Florence

Reducing Risk: developing an incident management policy that works

Incident management best practices for care home managers

The number one priority in any care setting is to make sure residents stay safe and get the best possible service. But despite best intentions, things sometimes go wrong.

When incidents happen, it's really important to deal with them properly and use them as opportunities to learn. A well-formulated governance and incident-management policy can help you create a reporting culture, gather evidence, provide support and write effective action plans.

> "Supporting, training and enabling your team can reduce the risk of incidents and make your organisation healthier."

Fiona Millington
Florence Chief Nurse

We'll begin this report by defining what an incident is and explaining the seven pillars of clinical governance. Then, we'll guide you through incident management best practices and teach you how to implement them at your care organisation.

1. What is an incident?

What type of caregiving error meets the definition of an “incident” or “near miss”? Mistakes in a care setting fall into three main buckets:

- Incidents and adverse events. These cause harm (including injury or death) to residents, service users, their family members, and staff. Weather events that lead to service disruption fall into this category.
- Errors or mistakes. Misjudgements or wrong decisions; for example, giving the wrong dose of a medicine.
- Near misses. When mistakes happen but don’t cause harm to residents, service users, family members or staff, they’re defined as “near misses”.

2. What is clinical governance?

In simple terms, clinical governance is a system designed to improve standards in a health or social care setting. The seven parts, or “pillars” of clinical governance can help you create a framework for care at your organisation.

1. Clinical effectiveness.

2. Risk management.

3. Information and IT.

4. Patient and public involvement.

5. Audits.

6. Staff management.

7. Education and training.

1. Clinical effectiveness. Treatments and programmes have to provide the best outcome for residents and service users.
2. Risk management. You must identify hazards, reduce risks and learn from mistakes to minimise the chances of incidents happening.
3. Information and IT. Resident information must be kept confidential and up to date on all paper and electronic systems.
4. Patient and public involvement. In a social care setting, this means working with residents, family members and the general public to find out how effective your services are.
5. Audits. Regular audits measure resident outcomes against set guidelines to monitor the care you provide.
6. Staff management. Staff members must be qualified for the roles they're in. Meanwhile, you should give team members the support and guidance they need to develop and advance.
7. Education and training. When staff have access to the right training, they can provide the best possible care.

3. Choose an incident management system

Tailored risk-management and incident-reporting solutions like Datix, Radar and Ulysses are investments, but they're very secure and easy to update.

If you don't have the budget for an expensive bespoke solution, that's okay. Basic incident management systems (IMS) can help you store digital information safely. When choosing IMS software, look for the following features:

- Confidential reporting. Reports are anonymous, and information gets shared on a need-to-know basis.
- Easy to use. Staff don't need to fill out multiple forms or answer confusing questions.
- Built-in analysis. You can pick out incident themes and trends.
- Automatic reminders. Root Cause Analysis, follow-up and trigger factor reminders get sent automatically.

You should be able to store everything in your IMS: written evidence, statements, duty-of-candour letters, root-cause analysis documents, regulatory notifications and more. Investigations are more manageable when documents are stored in a central location – and CQC, RQIA and CI regulators appreciate instant access to information during inspections.

4. Build a reporting culture

It's important to record all incidents, near misses and adverse events on your IMS system. Unfortunately, that doesn't always happen.

A culture of fear and secrecy can be a major barrier to reporting. If people are afraid of the consequences of reporting, they don't speak up, so incidents aren't recorded properly. Residents get let down because we lose the opportunity to reduce the risk of an incident happening again.

When reports are made promptly, residents stay safer and staff benefit from a chance to learn and grow.

Here are three ways to build an honest, open reporting culture at your care home:

1. Encourage reporting. Prompt reports lead to meaningful action.
2. Support staff. Listen to everyone involved, and take concerns seriously.
3. Give regular feedback. Update staff about how the investigation is going.

Your initial response to the report matters, too. Don't automatically choose discipline, and try to avoid blame.

Instead, take time to understand what has happened, look at the context, and treat each case as a learning experience. Most mistakes don't happen on purpose: many occur by accident or as the result of a chain of events.

5. Assess Risk

Conducting a regular risk assessment in your care home can reduce the number of incidents that happen. These three questions can help you locate hazards, determine who might be harmed (and how), and decide which safety measures to put in place.

1. Where are the hazards?

2. Who might be harmed, and how?

3. Which safety measures will work best?

4. Record your results

Where are the hazards?

