QHP201

RISK MANAGEMENT POLICY AND PROCEDURES

Table of Contents

1. POLICY INTRODUCTION

National Ambulance is committed to operating in a way that does not injure or cause ill health or harm to our staff, clients, the local community or the environment, while ensuring continuity of high quality services during routine conditions and during disruptions to the business or its operating environment. Risk management is integral to this commitment.

The aim of this policy and the associated procedures is to ensure QHSE and Business Continuity Risks are identified, assessed and controlled, and that appropriate control measures are implemented and monitored. In addition, this policy aims to appropriately handle near miss, hazard, and incidents in terms of identification, reporting, and investigation.

This document was developed based on 'Abu Dhabi Occupational Safety and Health System Framework' (SF) version 3.1, March 2017, OSHAD-SF Mechanisms - Mechanism 11.0 – Incident Notification, investigation, and reporting Version 3.0, and NCEMA 7000:2015.

This Policy also applies to Sentinel Events which must be treated in accordance with the DoH Standard on Adverse events management and reporting. Any clinical incidents should follow CGP149 Clinical Incident Reporting and Investigation Policy. Refer to ITP125 IT Operations Policy for IT incidents.

This policy and procedure relates to the Risk Management system component.

2. SCOPE

This policy applies to all personnel working on behalf of National Ambulance including staff, contractors, and visitors to National Ambulance managed sites, and is applicable to all business operations. It addresses:

- Health and safety risks;
- Environmental risks;
- Risks to quality of NA operations or assets; and
- Business continuity risks.

Financial and contractual risks are not addressed in this policy and procedure.

3. ROLES AND RESPONSIBILITIES

Employee roles and responsibilities relating to ensuring that all hazards, near misses, and incidents are identified, reported, investigated, and that corrective actions are implemented and audited to mitigate further occurrences are set below:

1. EXECUTIVE TEAM

- Demonstrate visible and active leadership that engages Employees to practice QHSE applications
- Make available resources needed for successful implementation of this policy, including appropriate PPE
- Empower employees to stop work or remove themselves from a work situation of immediate or imminent exposure to a hazard they consider presents a reasonable risk to the health and safety of themselves, their colleagues, the public, and/or the environment
- Provide information, instruction, training and supervision to employees, as is appropriate to enable those persons to perform their work safely
- Review specific near misses and incidents identified in the investigation and as required by the risk review procedure
- Review specific incident reports
- Act as the final approval authority for the QHSE Management System

2. QHSE & BC MANAGER

- Demonstrate visible and active leadership that engages Employees to practice QHSE applications
- Make recommendations for specific hazard areas

- Identify and appoint personnel as Lead Investigator in the event of a conflict of interest during an investigation
- Review near miss and incident investigations and ensure they are done in accordance with the established policy and procedures
- Review control measures implemented during an investigation
- Comply with all relevant QHSE Policy and Risk Management systems
- Lead and conduct an objective/non-biased investigation of reported and specific near misses and incidents
- Gather evidence to gain a clear picture of the incident
- Analyse the findings and identify why the incident occurred
- Identify any hazardous conditions or operations and determine safe procedures and control measures
- Recommend corrective actions based on findings of investigation
- Report findings and recommendations of the investigation to the Managers or relevant persons
- Develop and implement QHSE awareness campaigns as appropriate

3. MANAGERS & DIRECTORS

- Demonstrate visible and active leadership that engages Employees to practice QHSE applications
- Participate in risk assessments as needed
- Investigate reported and specific incidents as required by the risk review procedure
- Identify and appoint Lead Investigators
- Identify and appoint personnel to conduct the near miss and incident investigation
- Participate in the reported and specific near miss and incident investigation as needed
- Implement corrective actions as needed
- Comply with all relevant QHSE Policy
- Communicate identified QHSE hazards to staff
- Review the reported near misses and incidents
- Initiate an investigation for any near misses and incidents
- Participate in near miss and incident investigations as needed
- Implement corrective actions as determined by the investigation
- Escalate the implementation of corrective actions as needed to the Managers or relevant persons
- Implement QHSE control measures
- Escalate the implementation of QHSE control measures as needed
- Review reported, specific incidents as required by this policy
- Implement QHSE control measure as determined through the application of this Policy
- Escalate high risk incidents and near misses as needed to executives

4. LEAD INVESTIGATOR – QHSE TEAM

- Comply with all relevant QHSE Policy and Risk Management Systems
- Lead and conduct an objective/non-biased investigation of reported and specific near misses and incidents
- Gather evidence to gain a clear picture of the incident
- Analyse the findings and identify why the incident occurred
- Identify any hazardous conditions or operations and determine safe procedures and control measures

- Recommend corrective actions based on findings of investigation
- Report findings and recommendations of the investigation to the Managers
- Perform periodic inspections

5. ALL EMPLOYEES

- Exercise safe work practices to minimize the potential for an event to occur
- Participate in the practical application of Protective Personal Equipment
- Comply with all relevant QHSE Policy and Risk Management Systems
- Avoid intentionally and recklessly interfering with or misusing anything provided at the workplace in the interest of QHSE, welfare or the protection or management of the environment
- Participate in risk assessments as needed
- Report all hazards, near misses, and incidents via the QHSE Reporting Form
- Participate in hazard, near miss, and incident investigations as needed
- Implement all corrective actions as directed by the Management
- Participate in QHSE incident reporting system
- Apply QHSE control measures

Employee roles and responsibilities relating to QHSE and Business Continuity risk management are set out in Table A

