****

**Incident Management Policy**

**[Date of Issue]**

|  |  |
| --- | --- |
| Policy Lead: | [Policy Lead] |
| Version No. | 1 |
| Date of Issue: | [Date of Issue] |
| Date for Review: | [Date of Review] |

CONTENTS

[1. Introduction 3](#_Toc147999366)

[2. Policy Statement 3](#_Toc147999367)

[3. Scope 4](#_Toc147999368)

[4. Definitions 4](#_Toc147999369)

[5. Incident Reporting 4](#_Toc147999370)

[6. Incident Investigation 5](#_Toc147999371)

[7. Root Cause Analysis 6](#_Toc147999372)

[8. Trend Analysis 6](#_Toc147999373)

[9. External Reporting 6](#_Toc147999374)

[10. Training 7](#_Toc147999375)

[11. Monitoring 7](#_Toc147999376)

[12. Related Policies 7](#_Toc147999377)

[13. Legislation and Guidance 8](#_Toc147999378)

[14. Appendix 1: Incident Report 1](#_Toc147999379)

[15. Appendix 2: Root Cause Analysis 1](#_Toc147999380)

[16. Summary of Review 1](#_Toc147999381)

# Introduction

Responding appropriately to incidents or circumstances that have caused, or may cause, harm to clients, staff, or visitors is a key part of the way that [Company Name] continually improves the safety of its services.

[Company Name]’s responsibilities also include monitoring safety, preventing and reducing risk, carrying out risk assessments, raising the profile of any incidents and unsafe practices to staff, and adhering to the law.

[Company Name] aims to ensure that lessons are learnt from all accident, incident or near miss events which may have the potential to harm people or the business. Where possible, [Company Name] will aim to reduce or eliminate such incidents.

This policy outlines the processes for ensuring that incidents are reported in a timely and accurate way, robustly investigated, and improvements implemented when necessary.

# Policy Statement

[Company Name] recognises the importance of reporting all accident, incident or near miss events as an integral part of its risk identification and risk management strategy.

[Company Name] is committed to ensuring the safety of all clients who use its services, to improve the quality of care delivered, and to ensure the safety of staff and members of the public.

No matter how minor an incident or accident, or near miss is, [Company Name] expects that the event should be reported to management and recorded on the incident management system within 24 hours of the incident occurring.

The investigation of an incident forms part of a wider strategy of risk management, which promotes the use of root cause analysis to understand why an incident occurred. [Company Name] will ensure that business-wide learning and subsequent actions remain central to the risk management approach outlined in the Quality Assurance Policy and Governance and Risk Policy.

# Scope

This policy and the procedures apply to all staff and independent contractors within [Company Name].

The Registered Manager has overall responsibility for promoting an open and transparent culture.

# Definitions

**Accident -** an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.

**Incident** - an event that causes, or has the potential to cause, harm to an individual, financial loss or damage to property or the business and/or a threat to business operations or business reputation.

**Near miss** – an unplanned event that did not result in the harm described in the definition above but had the potential to do so.

# Incident Reporting

The reporting of all actual and near-miss incidents is a key factor in facilitating business wide learning, which will consequently reduce the risk of a similar incident happening again if appropriate remedial actions are implemented.

[Company Name] actively encourages all staff to report any incidents that they come across in their day-to-day work. [Company Name] understands that to build an open and transparent culture, it is preferable to over-report than under-report incidents and, as such, no staff members will be disciplined for incidents reported. However, staff should be mindful to use the appropriate reporting channel and use the Whistleblowing Policy or Grievance Policies if these are more appropriate.

Ideally the person to report an incident should be the person who was directly involved in or witnessed the incident first-hand. To report an incident, the incident form document should be completed in full. If for any reason the electronic incident reporting system is not available, a template form is available at Appendix 1 of this policy.

The report should include a full and comprehensive account of the incident, sticking to the facts as the reporter understands them. Details of any immediate actions taken should be included, as well as events from the time that the incident occurred, to ensure that the details surrounding the incident are accurate.