Begin by walking around your care home to find potential hazards – slippery floors, loose carpet or blocked fire exits, for example. Hazards aren't always physical: poor manual handling practices, poorly stored medicines and bad staff behaviour also count.

Talk to residents and staff about what they consider hazardous, and look at accident, illness and care records to see if incidents happen in particular places, or for specific reasons.

Who might be harmed, and how?

Some people in your care home might face more risk than others. People who need a lot of support from staff, including those with reduced mental capacity or low mobility, are particularly vulnerable.

Take staff into account, too – especially if they work with hazardous materials or perform manual handling activities regularly. What do the regulators expect?

Finally, remember that visitors to your care home won't know where your hazards are, so they'll be at greater risk of an accident.

Which safety measures work best?

The safety measures you decide to put in place will depend on the hazards in your home. Here are a few examples:

- Training. Up-to-date health and safety or manual handling training can help staff and residents stay safer.
- Mechanical aids. The right aids can help reduce manual handling injuries.
- Better housekeeping. Regular decluttering and prompt spillage cleanup can minimise risk.

Record your results

When you've answered all three questions, record the results of your risk assessment. Remember to review your risk assessment regularly: when new staff and residents enter your care home, hazards can change, so it's important to make sure the control measures you've come up with still work.

Take a look at the HSE (Health Service Executive) website for more ideas on how to conduct a risk assessment.

6. Escalate appropriately

If a serious incident occurs, you'll need to follow internal escalation procedures. Whoever is in charge of the shift must inform the registered service manager, then regional managers, company directors and your "Nominated Individual" about the adverse event where appropriate. Remember to include Duty of Candour actions.

7. Investigate thoroughly

It's important to investigate each incident report thoroughly. This five-step strategy can help you create a general incident management policy, organise your team, collect evidence and conduct a thorough investigation.*

**In the event of a serious or potentially criminal incident, call emergency services before proceeding.*

Assign a leader to the investigation

Collect evidence strategically

Use the right tools to investigate

Keep the resident and their family members involved

Consider referring to an external agency

Assign a leader to the investigation

First, appoint someone to lead the investigation. Depending on the size of your organisation, this might be the head of a department or the care home manager. Whoever you choose must understand that they have a duty to keep all information confidential.

Collect evidence strategically

Try to gather evidence about the incident as quickly and carefully as you can:

- Physical evidence. Injuries, objects, medication, clothing and other tangible items.
- Statements. Testimonials written or recorded by people who witnessed the incident.
- Documentary evidence. Medical records, camera footage, body map, MAR chart, text messages and other types of digital communication.

Remember to store all digital evidence in your IMS and physical evidence in a secure location (e.g. safe, locked cupboard).

Use the right tools to investigate

First, appoint someone to lead the investigation. Depending on the size of your organisation, this might be the head of a department or the care home manager. Whoever you choose must understand that they have a duty to keep all information confidential.

Keep the resident and their family members involved

Make sure you inform the resident's family as soon as possible after the incident occurs, and make sure you keep them informed and involved as the investigation progresses. Doing this will help them feel heard and provide reassurance that you're taking the event seriously.

Consider referring to an external agency

You might need to refer the incident to an external agency. Each authority has its own notification criteria:

- CQC/CI/CIW. Refer incidents involving resident or staff abuse, or alleged abuse. You'll also need to submit referrals for medication errors leading to death, injury or abuse (or alleged abuse), and medication errors reported to the police.
- NMC. Reasons to refer include accusations of abuse of professional position, serious or repeated mistakes in patient care, serious criminal offences, violence and dishonesty. Visit the NMC website for a full list of referral criteria.
- RQIA. Notify the RQIA about incidents resulting in death, serious injury, criminal charges and misconduct. See the Statutory Notification of Incidents and Deaths guide for a full breakdown of reportable events.
- RIDDOR. Referral reasons include deaths and injuries caused by workplace accidents, specified injuries to workers and dangerous occurrences. View a full list of reportable events here.

- MHRA. Report incidents involving medicines or medical devices. Referral guidelines vary in Scotland, Northern Ireland and Wales.
- Your staffing agency. If you work with Florence, you can report adverse events via phone, web chat or email (incidents@florence.co.uk).
- The police. If you believe a criminal offence has occurred, contact the police as soon as possible.

8. Support staff through investigations

Staff members shouldn't worry about reporting incidents. As we mentioned earlier, errors shouldn't automatically become HR or disciplinary issues.

When they're recorded and investigated properly, adverse events represent a chance to change for the better. So, do encourage team members to report, whether they're permanent or work for a staffing solution like Florence.

