ACCIDENTS, INCIDENTS, AND NEAR MISSES POLICY AND PROCEDURE

PRIMUS PLUS HEALTHCARE

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1. PURPOSE

The Accidents, Incidents, and Near Misses Policy and Procedure for Primus PLUS Healthcare ensures a comprehensive and transparent approach to managing accidents, incidents, and near misses in our Supported Living without Personal Care settings. The policy aims to safeguard the health, safety, and well-being of employees, service users, and visitors while ensuring compliance with CQC regulations, national health and safety laws, and industry standards. The key objectives are:

1.1 Ensure Compliance with Legal and Regulatory Requirements

- CQC Regulations:
    - Regulation 12 – Safe Care and Treatment
    - Regulation 17 – Good Governance
    - Regulation 18 – Staffing
    - Regulation 20 – Duty of Candour
- Health and Safety Legislation:
    - Health and Safety at Work Act 1974
    - RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013)

1.2 Promote a Culture of Safety and Continuous Improvement

- Foster a safety-first culture where employees and service users feel empowered to report incidents and near misses.
- Ensure compliance with Regulation 17 (Good Governance), ensuring the organisation has systems to review and improve safety measures.

1.3 Prevent and Mitigate Risks to Individuals and Primus PLUS Healthcare

- Conduct risk assessments and hazard identification to prevent accidents.
- Establish incident response protocols to minimize harm and disruption.

1.4 Transparent Reporting and Accountability

- Ensure all incidents are reported and investigated consistently in line with Regulation 20 (Duty of Candour) and Regulation 17 (Good Governance).
- Employees are accountable for reporting and addressing incidents as per Regulation 18 (Staffing).

1.5 Support and Protect Employees and Service Users

- Provide employee welfare support, including access to medical care and necessary adjustments.
- Regulation 12 ensures a safe environment for service users, protecting them from harm.

1.6 Promote Compliance with National Standards and Best Practices

- Align with national bodies like HSE, RoSPA, and NICE.
- Ensure compliance with Regulation 12, Regulation 17, and Regulation 18 to maintain high standards of safety and care.

1.7 Clear Roles, Responsibilities, and Procedures

- Define clear roles for staff in the reporting and investigation of incidents.
- Regulation 18 requires staff to be trained and understand their responsibilities.

1.8 Ensure Accurate Data Collection for Trend Analysis

- Record and analyse all incidents to identify trends and areas for improvement.
- Management reviews trends as required by Regulation 17 (Good Governance).

2. SCOPE

The Accidents, Incidents, and Near Misses Policy and Procedure applies to all activities and services provided by Primus PLUS Healthcare, including operations in the workplace, client sites, and during service delivery. This policy ensures that accidents, incidents, and near misses are reported, investigated, and managed to reduce harm and improve safety for all involved. It is in full compliance with CQC regulations, UK health and safety legislation, and industry best practices.

2.1 Applicability to All Personnel and Stakeholders

This policy applies to:

- All employees (permanent, temporary, part-time, or contract staff).
- Service users (individuals receiving care or services, including those with the following conditions): Adults over 65 years, Adults under 65 years, Dementia, Mental health conditions, Physical disabilities, Sensory impairments, Eating disorders, Substance misuse (drugs and alcohol), Autism, Learning disabilities
- Contractors and subcontractors (individuals or entities providing services or goods to Primus PLUS Healthcare).
- Visitors (individuals on premises for business, training, or service-related purposes).
- Volunteers (supporting activities and programs).

2.2 Types of Incidents Covered

This policy applies to all incidents, accidents, and near misses, including, but not limited to:

- Workplace Accidents: Injury, illness, or damage during work duties.
- Service User Incidents: Harm, distress, or injury to service users during care or services, including those related to: Dementia, Mental health conditions, Autism, Learning disabilities, Physical disabilities, Sensory impairments, Eating disorders, Substance misuse
- Near Misses: Incidents where harm was narrowly avoided.
- Property Damage: Loss or damage to physical property or equipment.
- Fire and Safety Incidents: Fire-related events, including alarms or accidental fires.
- Health and Environmental Incidents: Exposure to hazardous substances or breaches in infection control.
- Violence and Aggression: Aggressive behavior towards staff or others, including physical or verbal abuse.

- Workplace Equipment Failures: Malfunctions or misuse of equipment or machinery.

2.3 Service Areas and Locations

This policy covers accidents, incidents, and near misses across all operational settings, including:

- Primus PLUS Healthcare Premises: Offices, care facilities, training rooms, etc.
- Client Sites: Locations where care or support services are provided, including home visits, residential facilities, and community settings.
- Off-Site Locations: External meetings, conferences, or training events.
- Transport and Vehicles: Accidents during transportation of staff, service users, or goods.

2.4 Activities and Events Covered

This policy applies to accidents, incidents, and near misses arising from:

- Care and Support Services: Incidents or accidents during the provision of health, social, or domiciliary care services.
- Training and Development: Events occurring during employee training, development programs, or safety drills.
- Administration and Operational Tasks: Office-based incidents, IT system use, etc.
- Workplace Events: Any accidents or incidents that occur during internal meetings or events.
- Emergency Situations: Events arising in emergencies, such as medical emergencies, fire evacuations, or crisis management.

2.5 Excluded Incidents

While this policy covers a wide range of potential accidents and incidents, the following are not included:

- Incidents outside work scope: Accidents occurring outside of work duties or work-related environments.
- Criminal Acts: Deliberate criminal activity such as theft, assault, or fraud.

2.6 Incident Severity Levels

This policy categorizes incidents by severity:

- Minor Incidents: Low-impact incidents causing minimal harm or disruption.
- Moderate Incidents: Incidents causing moderate harm or requiring short-term adjustments.
- Major Incidents: Severe incidents that require immediate medical intervention or full investigation.

2.7 Legal and Regulatory Context

This policy ensures compliance with:

- Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations 1999

- RIDDOR (Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations) 2013
- CQC Regulations: Particularly Regulation 12 (Safe Care and Treatment).

2.8 Data Protection and Confidentiality

All incident records will be managed in compliance with the Data Protection Act 2018 and GDPR, ensuring personal data is kept confidential throughout the reporting, investigation, and resolution process.

3. POLICY STATEMENT

Primus PLUS Healthcare is committed to maintaining a safe environment for all employees, service users, contractors, and visitors through the prevention, reporting, and management of accidents, incidents, and near misses. The policy is designed to reduce harm, improve care quality, and ensure compliance with CQC regulations, UK health and safety legislation, and industry standards.

3.1 Commitment to Safety and Prevention

- A proactive approach to risk management by identifying, assessing, and mitigating hazards.
- Training and awareness programs for staff to ensure quick responses to unsafe conditions.
- Risk assessments and continuous evaluation of safety performance.

3.2 Incident Reporting and Transparency

- Encourages a culture of openness in reporting incidents, near misses, and hazards without fear of reprisal.
- Accident/Incident Report Forms to be completed within 24 hours.
- Non-punitive approach to reporting, focusing on learning and safety improvements.