Table A: Employee Roles & Responsibilities Relating to QHSE Risk

Roles & Responsibilities	Executive Team	Directors	Managers	QHSE & Business Continuity Manager	All Staff
1. Comply with QHSE and BC policies and procedures					X
2. Avoid or minimize risks to patient outcomes, company activities and assets, health & safety, environment, and quality					X
3. Carry out or participate in risk assessments in employee's area of duty					X
4. Apply risk control measures identified in procedures, risk assessments, investigations or other documented processes					X
5. Report new or changed hazards and risks, or risks with insufficient controls and participate in determining actions to eliminate hazards and reduce risks					X
6. Participate in risk management as required					X
7. Demonstrate visible leadership that creates and supports the QHSE culture	X				
8. Provide resources for responsible QHSE and BC risk management	X				
9. Enable employees to stop work or remove themselves from situations that present unknown or uncontrolled risks	X	X	X	X	
10. Investigate or provide oversight to specific incident investigations	X	X	X	X	
11. Communicate significant uncontrolled QHSE and BC risks to the Board of Directors	X				
12. Take full accountability for QHSE and BC risks	X				
13. Take final responsibility for QHSE and BC risks				X	
14. Communicate identified hazards and controls to staff, contractors and visitors			X	X	
15. Consult staff on workplace hazards, risk assessments, and controls, ensuring staff can discuss and report risks			X	X	
16. Recommend actions or controls for specific hazards			X	X	
17. Review risk assessments			X	X	
18. Train new employees in QHSE risk management as appropriate to their role				X	
19. Identify training or information needs arising out of risk assessments				X	
20. Provide information, training and supervision to employees to enable them to work safely, without causing environmental harm, and ensuring continuity of operations during disruptions			X	X	
21. Develop action plans, including timeframes, for implementing control measures		X	X	X	

22. Develop testing programs to check adequacy of business continuity plans				X	
23. Review risk management policies, procedures and plans				X	
24. Prepare BC plans for potential major disruptions to operations		X	X	X	
25. Maintain a register of risk assessments and other risk records				X	
26. Prepare and report on QHSE and BC risks on a periodic basis to the Executive Team, or sooner based on level of risk				X	

4. RISK MANAGEMENT POLICY

National Ambulance ensures that are all risks in the company are identified, assessed and controlled. There are various tools that are used to identify and control risk. Areas where the risk is managed is divided to Quality, Health and Safety, Environment, and Business Continuity.

4.1. QUALITY RISK MANAGEMENT

National Ambulance ensures to provide high quality services to stakeholders, patients, and government entities. Multiple tools are used to identify, asses, and control any potential quality risks.

4.1.1. FMEA

Failure Mode Effects Analysis is a step by step analysis of a procedure/process in ways it might fail. Failures are errors or non-conformances in processes, especially ones that affect the customer/patient. The "Effects analysis" refers to studying the consequences of those failures.

The JCI Accreditation Quality and Patient Safety Standard requires that an annual review of "high risk processes in terms of patient and staff safety, and then to use the tool on a priority risk process. The annual review of high risk processes is conducted as a part of the annual QHSE Executive Management Review meeting. Following analysis of these processes, "the organization's leaders take action to redesign the process or similar actions to reduce the risk in the process.". One tool recommended by JCI that provides such a proactive analysis of the consequences of an event that could occur in a critical, high-risk process is failure mode and effects analysis.

The standardized approach for FMEA is also used to identify "Actual Controls and Opportunities". These opportunities are then implemented based on priority and benefit of the opportunity. Each identified Failure Mode and Effect identified undergoes a likelihood and consequence to determine the risk rating. This is used to prioritize the opportunities and risks identified. Refer to QHF233 FMEA Register

4.2. HEALTH AND SAFETY RISK MANAGEMENT

National Ambulance ensures that risks affecting the health and safety of staff are captured, monitored, and controlled. Any report concerning activities, equipment, location, processes, whether existing or new, is given a high importance in health and safety.
Hazards, near misses, and incidents are taken seriously by National Ambulance. Risks are captured, monitored, and controlled to protect staff, public, contractors, visitors, and patients. Due to the potential risk associated with hazards, it can present early signs which can lead to a near miss or incident. National Ambulance has chosen to treat reoccuring near misses in the same manner as actual incidents.

All of these events are recorded, investigated, and analysed in such a manner that:

- Investigations are performed by competent persons in a timely manner
- Determines the root causes of incidents with participation of staff
- Identifies and determines the effectiveness of correction and corrective actions
- Identifies risk and opportunities and take action if needed
- Ensures effective communication of the investigation outcomes to relevant stakeholders

4.2.1. HAZARD, NEAR MISS, AND INCIDENT

While these adverse events have subtle differences, their root causes are remarkably similar. As such, they can be investigated, analysed, and controlled through the application of like processes. Below are some fundamental concepts that should be considered before applying the procedures in this policy.

Workplace hazard identification is done via site inspections, risk assessments, and audits which is monitored on a regular basis . It should be undertaken at various times including:

- If it has not been done before for a site, equipment, or activity.
- If a hazard has been identified
- When a change to the workplace or its surroundings may introduce or change a hazard, such as when changes occur to the work equipment, practices, procedures or environment.
- As a part of responding to a workplace incident, even where an injury has not occurred.
- Where new information about a risk becomes available or concerns about a risk are raised by workers

It is often more effective and easier to eliminate hazards if risk management approaches were used at the planning stage for services, processes, and places.

Identification of hazards, risks, and adverse situations that can lead to losses, impact the quality of services, health and safety, the environment, and or cause business disruptions. The main mechanisms for identifying risks are:

- Risk assessments;
- Hazard and risk reporting, through QHSE reporting procedures;
- Incident investigations, inspections, and audits.

Refer to COP401 Organizational Change Management Policy and Procedure for management of change.

