



Circle Voluntary Housing Association

Incident Management Procedure

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1.0 Values:

The actions we take underpin our vision to make a difference by providing quality homes for people in housing need. At Circle Voluntary Housing Association, we firmly believe that how we interact with our customers, communities, colleagues, and key stakeholders is of fundamental importance. Our passionate commitment to caring about our tenants and the services we deliver has led to the development of our core values - six behaviour-based principles that speak directly to the characteristics we hold high.

WE HEAR

Willingness to embody all our values in a driven manner.

Empowerment of our staff and tenants

Honesty allows for complete understanding, it aids in the delivery of integrity and putting our tenants' best interests at the heart of our decision-making

Excellence reminds us of our continuous strive to be better

Accountability benefits all, transparency will foster this, and the creation of solid and reliable documentation will ensure that this accountability is enforced

Respect is the foundation of these values, without respect for ourselves, others and the service we provide we must ask ourselves why we put so much of our valuable time into the job we do

2.0 Introduction:

Circle Voluntary Housing Association places the highest priority on the safety and wellbeing of employees, contractors, tenants, visitors and others affected by work carried out by or on behalf of the organisation. It is the policy of Circle Voluntary Housing Association that all incidents, accidents and near misses are reported, reviewed, and where required, investigated to ensure that there is learning from such events so that safety and quality of services within the organisation are improved.

Circle Voluntary Housing Association recognises the importance of learning from accidents, incidents and near misses and therefore promotes an environment which staff are encouraged to report, investigate, disseminate, and implement learning from accidents, incidents and near misses promptly.

2.1 Definitions:

Accident	An unplanned, unexpected, and undesired event, usually with an adverse consequence.
Incident	An unexpected or unplanned event which caused unintended or unnecessary harm to a person, or damage to, or loss of property or data system.
Near Miss	An incident which could have resulted in harm but did not either by chance or timely intervention.

Circle Voluntary Housing Association is committed to:

- Promoting a just, proportionate, and consistent approach to the management and investigation of incidents.
- Protecting the wellbeing of its staff, tenants, contractors, and others.
- Demonstrating compliance with legislative and regulatory requirements including those set out under the Safety Health and Welfare at Work Act, 2005, Safety Health and Welfare at Work (General Applications), 2007, and any other relevant legislation and regulation.
- Managing and investigating accidents, incidents and near misses in a timely and cost-effective way and in a manner which Circle Voluntary Housing Association management, staff, contractors, and others can be confident in.

This Incident Management Procedure and associated policy replaces all previous Incident Management Policies & Procedures and shall be applied consistently throughout the organisation for the management of all incidents. This procedure is intended to be used in conjunction with other relevant policies and guidance's listed in Section 19.0.



Fig. 1: Stages of Incident Management

3.0 Purpose:

The purpose of this Procedure is to establish the principles and methods used throughout Circle Voluntary Housing Association for the reporting, investigation, and management of all accident, incidents and near misses. Both documents also support the organisation to meet its obligations under the Safety, Health & Welfare at Work Act, 2005, and the Safety, Health & Welfare at Work, (General Applications), 2007. This Procedure also considers the standards of relevant bodies including the Approved Housing Bodies Regulation Authority (AHBRA), the Health and Safety Authority (HSA), and others.

The purpose of this Procedure and the associated Policy is to ensure that because of all accident, incident and near miss reviews and investigations, learning takes place and practices are developed and improved throughout the organisation to prevent similar incidents happening again.

This Procedure supports the purpose by:

- Outlining a process for review and investigation of incidents.
- Outlining the process for the communication and notification of incidents.

4.0 Scope:

This policy applies throughout Circle Voluntary Housing Association and shall be read in conjunction with other relevant policies listed in Section 19.0.

5.0 Procedure for Managing Incidents:

The primary objective of incident management is to learn from the incident to reduce the risk of recurrence and to make the workplace safe.

The goals of incident review is to determine the following:

1. What happened (**Identify**)
2. How it happened and why it happened (**Analyse**)
3. What can be done to reduce the risk of recurrence (**Correct**)
4. What is learned (**Prevent**)

5.1: Incident Identification:

An incident can be described as an unexpected or unplanned event which caused unintended or unnecessary harm, or damage to, or loss of property. The definition of incident includes near miss which may be defined as any event which potentially may have caused unintended or unnecessary harm to a person, or damage to or loss of property, (reference Appendix 1 for full list of definitions).

Critical incidents are those incidents which are either serious or which would not have occurred if the available preventative measures had been effectively implemented by Circle Voluntary Housing Association. All critical incidents must be reported to the CEO.