3.3 Investigation and Corrective Actions

- Thorough investigations to determine root causes.
- Corrective actions may include revising policies, improving training, or upgrading safety measures.

3.4 Compliance with Legal and Regulatory Standards

- CQC's Fundamental Standards, particularly Regulation 12 (Safe care and treatment).
- Health and Safety at Work Act 1974, Management of Health and Safety at Work Regulations 1999, and RIDDOR 2013.
- Ensuring compliance with national standards and maintaining high safety standards.

3.5 Continuous Improvement and Learning

- Regular audits of incident records to identify trends.
- Implementing lessons learned to improve operational procedures, risk management, and training.

3.6 Roles and Responsibilities

- Employees are responsible for reporting incidents and following safety protocols.
- Managers ensure proper reporting and corrective actions.
- Health and Safety Officer oversees policy implementation and audits.

- Senior Management ensures resources and compliance.

3.7 Employee Well-being and Support

- Provide first aid, counselling, and adjustments to help employees and service users recover after incidents.

3.8 Confidentiality and Data Protection

- Incident data is handled with confidentiality in compliance with the Data Protection Act 2018 and GDPR.

4. OBJECTIVES

The Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare aims to improve safety, reduce risk, and ensure compliance with all legal, regulatory, and organizational requirements within our Supported Living without Personal Care services.

4.1 Ensure Compliance with Legal, Regulatory, and Industry Standards

- Ensure compliance with CQC regulations, especially Regulation 12 (Safe Care and Treatment), to manage risks effectively.
- Adhere to UK health and safety laws, including Health and Safety at Work Act 1974 and RIDDOR 2013.
- Align with best practices from HSE, RoSPA, and NICE.

4.2 Promote a Safe and Healthy Environment

- Proactively identify and mitigate hazards to prevent accidents.
- Address incidents promptly and effectively to reduce risk or harm.
- Provide a safe environment for **employees, service users**, contractors, and visitors.

4.3 Incident Reporting and Documentation

- Ensure all incidents are reported promptly using standardized forms, in compliance with GDPR and Data Protection Act 2018.
- Foster open communication and transparency for staff to report incidents without fear of reprisal.
- Create a user-friendly system for reporting and managing incidents.

4.4 Investigate and Implement Corrective Actions

- Investigate incidents to identify root causes and contributing factors.
- Use tools like 5 Whys and Fishbone Diagrams for root cause analysis.
- Implement corrective and preventive actions, such as updating procedures, improving training, and upgrading safety measures.

4.5 Foster a Culture of Safety and Continuous Improvement

- Promote a shared responsibility for safety across all levels of Primus PLUS Healthcare.
- Integrate safety practices into daily operations and ensure ongoing training for staff.
- Encourage continuous improvement through feedback, audits, and refining policies based on incident data.

4.6 Support and Protect Affected Individuals

- Provide support to employees and service users involved in incidents, including medical care, counselling, and mental health support.
- Implement return-to-work programs for employees after injury or trauma, ensuring safe accommodations.

4.7 Facilitate Effective Communication

- Ensure clear communication between employees, managers, and external authorities (e.g., HSE, CQC).
- Keep all stakeholders informed about safety policies, incident outcomes, and actions taken.

4.8 Ensure Timely Compliance with Reporting Requirements

- Ensure incidents are reported in accordance with RIDDOR 2013 and CQC regulations, maintaining transparency.
- Maintain accurate records for auditing by regulatory bodies and use in performance reviews.

4.9 Monitor and Evaluate Policy Effectiveness

- Regularly monitor the policy's effectiveness in reducing risks and improving safety.
- Conduct annual reviews to assess the effectiveness of the policy and implement necessary updates.

5. LEGAL AND REGULATORY COMPLIANCE

The Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare is designed to ensure that we operate in full compliance with relevant UK legislation, regulatory requirements, and industry standards to ensure the safety of employees, service users, contractors, and visitors. The following outlines our legal and regulatory obligations:

5.1 Compliance with CQC Regulations

- Regulation 12 – Safe Care and Treatment: Ensure robust systems for identifying, reporting, and managing incidents to protect service users from unsafe care.
- Regulation 17 – Good Governance: Monitor and review incidents, ensuring proper documentation, investigation, and continuous learning.
- Regulation 18 – Staffing: Ensure staff are adequately trained to handle and report incidents, with a focus on safety.

5.2 Compliance with UK Health and Safety Legislation

- Health and Safety at Work Act 1974: Ensure the health, safety, and welfare of all employees and others affected by work activities.
    - Obligations: Risk assessment, providing training, and investigating accidents.
- Management of Health and Safety at Work Regulations 1999: Carry out regular risk assessments and ensure safety measures are in place.
    - Obligations: Training, risk management, and incident reporting.
- Control of Substances Hazardous to Health (COSHH) Regulations 2002: Protect employees from risks associated with hazardous substances.
    - Obligations: Risk assessments, proper storage, and handling of hazardous substances.
- RIDDOR 2013: Report serious work-related injuries, diseases, and dangerous occurrences to the HSE.
    - Obligations: Reporting major injuries, diseases, and near misses.

5.3 Compliance with Data Protection Act 2018 and GDPR

- Obligations:
    - Data Minimization: Collect only necessary data for incident reporting.
    - Confidentiality: Ensure personal data is kept confidential and secure.
    - Transparency: Inform individuals about the use of their data.
    - Access Control: Restrict access to incident reports and personal data to authorized personnel.

5.4 Compliance with NICE Guidelines

- Obligations:
    - Implement NICE guidelines for safety, risk management, and safe care delivery.
    - Align risk management strategies with NICE best practices to enhance service quality and reduce incidents.

5.5 Compliance with Fire Safety Legislation

- Regulatory Reform (Fire Safety) Order 2005: Ensure fire safety in non-domestic premises.
    - Obligations: Conduct fire risk assessments, provide fire safety training, and implement emergency evacuation procedures.

5.6 Compliance with the Equality Act 2010

- Obligations:
    - Ensure that accident and incident management procedures are accessible to all individuals, including those with disabilities.
    - Provide reasonable adjustments for employees with disabilities to ensure their safety and well-being.
    - Promote equality of opportunity in reporting, investigating, and addressing incidents.

5.7 Compliance with Local Authority and Insurance Requirements

- Obligations:
    - Report incidents to local authorities as required, particularly those affecting public health or safety.
    - Ensure compliance with insurance policies, reporting incidents as specified by insurers.
    - Cooperate with insurance companies during investigations, providing accurate and timely data.

6. DEFINITIONS

The Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare uses specific terminology to ensure clarity and consistency in the identification, reporting, and management of safety-related events within our Supported Living without Personal Care services. These definitions help all employees, service users, and stakeholders understand the scope and actions required for each type of event.

6.1 Accident

An accident is an unplanned event resulting in injury, illness, or damage to property, equipment, or the environment within our care settings.

