ACCIDENT/NEAR MISS REPORTING
DEALING WITH ACCIDENTS & INJURIES

POLICY AND PROCEDURE

Implemented December 2009. By Paul Graham – Registered Care Manager
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Policy Amended February 2021 – Rebecca Gritton – HR Manager
Policy Reviewed – Paul Graham – Director of Services April 2022

ASPECTS CARE ACCIDENT/NEAR MISS REPORTING
DEALING WITH ACCIDENTS & INJURIES

POLICY AND PROCEDURE

1. Introduction

It is the duty of all staff to report all accidents and dangerous occurrences, however minor, which occurs on Aspects Care Ltd premises or arises from work carried out on behalf of Aspects Care Ltd, either by its own staff or by third parties. This responsibility extends to accident/near miss involving members of the public and/or visitors.

2. Aims of the Policy

There are two principal aims of this Policy:

- to facilitate the identification of failures in safety management systems and improve them so that the conditions that led to the accident/near miss are not repeated

- to ensure legislative compliance within the Company (e.g. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

In order to achieve these aims managers in Aspects Care Ltd, the Company must ensure that:

- accurate and full information is quickly gathered and recorded from persons involved, facilitating fast managerial action and analysis of the problem

- Aspects Care Ltd is placed in a position to respond quickly, positively and appropriately to enforcement agencies, staff, members of the public or their legal representatives

- Investigations are carried out by staff with appropriate training in accident/near miss investigation.

3. Relevant Legislation

This Policy reflects the requirements of the following pieces of legislation:

- Health & Safety at Work, etc. Act 1974
- Management of Health & Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

- Social Security Act 1975

4. Definitions and Scope

This Policy uses the terms: accidents, near miss and accident/near miss they are defined as follows.

Accident

Any untoward or unplanned event that was created by a set of circumstances not foreseen, at the time and resulted in injury or loss.

Near-miss

An unplanned and unforeseen event which did not result in injury or any other loss but under different circumstances could result in injury or loss.

Incidents

Is the term that describes actions or events which are of note, and which involves acts or deeds of a service user.

Definitions

Aspects Care Ltd has adopted three definitions for grades of accident/near miss investigation:

- **Level 1** – Minor effect (e.g. first aid treatment) on the health or safety of a person
- **Level 2** – Serious effect (e.g. broken limbs) on health or safety of a person
- **Level 3** – Death of or life-threatening accident/near misses to a person.

Major Injury

Is the term used to cover a variety of defined types of injury as listed in schedule 1 of RIDDOR that need to be reported to the HSE see appendix 3.

Dangerous Occurrence

Is the term used to cover a wide variety of defined types of accident/near miss with the potential to cause personal injury as listed in schedule 2 of RIDDOR that need to be reported to the HSE see appendix 3

Reportable Disease

Is the term to cover a wide variety of defined disease as listed in schedule 3 of RIDDOR that need to be reported to the HS see appendix 3.

Responsible person

This is a person designated as being responsible for reporting RIDDOR events and managing their reporting and investigation. Since Aspects Care Ltd is not a large organisation, it is reasonably practicable to have one person in this key role.

Root Cause Analysis

Relates to finding the underlying factors that have contributed to creating the conditions that enabled the accident/near miss to occur initially.

Human Error

Is a failure by an individual that may have contributed to the accident/near miss.

5. Reporting Responsibilities

Employees

When a health and safety accident/near miss occurs, it is the duty of all employees to report its occurrence immediately to their line manager. Within 24 hours of the accident/near miss they should provide a brief, factual summary of the events as they occurred and the outcome of the accident/near miss.

Care Coordinators/ Deputy Care Manger personnel

When informed of an accident/near miss, Care Coordinators/ Deputy Care Manger personnel must satisfy themselves that they clearly understand the seriousness of the outcome (or the potential seriousness if a near miss). It is this understanding that will prompt the appropriate managerial action as dictated by this Policy.

Ideally, every accident/near miss should be properly investigated. However, it is recognised that due to operational demands this is not reasonably practicable. It is therefore necessary to grade the level of accident/near miss reporting to ensure appropriate use of resources.

The level of injury should dictate the level of investigation required where there has been no injury i.e. near miss then the reasonably foreseeable worst case injury should be used to dictate the level of investigation required.

Level 1 A minor injury such as a minor cuts and bruises.