Refer to clause 12 and 13 procedures if Hazard Identified and Incident Occurred

4.2.2. CAUSES OF INCIDENTS

Hazards, repeatable near misses, and incidents have many causes and can on analysis be seen as a chain of failures and errors that lead almost inevitably to the adverse event. These causes can be classified as:

- Immediate causes: the agent of injury, illness, or grievance
- Underlying causes: unsafe acts and unsafe conditions
- Root causes: the failure from which all other failings grow, often remote in time and space from the adverse event

Control measures must effectively address the immediate, underlying and root causes.

4.3. ENVIRONMENTAL RISK MANAGEMENT

National Ambulance ensures that minimal impact is done to the environment. Environmental risk management involves identifying the aspects and assessing and controlling the impacts.

5. RISKS ASSESSMENT

Risk assessments should be carried out by a person who is knowledgeable in the type of work or facility involved. Assessment should be carried out/ reviewed at regular or scheduled intervals appropriate to the nature of the workplace and the Issue, hazards and aspect present, in addition to the following specific circumstances:

- Changes to an existing procedure, activity and/or task;
- Introduction of a new procedure, activity or task, including by a contractor;
- Introduction of new equipment or substances into the workplace;

- Use of a new workplace;
- After a QHSE incident (including near miss);
- As required by laws or regulations, for example event risk assessment for a mass gathering;
- Following audit findings;
- Following changes to regulatory requirements.

The risk assessment creation and review process should include the participation of staff and coordination with stakeholders.

Issue, Hazards and Aspect identified during risk assessments are addressed through the use of Quality Risk Assessment, health and safety risk assessment , environmental risk assessment , business continuity risk assessment, the action plan process, and business continuity plans.

5.1. Risk assessment Categories and Components

Risk assessment categories include:

- Site Risk Assessment
- Equipment Risk Assessment
- Activities Risk Assessment

Risk assessment components include:

- Quality Risk Assessment: Quality Risk Assessment is conducted to capture the issues and implications related to patient outcomes, stakeholders, and complaints.
- Health and Safety Risk Assessment: Health and Safety Risk Assessment is conducted to capture the hazards and risks related to the health and safety of staff, contractors, visitors, or public.
- Environmental Risk Assessment: Environmental Risk Assessment is conducted to capture the aspects and impacts related to the environment

5.2. Risk Rating

Risks are evaluated according to type (health, safety, environmental, or business continuity), in terms of their likelihood of occurring, and severity of impact. This evaluation produces a relative rating, aimed at:

- Determining if the hazard exceeds NA's risk acceptance threshold;
- Ensuring management of hazards is appropriate to the level of risk each hazard presents – the highest risks are given priority and can justify greater spending.

5.3. Acceptance and Control of Risks

National Ambulance aims to reduce risks to as low as reasonably Practicable (ALARP), although not necessarily a risk-free environment. Low risk QHSE and business continuity hazards are accepted and do not require any controls.

5.4. Risk Reporting and Review

National Ambulance has a responsibility to be alert for hazards they may encounter during the course of their duties and to report these hazards as soon as possible. Risks may be reported using the QHF202 QHSE Reporting Form .

Completed Risk Assessments are transferred into the QHF702 Risk Assessment Register to enable consolidated tracking.

6. INCIDENT INVESTIGATIONS FUNDAMENTALS

6.1. WHY INVESTIGATE INCIDENTS?

There are hazards in all workplaces; control measures are put in place to reduce the risks to an acceptable level to prevent near misses, accidents, or cases of ill health. The fact that an adverse event on near miss has occurred suggests that the existing risk control measures were inadequate.

IT IS OFTEN PURE LUCK THAT DETERMINES WHETHER A NEAR MISS TRANSLATES INTO AN incident**.** The goal in investigating these events is to learn general lessons which can be applied across the entity thus preventing further occurrences.

The investigation should identify why the existing risk control measures failed and what improvements or additional measures are needed. More general lessons on why the risk control measures were inadequate should also be learned.

6.2. WHICH EVENTS SHOULD BE INVESTIGATED?

It is the potential consequences and the likelihood of the adverse event recurring that determines the level of investigation, not simply the injury or ill health suffered on this occasion. When making a decision, the potential for learning lessons is also taken into account.

6.3. WHO SHOULD CARRY OUT THE INVESTIGATION?

For an investigation to be worthwhile, it is essential that the management and the workforce are fully involved. Depending on the level of the investigation team may include members from departments and differing roles.

This joint approach ensures that a wide range of practical knowledge and experience will be brought together. This joint approach also reinforces the message that the investigation is for the benefit of everyone.

In addition to detailed knowledge of the work activities involved, members of the team should be familiar with QHSE good practice, standards and legal requirements. The investigation team must include people who have the necessary investigative skills.

The Lead Investigator is the competent individual responsible for leading the investigation team. The lead investigator prepares the investigation plan, conducts the meetings, and submits the formal investigation report.

Refer to CGP149 Clinical Incident and Investigation Policy for sentinel event reporting and incident that involve patient.

6.4. WHEN SHOULD IT START?

The urgency of an investigation depends on the magnitude and immediacy of the risk involved (e.g. a major accident involving an everyday job will need to be investigated quickly).

In general, adverse events need to be investigated and analysed as soon as possible. This is not simply good practice; it is common sense – memory is best and motivation greatest immediately after an adverse event. Refer to CGP149 Clinical Incident and Investigation Policy for sentinel event reporting.

6.5. WHAT DOES IT INVOLVE?

An investigation involves an analysis of all the information available, physical, verbal, and written, to identify what went wrong and determine what steps must be taken to prevent the adverse event from happening again.

