Title of Document	**Accident, Near Miss & Incident Reporting**
Name of Department	**Quality Assurance**

What type of document is this?	**Standard Operating Procedure (SOP)**	This sets out instructions for how a particular procedure in Helping Hands is to be routinely carried out	
Which Helping Hands policy/SOP does this document relate to?	N/A	**Index number of policy/SOP**	N/A

Which Operational Priority/Priorities does this document link to?	Governance Framework	Maximising Efficiency & Cost Management	People, Performance & Culture	

Custodian of document	Quality Director	**Committee responsible for this document**	Quality & Governance Committee
Approval date and committee chairperson signature	17.07.2024	**When is its next scheduled review?**	17.07.2027

Who does it apply to?	All Helping Hands staff at the facility / All staff working with Customers				
	Does it apply to bank workers?	Yes	**Does it apply to agency staff?**	Yes	**Does it apply to third party contractors?**	Yes

Purpose of the SOP	To give all staff clarity and guidance on accident, near miss and incident reporting and investigation responsibilities and procedure.

ROLES AND RESPONSIBILITIES

Role	Responsibility
C.E.O & Board	To have overall accountability for the companies Health & Safety and adherence to legal requirement to identify, report and reduce risks to harm. To promote duty of candour and continuous improvement through the business.
QA Director & H&S Responsible Person	To implement suitable and successful processes for reporting internally, and externally where required.
Directors	To champion the importance of incident reporting, duty of candour and make available resources for incident investigation and implementation of recommended actions. To ensure that the procedure is effectively implemented and manage performance through direct lines relative to the policy. To support the investigation process when appropriate.
All Staff	To adhere to this procedure and process, reporting all accidents, near misses and incidents
Line Managers	To ensure incident reports are completed in full of all relevant information, to conduct thorough investigations and implement appropriate measures to reduce risk of recurrence so far as is reasonably practicable.

1.0 Statement

1.1 This standard operating procedure outlines the procedures that are to be adopted when any employee, customer, visitor, or contractor experiences an accident, near-miss, incident or dangerous occurrence. It is the policy of the company to identify and investigate accidents, near misses and incidents to understand root cause and where possible, to try and prevent reoccurrence. To enable this objective to be achieved it is imperative that all accidents, near misses and incidents be reported according to the company's procedures. The company must ensure that full investigations are completed to reduce future operational impact and likelihood of recurrence.

1.2 All accidents, near misses and incidents **must be reported** in the first instance to the appropriate person. For operational teams this would be the line manager, and for occurrences that happen at the Support Office, report to a nominated First Aider.

1.3 All accidents, near misses and incident reports **must be recorded** via the Access system to generate the required report form with unique reference number and allow for centralised reporting and audit.

1.4 All accidents, near misses and incidents **must be investigated** sufficiently by an appropriate person. Maintaining records, updates, statements for the investigation file, outcomes and to close the investigation in a timely manner.

1.5 All accidents, near misses and incident investigations **must be evaluated** for learnings for continuous improvement and prevention of recurrence at both a local (branch, area or department) and business level (board, committee or region), to be reviewed in governance meetings for raising awareness and discussion of further actions which can improve safety.

2.0 Process

3.0 Occurrence

The company defines an occurrence as an event that could be categorised as either an accident, near miss or incident:

3.1 **Accident:** "an occurrence or event that happens unexpectedly and unintentionally, typically resulting in damage or injury"

Accident example: a customer falls resulting in bruising to their legs.

3.2 **Incident:** "an occurrence or event that happens unexpectedly which either adversely affects or could potentially adversely affect a customer, staff member of anyone involved in the provision of care. This usually doesn't result in injury but could result in damage"

Incident example: miscommunication results in a missed care visit.

3.3 **Near-Miss:** "an occurrence or event which does not cause injury or damage but could have done so if it had not been narrowly avoided"

Near-Miss example: a customer trips over the corner of a rug causing them to stumble and nearly fall, but they manage to steady themselves.

4.0 Response

4.1 Where applicable, treatment, first aid or emergency services must be sought in the first instance.

4.2 Where service delivery may be immediately impacted, Business Continuity guidance should be implemented.

4.3 Where the hazard contributing to a near miss or accident could be easily, safely, and responsibly mitigated, take appropriate action to do so. Where support is needed to make safe from other functions such as the property team or landlord this should be

requested.

