![Milewood Individual Care and Support logo]

POLICY NAME	**Incident and Accident Reporting**	VERSION NO.	1
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Revision History. (Version Controlled)

Version	Date	Page Number	Details of Change	Author

- **The Purpose of this Policy Guideline is:**

This policy has been developed to ensure Incidents involving people we support, our staff and visitors are reported correctly and actioned appropriately. The purpose of the policy is to ensure all incidents are recorded and there is an opportunity for learning and prevention of any future incidents which could be prevented. The purpose of the policy is also to ensure that there are effective procedures in place.

Incidents, mistakes, and accidents will happen. When they do, it is important to be honest and identify why and where errors have occurred to allow for:

- Immediate actions to be taken that may reduce the impact
- Lessons learnt to prevent future incidents; it may flag a need in change of policy and practice
- People we support, our staff and families to trust staff

The need to record incidents which occur within our services arches across various elements of our regulatory requirements. For example:

Regulation 12 (Safe care and treatment) states the provider must "do all that is reasonably practicable to mitigate any such risk". The CQC provide guidance on this:

> *"Incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. Staff who were involved in incidents should receive information about them and this should be shared with others to promote learning. Incidents include those that have potential for harm."*

> *"Outcomes of investigations into incidents must be shared with the person concerned and, where relevant, their families, carers and advocates. This is in keeping with Regulation 20, Duty of candour."*

Regulation 12 also states the provider must "ensure the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way." The CQC provides guidance on this:

"Providers should have and implement up to date induction and training plans for the safe operation of premises and equipment, including incident reporting and emergency and contingency planning."

Regulation 17 (good governance) states the provider must "assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)." The CQC provides guidance on this:

"Subject to statutory consent and applicable confidentiality requirements, providers must share relevant information, such as information about incidents or risks, with other relevant individuals or bodies. These bodies include safeguarding boards, coroners, and regulators. Where they identify that improvements are needed these must be made without delay."

Regulation 17 also states the provider must "maintain securely such other records as are necessary to be kept…". The CQC provides guidance on this:

"Records relating to the management of regulated activities means anything relevant to the planning and delivery of care and treatment. This may include governance arrangements such as policies and procedures, service and maintenance records, audits and reviews, purchasing, action plans in response to risk and incidents."

- **Helpful Definitions**

Incident
SCIE define an incident as *"an event that that leads to harm, loss or damage to clients, their family/carers, or staff."*
This gives a broad meaning to the term incident; in it's simplest form, it is something which was not predicted in a person's support plan, or is a result of staff not following a support plan. It could be something that put people we support at risk of harm or actual harm.

An example of an incident:
1. Mary receives 1:1 between the hours of 6am and 10am as she is particularly distressed during this time and tries to leave the building. Mary's support plan states she is not safe to be outside in the community alone as she is unable to cross roads safely, is likely to become disorientated and may get easily lost. This morning, at 06:15, she left the building unsupervised as her 1:1 was late to their shift and the fire exit had been left open due to

the hot weather. Mary crossed the road and sat on a bench; she was spotted by a member of staff and she was brought back to the service with no harm or injuries. Mary was out of the building for approximately 10 minutes.

This is an incident as Mary should have had 1:1 at the time of her leaving the building. The fire exit should not have been left open and Mary was put at risk of harm. This would also meet the threshold for a safeguarding referral to the local authority.

2. Mary's support plan states she is not safe to be outside in the community alone as she is unable to cross roads safely, is likely to become disorientated and may get easily lost. This morning, Mary left the service at 06:15 through the fire exit. The fire exit had been left open due to the hot weather. Mary crossed the road and sat on a bench; she was spotted by a member of staff and she was brought back to the service with no harm or injuries. Mary was out of the building for approximately 10 minutes.

This is an incident as Mary's support plan states she is not safe to leave the building unsupervised and she was able to do so through staff fault.