6.6. WHAT MAKES A GOOD INVESTIGATION?

It is only by carrying out investigations which identify root causes that National Ambulance can learn from past failures and prevent future failures.

Simply dealing with the immediate causes of an adverse event may provide a short-term fix. But, in time, the underlying/root causes that were not addressed will allow conditions to develop where further adverse events are likely, possibly with more serious consequences. It is essential that the immediate, underlying causes, and root causes are all identified and remedied.

Investigations need to be conducted with accident prevention in mind, not placing blame. Attempting to put blame before the investigation has started is counterproductive, because people become defensive and uncooperative. Only after the investigation has been completed is it appropriate to consider whether any individuals acted inappropriately.

Investigations that conclude that operator error was the sole cause are rarely acceptable. Underpinning the 'human error' there will be a number of underlying causes that created the environment in which human errors were inevitable.

The objective is to establish not only how the adverse event happened, but more importantly, what allowed it to happen.

The root causes of adverse events are almost inevitably physical, human, or organizational failures.

The investigation should be thorough and structured to avoid bias and leaping to conclusions. Don't assume the answer and start finding solutions before the investigation is completed. A good investigation involves a systematic and structured approach. QHF305 Root Cause Analysis Form should be used to remain focused and organized.

7. RELEVANT LEGISLATION

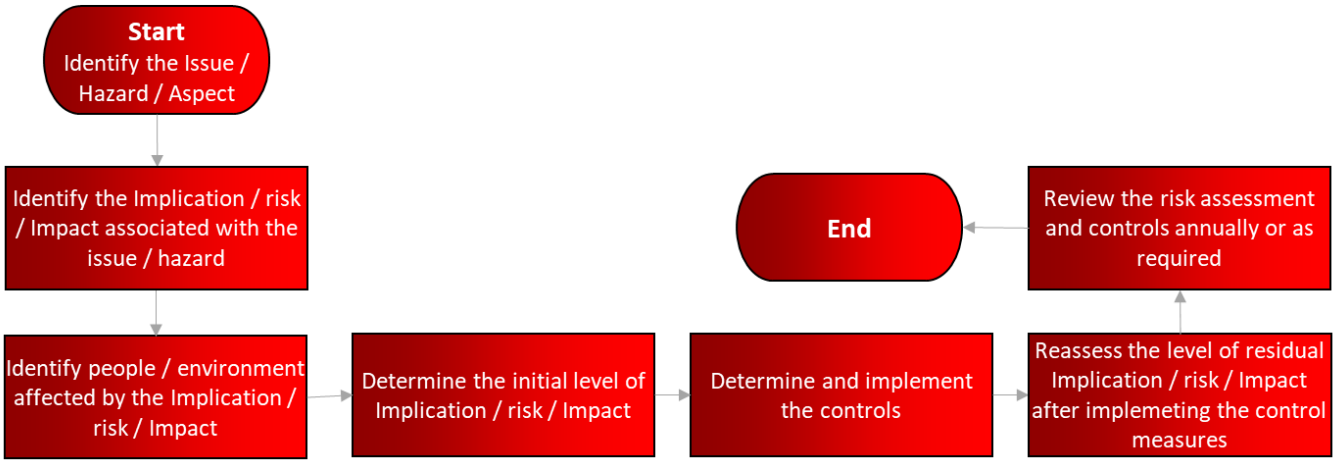
International, federal or local legislation and circulars relevant to this Policy, Process and Procedure is shown below.
Full detail on this legislation can be found in QHP109 Legal Register.

Code, Name of Legislation	Jurisdiction
OSHAD – Element 06 – OHS Performance Monitoring And Reporting Version 3.1 And Element 11 – Incident Notification – Investigation And Reporting	Abu Dhabi
NCEMA 7000:2015	UAE

8. PROCESSES

A summary of all key processes is provided within the QHSE Management System via QHF805 Key Process Register.

Process Name	Risk Assessment Procedure
Process Ownership	QHSE and BC Manager
Process Measurement	Staff awareness / audit reviews of risk assessments
Interaction with Other Processes	Risk Management
Forms Used	QHF205 Risk Assessment Form



9. PROCEDURES

The following procedures set out the risk assessment methods for:

- Quality, Health and safety (Section 9.1 and 9.1.2)
- Environment (Section 9.2)
- Business continuity (Section 9.3)

The risk assessments follow the same general process, with some variation as required to manage the subject area and applicable standards and regulations. Risk assessment method for special events follows the same procedures as the risk assessment methods of quality, health & safety, and environment.

9.1. QUALITY, HEALTH AND SAFETY RISK ASSESSMENT PROCEDURE

Quality, health and safety risk assessments are done in six general steps:

Step 1 Identify the Issue / hazard
Step 2 Identify the Implication / risk associated with the issue / hazard
Step 3 Identify who or what will be affected (people)
Step 4 Evaluate the implication / risk and identify suitable controls
Step 5 Implement controls
Step 6 Review risk assessment and controls (monitor)

The outcome of each of these steps is recorded in a report using the "QHF205 Risk Assessment Template", including further details of:

- Report number,
- Date,
- Person/s carrying out risk assessment, and
- Location.

Depending on the controls required, an action plan may be developed (which should be recorded in the QHF702 Risk Assessment Register), or the required actions should be entered and tracked through Task and Project Management Application.

9.1.1. QUALITY RISK ASSESSMENT PROCEDURE:

STEP 1: IDENTIFY THE ISSUE

A quality issue is any possible issue that may have an implication on the services (patient). In order to identify issues, sites, activities, and equipment must be reviewed to identify ways in which quality may be impacted. Quality issues can be considered under generic titles which may include:

- Failure of equipment
- Breakdown or major faults of vehicles
- Patient dissatisfaction with the services provided
- Delayed service provision
- Deviation from standards and policies

This information is recorded on the QHSE Risk Assessment Form (quality risk assessment section) under 'Issue' column.