Level 2 A moderate injury, ranging from cuts requiring stitches to minor fractures or illness

Level 3 A serious physical injury or illness (e.g. multiple fractures, career threatening injury).

All accidents should be recorded with the relevant Accident Book, a copy of which should be retained for local records. If the accident/near miss is graded as a level 2 or 3 then the Care Coordinators/ Deputy Care Mangers personnel must inform their Senior Manager at the earliest opportunity.

Where accident/near misses are graded at level 2 or 3 then an investigation should be instigated using the accident/near miss Book.

Where the accident/near miss may be RIDDOR reportable (see Appendix 3), the accident/near miss Book must be filled out at the earliest opportunity. The local line manager has the responsibility for ensuring that the accident/near miss Book is filled out accurately and competently. The completed accident/near miss Book must be passed to the Director/Senior Manager for further action.

Care Coordinators/ Deputy Care Manger personnel

Care Coordinators/ Deputy Care Manger personnel have the overall responsibility of ensuring that local accident/near misses are adequately and competently investigated, the findings recorded and any recommendations acted upon. It is recognised that it may not be reasonably practicable for them to carry out each and every investigation. They may therefore identify other personnel under their management to undertake this task. Due consideration should also be given for out of hours investigation where appropriate (e.g. cover for the night shift).

The investigation of Level 1 - 3 accident/near misses must be recorded on the Accident/near miss. The guidelines for carrying out an accident/near miss investigation can be found in Appendix 1 to this policy.

A copy of the investigation report is to be held in Aspects Care Ltd Head Office.

6. Risk Management Considerations

For a general health and safety accident/near miss the first document that must be checked after an accident/near miss is the risk assessment that covers the task in question. Note that the risk assessment does not have to cover exactly the accident/near miss; as long as it approximates it will suffice. Where a risk assessment is in place it should be reviewed, and the risk controls examined, and their effectiveness judged.

Care Coordinators/ Deputy Care Manger personnel will be responsible for quality assuring any accident/near miss investigations completed in their area of responsibilities. It is also imperative that they actively consider and implement any recommendations made when accident/near miss investigated. They should also endeavour to share good practice throughout Aspects Care Ltd as a result of this learning.

It is for Care Coordinators/ Deputy Care Manger personnel, through their staff managers to ensure that they have effective local arrangements to overcome the following barriers to accident/near miss reporting:

- lack of awareness of the need to report, what to report and why
- lack of understanding of how to report
- staff believing, they are too busy to report
- too much paperwork being involved
- the victim of the accident/near miss recovers, and the urgency goes out of the situation
- an assumption that someone else will make the report
- No evidence to local staff of timely feedback and/or corrective action being taken as a result of the report.

Any arrangements must be annually reviewed and adequately monitored.

7. Consultation

Aspects Care Ltd Directors are to review the findings of health and safety accident/near miss investigations.

Dealing with Accidents & Injuries

The purpose of this policy is to instruct Aspects Care Ltd staff with what steps they must follow in cases where service users have lost consciousness, collapsed, are acting abnormally, or become very ill.

This policy will also put in place mechanisms to ensure that staff follow these procedures, and that the best possible outcome is achieved in such emergencies.

Dealing with Emergencies, Accidents or Injuries

8. Introduction

Staff should firstly establish the nature of the emergency.

If it an emergency that has not yet affected or harmed the service user (e.g. gas leak, storm damage, flooding, etc.) then the staff member should take any immediate safe action to limit the hazard that they can (e.g. turn gas off, make temporary cordon, etc.). Staff should then remove themselves and the service user to a safe location and inform their manager and any relevant emergency services.

If the emergency directly affects the service user then staff members must establish that the area in which the service user is found is safe to enter and if not measures should be taken to ensure that it is made safe (e.g. switch of electrical supplies).

Staff should then establish the state of the service user's vital signs.

Staff should then clear the airway or check that the airway is cleared.

If possible and necessary, the staff member must turn the service user into the recovery position. Service users with a spinal or neck injury must never be moved. Staff must never move the service user unless it is absolutely imperative to do so. If it is dangerous or unnecessary to do so then rather try to make the service user comfortable. For example, cover them with a warm blanket and put a pillow under their head.

If the service user is conscious, ask the service user where the injury or pain may be before checking for bleeding.