This procedure applies to all incidents and near misses which meet these definitions. Some examples are set out below, however, this list is not exhaustive:

- Verbal aggression
- Physical aggression
- IT incidents
- Infection control incidents, e.g., Covid-19; Legionella
- Equipment incidents
- Health & Safety incidents
- Fire
- Accident or injury to staff and/ or others
- Slips, trips, and falls
- Death
- Partial or full loss of building function that critically impacts staff or tenants, e.g., fire, flood

Incidents may be identified via different reporting routes, for example, complaint and feedback process, legal case. All such incidents shall be investigated in line with this procedure, however Circle

Voluntary Housing Association's primary tool for reporting accident, incident or near miss is the CalQRisk database.

5.2 Immediate Action Required Following an Incident:

When an incident is identified, the first responsibility is to ensure that the safety, health, and welfare of the person(s) affected are protected. The following is a list of essential steps to be taken to manage immediate safety concerns following the identification of any incident:

- Any care that is required because of the incident must be provided without delay and circumstances reported to the department manager or next available Manager/ Department Director.
- Any threat to the future safety, health, and welfare of staff, tenants and/or others must be removed or minimised as far as is reasonably practicable.
- Relevant materials, equipment or supplies that may have contributed to the incident must be preserved and retained. If the incident involves equipment, the device/ equipment should be retained including any packaging. If possible, all switches and controls should be left as they were at the time of the event. All information relating to the batch/ serial number should be recorded in the incident form.
- Records must be preserved and retained in line with Circle Voluntary Housing Association Records Management Policy.
- Where there is a requirement to photograph a person for investigation purposes, consent must be obtained from the individual/s when creating and retaining such photographs.
- Normal services/ work should be maintained or resumed as soon as it is practicable and safe to do so.
- Whether any individuals' actions present an immediate safety concern should be determined. There may be a need for precautionary action (e.g., step down from duty). Similarly, staff may be stepped down to ensure that they receive appropriate care and support following an incident.
- If staff or other persons are not aware that he or she has been involved in or affected by an incident (e.g., Legionella detected; close contact of confirmed case of Covid-19), they should be informed of incident at the earliest opportunity.
- Appropriate support should be provided to staff as soon as possible where a critical or serious incident has occurred.

6.0: Reporting an Incident:

This procedure requires the following to take place:

- The details of all incidents must be clearly and accurately recorded on CalQRisk as soon as possible, ideally at the first opportunity but no later than within 24 hours from time the incident occurred or was reported.
- All incidents, including near miss incidents must be reported so that action can be taken to investigate and to address contributory factors to prevent future harm arising. Where this is not possible, steps will be taken to reduce the risk of harm in so far as is reasonably practicable.
- Incident reports are potentially discoverable in law and must therefore be accurate, factual and should not exaggerate or minimise incident. If alterations are required, these should be recorded within the original Incident report along with an explanation for amendment, the date and the name of the person altering the record.
- The incident report is a live, on-going reporting record and should be updated with new information as it comes to light, for example, statements, photographs, diary entries, details of phone calls, copies of emails and texts that relate to the incident all must be recorded and retained with the report. Any information to be provided by staff regarding the incident

should be sent securely to the incident investigator, referencing the original incident number, date of the incident and name of any individual(s) involved.

6.1: Guidance on Completing an Incident Report:

- All incidents/ accidents/ near misses must be reported using the CalQRisk database. The Incident record must be completed by the member of staff involved in, or witness to the incident as soon as possible, ideally at the first opportunity but no later than within 24 hours from time the incident occurred or was reported. Where a member of staff is not able to complete the record (e.g., where her or she has been physically injured because of the event), the incident report should be completed by the next appropriate person. This will be another employee who has witnessed the incident or the Department Director/ Manager.
- The incident event should be described clearly and in a manner that is factual and objective. The database incident record provides for the recording of information describing the circumstances leading up to the event, conditions at the scene, witnesses involved (including staff, tenants, contractors), any injury sustained, any action taken, and the outcome of the incident. All such details should be fully recorded.
- Details on the incident record must be accurate and factual and must not contain opinions or apportion blame.
- If an incident has not been observed by a member of staff, then this must be made clear in the incident form, e.g. *"the tenant/ visitor states....."*
- The recording of the incident should commence as soon as possible after occurrence and all subsequent actions should be recorded in chronological order.
- Immediate actions taken to manage the incident should be recorded.
- Where there is more than one person affected by the incident, all affected persons should be referenced within the incident form.
- Abbreviations should not be used unless they are specific to abbreviations that have been approved by Circle Voluntary Housing Association.
- The 24-hour clock should be used when documenting events.
- Incident record must be completed in black indelible ink and write clearly using block capitals.
- For hard copy documents, e.g., witness statements, recognisable signatures are essential, therefore block capital spelling of staff members name must be adjacent the persons signature and the document must be dated.
- Correction fluid must not be used paper-based documents. Any errors should be corrected by putting a line through them with staff members initial clearly legible beside or above crossed out error. An incorrect entry must not be made difficult to read.
- Additions to existing entries should be individually dated, timed, and signed.
- If the incident has been notified to an external body, e.g. HSA, insurance company, the details of this must be noted on the incident record, including date, time and person who reported this. If possible, please record the name of the representative of the external body incident was reported to.

