Carriglea Cáirde Services

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H&S-02

ACCIDENT/INCIDENT MANAGEMENT POLICY AND PROCEDURE (Including Dangerous Occurrences)

Approved By: _____

Effective Date: 17th January 2019

(This policy will be reviewed as necessary)

Title: Accident/Incident Management Policy and Procedure

1.0 Scope

The management of, recording and reporting of all accidents, incidents and dangerous occurrences throughout all areas of Carriglea Cáirde Services.

2.0 Aims and Values

- To comply with the Safety, Health and Welfare Act, 2005, the General Application Regulations 2007 and associate legislation
- To manage incidents in line with the HSE Integrated Risk Management Policy in so far as is feasible.
- To ensure that staff are aware of how to deal with and report an accident/incident or dangerous occurrence and the steps that need to be adhered to following an incident.
- To ensure that managers and all staff are aware of their responsibilities when reporting an incident and following up after an incident.

3.0 Contents

4.0 Referenced Documents

SD-30 Medication Management Policy
SD-41 Restrictive Procedures Policy
SD-59 Open Disclosure
H&S-09 Risk Management /Risk Assessment Policy
C4-05 Behaviour Support Plans
C4-36 Medication Incident Report Form
C4-44 Notice of Property Incident / Dangerous Occurrence Form
C4-61 Risk Assessment Form
C4-85 Notice of Accident/Incident to Person
Health & Safety Authority Form IR1 & IR3
HSE Incident Management Framework

5.0 Responsibilities

Management and all Staff

6.0 INTRODUCTION

It is the policy of Carriglea Cáirde Services that all incidents are identified, reported and reviewed so that learning from events can be shared and the possibility of re-occurrence reduced. The Services aims to prevent incidents/accidents through supporting a culture where safety is a priority and staff are supported to report any concerns regarding health and safety.

Consistency and proportionality in response to incidents which occur is important. In line with the Risk Management Policy every effort is directed towards identifying areas where incidents are likely to occur and putting in place systems to prevent or reduce the likelihood of the risk of their occurrence.

The management of risk in the Services includes the identification, recording, investigation, follow up and analysis of all accidents/incidents and dangerous occurrences which could cause injury to service users, staff, contractors or visitors or damage to property. This policy and procedures sets out the principles, governance requirements, roles and responsibilities and process to be applied for the management of incidents in all service areas. The procedures take account of the HSE *Incident Management Framework, 2018* which is available on the HSE website.

7.0 DEFINITIONS

Accident: An unfortunate event that happens unexpectedly and unintentionally, typically resulting in damage or injury [Oxford Dictionary] e.g. a crash involving vehicles, typically one that causes serious damage or injury.

Incident: *(As defined in the HSE Incident Management Framework, 2018)* is an event or circumstance which could have, or did lead to unintended and/or unnecessary harm. Incidents include adverse events which result in harm; near-misses which could have resulted in harm, but did not cause harm, either by chance or timely intervention; and staff or service user complaints which are associated with harm. Incidents can be clinical or non-clinical and include Incidents associated with harm to,

- service users,
- staff and visitors
- the attainment of the Services objectives
- ICT systems
- data security e.g. data protection breaches
- the environment

Near Miss: *(As defined in the HSE Incident Management Framework)* is an incident that was prevented from occurring due to timely intervention or chance and which there are reasonable grounds for believing could have resulted, if it had not been so prevented, in unintended or unanticipated injury or harm to a service user during the provision of a health service to that service user.

Dangerous Occurrence Dangerous occurrences may result from a sequence of events and circumstances involving a combination of unsafe acts, unsafe conditions, system failures, human factors and/or omissions. It most directly relates to the term 'reportable circumstance' as defined by the WHO (2009)
Examples of dangerous occurrences are set out at Appendix I.

8.0 GENERAL RESPONSIBILITIES

8.1 Service Provider

Ultimate responsibility and accountability for the effective management of incidents, rests with the Board of Directors of Carriglea Cáirde Services. Governance arrangements for incident management is integrated with the service's overall governance arrangements for quality and safety and responsibility for the effective managements of incidents is delegated to the Chief Executive and members of the Senior Management team.

