The John Graham Centre
17 Blean Hill, Blean, Canterbury, kent , CT2 9EF

Review Sheet

Last Reviewed 16 Jan '23	Last Amended 16 Jan '23	Next Planned Review in 12 months, or sooner as required.

Business impact	Minimal action required circulate information amongst relevant parties.
Reason for this review	Scheduled review
Were changes made?	Yes
Summary:	This policy will support a service to ensure that accidents and incidents are recorded and reported correctly. It has been reviewed with no significant changes and with references checked and updated.
Relevant legislation:	• Care Quality Commission (Registration) Regulations 2009 • Control of Substances Hazardous to Health Regulations 2002 • The Controlled Drugs (Supervision of Management and Use) Regulations 2013 • Health and Social Care Act 2008 (Registration and Regulated Activities) (Amendment) Regulations 2015 • Health and Safety at Work etc. Act 1974 • The Health and Safety (First Aid) Regulations 1981 • The Ionising Radiation (Medical Exposure) Regulations 2000 • Management of Health and Safety at Work Regulations 1999 • The Medical Devices (Amendment) Regulations 2012 • The Workplace (Health, Safety and Welfare) Regulations 1992 • The Health and Safety (Miscellaneous Amendments) Regulations 2002 • Health and Social Care (Safety and Quality) Act 2015 • Data Protection Act 2018 • Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) • The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012 • Coronavirus Act 2020 • UK GDPR
Underpinning knowledge - What have we used to ensure that the policy is current:	• Author: HSE, (2022), *RIDDOR reporting of COVID-19*. [Online] Available from: https://www.hse.gov.uk/riddor/coronavirus/index.htm [Accessed: 16/1/2023] • Author: HSE, (2017), *Key definitions*. [Online] Available from: https://www.hse.gov.uk/riddor/key-definitions.htm [Accessed: 16/1/2023] • Author: HSE, (2017), *How to make a RIDDOR report*. [Online] Available from: https://www.hse.gov.uk/riddor/report.htm [Accessed: 16/1/2023] • Author: CQC, (2022), *Regulation 18: Notification of other incidents*. [Online] Available from: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-notification-other-incidents [Accessed: 16/1/2023] • Author: GOV.UK, (2022), *Adult social care guidance*. [Online] Available from: https://www.gov.uk/government/collections/coronavirus-covid-19-social-care-guidance [Accessed: 16/1/2023] • Author: HSE, (2013), *Reporting accidents and incidents at work: A brief guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)*. [Online] Available from: https://www.hse.gov.uk/pubns/indg453.pdf [Accessed: 16/1/2023]
Suggested action:	• Encourage sharing the policy through the use of the QCS App

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Equality Impact Assessment:	QCS have undertaken an equality analysis during the review of this policy. This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

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1. Purpose

1.1 To describe the arrangements in place at The John Graham Centre which ensure that accidents and incidents are recorded and reported in order to comply with all relevant health and safety obligations.
1.2 To describe how The John Graham Centre reduces the risk of harm arising from its activities by investigating incidents and accidents and taking action based on lessons learned.
1.3 To support The John Graham Centre in meeting the following Key Lines of Enquiry/Quality Statements (New):

Key Question	Key Lines of Enquiry	Quality Statements (New)
EFFECTIVE	E1: Are people's needs and choices assessed and care, treatment and support delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes?	QSE1: Assessing needs QSE2: Delivering evidence-based care & treatment
EFFECTIVE	E2: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care and support?	QSE2: Delivering evidence-based care & treatment QSE3: How staff, teams & services work together
RESPONSIVE	R2: How are people's concerns and complaints listened and responded to and used to improve the quality of care?	QSR4: Listening to and involving people
SAFE	S5: How well are people protected by the prevention and control of infection?	QSS7: Infection prevention and control
SAFE	S6: Are lessons learned and improvements made when things go wrong?	QSS1: Learning culture
WELL-LED	W2: Does the governance framework ensure that responsibilities are clear and that quality performance, risks and regulatory requirements are understood and managed?	QSW5: Governance, management and sustainability