- Examples:
    - A service user falls and gets injured during a home visit.
    - An employee is hurt by faulty equipment during care provision.
    - A contractor sustains harm while performing maintenance tasks.

Characteristics:

- Results in actual harm or injury.
- May cause property damage.
- Requires medical care or follow-up.

Accidents must be reported and investigated to prevent further harm and ensure compliance with safety regulations.

6.2 Incident

An incident refers to an event that could potentially cause harm but does not result in injury, illness, or loss at the time.

- Examples:
    - A service user's medication is administered incorrectly but does not cause harm.
    - A piece of equipment malfunctions without injury or damage.
    - Employee safety equipment is improperly used but no injuries occur.

Characteristics:

- Potential to cause harm but does not always result in injury.
- May indicate a failure in safety protocols, requiring investigation and corrective actions.

6.3 Near Miss

A near miss is an event where harm was narrowly avoided due to quick action or existing safety measures.

- Examples:
    - A service user nearly falls but is caught by staff.
    - A piece of equipment malfunctions but is fixed before harm occurs.
    - A wet floor is noticed and addressed before anyone slips.

Characteristics:

- No actual harm occurs.
- Clear potential for harm, requiring action to prevent recurrence.

Near misses should be treated with urgency to prevent more serious incidents.

6.4 Hazard

A hazard is a potential source of harm, injury, or damage.

- Examples:
    - Slippery floors.
    - Faulty equipment.

    - Untrained staff handling hazardous materials.

Characteristics:

- A condition or situation that could lead to harm.
- Requires identification and mitigation to reduce risk.

Identifying hazards is critical to preventing accidents and incidents.

6.5 Root Cause

The root cause is the underlying factor or issue that led to an accident, incident, or near miss.

- Examples:
    - Lack of training on equipment.
    - Failure to follow safety procedures.
    - Poor equipment maintenance.

Characteristics:

- Identifies the foundational issue leading to an event.
- Root cause analysis is necessary for corrective actions to prevent recurrence.

6.6 Corrective Actions

Corrective actions are steps taken to address the immediate causes of an event and restore safety.

- Examples:
    - Additional training for employees.
    - Repair or replacement of faulty equipment.
    - Updating safety procedures.

Characteristics:

- Focuses on resolving the immediate issue and preventing recurrence.
- Involves changes to processes, equipment, training, or supervision.

6.7 Preventive Actions

Preventive actions are proactive measures implemented to reduce the likelihood of future accidents, incidents, or near misses.

- Examples:
    - Implementing new safety protocols based on past incidents.
    - Installing additional safety features or equipment.
    - Conducting regular safety audits and risk assessments.

Characteristics:

- Aimed at eliminating or reducing risks before they result in harm.
- Proactively improves safety across Primus PLUS Healthcare.

6.8 Risk Assessment

A risk assessment is the process of identifying, evaluating, and prioritizing risks to health and safety in our care settings.

- Examples:
    - Assessing risks of service users falling during care activities.
    - Evaluating equipment safety.
    - Analysing environmental hazards (e.g., wet floors or fire hazards).

Characteristics:

- A systematic process identifying potential hazards and evaluating their likelihood.
- Leads to the identification of control measures to reduce risks.

7. REPORTING PROCEDURE

The Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare ensures that accidents, incidents, and near misses are promptly, accurately, and effectively reported, documented, and investigated. This structured approach is designed to meet CQC regulations, UK legislation, and relevant safety standards, ensuring the identification of potential hazards and the implementation of appropriate corrective and preventive actions. These measures help safeguard the well-being of employees, service users, contractors, and visitors within our Supported Living without Personal Care services.

7.1 General Reporting Principles

The following principles must be adhered to when reporting accidents, incidents, and near misses:

- Timeliness: All accidents, incidents, and near misses must be reported immediately. Quick reporting ensures that timely intervention can be made to prevent further harm or damage. This applies to all staff members, including those involved in or witnessing the event, and is critical for ensuring that issues are addressed as soon as possible.
- Accuracy: Reports must contain clear and accurate details of the event. This includes the sequence of events leading up to the occurrence, the individuals involved (including witnesses), any actions taken at the time, and the outcomes. Accurate reporting is essential for understanding the nature of the event, its causes, and the appropriate follow-up actions.
- Non-Punitive Approach: Primus PLUS Healthcare follows a non-punitive reporting system. This means staff should not fear reprimand or punishment for reporting accidents or incidents. The focus of reporting is on improving safety and learning from the event, not assigning blame. This encourages a culture of openness where staff feel safe to report all types of incidents, even if they were not directly involved.
- Confidentiality: All reports and information related to accidents, incidents, and near misses will be treated as confidential and handled in accordance with the Data Protection Act 2018 and General Data Protection Regulation (GDPR). Confidentiality is critical to ensuring that personal information about employees, service users, or others involved is protected throughout the process.

7.2 Immediate Action and Reporting by Involved Personnel

1. Immediate Response to Accidents or Incidents:

- Ensure Safety: The first priority in any accident or incident is to make the situation safe for everyone involved. This includes providing necessary first aid or emergency medical care if required. The safety of the individual(s) involved and others in the vicinity is paramount.
- Notify Relevant Personnel: The person who witnesses or is involved in the accident, incident, or near miss must immediately notify their line manager or supervisor to ensure appropriate steps are taken. These steps may include calling emergency services, securing the area to prevent further harm, or initiating evacuations if necessary.
- Limit Further Risk: After addressing immediate safety concerns, steps must be taken to limit further harm. This could include actions such as shutting down malfunctioning equipment, cordoning off hazardous areas, or alerting others to potential risks.

2. **Reporting to Supervisors/Managers**:
   - The supervisor or manager must be informed about the event without delay, ensuring that they can assess the situation and provide further guidance as necessary.
   - The manager should ensure that the proper documentation is completed and that the necessary follow-up procedures (e.g., investigations, risk assessments) are initiated promptly.

7.3 Documentation of Accidents, Incidents, and Near Misses

Accurate documentation is essential for tracking incidents, analysing trends, and ensuring compliance. The following documentation is required for accidents, incidents, and near misses:

1. Accident/Incident Report Form:
   - A standardized Accident/Incident Report Form must be completed by the person reporting the event or the line manager/supervisor within 24 hours of the incident.
   - Key Information to Include:
     - Date, time, and location of the event.
     - Names of those involved (including witnesses).
     - A detailed description of what happened, including the sequence of events leading to the incident, the type of injury or damage, and any immediate corrective actions taken.
     - The cause of the incident (if known at the time), including identification of hazards, human errors, or process failures.
     - Any first aid or medical treatment provided.
     - Follow-up actions required or taken, such as further investigations, risk assessments, or equipment repairs.
     - Signatures from both the person reporting the incident and the manager/supervisor.