6.2: Review of the Incident by Department Director/ Manager:

Once the incident report has been completed by staff member, the incident must be reviewed by the Department Director/ Manager to whom that member of staff reports. The Department Director/ Manager should seek to ensure that the following information has been correctly captured within the incident record:

- Does record clearly indicate that matter reported is an incident, accident or near miss.
- The personal details of the affected person.
- Identity of the affected person, i.e., was the person staff member, tenant, contractor, visitor, other.

- The date incident was reported.
- The name of person who reported the incident is recorded.
- Provide information regarding injury or damage sustained, with details of any medical treatment received also recorded.
- Has the incident, including the immediate actions taken following the event and the outcome of the event, been described sufficiently to support the Department Director/ Manager assessment of the incident with a view to deciding on the following:
 - The appropriate level of investigation required, if any.
 - Any further actions required to be taken arising from the occurrence of the incident. The Corrective & Preventative Model (CAPA) is used by Circle Voluntary Housing Association to develop action plans in response to incidents. CAPA seeks to eliminate the causes and prevent recurrence of incidents in as far as is reasonably practicable, usually through Circle Voluntary Housing Association risk analysis process.
 - Any learning to be ascertained from the incident with a view to preventing the risk of recurrence of similar incidents
 - Should the incident lack any of the above required information, the Department Director/ Manager should, as soon as possible seek to discuss the event in person with the staff member who reported the incident to secure any outstanding information.
- It is the role of the Department Director/ Manager to assess the actual level of harm resulting from an incident (Actual Impact). This should be completed using the Circle Voluntary Housing Association Risk Assessment Tool contained within Appendix 2 of this document. This in turn will inform the level and type of investigation required.
- The Department Director/ Manager confirms the category of incident, e.g., health and safety incident, near miss etc., which in turn determines the level of investigation necessary and requirement to report to any external body.
- Should it appear to the Department Director/ Manager from an initial review of the incident that the event in question is more than a negligible event, the Department Director/ Manager should, as soon as possible and before completing their assessment of the incident, seek to discuss the event in person with the staff member who initially reported the incident.
- The Department Director/ Manager should ensure that all incidents of death or serious harm or damage are communicated/ escalated immediately to the Senior Accountable Officer and the Chief Executive Officer.
- The Department Director/ Manager should ensure that all necessary people are informed, for example, relevant members of the management team, family of affected person.
- In most cases an incident can be managed locally. There are situations where it is appropriate to escalate/ communicate the incident to the next level of management.

7.0: External Agencies:

Several external agencies require Circle Voluntary Housing Association to report incidents to them, e.g., Health and Safety Authority (HSA); Approved Housing Bodies Regulatory Authority (AHBRA), Circle Voluntary Housing Association insurance company; Data Protection Commissioner; Gardai. This list is not exhaustive, and should staff be unsure about external reporting requirements, they should contact their line manager or the Senior Accountable Officer (currently Director of Property).

8.0: Critical and Serious Incidents:

All incidents which result in death or serious harm must be reported to the Senior Accountable Officer and the Chief Executive Officer immediately. These include incidents categorised as 'Major' or 'Extreme' on the Circle Voluntary Housing Association Risk Assessment Tool (see Appendix 2).

9.0: Categorisation and Initial Assessment:

The purpose of categorising and assessing incidents is to assist with determining whether an investigation is necessary and if so, the level and type of investigation that is required to find out what happened, why it happened, and what learning can be gained to minimise risk of similar incident occurring in the future.

The level and depth of investigation should be proportionate to the impact, scale, complexity, and potential for improving the service and will depend on several factors such as:

- The impact of the incident.
- The number of people harmed.
- The potential for learning from the incident.
- The degree to which tenant/ staff/ public confidence is an issue.
- The need to involve other services/ external bodies.

Categorisation is carried out by using the Circle Voluntary Housing Association Risk Assessment Tool as contained within Appendix 2. The categorisation is based on the impact of harm that has occurred.

Incidents are categorised as follows:

- **Major:**
Such incidents include critical or serious incidents resulting in death, major permanent incapacity, sustained loss of core services or facility, gross failure to meet legal or regularity standards.
- **Moderate:**
Such incidents include those involving significant harm requiring medical treatment, subcritical facilities failure, serious reportable events not covered by the categories of Major or Extreme.
- **Minor:**
Such incidents include those involving no harm or low harm injury or short time service interruption.

