases the concept of 'fair blame' (individual responsibility for individual actions in line with accepted principles of care and organisational governance) will apply.

8. INFORMATION & TRAINING

8.1 Managers are expected to ensure that all workers both permanent and temporary are appropriately skilled and trained to undertake the role, including information on how to report incidents.

8.2 Managers must ensure that they undertake training in carrying out incident investigations and that any staff involved in the process, for instance to input information onto the IT system, have the necessary competence required to carry out their duties.

8.3 The level of training should be appropriate to the needs identified in risk assessments.

9. EMPLOYEE AND TEMPORARY WORKERS RESPONSIBILITIES & RIGHTS

9.1 All employees and temporary workers have a general duty to take care of their own health, safety and welfare and that of other people who may be affected by their actions.

9.2 All employees and temporary workers are responsible for ensuring that:

- incidents are reported in accordance with this policy;
- they co-operate fully with investigations that may arise from an incident, including the retention of evidence relating to an incident;
- they attend necessary training related to incident reporting.

9.3 All types of incidents must be reported as soon as possible after the event. If staff (for any reason) do not feel able to report an incident or concern, to their line manager via this procedure, they must report the issues to an appropriate senior manager or via the Whistle Blowing Policy.

9.4 Whatever the nature of the incident it is the responsibility of the person(s) witnessing or discovering the incident or near miss to take appropriate

Immediate action to manage the incident, to minimise the potential adverse effects of the incident, to minimise the risk of the incident occurring again in the future and to inform the line/duty manager on site or wait until a senior manager arrives. This may involve:

- first-aid to an injured or distressed person (qualified persons only);
- securing individual service user's records; or
- modifying the environment by removing a hazard or placing a warning sign to alert others to the presence of the hazard.

9.5 If an employee or temporary worker is incapacitated enough to prevent them from reporting an accident, incident or near miss in person then a representative can do it for them.

9.6 In addition, employees and temporary workers have a right to be treated with fairness, equality, dignity and without discrimination; to know what is expected of them and be supported in managing their workload; be consulted about changes which affect their job; receive regular, constructive feedback on their performance at work and express their views and opinions in an appropriate manner without fear of reprisal.

10. MONITORING & REVISION

10.1 This procedure will be monitored and reviewed to ensure that standards are being achieved. A representative sample of workplaces will be selected for audit by the A24Group to monitor implementation of this policy.

11. MANAGEMENT PERFORMANCE STANDARDS

11.1 To comply with this policy the following standards must be met.
Line Managers will:

- read this policy thoroughly and follow the mandatory reporting and investigating procedures adopted by A24Group
- ensure that all staff both permanent and temporary are aware of their role in the reporting and immediate management of all grades of incidents and near misses
- ensure that there is an Accident Book available for workers to access and use where the IT system is not adopted. Where the IT based system is not in use the following process should be adopted:
  - make entry in the Accident Book
  - complete an incident form
  - decide classification of incident, i.e. Minor, Serious or critical
  - send copy of completed incident form to the complaints team
- ensure that copies of incident forms are available to Trades Union Reps where permission has been given by the employee or temporary worker concerned
- take responsibility for the immediate management of incidents as soon as they have been informed
- take appropriate immediate remedial action is taken to prevent recurrence, until the incident is fully investigated
  - carry out an investigation when necessary

- seek help and advice from appropriate persons within the department, e.g. complaints team when they are unsure about any aspects of an investigation
- report to external enforcing authorities or Police etc.
- ensure that action plans, for issues that are identified as a consequence of incident investigation, are implemented
- promote a culture of openness and honesty that will provide staff with the confidence to report incidents within a learning environment
- provide support to staff who have been involved in incidents to ensure that there is an opportunity to debrief fully and receive counselling where necessary
- ensure appropriate support is provided to victims, carers and families
- provide feedback regarding incidents to staff to enable the learning process to occur
- ensure that if an incident could affect the public health or be of public concern, information will be released (through the relevant channels) following authorisation from the Managing Director

11.2 The Complaints Team will:

- monitor all incident data collected.
- ensure that all SERIOUS incidents have been investigated and reported to the HSE where necessary
- participate as necessary in CRITICAL incident enquiries
- consider any reports brought to them regarding the outcome and lessons learned from incidents and recommend changes where necessary, to policies and procedures
- consider reports following Critical Incident investigations, endorse action plans and monitor their implementation