STEP 2: IDENTIFY THE IMPLICATION ASSOCIATED WITH ISSUE

Implication is a possible effect on the service (patient) that resulted from the Issue. Every issue listed in the QHSE Risk Assessment / QHF702 Risk Assessment Register must have a corresponding implication. Possible implications include:

- Damaged reputation
- Complaints
- Patient dissatisfaction

Implications must be recorded in the QHSE Risk Assessment Form (quality risk assessment section) under 'Implication' (second column).

STEP 3: IDENTIFY PEOPLE WHO MIGHT BE HARMED

Identify who may be exposed to the implication. People who may be harmed are generally grouped to either patients, National Ambulance staff, stakeholders, or National Ambulance (organization) as a whole.

People who might be harmed must be recorded in the QHSE Risk Assessment Form (quality risk assessment section) under 'People who might be harmed' (third column).

STEP 4: EVALUATE THE RISK AND DEVELOP CONTROLS

4.1 Risk evaluation is carried out, by estimating the likelihood (or probability) of an issue occurring, eventuating, and then the severity (or consequences) of that implication, should it occur. Guidance for assigning likelihood and severity is provided in Appendix A, Tables 1 and 2 respectively. Existing measures to control issues and implications should be considered as part of this.

The resultant risk rating is estimated as a product of these two factors, as shown in the matrix provided at Appendix A, Table 3. These ratings are interpreted according to Appendix A, Table 4.

This is referred to as the **initial risk.** NA aims to reduce QHSE risk to as low reasonably practicable ('ALARP').

4.2 Control measures are required for risks that are evaluated as moderate or higher. Appropriate control measures that eliminate or reduce the risk should be identified and given priority.

Following application of the controls, a second risk assessment to determine the **residual risk** should be carried out to confirm the adequacy of the risk treatment.

The control measures and evaluation of residual risk must be documented in the QHSE Risk Assessment Form, with details entered into the QHF702 Risk Assessment Register.

STEP 5: IMPLEMENT THE CONTROLS

Some control measures can be put in place or completed relatively easily and quickly. Once completed, these immediate/ short term issues can be marked as complete directly in the QHF702 Risk Assessment Register.

Medium term solutions can be assigned and tracked through the Task and Project Management Application in addition to being updated in the QHSE Risk Assessment Register.

More complex issues and implications will require investigation, consultation, planning, and approval for finance, change of procedures, and therefore will take longer to complete. An **Action Plan** should be prepared in such cases, and recorded in the QHF702 Risk Assessment Register.

STEP 6: REVIEW THE RISK ASSESSMENT AND CONTROLS

Completed risk assessments must be reviewed periodically to check their efficacy and accuracy, as part of the management review cycle.

Appendix A, Table 5 outlines the maximum time frame between re-evaluation of risks. This is taken from the specific risk with the highest residual risk rating. If these reviews find controls are inadequate or conditions change, the risk assessment must be carried out again. All Risk Assessments are reviewed at least annually.

9.1.2. HEALTH AND SAFETY RISK ASSESSMENT PROCEDURE:

STEP 1: IDENTIFY THE HAZARD

Hazards are physical aspects, actions or conditions that under certain conditions eventuate in risk. In order to identify hazards, review the physical workplace, activities and people present, and identify the ways that people or assets could be harmed either immediately or through longer-term repeated exposure to them or interaction of these factors. Unsafe conditions and unsafe acts should be considered as well. These factors include:

- **Workplace facilities**, eg building, site, furniture, electrical infrastructure, neighbors, new or transfer
- **Activities** carried out (routine, non-routine, emergency), including prescribed safety measures, change of activities or new activities
- **Vehicles, tools, and equipmen**t used to carry out the task, change of equipment, change of procedures, products lifecycle
- **Work environment**, eg temperature range, lighting levels, noise levels, gases, liquids, wet weather, stored goods such as chemicals or fuel.

A physical inspection should usually be carried out for all risk assessments of workplace or equipment, which can provide up-to-date information on the above elements and their interaction.

Familiarity with a workplace, task, or equipment can result in higher tolerance of hazards and risks. Techniques to avoid this include:

- During the inspection, ask staff questions about any of the elements or their views of hazards and risks in their workplace. They may know about abnormal conditions and risks not apparent during that inspection,
- Walk through every room or area of a workplace, even those with assumed low-risk,
- Check manufacturers' instructions for equipment and chemical safety data sheets for chemicals and equipment,

- Review sick leave records and incidents, which may help to identify the less obvious hazards,
- Consider longer-term hazards to health, such from chronic exposure to noisy environments, ergonomics, repetitive movements and manual handling requirements, and radiation/ magnetic field exposure to unborn babies from high voltage electricity.

Hazards must be recorded in the QHSE Risk Assessment Form under 'Hazard' (first column) / QHF702 Risk Assessment Register

STEP 2: IDENTIFY THE RISK ASSOCIATED WITH HAZARD

Risk is the undesirable condition or event that arises from a given hazard [1]. Every hazard listed in the QHSE Risk Assessment / QHF702 Risk Assessment Register must have a corresponding risk. Risks must be recorded in the QHSE Risk Assessment Report under 'Risk' (second column).

STEP 3: IDENTIFY PEOPLE WHO MIGHT BE HARMED

Identify who may be exposed to the risks. This must include NA permanent and temporary staff, contractors, third-party visitors, public, and staff visiting from other locations. These people should be identified according to either their role (for example, paramedic, office staff), as staff in general, contractor or visitor. It is not necessary to provide people's names or position title.