The Chief Executive Officer is responsible for:

- Ensuring that the Services has in place and complies with a procedure for the management of incidents that is in line with the requirements of the HSE's Incident Management Framework.
- Being accountable for quality and safety within the Services
- Ensuring that robust structures and processes are in place to proactively enhance quality and safety systems throughout the Services
- Ensuring that appropriate review of incidents is conducted in an effective and timely manner
- Having clear systems of governance in place for the management of all incidents and implementation of actions required as a consequence of recommendations made following the review of incidents
- Notifying the HSE of the occurrence of any serious incidents in accordance with the Service Level Arrangement
- Ensuring that actions required as a consequence of incidents are included in the Services Quality Improvement Plan
- Ensuring that processes are in place to report accidents/incidents to the Health Information and Quality Authority (HIQA), The National Treasury Management Agency (NTMA) and the Health & Safety authority as appropriate.
- Reviewing and analyzing accident/incident statistics for trends/patterns and bringing these to the attention of the Board of Directors.
- Where reasonably practicable and within budget restrictions, ensure that adequate resources are made available to prevent accidents / incidents.
- Following the correct processes relating to Freedom of Information requests, Data Protection access requests, parliamentary questions, media queries and briefing documents in the management of safety incidents.

8.2 Line Managers

Line Managers who have responsibility for the management of resources and supervision of staff are responsible for:

- Promoting compliance with this Incident Management Policy
- Ensuring that incidents are reported and managed in line with the Services policy and procedures.
- Ensuring that all staff within their area of control are familiar with this policy and procedure and know the importance of reporting an accident/incident immediately after it occurs.
- Ensuring that staff are aware of how to complete an Accident/Incident Report Form.
- Reviewing any accident/incident forms completed by a staff member/contractor and ensuring that all relevant sections have been completed correctly.
- Determining follow-up and corrective action to be carried out, delegating responsibility to the relevant personnel and documenting same on the accident/incident form.
- Determining whether an injured person needs medical attention, including attending GP or hospitalisation.
- Dating and signing the completed form.

- Submitting the form to the relevant Senior Manager or to the Health and Safety Coordinator as appropriate.
- Liaising with the Health and Safety Coordinator with regard to analysing and investigating accidents/incidents.
- Ensuring that action is taken where appropriate, to reduce or eliminate any potential risk. Where assistance is required with follow up actions, line managers should liaise with the Health and Safety Coordinator and the relevant Senior Manager as appropriate.
- Reviewing risk assessments and/or care plans following an accident/incidents to a service user.
- Facilitating Health & Safety training for staff
- Monitoring compliance with accident/incident management procedures within their area of responsibility

8.3 Health and Safety Coordinator

Is responsible for:

- Analysing and identifying risks from accident/incident report forms.
- Where risks are identified, liaising with and assisting line managers to ensure corrective action is undertaken to reduce or eliminate the risks.
- Reviewing and analyzing accident/incident reports for trends/patterns and producing ~~three~~ monthly reports to relevant managers.
- Bringing accident/incident statistics to the attention of the Chief Executive, Senior Management and Line Managers.
- Bringing accident/incident forms involving staff to the attention of the Human Resource Officer and/or payroll staff if appropriate.
- Providing information to the insurance company where relevant
- Reporting any reportable accidents (>3 days absent from work) and dangerous occurrences to the Chief Executive, the Administrator/Quality & Standards Manager and Health and Safety Authority using Forms IR1 and IR3 as relevant.
- Logging of required information regarding incidents onto the National Incident Management System (NIMS) in a timely manner.

8.4 Health & Safety Committee

The Health & Safety Committee may make recommendations and provide input on trends/patterns identified in the accident/incident statistics and on Accident/Incident Management policy and procedures.