5.0 Report

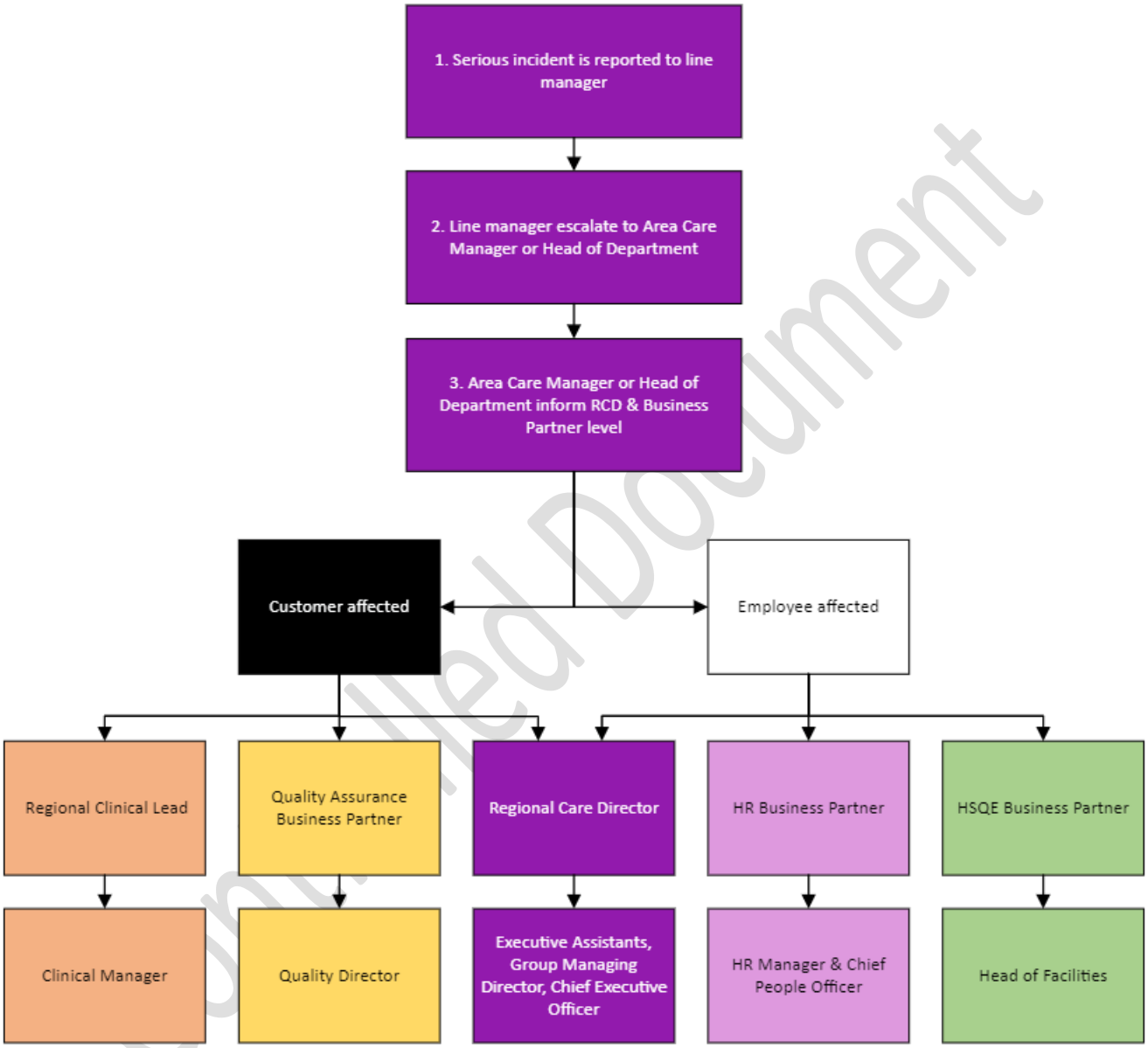
5.1 Where the customer is affected, carers should report the occurrence via a **Customer Notification Form** on Access using their phone or tablet. This form will be received and reviewed by the Care team. If the concern is a matter of urgency, you should also report directly by telephoning the office team or out of hours team as applicable.

5.2 Where an employee is affected, the employee or a witness should report the occurrence **verbally to their line manager** or appropriate person such as a first aider or head of department in support office. Text message, social media or email is not acceptable as it does not provide opportunity to discuss and obtain all relevant information.