Consider the range of workers and visitors, not only the 'average' worker (male, average age and health, reads and speaks English), as so personal attributes will result in higher risk levels, for example:

- Contractors and visitors to property who are unfamiliar with the layout and activities;
- Pregnant or potentially pregnant women;
- Youth or inexperienced workers;
- Injured or disabled people;
- Workers with low literacy level, with low fluency in English or Arabic;
- Lone workers.

Document this information in the third column of the QHSE Risk Assessment Form.

STEP 4: EVALUATE THE RISKS AND DEVELOP CONTROLS

4.1 Risk evaluation is carried out, by estimating the likelihood (or probability) of a hazard occurring, eventuating, and then the severity (or consequences) of that risk, should it occur. Guidance for assigning likelihood and severity is provided in Appendix A, Tables 1 and 2 respectively. Existing measures to control hazards and risks should be considered as part of this.

The resultant risk rating is estimated as a product of these two factors, as shown in the matrix provided at Appendix A, Table 3. These ratings are interpreted according to Appendix A, Table 4.

This is referred to as the **initial risk.** NA aims to reduce QHSE risk to as low reasonably practicable ('ALARP') to protect people, the environment and assets from harm.

4.2 Control measures are required for risks that are evaluated as moderate or higher. Appropriate control measures that eliminate or reduce the risk should be identified, giving priority to the types of controls in the following order ('hierarchy of controls'):

The preference for applying controls to risks is described in Appendix B, and summarised here:

[1] The definition provided for 'risk' relates specifically to its usage in the 'QHSE Risk Assessment.

1st preference: Elimination of risk or hazard, for example by reassessment of needs or process redesign
2nd preference: Substitution of hazard for less hazardous options
3rd preference: Engineering Controls such as ventilation, filtration, noise barriers, guards on sharp tools.
4th preference: Administration Controls, such as procedures, HSE induction, training
5th preference: Personal Protective Equipment (PPE), such as dust masks or gloves

Following application of the controls, a second risk assessment to determine the **residual risk** should be carried out to confirm the adequacy of the risk treatment.

The control measures and evaluation of residual risk must be documented in the QHSE Risk Assessment Form, with details entered into the QHF702 Risk Assessment Register.

STEP 5: IMPLEMENT THE CONTROLS

Some control measures can be put in place or completed relatively easily and quickly. Once completed, these immediate/ short term issues can be marked as complete directly in the QHF702 Risk Assessment Register.

Medium term solutions can be assigned and tracked through the Task and Project Management Application in addition to being updated in the QHSE Risk Assessment Register.

More complex hazards and risks will require investigation, consultation, planning, and approval for finance, change of procedures or permits, for example, and therefore will take longer to complete. An **Action Plan** should be prepared in such cases, and recorded in the QHF702 Risk Assessment Register.

STEP 6: REVIEW THE RISK ASSESSMENT AND CONTROLS

Completed risk assessments must be reviewed periodically to check their efficacy and accuracy, as part of the management review cycle.

Appendix A, Table 5 outlines the maximum time frame between re-evaluation of risks. This is taken from the specific risk with the highest residual risk rating. If these reviews find controls are inadequate or conditions change, the risk assessment must be carried out again. All Risk Assessments are reviewed at least annually.

9.2. ENVIRONMENTAL RISK ASSESSMENT PROCEDURE

Environmental risk assessments should be conducted by a competent person with knowledge of the principles of the industry, task or equipment being assessed, and environmental impacts arising from them.

The environmental risk assessment can be done in five steps:

Step 1 Identify the aspect
Step 2 Identify the impacts
Step 3 Determine the impact rating
Step 4 Develop and implement mitigation and controls
Step 5 Review the assessment and controls

Environmental risk assessments are completed using the QHSE Risk Assessment Form. Environmental risks can be grouped and recorded at the end. This report should include further information:

- Report number,
- Date,
- Person/s carrying out risk assessment, and
- Location.

The "Risk Being Assessed" should identify the asset, task, or site being evaluated.

STEP 1: IDENTIFY THE ASPECTS

An environmental aspect is an element of NA's activities, products or services that can interact with the environment (may be referred to as environmental hazard or environmental source). Environmental aspects can be considered under generic titles which may include:

- Use of natural resources, including energy
- Waste generation and management, including hazardous waste
- Pollution of air, water and land
- Carbon emissions from transport
- Noise and light pollution
- Fauna, flora, and habitat loss

Additional environmental aspects headings may be included as required.

This information is recorded on the QHSE Risk Assessment Form (environmental risk assessment section) under 'Environmental Aspect'.

STEP 2: IDENTIFY THE ENVIRONMENTAL IMPACTS

Review each aspect and identify how NA activities related to these aspects (significant, non-significant) create potential for adverse environmental impacts. Determining whether an aspect is significant or non-significant is detailed QHP103 QHSE and BC Management System Manual.

Identify the environmental impacts of each activity identified in Step 2. Examples of these impacts include:

- Carbon dioxide, nitrous oxides, sulphur dioxide emissions from use of petrol in vehicles,
- Carbon dioxide, nitrous oxides, and sulphur from electricity and water consumption (fossil fuel source),
- Depletion of non-renewable resources, such as metals in batteries,
- Contamination of land and groundwater from landfilling of wastes.

This information is documented in the QHSE Risk Assessment Form (environmental section), under the column 'Impact'.

STEP 3: DETERMINE THE IMPACT RATING

. There are three parts to this, the identity of the aspect, the probability of the environmental receptors being exposed to the aspect and the probability of harm resulting from exposure to the aspect. Appendix A, Table 1 defines the frequency of the operation. Appendix A, Table 2 details the criteria against which the consequence (impact) is quantified. Once the above have been defined utilize Appendix A, table 3 to define the initial risk/impact rating.