The assessment of incidents will:

- Establish the context of the incident (where an incident occurred and what occurred).
- Assess the impact of an incident according to the Circle Voluntary Housing Association Risk Assessment Tool (Appendix 2).
- Decide the appropriate type of review or investigation required, reporting requirements, ongoing management plan and whether onward communication or escalation is required.
- Development a CAPA plan.

10.0: Review and analysis of the incident:

The purpose of review is to find out what happened, why it happened and what learning can be gained to minimise the risk of a similar incident occurring in the future. The review and analysis of incidents is a key tool in relation to quality improvement.

There is a need to understand not just what happened at the point of occurrence of the incident, but to understand the factors that contributed to or influenced the occurrence. As a result, it is important that the approach to the review seeks to examine the systems in place to understand the factors that contributed to the incident.

Failure to correct systems issues identified will result in them failing again in the future with similar incidents recurring. Adopting a systems approach to the review of incidents helps to move the focus from simply responding to incidents to actively preventing them, enabling safety management that is underpinned by learning and improvement.

Some incidents may require a deeper and more detailed examination of the incident to comprehensively understand the causes of the incident and the factors that contributed to these causes.

				
TASK	MATERIAL	ENVIRONMENT	PERSONNEL	MANAGEMENT
Work procedures, Workplace conditions, Tools & devices	Equipment, Machinery, Hazardous Materials & products	Light, Noise, Temperature, Weather	Skills, Experience, Health & Fitness, Stress, Time pressure	Supervision, Policy & Procedure, Safety training, Risk identification and controls

Table 1: Incident investigation – Causation Categories (Dekra, 2021)

A degree of independence is always required when reviewing incidents and the review of incidents should not be led or facilitated by any person who was directly involved in the incident as there may be an element of bias and a real or perceived conflict of interest.

The Department Director/ Manager should seek to identify any key causal factors that contributed to the incident i.e., were there any issues that arose in relation to the delivery of work which influenced the incident. Should the Department Director/ Manager identify any key causal factors which warrant further investigation, the Department Director/ Manager should initiate an investigation of the incident.

If there is any doubt about whether an incident was unforeseeable/unavoidable, the first three steps of a systems analysis investigation should be undertaken as follows:

- Organise the investigation and gather the data.
- Establish the incident chronology to determine what happened and when.
- Identify the key causal factors and incidental findings. For further information in relation to the above-mentioned steps, see Appendix 3.

If the event was unforeseeable/unavoidable, no key causal factors will be identifiable upon analysis of the chronology and it can be confirmed that, while it is regrettable that harm occurred, it is not an

incident of harm caused by some act or omission on the part of Circle Voluntary Housing Association. The Department Director/ Manager may therefore determine that no further investigation is required.

For incidents where no further investigation is required, the Department Director/ Manager must ensure that:

- The data from the incident report form is captured for aggregate review.
- The decision not to investigate further and the reasoning/factors influencing this decision are noted clearly in documentation and conveyed to all concerned including staff/tenants/ others involved in the incident in a manner that respects the rights of all to privacy and confidentiality.
- The Department Director should seek assurance through documentation that a decision not to investigate further is appropriate.
- There is appropriate communication with the staff member/ tenant/ other.

10.1: Determining if incidents must be escalated to the next level of management:

In the context of this Procedure, escalation refers to the process whereby the Department Director/ Manager reports the incident to the management level above him, her, them, and/or the Senior Accountable Officer/Chief Executive Officer (in relation to serious incidents).

An incident is escalated when the Department Director/ Manager determines that additional support is required for managing and investigating the incident.

The following considerations may influence the decision to escalate an incident for additional support:

- The incident involves more than one area/ department which makes the incident management or investigation problematic.
- The area/ department does not have the capacity or capability to manage and investigate the incident in accordance with this Procedure.
- The internal investigators of the incident deem that external input to the investigation is required.
- Where the assessment of an incident indicates that a look back review is required.
- If there is a significant risk to public confidence in services.
- Where another investigation is being conducted by an external agency for example investigations by professional or other regulators such as the Approved Housing Bodies Regulation Authority (ABHRA), the Health and Safety Authority (HSA), the Gardai, and others.

The level to which any incident is escalated will be determined by taking the above considerations into account. The risk of litigation is not a criterion for escalation.

10.2 Aggregate analysis of incidents that resulted in negligible, minor, or moderate harm:

It is the policy of Circle Voluntary Housing Association that, at a minimum, there will be aggregate analysis of the causes of low impact incidents according to incident type (e.g., slips, trips, and falls). Aggregate analysis includes examination of near miss incidents and incidents that resulted in major, moderate, or minor harm.

Aggregate analyses should be monitored by the Department Director/ Manager and corrective actions planned, implemented, and reviewed. Any pattern or trend should be notified by the Department Director whom the manager reports to, the Management Team and the Leadership Team.

