Incident Reporting Policy

Kernow Positive Support

SPECIALISED HIV
INFORMATION,
SUPPORT,
RESPITE &
RETREAT

POLICY DOCUMENT 2017

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KPS Serious Incident Investigation & Reporting Policy

Introduction

As part of its commitment to risk management KPS will ensure that a system is in place to enable any Accident, Serious Incident or Near Miss to be reported, recorded and investigated. An effective reporting system will enable KPS to identify and rectify any weaknesses, failings to enable provision of a safe working environment.

It is the policy of KPS to identify and investigate Serious Incidents, Accidents or Near Misses, their source and hence their underlying causes. This will enable staff to provide effective support to those who may have been affected. This policy outlines the procedures that are to be adopted when any employee, client (service user), visitor or contractor experiences an Accident, Serious Incident or Near-miss on the company's premises.

To enable this objective to be achieved it is imperative that all accidents, irrespective of the resulting injury or damage, be reported according to the laid down procedures.

Definitions

Accident: “any unplanned event that results in personnel injury or damage to property, plant or equipment.

Serious Incident: The definition of a Serious Incident any serious incident in which a Client (service user), member of staff or volunteer comes to such harm that it is likely to result in legal action and/or adverse media coverage.

Near Miss: an unplanned event which does not cause injury or damage, but could have done so.

In order to avoid misunderstanding, the company deem an Accident, Serious Incident, and Near-Miss to be defined thus:-

- Death of an employee, client (service user), visitor or contractor
- Personal injury or harm to an employee, client (service user), visitor or contractor
- Physical assault
- Abuse or allegations of abuse
- Damage to KPS property, equipment; personal or organisational information
- Complaint relating to Service User Care/Support
- IT or equipment failure; prevention or threat of prevention to the organisation’s ability to continue to deliver services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment.
- Unplanned events which do not cause injury or damage, but could have done so.
- Examples include: items falling near to personnel, incidents involving equipment and systems. (Near Misses)
- Adverse media coverage or public concern about KPS.

Predictable and regular behaviours of a service user should not be considered as an adverse incident unless these involve physical assault.

Objectives

The main objectives of this Policy are:-

• To enable prompt remedial action to be taken and to prevent recurrence.

• To ensure compliance with current legislation, e.g. RIDDOR.

• To enable the KPS Responsible Trustee and Trustees to monitor the effectiveness of

health, safety and risk management arrangements
• To assist decision making, planning and future resource allocation

Scope of procedure

These procedures should be used in the case of any Accident, Serious Incident or Near Miss involving a member of staff, Volunteer , Client (service user) or visitor or contractors to KPS premises. This also includes Serious Incidents involving any member of staff in the course of their duties away from KPS premises or service users on day outings or elsewhere whilst under the care of KPS. In the context of this policy, it is inappropriate to report the long-standing behaviours of a Client (service user) that regularly occur, which are clearly addressed within that service user's support plan (e.g. verbal abuse). However, any incident, which results in physical injury or where the risk of physical injury is narrowly avoided, must be reported using an Accident, Serious Incident Report Form.

General principles

It is the responsibility of all staff to take reasonable care of themselves and of others who may be affected by their acts or omissions.
Staff shares a responsibility for being alert to the behaviour of their employer, other employees, clients and volunteers. Individually staff members must be aware that anything they notice at work that appears to be unusual practice or behaviour or causes them to feel uncomfortable should be raised by informing the Responsible Trustee or a Trustee.
Verbal aggression, actual or attempted physical aggression is not an acceptable part of any job and requires a considered, co-ordinated and professional response. KPS is a charity specialising in the provision of support for people affected by HIV whose ability to communicate may be frustrated by significant intellectual impairment or illness. Our service users may also have underdeveloped or impaired emotional control. These factors may result in high levels of aggression at times.
It is the responsibility of each member of staff to inform the Responsible Trustee promptly (within 24 hours) of any Accident, Serious Incident or Near Miss. Each member of staff must be fully aware of the reporting procedure and it is the responsibility of the Responsible Trustee to ensure that this is done.
When a Serious Incident involves major injury the scene of the incident should not be disturbed until an investigation has taken place.

Accident Books

All accidents must be entered in the appropriate KPS Accident Book either by the injured person or if this is not practical someone else present at the time.
These accident books will be reviewed regularly by the Responsible Trustee to ascertain the nature of incidents which have occurred in the workplace. This review will be in addition to an individual investigation of the circumstances surrounding each incident.
All near-misses must be reported to the Responsible Trustee, as soon as possible so that action can be taken to investigate the causes and to prevent recurrence.

Reporting Procedure:-

Employees/Volunteers

The Staff Member or Volunteer must then:-

- Note that the accident has occurred.
- Ensure that the Accident Book has been correctly and fully completed.
- Immediately alert the Responsible Trustee of The Accident Report.