Document these in the QHSE Risk Assessment Form in the Environment Section named "initial risk/ Impact Rating".

STEP 4: DEVELOP AND IMPLEMENT ASPECT MITIGATION AND CONTROLS

Mitigation is any process or activity that is designed to avoid/ reduce or remedy any adverse environmental impacts that are likely to be caused by the activity. Any potential and/or actual impact mitigation processes can be documented in the Environmental Risk Assessment. When deciding on mitigation/ control processes or activities utilize the Environmental Control Hierarchy (Appendix C) as guide to implementing controls.

If new controls are needed, create an Action Plan.

The Action Plan should be created in the Task and Project Management application by the allocated owner. This should be determined by the person ultimately accepting the risk/hazard.

Once the actions detailed on the action plan have been implemented, work out the residual risk rating using Appendix A, tables 1, 2 and 3 documenting in the residual risk column in the QHSE Risk Assessment Form.

STEP 5: REVIEW THE RISK ASSESSMENT AND CONTROLS

After a Risk Assessment has been completed and the control measures implemented, its efficacy must be reviewed. Appendix A, table 4 outlines the maximum time frame between re-evaluations. If controls are noted to be inadequate or conditions change, the Risk Assessment should be repeated. All Risk Assessments are reviewed at least annually.

9.3. BUSINESS CONTINUITY RISK ASSESSMENT

Business continuity risk assessment is detailed in Business continuity plan.

10.QHSE REPORTING PROCEDURE

The QHSE Reporting Form is utilized as the initial reporting tool for Hazards, Non-conformances, Near Misses, and Incidents, and as a Feedback tool. This form is used to initiate a procedure that is transparent, provides feedback to the reporter, ensures the adverse event (or potential event) is tracked from recognition to mitigation, to re-evaluation. Any events happen should be reported to QHSE@nationalambulance.ae

It is important for all staff to realize what this form should be used for. This is not a tool to air grievances, to complain, or to 'point fingers' at other staff or partners. To this end, neither names nor unique identifiers should be included in hazard reports. Terms such as "A staff member" or "An employee" should be used. During events that warrant investigations, Managers may request that individuals be named; in that case access to the report must be limited and the information treated as highly confidential.

Initial steps to take when a risk has been identified:

- Maintain personal safety
- Take prompt action to mitigate the risk where safely possible
- Where you cannot make the area safe, minimize the access.

11.WHAT TO DO IF A HAZARD IS RECOGNIZED:

- Remove (eliminate) the hazard if possible
- Check if the recognized hazard is included in the risk assessment to determine if the current control measure is enough, further control measures are required, or if the hazard is new.
- Send an email to QHSE@nationalambulance.ae and inform your Line Manager and include any relevant department
- Wait for QHSE's instruction

12.WHAT TO DO IF AN INCIDENT OCCURRED:

- Inform your Line manager and any relevant person
- Action immediately if needed

- Fill up the QHF202 QHSE Reporting Form and send it to QHSE@nationalambulance.ae including your manager in the email and attach relevant documentation and evidence (e.g. picture)

13. ACTIONING RECEIVED QHSE REPORTS

- The QHSE Department will acknowledge the sender of the report within 3 working days
- QHSE will log the Report into the QHSE Report Register, QHSE Suggestion Register or External Feedback Register.
- QHSE will Update the QHSE Report Register in the Task and Project Management Application and generate a unique report number
    - All reports for non conformance, hazard, near miss, incident, and suggestion for Improvement will be logged in the Task and Project Management Application for the action Plan
    - QHSE will assign the report to relevant department or person
    - Complaints and compliments will not be logged in the Task and Project Management Application as it will be tracked in the QHF401 External Feedback Register
- The completed QHSE Reporting Form is saved to N:\QHSE\7.0 QHSE Registers and Submitted Forms \ Submitted QHSE Reporting Forms placing the newly created report number at the front giving the file the following format "QHSE Reporting Form RNXXXXX YYYYMMDD LASTNAME".
- For feedback related reports, it will be logged in to QHF401 External Feedback Register and the Feedback Form will be saved in N:\QHSE\10.0 Customer and Staff Feedback\Feedback\Feedback Soft Copy
- If the report is a high risk report, it will be escalated immediately to the relevant person or to Head of Department
- All reports must be closed within 7 months

13.1. DURING INVESTIGATION

- QHSE Team will conduct an initial investigation to determine, to whom, which department, and what is the impact to the patients, staff, or the environment
- For suggestions, it will be discussed with the relevant Department Manager to determine whether the suggestion is accepted or not
- QHSE Team will review the Risk Assessment to ensure that the current control measures are effective or needs revision
- Assigned person in Task and Project Management Application should conduct a root cause analysis for recurring near miss, incident, and non-conformance reports
- QHSE Team will follow up with the assigned person to update the report
- QHSE Reporting Register or/and QHF305 Root Cause Analysis (RCA) Form will be used to record the Root cause Analysis

13.2. APPROPRIATE PERSONNEL ARE NOTIFIED OF THE OUTCOME OF THE REPORT

- The appropriate level of management, as per Appendix A, Table 5, must be notified by email with delivery confirmation once the Residual Risk has been determined.
- Staff / department involved in the incident, repeated near miss, or nonconformance will be notified.

13.3. THE EVENT IS REVIEWED AT THE APPROPRIATE INTERVAL

- As per Appendix A Table 5, QHSE & BC Manager reviews all reports in the QHSE Reporting Register in which the residual risk has been designated "Extreme" on monthly basis, reports in which the residual risk has been designated "High" on Semi-annual basis, and reports in which the residual risk has been designated "Moderate" on annual basis to

ensure the controls are still sufficient. If they are not, the report will be reopened and further review and implement additional controls if needed.