8.5 Safety Representatives

Under the Safety, Health and Welfare at Work Act, 2005, the Services' safety representatives can if they so wish, inspect the workplace immediately, in the event of an accident, dangerous occurrence or imminent danger or risk to the safety, health and welfare of any person.

8.6 Employee Responsibilities

All employees must:

- Comply with the services procedures set out in this document in relation to reporting of accident/incidents in the course of their duty
- Ensure that incidents are reported in a timely manner
- Participate in and co-operate with reviews conducted in accordance with service procedures
- Participate in the introduction of change identified as a consequence of a review
- Comply with their professional codes of conduct as they relate to incident management.

Employee Support: If an employee requires support following involvement in an accident/incident 'Inspire Workplaces' provides a confidential counselling support and referral service for all staff with personal or work related difficulties.

9.0 REPORTING AN ACCIDENT/INCIDENT

9.1 It is important that no person is exposed to any preventable injuries, hence all staff are made aware that any accident/incident arising in the workplace must be reported immediately after all persons involved have been made safe. The correct documentation must be completed and submitted within the next working day of the accident/incident occurring so that it can be reviewed and hazards eliminated or reduced as soon as possible.

9.2 Where service users are involved in an accident/incident, it must be reported by the staff member who witnessed the accident/incident or who becomes aware that an incident occurred.

9.3 Should an employee/student/agency worker be involved in an accident/incident at work, it is their responsibility to report it with immediate effect.

9.4 Accidents/incidents that occur on site to visitors/contractors must be reported by the staff member who witnessed the incident or by the staff member to whom the incident was reported.

9.5 Family members must be informed of any accident/incidents involving service users. The relevant section on the accident/incident form must be completed when a family member has been informed.

10.0 COMPLETING AN ACCIDENT/INCIDENT FORM

There are three types of Accident/Incident Forms all of which can be located on the Forms section of the Governance & Service Delivery Cared 4 Folder.

All sections on the forms must be completed in a clear and detailed manner especially when describing the accident/incident.

All names (including service users) and addresses must be written in full – do not use initials.

The line manager must document the name of the person assigned responsibility for following up on any action resulting from an accident/incident and sign the accident/incident form.

Where follow up is carried out by a Senior Manager, Line Managers or the Health and Safety Coordinator, this must be documented in the relevant section on the form.

Where risk assessments and/or behaviour support plans are in place and it is identified that the incident occurred due to the failure of control measures and/or management plan for prevention of triggers, this must be documented on the form. The risk assessment / behaviour support plan should be reviewed. The line manager should not sign off the form if this section is relevant but is not completed.

10.1 Notice of Accident/Incident to Person Form

10.1.1 In the case of an accident/incident involving a service users the form should be completed by a staff member who witness the accident/incident (if witnessed). The form should not be completed by a third party.

10.1.2 Where an incident involved any form of restraint measure for a service user, staff must confirm on the accident/incident form that the Restraint Assessment/Behaviour Support Plan has been reviewed.

10.1.3 In the case of an accident/incident to a staff member (including agency worker), volunteer, student, contractor or member of the public, if possible, the form should be completed by the person directly impacted in an incident.

10.1.4 Where a service users incident results in a staff/volunteer/student/contractor/member of the public being impacted, triggers that may have led to the incident must be outlined in detail. Refer to triggers listed on behaviour support plans in place where applicable. The name and details on the top of the form should be those of the person impacted.

10.2 Medication Incident Report Form

10.2.1 Where errors occur regarding medication management, kardex misinterpretation or completion, the Medication Incident Report form must be completed by the person who made the error or the person who discovered the error, as appropriate.

10.2.2 All other medication incidents e.g. medication found on floors, medication not administered by families, service users refusing to take medication, medication crushed in blister packs, self-medication incident, etc., the form must be completed by the staff member who encountered the incident.

10.4 Notice of Property Incident Form / Dangerous Occurrence

10.4.1 To be completed by the person who was directly involved in the incident or who directly witnessed the incident – it should not be completed by a third party.

