Staffordshire Social Care Workforce

CMDT
Care Market Development Team

Incident Guide

V1 MAY 2024

Contents

Foreword

This guide has been developed to introduce the subject and further research and learning is recommended to provide a complete understanding. Requirements are often unique to individual care services, and you should consider how best to implement practices.

Introduction

In any care environment, the occurrence of incidents is a reality, even with the best preventative measures in place.

Incidents can affect both staff and people in receipt of care and will include accidents within the setting.

Learning from events and proactively managing risk evidences a proactive culture of risk management and provides a safer environment for staff and people in receipt of care.

Responding to any incident in a care setting involves a systematic approach of recording, investigating, responding, and learning. There should be a positive culture of self-reflection and understanding to reduce the possibility of future events, where everyone can contribute.

Recording

Recording incidents in a care setting is crucial because it helps keep track of what happened, when, and how. Documentation ensures clear communication, helps identify patterns or concerns, and ultimately improves the quality of care provided to individuals.

Responsibility

Everyone is responsible for incidents. Even if there is a designated lead for the process, all staff should ensure they escalate that an event has taken place and be involved in the process.

The most appropriate member of staff available will complete the initial documentation to ensure that there is not a time delay.

Documentation

Record the incident comprehensively, including the date, time, location, and a detailed description of what happened. Note the names of those involved, witnesses, and any immediate actions taken.

A standard form should be used to ensure consistency and there might be benefit in utilising a digital system, which could also help with further theme and trend analysis.

The people who were involved in or witnessed the event should be interviewed as soon as possible to ensure the most accurate reflection of events.

Managing the process outside of the setting can reduce the effectiveness of an investigation as they will potentially not properly understand the environment and context.

Evidence

If applicable, take photographs of the incident scene, injuries, or any relevant environmental factors. Body maps are also useful to detail injuries.

Notifications

There are often legal requirements to submit notifications to different organisations, both local and national.

Next of Kin

Should an individual in receipt of care be involved in the incident then their next of kin should be promptly notified unless there is a prior agreement. This could for example be if a next of kin only wants to be notified at night if there is a hospitalisation.

When contacting the next of kin it should be confirmed if any immediate action that has been taken and the impact to the individual.

Care Quality Commission

The Care Quality Commission require notifying of incidents, depending on what has occurred. Should an incident occur, the need for a referral to the regulator should be considered.

Safeguarding

Where it believed that an event has occurred that requires a safeguarding referral, it should promptly be made to the Local Authority without delay.

Even in the event of an incident being raised as a safeguarding referral, it does not mitigate the need for continuation the incident process. The process should continue and information from the investigation might be feed into any established safeguarding process.

Contractual

There are obligations under some contracts to submit a notification for certain incidents. You should consider contractual notification requirements should an incident occur.

RIDDOR

A RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) notification should be submitted when a workplace incident falls under specific categories outlined by the regulations. These categories include:

- Fatalities: When a work-related incident leads to the death of a worker.
- Major Injuries: Any major injury, such as fractures, amputations, or injuries that require hospitalization for more than 24 hours.
- Over-7-Day Injuries: When a worker is unable to perform their regular work duties for more than seven consecutive days because of a workplace injury.
- Diseases: Cases of certain occupational diseases, such as asbestosis or occupational asthma.
- Dangerous Occurrences: Incidents that pose a significant risk, like the collapse of scaffolding, or release of a hazardous substance.

Investigate

The investigation should have a designated lead but it should not be someone who was involved or impacted by the event.

Documentation and Evidence Collection

Document information thoroughly, including the date, time, location, and individuals involved. Physical evidence such as photographs, CCTV, damaged equipment, and any other relevant items are collected for analysis.

Interviews and Statements

Conduct interviews with all relevant parties, including witnesses, staff members present during the incident, and those directly involved. These interviews aim to gather firsthand accounts of the events leading up to, during, and after the incident.

Review of Policies and Procedures

Policies and procedures should be reviewed to determine if they were followed correctly and if any deficiencies contributed to the incident. This includes examining training protocols, safety guidelines, and standard operating procedures.

Root Cause Analysis

An analysis should be conducted to identify the root causes of the incident. This involves examining various factors such as human error, equipment failure, environmental conditions, communication breakdowns, and systemic issues.

The five whys is a common method of undertaking the analysis.

Reporting and Documentation

Document the findings of the investigation in a formal report, outlining the sequence of events, contributing factors, and root causes identified. This report serves as a comprehensive record of the investigation process and its outcomes.

The findings will typically be documented by a manager or clinical lead, with input from other members of staff. The investigation lead should be responsible for reviewing the documentation and ensuring the process is properly followed.

Recommendations for Preventive Measures

Based on the investigation findings, recommendations should be documented to address the root causes of the incident and minimise the risk of similar incidents in the future. These may include policy revisions, additional training programs, equipment upgrades, or changes in culture.

Response

Risk Reduction

Implement immediate measures to prevent a recurrence or escalation of the incident. It should be clearly documented what action has been taken to reduce the likelihood of the incident occurring in the future.

- Policies and procedures - Review and, if necessary, revise policies and procedures based on the incident and investigation findings.
- Risk assessments - Conduct a new risk assessment or review existing risk assessment documentation to include factors that were not previously considered.
- Training – Review the existing training programme, to identify if it is effective or if one or members of staff require a repeat of their training. This could also include implementing additional training.

