Incident and Accident Reporting and Duty of Candour Policy

Supportive Bridge Ltd | Community Support and Healthcare Staffing | Bradford, England

POLICY AT A GLANCE

- **Report everything, the same day.** Accidents, injuries, near misses, medication errors, missed shifts, aggression, damage, anything that went wrong or nearly did.
- **Near misses matter as much as incidents.** They are free warnings.
- **Person first:** make sure the person is safe, get medical help, call 999 if needed. Paperwork comes after.
- **Be open and say sorry.** When something goes wrong and a person is harmed, we tell them, apologise, explain and put it right. That is the Duty of Candour, and it is the law.
- **An apology is not an admission of liability.** It is a legal duty and basic decency.
- **No blame for honest mistakes reported promptly.** Hiding or falsifying is a disciplinary matter; an honest error is a learning opportunity.
- **Some incidents must be reported outside:** to CQC, the council, the HSE, the ICO or the police. The Registered Manager decides and does this.

SERVICE DETAILS (fill in before issuing)

Registered Manager	
Nominated Individual	
Office phone	
Out-of-hours / on-call number	
Date issued	
Next review date	

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1. PURPOSE

1.1 This policy explains how Supportive Bridge Ltd ("Supportive Bridge", "we", "us") reports, records, investigates and learns from incidents and accidents, and how we meet the Duty of Candour when something goes wrong.

1.2 It reflects Regulation 12 (Safe care and treatment), Regulation 17 (Good governance) and Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the notification requirements in the Care Quality Commission (Registration) Regulations 2009, and RIDDOR 2013.

1.3 Things go wrong in every service. What separates a good service from a poor one is whether people report them, whether managers act, and whether anything changes as a result.

2. SCOPE

2.1 Supportive Bridge Ltd operates two arms, and this policy applies to both: our **healthcare staffing service**, supplying care and support workers to care homes, hospitals and other providers; and our **community support service**, where our own support workers visit adults and older people in their own homes, including council housing, on morning and evening shifts, to support them with daily living.

2.2 Supportive Bridge does **not** provide personal care. Personal care is a regulated activity under the Health and Social Care Act 2008 and we will provide it only if and when we are registered with the Care Quality Commission. Our support workers provide non-personal support such as companionship, meal preparation, shopping, domestic help, prompting, and support to get out and about. This policy is written to meet both local authority provider assurance requirements and the standards we will be assessed against at CQC registration.

2.3 It applies to everyone who works for us, and to incidents involving the people we support, our workers, visitors, members of the public or property.

2.4 Where our worker is involved in an incident while supplied to a client organisation, they report it to that organisation immediately under its procedures **and** to our office the same day.

2.5 Deliberately failing to report an incident, or falsifying a record, is a disciplinary matter and may be gross misconduct.

3. WHAT MUST BE REPORTED

3.1 Everything below is reported to the office the same day, however minor it seems:

- any injury to a person we support, a worker or anyone else, including falls, cuts, burns, scalds, bruises and skin tears;
- any fall, whether or not the person was injured, including a fall found after the event;
- a person found unwell, unresponsive, confused or in pain;
- any medication error: missed, wrong, extra, refused, or a MAR chart gap;
- a missed, late or shortened shift, and any no-reply at the door;
- aggression, threats, abuse or violence towards a worker or by anyone in the home;
- any safeguarding concern (report under the Safeguarding Adults Policy as well);
- faulty or unsafe equipment, and any device giving wrong readings;
- a fire, flood, gas leak, power failure or break-in;

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- damage to a person's property, or to a worker's vehicle while working;
- money or property missing, or a dispute about money;
- loss of records, a phone, keys, or any data breach;
- a sharps injury or exposure to blood or body fluids;
- the death of a person we support, however it occurred;
- **near misses:** anything that could have caused harm but did not.

3.2 Workers report by telephone to the office or the on-call manager first, then complete an incident form before the end of their shift, or as soon as possible afterwards.

4. WHAT TO DO AT THE TIME

AT THE SCENE

1. Make sure everyone is safe. Call **999** if there is serious injury, a person is unresponsive, or there is fire, gas or violence.
2. Give first aid within your training. Do not move a person who has fallen until you know it is safe; follow the falls plan.
3. Stay with the person, keep them warm and reassured, and stay on the line with the emergency operator if asked.
4. Ring the office or on-call manager as soon as it is safe.
5. Do not clean up or move anything if it may be evidence, unless you must to keep someone safe.
6. Write down what happened while it is fresh: times, what you saw, what you did, who you called, and the person's own words.
7. Do not speculate about the cause, blame anyone, or discuss it with other people we support or on social media.