Check for bleeding. If the service user is bleeding, then the staff member must put pressure on the bleeding spot in the manner that they have been trained. Staff must always use a clean handkerchief, towel or other type of clean surface that forms a pad between their hands and the bleeding surface.

When the emergency is of such a nature that external medical assistance may be needed, then the staff member must first dial the 999 emergency services number and then contact the service user's doctor and advise him/her.

If the service user is removed from the premises, staff must make sure that the paramedics are given all the service users other medication and if applicable their Health Action Plan.

Staff should contact their immediate manager to report the emergency incident and also the family or representative of the service user.

9. Documentation

Where applicable staff members should record the nature of any injuries in the accident book and if relevant any near misses in the Near Miss Forms provided within Incident/Accident Folder.

10. Good Practice

It is always good practice for staff to keep proper records of all occurrences, emergencies or steps taken relating to the service users health. All staff members should record their exact steps in the daily living record.

APPENDIX 1

GUIDELINES FOR COMPLETING REPORT OF AN ACCIDENT/NEAR MISS BOOK

These guidelines are meant for anyone who is required to report an accident, near miss, accident/ near miss, major injury or dangerous occurrence. The accident/near miss must be recorded as soon as possible by completing the Accident/near miss Book.

Accident

An untoward or unplanned event that was created by a set of circumstances not foreseen, at the time and resulted in injury or loss.

Near-miss

An unplanned and unforeseen event which did not result in injury or any other loss but under different circumstances could result in injury or loss.

Accident/near miss

Is the term that describes both accidents and near misses. Therefore, this Policy will use the word accident/near miss as a collective term. Aspects Care Ltd has adopted three definitions for grades of accident/near miss investigation.

- Level 1 – Minor effect (e.g. first aid treatment) on the health or safety of a person
- Level 2– Serious effect (e.g. broken limbs) on health or safety of a person
- Level 3 – Death of or life-threatening accident/near misses to a person.

Major Injury

Is the term used to cover a variety of defined types of injury as listed in schedule 1 of this policy that need to be reported to the HSE.

Dangerous Occurrence

Is the term used to cover a wide variety of defined types of accident/near miss with the potential to cause personal injury as listed in schedule 2 of RIDDOR that need to be reported to the HSE.

Reportable Disease

Is the term to cover a wide variety of defined disease as listed in schedule 3 of this policy that need to be reported to the HSE.

Once the Accident/near miss Book has been completed then a copy must be sent immediately to Aspects Care Ltd Head Office.

Any accident/near miss causing more than three days absence from work, including rest days, is required by health and safety legislation to be reported within ten days, to the Health and Safety Executive (HSE).

Immediate notification to the HSE is required, normally by a phone call to 0845 3009923, of the following:-

Any fatal injuries to a staff member, connected to work
Any major injuries to staff member connected with work
Any dangerous occurrences

(See appendix 3 for further guidance on reporting of major injuries, diseases and dangerous occurrences to the HSE).
Completing the Accident/Near Miss Book Report

Level 1 - any accident/near miss considered by the line manager to be minor (e.g. first aid treatment) can be dealt with by ensuring that all details are complete on the Accident/near miss Book.

Level 2 - any accident/near miss that results in or could have resulted in a more serious outcome (e.g. broken bones) or requiring three days or more sickness needs a more formal investigation involving relevant Care Coordinators/ Deputy Care Mangers personnel.

Investigation should be carried out by a competent person using the Accident/Near Miss Book.

Level 3 - any accident/near miss giving rise to a fatal, major injury or dangerous occurrence requires a formal investigation using Accident/Near Miss Book by a senior management team, including Care Coordinators/ Deputy Care Mangers personnel together with appropriate Directors. All Accident/near miss of this severity are to be reported immediately to the HSE, usually by phone, who may then become part of the investigation team.

APPENDIX 2

GUIDELINES FOR COMPLETING AN ACCIDENT/NEAR MISS INVESTIGATION

These guidelines are meant to be a brief over-view of the investigation process, a minimum standard for individuals who have completed Accident/near miss Investigation training.

They are not meant to be used as a step-by-step guide of how to carry out an investigation. Investigation techniques and the way that investigations evolve during the process will be different depending on the accident/near miss faced. The ability to recognise an appropriate method or approach and formulate the right questions is the subject of specialist training.