INCIDENTS THAT MUST BE REPORTED TO HSE

1. Any work-related incident where the employee or temporary worker is off work for more than 3 days, as defined in RIDDOR (see below), is reportable to the Health and Safety Executive (HSE). Incidents should therefore be reported promptly as we have to report the accident to HSE within 10 days.
2. Any incident that results in death or is serious or "major", as defined in RIDDOR (see below) and the employee or temporary worker is taken to hospital. These incidents must be reported to HSE within 24 hours by calling their contact centre http://www.riddor.gov.uk/
3. Any incident where a member of the public is injured, and this includes service users in Residential/Nursing Homes or at a Day Centre, and is taken to hospital, use the same procedure as in 2 above

Major Injuries (defined under RIDDOR):

1. Any injury which results in admission to hospital for more than 24 hours
2. Any fracture other than fingers, thumbs or toes
3. Any amputation
4. Dislocation of the shoulder, hip, knee or spine
5. Loss of sight (temporary or permanent)

6. Chemical or hot metal burn to the eye or any penetrating injury to an eye
7. Either acute illness requiring medical treatment or loss of consciousness that results from the absorption of any substance by inhalation or ingestion

Over three day injuries (defined under RIDDOR)

For RIDDOR reporting purposes, this means any injury that results in over three days incapacity for normal work. That is any time that extends into a fourth day or beyond but excluding the day of the accident itself.

When some of the incapacity includes weekends, holidays or off-shift time, it is still incapacity for work and the days must be counted. The sole criterion is whether the person would have been fit for normal duties, regardless of whether they were called upon to work or not.

"Incapacity for work" does not necessarily mean actual absence from work. If a person is incapable of doing the work which they might reasonably be expected to do, that is equally "incapacity for work".

SOME EXAMPLES OF WHAT SHOULD BE REPORTED TO THE HSE

1. An employee or temporary worker at work trips over, hurts themselves and is off work for 4 days.

2. An employee or temporary worker at work falls down a staircase and breaks her/his leg and is taken to Hospital.

3. An employee or temporary worker is attacked by a service user and as a result is off work for a period of time exceeding three days.

4. An employee or temporary worker is attacked and is taken to hospital with a serious (major) injury.

5. An employee or temporary worker is off work (for more than three days) from an upper limb disorder, e.g. from working too long at or sitting incorrectly at display screen equipment or from repetitive use of a piece of equipment.

6. An elderly resident falls and breaks their leg as a result of a hole in the carpet, or tripping over a vacuum cleaner lead or some other premises-related event.

7. An employee or temporary worker hurts her/his back as a result of moving and handling a person or object and is off work.

8. An employee or temporary worker is off work as a result of a bite from an animal while visiting a service users home.

9. An employee or temporary worker suffers a needlestick injury when they are accidentally pricked by a discarded hypodermic needle (dangerous occurrence).

CRITICAL INCIDENT STEP-BY-STEP GUIDE

1. If an incident is identified it should be reported to a line manager as soon as it is recognised. It is the line manager's responsibility to assess the severity of an incident and decide upon the level of investigation to take place. The manager should initiate investigations into the circumstances of an incident, even if they think it may turn critical,

Critical Incidents are:

- Death of any person other than expected deaths due to natural causes
- Serious assault or abuse of a service user, member of staff / temporary worker or member of the public
- Very serious injuries, harm or threat to any person
- Significant fire or explosion
- Missing person
- Hostage situation
- Serious environmental incidents
- Unplanned temporary service closure

2. If the line manager believes they have identified a critical incident they should contact the complaints team to advise/discuss the case and consider whether they should instigate a critical incident enquiry.

3. A24Group will identify a "lead" person for the critical incident investigation – usually a senior manager. They will also agree an investigation team within two working days of the incident. The investigation team appointed will vary according to the nature of the incident and will involve specialist advisers to support the team as necessary.

The team as a minimum will consist of the following members:

- an Investigation Team Chair – a senior manager (suitably trained) who is not directly involved in the sector where the incident took place
- the Manager of the sector where the incident occurred, or their nominee
- a professional adviser where appropriate

4. It is the Investigation Team Chair who is responsible for drawing up clear terms of reference, areas of responsibility and a timeframe for the Critical Incident Investigation Team. This should include a review of care and treatment (if relevant), risk assessment and risk management, whether actions carried out were done with reference to relevant legislation, company and national policies, agreed good practice, and with reference to the findings of any other relevant investigations or reports. Reference should also be made to obtaining the views of any victims, families and carers (of victim and perpetrator).
5. The Critical Incident Investigation Team is responsible for investigating the incident to to determine the immediate causes of the incident, any underlying

causes that contributed to the situation and to produce a report setting out their findings.

The Incident Investigation Team will:

- establish the basic facts of the incident (these should have been recorded initially on the incident form)
- confirm who was involved with the occurrence and who may have been a witness
- interview any individual who may be able to contribute to determining the causes of the incident
- obtain signed statements and give copies to the witnesses
- identify the exact location of the incident and visit the incident site if necessary
- quarantine the site if appropriate and/or take photographs
- identify whether equipment has been involved and if it has it should be labelled **do not touch** and preserved.(it may be necessary to seek advice/assistance from the appropriate supplier and care should be taken to ensure that no settings or dials are moved)
- ensure that where small items of equipment are involved, e.g. disposable items such as sharps, these should be removed, labelled and stored in a safe manner
- take expert or specialist advice to assist the work of the team
- identify strengths and weaknesses in systems, policies or procedures
- focus on the root causes of incidents and identify the nature of any interventions which may have prevented the incident from occurring or reduced the impact
- identify any learning points that need to be reinforced
- make recommendations that will prevent the incident reoccurring or reduce its likelihood or severity
- recommend improvement strategies to help prevent, or minimise recurrences
- agree a feedback process

6. Recommendations made by the Critical Incident Investigation Team will be discussed at senior management strategy meetings They will consider what needs to be done to ensure appropriate learning and feedback occur.

10. Senior Directors of the organisation will lead on all contact with the media.

11. Arrangements to inform members of families affected by the incident will be separate from the above.

12. In some circumstances an independent investigation may be needed in order to provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent.

An independent investigation should be undertaken in the following circumstances:

- when a homicide has been committed by a person who is or has been under the care (i.e. subject to a regular or enhanced care programme approach) of specialist mental health services in the six months prior to the event.

- in addition, the A24Group may itself, in certain circumstances of its own volition, commission an independent investigation. This decision rests with the Managing Director

14 When an incident involves the Unexpected Death of an older person, a decision about the nature of the investigation may be influenced by the outcome of the Coroner's findings.

Note:

It is important to note that the report following an investigation and all witness statements related to the incident are not legally privileged information. The data, to ensure compliance with Freedom Of Information Act 2005 might therefore be released to a client, the legal representative of the client, or the coroner. The report and the supporting information must be clear, accurate, concise and unambiguous. It is equally important to distinguish fact from opinion in the findings and recommendations.

The report may be submitted to the Coroner prior to any Inquest as they act as a useful summary of the care and treatment provided to the service user by the County Council. In such circumstances, the report will form part of the inquest documentation and could be made available to the family of the deceased.

MISSING PERSON PROTOCOL

This protocol summarises the arrangements that must be in place to ensure that every action to find a missing service user is carried out as quickly and effectively as possible..

1. Staff to keep themselves aware of the movements and habits of all service users, so far as is reasonably practical.

2. Staff to respond to alarm systems as soon as possible and try to prevent an event, such as someone leaving a building, escalating into a missing person incident.

3. If a Service User has shown a tendency to leave their care environment, or is known to be at risk of leaving on admission, an up to date photograph must be held on file. In addition a daily record of clothing needs to be maintained. In the event that the resident has left the Home this will assist the Police in finding the resident.

4. Particular attention to service users whereabouts should be maintained during summer months when outer doors are likely to be open to the garden, etc.

5. If trips are made out into the community by transport (such as a minibus), checks should be made to ensure everyone has re-boarded the transport after any stops have been made.

6. Any apparently missing service user must be reported to the Duty Manager without delay. Then if suspected missing:-

   6.1 Check with other members of staff and service users to discover if a anyone knows the whereabouts of the service user assumed missing.

   6.2 Organise a local search of the whole premises. Do not forget to checks staff toilets, walk in cupboards, laundry rooms, etc.

   6.3 Organise a search of the grounds and the immediate vicinity.

   6.4 Do a risk assessment and agree level of risk to self/others.

   6.5 Notify next of kin/ family/ or chosen contact.

   6.6 Contact by telephone any person the service user may have decided to v visit. This is particularly important in the case of a mobile service user who makes v visits on his/her own and may have forgotten to tell a member of staff.

   6.7 If the missing service user has not been seen during this working period, telephone all members of the previous working period to gain more information.

7. When all steps have been taken to locate the missing service user, and if it is judged by the Duty Manager that the service user could be at risk, the following steps must be taken:

7.1 A report must be made to the nearest Police Station by telephone (this report must in any case be made after 2 hours of the service user going missing).

7.2 The Registered Manager must be contacted by telephone.

7.3 The Operations Manager must be contacted by telephone.

7.4 The relevant details must be entered on the service users Care Plan.

7.5 An incident report must be completed, noting all persons contacted and the time of that contact.

8. The Registered Manager or Operations Manager will ensure all relevant Senior Managers are contacted and the Care Quality Commission must be notified on a Reg. 37 Form.

9. All relevant information, for example a photograph and details of clothing should be forwarded to the police as soon as possible following the initial contact made with them.