ACCIDENT AND INCIDENT REPORTING PROCEDURE

Introduction

Anglia Care Trust is committed to learning from incidents therefore it is very important that incidents are reported promptly and that a full record of the circumstances is completed within the timeframes outlined in these guidelines.

All accidents and incidents need to be reported promptly and investigated as soon as possible so that we can:

- Meet our legal obligations to report certain incidents
- Reduce risk to staff, volunteers, contractors and members of the public
- Collect and study information on accidents, incidents and near misses to learn lessons
- Identify trends and take action to prevent accidents from happening or being repeated.

All incidents and near misses should be reported as soon as possible using the Incident Reporting Form Part A and follow the process detailed below.

Following any incident or near miss the Operational Manager should complete Part B of the form, which details further investigations of this is required, and follow the process below.

Definitions

Incidents can be categorised using the following definitions:

Health and Safety Incident - Any **work related** incident that caused harm or could potentially have caused harm. This includes accidents to employees and non-employees, damage caused by physical environment, ill health, acts of violence (including physical and verbal abuse and threats) and road traffic accidents.

Support Incident - A support incident is an event or circumstance resulting from support which led to unintended harm to a person (including employees, and non-employees), loss or damage, and/or a complaint (in this instance, the complaint and incident reporting process is to run concurrently). This includes exposure or potential exposure to incidents relating to or resulting from keyworking and support planning. **(See Appendix B for examples).**

Non-Support Incidents – are events which expose the organisation to business risk such as financial imbalance, reputational risk through media interest.

Near Miss - Near misses are non-injury incidents that had the potential to cause harm (also known as “dangerous occurrences”). It is an incident where although no immediate harm, loss or damage was suffered, if not investigated the incident could reoccur.

Incident and Near Miss Reporting

A brief summary of procedures is given below:

Immediate action

When an incident or near miss has happened it is important that:

- The immediate needs of those involved are dealt with
- The environment is made safe to prevent further incidents and to safe guard others
- All evidence is retained intact and in safekeeping for examination
- Any defective equipment is withdrawn from use.

Initial reporting

When an incident or near miss occurs, it is reported by the primary witness or relevant member of personnel to an appropriate line manager using the Incident Reporting Form. **This must be done without delay.** This should be completed electronically to ensure clarity.

Line manager

1. Checks that the Incident Reporting Form section has been completed correctly
2. Completes Part B of the Incident Reporting Form (also electronically)
3. Forwards both sections of the Incident Reporting Form to the Operational Manager to review and then forward to the Director of Business Support **within 3 working days of the incident happening**. Incidents that have scored 15 and over must be reported within 24 hours (please see the Critical Incident reporting procedure below for more information)
4. Investigates the incident and develops an action plan
5. Implements the action plan
6. On completion of the investigation and implementation of the action plan the risk score must be revised to minimise the risk to an acceptable level (i.e. 9 or below). If this is unachievable advice should be sought from the Director of Business Support.

If the incident relates to a Service User their confidentiality must be maintained. This can be achieved by using their initials and date of birth.

Critical Incident

A Critical Incident is an accident or incident meeting one or more of the following criteria:

- A Service User, member of personnel or member of the public suffers serious injury, major permanent harm or unexpected death
- A Service User, member of personnel or member of the public is at risk of death or serious injury
- An event that might seriously impact upon the delivery of Anglia Care Trust's services
- An event that may attract media attention and/or result in a settlement following litigation
- An event that reflects a serious breach of health and safety, standards or quality of service
- An event constituting a breach of duty of care or professional governance giving rise to the suspension of a member of personnel or allegations of gross misconduct and requires an investigation of incident alongside disciplinary investigation
- A red rated incident – (i.e. scores 17 or over on the Risk Assessment Matrix).

All Critical Incidents should be reported on the Incident Reporting Form within **24 hours** of the incident taking place and forwarded to the Director of Business Support.

Immediate measures must be put in place pending an in depth investigation. In addition, the line manager will either undertake or appropriately delegate the following:

- The production of the Critical Incident Summary Sheet which must contain an accurate chronological report of the support of the client leading up to the incident;
- Provide a copy of the Service User's most recent Support Plan and Risk Assessment;
- Recommendations to prevent further incidents.

This must be forwarded electronically to the Director of Operations and Director of Business Support within 5 working days of the date of the incident.

This information will be presented to the Senior Management Team to determine whether further investigation is necessary. If this is the case, a Full Critical Incident Investigation will be requested. It is the responsibility of the relevant Director and Operational Manager to ensure that all appropriate remedial action is undertaken following the investigation.