2. Near Miss Reporting:
    - Near misses must also be reported using the same Accident/Incident Report Form. Although no injury occurs, the report must detail the potential hazard and describe how harm was avoided.
    - Documentation of near misses is essential for identifying safety gaps and implementing preventive measures to stop accidents from happening in the future.
3. Service User Incidents:
    - For incidents involving service users, the report must be cross-referenced with the service user's care plan, and a care review must be initiated to ensure their ongoing safety and well-being.
    - Service user incidents should also be documented in the service user's care record and communicated to relevant healthcare professionals to ensure they are aware of the incident and involved in any necessary follow-up.

7.4 Reporting to External Authorities (as Required)

Certain incidents must be reported to external authorities according to regulatory requirements:

1. RIDDOR Reporting (for Work-Related Injuries and Dangerous Occurrences):
    - RIDDOR (2013) requires certain types of workplace incidents to be reported to the Health and Safety Executive (HSE) or local authority. This includes:
        - Fatal accidents or major injuries (e.g., fractures, amputations).
        - Work-related diseases (e.g., respiratory issues due to hazardous substances).
        - Dangerous occurrences (e.g., near misses involving machinery).
    - Incidents meeting RIDDOR criteria must be reported within 10 days.
2. CQC Reporting (for Service User Incidents):
    - In accordance with CQC regulations, incidents involving serious harm or death to service users must be reported to CQC within 48 hours.
    - The Managing Director or designated compliance officer will ensure the incident is reported in compliance with CQC's requirements.
3. Other Regulatory Bodies:
    - If the incident involves sectors like food safety, hazardous substances, etc., Primus PLUS Healthcare may need to report the event to other relevant authorities (e.g., Food Standards Agency (FSA) or the Environment Agency).

7.5 Investigation and Follow-Up Procedures

Once an incident is reported, it must be thoroughly investigated:

1. Initial Investigation:
    - The immediate manager will lead the investigation, collecting witness statements and inspecting the site (e.g., faulty equipment, unsafe conditions).
    - Immediate corrective actions must be taken to prevent further harm, such as shutting down equipment or notifying safety teams.

2. Further Investigation and Root Cause Analysis:
    - A detailed investigation will be conducted by a designated team, potentially including Health and Safety Officer, managers, and external specialists.
    - Root cause analysis will be performed to identify systemic issues and determine the underlying factors contributing to the incident.
3. Corrective and Preventive Actions:
    - After the investigation, a Corrective Action Plan (CAP) will be developed to address the immediate and underlying causes of the incident.
    - Preventive actions will be implemented to ensure that similar incidents do not occur again.
4. Reporting and Feedback:
    - The findings of the investigation and actions taken will be communicated to all relevant stakeholders (employees, service users, contractors, regulatory bodies).
    - Lessons learned from the incident will be shared across Primus PLUS Healthcare to improve safety and encourage a culture of continuous learning.

7.6 Monitoring and Review of Incident Reports

1. Monthly Review:
    - All incidents will be reviewed monthly by the Health and Safety Committee or senior management to assess trends, ensure corrective actions are implemented, and identify recurring patterns (e.g., equipment failures, unsafe practices).
2. Quarterly and Annual Audits:
    - Quarterly audits will assess compliance with the reporting procedure, ensuring that investigations are thorough and corrective actions are effective.
    - Annual reviews will evaluate the policy's effectiveness and ensure it remains compliant with CQC regulations, health and safety laws, and organizational standards.

8. INVESTIGATION PROCEDURE

The Investigation Procedure for Accidents, Incidents, and Near Misses in the Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare outlines a systematic approach for investigating accidents, incidents, and near misses. The goal is to identify the root causes, implement corrective and preventive actions, and ensure that lessons are learned to prevent recurrence. This procedure ensures that all incidents are thoroughly investigated in compliance with CQC regulations, UK health and safety laws, and relevant national standards, ensuring a safe environment for employees, service users, contractors, and visitors.

8.1 Objectives of the Investigation Procedure

The primary objectives of the Investigation Procedure are to:

1. Identify the root causes of accidents, incidents, and near misses.
2. Evaluate the effectiveness of existing safety protocols, procedures, and controls.

3. Develop and implement corrective actions to address identified issues and prevent recurrence.
4. Ensure compliance with regulatory and legal requirements, including CQC regulations, Health and Safety legislation, and RIDDOR reporting requirements.
5. Foster a culture of continuous improvement by using incidents as learning opportunities to enhance safety and quality standards.
6. Maintain transparency and accountability throughout the investigation process.

8.2 Immediate Response to Accidents and Incidents

1. Ensure Safety First:
    - Prioritize the health and safety of those involved in the incident, providing first aid or emergency medical care as necessary.
    - If the incident poses ongoing risks (e.g., hazardous materials, equipment failure), appropriate safety measures must be implemented to control or mitigate the risk, such as cordoning off the area or shutting down equipment.
2. Notify Relevant Personnel:
    - The individual involved or a witness must immediately notify their line manager or supervisor to ensure that the incident is recorded and addressed.
    - The Health and Safety Officer or designated staff member must be informed to provide guidance on how to proceed with the investigation.
3. Secure the Scene:
    - If necessary, the scene of the incident must be secured to prevent further harm or contamination. This includes preserving evidence, such as photographs of the scene or malfunctioning equipment, and ensuring that the environment is not altered until the investigation begins.

8.3 Initial Reporting and Documentation

1. Accident/Incident Report Form:
    - A standardized Accident/Incident Report Form must be completed as soon as possible by the person reporting or the line manager/supervisor within 24 hours of the incident.
    - Key Information to Include:
        - Date, time, and location of the event.
        - Names of individuals involved (including witnesses).
        - A detailed description of the event, including what happened, immediate causes, and consequences (e.g., injury, property damage).
        - Immediate actions taken (e.g., first aid administered, medical treatment sought, area secured).
        - Root causes of the event, if known at the time.
        - Corrective actions taken immediately to prevent further harm.
2. Incident Notification to Senior Management:

- The incident report must be submitted to senior management and the Health and Safety Officer within 24 hours of the event.
- The senior management team will assess the situation and determine whether further escalation or external reporting is needed (e.g., to CQC, RIDDOR, or HSE).

8.4 Investigation Team Formation

1. Investigation Team:
    - The investigation will be led by a designated individual (typically a Health and Safety Officer or senior manager) who has the authority and expertise to conduct the investigation. The team may include:
        - Managers from the affected department.
        - Health and Safety Officer or external health and safety consultants.
        - Employee representatives (e.g., union representatives, if applicable).
        - Subject matter experts (e.g., equipment specialists if equipment failure is involved).
    - The team will gather information, conduct interviews, and recommend corrective actions.
2. Scope of Investigation:
    - The investigation will focus on both immediate and underlying causes of the incident:
        - What happened: Thorough examination of the event itself.
        - Why it happened: Root cause analysis to uncover contributing factors.
        - How to prevent recurrence: Recommendations for corrective and preventive actions.

