(NAME OF HOME)

Procedures Manual

Title:	**ACCIDENT / INCIDENT / NEAR MISS REPORTING** ***(KLOE)***

1.0 Scope

1.1 The system for reporting accidents and incidents.

2.0 Aims and Values

2.1 To minimise and prevent accidents and incidents.

2.2 To ensure staff are clearly aware of the process for reporting accidents and incidents.

3.0 Contents

6.0 General procedure.
7.0 Analysis of accident / incident / near misses.
8.0 Learning from accident, incident near misses.
9.0 Flowchart for accident /incident reporting.

4.0 Referenced Documents

C4-001 Accident / Incident / Near Miss Report Form.
C4-079 Person Centred Care Plan.
C4-081 Service User's Daily Report Record.
C4-085 RIDDOR Notification Form F2508.
C4-106 Falls Monitoring Form.
C4-107 Monthly Monitoring of Service User Falls.
C4-132 Accident / Incident / Near Miss Report Log.
C4-SSCB Senior Staff Communications Book.
MA-22 Care Quality Commission Statutory Notifications.

5.0 Responsibilities

5.1 Management and all care staff.

© Bettal Quality Consultancy Cared 4 December 18

This is the procedure to be followed

6.0 GENERAL PROCEDURE

6.1 In the event of an accident or incident occurring, staff should remain calm and deal with the situation in a professional manner.

6.2 The manager should ensure that staff are able to recognise the difference between an accident and an incident, and the action that is required to deal with either.

6.3 The manager ensures that staff are made aware through induction and staff training of their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate.

6.4 All senior staff should know the circumstances under which an accident would become reportable as part of the RIDDOR Regulations, using RIDDOR Notification Form F2508, C4-085.

6.5 All senior staff should be aware of the requirement to notify the Care Quality Commission of "important events which affect the welfare, health and safety of a Service User", as described in Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Details of these notifications, and the forms required, can be found in the Care Quality Commission Statutory Notifications procedure, MA-22.

6.6 If an accident or incident is reported in the home, the senior member of staff on duty is responsible for completing the Accident / Incident Report Form, C4-001, and recording an entry in the Accident / Incident / Near Miss Report Log, C4-132.

6.7 When an accident or incident involves a Service User, and reports are completed as in 6.5 above, additional records should be made in the:

- Person Centred Care Plan, C4-079.
- Service User's Daily Report Record, C4-081.
- Falls Monitoring Form, C4-106, if the accident or incident involves a fall.
- Monthly Monitoring of Service User Falls, C4-107.
- Accident / Incident / Near Miss Report Log C4-132.

6.8 The manager should enable staff to feel confident that they can report concerns about risks to Service Users, poor practice and adverse events without fear that they will be treated unfairly as a result of raising their concern, and promote a culture of openness.

6.9 In the event of a Service User sustaining a serious injury, the Care Quality Commission must be informed without delay and followed up in writing.

6.10 In the event of an accident / incident / near miss involving the use of medicines or medical devices, a full report should be forwarded to the Medicines and Healthcare Products Regulatory Agency.

© Bettal Quality Consultancy Cared 4 December 18

6.11 The manager should ensure that all staff are aware of the correct response to members of the media when an incident has occurred. Inappropriate comments by staff might indicate the admission of liability on behalf of the home, which might have a prejudicial effect in the event of subsequent legal action being taken.

7.0 ANALYSIS OF ACCIDENT / INCIDENT / NEAR MISSES

7.1 The manager should carry out an analysis of the Accident Incident Near Miss Report Log, C4-132, to identify adverse events, incidents, errors and near misses to establish what caused them.

7.2 The results of the analysis should be used to improve practice, reduce risk and prevent recurrence, to ensure that any non-compliance, or any risk to non-compliance to the regulations is resolved as quickly as possible.