Introduction

It should be remembered that the prime aim of any accident/near miss investigation is prevention rather than apportioning blame. This guidance sets out to record the process to be followed when carrying out an investigation. It therefore is not an exhaustive description of what should be done. It is the responsibility of the accident/near miss investigator to add to the requirements of these guideline's as they feel appropriate.

Capturing and recording information on adverse events and analysing them in the right way is an essential step to reducing risk to staff and others. Recognising that it is weak systems that create the conditions for, and the inevitability of, accident/near miss is vital to achieving higher levels of staff and public safety. It is therefore essential that accident/near miss investigators are competent to understand how to identify the root causes of accident/near miss so that safety management systems can be upgraded appropriately in the light of learning from an accident/near miss.

Legal Timescales

When a legal suit is brought against Aspects Care Ltd care, it has 21 days to acknowledge the claim and three months to collect the following types of information where it is deemed relevant:

- Accident/near miss records
- Any pre-accident risk assessment
- Any post-accident assessment
- Accident/near miss investigation report(s)
- Copy of information supplied to employees
- Training records
- Specific documentation relating to particular relevant regulations

It is therefore the view of Aspects Care Ltd that investigations will be carried out within a few days of the accident/near miss occurring. This will ensure that detailed information can be gathered whilst it is still fresh. It will also mean that when Aspects Care Ltd is notified of a claim, it will have 21 days to consider its response properly instead of chasing to try and find out what happened. It will also enable Aspects Care Ltd to utilise the 3 months' preparation more effectively in the consideration of its defence.

Notification of the accident/near miss

The details of who should be informed and when is given in the main Policy.

Arriving at the scene
In any accident/near miss the first and most immediate action should be make the scene safe for rescuers to attend to the casualty(ies).

Once the casualty is taken away, the site should be isolated and not disturbed, particularly if the accident/near miss is regarded as being serious.

Investigation

A good accident/near miss investigation is prompt. It should have 4 stages:

- collect evidence
- assemble and consider evidence
- compare findings with appropriate standards and draw conclusion(s)
- implement findings

Evidence is first collected by observation and is time critical. Physical evidence can change (or be altered) quickly. Premises, equipment and substances, etc., must all be examined. If sketches and photographs are being employed, measurements and scale are important pieces of information. The location of each witness at the time of the accident/near miss (if appropriate) should be clarified on the diagrams. Photographs should be taken of the scene from each witness's location.

Evidence is then gathered from risk assessments, audit information, policies, procedures (formal and informal), inspection reports, memoranda, etc. Once all of this evidence has been gathered it must be checked to identify its reliability, accuracy and any potential conflicts or gaps.

Concurrently, the victim and witnesses will be interviewed along with line managers, safety representatives and any other 'stakeholders'. Witnesses must be interviewed as soon as possible, and when taking note of their evidence, care should be exercised to differentiate between what are measurable facts and what is hearsay or opinion. Preferably, witnesses should be kept apart until they are interviewed.

At the interview great care must be taken not to lead the witness during questioning. The truth should be 'distilled' by asking a selection of open and closed questions. Do not forget that people have five senses and so may have useful information learnt from senses other than sight. If the witness desires, they are to be allowed a friend or a union representative in the interview with them. The object of the questioning is to establish the cause of the accident/near miss not to apportion blame.

During an interview of a witness, the investigator is required to take a statement. At the end of the interview, the witness is asked to read the statement and sign it if they agree it to be a true and accurate record of their testimony. If not, amendments are agreed and made before the signature is appended. Any changes made on the statement must be initialled by the witness. This record must make it clear what are facts and which are the opinions of the witness.

Any discrepancies between witness testimonies must be checked.

While assembling and considering the evidence the investigator must look to identify the immediate causes and the underlying causes. Actual performance should be measured against any relevant standards (law or good practice).

The investigator should use the following framework in order to assist them in identifying underlying contributory factors that created the conditions that caused the accident/near miss.

Factor	**Influencing Contributory Factors**
Organisational and Management Factors	Financial resources & restraints Organisational structure Policy standards and goals Safety culture and priorities
Work Environment Factors	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support

Team Factors	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership, etc)
Individual (staff) Factors	Knowledge and skills Competence Physical and mental health
Task Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results

Taken from the Protocol for the Investigation and Analysis of Clinical Accident/near misses, ALARM

Accident/Near Miss Reporting

The Accident/Near Miss Book must be completed. The person reporting the accident/near miss must record the full immediate circumstances that created the accident/near miss. In doing so they should try to be objective in the way they write-up the information.