5.3 Occurrence of an Accident, Incident or Near Miss should be reported as soon as it is safely possible to do so.

5.4 Where appropriate, other stakeholders in the business may need to be informed of the incident as soon as possible. This may be applicable for serious incidents which did or could have resulted in death, significant injury, damage to property, events which could foreseeably lead to reputational damage, or where we may need to inform our insurers.

5.5 The flow chart below shows the escalation process which should be followed in informing the relevant stakeholders of a serious incident as per section 5.4.



6.0 Record

6.1 It is the responsibility of the line manager or informed appropriate person to record the reported accident, incident or near miss on the digital Accident-Near Miss & Incident form on Access Care Planning. This encourages an objective account of events and allows for instances where the affected individual may be absent, seeking treatment or working in the field.

6.2 The report should be recorded on Access Care Planning using the Accident-Near Miss & Incident form.

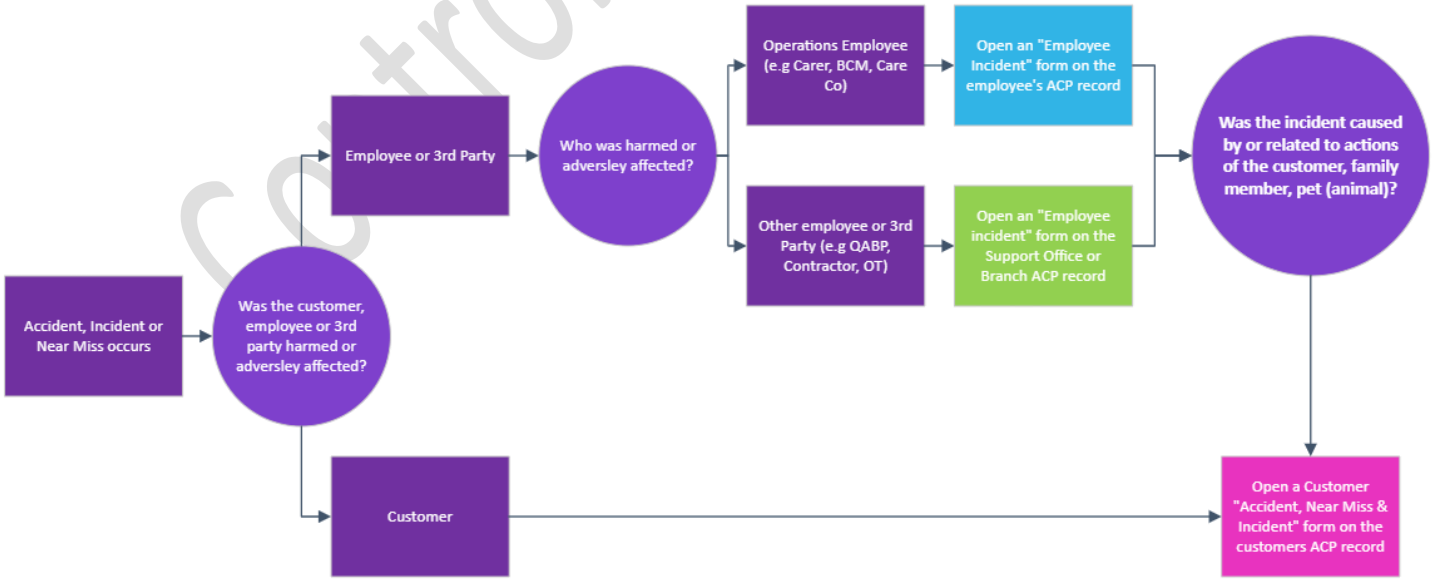
6.2.1 In the instance a customer is the affected individual the report should be recorded under the customer's Access record.

6.2.2 In the instance an operational team member such as a Carer, Branch Manager, Care Co, CTP, Area Manager or Live In Relationship Manager is the affected individual, the report should be recorded under their employee Access record.

6.2.3 In the instance a member of public or 3rd party contractor is the affected individual, the report should be recorded under the Branch Access record.

6.2.4 In the instance an employee from elsewhere in the organisation is the affected individual, the report should be recorded under the Support Office Access record.

6.2.5 In the instance a customer and employee / member of public or 3rd party were both affected as a result of a hazard specific to the customer (for example, worsening of a condition or behaviour, or a physical hazard in the home such as pets or trip hazards), the report should be recorded under both the customer profile, and either the employee or branch profile as per section 6.2.2, 6.2.3 and 6.2.4.