Visitors / Contractors

Any non-employee who experiences an accident or near-miss incident whilst on the premises must report the incident immediately to the person responsible for his or her premises on site. If the person responsible is not available, the visitor/contractor

must obtain the assistance of a responsible person to ensure that the company procedure is adhered to.
All injuries must be reported in the accident book, however minor. Visitors and contractors who are unable to enter their account into the book must arrange for another person to make an entry on their behalf. Visitors and contractors should also notify their own employer where applicable.
Immediately alert the Responsible Trustee of The Accident Report.

Damage / Theft

All accidents / incidents which result in the loss or damage to property or equipment should be reported. Damage could be as a result of impact from moving objects, vandalism, fire, storm, collapse; but not necessarily personal injury must be reported to the Responsible Trustee. Unexplained loss of any equipment or personal belongings of any Client (service user) or staff member is also reportable.
Reporting a serious incident:
The staff who were involved in, witnessed or discovered the incident, should complete the Incident form(s)
When completing the incident form, record only facts not opinions or assumptions
The Responsible Trustee or responsible member of staff must ensure that as far as reasonably practicable all appropriate actions have been taken to remove or reduce the likelihood of the incident occurring again.

RIDDOR

An adverse incident report must be completed within 24 hours for any incident that has or may adversely affect any individual. In certain cases this is a legal requirement in some cases,
INCIDENTS REPORTABLE UNDER THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 1995 (RIDDOR)
Employers are required to report to the Health & Safety Executive any adverse incident involving:

- deaths or major injuries
- accidents resulting in over 3 day injury
- diseases
- dangerous occurrences
- injury to members of the public
- some work related diseases

In all cases factual information must be gathered as soon as is practicable after the event in order to prevent a recurrence by accurately determining the causes and contributing factors.
The Responsible Trustee will ensure that the Trustees are advised promptly of any incident that may be reportable under RIDDOR. The Responsible Trustee will inform the Health & Safety Executive.
Reporting should be done online at: http://www.hse.gov.uk/riddor/report.htm

Procedure

The following procedure should be followed in the case of all Serious Incidents.
In the event of injury the first priority is to identify the extent of the injury and ensure that appropriate treatment is given. Managers should ensure that, where deemed necessary, the injured person’s next of kin or anyone else that needs to know is informed of the incident.

Any faulty equipment, or other contributing factors to the Serious Incident should be immediately withdrawn from use and the area made safe. However any material evidence relating to the incident should be retained for investigatory purposes.
Any faulty equipment withdrawn from use should be clearly labelled as such and logged.
In the case of accidents resulting in an injury to a staff member, an entry must be made in the Accident Book, by the injured person or someone on theirbehalf. It is important that all details are filled in accurately.
All staff should be aware of the location of his book.
When completed, a copy is given to the injured staff member if requested.
In the case of accidents involving a Client (service user), full details should always be recorded in the Client (service user's) records.

When completing a Serious Incident form.

Take care to include all information available on the form, including names of witnesses to the serious incident.
When recording injuries always state clearly whether the left or right side of the body is involved.
Be as precise as possible concerning the cause of the incident, actions taken at the time and any follow up action.
A record should be made of any action taken to investigate the incident and/or any advice or treatment given, e.g. taken to Accident and Emergency or Minor Injuries Unit., GP visit, etc.
Particular attention should be given to identifying the causes of any incident and to the specific actions that should be taken to prevent re-occurrence.
All forms should read and countersigned by the Responsible Trustee before submitting to the Trustees.
If it is considered that the serious incident comes into the category of a critical incident, inform the Responsible Trustee immediately.
Evaluate the accident/incident and eliminate or reduce the risk of it happening again.
Some accidents are subject to RIDDOR reporting. Any 3-day absence by staff as a result of an accident at work is subject to RIDDOR reporting. Also if a visitor sustains an injury on the premises and taken directly to hospital that this also needs reporting online at: http://www.hse.gov.uk/riddor/report.htm
The Responsible Trustee will complete all RIDDOR reports; taking into account where absence from work has occurred as a result of a work-based accident.
If it is suspected that a significant risk still remains, it may be necessary for the Responsible Trustee or another nominated person to carry out a further investigation to ensure that an appropriate risk management strategy is in place.
The Responsible Trustee will submit a report to the HSE for any accident that meets the RIDDOR criteria.
NB. Investigation of an alleged accident does not necessarily imply that sick pay will be paid. This will depend on the result of the investigation.

Accidents due to defects in equipment or systems

Any defects or potential hazards found by staff should be reported to the Responsible Trustee and a report completed. Full details should be given of the incident and nature of the defect. A record should be made of any relevant information, e.g.
equipment, manufacturer's name, serial number.
Defective equipment should be immediately taken out of use, but not interfered with except for safety reasons. Items must be kept for inspection.

Any material evidence should be kept by the Responsible Trustee and where appropriate settings and control positions should be recorded at the time of the incident.
In the event of equipment failure, or an incident involving injury from equipment, the equipment should be quarantined until such times a full examination has been carried out.
If an incident involving faulty equipment or supplies is reportable under the RIDDOR regulations, a copy of the RIDDOR report should be sent to the Health & Safety Executive.