The following should be summarised in a brief report to the Management Team and the Leadership Team:

- The identification of key causal factors contributing to the incidents by type (see table 1).
- The identification of contributory factors for each key causal factor.
- The identification of control measures and quality improvement plans, using CAPA model, to address the contributory factors identified.

Data produced will be used for organisational analysis which may trigger a look-back review if necessary. Contributory factors or hazards identified should be managed and communicated via the department risk register in accordance with Circle Voluntary Housing Association Risk Management Policy.

11.0 Look-back review:

A look-back review is conducted as a matter of urgency when several people have been exposed to a specific hazard, to identify if any of those exposed have been harmed and how to take care those harmed.

Examples of hazards that should require a look-back review include but are not limited to the following:

- Audits showing that the results delivered in an area or department, or an individual may not be up to best practice standards.
- Equipment found to be faulty or contaminated in a manner that puts people at risk of harm.
- Concern about the level of injury.

The process must be overseen by an incident management team, to be elected by the Senior Accountable Officer. The look-back review team must conduct its investigation and deliver its completed report to the investigation commissioner (CEO and Senior Accountable Officer) in as timely a manner as is possible.

Any incidents of major, extreme harm, death or serious harm identified by a look-back review which were not identified previously should be investigated further.

11.1 Convening an incident management team:

All incidents that require investigation will be managed by an incident management team. An incident management team is convened by the Senior Accountable Officer and the Chief Executive Officer and must be convened for incidents of death and serious harm and rated as high according to the Circle Voluntary Housing Association Risk Assessment Tool (Appendix 2).

An incident management team must be convened within 24 hours of the Senior Accountable Officer and Chief Executive Officer being informed of the incident. Members of an incident management team should not include individuals involved in the incident.

The incident management team must be chaired by an individual with training and experience in conducting systems analysis investigations. For Circle Voluntary Housing Association, if no internal staff have been trained or available to conduct a systems analysis, for the purposes of the investigation of such incidents, an external incident management team may be commissioned.

For further information on the process to be followed in relation to systems analysis investigations, please see Appendix 3.

11.2 Communication of safety concerns by the investigation team to the investigation commissioner:

In all incident investigations, there must be communication and management of safety concerns to the investigation commissioner as soon as they are identified. The investigation commissioner is typically the Senior Accountable Officer and Chief Executive Officer.

An incident investigation may identify contributory factors/hazards that exist at the site where the incident occurred or at other similar Circle Voluntary Housing Association sites. In these instances, the investigators must immediately convey such safety concerns to the investigation commissioner who must ensure that the details of the contributory factors/hazards identified, and the associated recommendations are urgently communicated within Circle Voluntary Housing Association for learning and quality and safety improvement purposes as soon as they are identified, even if this is before an investigation is finalised.

12.0 Improvement planning & monitoring:

Making recommendations to improve the quality and safety of services is one of the most important elements of an investigation report. The CAPA model is used by Circle Voluntary Housing Association in developing such action plans.

The following are important in making recommendations to enhance safety:

- Recommendations must be linked to the factors that contributed to the incident i.e., contributory factors.
- Recommendations should be written in a way that ensures they are Specific, Measurable, Achievable, Realistic (implementable) and state a Timeframe for completion (SMART).
- Recommendations should be developed to ensure that they:
 - Address local incident causes/contributory factors.
 - Address incident causes/contributory factors that exist at other Circle Voluntary Housing Association locations.
 - Are easy to follow and implement and are cost-effective.
 - Are made with input from those directly involved in the incident; the Incident Management Team (where applicable); and external experts (where applicable).
- Recommendations should reference existing relevant initiatives including Circle Voluntary Housing Association standards and guidelines.
- All recommendations should be appropriately assigned to person(s) who are accountable and responsible for their implementation with a designated timeframe for completion.

13.0: Circulation of reports and recommendations:

Once the investigators submit a report to the investigation commissioners. The investigation commissioner is responsible for ensuring the assessment, circulation, monitoring and implementation of the recommendations and sharing of the learning throughout the organisation.

Final investigation reports should be provided to the staff member/ tenant/ other, unless they have expressed a wish not to receive the final report.

Anonymised final investigation reports relating to incidents may be provided to third parties. Examples of third parties (other than staff member/ tenant/ contractor) who may receive final anonymised versions of investigation reports and recommendations include the Approved Housing Bodies Regulation Authority (ABHRA) and the Health and Safety Authority (HSA).

Final investigation reports may also be communicated to relevant staff to create safety awareness and may be used as learning resources for incident management training purposes, ensuring no personal information of any parties involved is disclosed.

13.1 Monitoring the implementation of recommendations:

Circle Voluntary Housing Association must have in place adequate mechanisms for monitoring the implementation of recommendations. Appropriate monitoring tools include the development of action plans with periodic review and monitoring of such action plans up to implementation of all recommendations.