3. Mary's support plan states she is able to access the community independently but for her to inform a member of staff where she is going and what time she is hoping to be back. Mary has consented to her support plan and if she does not return at the time she has stated, there is an escalation plan in place. This morning, Mary left the service at 06:15 through the fire exit. The fire exit had been left open due to the hot weather.

This is an incident as it is an event which does not follow the support planning and is not her typical behaviour. The incident may prompt a review in Mary's support plan. The fire exit was left open and this put Mary and other people we support at an increased risk of harm; there was a staff fault.

4. Mary's support plan states she is able to access the community independently but for her to inform a member of staff where she is going and what time she is hoping to be back. Mary has consented to her support plan and if she does not return at the time she has stated, there is an escalation plan in place. This morning, Mary left the service at 06:15 and didn't tell staff where she was going.

This is an incident as it is an event which does not follow the support planning and is not her typical behaviour. The incident may prompt a review in Mary's support plan.

Incidents are not negative events and should not be thought of as a negative. They are an opportunity to review service delivery and consider if our practice needs to change. In the above examples, these incidents once recorded and shared; could leave to positive consequences and discussions. For example:

- Why are staff leaving the fire exit open, is the building too warm?
- Why is the fire alarm not sounding when the fire exit is left open?

- Why is Mary leaving the service when she is distressed?
- Why is Mary changing her usual behaviour and not informing staff of her plans; is this an early warning sign of a decline in her mental wellbeing, sign of infection – does her support plan and risk assessment need reviewing?

Examples of incidents include:

- Slip/Trip/Fall
- Pressure Sore
- Burn or scald
- Electrical
- Fire/Arson
- Missing Person
- Choking
- Traffic/Vehicle
- Physical altercation
- Near Miss
- Assault
- Self Harm
- Trapping/Crushing
- Impact with a stationary object
- Unexplained injury

Near Miss – An event that could have caused harm, loss, and damage, but fortunately did not do so on this occasion. These are just as important to document as they are also opportunities to shape practice.

Medication Error – This is an occurrence with medication where it has not been administered as prescribed. Examples of medication errors are:

- Omission (missed dose)
- Wrong dose
- Wrong medication
- Wrong time
- Wrong Route
- Wrong Person
- Expired
- Discontinued medication

- **Immediate Actions**

When an incident occurs, the staff member should take immediate actions to ensure the person is safe. For example, put the person in the recovery position or call for support. There should not be any delay.

First Aid
Where required, first aid should be provided and documented accordingly. Each service will have a designated first aid lead for each shift, this should be identifiable via a poster in the entrance of the service and the staff rota. It should also be outlined in the morning meeting/allocations.

Falls
When a person has fallen, staff should not immediately attempt to get the person up; the person should not be moved by staff until checks for injuries have been completed. This will inform decisions about safe handling. If a person has a potential head or spinal injury, moving them could be detrimental. Always speak with the person to identify their pain and potential injuries. If they cannot support themselves from the floor – please call for medical support – 999 to do so.

Post-fall checks should be completed as standard. This will include monitoring the person for 24 hours to check for any bruises, marks, behaviour which may indicate lack of consciousness or signs of pain.

Head Injury
If a person has a suspected head injury, or has banged their head during a fall – this should be treated as a potential head injury. Where a person has hurt their head; witnessed or unwitnessed; medical advice should always be sought from 111 or 999 where there are the following symptoms.

Remote advice services (for example, NHS 111) should refer people who have sustained a head injury to a hospital emergency department if there are any of these risk factors (see NICE's guidelines on shared decision making and decision making and mental capacity):

- any loss of consciousness ('knocked out') because of the injury, from which the person has now recovered
- amnesia for events before or after the injury ('problems with memory'; it may not be possible to assess amnesia in adults who are non-verbal
- a persistent headache since the injury
- any vomiting episodes since the injury
- any previous brain surgery
- any history of bleeding or clotting disorders
- current anticoagulant or antiplatelet (except aspirin monotherapy) treatment
- current drug or alcohol intoxication
- any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected)
- irritability or altered behaviour (easily distracted, not themselves, no concentration, no interest in things around them),

6

There should be evidence of staff monitoring a person for 24 hours after a potential head injury to ensure there are no symptoms of the above.