8.5 Investigation Process

1. Data Collection:
    - The investigation team will gather all relevant data and evidence, including:
        - Witness statements: Interviews with individuals involved or who witnessed the event.
        - Physical evidence: Photographs, equipment inspections, or environmental assessments.
        - Documentary evidence: Review of records such as training records, maintenance logs, risk assessments, and safety protocols.
        - CCTV footage or digital logs, if applicable.
2. Root Cause Analysis:
    - The team will use tools like the 5 Whys, Fishbone Diagram (Ishikawa), or Failure Mode Effects Analysis (FMEA) to conduct a root cause analysis.
    - Root cause analysis will identify factors such as:
        - Human factors (e.g., lack of training, distraction, fatigue).

        - Organizational factors (e.g., inadequate policies, insufficient supervision).
        - Environmental factors (e.g., unsafe working conditions).
        - Equipment failure (e.g., malfunctioning machinery).
3. Impact Assessment:
    - Assess the severity of the incident in terms of harm or damage caused:
        - Evaluate injuries, property damage, and disruption to service delivery.
        - For service user incidents, assess health and safety impacts and whether care delivery was affected.

8.6 Corrective and Preventive Actions

1. Corrective Actions:
    - After identifying root causes, the investigation team will recommend corrective actions to address the immediate issues. These may include:
        - Repairing faulty equipment.
        - Implementing improved safety measures (e.g., hazard signage, barriers).
        - Revising procedures (e.g., clearer protocols, stricter enforcement of safety checks).
2. Preventive Actions:
    - In addition to corrective actions, the team will recommend preventive actions to reduce the likelihood of similar incidents occurring in the future:
        - Updated training programs on safety procedures or equipment handling.
        - System improvements (e.g., better reporting systems, enhanced safety management).
        - Policy updates (e.g., new checklists, revised risk assessments).
3. Implementation of Actions:
    - Designated managers will oversee the implementation of corrective and preventive actions, ensuring timely execution.
    - The Health and Safety Officer will monitor the effectiveness of the actions, making adjustments as needed.

8.7 Reporting Findings and Feedback

1. Incident Investigation Report:
    - A formal Incident Investigation Report will be compiled and submitted to senior management within 5 working days of completing the investigation. The report will include:
        - A summary of the event and timeline of the incident.
        - Findings on the root cause and contributing factors.
        - Recommended corrective and preventive actions.
        - Follow-up plans to monitor the effectiveness of implemented actions.

2. Feedback to Affected Parties:
    - The findings and actions will be shared with relevant stakeholders, including:
        - Employees involved in the incident and their line managers.
        - Service users, if they were affected.
        - Health and Safety Committee or Board of Directors.
    - Regular updates will be provided to all parties to ensure transparency and demonstrate Primus PLUS Healthcare's commitment to safety.

8.8 Monitoring and Review

1. Monitoring Effectiveness:
    - The effectiveness of corrective and preventive actions will be reviewed quarterly during Health and Safety audits.
    - Additional actions will be identified to ensure continuous safety improvements.
2. Trend Analysis:
    - Incident report data will be analysed for patterns or recurring issues. This allows Primus PLUS Healthcare to address systemic safety concerns and prioritize areas for improvement.

9. CORRECTIVE AND PREVENTIVE ACTIONS (CAPA)

The Corrective and Preventive Actions (CAPA) procedure is an essential part of the Accidents, Incidents, and Near Misses Policy for Primus PLUS Healthcare. This procedure ensures that Primus PLUS Healthcare not only addresses the immediate causes of accidents, incidents, and near misses but also implements long-term measures to prevent recurrence and improve overall safety practices. The CAPA process complies with CQC regulations, UK health and safety legislation, and relevant national standards, ensuring continuous improvement in safety management and organizational performance within our Supported Living without Personal Care services.

9.1 Objectives of Corrective and Preventive Actions (CAPA)

The primary objectives of the CAPA process are to:

1. Corrective Actions: Address and resolve the immediate causes of accidents, incidents, and near misses to prevent any further harm or recurrence of similar events.
2. Preventive Actions: Identify and mitigate underlying issues that could lead to similar events in the future, ensuring long-term safety improvements.
3. Compliance: Meet legal and regulatory requirements set by CQC, Health and Safety Executive (HSE), and other relevant bodies, ensuring Primus PLUS Healthcare maintains a safe environment.
4. Continuous Improvement: Foster a culture of continuous learning within Primus PLUS Healthcare, improving safety practices, processes, and the work environment to enhance overall care and safety.

9.2 Corrective Actions

Corrective actions are immediate steps taken to address the specific issues identified during the investigation of an accident, incident, or near miss. These actions aim to resolve the immediate safety concern and prevent the recurrence of the same or similar event.

Steps for Corrective Actions:

1. Immediate Action:
    - Contain the Hazard: If an incident involves ongoing risks (e.g., malfunctioning equipment), immediate steps must be taken to control or eliminate the hazard (e.g., shutting down equipment, isolating the area, and providing first aid).
    - Implement Temporary Measures: If the root cause is not immediately clear, temporary measures should be put in place to prevent further harm while a full investigation is carried out.
2. Root Cause Identification:
    - Corrective actions are based on findings from root cause analysis (e.g., human error, inadequate procedures, faulty equipment). The corrective actions must directly address these identified causes.
3. Implementation of Corrective Measures:
    - Equipment Repair or Replacement: If faulty equipment contributed to the incident, it must be repaired or replaced. All similar equipment should be inspected for similar faults.
    - Training or Re-training: If lack of training or procedural knowledge contributed to the incident, employees must be re-trained on safe working practices, correct equipment use, safety protocols, and emergency procedures.
    - Update Safety Procedures: Revise or create new safety procedures or protocols to address identified gaps, ensuring that all employees are informed of changes.
4. Monitoring Effectiveness:
    - After implementing corrective actions, regular checks will be carried out to ensure that the actions are effective in mitigating the risk and preventing recurrence. The Health and Safety Officer or designated manager will monitor the implementation and effectiveness of these actions.

9.3 Preventive Actions

Preventive actions are proactive steps taken to reduce the likelihood of similar incidents occurring in the future. These actions focus on addressing systemic issues and improving Primus PLUS Healthcare’s safety culture.

Steps for Preventive Actions:

1. Analysis of Root Causes:
    - Preventive actions are based on an in-depth analysis of the root causes and contributing factors. This analysis will focus on identifying any weaknesses in processes, policies, or training that could potentially lead to future incidents.
2. Identifying Patterns and Trends:

- Investigating patterns in multiple incidents (e.g., recurring equipment failures, human error, unsafe working conditions) can highlight systemic issues that need to be addressed on a broader scale.