Recommendations must be communicated and implemented within the shortest timeframe possible. If there is a cost associated with the implementation of recommendations, issues identified should be prioritised for funding.

13.2 Taking Responsibility:

It is understood that fear of disciplinary action and subsequent sanctions may deter staff from reporting incidents.

This Procedure has been written in line with a “just and supportive” culture where the focus following an incident is **“What went wrong?”** not **“Who went wrong?”**

Where errors have occurred and are openly reported, an investigation into the facts may take place but the disciplinary process may not be instigated in respect of a member of staff, except in well-defined circumstances to include:

- An incident in which Circle Voluntary Housing Association considers that a fundamental breach of professional conduct has occurred.
- Further occurrences of actions involving a staff member who has previously been warned and/or subjected to disciplinary action related to the type of error that might have led to the incident.
- Where it appears that a member of staff may have been guilty of a criminal offence or some act or omission which may result in formal action by a regulatory body.
- Failure or significant delay in reporting an incident in which a member of staff was directly involved or about which they were aware.

The decision to instigate the disciplinary process is a matter for the Human Resources Department.

14.0 Process for staff to raise concerns:

Whilst Circle Voluntary Housing Association requires all incidents to be reported in accordance with this Procedure, it recognises that members of staff may have personal concerns about raising a “concern” in the context of an incident where such an incident has or may compromise standards of conduct and performance, or where the staff member may have concerns that they may be victimised because of a disclosure. Staff should be aware that Circle Voluntary Housing Association has a Whistle Blowing Policy in place through which they can disclose in confidence.

15.0 Staff Support:

Even with the various systems, procedures, and protocols in place to protect staff as far as is reasonably practicable, from serious incident, there is no guarantee that staff will be able to completely avoid such. It is important that staff know where they can go for support and help should they suffer an incident or accident.

Any Circle Voluntary Housing Association staff member who has been involved in or affected by an accident or incident at work, will be provided with support from the organisation. The supports offered will be determined through debriefing meeting which will take place with the affected staff member, their line manager and a member of the HR team. If specialist support is required, the employees line manager and the HR team will make the necessary arrangements in consultation with the employee.

Where a serious incident has occurred, the relevant risk assessment(s) should be reviewed, and changes made where necessary.

As an additional staff support, Circle Voluntary Housing Association has implemented an Employee Assistance Program (EAP) with VHI. This support service can be contacted as follows:

Phone: 1800 995 955;

Email: eap@vhics.ie

15.1 Protected Earnings:

Should an employee suffer injury or ill health due to work related accident or incident, it is the policy of Circle Voluntary Housing Association to ensure the employees income is protected and that the person continues to receive full pay until they are certified fit to return to work.

All work-related accident or incidents which result in the affected employee/s being absent from work for three or more days are reported to the Health and Safety Authority (HSA) by the HR team and the organisations insurance company.

15.2 Redeployment:

Should an employee suffer injury due to work related accident or incident, it is the policy of Circle Voluntary Housing Association to require the employee to attend an occupational health assessment with a company appointed health care professional. The purpose of this assessment is to confirm fitness to return to work and will be arranged by the organisations HR team. If it is recommended by the occupational assessment professional that the staff member be temporarily or permanently redeployed, it is the policy of Circle Voluntary Housing Association to accommodate this in consultation with the employee and where a suitable vacancy exists.

16.0 Dissemination:

This Procedure is available in the Circle Voluntary Housing Association SharePoint Health & Safety Policies folder, located on "CVHA Home page".

17.0 Implementation:

In conjunction with requirement to familiarise themselves with this policy and the associated procedure and in support of the implementation of same, all Circle Voluntary Housing Association employees must complete Circle Voluntary Housing Association Incident Management training program.

18.0 Review and Audit of Policy and Procedure:

This Procedure will be reviewed in line with the Circle Voluntary Housing Association Policy Framework Document or when directed by changes in local practices or national legislation.

19.0 Related Policies:

- Incident Management Policy
- Risk Management Policy & Procedure
- Complaints Management Policy
- Safety Statement
- Child Protection & Welfare
- Data Protection Policy
- Water Management Policy (Legionella)
- Driving for Work Policy & Procedure

20.0 References:

Dekra (2021): Safety Incident Investigation.