No personal identifiable information should be used on incident reports, instead clients reference numbers or staff roles should be utilised. This is to protect clients and staff confidentiality should [Company Name] be asked to share details of the incident externally.

# Incident Investigation

The aim of an investigation is to understand the circumstances which led to the incident occurring and to reduce the risk of such an incident happening again in the future. The lessons learned will be shared widely to ensure that each business area is able to benefit.

The purpose of an investigation is not to blame any individual for the fact that the incident happened, however, if there has been a deliberate violation of policy, the perpetrator will be held to account for their actions and may be subject to disciplinary action. [Company Name] understands that everyone makes mistakes, and the investigation process should be a supportive one for staff members.

Once an incident has been reported, the Registered Manager is responsible for completing an investigation. The investigation should be completed within 4 weeks of the incident occurring and should address each of the following four points:

1. Documentation of the outcome of the incident (e.g., did the client suffer harm and if so what harm?).
2. What controls had already been implemented prior to the incident to reduce the risk of the incident occurring (e.g., had a risk assessment already been completed?).
3. What actions can be implemented now to reduce the risk of a similar incident happening again for this individual (e.g., use of a lo bed).
4. What wider actions can be implemented to reduce the overall risk of a similar incident happening for someone else (e.g., falls training for the team?).

Investigations may make use of some, or all, of the following techniques:

* interviews with concerned parties
* obtaining written witness statements
* photographs of the scene of the incident
* inspection of the location of the incident (including any equipment involved)
* cross referencing of actual events with [Company Name]’s policies and procedures.

# Root Cause Analysis

[Company Name] is committed to reducing harm to clients wherever possible and, to ensure continuous improvement, some incidents have been identified as requiring a more in-depth analysis.

Incidents which result in moderate (resulting in a moderate increase in treatment but did not cause permanent harm) or severe (permanent) harm will trigger the requirement for the Registered Manager to complete a (RCA) Root Cause Analysis. A sample form is attached in Appendix 3 below.

The RCA should identify the trigger factors for the incident and most importantly outline a clear action plan with SMART actions (Specific, Measured, Agreed, Resourced, Timed). Completion of the RCA investigation will dovetail with the process outlined within the Duty of Candour Policy, and as such should be made available to the Relevant Person.

# Trend Analysis

The Registered Manager is responsible for ensuring that incident trends are analysed at a business and operational level and that the findings and lessons learned are discussed at the monthly quality meetings.

# External Reporting

Sometimes there is a need to report incidents to external parties within a given time frame. The Registered Manager is responsible for ensuring that the external parties below are notified immediately:

* The Police must be informed of any death directly because of an incident, or any major injury as a result of a Road Traffic Collision or assault whilst on company business. Copies of any available details should be sent to the police and a record should be kept on the Incident Management System of the police officer’s name together with a summary of the discussion.
* The Care Quality Commission (CQC) must be informed of all incidents that relate to a death, injury, abuse or an allegation of abuse or an incident being investigated by the police.
* Incidents involving safeguarding concerns should be notified to the local authority safeguarding team, in line with the Safeguarding Adults and Safeguarding Children Policies and Procedures.
* The Health and Safety Executive (HSE) must be informed of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents (see [Company Name]’s Health and Safety Policy for further details).
* [Company Name]’s insurer should be informed of all RIDDOR reportable incidents, deaths following an incident, cases of alleged abuse or neglect, incidents involving a head injury or incidents where the threat of a claim has been made.

# Training

The Registered Manager is responsible for ensuring that all new staff members are made aware of how to report an incident during their induction.

# Monitoring

Compliance with this policy will be monitored through the analysis of themes and trends identified from incident reports and Root Cause Analyses.

These will then be discussed at monthly team meetings and the outcomes and improvements shared throughout the business.