1.4 To meet the legal requirements of the regulated activities that {The John Graham Centre} is registered to provide:

- Care Quality Commission (Registration) Regulations 2009
- Control of Substances Hazardous to Health Regulations 2002
- The Controlled Drugs (Supervision of Management and Use) Regulations 2013
- Health and Social Care Act 2008 (Registration and Regulated Activities) (Amendment) Regulations 2015
- Health and Safety at Work etc. Act 1974
- The Health and Safety (First Aid) Regulations 1981
- The Ionising Radiation (Medical Exposure) Regulations 2000
- Management of Health and Safety at Work Regulations 1999
- The Medical Devices (Amendment) Regulations 2012
- The Workplace (Health, Safety and Welfare) Regulations 1992
- The Health and Safety (Miscellaneous Amendments) Regulations 2002

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- Health and Social Care (Safety and Quality) Act 2015
- Data Protection Act 2018
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012
- Coronavirus Act 2020
- UK GDPR

2. Scope

2.1 The following roles may be affected by this policy:
- All staff

2.2 The following Service Users may be affected by this policy:
- Service Users

2.3 The following stakeholders may be affected by this policy:
- Family
- Advocates
- Representatives
- Commissioners
- External health professionals
- Local Authority
- NHS

3. Objectives

3.1 To ensure that The John Graham Centre has procedures and trained staff in place to appropriately record, report and investigate all accidents, incidents and near misses.
3.2 To ensure that, following investigation, and where found to be necessary, action is taken to prevent a recurrence and reduce the risk of future similar incidents.

4. Policy

4.1 The John Graham Centre will record, and, where necessary, report to the relevant authorities, all incidents which occur in connection with its service activities. Incidents of all types, whether or not they result in actual injury or property damage, will be recorded and investigated.
4.2 All incidents which involve employees, contractors, visitors, members of public and Service Users that occur at the premises of The John Graham Centre will be recorded and investigated.
4.3 Incidents which occur in connection with our service activities and affect our employees or Service Users at any location will be recorded and investigated.
4.4 All accidents, incidents and near misses will be recorded on an appropriate form which may be held in paper or electronic copy. All completed reports will be stored in accordance with UK GDPR principles, policies and procedures.

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5. Procedure

5.1 Immediate Response
In the event of an incident, the immediate priority will be the safety of all employees, Service Users and other visitors. Before responding to any incident, the area will be secured and employees will not put themselves in the line of danger.
5.2 As soon as it is safe to do so, any person harmed as a result of the incident will be given the necessary First Aid treatment or medical assistance by a suitably qualified person.
5.3 Notification and Recording
Angela Cook will then be notified of the incident by the quickest means achievable and initial incident details recorded on the relevant incident or accident form.
The completed incident or accident report form will be submitted to Angela Cook who will review the report and ensure the appropriate level of incident investigation has been completed or will ensure that an appropriate investigation is instigated.
5.4 Angela Cook will ensure that the causes of the incident are carefully examined and appropriate actions are identified to make safe any hazardous conditions and prevent recurrence of the incident. These actions will be recorded and tracked to completion by Angela Cook.
The progress of the treatment of any injury must also be recorded, together with any final outcomes evident at the time of completion and transmission of the form. Angela Cook must sign the form on completion of the investigation in order to denote that they have discharged their responsibility.
5.5 If the incident involves Service Users, the Duty of Candour Policy and Procedure will be referred to and, in the event of a notifiable safety incident, appropriate actions taken.
The John Graham Centre must notify the CQC of all incidents that affect the health, safety and welfare of people who use services. The full list of incidents is detailed in the text of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, which can be found at - https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-notification-other-incidents
Further information about reporting incidents can be found in the Serious Incident Notification Policy and Procedure.
5.6 After the accident/incident investigation and when all matters concerned with it are complete, a copy of the signed accident/incident form should be placed in the personnel file of any person(s) affected by the accident, and the original placed in the accident book.
In the case of employees, the record must be kept on their personnel file, and in the case of a Service User, kept in the Care Plan.
5.7 Angela Cook is responsible for the submission of reports to the HSE in accordance with RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).
Angela Cook will maintain all records of accidents and incidents, including copies of submitted RIDDOR reports, for a minimum of 3 years.
5.8 RIDDOR 2013 Reporting Requirements
The following injuries are reportable under RIDDOR when they result from a work-related accident:

- The death of any person
- Specified injuries to workers (see below)
- Injuries to workers which result in their incapacitation for more than 7 days
- Injuries to non-workers resulting in them being taken to hospital for treatment