3. Development and Implementation of Long-Term Measures:
    - Process Improvement: If procedural or workflow issues were identified (e.g., gaps in risk assessment, lack of checks and balances), relevant processes should be reviewed and optimized. For example, establishing additional safety checks, regular equipment inspections, or more frequent risk assessments.
    - Safety Culture Enhancement: Engage in initiatives that foster a culture of safety within Primus PLUS Healthcare. This could include safety campaigns, employee engagement activities, or leadership initiatives that prioritize safety and encourage everyone to take ownership of safety protocols.
    - Preventive Maintenance: Ensure all equipment, tools, and machinery undergo regular preventive maintenance and inspections to identify potential issues before they result in incidents.
    - PPE (Personal Protective Equipment) Review: Review and improve the use of appropriate PPE, ensuring that employees are provided with the necessary equipment to protect them from hazards and are trained on its correct use.
4. Policy and Procedure Updates:
    - Review and Revise Policies: If an incident or near miss highlights deficiencies in current policies or procedures, these should be revised to ensure they are comprehensive, clear, and aligned with best practices and regulatory requirements.
    - Risk Assessment Updates: After each incident, update risk assessments to reflect new hazards identified, ensuring that preventive measures are included for future risk mitigation.
5. Staff Training and Awareness:
    - Ongoing Training: Provide continuous education and training for staff to enhance their awareness of safety protocols, equipment handling, emergency procedures, and the importance of reporting incidents or near misses.
    - Competency Checks: Implement regular competency checks to assess employees' adherence to safety practices and their ability to handle emergency situations effectively.
6. Monitoring and Evaluation:
    - Preventive actions must be regularly monitored to ensure that they are effectively reducing the risk of recurrence. This may include quarterly audits of safety practices, checks of maintenance schedules, and evaluations of training program effectiveness.

9.4 Corrective and Preventive Action Planning

1. Action Plan Development:
    - After each investigation, an Action Plan will be created by the investigation team and submitted to senior management. The plan will include:
        - A clear description of corrective and preventive actions.

- Responsible individuals or departments for each action.
- Timeframes for completion.
- Expected outcomes and how success will be measured (e.g., reduced number of incidents, improved employee safety scores).

2. Approval and Allocation of Resources:
    - The Action Plan must be approved by senior management, ensuring that the necessary resources (e.g., budget, personnel, time) are allocated to implement the actions effectively.
3. Implementation and Follow-Up:
    - Once the actions are approved, they will be implemented by the responsible individuals or departments. Regular follow-up meetings will be held to track progress and resolve any issues that may arise during implementation.
4. Documentation and Reporting:
    - All actions taken, including the rationale for each corrective and preventive measure, will be documented and reported to relevant stakeholders, including employees and regulatory bodies (if required).
    - The effectiveness of implemented actions will be reviewed and documented in quarterly safety audits or ongoing management reviews.

9.5 Monitoring and Effectiveness Review

1. Quarterly and Annual Audits:
    - Quarterly audits will be conducted to assess the effectiveness of corrective and preventive actions, ensuring they remain relevant and effective.
    - Annual reviews will ensure that all actions are still aligned with Primus PLUS Healthcare's safety standards and regulatory requirements.
2. Employee Feedback:
    - Regular feedback from employees will be sought to assess the effectiveness of corrective and preventive measures. This feedback can be gathered through surveys, safety meetings, or focus groups.
3. Trend Analysis:
    - Data from incidents, near misses, and reports will be analysed for patterns and trends. This helps identify areas requiring additional corrective or preventive actions, ensuring that Primus PLUS Healthcare is proactive in addressing safety risks.

10. ROLES AND RESPONSIBILITIES

This section outlines the key roles and responsibilities for reporting, investigating, and addressing accidents, incidents, and near misses at Primus PLUS Healthcare, ensuring a safe environment in compliance with CQC regulations, UK legislation, and national safety standards.

10.1 Senior Management (Board of Directors / Managing Director)

- Accountability for the policy's implementation and regular review.
- Ensure resource allocation for safety measures and corrective actions.
- Ensure regulatory compliance with CQC, Health and Safety laws, and RIDDOR.
- Approve corrective and preventive actions and ensure timely communication of investigation findings.

10.2 Health and Safety Officer / Safety Manager

- Lead investigations of accidents, incidents, and near misses.
- Conduct risk assessments and safety audits.
- Monitor safety performance and track incident trends.
- Ensure legal compliance with CQC standards, RIDDOR, and other regulations.
- Develop and deliver safety training for employees.

10.3 Line Managers / Supervisors

- Ensure immediate response to incidents and ensure timely reporting.
- Support investigations by gathering data and providing witness statements.
- Implement corrective actions at the departmental level.
- Support employees involved in incidents and promote a culture of safety.

10.4 Employees

- Report accidents, incidents, and near misses promptly.
- Take immediate action to safeguard themselves and others during incidents.
- Cooperate with investigations by providing accurate information.
- Adhere to safety protocols and attend necessary training.

10.5 Accident/Incident Investigation Team

- Lead investigations into significant incidents, focusing on root cause analysis.
- Develop CAPA (Corrective and Preventive Action) plans based on findings.
- Ensure the implementation of corrective and preventive actions to prevent recurrence.

10.6 Service User and Family (Where Applicable)

- Report service user incidents and update care plans.
- Collaborate in investigations to provide insight into service user care.
- Communicate with families promptly and support them during investigations.

10.7 Contractors and External Service Providers

- Comply with safety policies and report accidents, incidents, and near misses.
- Cooperate with investigations and follow safety protocols while on premises.

10.8 Regulatory Authorities (CQC, HSE, etc.)

- Monitor compliance with safety and regulatory standards.

- Report significant incidents involving service user harm or serious injuries.
- Provide documentation and cooperate with investigations by regulatory bodies.

11. TRAINING AND AWARENESS

The Training and Awareness program at Primus PLUS Healthcare ensures that all staff, contractors, and stakeholders are adequately trained and aware of their roles in reporting, responding to, and preventing accidents, incidents, and near misses. The goal is to maintain a safe environment and comply with CQC regulations, UK health and safety legislation, and relevant industry standards.

11.1 Objectives of Training and Awareness

- Equip Staff with Knowledge: Ensure all employees understand the Accidents, Incidents, and Near Misses Policy and how to report, respond to, and prevent incidents.
- Ensure Compliance: Meet CQC and health and safety training requirements.
- Promote a Culture of Safety: Foster a safety-first environment where employees feel empowered to report incidents without fear of reprisal.
- Improve Incident Prevention: Equip staff with skills to effectively manage incidents and identify risks.
- Continuous Improvement: Ensure training is regularly updated to reflect changes in regulations and best practices.

11.2 Training for New Employees

- Induction Program: Includes an overview of health and safety protocols, reporting procedures, and the roles of Health and Safety Officer, line managers, and employees.
- Hands-on Safety Training: Practical training on hazards specific to the employee's role, including equipment handling and service user care.

11.3 Ongoing Training and Refresher Courses

- Annual Refresher Training: Revisits key aspects of the policy, root cause analysis, corrective actions, and safety protocols.
- Specific Role-Based Training: Tailored training for higher-risk roles (e.g., care staff, facility management, contractors).
- Emergency Response Training: Focuses on evacuation procedures, first aid, and incident management.