# Related Policies

* Bullying and Harassment Policy
* Complaints Policy
* Disciplinary Policy
* Duty of Candour Policy
* Health and Safety Policy
* Infection Prevention Policy
* Governance and Risk Policy
* Quality Assurance Policy
* Safeguarding Policy

# Legislation and Guidance

**Relevant Legislation**

* Health and Safety at Work etc Act 1974
* Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
* Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

**Guidance**

* HSE HSG: Reducing Error and Influencing Behaviour
* National Patient Safety Alerts - <https://www.england.nhs.uk/patient-safety/patient-safety-alerts/>
* HSE Health Service Information Sheet No 1 – Reporting injuries, diseases and dangerous occurrences in health and social care. Guidance for employers (10/2013)

# Appendix 1: Incident Report

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Incident REF Number
 | 1. Date of Incident
 | 1. Time of Incident
 | 1. Location of Incident
 |
|  |  |  |  |
| 1. Details of Injured Person
 |
| Forename | Surname | Address |  |
| 1. Status of Affected / Injured Person (tick box)
 |
| Employee |  | Patient  |  | Member of the public |  | Other  |  |
| 1. Type of Incident
 |
| Slip/ trip or fall at same level |  | Exposure to fire |  | Injured while moving and handling |  | Exposure to, or in contact with, a harmful substance |  |
| Act of violence or assault to staff |  | Fall from height |  | Contact with equipment / machinery |  | Hit by a moving / flying / falling object |  |
| Restraint used |  | Diagnostic incident |  | Medication prescribing incident |  | Infection related incident  |  |
| Failure or delay in acting on results |  | Known complication of surgery |  | Medication administration incident  |  | Other |  |
| 1. Description of incident *(What was the injured person doing at the time of the incident / how did the incident occur? Attach drawings and photographs as necessary)*
 |
|  |
| 1. Details of Injury
 |
| What was the injury?*(e.g., laceration, fracture, burn etc)* |  |
| What part of the body was injured?*(Include left or right)* |  |
| 1. Treatment required YES / NO
 |
| First aid |  | Referred to GP |  | Referred to A&E |  | Hospitalised  |  | Major injury  |  | Death  |  |
| Absence from work |  | Date Absence started  |  | Date returned to work  |  |
| 1. Details of Treatment Given *(include reports from hospital. Include pulse & BP, resps, GCS score (if taken))*
 |
|  |
| 1. Witnesses *(include statements if necessary)*
 |
| Name  | Name |
| Address | Address |
| 1. Follow up Actions Required YES / NO
 |
| Duty of Candour triggered YES / NO | RCA required YES / NO | RIDDOR Reportable YES / NO |
| Reported to CQC YES / NO | Reported to LA under Safeguarding Policies YES / NO |
| 1. Registered Manager informed
 | 1. Relevant Person Informed (if Duty of Candour Triggered)
 |
| By whom:Date / Time | Name of Relevant Person:Notified by:Date / Time: |
| 1. Person Completing this form
 | 1. Job Title
 | 1. Date of Completion
 | 19 Signature  |
|  |  |  |  |

|  |
| --- |
| **CONFIDENTIAL** |
| **Root Cause Analysis - Investigation** **This documentation need only be completed where risk rating scores are 8 or above** |