When care professionals are involved in incidents, they can feel anxious, and it's up to you to support them as the investigation progresses.

- Listen. Staff need to know you've heard their side of the story.
- Be proportionate. Some things can be made better, while others can't. Your investigation and the consequences of it should reflect incident severity.
- Keep them updated. Don't leave staff in the dark about the progress of your investigation. Always make sure they know what's going on.
- Think about the future. If the incident is remediable, treat it as a learning opportunity. If it isn't, discuss next steps with your team member.
- Create a personal development plan. If appropriate, speak to your member of staff about training and other development opportunities to avoid a similar incident in the future.

9. Create an effective action plan

Effective action plans play a big role in incident management. You can use what you learn from the investigation to create a thorough, realistic improvement strategy with clear goals and measurable outcomes.

If you've been stuck in a "Root Cause Analysis rut", think about what you can do to reduce risk and prevent incidents from happening in the first place.

Make a list of actions, focusing on the ones you believe will really make a difference, and be clear about who's responsible for what. For example, if residents fall frequently, you might need to change the lighting or the carpets, retrain staff or conduct

falls timeband analysis to see if accidents happen at the same time, or during a certain time period each day.

As time passes, revisit actions to ensure they're still relevant and effective. If actions aren't completed (or if your plan doesn't change from month to month) they're probably not reducing risk at your care home.

Keep track of successes, too. If actions make a difference – if you see a reduction in the number of falls at your care home, for instance – document those victories and present them at your next CQC, RQIA or CI inspection.

To recap, here's what an effective action plan includes:

1. Clear, logical actions.
2. Owners for each action.
3. Realistic completion dates.

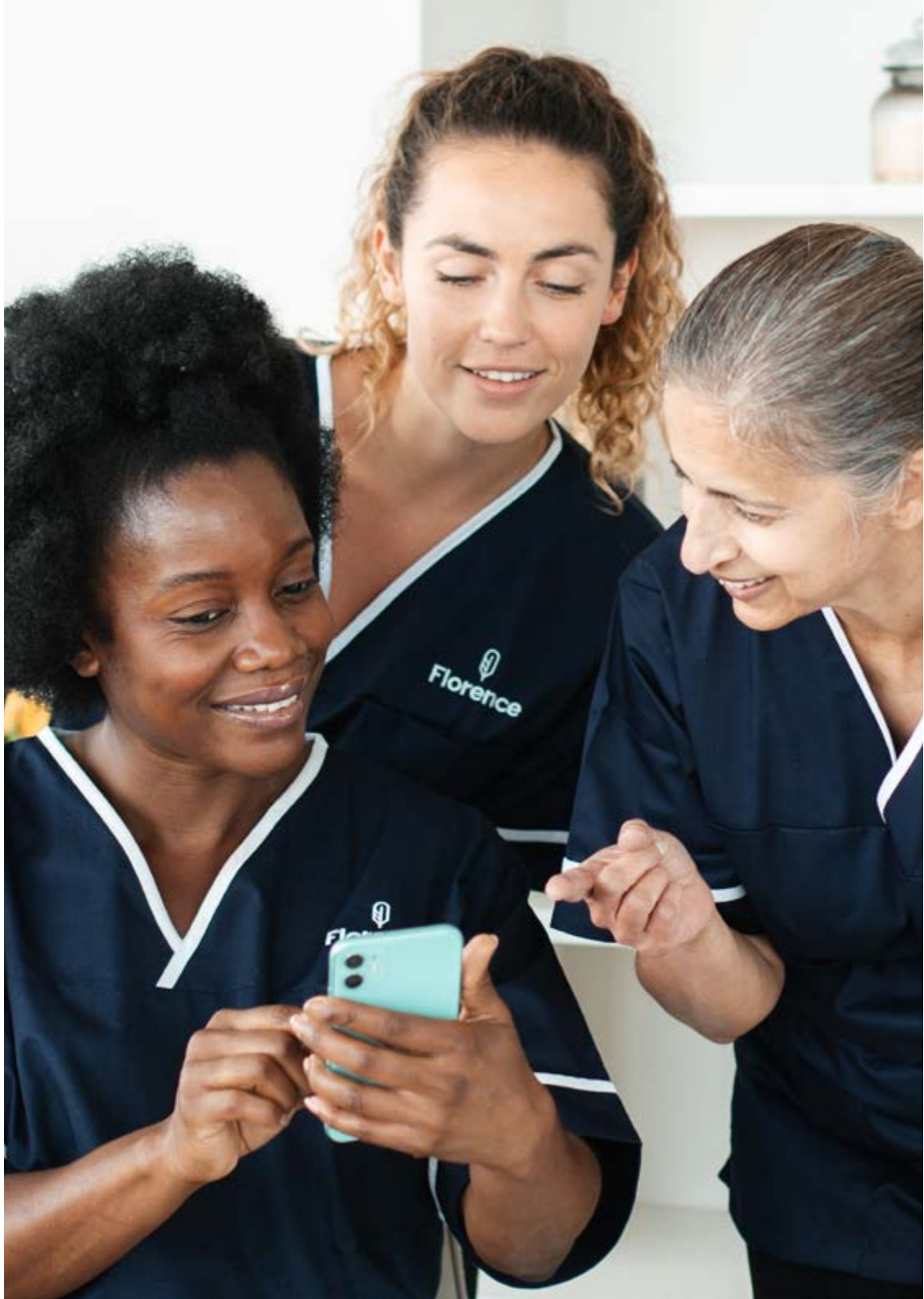
Share your risk-reduction plan with all staff, keep track of which actions work (and which don't), and write an account of what you learn as the months roll by.