In the case of serious harm / death of a Service User or member of the public, the Senior Management Team have direct responsibility for ensuring that any possible compromise in the delivery of service is contained and addressed, and that any media interest is properly dealt with, through the Business Support Team.

Investigating a Critical Incident

Should there be a request for a further investigation the required paperwork must be completed without delay. This should contain a root cause analysis, and identify specific factors / triggers that have contributed to the incident occurring. In addition to forwarding this information to the Director of Operations and Director of Business Support these forms must also be stored locally and be readily available should an external investigation take place.

When documenting a Critical Incident the account should be factual and objective. Electronic records and the Service User file should be used to create this report.

You should include the following information:

- Date and route of referral
- Dates of Service User contacts and issues arising (include all support plans and reviews, GP appointments, crisis interventions, correspondence with relevant agencies, hospital admissions etc)
- Dates and details of events immediately leading up to the incident.
- Date service informed of the incident and action taken.
- Detail Anglia Care Trust involvement and attempts to engage.

RIDDOR incidents

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (known as RIDDOR) require us to make a report of specified accidents and injuries to the relevant enforcing authority within certain time-scales. All RIDDOR incidents should be reported to the Business Support Team by the Operational Manager. A table in **Appendix A** explains the type of event that is RIDDOR reportable, but the main categories are:

- Death or major injury e.g. fracture of limb, amputation etc
- Over 7 day injury where someone is off work for more than 7 days as a result of an injury at work.
- Member of the public taken to hospital from our premises (if actual injury occurs, not just as a precautionary measure).
- Certain occupational diseases.

It should be noted that RIDDOR incidents must be work related. The fact that there is an accident at a work premises does not, in itself, mean that the accident is work-related – the work activity itself must contribute to the accident. An accident is 'work-related' if any of the following played a significant role:

- the way the work was carried out
- any machinery, plant, substances or equipment used for the work or
- the condition of the site or premises where the accident happened

Reporting can be done online at www.hse.gov.uk/riddor

Shared Premises and Outreach

Any incident which happens on Anglia Care Trust or non-Anglia Care Trust premises involving an Anglia Care Trust member of personnel or an Anglia Care Trust Service User should be reported and investigated. This includes incidents and near misses that occur at an outreach or satellite/host location.

All incidents on Anglia Care Trust premises (including those that involve partner agency staff or clients or contractors) should be reported.

Record keeping

Copies of the Incident Reporting Form should be retained for 2 years in a secure and easily retrievable way by the Business Support Team. Following this time frame they should be archived for a minimum of 6 years. These must be readily available for inspection by the enforcing authorities or during internal audit.

Anglia Care Trust staff at host locations / off site

Anglia Care Trust is responsible for making RIDDOR reports for all incidents that involve injury to directly employed Anglia Care Trust personnel, wherever they are based or were working at the time. A host may also make a report, but the legal duty to report under RIDDOR remains with Anglia Care Trust.

Volunteers

Volunteers should always be treated as if they are directly employed.

Incidents involving more than one person

If there are several people involved in an incident, there is room on the form to complete the basic details for each person.

Investigating accidents

For those incidents classed as 'Accidental Injury' that require investigating, the following may be useful:

- It is hard to get too much information about an accident. What may appear to have been a simple accident may have contributing circumstances that are quite involved. Underlying causes need to be revealed so that the organisation can learn any important lessons

there are, and take action to make sure the same accident cannot happen again.

- A report that a member of personnel “fell over” or “tripped on the stairs”, gives no clue as to how or why the accident happened. How far did they fall? Were they at the top or bottom of the stairs? Was the trip due to a fault in the carpet, an obstacle on the stairs, or because they were running? If so, why were they running? Get the whole story. Never say a colleague was “careless”. This is an effect, not a cause. If you think they were careless, find out why – there is always a reason
- The level of detail you go into when investigating should be in proportion to how serious the incident **could** have been, not only how serious it actually was
- Remember that photographs and drawings are often very helpful and can reduce the amount of narrative you need to include
- An incident of violence will need particularly careful investigation to find out if there were any weaknesses in training or procedures etc.

When investigating, bear in mind the following principles:

- **Use common sense** – stick to the facts, weigh their value, and reach justified conclusions.
- **Investigate each clue** – exploring factors that may not appear to be important will often change an apparently reasonable conclusion.
- **Check for unsafe conditions and unsafe acts** – both are present in the great majority of accidents.
- **Make recommendations** – no investigation is complete unless corrective action is suggested.
- **Investigate all accidents** – chance is often the sole difference between a trivial accident and a serious one. Results cannot be predicted.