5. RECORDING

5.1 Every incident is recorded on an incident form and, where a person or worker was injured, in the accident book. Accident book entries with personal details are kept confidential.

5.2 Records must be factual: what happened, when, where, who was present, what was done, who was contacted and when. Opinions, blame and speculation do not belong in the record. The person's own words are recorded in quotation marks.

5.3 A note is also made in the person's daily record, but the incident investigation itself is held in the office file, not in the home.

6. INVESTIGATION AND GRADING

6.1 The Registered Manager reviews every incident within one working day and grades it:

Grade	Examples	What happens
Low	Near miss, minor issue with no harm	Recorded, immediate action, reviewed in the monthly analysis
Medium	Minor injury, medication error with no harm, missed shift with no harm	Manager review within 3 working days, actions agreed, worker supported and retrained if needed

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Grade	Examples	What happens
High	Significant injury, hospital admission, medication error causing harm, allegation of abuse, serious aggression, data breach	Full investigation, external reports as required, Duty of Candour, actions and review by the Nominated Individual

6.2 Investigation asks what happened, why it happened, and what will stop it happening again. It looks at systems as well as individuals: rotas, training, plans, equipment and communication. Where a worker made a mistake, we consider whether the system made that mistake likely.

6.3 Actions are recorded with a named owner and a completion date, and are tracked until closed. The person affected, their family where appropriate, and the workers involved are told the outcome.

7. REPORTING OUTSIDE THE COMPANY

7.1 The Registered Manager decides what must be reported externally, makes the report, and records it.

To whom	When	Timescale
999 / emergency services	Serious injury, unresponsiveness, fire, gas, crime in progress	Immediately
Durham County Council, Social Care Direct	Any abuse, neglect or risk of harm to an adult (03000 267 979)	Same day
Care Quality Commission	Once registered: deaths, serious injuries, abuse or allegations of abuse, police involvement, events stopping the service running	Without delay, using the statutory notification forms
Health and Safety Executive (RIDDOR)	Work-related deaths, specified injuries, over-seven-day worker absence, injuries to non-workers taken to hospital, dangerous occurrences	Deaths and specified injuries without delay; over-seven-day within 15 days
Information Commissioner's Office	Personal data breach likely to risk people's rights and freedoms	Within 72 hours of becoming aware
Police	Any suspected crime, including theft, assault and fraud	Immediately or as soon as practicable
Funding authority / commissioner	As set out in the contract	As specified, usually within 24 hours
MHRA (Yellow Card)	Adverse incident involving a medical device or medicine	As soon as possible
Insurers	Any incident that may lead to a claim	As soon as possible

7.2 Until our CQC registration is granted, the CQC notification duties above do not apply to us, but we will report serious incidents to the local authority and the funding body, and we will put the notification process in place from the day registration takes effect.

8. DUTY OF CANDOUR: BEING OPEN WHEN SOMETHING GOES WRONG

8.1 Regulation 20 requires registered providers to act in an open and transparent way with people in relation to their care, and imposes specific duties when a **notifiable safety incident** occurs.

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8.2 For adult social care, a notifiable safety incident is an unintended or unexpected incident that, in the reasonable opinion of a health care professional, appears to have resulted in, or could still result in:

- the death of the person, where the death relates directly to the incident rather than the natural course of their illness or condition;
- an impairment of sensory, motor or intellectual function lasting, or likely to last, at least 28 days;
- changes to the structure of the person's body;
- prolonged pain or prolonged psychological harm, meaning pain or harm experienced, or likely to be experienced, for at least 28 days;
- a shortening of life expectancy;
- the need for treatment by a health care professional to prevent death, or any of the above.

What we must do

- tell the person, or their representative, **in person** and **as soon as reasonably practicable** after the incident is identified;
- give a full account, in plain language, of all the facts we know at that point;
- **give an apology**, sincerely and without qualification;
- explain what further enquiries we believe are appropriate;
- tell them what support is available to them;
- follow up in writing, giving the same information, and keep a copy;
- keep a written record of the notification, including any attempt to contact the person and any occasion where they declined to discuss it;
- keep them informed of the outcome of any enquiry, and tell them what we are changing.

8.3 An apology means saying sorry that something has happened. It is not an admission of legal liability, and our insurers do not object to it. Saying nothing, or being vague, is what damages trust and leads to complaints and claims.

8.4 Candour is not only for notifiable incidents. We are open about smaller things too: if a shift was missed, a worker was late, a task was not done, or something was broken, we say so, apologise and put it right.

8.5 Failing to comply with Regulation 20 is a criminal offence for which CQC can prosecute without first serving a warning notice.

