HSP 01 Accident Reporting & Investigation

Procedure Index

1. Introduction

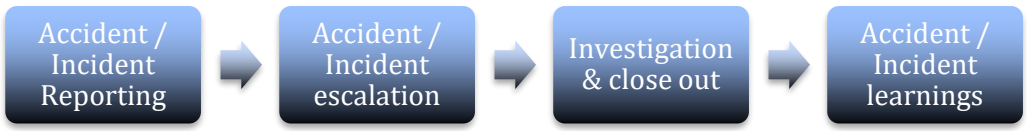
It is important that all incidents & accidents are reported to help prevent re-occurrence. Timely investigation of an incident can identify short comings and prevent a subsequent accident. This procedure deals and covers reporting of accidents & incidents to residents, staff, volunteers, contractors and members of the public on EFHL property.

The terms accident and incident are used to describe the event depending on whether actual harm was recorded. Definitions are as follows:

- Incident – An unplanned event that did not result in injury or damage. Also referred to as a Near miss.
- Accident - An unplanned event that resulted in injury or ill health of people or damage or loss to property.

2. Accident & incident reporting process

The steps for managing incidents effectively for health and safety are:



Step 1 Step 2 Step 3 Step 4

Step 1 deals with the issue of reporting and recording incidents and explains the procedure to follow and the timescales for reporting.

Step 2 deals with issues associated with escalation and provide you with advice on who to notify for various incidents.

Step 3 explains what you need to do to investigate incidents and provides further guidance on how to close them out.

Step 4 of this section explains the importance of identifying learning's from incidents and ensuring that these are translated into action to avoid future incidents.

3. Accident & Incident Reporting

EFHL uses different reporting tools dependent on whether the accident relate to a resident or employee / visitor. The principal reporting tools are detailed below: -

	Reporting Tool	**More details**
Residents	iCare – Accident reporting form	Section 5
Medication errors	iCare – Medication reporting form	Section 5
Staff, Visitors or Contractors	HSE Accident Book Access Compliance	Section 8

Property issues / Near miss	Paper form	Section 9

It is important that all individuals (staff, volunteers and visitors) understand the importance of reporting incidents as soon as possible and getting the facts relating to an incident i.e. when it occurred, where it occurred, what actually happened, who was involved and what plant, equipment or substances were involved.

4.Classifying severity of accidents & incidents

Classification of unplanned events should be either as an accident or incident and assigned one of three severity levels (Low, Medium, High) as in table below.

Category	Definition	Internal notification requirements
Incident Low	Any incident with minimum impact to home.	Clinical Care Manager
Incident Medium	Presents a significant risk of injury or ill health. Potentially large impact to home.	Clinical Care Manager General Manager Operational Support Manager
Incident High	Serious breach of legislation, regulatory requirements or a corporate policy. Potential to warrant publicity or Regulator involvement.	Clinical Care Manager General Manager Operational Support Manager Health & Safety Manager
Accident Low	Any minor injury. • Minimal minor Injury, (small cuts, grazes) • Minimal minor intervention • No or minimal treatment required • Low level self-protection skills • Missed/wrong medication (no harmful effects)	Clinical Care Manager
Accident Medium	• Any injury that requires GP, A&E or other healthcare intervention • Moderate Intervention including the use of none floor RPI techniques • Requires moderate treatment requiring healthcare intervention or first aid • An element of service provision cannot be delivered (boiler broken for a short time etc)	Clinical Care Manager General Manager Health & Safety Manager Operational Support Manager

	• Missed medication (some harmful effect) • No medication (service or Pharmacy issue) • Wrong medication given (no harmful effect)	
Accident High	• Major injury that requires GP, A&E, Emergency service response or other healthcare intervention and includes at least one overnight stay in hospital • Major intervention that may include the use high level RPI techniques that require two or more people to carry out. • 999 response or emergency admission for more than one night • Incident or accident leading to death, life changing injuries or semi-permanent injuries • Is RIDDOR reportable • Service provision cannot be provided (power outage, complete loss of IT systems etc) • Missed medication (harmful effect requiring medical intervention) • Wrong medication (harmful effect requiring medical intervention) • Loss of information or information shared without permission.	Clinical Care Manager General Manager Operational Support Manager Health &Safety Manager

