ACCIDENT, INCIDENT, AND RIDDOR POLICY - NORTHERN IRELAND

Policy title:	Accident, Incident and RIDDOR Policy – Northern Ireland
Outcome:	TXM Healthcare Ltd endeavours to detail the measures to be taken to investigate accidents and to determine if additional measures or a change in procedures may reduce or eliminate future occurrences.
Target Audience:	All TXM members meaning TXM Healthcare staff, whether employed full-time or part-time, paid, or unpaid, granted practising privileges, volunteers, students, and external contractors. This may also be provided to clients, service users, and members of the public.
Authorised by:	Ciaran Maynes - Registered Manager TXM Healthcare Ltd
Approved by:	Ciaran Maynes - Registered Manager TXM Healthcare Ltd
Date issued:	22 August 2023
Next review date:	22 August 2024 (Or before if there is a change in practice or circumstances)

Purpose
TXM Healthcare has a duty to protect the health, safety, and well-being of all individuals who are associated with its activities. Accidents are to be avoided but will happen on occasion. This policy details the measures to be taken to investigate accidents and to determine if additional measures or a change in procedures may reduce or eliminate future occurrences.

Statement
Accidents and incidents are unfortunate occurrences of day-to-day life. Most are avoidable and if proper care and attention are given to risk assessment prior to carrying out a task, the risks can be significantly reduced.

The DHSSPSNI document “Safety First: A Framework for Sustainable Improvement in the HPSS” defines an error or incident as:

“Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation”.

This definition includes ‘near misses’ as it acknowledges that not all errors result in harm.

Recent research has indicated that workplace ill health is estimated to be costing the Northern Ireland economy over £238 million per year. In Northern Ireland alone it is estimated that 395 people die each year due to work-related diseases (https://www.hseni.gov.uk).

Reporting accidents and incidents are covered by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR). These regulations place a requirement on employers to report certain incidents and accidents to the HSE.

These include:

- deaths and certain specified injuries
- injuries resulting in incapacitation lasting seven days or more.
- some work-related diseases
- dangerous occurrences (near misses)
- gas incidents

More information on how to report incidents and accidents can be accessed here: https://www.hseni.gov.uk/report-incident

Accidents and incidents can and will happen, but with proper safety management techniques in place, we can keep them to an absolute minimum. This policy aims to establish a clear incident-reporting and investigation procedure and to comply with all relevant legislation, including the:

- Health and Safety at Work (Northern Ireland) Order 1978.
- Management of Health and Safety at Work Regulations (Northern Ireland) 2000.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR).

Procedure and guidance
To ensure that any accidents, incidents, and near misses are recorded, correctly investigated and, where appropriate, reported to the relevant authorities, we will:

- ensure that a clear accident, incident, and near-miss reporting protocol is communicated throughout TXM Healthcare.
- appoint a responsible person who will report reportable accidents/incidents/near misses to the relevant authorities.
- ensure all accidents and incidents are recorded in the accident book.
- investigate all accidents and incidents fully, establish their root cause, and develop new procedures to reduce recurrence.
- review accident and incident statistics periodically, to identify trends.
- review this policy at least annually, but more frequently if necessary.

To fulfil our responsibilities as outlined above, we will:

- establish and communicate a clear accident, incident, and near-miss reporting protocol, where any such occurrence is reported to the responsible person.
- provide easily accessible accident books for the reporting of accidents and incidents.
- appoint a responsible person to report appropriate accidents, incidents, and near misses, and to provide training, where practicable.
- ensure all employees are aware of emergency procedures in the event of a major accident or incident.
- establish whether an accident or incident is reportable and contact the relevant authorities as soon as possible, through the online accident reporting toolkit.
- cooperate with the relevant authorities on any external investigations.
- investigate incidents fully, taking witness statements where possible, to establish their root cause and to develop new procedures to reduce recurrence.
- ensure disciplinary action is taken if breaches of policy or misconduct are established by the investigation.
- ensure all elements of an accident, incident or near-miss investigation are recorded and filed for future reference.
- protect the health, safety, and welfare of our employees by providing appropriate support facilities (such as counselling) for those affected by the accident.
- periodically review accident, incident, and near-miss statistics to identify trends and set realistic timescales for improvement actions.