6.3 Recording the accident, incident or near miss should be accurate, comprehensive, written factually and include the following;

6.3.1 **Where** it happened–

- Including address and specific location where applicable, such as which room in the building.
- Include environmental conditions such as weather, visibility, distractions.

6.3.2 **When** it happened –

- Including date, time
- What activity was being completed at the time.

6.3.3 **What** happened –

- Including specificities of injury such as body part effected, nature and severity, and immediate cause.
- Prior events, including presumed causes / contributing factors
- Detailed account of the accident, incident or near miss occurring
- Following events, including any treatment or discussions which followed.
- Known impacts such as employee absence, medical advice, assistance or treatment, damage to equipment or property, effect on service delivery / receipt.

6.3.4 **Who** was involved –

- Detail of affected persons
- Detail of witnesses and witness statements
- Detail of participants / persons of interest
- Who has been informed (Internal departments / stakeholders such as Quality Assurance Business Partner, Clinical Lead, Line manager, ACM/ RCD, Head of Department, relevant directors, H&S Representative, local authority, next of kin, police, CQC/CIW etc)
- If the incident has been escalated due to the nature or severity of the incident for further investigation, such as safeguarding or disciplinary matters, who this has been escalated to and why.

7.0 Investigation

7.1 It is good practice for the investigation to take place separately to the incident and by somebody who was not involved in the incident, wherever possible to increase objectivity and ensure it is treated with appropriate importance.

7.2 Typically, this will be the line manager, although depending on the nature of the incident it may be appropriate to delegate to a competent person or assign a subject matter expert such as Head of Facilities, Clinical Lead. If unsure consult your HRBP for advice.

7.3 The purpose of an investigation is to;

- 7.3.1 Confirm all causes behind an accident, incident or near miss – from root cause to underlying and immediate causes (see 7.4).
- 7.3.2 Identify hazards or issues which can be mitigated to prevent future occurrences.
- 7.3.3 Clarify parts of the report which are unclear or ambiguous.
- 7.3.4 Identify hazards from a near miss which could become an accident or incident in future occurrences.
- 7.3.5 Identify and document measures already in place which could have prevented the occurrence.
- 7.3.6 Evaluate remaining risk and document measures which are being put in place to mitigate said risk.

7.4 Conducting an investigation should include;

- 7.4.1 Gathering evidence such as relevant photographs of locations or items involved, records such as risk assessments, support plans, record notes, previous communications or body mapping injuries.
- 7.4.2 Interviewing witnesses, effected persons and persons of interest where appropriate and obtaining statements.
- 7.4.3 Reviewing medical reports / updates where applicable
- 7.4.4 Documenting time lost / absence as a result of injury
- 7.4.5 Assessing risk – For example reviewing equipment involved, visiting a location, reevaluating a customer's needs or internal processes.

7.5 Where misconduct is suspected and may have contributed to the accident, incident or near-miss, the line manager should refer to HHH-POL-013 Disciplinary Policy & Procedure and an Investigating Chairperson will be appointed. A HRBP can advise on who will be the appropriate Chairperson. The Chairpersons investigation is separate from the standard investigation required for all reported occurrences but should consider the original investigations findings as evidence.