- **Reporting and Documentation**

Nourish

There are only three streams of recording an incident on Nourish. These are:

1. **Incident & Accidents – People We Support**
2. **Incidents & Accidents – Staff, Contractors & Public**
3. **Incidents – Medication Error We train to 5 levels of behaviour:**

We train to 5 levels of behavior – these levels determine whether an incident is logged as a ABC or a Incident as describe below: -

ABC Records - Low Level behavioral occurrence

- **Agitated** - Low level behaviours, away from baseline behaviour, usually a way of the service user communicating "I'm distressed" and resulting in the individual receiving a verbal response or prompt to Primary Prevention Strategies and de-escelation techniques

- **Disruptive -** Low level behaviours, away from baseline behaviour, usually resulting in the individual "disturbing the environment", requiring the staff member to "PAY ATTENTION" and to promote Primary Prevention Strategies and de-escelation techniques

Incident forms - Serious incident

- **Destructive** - Typical evidenced by an increased in Gross Motor Activity (GMA) An event resulting in destruction to property.

- **Dangerous** - Typical evidenced by an increased in Gross Motor Activity (GMA) An event resulting in harm, aimed at self or others.

- **Threat of lethal** - An event which gives intent or threat of serious harm or the potential to cause death

Support workers
Staff delivering care are responsible for recording the incident in the first instance. The first person to know about the incident is the person who should complete the incident report on Nourish. The incident form prompts for various questions and these should be completed in as much detail as possible. As always, it is important the information is factual, respectful and a true account of the incident.

The incident should be recorded onto Nourish as soon as is reasonably possible. This means, once the person we support is safe and any immediate actions have been taken. Staff should not leave a shift without recording an incident which occurred on shift. When inputting an incident into Nourish, you can tick the "handover" box and add narrative to inform support workers on the next shift of the incident.

If the incident required staff to use physical intervention, as well as the Incident form, they should also complete a "Use of Restrictive Physical Intervention" interaction. This will prompt further questions relating to the use of physical intervention to ensure it was proportionate, this is modelled from the "Serious Incident" NAPPI forms.

The incident record for people we support is the same format as the incident report for visitors, public and staff.

Nourish will inform management of the incident but it is good practice to also inform them of the incident in person. The manager will inform you if any further actions need to be taken.

Body Map
Staff should always include a body map with the incident report where there is an injury, mark or bruise. If the need for a body map occurs after the incident has inputted into Nourish; this can be added via "Record Concern with Skin Integrity/Wound" interaction.

Service Management
Once a support worker has created an incident interaction on Nourish; it will automatically generate a new interaction which 'triages' the incident to any staff in the service which have a "management" role on Nourish; this will include the manager and deputy of all sites. Support workers cannot see or edit this interaction. In addition, the management team for the service will receive an escalation email and alert on Nourish to inform them of an incident.

It is the service manager's responsibility to ensure all immediate actions have been taken by the staff to make the person we support safe. It is your responsibility to ensure any required monitoring, first aid or treatment has been sought.

This triaging form needs to be completed by management as soon as possible. This form will prompt and ask if a safeguarding concern needs to be completed, (if it doesn't – you must add narrative as to why not). It is the management's responsibility to ensure the triaging is completed within 24 hours and the correct referrals have been made (CQC, safeguarding, MDT etc).

Where RPI has been used, as management, you need to ensure you are confident the physical skills used form part of the person's support plan, they were proportionate to the risk of harm if not used and there has been a de-brief completed with staff involved. For further support regarding this, please contact PBS Lead or Tina Kelly, Training manager.

Once the triaging interaction has been completed by management, Nourish creates a "sign off" interaction.