9. SUPPORTING PEOPLE AFTER AN INCIDENT

9.1 Incidents affect people. After any significant incident:

- the person and their family are kept informed and offered a meeting;
- the worker involved is spoken to, supported and offered a debrief; they are not left to worry over a weekend;
- where a worker is suspended or moved during an investigation, they are told this is a neutral act and are kept updated;
- where the incident was distressing, workers are signposted to further support;
- we consider whether other people we support may be at similar risk and act immediately if so.

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10. LEARNING

10.1 The Registered Manager analyses all incidents monthly, looking for patterns by person, worker, time of day, area, and type. Themes and lessons are shared with the team through meetings, supervision and written briefings, and fed into training, support plans and risk assessments.

10.2 Where an action was agreed, we check it actually happened and that it worked. Recording an action that was never completed is worse than not recording one.

10.3 The Nominated Individual reviews incident data, trends and completed actions at least quarterly as part of our governance, and the results feed into our Governance and Quality Assurance reporting.

11. RECORDS AND RETENTION

11.1 Incident records, investigation notes, Duty of Candour letters and external reports are kept securely in the office, separately from support records, and retained for at least eight years. RIDDOR records are kept for at least three years, and accident book entries in line with data protection requirements.

12. TRAINING

12.1 All workers are trained at induction in what to report, how and when, in first aid awareness, and in the principles of candour, with refreshers as set out in our Staff Training and Competency Policy. Managers receive additional training in investigation, notification and candour conversations.

13. MONITORING AND REVIEW

13.1 The Registered Manager reports monthly on incident numbers, grades, actions outstanding and any external reports made. The Nominated Individual reviews this quarterly.

13.2 A fall in reported near misses is treated as a warning sign about reporting culture, not as good news.

13.3 This policy is reviewed every year, or sooner if the law changes or a serious incident shows it needs to change.

14. LEGISLATION AND GUIDANCE

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, especially Regulation 12, Regulation 16, Regulation 17 and Regulation 20 (duty of candour)
- Care Quality Commission (Registration) Regulations 2009, Regulations 14 to 18 (notifications)
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Health and Safety at Work etc. Act 1974
- Care Act 2014
- UK General Data Protection Regulation and Data Protection Act 2018
- Compensation Act 2006, section 2 (an apology is not an admission of liability)
- CQC guidance on Regulation 20 and on statutory notifications
- NICE guideline NG21: Home care

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15. RELATED POLICIES AND FORMS

Related policies: Safeguarding Adults; Health and Safety; Lone Working; Infection Prevention and Control; Medication; Medical Devices; Missed and Late Visits; Complaints, Concerns and Compliments; Whistleblowing; Data Protection and Confidentiality; Business Continuity; Governance and Quality Assurance; Disciplinary.

Forms: Incident and Accident Report (Appendix A); Accident Book; Duty of Candour Record (Appendix B); Incident Log and Trend Analysis; CQC Statutory Notification; RIDDOR report.

16. DOCUMENT CONTROL

Version	Date	Approved by	Role	Reason
1.0			Nominated Individual	New policy for local authority assurance and CQC registration

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APPENDIX A: INCIDENT AND ACCIDENT REPORT

Complete before the end of your shift. Facts only. Ring the office first.

Date and time of incident / date and time reported	
Where did it happen?	
Who was involved and who was present?	
Type: injury / fall / near miss / medication / aggression / property / other	
What happened? (facts only, in order)	
The person's own words	
Any injury? Describe (use a body map if needed)	
What did you do? (first aid, 999, stayed with person)	
Who did you contact, and at what time?	
Your name, role and signature	

Office use: Grade: Low / Medium / High Investigated by: _____ Safeguarding referral: Y/N CQC: Y/N RIDDOR: Y/N ICO: Y/N Police: Y/N Duty of Candour applies: Y/N Actions and owner: _____ Closed on: _____

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APPENDIX B: DUTY OF CANDOUR RECORD

Complete whenever a notifiable safety incident occurs. The conversation must happen in person and as soon as reasonably practicable.

Person affected / date of incident	
Why this is a notifiable safety incident	
Who we spoke to (person or representative), and their relationship	
Date, time and place of the face-to-face conversation	
Who attended from Supportive Bridge	
What we told them: the facts known at that point	
Apology given (record the words used)	
Further enquiries we said we would make	
Support offered to the person and family	
Date the written follow-up was sent (copy on file)	
Outcome of enquiries shared with them, and date	
What we have changed as a result	
If contact could not be made or was declined: what we did	
Signed (Registered Manager) and date	

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