Q1. What is the likelihood for re-occurrence of this event? Use the table below to assign this accident/near miss a category code.

Level	Descriptor	Description
3	Almost certain	Likely to reoccur on many occasions, a persistent issue.
2	Likely	Will probably re-occur but is not a persistent issue.
1	Unlikely	Do not expect it to happen again but it is possible.

Q2. What is the likely consequence of this happening again?
Use the table below and place a tick in the appropriate box under each column heading. The highest level ticked determines the overall Consequence Category rating. If in doubt do grade up.

Level	Descriptor	Actual or Potential Impact on Individuals
3	Major	DEATH /PERMANENT INJURY Loss of body part(s) RIDDOR reportable
2	Moderate	SEMI-PERMANENT INJURY/DAMAGE e.g. injury that takes up to one year to solve.
1	Minor	SHORT TERM INJURY/DAMAGE e.g. injury that has been resolved in one month

These scores give an overall rating of significance as follows

Likelihood	Consequence		
	1 - Minor	2 - Moderate	3 Major
1 - Unlikely	Low	Low	Medium
2 – Likely	Low	Medium	High
3 – Almost Certain	Medium	High	High

Accident/near miss Investigation Reports

All accident/near miss are to be reported using the Accident/near miss Book. In moderate, serious or complex accident/near miss, the entry may prove inadequate for recording and analysing the information. In such circumstances the Accident/near miss Book is still to be completed, but reference to an attached investigation can be made.

When the conclusions are drawn and recommendations made, they should be prioritised and turned into specific objectives. A person should be held accountable for the effective implementation of each objective. Line managers, particularly the Manager should monitor and ensure progress with the implementation of these objectives.

Safety Representatives

Where a Union or non-union health & safety representative request it, a joint investigation should be carried out.

APPENDIX 3

GUIDANCE FOR REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES

Aspects Care Ltd needs to report:

- Deaths
- Major injuries
- Accidents resulting in over 3 days off work
- Diseases
- Dangerous occurrences

Death or major injury

If there is an accident connected with work and:
Your employee or a self-employed person working on your premises is killed or suffers a major injury (including as a result of physical violence);

Or a member of the public is killed or taken to hospital;

You must notify the enforcing authority without delay. You can either telephone or complete the appropriate form on the internet.

Reportable major injuries are:

- fracture other than to fingers, thumbs or toes;
- amputation;
- dislocation of the shoulder, hip, knee or spine;
- loss of sight (temporary or permanent);
- chemical or hot metal burn to the eye or any penetrating injury to the eye;
- injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- any other injury: leading to hypothermia, heat-induced illness or unconsciousness; or requiring resuscitation; or requiring admittance to hospital for more than 24 hours;
- unconsciousness caused by asphyxia or exposure to harmful substance or biological agent;
- acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
- acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material

Over-three-day injury

If there is an accident connected with work (including an act of physical violence) and your employee, or a self-employed person working on your premises, suffers an over-three-day injury you must report it to the enforcing authority within ten days.

An over-three-day injury is one which is not major but results in the injured person being away from work or unable to do their normal work for more than three days (including any days they would not normally be expected to work such as weekends, rest days or holidays) not counting the day of the injury itself.

Disease

If a doctor notifies you that your employee suffers from a reportable work-related disease then you must report it to the enforcing authority.

Reportable diseases include:

- certain poisonings;
- some skin diseases such as occupational dermatitis, skin cancer, chrome ulcer, oil folliculate/acne;
- lung diseases including: occupational asthma, farmer's lung, pneumoconiosis, asbestosis, mesothelioma;
- infections such as: leptospirosis; hepatitis; tuberculosis; anthrax; legionellosis and tetanus;
- other conditions such as: occupational cancer; certain musculoskeletal disorders; decompression illness and hand-arm vibration syndrome.

The full list of reportable disease and the work activities they are related to, can be found in the detailed guide to the regulations.

Dangerous occurrence

If something happens which does not result in a reportable injury, but which clearly could have done, then it may be a dangerous occurrence which must be reported immediately to the relevant line manager, who may then foreword the information onto the Health & Safety Executive.