10. Learn and grow

Try to think of building and refining your incident management policy as a chance to learn and grow. With a robust policy in place, your organisation will be stronger, your staff will feel more confident, and you'll reduce the risk of incidents occurring in the first place.

A solid incident-management policy could also improve your inspection rating.

While visiting, the inspector will look at your incident management process to check you're doing everything possible to keep residents safe and tackle adverse events in a thorough and transparent way.



The importance of training

Good governance and thorough incident management create an excellent foundation for safety in any care setting. But the right training can also help prevent adverse events from happening.

Regular training can:

- ➔ Keep essential skills up to date
- ➔ Reduce the likelihood of medication errors
- ➔ Help staff identify early warning signs of a potential incident
- ➔ Improve communication between team members
- ➔ Nurture a culture of continuous improvement at your care home

With a provider like Florence Academy, you can create custom training plans, assign courses, set goals and track learning and development. You can choose from more than 75 CPD-accredited and CTSF-aligned courses, all of which are accessible online.

Here are just a few of the safety-focussed modules available:

- ➔ An Introduction to Incident Management
- ➔ Health, Safety and Welfare
- ➔ Moving and Handling Theory
- ➔ Medication Administration
- ➔ Oral Health and Dysphagia

11. Working with your agency

If an incident involves an agency worker, you shouldn't have to investigate alone. Well-run agencies work with clients to resolve problems quickly and professionally.

Your agency should:

- ➔ Have a dedicated governance team and a robust incident-management policy.
- ➔ Set a realistic timeframe for the investigation.
- ➔ Communicate and provide feedback at every stage of the process.
- ➔ Support temporary staff throughout.
- ➔ Work with you to create an action plan where required.

At Florence, we believe in full transparency and the potential for growth and change. Because of this, we support both care providers and care professionals through investigations.

How Florence supports care providers

If an incident involving a Florence professional happens at your care home, we'll work with you to resolve it.

You can report an incident to us 24 hours a day via incidents@florence.co.uk.

First, we log details about the adverse event on the Florence Incident Management System (IMS). Next, you'll hear from a member of our governance team, who will work alongside you as the investigation progresses.

If you need to refer the event to an external agency (Safeguarding, Adult Support and Protection, NMC or police, for example), we'll support you throughout.

Depending on the outcome of the investigation, we might:

- → Issue a warning letter or have a professional discussion with the individual
- → Provide additional training or ask the individual to complete a reflective account
- → Remove the individual from the Florence platform
- → Refer the individual to a regulatory body, like the NMC, NISCC, DBS, PVG or AccessNI.

We aim to resolve incidents within four weeks, although events involving external agencies may take longer to conclude.

How we support care professionals

We contact Florence care professionals within one working day of receiving incident reports, asking them to provide us with a statement of events. We'll then share the statement confidentially with the lead investigator, and collaborate with you on a course of action.

As the investigation progresses, we'll stay in close touch with the nurse, care assistant or support worker to ensure they feel heard and understood. We might also refer them to supportive agencies and advocacy groups. If a Florence professional gets referred to a regulatory body because of the investigation, we attend hearings with them.

Finally, we help individuals understand any actions taken and guide them through next steps.

Learn more about Florence

Learn more about Florence's approach to incident management and discover how we can help you find, retain and train an experienced team. We're on your side.