10.4.2 Damage to property must be reported to the Finance Manager who will inform the Insurance company if required.

11.0 CATEGORISATION AND REVIEW OF INCIDENTS

The purpose of categorising and assessing incidents is to assist with determining the level of review required. The level and approach to review must be proportionate to the impact of the incident and the opportunity provided by the incident to identify learning that can be used to minimise the risk of a similar incident occurring in the future.

The level of harm experienced informs the categorisation of the incident. Incidents are categorised as follows:

- Category 1 Major/Extreme – Clinical and non-clinical incidents rated as major or extreme.
- Category 2 Moderate – Clinical and non-clinical incidents rated as moderate.
- Category 3 Minor/Negligible – Clinical and non-clinical incidents rated as Minor or Negligible.

The above categorisation is auto-generated on the NIMS report form when the level of impact resulting from the incident is entered on the system.

The Health & Safety Co-ordinator prepares reports of incidents for discussion at monthly managers meetings. Minutes of these meetings are kept and any follow-up action is agreed.

Category 1 incidents must be referred to the Chief Executive immediately.

12.0 SIGNING ACCIDNET/INCIDENT FORMS

12.1 Where relevant, signatures and dates are required from the following:

- Doctor's Signature where applicable
- Witness to Incident/Person who completed form
- Line Manager
- Senior Manager
- Health & Safety Coordinator
- Service User or Advocate (on behalf of the Service User), where applicable

12.2 Any forms received by the Health and Safety Coordinator will be returned where relevant sign off has not been completed.

13.0 SUBMITTING AND FILING OF ACCIDENT/INCIDENT FORMS

13.1 Line managers are responsible for submitting the **completed** accident/incident forms to the relevant Senior Manager or to the Health & Safety Co-Ordinator as per individual arrangements with the relevant Senior Manager.

13.2 Completed forms must be submitted as soon as possible, but at latest within a week of the accident/incident occurring. However, the relevant senior manager should be informed verbally as soon as possible, in the event in an incident/ injury which is reportable to HIQA within 3 working days.

13.3 When a resident is involved in an accident/incident in a day service, the day service manager should send the completed form to the Person in Charge (PIC) of the relevant residential home.

13.4 When a service user is referred to a doctor, the doctor must sign the accident/incident form which is then submitted to the Senior Manager immediately thereafter. A note must be made in the service user's medical records.

13.5 When forms are referred to a Senior Manager, he/she will review, sign and submit original forms to the Health and Safety Coordinator.

13.6 The completed original form will be retained on file by the Health and Safety Coordinator and inputted into a database for statistical purposes and the National Incident Management System

13.7 In the case of report forms involving a service user, depending on the system being used by the relevant Senior Manager, the Health & Safety Coordinator may copy the completed original form and send it to the relevant service area, to be filed in the Orange Accident/Incident folder. There should be no other copies on file.

13.8 In areas where the Orange coloured Accident/Incident folder is not being maintained, the manager or key worker should request a report of accident/incidents for individual service users (as part of their annual PCP review) from the Health & Safety Coordinator.

13.9 Where a staff member has been absent for 6 days or more due to a work related accident/incident, a copy of the accident/incident form may be requested by Payroll for Social Welfare purposes and filed on the payroll file.

14.0 PROCEDURE IN CASE OF A DANGEROUS OCCURRENCE

1. In the event of a dangerous occurrence *(see examples set out in Appendix I)*, where relevant, raise the alarm by activating pagers, fire alarms as appropriate.

2. Clear the area immediately of staff and service users.

3. Notify the following personnel:
   - The Line Manager/ Person in Charge
   - The C.E.O.
   - Relevant Senior Manager
   - Health and Safety Co-ordinator

4. The Line Manager / Person in Charge must arrange to have the area cordoned off.

5. The Line Manager/Supervisor/Person in Charge must arrange to seek professional assistance where necessary.

6. The Health and Safety Coordinator must carry out an assessment to determine the cause of the occurrence and how to prevent reoccurrence.