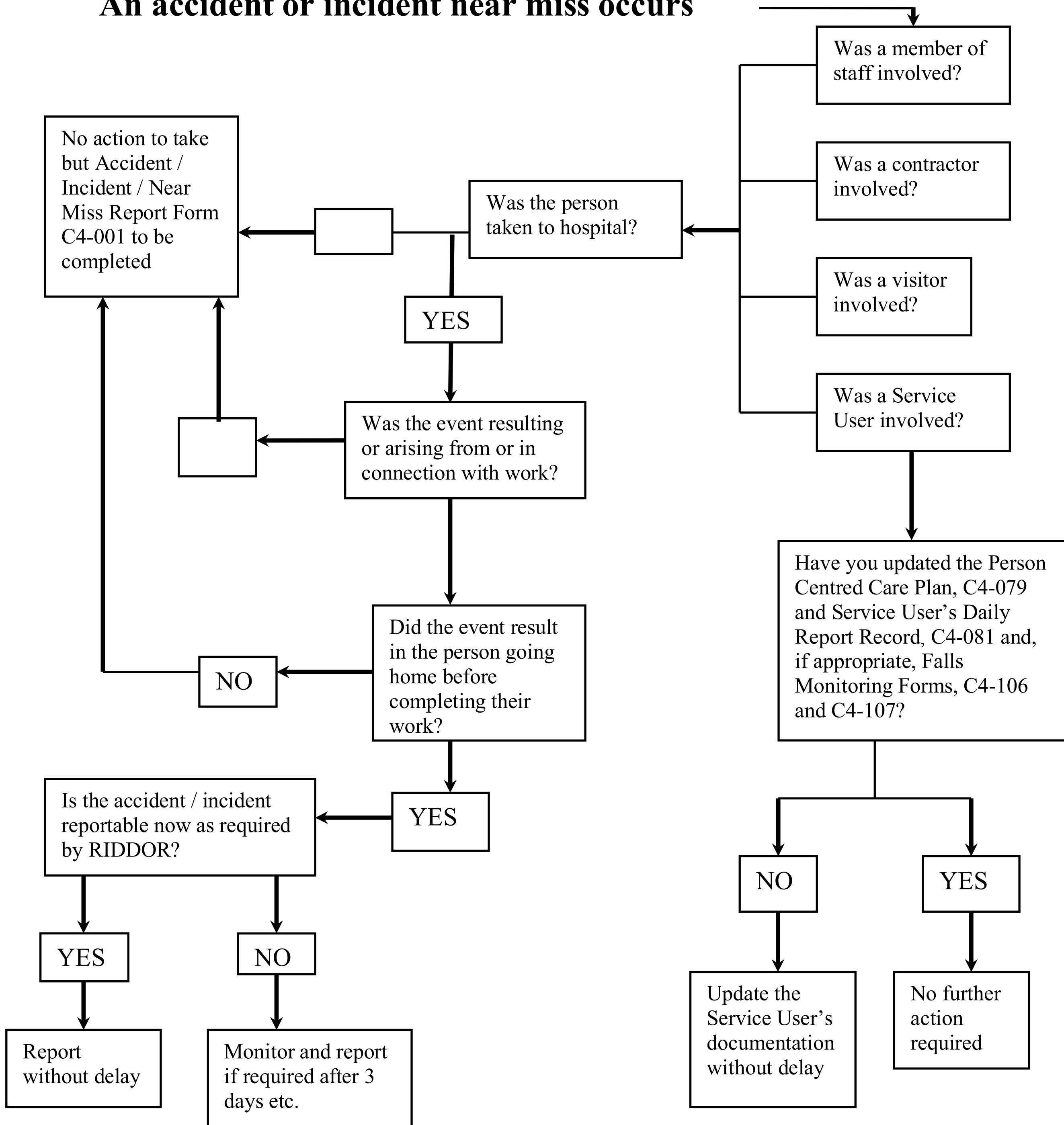
8.0 LEARNING FROM ACCIDENT INCIDENT NEAR MISSES

8.1 Following an accident, incident near miss investigation, the manager should identify what can be done to prevent recurrence and improve the service. The manager should discuss the outcome with the Service User where they are involved. Review policies and procedures and provide staff training where necessary.

See the following page for the flow chart on accident / incident / near miss reporting.

© Bettal Quality Consultancy Cared 4 December 18

9.0 FLOWCHART FOR ACCIDENT / INCIDENT NEAR MISS REPORTING



NO

© Bettal Quality Consultancy Cared 4 December 18

Guidance for managers

What the Care Quality Commission requires

Key Lines of Enquiry 2018 - **Safe S6: Are lessons learned and improvements made when things go wrong?**

Prompt	Compliance Evidence
S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate?	Section 6.0 of this procedure addresses the prompt
S6.3 How are lessons learned and themes identified, and is action taken as a result of investigations when things go wrong?	Section 7.0 and 8.0 of this procedure addresses the prompt Refer to SD-13 Risk Management

Key Lines of Enquiry 2018 – Well Led W4: How does the service continuously learn, improve, innovate and ensure sustainability?

Prompt	Compliance Evidence
W4.4 How is information from incidents, investigations and compliments learned from and used to drive quality?	Para 7.2 of this procedure addresses the prompt Refer to SD-16 Comments Suggestions and Complaints Refer CI-03 Management Review of the Quality System

© Bettal Quality Consultancy Cared 4 December 18