5. Accidents to Residents

Accidents to residents should be recorded via iCare. The recording forms within iCare are as follows: -

3.00 Accident / Incident / Near Miss Report
3.01 Managers follow on record
3.02 Medication Incident form

3.00 Accident / Incident / Near Miss Report

This is the initial report form and should be completed by care staff when discovering an accident has occurred. These forms are selected via the resident details and it is important to enter as much information as possible relating to the accident.
Part of the iCare Accident Report includes a drop-down menu where you can select the type of accident / adverse incident that occurred. There are a large number of options here including falls, infection, wound, and Never events.

Setting the review date requires a Manager to sign the accident off.

3.01 Managers follow on record

This report is completed by a senior clinical team member of staff. It demonstrates that the accident has been reviewed, appropriately acted upon and individuals notified.

3.02 Medication Incident Form
Report used to record any issues relating to the incorrect medication.

	Who does what?	Timescale
Employee	1. Record accident / incident on iCare and notify line manager.	As soon as possible.
Senior Care staff (Nurse, Head of Care/ CCM)	2. Review accident and identify any items to prevent re-occurrence. 3. Complete Duty of Candour 4. Complete Managers follow on record on iCare	Within 24 hours Within 24 hours Within 1 month
CCM / General Manager	5. Notify OSM of Medium / High accidents 6. Complete CQC / Safeguarding Notification (if required) 7. Copy CQC Notification to OSM's & H&S Manager.	Within 24 hours Within 48 hours Within 7 days
Operational Support Manager	8. Assesses consequences of accident and investigation level required. 9. Inform C.E.O E FHL / C.E.O.Turn2us if severity classified as Major 10. Site Investigation commenced (if severity requires) 11. Record & report on KPI for monthly SMT. 12. Record & report via H&S Committee	Within 24 hours Within 24 hours Within 24 hours Within 30 days 3 Months
Safeguard Lead	13. Notify Charity, Safeguarding Board	Within 48 hours

6. Safeguarding incidents

Safeguarding incidents refer to abuse or allegations of abuse concerning residents and or any other vulnerable individuals. If abuse is believed to have occurred this must be reported immediately to both the General Manager and Operational Support Manager who will follow the EFHL's Safeguarding Policy which involves reporting to CQC and to the Charity Commission. Please refer to EFHL Safeguarding Policy document for more information on safeguarding.

7. Duty of Candour

EFHL has a statutory requirement to be open and transparent with residents if mistakes are made in residents care and treatment which cause moderate or serious harm. These situations must be notified to the CQC and trigger a formal requirement to exercise a duty of candour as defined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The Regulations also define 'Notifiable Safety Incidents'

Notifiable Safety Incidents

A notifiable safety incident must meet all 3 of the following criteria:

- It must have been unintended or unexpected.
- It must have occurred during the provision of an activity we regulate
- In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

If any of these three criteria are not met, it is not a notifiable safety incident (but remember that the overarching duty of candour, to be open and transparent, always applies).

The criteria for harm is:

- The death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- the person experiencing a sensory, motor or intellectual impairment that has lasted, or is likely to last, for a continuous period of at least 28 days
- changes to the structure of the person's body
- the person experiencing prolonged pain or prolonged psychological harm, or
- a shorter life expectancy for the person using the service.

The registered manager or a suitable person in authority will: -

- be open with the resident and other relevant persons about the incident
- provide suitable support to the resident and others affected by the incident
- explain directly and in person to the resident and / or their representatives exactly what has happened
- apologise - for example express sorrow and regret for what has happened
- say what is being done to investigate and learn the lessons from what has happened and further actions that might be taken
- Complete a written notification to the relevant persons
- keep full records of the incident, including all associated correspondence and the actions that have been taken to carry out the duty of candour with the resident and/ or representatives.

Where the person has given consent to their care and support the above actions will be directed at them personally and to others with their agreement. Where the person has been unable to give their consent to their care because of mental incapacity the actions will be

followed through communication with their lawful representatives with the expectation that the resident will be involved as much as possible.