7. No work/activity should resume until the C.E.O., Health and Safety Coordinator/Line Manager or Person in Charge is satisfied that it is safe to do so.

Where the incident involves a fire or collapse of a building structure, under no circumstances should any staff re-enter a building until the area has been assessed by qualified personnel.

15.0 SERIOUS REPORTABLE EVENTS

Serious Reportable Events are a defined subset of incidents which are either serious or that should not occur if the available preventative measures have been effectively implemented by healthcare providers. Serious Reportable Events are mandatorily reportable by services to the HSE. *See list of Reportable events at Appendix II.*

16.0 OPEN DISCLOSURE

Open Disclosure is defined by the Australian Commission on Safety and Quality in Health Care as "an open, consistent approach to communicating with patients when things go wrong in healthcare. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event."

The principles of Open Disclosure form the basis of an ethical response by the organisation to the service user/family in relation to an adverse event. *See Policy on Open Disclosure.*

17.0 REPORTING TO THE STATE CLAIMS AGENCY

The National Treasury Management Agency is a State body which operates with a commercial remit to provide asset and liability management services to Government. The Health & Safety Coordinator reports all accidents/incidents, including safeguarding incidents, to the State Claims Agency using the on-line National Incident Management System (NIMS).

Any claims which the Services may have with regard to public liability, employer liability or motor insurance are covered by the State Claims Agency.

Statistical Reports with regard to incidents reported are available on the NIMS programme.

18.0 NOTIFICATION OF INCIDENTS TO HIQA

In accordance with the Health Act, 2007 (Regulations 2013), the person in charge shall notify the Health Information and Quality Authority (HIQA) in writing **within 3 working days** of the following adverse incidents occurring in a designated centre:

(a) the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre also setting out the cause of the death when same has been established.

(b) an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre;

(c) any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place;

(d) any serious injury to a resident which requires immediate medical or hospital treatment;

(e) any unexplained absence of a resident from the designated centre;

(f) any allegation, suspected or confirmed, of abuse of any resident;

(g) any allegation of misconduct by the registered provider or by staff; and

(h) any occasion where the registered provider becomes aware that a member of staff is the subject of review by a professional body;

The person in charge shall ensure that a written report is provided **at the end of each quarter of each calendar year** in relation to any of the following incidents occurring in the designated centre:

(a) any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used;

(b) any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment;

(c) where there is a recurring pattern of theft or burglary;

(d) any injury to a resident not required to be notified within 3 working days

(e) any deaths, including cause of death, not required to be notified within 3 working days

(f) any other adverse incident the chief inspector may prescribe.

Where no incidents which require to be notified have taken place, the registered provider shall notify HIQA of this fact on a six monthly basis.

Appendix I

Dangerous occurrences include:

1. The collapse, overturning, or failure of any load-bearing part of:
   (a) any lift, hoist, crane, or mobile powered access platform;
   (b) any excavator or any pile-driving frame or rig having an overall height, when operating, of more than seven metres.

2. The explosion, collapse or bursting of any closed vessel, including a boiler, in which the internal pressure was above or below atmospheric pressure.

3. Electrical short circuit or overload attended by fire or explosion which results in the stoppage of the plant involved for more than 24 hours.

4. An explosion or fire occurring in any plant or place which resulted in the stoppage of that plant or suspension of normal work in that place for more than 24 hour.

5. The sudden uncontrolled release of highly flammable liquid, liquefied flammable gas, flammable gas or flammable liquid from any system plant or pipe-line.

6. The collapse or partial collapse of any scaffold more than five metres high which results in a substantial part of the scaffold falling or overturning, collapse or part collapse of the suspension arrangements which causes a working platform or cradle to fall more than five metres.

7. Any unintended collapse or partial collapse of:

   (a) any building or structure under construction, reconstruction alteration or demolition,
   (b) any floor or wall of any building being used as a place of work, not being a building under construction, reconstruction, alteration or demolition.