Reporting incidents

- The safety and welfare of the individual(s) affected by the incident is the priority.
- All incidents including near misses are reported to the Registered Manager. For example, clinical care, social care coma personal accidents, violence, abuse or harassment, security, equipment, add fire incidents.
- Registered Manager will determine the immediate actions required following the incident so that the safety and care and services to all individuals are maintained.
- If out of hours the Senior Nurse in Charge should be contacted
- The individuals directly involved in the incident should immediately complete the client or service user's incident report form. This may be done in conjunction with the individual charge at the time of the incident.
- All local incident reporting policies and procedures should be adhered to.
- Incident report forms should provide a clear and factual description of the circumstances of the incident. Opinions should not be provided.
- Do not make offensive, personal, or humorous comments.
- Do not erase, overwrite, or ink out entries. Errors should be scored out with a single line, the corrected entry written alongside, and this should then be dated and signed.
- All individuals involved in the incident must be clearly identified on the incident report.
- Original statements should be forwarded to the Registered Manager.

Assessing risk
Based on the information received the Registered Manager should grade the incident as Very Low (Green), Low (Yellow), Medium (Orange), High (Amber), and Very High (Red).

The Registered Manager will assess the risk and impact of the incident to determine whether it is considered a serious incident. Head of Nursing/Responsible Person/ Clinical Governance and Quality Team notified immediately for Very High (Red) and High (Amber) graded incidents.

Recording information
The Registered Manager will record a description of events (e.g. Injuries or damage subsequently detected, or deterioration in patient/client's condition), and document it onto the incident spreadsheet.

The Registered Manager will send an email acknowledgement to the client and contact the worker by telephone & email of the incident within 24 hours.

The Registered Manager will notify relevant teams of any restrictions or requirements & note them on the system.
Original statements should be forwarded to the Registered Manager

The Registered Manager will request a meeting with the worker if required.

Reporting incident
The Registered Manager to notify relevant bodies. E.G. Regulation and Quality Improvement Authority (RQIA); Northern Ireland Adverse Incident Centre (NIAIC); PSNI; Vulnerable Adults Designated Officer; and Coroner

The Registered Manager will report Serious Adverse Incidents to the Health and Social Care Board (HSCB)and Public Health Agency (PHA).

The Registered Manager will report Early Alerts to DHSSPSNI.

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The Registered Manager will report Injuries, diseases, and dangerous occurrences to the Health & Safety Executive for NI or the relevant Local Authority

Serious adverse incidents
The following criteria will determine whether an adverse incident constitutes a Serious Adverse Incident (SAI):

- serious injury to, or the unexpected/unexplained death of a service user; staff at work; and visitor to the facility.
- any death of a child in receipt of HSC services or on the Child Protection Register.
- unexpected serious risk to a service user and/or staff member and/or member of the public.
- unexpected or significant threat to provide service and/or maintain business continuity.
- serious self-harm or serious assault by a service user, staff, or a member of the public within any healthcare facility.
- serious self-harm or serious assault on other service users, staff, or members of the public by a service user in the community who has a mental illness or disorder.
- suspected suicide of a service user who has a mental illness or disorder.
- serious incidents of public interest or concern relating to theft, fraud, information breaches, or data losses.

A Serious Adverse Incident (SAI) should be reported to the Health & Social Care Board (HSCB).

Incident closure
Once satisfied that the outcome has been met notify the worker/client/external bodies in writing. All internal staff will be notified of any change of restrictions/exclusions/requirements. All information will be entered onto relevant reports. The Registered Manager will track trends and monitor activity. The Registered Manager will report to Clinical Governance and Standards Team.