11.4 Training for Line Managers and Supervisors

- Advanced Safety and Investigation Training: Covers responsibilities for managing safety, conducting investigations, and implementing CAPA.
- Reporting and Documentation: Training on accurate incident reporting and documentation of corrective actions.
- Health and Safety Audits: Supervisors are trained on risk assessments and conducting regular safety audits in their areas.

11.5 Specialized Training for Health and Safety Officers

- In-Depth Safety Management: Specialized training in safety management, regulatory compliance, and incident analysis.
- Incident Investigation Mastery: Advanced training on investigation techniques, root cause analysis, and long-term preventive measures.

11.6 Training for Contractors and External Service Providers

- Safety Induction: Contractors must complete a safety induction program covering safety protocols, PPE requirements, and how to report incidents.
- Compliance with Safety Standards: Contractors receive specific training based on the work environment (e.g., building safety, hazardous substances).

11.7 Communication and Awareness Campaigns

- Safety Communication: Regular safety communications (e.g., posters, newsletters) will raise awareness about incident reporting and share lessons learned.
- Employee Feedback and Engagement: Employees will be encouraged to provide feedback on training effectiveness through surveys or focus groups.

11.8 Evaluation and Monitoring of Training Effectiveness

- Training Evaluations: Employees will complete evaluations after each training session to assess effectiveness.
- Monitoring Training Competency: Employees' performance in safety tasks will be monitored during workplace audits and real-life scenarios.
- Continuous Improvement: The training program will be reviewed annually to ensure it stays current with regulations, laws, and organizational needs.

12. MONITORING AND EVALUATION

The Monitoring and Evaluation process at Primus PLUS Healthcare ensures that safety practices are effective, corrective and preventive actions are properly implemented, and that continuous improvement occurs in compliance with CQC regulations, UK health and safety laws, and other relevant safety standards.

12.1 Objectives of Monitoring and Evaluation

- Track Effectiveness: Ensure corrective and preventive actions are working.
- Ensure Compliance: Verify compliance with CQC, HSE, and other regulations.
- Identify Trends: Identify recurring patterns in incidents to address systemic risks.
- Measure Training Success: Assess how well training programs reduce incidents.
- Continuous Improvement: Update safety practices based on findings from monitoring.

12.2 Monitoring Mechanisms

1. Incident Reporting and Tracking System:
    - Document and track all accidents, incidents, and near misses through a standardized reporting system that captures details and tracks corrective actions.
2. Monthly Incident Review Meetings:

- Review all reported incidents monthly with Health and Safety Officer, senior management, and department heads to ensure appropriate actions are taken and trends are identified.

3. Quarterly Safety Audits:
    - Conduct audits to assess the effectiveness of the Accidents, Incidents, and Near Misses Policy, focusing on incident reporting, corrective actions, and compliance with safety procedures.
4. Key Performance Indicators (KPIs):
    - Track KPIs such as:
        - Incident frequency and severity.
        - Timeliness of reporting and resolution.
        - Repeat incidents and training participation.

12.3 Data Analysis and Reporting

1. Incident Trend Analysis:
    - Health and Safety Officer will analyse incident data to identify trends (e.g., recurring hazards or human errors) and implement additional safety measures as needed.
2. Root Cause Trend Identification:
    - Review root cause analysis results to identify common causes and apply targeted preventive actions.
3. Comparative Analysis:
    - Compare incident data with industry benchmarks and historical records to identify areas for improvement.
4. Annual Safety Report:
    - Prepare an Annual Safety Report summarizing incidents, trends, actions taken, and lessons learned. This report includes a review of CQC and legal compliance.

12.4 Evaluation of Corrective and Preventive Actions (CAPA)

1. CAPA Effectiveness Review:
    - Regularly review the effectiveness of corrective and preventive actions, ensuring they are reducing incidents and improving safety.
2. Corrective Action Follow-Up:
    - Track the implementation of corrective actions to ensure they are completed on time and are effective.
3. Preventive Action Tracking:
    - Monitor preventive actions to ensure that they are reducing risks before incidents occur.

12.5 Review and Update of the Policy

1. Policy Review:

- Annually review the Accidents, Incidents, and Near Misses Policy to ensure it addresses emerging risks and complies with CQC and health and safety regulations.

2. Policy Updates:
    - If necessary, update the policy based on feedback, incident trends, and external audits.

12.6 Continuous Improvement

1. Feedback Loops:
    - Use feedback from monitoring and evaluations to improve safety processes, training programs, and risk management strategies.
2. Safety Culture Enhancement:
    - Strengthen Primus PLUS Healthcare's safety culture by applying lessons learned from incidents and continuously improving safety protocols.

13. CONFIDENTIALITY AND DATA PROTECTION

The Confidentiality and Data Protection section ensures that all information related to accidents, incidents, and near misses is handled in compliance with legal and regulatory requirements, including CQC regulations, Data Protection laws, and UK legislation, safeguarding personal data and maintaining trust.

13.1 Objectives of Confidentiality and Data Protection

- Protect Personal and Sensitive Data: Ensure all data collected is kept confidential and used appropriately.
- Ensure Legal Compliance: Comply with Data Protection Act 2018, GDPR, and CQC regulations.
- Maintain Confidentiality: Safeguard the confidentiality of employees, service users, contractors, and visitors.
- Facilitate Safe Reporting: Encourage incident reporting by ensuring the secure handling of personal data.
- Enable Effective Incident Management: Share necessary information for incident management while maintaining privacy.

13.2 Legal and Regulatory Framework

- Data Protection Act 2018 and GDPR: Ensure lawful and transparent handling of personal data, including securing and limiting data access.
- CQC Regulations (Regulation 17): Require secure management of incident records, ensuring data protection.
- Health and Safety Legislation: Ensure compliance with RIDDOR and other regulations for incident reporting while maintaining confidentiality.

13.3 Types of Data Collected

- Personal Data: Includes information that identifies individuals (e.g., names, contact details, job titles).

- Special Category Data: Includes sensitive information (e.g., health data), which requires extra protection.
- Incident-Related Data: Includes details of the incident, witness statements, and investigation findings.

13.4 Principles of Data Protection

- Data Minimization: Only collect necessary data for incident management.
- Purpose Limitation: Use data only for the purpose it was collected for (e.g., incident reporting).
- Confidentiality: Share data only with those who have a legitimate need to know.
- Data Security: Implement security measures like encryption and access controls to protect data.
- Accountability and Transparency: Maintain records of how data is processed and ensure compliance with CQC and GDPR.

13.5 Data Access and Sharing

- Internal Access: Access granted only to those who need it (e.g., managers, HR, Health and Safety Officers).
- External Access: Incident data may be shared with regulatory bodies (e.g., CQC, HSE) or healthcare providers as necessary.
- Sharing with Third Parties: Obtain consent before sharing data with third parties (e.g., insurance companies), unless legally required.

13.6 Data Retention and Disposal

- Data Retention: Incident data should be retained for no longer than necessary, typically three years or as required by law.
- Data Disposal: Securely dispose of data (e.g., shredding paper records, deleting electronic files).