# Appendix 2: Root Cause Analysis

**GUIDANCE ON HOW TO COMPLETE THIS CAN BE FOUND ON PAGE 7**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Incident ID Number** | Click here to enter text. |  | **Incident Risk Score** | Choose an item. |
| **Location of Incident** | Click here to enter text. |  |  |  |
| **Date of Incident** | Click here to enter a date. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Investigating Officer** | Click here to enter text. | **Job Title** | Click here to enter text. |
| **Telephone Number** | Click here to enter text. | **Fax Number** | Click here to enter text. |
| **Team** | Choose an item. | **Home** | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| **No.** | **Investigation Query** | **Investigation Findings (please delete guidance notes)** |
| **1.** | **Background and any relevant information / history** |  |
| **2.** | **Description of the event and immediate actions taken** |  |
| **3.** | **Sources of information gathered** |  |
| **4.** | **Did you identify any deviation from current systems during your investigation?** | **Yes** | ☐ | **No** | **☐** | If ‘yes’, what remedial action have you taken? |
|  |
| **5.** | **Have any of the following issues been identified during the investigation? (place a X in the relevant box)** | **Training / Education** | ☐ | **Staffing resource** | ☐ | **Communication**  | ☐ | **Local environment factors** | ☐ | **External factors**  | ☐ | **Other Factors** | ☐ |
| If ‘yes’ to any, Include remedial action that you have taken or plan to take in the action plan  |
| **6.** | **Duty of Candour** When patients are harmed as a result of an incident, it is a legal requirement to inform the Relevant Person as soon as possible.  | **Please advise what was said to the relevant person immediately following the incident** |  |
| **Who spoke to the relevant person** | **Name and title** |  |
| **Has the Duty of Candour been triggered?**  |  |
| **If yes, has the Relevant Person received written notification?** |  |
| **7.** | **Was there a need to provide immediate support to the team members involved?** | **Yes** | ☐ | **No** | ☐ | If ‘yes’, Include remedial action that you have taken or plan to take in the action plan |
|  |
| **8.** | **Is there or should there have been a risk assessment completed in relation to this incident?** | **Yes** | ☐ | **No** | ☐ | If ‘yes’, Include remedial action that you have taken or plan to take in the action plan |
|  |
| **9.** | **What trigger factors have you identified as the Root Cause of this Incident?** |  |
| **10.** | **What lessons have been learnt as result of this investigation?****Please also document how this information will be communication and acted upon.** | **Local Learning (implications for the team / business area)** |
|  |
| **Business-wide Learning**  |
|  |
| **11.** | **Distribution List** | Copy to:* Registered Manager
* Team leader
* Attached to incident management system
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Action** | **Person Responsible for Implementing Action****(named individual)** | **Evidence** | **Uploaded to incident management system** **(Yes / No)** | **Date for completion****(i.e 30/09/2021)** |
| Share the outcome of the investigation with all team members in which the incident occurred.  | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Ensure actions related to Duty of Candour are completed and documented on incident management system | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Choose an item. | Click here to enter a date. |

**Root Cause Analysis (RCA)**

**Root Cause Analysis is an investigative tool used to understand why an incident has occurred.**

**Purpose**

The business has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and more specifically in accord with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. It is also a requirement to report certain incidents to a national body (e.g. Medicines and Healthcare Regulatory Agency, Care Quality Commission) within a specific timeframe.

**How to Complete this Document**

* This document is designed to be completed electronically.
* If you are unsure about any section, please contact your Registered Manager for guidance.
* Following completion of the RCA, review any areas in which you have ticked ‘yes’. For each section with a ‘yes’ you should consider an action to prevent or minimise the risk from recurring.
* In developing your action plan, consider the following headings:
	+ **Eliminate**; can you eliminate the problem, for example stopping a high-risk procedure altogether or not using a hazardous piece of equipment?
	+ **Substitute**: can you substitute the problem with something less harmful? An example is the use of latex free gloves for staff allergic to latex.
	+ **Isolate/distance**; can you isolate or distance the problem from people?
	+ **Safe Systems of Work**; can you create, or improve upon, safe operating procedures to minimise or eliminate the problem?
	+ **Training/knowledge/information/supervision**; can you provide additional training or supervision to team members to minimise or eliminate the problem?
	+ **Personal protective equipment**; can you provide protective equipment to staff or patients to minimise harm to them? Examples include hip protectors for patients at risk of falls, eye protectors to prevent splash injuries, sharp boxes to prevent sharps injuries etc.

# Summary of Review

|  |  |
| --- | --- |
| Version | 1 |
| Last amended | [Date of Issue] |
| Reason for Review |  |
| Were changes made? |  |
| Summary of changes |  |
| Target audience | Care staff, Managers |
| Next Review Date | [Date of Review] |