8. Accidents to Staff, Visitors & Contractors

Accidents to individuals other than residents should be recorded via the homes Accident book. This is a paper-based accident book (shown below) and kept at Reception.

Completed accident records should be sent to scanned to Stephen.andrews@efhl.co.uk immediately and the hard copy should be stored confidentially by the General Manager. Records should be stored for 3 years.

	Who does what?	Timescale
Employee	1. Record accident in accident book and notify line manager.	As soon as possible.
General Manager	2. Review accident and identify any items to prevent re-occurrence.	Within 24 hours
	3. Send copy of accident to H&S Manager.	Within 24 hours
	4. Notify H&S Manager where time off likely to exceed 7 days.	Within 7 days
H&S Manager	5. Assesses consequences of accident and investigation level required.	Within 24 hours
	6. Copy of accident report saved to I: Health&Safety/ 01 Accidents & Access Compliance database	Within 24 hours
	7. Site Investigation commenced (if severity requires)	Within 24 hours
	8. Notify HR Managers	Within 24 hours
	9. Notifiy OSM, Safeguard Lead & EFHL Directors (High Severity only)	Within 48 hours
	10. Report RIDDOR accidents via HSE	Within 10 days
	11. Record & report on KPI for monthly SMT.	1 Month
	12. Circulate learnings via Safety Alerts	Within 10 days

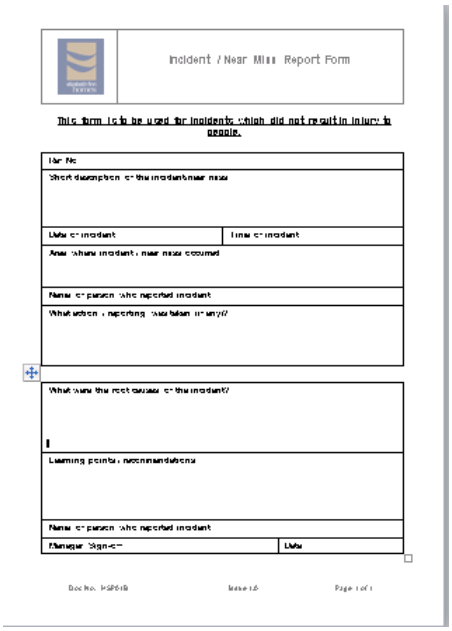
	13. Record & report via H&S Committee	Within 3 Months
Operational Support Manager	14. Report to CQC / Safeguarding if required	Within 48 hours
Safeguard Lead	15. Notify Charity, Safeguarding Board	Within 48 hours

9. Incident / Near miss reporting

Incidents which do not result in physical injury to individuals should be recorded as incidents or near misses. Typically, these are equipment failures or procedural defects which require rectification. Recording of incidents is important as it aids spotting trends and justification for expenditure. Examples are as follows: -

- Power Loss
- Gas Loss (heating/hot water loss)
- Flood (rainwater or supply failure)
- Lift Breakdown (whether Jacksons are called or the fault is resolved internally.)
- Fire Alarm Loss
- Nurse Call Loss
- Fire

Recording of these incidents is initially completed via the Maintenance Incident book held on site. The more significant near misses (those with either local or companywide learning points) will also be recorded via Incident form (HSP 01A – Near miss Accident Report form) and stored under I:/Health&Safety/02 Home incidents.
A database recording format is also provided on the homes Shared area (HSP 01B – Home Incident database).


Incident / Near Miss Report Form

This form is to be used for incidents which did not result in injury to people.

Ref No

Short description of the incident/near miss

Date of incident

Time of incident

Area where incident / near miss occurred

Name of person who reported incident

What action / reporting was taken if any?

What were the root causes of the incident?

Learning points / recommendations

Name of person who reported incident

Manager Sign-off

Date

Doc No. HSP01B Issue 1.0 Page 1 of 1

The data is collated monthly for the SMT.