A key part of the learning process is to review the effectiveness of the implemented measures. There should be a review of the measures that were implemented to reduce the risk to gauge their effectiveness. If the measures have not been as effective as anticipated, they should be reviewed and either updated or alternative measures implemented.

It is recommended that a review of measures is incorporated into a monthly incident audit.

Lessons Learnt

Lessons learned following an incident are a crucial to improving resilience against risk. They provide a way to enhance safety and reduce the likelihood that the incident could occur in the future.

These are best communicated through staff meetings, but staff communication platforms can also be useful. Support for staff should also be available should they have questions.

- Staff preparedness – Awareness of how an incident has occurred and could occur in the future is the first step to supporting staff to prevent future occurrences.
- Culture of improvement – Evidencing a culture of improvement is key in evidencing that the organisation is both responsive but also open to change.
- Improved safety – Ensuring that the lessons learnt are implemented helps to keep people safe, this includes everyone living, working or visiting the care setting.

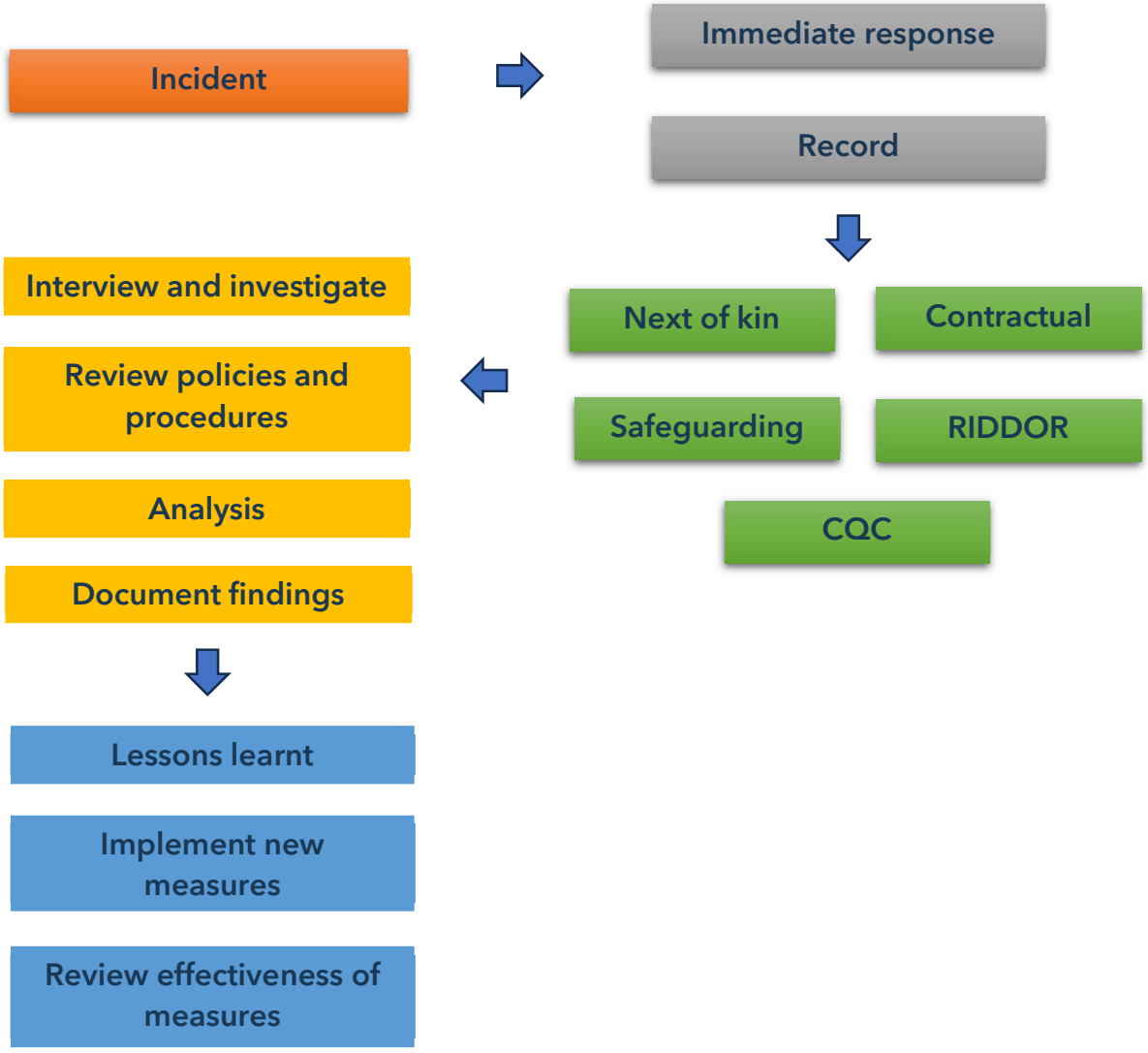
Audit

A monthly audit of all active incidents should take place to identify how the investigation and response is progressing. The audit should also review previously implemented measures to ensure they are effective.

Summary

Each stage serves a pivotal role in ensuring the safety and well-being of individuals within care environments.

Through having a robust incident process, it can help to evidence that the care service is transparent and strives for continuous improvement, creating an environment that prioritises safety and wellbeing.



For further information, please contact cmdt@staffordshire.gov.uk

Staffordshire Social Care Workforce

CMDT
Care Market Development Team