<https://www.dekra.com/en/safety-incident-investigation/>

21.0 Appendices:

Appendix 1: Definitions:

Term:	Definition:
Accident	An unplanned, unexpected, and undesired event, usually with an adverse consequence.
Incident	An unexpected or unplanned event which caused unintended or unnecessary harm, or damage to, or loss of property or data system
Near Miss	An incident which could have resulted in harm but did not either by chance or timely intervention.
Harm	Harm to a person: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury.
Serious Harm	Serious Harm is serious injury to a person, or serious damage done to a thing. It includes an injury which creates a substantial risk of death, or which causes serious disfigurement or substantial loss or impairment of the mobility of the body, or of the function of any bodily member or organ.
Hazard	An event or circumstance which could have or did lead to unintended and/or unnecessary harm. Incidents include events which resulted in harm; near-misses which could have resulted in harm but did not cause harm, either by chance or timely intervention; and staff or tenant complaints which are associated with harm. Incidents are associated with harm to: • staff, tenant's, contractors, and others • the attainment of Circle Voluntary Housing Association objectives • ICT systems • data security e.g., data protection breaches • the environment
Contributory Factor	A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.
Integrated Risk Management	A continuous, proactive, and systematic process to understand, manage and communicate risk from an organisation-wide perspective.
Investigation Commissioner	The commissioner of an investigation is typically the Senior Accountable Officer/Chief Executive Officer in the organisation that commissions an investigation of a critical incident.
Investigator	An individual who has training and experience in conducting investigations i.e., Systems analysis investigations of incidents
Just Culture	A just culture seeks to balance the need to learn from mistakes and the need to take disciplinary action.
Key Causal Factors	Issues that arise in the process of which influenced the eventual adverse outcome.

Look Back Review	Where several people have been exposed to a specific hazard, a Look Back Review is carried out to identify those exposed and to assess if they have been harmed and how to take care of them.
Risk	The chance of something happening that will have an impact on objectives.
Risk Management Process	The systematic application of management policies, procedures and practices to the activities of communicating, consulting, establishing the context, and identifying, analysing, evaluating, treating, monitoring and reviewing risk.
Incident Management Team	An Incident Management Team is convened by the Senior Accountable Officer or the Chief Executive Officer in the organisation, particularly for incidents of death and serious harm. The team is convened within 24 hours of the Senior Accountable Officer or Chief Executive Officer being informed of the incident. The Incident Management Team may be an existing appropriate management team or a subgroup of an existing appropriate management team or any other similar group provided that the team has a chair and appropriate membership.
Senior Accountable Officer	The Senior Accountable Officer is the person who has ultimate accountability and responsibility for the services under his/her governance. In Circle Voluntary Housing Association it is the Director of Property Services.
Serious Harm	Serious Harm is serious injury to a person, or serious damage done to a thing. It includes an injury which creates a substantial risk of death, or which causes serious disfigurement or substantial loss or impairment of the mobility of the body, or of the function of any bodily member or organ.
Systems analysis investigation of an incident	A methodical investigation of an incident which involves collection of data from records, interviews with those involved where the incident occurred, and analysis of this data to establish the chronology of events that led up to the incident. This information is used to identify the key causal factors that influenced the incident, the contributory factors, and recommended control actions to address the contributory factors to prevent future harm arising as far as is reasonably practicable.

Appendix 2: Circle Voluntary Housing Association Risk Assessment Tool:

Circle Voluntary Housing Association RISK ASSESSMENT TOOL

1. IMPACT TABLE	Negligible	Minor	Moderate	Major	Extreme
Harm to a Person	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning.	Minor injury or illness, first aid treatment required <3 days absence < 3 days extended hospital stay Impaired psychosocial functioning greater than 3 days less than one month	Significant injury requiring medical treatment e.g., Fracture and/or counselling. Agency reportable, e.g., HSA, Garda (violent and aggressive acts). >3 Day's absence 3-8 Days extended hospital Stay Impaired psychosocial functioning greater than one month less than six months	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling Impaired psychosocial functioning greater than six months.	Incident leading to death or major permanent incapacity. Event which impacts on large number of tenants or member of the public Permanent psychosocial functioning incapacity.
Tenant Experience	Reduced quality of tenant experience related to inadequate provision of information	Unsatisfactory tenant experience related to less-than-optimal service and/or inadequate information, not being talked to & treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable	Unsatisfactory tenant experience related to less-than-optimal treatment resulting in short term effects (less than 1 week)	Unsatisfactory tenant experience related to poor service resulting in long term effects	Totally unsatisfactory tenant outcome resulting in long term effects, or extremely poor experience.
Compliance (Statutory, Professional & Management)	Minor non-compliance with internal PPPG's. Small number of minor issues requiring improvement	Single failure to meet internal PPPG's. Minor recommendations which can be easily addressed by local management	Repeated failure to meet internal PPPG's. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Failure to meet national norms and standards / Regulations (e.g., Child Care Act etc). Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objectives/Projects	Barely noticeable reduction in scope, quality, or schedule.	Minor reduction in scope, quality, or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over – run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity	Interruption in a service which does not impact on the delivery of tenant services or the ability to continue to provide service.	Short term disruption to service with minor impact on tenant.	Some disruption in service with unacceptable impact on tenant. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of tenant services or resulting in major contingency plans being involved	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect
Adverse Publicity/ Reputation	Rumours, no media coverage. No public concerns voiced. Little effect on staff morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on staff morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News stories & features in national papers. Local media – long term adverse publicity. Public confidence in the organisation undermined. Circle Voluntary Housing Association use of resources questioned. Possible external review/investigation by ABHRA	National/International media/ adverse publicity, > than 3 days. Editorial follows days of news stories & features in National papers. Public confidence in the organisation undermined. Circle Voluntary Housing Association use of resources questioned. CEO's performance questioned. Public calls (at national level) for specific remedial actions to be taken. Court action. Public (independent) Inquiry.
Financial					
Environment	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