Questions to consider:

1. What exactly was the person doing at the time of the incident?
2. What are the safety procedures or standards covering the task?
3. What was the person's competence to undertake the task?
4. What do you think were the causes of the incident?
5. What led up to each of the causes?

1. Preliminary cause

Unsafe conditions	**Unsafe behaviour**
Congestion and obstruction	Failure to secure
Defective equipment	Equipment improperly used
Housekeeping	Protective equipment not used
Inadequate guarding	Safety device made inoperable
Inadequate protection	Use of defective equipment
Poor lighting	Operating without authority
Hazardous surface	Abuse/misuse
Inadequate tool	Failure to use correct procedures
Environmental	Horseplay

2. Underlying causes

Safety management	**Personal factors**
Poor design	Lack of training
Poor maintenance	Lack of skill and knowledge
No safe operating procedures	Physical incapacity
Poor equipment standard	Taking short cuts

Poor supervision	Failure to report fault
Poor job layout	Physical stress
Inadequate procedure/standard	Psychological stress

Witness statements

In even relatively trivial incidents brief statements should be taken from witnesses, including the injured person where appropriate. Witnesses should be interviewed as soon as possible after the event, and a record made of what they say. Clearly, there is a need to be sensitive when interviewing people who may be very distressed, but it is important that a record is made before minds become clouded by rumour and hearsay.
Interview people at the scene of the incident if possible, as this helps with memory and accuracy.

Statements should be written using the witness' own words. Write (or type them up) on plain paper, include the witness' name, address and age, and ask them to sign and date each page. The interviewer should also sign and date the witness statement.

When interviewing, get the witness to talk about what led up to the incident, not only what happened afterwards. This is often the most important information so try to make sure it is included in the statement. Remember to remain unbiased – it is important to ask open questions that are not leading.

The person is entitled to a copy of his or her own statement, but copies should not be given to anyone else without first seeking advice from the Business Support Manager.

Date of next review – October 2019

Appendix A

RIDDOR reportable incidents
The following table gives a list of RIDDOR reportable incidents and the timescales within which a RIDDOR report should be made.

Event	Legal reporting requirement and time scale
Work-related death or major injury to a member of staff, including: ▪ broken bone (other than finger, thumb or toe) ▪ any amputation ▪ dislocated shoulder, hip, spine or knee ▪ temporary or permanent loss of sight ▪ hot metal, chemical or penetrating injury to the eye ▪ injured by electric shock or burn leading to unconsciousness, or requiring resuscitation or admittance to hospital for more than 24 hours ▪ hypothermia or heat-induced illness ▪ unconsciousness ▪ requires resuscitation ▪ is admitted to hospital for more than 24 hours ▪ illness due to exposure to dangerous chemical or gas that has been inhaled, ingested or absorbed through the skin	Report as soon as possible. Telephone reports to be followed-up with a written report within 10 days.
Member of staff suffers an injury or ill health condition caused by work that causes them to be off sick or unable to do their normal work for **more than 7 days**. This includes absence or inability to do your normal work following an assault.	Written report within 15 days of the incident or within 15 days of finding out about it. When calculating the 7 day period, include: ▪ non-working days e.g. weekends and days off ▪ days someone is still at work but on "light duties" because of an accident at work
Client or member of the public/relative is taken **directly** to hospital from the project as a consequence of injury sustained while on the premises and related to Anglia Care Trust's operations. **Does not include**: ▪ heart attack/stroke etc	Written report within 10 days of the incident or within 10 days of finding out about it.

Event	Legal reporting requirement and time scale
▪ assault by one member of the public against another **Does include**: ▪ tripping over carpet or trailing lead ▪ child scalded by hot liquid	
Member of staff contracts HIV, hepatitis or any other blood borne infection known or suspected to have arisen as a result of exposure to infective material **while at work**.	Written report within 10 days of the incident or within 10 days of finding out about it.
A needle stick injury is only RIDDOR reportable if it involves a needle used or known to have been used by an infected person, or if disease develops in the injured person.	Written report within 10 days of the incident or within 10 days of finding out about it.
Various other serious events such as catastrophic failure of a lift, fires and explosions rendering the building unusable for 24 hours or more, building collapse etc. (fault or premises failure)	Seek advice from Director of Business Support
Acute and chronic conditions in hands, wrists and forearms, potentially related to repetitive movements e.g. typing.	Seek advice from Director of Business Support.

Appendix B

Examples of reportable incidents or near misses

Finding of sharps on premises

Finding of drugs on premises

Needle stick injury

Drug overdoses

Violence and aggression (including client's intent to cause harm to themselves or others)

Assault

Allegations of Sexual Assault

Car Accidents