13.7 Employee Rights under Data Protection Laws

- Right to Access: Employees and service users can request access to their personal data.
- Right to Rectification: Individuals can request corrections to inaccurate or incomplete data.
- Right to Erasure: Individuals can request the erasure of personal data, subject to legal requirements.
- Right to Object: Individuals can object to the processing of their data in certain circumstances.

14. FORMS

Form 1: Accident/Incident Report Form

Purpose: To document the details of any accident, incident, or near miss to ensure proper reporting, investigation, and follow-up actions.

Section	Details/Instructions
Date of Incident	DD/MM/YYYY
Time of Incident	HH:MM
Location of Incident	[Write location or area where incident occurred]
Person Reporting Incident	Name:
Job Title	
Names of Individuals Involved	[Write names of all individuals involved, including service users, staff, and contractors]
Description of Incident	[Provide a detailed description of what happened, including the sequence of events leading to the incident]
Type of Incident	[ ] Accident [ ] Near Miss [ ] Other (Specify: _____)
Injury or Damage Reported	[ ] Yes [ ] No
If Yes, Type of Injury	[ ] Minor Injury [ ] Moderate Injury [ ] Major Injury (Describe injury or damage in detail)
Immediate Actions Taken	[ ] First Aid [ ] Emergency Services Called [ ] Equipment Isolated/Stopped [ ] Other: _____ (Write actions taken)
Witnesses (if any)	1. [Name: _____] (Contact Details: _____) 2. [Name: _____] (Contact Details: _____)
Root Cause (if identified)	[Write root cause of the incident or what you believe contributed to the incident]
Corrective Actions	[Write the actions that will be taken to prevent recurrence, including corrective measures and timelines]
Follow-up Actions	[Write any follow-up actions needed after incident resolution, including monitoring or additional risk assessments]
Supervisor/Manager Name	[_____]
Supervisor/Manager Signature	[_____]
Date of Report	DD/MM/YYYY

Form 2: Incident Investigation Report Form

Purpose: To document the findings from the investigation of accidents, incidents, or near misses, including root causes, corrective actions, and preventive measures.

Section	**Details/Instructions**
Incident Reference Number	
Date of Investigation	DD/MM/YYYY
Investigating Officer(s)	1. Name: 2. Name:
Incident Description	[Provide a detailed summary of the incident, including what happened, who was involved, and where it occurred]
Immediate Causes Identified	[Write immediate causes of the incident]
Root Cause(s) Identified	[Use Root Cause Analysis tools such as "5 Whys" or Fishbone diagram to identify underlying causes. Write identified causes]
Investigation Findings	[Provide findings, including any unsafe conditions, human error, equipment failure, or process failures that contributed to the incident]
Corrective Actions Taken	[Write the actions taken immediately after the incident, e.g., equipment shutdown, retraining, first aid, etc.]
Preventive Actions Proposed	[Write the actions or recommendations for preventing similar incidents, such as improved training, updated safety protocols, or equipment maintenance]
Monitoring of Effectiveness	[Describe how the effectiveness of the corrective and preventive actions will be monitored over time]
Follow-up Review Date	DD/MM/YYYY
Final Outcome	[Write a summary of the outcome of the investigation, including whether corrective actions were successfully implemented]
Signatures	Investigating Officer: [] Supervisor/Manager: []
Date of Report	DD/MM/YYYY

Form 3: Corrective and Preventive Action (CAPA) Plan

Purpose: To document corrective and preventive actions following an incident, ensuring that appropriate measures are taken to address identified root causes.

Section	**Details/Instructions**
Incident Reference Number	
Date of CAPA Plan	DD / MM/YYYY
Root Cause of Incident	[Write the identified root cause(s) of the incident]
Corrective Actions Required	[Write the immediate corrective actions needed to resolve the specific incident, including actions taken to control or mitigate risk]
Responsible Person(s)	[Name(s) of person(s) responsible for implementing corrective actions]
Timeline for Completion	[Date for completion of corrective actions]
Preventive Actions Proposed	[Write any preventive actions to mitigate the risk of similar incidents in the future]
Responsible Person(s)	[Name(s) of person(s) responsible for implementing preventive actions]
Timeline for Completion	[Date for completion of preventive actions]
Follow-Up and Monitoring	[Write how the effectiveness of the corrective and preventive actions will be monitored after implementation]
Review Date for Effectiveness	DD / MM/YYYY
Final Outcome	[Describe the final outcome of the corrective and preventive actions and any further steps taken]
Signatures	Responsible Person(s): [] Manager/Supervisor: []
Date of Report	DD / MM/YYYY

Form 4: Risk Assessment Form

Purpose: To document the assessment of risks associated with incidents, ensuring that identified hazards are evaluated and controlled appropriately.

Section	**Details/Instructions**
Risk Assessment Reference	
Date of Assessment	DD / MM/YYYY
Assessed by	[Name of the person conducting the assessment]
Location/Area Assessed	[Location or department where the risk is being assessed]
Hazard(s) Identified	[Describe the hazards that were identified during the assessment (e.g., slippery floors, faulty equipment)]
Risk Level	[ ] Low [ ] Medium [ ] High
Likelihood of Occurrence	[ ] Rare [ ] Occasional [ ] Frequent
Potential Impact	[ ] Minor [ ] Moderate [ ] Major [ ] Catastrophic
Control Measures in Place	[Describe any existing control measures that are currently in place to reduce the identified risk (e.g., PPE, safety signs)]
Additional Control Measures Needed	[Describe additional measures needed to control or mitigate the risk, such as training, equipment checks, procedural changes]
Responsible Person(s)	[Name(s) of the person(s) responsible for implementing additional control measures]
Review Date	DD / MM/YYYY

Form 5: Incident Notification and Escalation Form

Purpose: To ensure that accidents, incidents, and near misses are promptly escalated to the appropriate internal or external authorities in compliance with regulations.

Section	**Details/Instructions**
Incident Reference Number	
Date of Notification	
Incident Description	[Brief description of the incident
Internal Notification	[ ] Line Manager [ ] Health and Safety Officer [ ] Supervisor [ ] HR [ ] Other:
External Notification	[ ] CQC [ ] RIDDOR [ ] HSE [ ] Local Authorities [ ] Other:
Date of Escalation	DD / MM/YYYY
Responsible Person for Escalation	[Name(s) of the person(s) responsible for escalating the incident]
Follow-Up Actions	[Describe any follow-up actions required for reporting to external bodies, such as submitting further details

Review and Closure [Date when incident escalation and follow-up were reviewed and closed]

17. REFERENCES

Here is a list of potential references that could be used for the Accidents, Incidents, and Near Misses Policy and Procedure for Primus PLUS Healthcare. Please note that the following references are examples based on the content discussed, including relevant laws, regulations, and guidelines. For more accurate citations, specific documents or websites may need to be referenced directly.

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