A report must be received within 10 days of the accident.
5.9 The following 'specified injuries' are reportable:

- Fractures, other than to fingers, thumbs and toes
- Amputations
- Any injury likely to lead to permanent loss of sight or a reduction in sight
- Any crush injury to the head or torso causing damage to the brain or internal organs
- Serious burns (including scalding) which cover more than 10% of the body, or causing significant damage to the eyes, respiratory system or other vital organs
- Any scalding requiring hospital treatment
- Any loss of consciousness caused by head injury or asphyxia

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- 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

5.10 Seven Day Injuries
Where an employee is unable to work for more than seven consecutive days following a work-related accident and remains unable to perform their normal duties throughout this period, a RIDDOR report must be submitted as soon as practicable and within 15 days of the accident.

5.11 Injuries to Non-workers
Where an injury occurs to a non-worker (e.g. member of the public, visitor or Service User) and they require transportation to hospital by any means for treatment of that injury, this is RIDDOR reportable. If the accident occurred at a hospital, only 'specified injuries' need reporting.

5.12 The following diseases are reportable where they are linked to occupational exposure to specified hazards:

- Carpal tunnel syndrome
- Severe cramp of the hand or forearm
- Occupational dermatitis
- Hand-arm vibration syndrome
- Occupational asthma
- Tendonitis or tenosynovitis of the hand or forearm
- Any occupational cancer
- Any disease attributed to an occupational exposure to a biological agent
- A worker has been diagnosed as having COVID-19 and there is reasonable evidence that it was caused by exposure at work

5.13 Dangerous Occurrences Requiring Reporting - for example:

- The collapse, overturning or failure of load-bearing parts of lifts and lifting equipment
- Explosions or fires causing work to be stopped for more than 24 hours
- An unintended incident at work has led to someone’s possible or actual exposure to coronavirus

5.14 How to Report
Online
Go to www.hse.gov.uk/riddor and complete the appropriate online report form. The form will then be submitted directly to the RIDDOR database. You will be able to download and print a copy for your records.
In the case of COVID-19, this is reported as "a disease" due to exposure of a biological agent.
Telephone
All incidents can be reported online but a telephone service remains available for reporting fatal and specified injuries only. Call the Incident Contact Centre on 0845 300 9923 (opening hours Monday to Friday 8.30 am to 5 pm).

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6. Definitions

6.1 Near Miss

- A near miss is an incident that did not result in injury, illness or damage

6.2 Dangerous Occurrence

- A dangerous occurrence is an adverse event with the potential to cause significant harm, as specified by RIDDOR, which must be reported to the HSE

6.3 Responsible Person

- Persons filling in the reporting form should not be concerned about differentiating between an incident and an accident if the allocation is unclear. The Registered Manager will complete the allocation on review of the form

6.4 Work-Related Accident - RIDDOR

- For a specified or over 7 day injury to require notification to the HSE under RIDDOR, it must result from an accident and this accident must be work related
- Accident:
  - In relation to RIDDOR, an accident is a separate, identifiable, unintended incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work
  - Injuries themselves, e.g. ‘feeling a sharp twinge’, are not accidents. There must be an identifiable external event that causes the injury, e.g. a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g. repetitive lifting), are not classed as ‘accidents’ under RIDDOR
- Work-Related:
  An accident is ‘work-related’ if any of the following played a significant role:
  - The way the work was carried out
  - Any machinery, plant, substances or equipment used for the work or
  - The condition of the site or premises where the accident happened

6.5 Accident

- An accident is an incident which results in an injury to a person or multiple people

6.6 RIDDOR

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. A legal requirement to report specified injuries, diseases and occurrences to the Health and Safety Executive (HSE) or Local Authority (LA)

6.7 Incident

- An incident is any unintended event or occurrence which had the potential to result in undesirable consequences

Key Facts - Professionals

Professionals providing this service should be aware of the following:

- All professionals of The John Graham Centre must report accidents, incidents and near misses through their Registered Manager and Safety Officer, Ellie
- Near miss reporting should not be ignored or minimised; it can help prevent future incidents and reduce the likelihood of injury
- Angela Cook should use the Safety Officer, Ellie, as a single point of contact for advice and support with regards to accident and incident reporting
- The John Graham Centre should support the Registered Manager and staff with concerns which can improve services and reduce accidents and incidents occurring