	Who does what?	Timescale
Maintenance Manager	1. Record incident in Maintenance Incident book. 2. Notify either GM, Estate Manager and or H&S Manager of any item that requires immediate resolution. 3. Send details of monthly incidents to Estates & H&S Manager.	As soon as possible. Within 24 hours Monthly
Estate Manager / H&S Manager	4. Review incidents and identify any that require additional investigation. 5. Complete HSP 01A – Near miss Accident Report form (incidents which classify) and identify measures to prevent re-occurrence. 6. Collate monthly data into monthly KPI report.	Within 24 hours Within 24 hours Monthly

10. External Reporting requirements – EFHL

It is essential as per the table above, that all incidents are reported to the appropriate level of management within EFHL depending on severity.

Significant incidents may also be reportable to external bodies such as Care Quality Commission (CQC), Safeguarding or the Health & Safety Executive (HSE) and some may be reportable to multiple external bodies.

Significant incidents will require notification to Turn2Us as the charity has a reporting requirement to towards the Charity Commission

You should also be aware that reportable incidents can also be the catalyst to prompt a visit from enforcing authorities.

	Category	Definition	External notification	Regulation	Responsibility
Employee / visitor	**Over 7-day injury**	Accident that results in an employee taking over 7 day's absence from work.	HSE	RIDDOR	Health & Safety Manager
	Fracture	Employee fractures any bones (other than fingers, toes & thumbs).	HSE	RIDDOR	Health & Safety Manager
	Specified injuries / Hospital admission	Loss of sight Head injuries Scaldings (10% of body) Injuries requiring hospital admission.	HSE	RIDDOR	Health & Safety Manager

	Sharps injuries	Sharp injuries with a sharp contaminated with a blood borne virus.	HSE	RIDDOR	Health & Safety Manager
	Reportable infectious & occupational diseases	Occupational dermatitis / asthma Carpal tunnel syndrome	HSE	RIDDOR	Health & Safety Manager
Equipment	**Dangerous occurrence**	Failure of Patient hoist (but not slings) Failure of pressure vessel (Oxygen).	HSE	RIDDOR	Health & Safety Manager
	Equipment failure	Failure of medical equipment (eg trapped resident in bath)	Manufacturers of Product	Medical Devices Regulations	Health & Safety Manager
	Loss of service / flood	Events that prevent or threaten to prevent the home from carrying on an activity safely and to an appropriate standard	CQC	Health & Social Care (Reg 18(2)[4]	General Manager
	Safeguarding	Any aspects relating to safeguarding of residents	Safeguarding	Section 42 of the Care Act 2014.	General Manager
Resident	**Mistakes causing moderate or serious harm**	Mistakes in care and treatment that result in moderate suffering.	CQC	Health & Social Care Act (Reg 20) Duty of Candor	General Manager
	Notifiable Safety incidents	Safety incidents	CQC	Health & Social Care Act (Reg 20) Duty of Candor	General Manager
	Suspected case of Legionnaires Disease	Cases of suspected or confirmed Legionnaires disease.	Public Health England	Health Protection Regulations	Health & Safety Manager Health & Safety Manager
	Abuse or harm to vulnerable individual	Abuse of a resident	CQC / Police	Health & Social Care (Reg 18(2)[1]	General Manager
	Resident fall	Fall from window All falls if no assessment or defect in environment identified.	HSE	RIDDOR Health & Social Care (Reg 18(2)[2]	Health & Safety Manager
	Serious injury	An injury that permanently impairs residents sensory,	CQC	Health & Social Care (Reg 18(2)[2]	General Manager

		motor or cognitive functions; or causes prolonged pain; or changes the structure of their body; or shortens their life expectancy.			
	Death of resident	Death of a resident.	CQC	Health & Social Care Act Reg 16[5]	General Manager
	Incidents reported to the Police	Incidents reported to the Police	CQC	Health & Social Care (Reg 18(2) [3]	General Manager

[1] CQC Statutory Notification 18(2) Abuse or allegations of abuse concerning a person who uses the service.
[2] CQC Statutory Notification 18(2) Serious injury to a person using the service.
[3] CQC Statutory Notification 18(2) Incidents reported to or investigated by the Police.
[4] CQC Statutory Notification 18(2) Events that stop a service running safely and properly.
[5] CQC Statutory Notification 16 Notification of a death of a service user.