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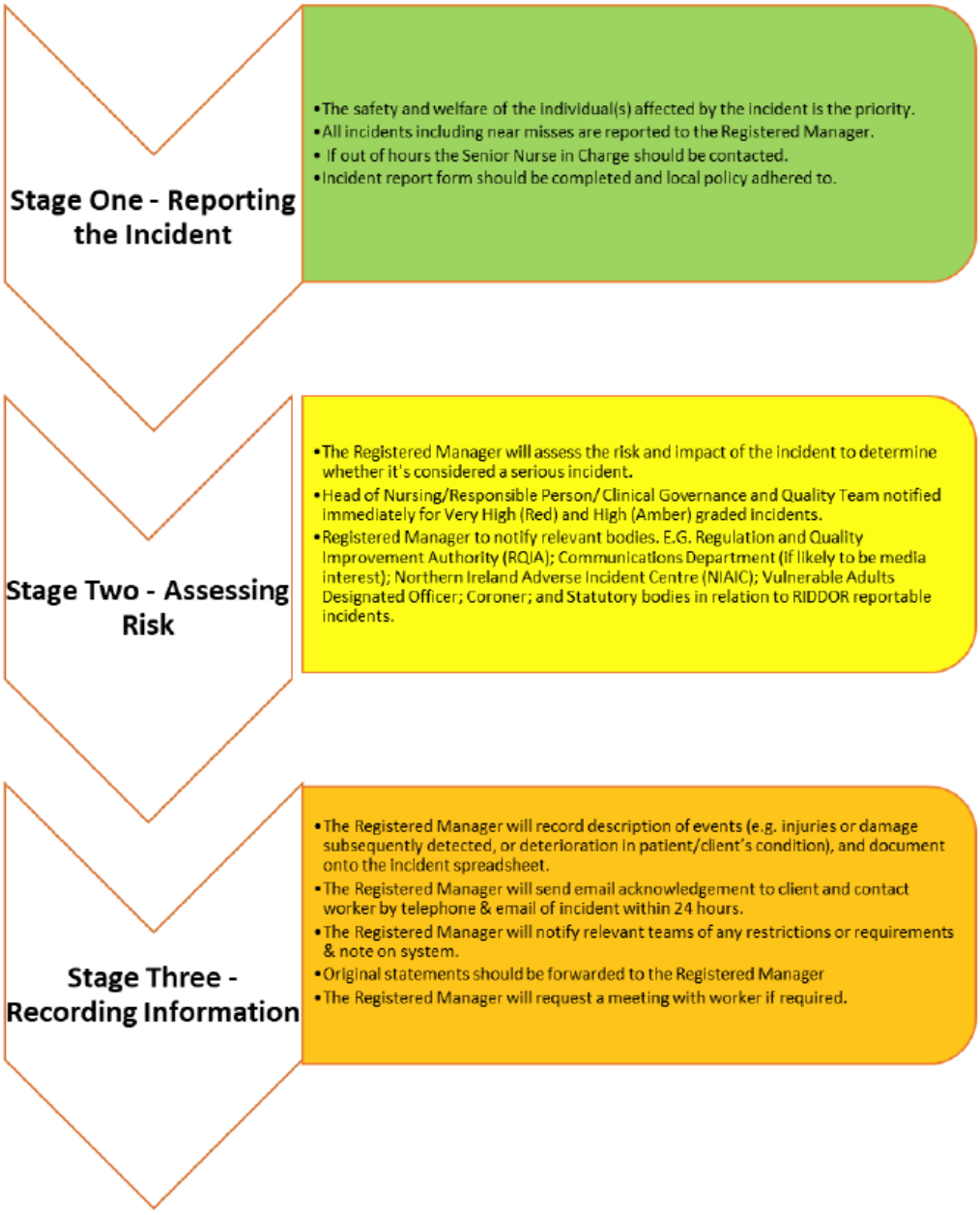