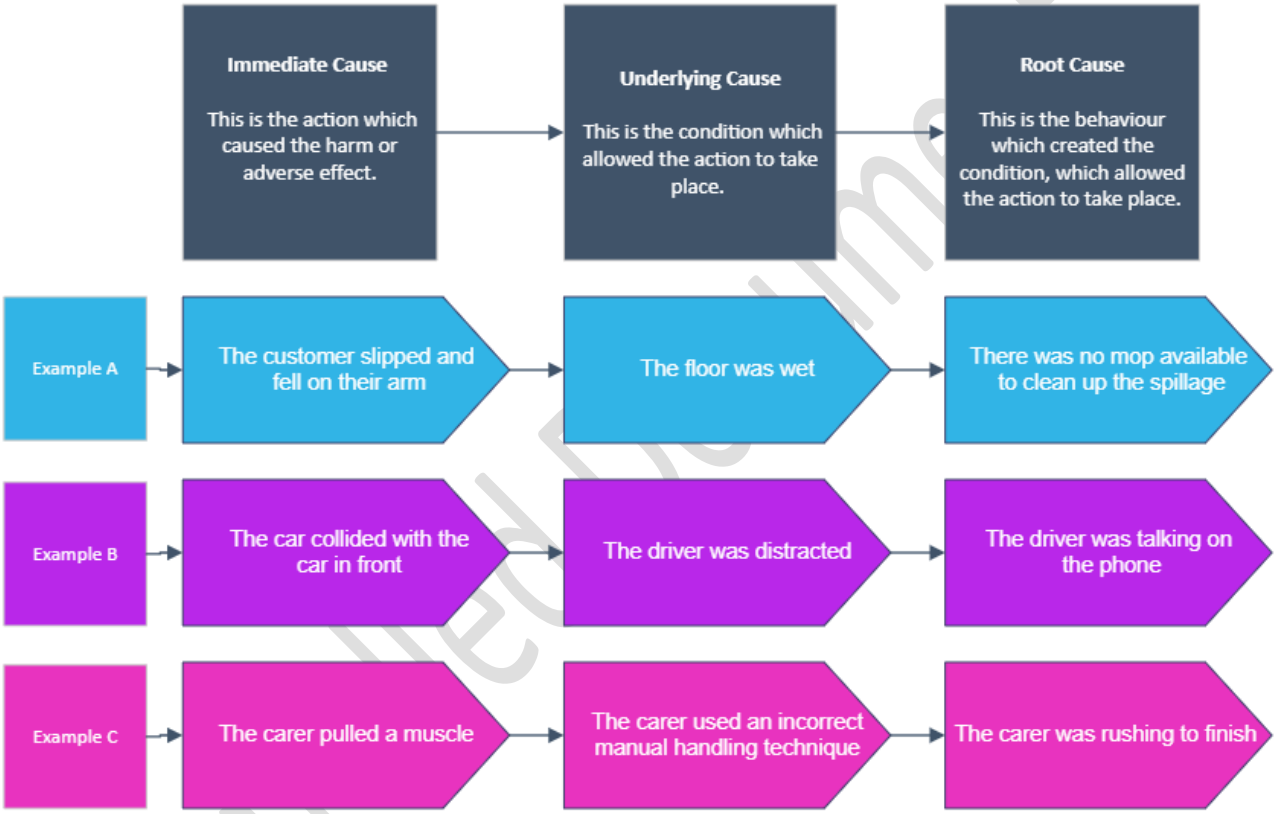
7.6 **Cause**

All accidents, incidents and near misses can be analysed for cause. Cause should be evaluated as follows;

7.6.1 Immediate Cause – This is **the action** which caused the harm or adverse effect.

7.6.2 Underlying Cause – This is **the condition** which allowed the action to take place.

7.6.3 Root Cause – This is **the behaviour** which created the condition, which allowed the action to take place.



8.0 Reporting to External bodies

8.1 **Reporting the regulator** (CQC or CIW) should be completed the same day, or no later than 48 hours after the occurrence. Guidance for applicable occurrences can be found in "CQC Registration Regulations 2009: Regulation 18" for England, and the "Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017" Regulation 60 for Wales. For support, please consult your Quality Assurance Business Partner.

These include incidents that affect the health, safety and welfare of people who use services, typically where in the opinion of a health care professional the service users standard of life has been negatively affected on a long term basis (more than

28 days) or has suffered a serious injury. Some examples are;

- Injuries which impair sensory, motor or intellectual functions such as a burn in the mouth resulting in loss of taste.
- Changes to the customer's body structure or functionality such as a bone fracture.
- Customer experiencing prolonged pain or psychological harm such as
- Shortening life expectancy
- Injury or incident which requires treatment to prevent death or further lasting harm, physical or psychological

8.2 Reporting to the Health & Safety Executive (HSE) under RIDDOR is actioned centrally by informing **RIDDOR@helpinghands.co.uk**. RIDDOR concerns instances which result in harm **as a result of** work activity. Guidance for applicable occurrences in Health and Social Care can be found in HSE Guidance Document HSIS1 (**HSE.Gov.UK/pubns/hsis1.htm**). For support, please consult your H&S Representative or RIDDOR@helpinghands.co.uk.

Some typical applicable occurrences include;

- Customer or member of public injury occurs as a result of our work activities **and** in which a customer visits the hospital. For example, a customer falls from a hoist due to a carer using the wrong size sling and is taken to hospital.
- Employee injuries from work which result in 7 or more consecutive days absence (includes planned days off).
- Serious injuries such as fracture, serious burns, amputations.
- Work related musculoskeletal injuries such as carpal tunnel syndrome, if developed because of work.

9.0 Duty of Candour

9.1 The Duty of Candour process must be followed when a **Notifiable Safety Incident** occurs in an accident, incident or near miss concerning a service user.