11. External Reporting requirements – NHS Learnings database

The LfPSE service is a national NHS system set up to record information about patient safety events, to support the improvement of safety across all care settings including care homes.

All healthcare staff in England are encouraged to use the system to record any events where:

- An NHS patient was harmed, or could have been harmed
- There has been a poor outcome, but it is not yet clear whether an incident contributed or not
- Risks to patient safety in the future have been identified
- Good care has been delivered that could be learned from to improve patient safety

Entries onto the database with will administrated by the Quality Compliance team.

NHS Never events

Never events are serious, largely preventable patient safety incidents that should not occur if preventative measures have been implemented by healthcare providers.
Incidents are considered 'Never events' if they have

- resulted in severe harm or death,
- evidence events have occurred in the past,
- there is existing national guidance or safety recommendations.
- Occurrence can be easily identified and measured.

There are twenty-five never events specified by NHS in England, the three most relevant to care homes are: -

- Falls from unrestricted windows
- Entrapment in bedrails
- Severe scalding of patients (bathing / washing only)

If a Never event is suspected a full investigation will be completed and shared via the NHS learnings database.

12. External Reporting requirements – Turn2us

The Charity Commission requires charities (Turn2us) to report serious incidents which involve partner organisations (EFHL). The Charity trustees will decide whether an incident is significant and should be reported.

Charity Commission definition of a serious incident is an adverse event, whether actual or alleged, which results in or risks significant:

- harm to your charity's beneficiaries, staff, volunteers or others who come into contact with your charity through its work (who are collectively referred to throughout this guidance as people who come into contact with your charity through its work)
- loss of your charity's money or assets
- damage to your charity's property
- harm to your charity's work or reputation

	Who does what?	Timescale
EFHL Safeguard Lead / Directors	1. Notify Turn2us of any significant incidents within EFHL with potential to be classified as 'Serious Incidents'.	Within 24 hours
Turn2us Trustees	2. Decide on whether incident classifies under Charity Commission reporting criteria. 3. Report to Charity Commission.	Within 24 hours Within 48 hours

13. Investigation and close out

It is of vital importance that all incidents occurring within the care home are subject to thorough investigation in order to identify the root causes and prevent a reoccurrence. Managers must ensure that this is done effectively, either by themselves or a nominated person within your team.

All accidents and incidents should be recorded and initial investigation started within 24 hours. Major incidents should be responded to by OSM within 24 hours.

For resident accidents the investigation information is completed on iCare and should be proportionate to the severity of the incident or accident.

A more detailed investigation is required for medium and high accidents and incidents. It is mandatory for General Managers to review all moderate and major severity accidents.

<u>Information gathering</u>

At the beginning of the investigation you will need to collect all the information that you can about the incident. This will involve the collection of basic information relating to the events leading up to the incident and the circumstance surrounding it.

To assist you in your investigation you should answer the following questions:

- Was the risk adequately assessed (via care plans / risk assessments).
- Was there something wrong with the room or environment of the home?
- Is there a history of similar incidents?
- Was there something wrong with the way in which the activity was being carried out including, how the work was organised, how the work was supervised or how the work was being performed?
- Was there something wrong with any equipment used?
- Was something wrong in relation to the people carrying out the task that contributed to the incident for example, their training?

For incidents which are likely to be reviewed in a Coroner's Court – Witness Statements and detailed timeline of events will be required – these are best obtained as soon as possible after the incident.

Be mindful that some incidents may be stressful and upsetting for staff and they may require counselling.

14. Accident & incident learnings

Any remedial actions required to prevent a recurrence of the event should be identified at this stage and recorded on iCare.

It is absolutely essential to capture the learning from any incident and to ensure that they are applied in your care home and others with EFHL.

Actions may range from reviewing and updating care plans to providing additional equipment or appropriate training. Managers must ensure that all actions are recorded on iCare and track them to conclusion.