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Key Facts - People affected by the service

People affected by this service should be aware of the following:

- You should report any accidents that you have to your Care Worker so that you receive appropriate support and care

Further Reading

As well as the information in the 'underpinning knowledge' section of the review sheet we recommend that you add to your understanding in this policy area by considering the following materials:

Napthens Podcast - The importance of Near Miss Reporting:
https://youtu.be/96ThPBrfnfk
Serious Incident Notification Policy and Procedure
Duty of Candour Policy and Procedure

Outstanding Practice

To be ‘ outstanding ’ in this policy area you could provide evidence that:

- There is a regular programme of training and a learning culture that is subject to regular audit
- The John Graham Centre undertakes a root cause analysis of accidents, incidents and near misses and applies lessons learned to support continuous improvement
- The John Graham Centre adopts an open and transparent culture where staff feel comfortable to raise concerns, identify measures to improve safety and share innovative ideas
- The wide understanding of the policy is enabled by proactive use of the QCS App

Forms

The following forms are included as part of this policy:

Title of form	When would the form be used?	Created by
Reporting of Accident or Incidents - HS01	When an individual, or group of people are involved in an accident or an incident has occurred	QCS

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Accident and Incident Log – Employees or Other Non-Service User Persons

Name of the person involved in accident/incident:	
Job Title or other description (e.g. visitor):	
Time and date of accident/incident:	
The precise location of the accident:	
How did the accident/incident happen?	
Name of witness(es):	
Details of apparent injuries:	
What immediate action was taken?	
Reasons given for cause of accident/incident (by employee/other person):	
Reasons given for cause of accident/incident (by witnesses):	

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Accident and Incident Log – Employees or Other Non-Service Users – Management Review

At the time of the accident/incident: 1. Should the person have been on the premises?	Y/N
2. Were they carrying out normal duties?	Y/N
3. Were they acting in accordance with policy, procedure and training?	Y/N / N/A
4. Was personal protective equipment provided for the work?	Y/N / N/A
5. Was the personal protective equipment being worn?	Y/N / N/A
If the answer to any of these questions is 'no', provide full details on a separate but attached sheet	
Is the employee able to continue work?	**Y/N**
Date work resumed:	
Registered Manager's investigation notes:	
Registered Manager's recommendations:	
Signature:	Date:
Title:	Date:
HSE informed by:	Date:
Insurance company informed by:	Date:
Reported to Management Meeting by:	Date:

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Accident and Incident Log – Service User

Name:	Date of birth:
Time and date of accident/incident:	
Precise location of accident/incident:	
How did the accident/incident happen (initial report)?	
Name of witness(es):	
Details of apparent injuries or harm (refer to policy definitions for clarification):	
What immediate and monitoring action was taken to ensure that the Service User was appropriately supported, and their health was effectively managed?	
Reasons given for cause of accident/incident by Service User:	
Reasons given for cause of accident/incident by witness(es):	
Report causes and recommended action by investigator:	
Signed (investigator): Designation: Date:	

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Accident and Incident Log – Service User – Management Review

At the time of the accident/incident: 1. Was the Service User accompanied?	Y/N
2. If accompanied, by whom?	
3. Was the accompanying person acting in accordance with policy, procedure and training?	Y/N
4. Was equipment provided for the processes resulting in the accident/incident?	Y/N
5. Was personal protective equipment being worn?	Y/N
If the answer to any of these questions is 'no', provide full details on a separate but attached sheet	
6. Did the Service User require medical attention?	Y/N
If medical attention was required, please describe:	
Investigator's summary:	
Investigator's recommendations, including Care Plan changes:	
Signature: (investigator)	
Designation:	Date:
Service User informed by:	Date:
Insurance company informed by:	Date:
Reported to Management Meeting by:	Date:
Care Quality Commission (CQC) informed by:	Date:

Refer to Management Meeting Action Plan for planned outcomes arising from the investigation.

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Accident Statistics Total

Month:	**Year:**

	Slips/Trips/Falls ***e.g. D - Day*** ***N - Night***	**Cuts/Bruises**	**Burns/Scalds**	**Moving & Handling**	**Chemical**	**RIDDOR**	**Total**
Service Users							
Employees							
Visitors							
Other							
TOTAL							

Day hours total:	**Night hours total:**

Manager's Signature:	**Date:**

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