2. LIKELIHOOD SCORING

Rare/Remote (1)		Unlikely (2)		Possible (3)		Likely (4)		Almost Certain (5)	
Frequency	Actual Probability	Frequency	Actual Probability	Frequency	Actual Probability	Frequency	Actual Probability	Frequency	Actual Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At least monthly	99%

3. RISK MATRIX	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Appendix 3: System Analysis Review of Incidents:

System analysis is a well-recognised way of reviewing incidents.

The aim of a Systems Analysis review is to find out:

- How the incident happened?
- Why the incident happened?
- What the organisation can learn from the incident and the changes the organisation should make to prevent it happening again?

The purpose of a Systems Analysis review is to:

- Improve safety and by doing this to improve the quality of services.
- Identify the factors that contributed to the incident occurring.
- Identify problems or deficiencies.
- Ensure that lessons are learned.
- Act as early warning mechanisms.

The purpose of an investigation is NOT to:

- Identify publicly the individuals or locations linked to the incident.
- Apportion blame or fault.
- Exonerate individuals or management.
- Make decisions about negligence.
- Identify legal liability.

Stages in the System Analysis Process:

Stage 1: Organise the investigation and gather the data:

- The chair of the Incident Management Team (the Investigation Commissioner) will commission the Investigation and establish the investigation team (typically 2 members)
- An investigation plan is put in place by the Incident Management Team ("IMT") which will be monitored by the IMT throughout the investigation.
- All relevant consent is obtained to access relevant records.
- The IMT collect all pertinent information about the incident and will plan and conduct the required interviews.

Stage 2: Determine the incident chronology:

The IMT will develop a detailed chronology that demonstrates what happened and when.

Stage 3: Identify the Key Causal Factors and Incidental Findings:

From the analysis of relevant data and careful consideration of the chronology, the IMT will determine whether any key causal factors can be identified

Once the key causal factors have been identified, the factors that contributed to each of the key causal factors are identified. The IMT may also highlight incidental findings. These are issues identified during an investigation, which in the view of the IMT did not impact on the outcome of care but point to a need for system improvement.

Stage 4: Identify the Contributory Factors

Contributory factors are identified under the following areas:

- Individual affected or harmed.
- Task and technology related factors.
- Individual (Staff) factors.
- Team factors.
- Work environmental factors.
- Organisational and management factors.

Stage 5: Make recommendations

- Recommendations are developed to address each contributory factor. In the context of the Systems Analysis Investigations, recommendations are reasonable courses of action based on the best available evidence. They should address the identified contributory factors and should have the best potential for preventing or reducing the risk of future harm arising from these factors.
- If the contributory factor is one that might exist somewhere else across the organisation, this should be reflected in the investigation report and the relevant recommendations should be communicated by the Investigation Commissioner to other relevant parts of the organisation for learning and quality and safety improvement purposes.

Stage 6: Write the investigation report and submit to the Investigation Commissioner:

The purpose of the report is to convey the methods and findings of the investigation and the proposed risk reduction and quality and safety improvement recommendations. These should be detailed in a logical, concise, and comprehensive manner.

The report itself will describe:

- The IMT and the Terms of Reference for the Investigation.
- The sources of information that were used (e.g., interviews/review of records etc.)
- The sequence of events or chronology that led to the incident.
- Analysis of the key causal factors identified.
- Recommendations to prevent these causes from resulting in an incident in the future.

The recommendations contained in the final report of the investigation must inform the development of an action plan for how the organisation will manage the causes of harm identified by the investigation.

Fair Procedure and Natural Justice:

The investigation process must always ensure that fair procedures are afforded to all parties involved in the investigation.

Publishing reports:

Final investigation reports are anonymised in terms of location/department and identifiable persons. They should be provided to the staff member/ tenant/ other, unless they have expressed a wish not to receive the final report. They are also made available to relevant stakeholders who have responsibility for making decisions, allocating resources, planning for, and implementing related recommendations.

Appendix 4: Incident Management Workflow:

