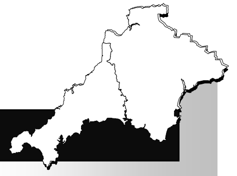


"Some accidents may not be serious..... but they might have been."

"Incidents do not result in harm...... but they might have done."

These guidelines help you to look at what did, or might, happen – with a view to avoiding repetition and perhaps more serious consequences. They also provide a simple way of reporting and recording incidents/accidents as required for PCT governance and in some cases under Health and Safety legislation (RIDDOR).

INVESTIGATING ...... Ask yourself and/or others

The 'Facts'

- **WHAT** happened?
- **WHERE**?
- **WHEN**?
- **WHO** was involved?
- **WHO** saw anything?
- **WHAT** harm arose? (or might have done, if the incident had been 'worse'?)

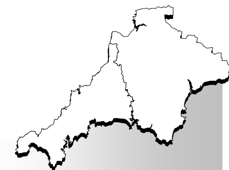
The 'Analysis'

- WHY did it happen?
- What are the consequences of this?
- Are there further consequences – real or potential?

The 'Solution'

HOW can we avoid a repetition?

- Change to premises, equipment, procedure.
- 'Educate' or train people – who?
- 'Inform' – who, how?
- Substitute what you are doing with something safer.



'Close the Loop'

- Make sure any resulting planned actions have been completed.
- Communicate new systems/procedures to all staff.
- Where appropriate, 'test the system' you have put in place.

'Remember'
In many cases:

"It should never have happened."

"A sequence of minor events led up to this incident."

"We want to learn, not blame."

REPORTING...... to meet your legal obligations and for future management purposes

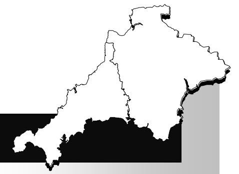
Record the event using the framework above – if you employ ten or more staff you are legally required to have an accident book – it is good practice anyway (details below).

Some accidents/incidents have to be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Illnesses and Dangerous Occurrence Regulations 1995 (RIDDOR) see guidance attached.

NEED HELP/ADVICE?

Contact the Occupational Health Service on 01752 762116

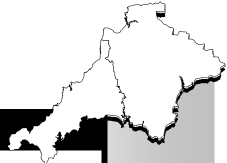
Accident book (BI 510 ISBN 0 7176 2603 2), introduced in May 2003, is obtainable from HSE.
Tel No: 08701 545500   www.hse.gov.uk



Incident/Accident Report Form

(To be used in conjunction with attached 'Guidelines on Investigating and reporting Incidents and Accidents)

The 'Facts'	
WHAT happened?	
WHERE did it happen?	
WHEN did it happen?	
WHO was involved	
WHO saw anything?	
WHAT harm arose? (or might have done if the incident had been worse i.e. a near miss.)	
The 'Analysis'	**It is suggested that at this stage the investigation is linked into your Significant Incident Review to ensure a clear process for reviewing the incident as a team. This will enable any identified changes or training to be authorised and ensure everyone is aware of the event and changes.**
WHY did it happen?	



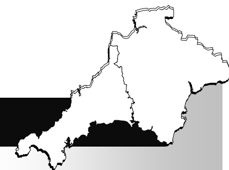
'Analysis' contd.	
WHAT are the immediate consequences of this for the Practice?	
Are there further consequences of this – real or potential?	
The 'Solution'	
HOW can we avoid a repetition?	

'Close the Loop'	**Date Completed**	**Signature**
Planned actions completed?		
New systems/procedures communicated to all staff?		
New system tested (where appropriate)?		
Reported re RIDDOR (see attached guidance)		

Investigation and reporting completed by:

Name: ....

Job Title:...Date: ....



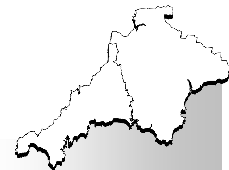
Incident/Accident Report Form – WORKED EXAMPLE

To be used in conjunction with attached 'Guidelines on Investigating and Reporting Incidents and Accident'.

Thanks to Liz Brimacombe of Waterloo Surgery, Plymouth for her contribution to these guidelines and worked example.

The 'Facts'	
WHAT happened?	Patient tripped over delivery of sterilised instruments in entrance way.
WHERE did it happen?	Entrance way to surgery.
WHEN did it happen?	20 April 2004.
WHO was involved	Mrs B Grey – patient. Receptionists.
WHO saw anything?	A Brown } C Green } Receptionists. E White }
WHAT harm arose? (or might have done if the incident had been worse i.e. a near miss.)	Patient grazed knee and hand on carpet.
The 'Analysis'	**It is suggested that at this stage the investigation is linked into your Significant Incident Review to ensure a clear process for reviewing the incident as a team. This will enable any identified changes or training to be authorised and ensure everyone is aware of the event and changes.**
WHY did it happen?	Delivery men leave parcels in reception without considering trip hazards. Busy time of morning and reception had not realised the risk.

Example



‘Analysis ‘contd.	
WHAT are the immediate consequences of this for the Practice?	Patient shocked and injured. Disruption to surgeries. Doctor/nurse involved in treating injured patient.
Are there further consequences of this – real or potential?	Patient complaint/litigation.
The ‘Solution’	
HOW can we avoid a repetition?	Speak to delivery companies. Display notices instructing on safe delivery and location. Identify safe location for deliveries. All staff to be aware of potential for trip hazards.
‘Close the Loop’	**Date completed Signature**
Planned actions completed?	30/4/04
New systems/procedures communicated to all staff?	28/4/04
New system tested (where appropriate)	N/A
Reported re RIDDOR (see attached guidance)	N/A

Example

Investigation and reporting completed by

Name: PA Manager

Job Title: Practice Manager Date 30/4/04