Accidents due to failure of systems or procedures

Accidents can be caused by failures of systems or procedures. When evaluation of accidents takes place, care should be taken to check:

- Whether the correct procedure was being used at the time
- Whether the procedure being used could have contributed to the accident
- If the procedure being used requires adjusting

Adjustments in systems can be necessary due to the:

- Change in the service user's needs
- Changes in the environment
- Changes in materials/equipment being used
- Changes in working practices
- Changes in technology

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Any defects or potential hazards found by staff should be reported to the Responsible Trustee and an incident form completed. Full details should be given of the incident and nature of the defect. A record should be made of any relevant information, e.g. equipment, manufacturer's name, serial number.
Defective supplies or equipment should be immediately taken out of use, but not interfered with except for safety reasons.
Items must be kept for inspection.
Any material evidence should be kept by the Manager and where appropriate settings and control positions should be recorded at the time of the incident.
In the event of equipment failure, or an incident involving injury from equipment, the equipment should be quarantined until such times a full examination has been carried out.
If an incident involving faulty equipment or supplies is reportable under the RIDDOR regulations, a copy of the RIDDOR report should be sent to the Health & Safety Executive.

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Reference to Care/Support Plans should be made during the evaluation

Near miss

An accident is commonly defined as “an unplanned event, which may or may not result in injury or damage.”

It is clear from this definition that it is not essential for an injury to have been sustained or for damage to have occurred for an accident to have happened. It should be regarded as a warning that a problem exists if the event had occurred under slightly different circumstances the outcome could have been different. This means that the same immediate and basic potential causes of the accident are in place but on this occasion the outcome is limited to the events occurrence without resultant injury or damage. Because of the potential for harm, the Responsible Trustee should still investigate all these Incidents in the same way as accidents resulting in injury.

Client (service users) support plans

Following an Accident/incident involving a Client (service user), a Serious Incident report form should be completed and those details should also be added to the Client (service user’s) File

Debriefing

A serious incident debriefing will be offered to staff after post event actions have been completed. The debriefing, to be effective, should be completed as soon as is practicable after a serious incident. The debrief is a group activity involving all employees who were directly involved in or witnessed a serious incident. The debrief may also include employees affected by the incident who were not present at the time. Attendance is optional; its purpose is to share immediate reactions, piece together factual information, and offer mutual support. Every effort should be made to prevent attributing blame or responsibility; the debrief is confidential and does not form part of any investigative process; staff members should be made aware of sources of individual and confidential support available to them, should they wish to further discuss their own response to the incident

Root Cause Analysis

Root Cause Analysis should be carried out on all incidents that come within the scope of this Policy; the analysis will examine each of the underlying or root causes that led to, or nearly led to, the event in order to establish an understanding of why it happened and how it can be avoided in the future.

Each root cause may include several factors which could be at different levels and at different stages both prior to and throughout the incident.

The following is not an exhaustive list but should all be considered:

Look at human factors such as:

- lack of knowledge or experience of the person/s involved
- outside influences/pressures on the involved person/s
- the quality of written and verbal communication and morale within the department
- the workload, adequacy of staffing, level of supervision, departmental background/recent history
- delay/failure to monitor, observe, diagnose or act
- failure to risk assess or establish faults/errors/anomalies in equipment/procedures
- failure to follow established procedures/policies

What other factors may be involved (systems, processes, equipment, data, environmental etc.)

- lack of policies, non-availability of equipment
- premises problems
- equipment or systems failure
- poor systems/incorrect and ambiguous policies and procedures
- poor/incorrect records

Identify each area of possible risk and establish its potential for contributing to the event.

Examine the degree of risk in each part of the process that led to the incident and consider the likelihood of the same factors occurring again.

The possible improvements that could be made (if any) and the potential that these improvements have for reducing or eliminating the risk must be considered in relation to the likely recurrence.

The risk scoring methodology and matrix in the Risk Management Strategy should be used for assessing each risk

The prevention of future incidents relies on the identification of general systemic problems rather than isolated difficulties that are unlikely to reoccur.

Conducting a full Root Cause Analysis will usually require:

- a team to analyse the incident
- a review of the records
- interviewing those involved
- establishing the chronology of events
- establishing how it happened
- a brainstorming session to identify all potential and contributory factors
- a list of underlying causes
- an action plan and review

Freedom of Information Act

Any request for information regarding serious incidents should follow local Freedom of Information Act (FOI) policies and Caldicott, data protection and information governance.

Any incidents involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious.

In the majority of circumstances, healthcare provider organisations must comply with Caldicott data protection and information governance requirements when reporting serious incidents. They should not refer to individuals by their name or give other identifiable information and should ‘restrict access to patient information within each organisation by enforcing strict need to know principles’. For example, the content of a report should not contain the names of practitioners or patients. Person identifiers must be documented separately.

However, the principle should be that the safety of patients is paramount and staff should act in the public interest. In certain circumstances, therefore, it will be necessary to identify an individual; for example in making a ‘safeguard’ alert.

Policy Document References

Related Policy Documents:

KPS Health & Safety Policy

KPS Confidentiality and Data Protection Policy

KPS Safeguarding Policy