8. The uncontrolled or accidental release or the escape of any substance or pathogen from any apparatus, equipment, pipework, pipe-line, process plant, storage vessel, tank, which, having regard to the nature of the substance or pathogen and the extent and location of the release or escape, might have been liable to cause serious injury to any person.

9. Any unintentional ignition or explosion of explosives.

10. Any incident in which a container, tank, tank vehicle being used for conveying a dangerous substance by road overturns or suffers damage to the tank in which the dangerous substance is being conveyed.

11. Any incident where breathing apparatus while being used to enable the wearer to breathe independently of the surrounding environment malfunctions in such a way as to be likely either to deprive the wearer of oxygen or, in the case of use in a contaminated atmosphere, to expose the wearer to the contaminant to the extent in either case of posing a danger to his health.

12. Any incident in which plant or equipment either comes into contact with an overhead electric line.

Appendix II

Serious Reportable Events

1	**Surgical Events**
A	Surgery performed on the wrong body part by a healthcare provider.
B	Surgery performed on the wrong patient by a healthcare provider.
C	Wrong surgical procedure performed on patient by a healthcare provider.
D	Unintended retention of a foreign object in a patient after surgery or other procedure performed by a healthcare provider
E	Intra – operative or immediately post-operative death of a normal health patient with no known medical problems after surgery or other procedure performed by a healthcare provider.
2	**Product or Device events**
A	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by a healthcare provider.
B	Patient death or serious disability associated with the use or function of a device in patient care provided by the healthcare provider in which the device is used or functions other than as intended or anticipated.
C	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for by a healthcare provider but excluding death or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
3	**Patient protection Events**
A	Child or other dependent person discharged to the wrong person by a healthcare provider.
B	Patient death or serious disability associated with patient absconding from a healthcare facility whilst under medical supervision but excluding where the patient advises the healthcare provider that he or she is leaving against medical advice.
C	Patient suicide, or attempted suicide, resulting in serious injury or disability while receiving health services from a healthcare provider.
4	**Care Management Events**
A	Patient death or serious disability associated with a medication error by the healthcare provider but excluding reasonable differences in clinical judgement involving drug selection and dose.
B	Wrong route administration of chemotherapy by a health care provider.
C	Intravenous administration of mis–selected concentrated potassium chloride by a healthcare provider.
D	Patient death or serious disability associated with a haemolytic reaction due to the administration of incompatible blood or blood products by a healthcare provider.
E	Maternal death or serious disability, occurring within 42 days post-delivery, associated with labour or delivery in any pregnancy while being cared for by a healthcare provider.
F	Death or serious injury of a neonate associated with labour or delivery in a low-risk pregnancy.
G	Patient death or serious disability associated with hypoglycaemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
H	Death or serious disability (kernicterus) associated with failure by a healthcare provider to identify and treat hyperbilirubinermia in infants within the first 28 days of life.
I	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility but excluding progression from stage 2 to stage 3, if stage 2 was recognised upon admission.
J	Patient death or serious disability due to spinal manipulative therapy by a healthcare provider.
K	Artificial Insemination with the wrong donor sperm or wrong egg by a healthcare provider.
5	**Environmental events**
A	Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility but excluding events involving planned treatment such as electric counter-shock or elective cardioversion.

B	An incident in which a line designated for oxygen or other gas to be delivered to a patient while being cared for by a healthcare provider contains the wrong gas or is contaminated by toxic substances.
C	Patient death or serious disability associated with a burn incurred within a healthcare facility.
D	Patient death or serious disability associated with a fall while being cared for in a healthcare facility.
E	Patient death or serious disability associated with the use of physical restraints or bedrails while being cared for in a healthcare facility.
6	**Criminal Events**
A	Any instance of care ordered by someone impersonating a healthcare professional.
B	Abduction of a patient of any age while being cared for in a healthcare facility.
C	Sexual assault on a patient within or on the grounds of a healthcare facility.
D	Death or serious harm of a patient or other person resulting from a physical assault that occurs within or on the grounds of a healthcare facility.
E	Patient death or serious disability associated with physical assault while being cared for in a health care facility.