9.2 To be a notifiable safety incident an event must meet all 3 of the following criteria:

9.2.1 It must have been unintended or unexpected.
9.2.2 It must have occurred during the provision of a regulated activity.
9.2.3 In the reasonable opinion of a healthcare professional, the incident already has, or might, result in death, or severe or moderate harm to the person

receiving care.

9.3 For further clarification on **Notifiable Safety Incidents**, please refer to the Duty of Candour Standard Operating Procedure & Policy which can be found on collaborate.

10.0 Lessons Learned

10.1 Continuous improvement is important to Helping Hands and we encourage an open culture and duty of candour, to build a safer environment for our customers and staff through learning together.

10.2 On closing an investigation, the investigating manager should complete lessons learned parts of the incident report in reflection;

- Why did it happen? *What was the Root Cause?*
- How can we improve ways of working and prevent a recurrence? *What tangible actions can be put in place to prevent this incident or similar incidents happening again?*

10.3 Where risks are identified, or mitigations implemented, which could hold value for the business overall these should be escalated to persons with appropriate seniority to review. Where appropriate this can influence processes or be shared as best practice and lessons learned using the Lessons Learned process.

10.4 Accident, Incident and Near Miss trends and volumes should be reviewed and discussed at all levels of the business, from local branch / service to corporate governance to develop further understanding, ensuring continuous learning and improvement.

10.5 Governance meetings should be held at both a functional and business level where trends and causes are analysed, and actions developed to improve safety. This includes local branch monthly governance meetings where actions relating to specific team members, routines, customers or locations should be discussed, and business level governance committee meetings where overall trends, ways of working, or serious incidents should be discussed.

TRAINING

Is training required?	Yes
Details of training	It is recommended that line managers should undertake investigation training which is available via the Learning Management System. The Accident, Incident and Near Miss reporting process is covered in all operations staff inductions.

COMPLIANCE

How is compliance with the SOP going to be monitored	Quality Assurance team will monitor that the Accident, Near Miss & Incident Standard Operating Procedure is adhered to at all stages. Compliance will be reported through Quality Team meetings, Governance Meetings and Quality Assurance auditing. H&S Responsible person & team will monitor the quality of employee accidents & investigations through spot-checks and compliance of external reporting through quantities of RIDDOR reporting against absence.

EQUALITY IMPACT ASSESSMENT AND PROCEDURAL INFORMATION

	Yes / No	Comments
Does the document have a positive or negative impact on one group of people over another on the basis of their:		
• age?	NA	
• disability?	NA	
• gender reassignment?	NA	
• pregnancy and maternity (which includes breastfeeding)?	NA	
• marriage and civil partnership		
• race (including nationality, ethnic or national origins or colour)?	NA	
• religion or belief?	NA	
• sex?	NA	
• sexual orientation?	NA	
If you have identified any potential impact (including any positive impact which may result in more favourable treatment for one particular group of people over another), are any exceptions valid, legal and/or justifiable?	NA	
If the impact on one of the above groups is likely to be negative:		
• Can the impact be avoided?	NA	
• What alternatives are there to achieving the document's aim without the impact?	NA	
• Can the impact be reduced by taking different action?	NA	
• Is there an impact on staff, client or someone else's privacy?	NA	

What was the previous version number of this document?	Version 03
Changes since previous version	• Review of document to incorporate reporting and recording of staff near misses, accidents and incidents.

	• Review of process from occurrence through to outcomes and learning • Included the escalation process for 'serious incidents' • Review of what is required as part of an investigation • Addition of immediate, underlying and root cause definitions and examples • Included reference to notifiable safety incidents and duty of candour • Review of reporting to external bodies including requirements for reporting to HSE under RIDDOR	
Author of the document	Quality Director	
Who was involved in developing/reviewing /amending the SOP?	Quality Assurance Business Partners Quality Development Lead Head of Property HSQE Business Partner	
How confidential is this document?	Public	Can be shared freely within and outside of Helping Hands

References	RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) Reporting injuries, diseases and dangerous occurrence in health and social care guidance HSIS1 HHH-SOP-018 Trend Analysis & Lessons Learned HHH-POL-047 Duty of Candour Policy HHH-SOP-035 Duty of Candour HHH-POL-013 Disciplinary Policy and Procedure
Associated Documents	Accident, Near Miss & Incident form Customer Notification Form Employee Accident, Near Miss & Incident form