Any learning's from the incident should be discussed with the team either at team meetings or the local health and safety meeting.

15. Associated documents

- Safeguarding Policy

16. A Summary of the main points

Check that:

- All staff are aware of the importance of reporting incidents and accidents.

- Staff understand and follow duty of candour requirements.
- Staff know how to correctly report resident accidents on iCare and other incidents via paper-based systems.
- Accident & incidents are escalated correctly according to severity.
- External reporting requirements are followed.
- Actions to prevent reoccurrence are tracked to completion.

17. Document history

Author	Steve Andrews (Health & Safety Manager)
Date of Implementation	01/08/2015
Date of next full review	01/01/2027

Issue	Date	Reviewer	Reason
1.0	01/08/2015	Steve Andrews	New document.
2.0	03/01/2018	Steve Andrews	Full document review – no changes.
3.0	14/06/2018	Steve Andrews	Updated procedure in line with implementation of new Care software (iCare).
4.0	11/02/2019	Steve Andrews	Combined three documents – added Duty of Candour section.
5.0	06/01/2021	Steve Andrews	Full document review – added section on Safeguarding and referenced CQC Reports.
6.0	13/06/2022	Steve Andrews	Full review of document – expanded reporting responsibilities and timescales for investigation. Added new section on Charity reporting requirements.
6.1	21/09/2022	Steve Andrews	Added more details around 'Notifiable Safety Incidents' under Duty of Candour.
7.0	19/01/2024	Steve Andrews	Full review – Added details of Access Compliance software / changed terminology of severity to Low, medium, high. Added Section 14 (Associated documents)
7.0	27/02/2024	Steve Andrews	Banner updated, no other changes, issue number kept same.
7.1	25/03/2024	Steve Andrews	Added new section 11 - NHS Safety database and NHS Never events.
7.2	22/09/2025	Steve Andrews	Appendix A added – Incident Risk Matrix

Appendix A : Elizabeth Finn Homes Incident Risk Protocol

We statement

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Purpose

To ensure consistent and appropriate responses to all incidents within the homes, based on severity—ranging from minimal harm to life-threatening situations.

Incident Levels

Level	Severity	Definition	Example	Action Summary
1	Low Seriousness	Minimal/no harm; isolated	- Cough while eating with no further issue - One-off missed medication with no adverse effects - Mild inappropriate language without distress - Fall with no injury or near miss - Identification of pressure damage (up to type 2).	- Document appropriately, internally - Handled by Shift Lead or General Manager - Monitor internally and reflect to prevent recurrence - Local response, based upon county safeguarding requirements - Professional judgment for escalation - Family to be informed within 24 hours and recorded on iCare.
2	Significant	Some harm; potential pattern	- Repeating coughing with history of choking after swallowing. - Choking, where intervention is required. - Identification of pressure damage (type 3+) - Multiple medication errors. - Medication error, with side effects - Financial irregularities in resident funds - Discriminatory or inappropriate behavior affecting care - Fall with injury - An event that possibly disrupts the service (for example, lift break down).	- Inform GP/Healthcare professionals and monitor for 48 hours. - Report to SMT within 48 hours - Update plans and document accordingly, within 24 hours - Submission of safeguarding referral, with 48 hours - Completion of Root Cause Analysis, within 48 hours - CQC Notification Submission, within 48 hours - Duty Of Candor Completion, within 24 hours
3	Critical	Severe harm, abuse, or death	- Choking leading to hospitalisation or death - Confirmed/suspected sexual assault - Serious physical abuse or neglect - Financial exploitation with coercion - Severe neglect causing pressure ulcers or death - An event that possibly disrupts the service (For example, Fire, Gas Leak)	- Immediate notification to SMT/On Call SMT, if out of hours. - Inform Police (if applicable) - SMT to inform Charity Commission (if applicable) - Update plans and document accordingly (H&S Manager) - Submission of safeguarding referral, within 24 hours - Completion of Root Cause Analysis, within 24 hours - CQC Notification Submission, within 24 hours - Duty Of Candor Completion, within 24 hours
If clarity is required, please contact a member of the SMT				