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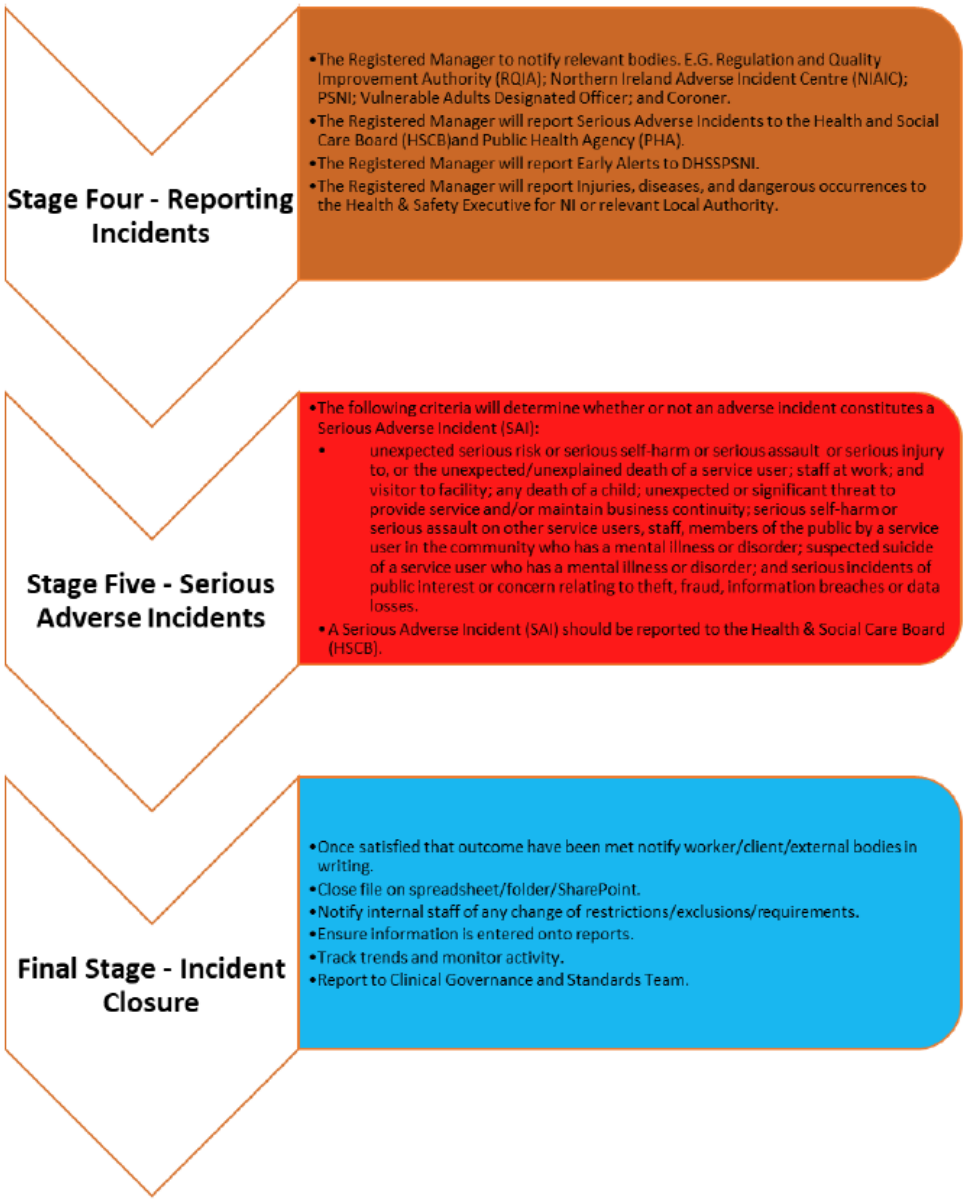

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INCIDENTS MATRIX

TYPE	SEVERITY
Very Low	Isolated or one-off incident. No impact or risk to provision of care or treatment. Usually a single resolvable issue. Minimal impact and relative minimal risk to the delivery of care, treatment or service. Minimal investigation required by the Registered Manager. However, they must be monitored regularly to identify patterns or trends and, where necessary, develop and implement actions. Should normally be completed and closed within 7 days.
Low	Infrequent incident but may have happened before. Usually a resolvable issue. Minimal impact and relative minimal risk to the provision of care treatment or service. Requires a formal investigation by the Registered Manager to determine recommendations and outcome. Tracking of potential trends and to mitigate further similar complaints. Should normally be completed and closed within 7 days.
Medium	Previously occurred but is not frequent or regular. The service or experience below reasonable expectations in several ways but not causing lasting problems. Has potential to impact on service provision. Minimal impact and relative minimal risk to the provision of care treatment or service. Requires a formal investigation by the Registered Manager to determine recommendations and outcome. Tracking of potential trends and to mitigate further similar complaints. Should normally be completed and closed within 10 days.
High	Significant degree of seriousness, and impact on individual(s) involved. Incidents with clear quality assurance or risk management issues that may cause lasting problems for the organisation, staff, client or service user. Head of Nursing/Responsible Person/ Clinical Governance and Quality Team notified. May require multi-disciplinary or independent investigation. Should normally be completed and closed within 21 days.
Very High	Serious incident that may cause long term damage such as grossly substandard care, professional misconduct or death. Requires immediate comprehensive investigation by the Registered Manager. Head of Nursing/Responsible Person/ Clinical Governance and Quality Team notified. The Head of Nursing and the Clinical Governance and Quality Team will determine whether a Root Cause Analysis is required. Should normally be completed and closed within 21 days. However, it is depending on the complexity of the incident. Closure or down-grading of red incidents requires approval by the Head of Nursing, and Clinical Governance and Quality Team.

	Severity	Very Low	Low	Medium	High	Very High
Likelihood	Very Likely	Low	Medium	High	Very High	Very High
	Likely	Low	Low	High	Very High	Very High
	Possible	Very Low	Low	Medium	High	Very High
	Unlikely	Very Low	Very Low	Low	High	High
	Very Unlikely	Very Low	Very Low	Low	Medium	High

Policy Ownership

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