Regional Manager
The regional manager is responsible for signing off each interaction. To "close" an incident. The regional manager must be satisfied the incident report has sufficient detail, to good quality, all

actions and referrals have been made. If the regional manager is satisfied with this, they can close the incident.

If there are actions outstanding, the regional manager should ensure these have been communicated with the manager and completed before closing the incident on Nourish.

Safeguarding concerns

An incident does not always need to be referred to the local authority safeguarding team. Please refer to the safeguarding policy and local threshold guidance when considering this. Each local authority has a slightly different interpretation of legislation and different operating procedures. Therefore, it is important to build relationships with link workers, local authorities and ask questions following incidents. If a safeguarding referral is not made, please document the rationale for this.

The Local Government Association (LFA) use an analogy of a bus journey:

"You can get on the 'safeguarding bus' at the start of the journey if there is reasonable cause to suspect that those two criteria (S42(1a and b)) are met. Then, if a little down the route it turns out that this isn't a safeguarding concern after all, you can get off the bus and take a different route. However, in broad terms significant work in the early intervention/prevention space may have taken place."

For general guidance:

If the incident could have been prevented and/or was the result of staff action or omission – it will likely need to be reported to the local authority safeguarding team. Safeguarding alerts should be submitted within 24 hours of the incident occurring.

Notifications

Where an incident has met certain criteria, there may be other statutory notifications which need to be completed.

Allegations of Abuse (safeguarding)
If the incident has been reported to the local authority safeguarding team, a notification will need to be shared with the CQC – "Allegation of Abuse". **This should be done at the time of the alert going to the safeguarding team** and not following an outcome from the referral. The CQC notification should be submitted within 48 hours of the incident.

Death of a person using the service

Police Involvement in an incident
A notification must be sent to the CQC to inform them of police involvement of an incident. This may be relating to staff misconduct, a peer on peer incident; or perhaps an incident which occurred in the community – for example, a person we support being arrested. It may also be theft or vandalism to property. This should be reported as an incident on Nourish and a notification sent to CQC within 24 hours.

Serious injury to a person using the service

If a person suffers a serious injury following an incident, but the incident hasn't already been reported to CQC as an allegation of abuse. Then it should be shared as a serious injury notification. The CQC regulation defines serious injury as:

"the incidents referred to in paragraph (1) are—

a. *any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in—*

  i. *an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary,*

  ii. *changes to the structure of a service user's body,*

  iii. *the service user experiencing prolonged pain or prolonged psychological harm, or*

  iv. *the shortening of the life expectancy of the service user;*

b. *any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent—*

  i. *the death of the service user, or*

  ii. *an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a);"*

Other statutory notifications

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

Incidents must be reported to RIDDOR when the incident is both work related and results in a reportable injury. A reportable injury is defined as:

- the death of a person
- fractures (other than to fingers, thumbs, and toes)
- amputation of an arm, hand, finger, thumb, leg, foot or toe
- any injury likely to cause permanent blinding or reduction in sight in one or both eyes
- any crush injury to the head or torso causing damage to the brain or internal organs in the chest or abdomen
- serious burns (including scalding) which:
  - cover more than 10% of the body
  - cause significant damage to the eyes, respiratory system, or other vital organs
- any scalping requiring hospital treatment

- any loss of consciousness caused by head injury or asphyxia
- any other injury arising from working in an enclosed space which:
  - leads to hypothermia or heat-induced illness
  - requires resuscitation or admittance to hospital for more than 24 hours

- **<u>Lessons learnt</u>**

In order to prevent incidents and learn from them, they will need to be analysed for themes and trends; and any future possible lessons learnt. Debriefs will take place after most incidents (as mentioned above) for any immediate actions or support which need to be taken or addressed – such as abuse or misconduct.

Managers should complete the monthly safeguarding and lessons learnt audit provided on safety culture and share any lessons learnt in the following monthly team meeting.

- **<u>Related Policies</u>**

This policy should be read in conjunction with our other Policy Guides:

- Safeguarding
- Use of RPI
- Training