- Annually, Executives review all reports in QHSE Reporting Register in which the residual risk has been designated "High or Extreme" to ensure the controls are still sufficient during the Management Review meeting. If they are not, the report will be reopened and further review and implement additional controls if needed.
- These review dates are recorded on the QHSE Report Register in the QHSE Management Status field.
- The QHSE & BC Manager periodically, at an interval of no more than quarterly, audits the QHSE Report Register specifically to determine if trends are appearing. If so, these trends are further investigated and mitigated.

14. CREATING AN ACTION PLAN

To create an Action Plan using the Task and Project Management Application:

1. Log into Asana.com and go to the QHSE Section and Select Action Plans.
2. Create a duplicate of the Default Action Plan – (the default action plan is used as a guide to show the fields that need to be filled in).
3. To create a duplicate of the Default Action Plan, select the Default Action Plan (shown in the first line of the Action Plans) and in the right hand corner of the screen click on the three dots (…) then select DUPLICATE TASK. Select CREATE NEW TASK.
4. Once a new default task is created it will appear in line two. Select this "Copy of Default Action Plan" and rename it to the Action Plan Code and Title. In the description box write a description of the risk/hazard the action plan is addressing. Allocate the responsibility or ownership of the Action Plan but do not allocate a due date.
5. Copy the Hyperlink to the Action Plan and add it to the QHSE Risk Assessment Register.
6. Create the required Actions as sub tasks.
7. Enter each subtask and write any additional notes that are required for that sub task and then allocate an owner/responsibility.
8. This will generate an email to the allocated owner advising them they have actions allocated to them. It is their responsibility to assign a date of delivery to their task. This also shows QHSE that they are aware of their task and have accepted it.

15. WITHDRAWAL FROM OBLIGATION

In the event that a situation is deemed unsafe for National Ambulance personnel, they may be withdrawn according to the policy below. This may simply be a withdrawal from the physical area to a safe distance or removal of the National Ambulance personnel from a contract pending correction of an issue.

The decision to withdraw from a commitment is a significant one and should not be taken lightly. This must be authorized by Managers and above.

This process is documented below though the acute nature of these events may outpace the documentation. Refer to PUP302 Warehouse Management Policy for assets withdrawal from obligation and OPP126 ACC Evacuation and Escalation Plan for ACC withdrawal from obligation. f

STEP 1: IDENTIFY THE NEED FOR A WITHDRAWAL OF PERSONNEL

This is typically done at the level of a Manager. This can be from first hand observation, via telephone notification from affected staff, or from the receipt of a QHSE Reporting Form. (While employees are instructed to report events of this magnitude via telephone before completing a report, they may not be cognizant of the severity of the hazard present.)

STEP 2: ADVISE THE APPROPRIATE MEMBER OF THE EXECUTIVE TEAM OR THEIR DESIGNEE

Once the Manager has determined there is imminent danger to National Ambulance personnel, immediate steps should be taken. If the danger can be partially or totally mitigated and remain within contractual specifications, the affected staff must be removed from harm's way.

If this is impossible, the Executive Team Member or their designee is responsible for the affected area or department must be contacted via telephone or face-to-face meeting. If the Manager is unable to make direct contact within fifteen minutes, they should make contact with the Executive Team Members in the order listed below until contact is established:

- Chief Executive Officer
- Chief Administrative Officer
- Chief Operations Officer
- Chief Financial Officer

STEP 3: MAKE THE DECISION TO WITHDRAW PERSONNEL AND TO WHAT DEGREE

The Executive should take into account the information relayed by the Manager, the potential severity, and the consequences of the event. While the Risk Matrix can give some direction, situations requiring a withdrawal of service are rare and have the potential to fall outside the parameters of the Matrix. Though the Executive must weigh many considerations and may require further information, the nature of these events requires prompt action.

The requesting Manager should be informed of the decision as quickly as practically possible. The following points should be decided upon and communicated:

- Scope, (i.e. remove all personnel, etc.)
- The distances/location (i.e. relocate to another site, return to headquarters, etc.)
- The anticipated duration (i.e. until the fire is out, 24 hours, etc.)
- Additional company support required (i.e. emergency transport, alternate work station, etc.)
- Any other specific points

This decision must be communicated to the client representative immediately and the entire Executive Team must be informed within the following six hours. It is the responsibility of the person making the decision to make these notifications.

STEP 4: IMPLEMENT THE AGREED UPON ACTION

The requesting Manager will execute the actions agreed upon with the Executive.

The Manager is responsible for passing the information to the affected employees.

STEP 5: RE-EVALUATE THE NEED FOR CONTINUED SERVICE WITHDRAWAL

The first twelve hours of an event remain the responsibility of the Executive making the decision.

During ongoing events, the Executive Team as group, must re-evaluate the situation at the twelve hour period and at least every twenty-four hours and decide upon further or continued modifications to services.

This decision must be communicated to the Manager who will then pass the information to the affected staff.

STEP 6: RETURN TO NORMAL OPERATIONS

The Executive/Executive Team will make the decision to return to normal or modified service that complies with the contractual requirements. This may require additional actions by National Ambulance and should be documented in accordance with this policy. This decision must be communicated to the Managers who will then pass the information to the affected staff.

STEP 7: INVESTIGATE THE EVENT AND COMMUNICATE THE FINDINGS

By definition, events that require National Ambulance to deviate from its contractual obligations fail to conform to the established policies and procedures. As such these must be investigated and communicated in relevant stakeholder

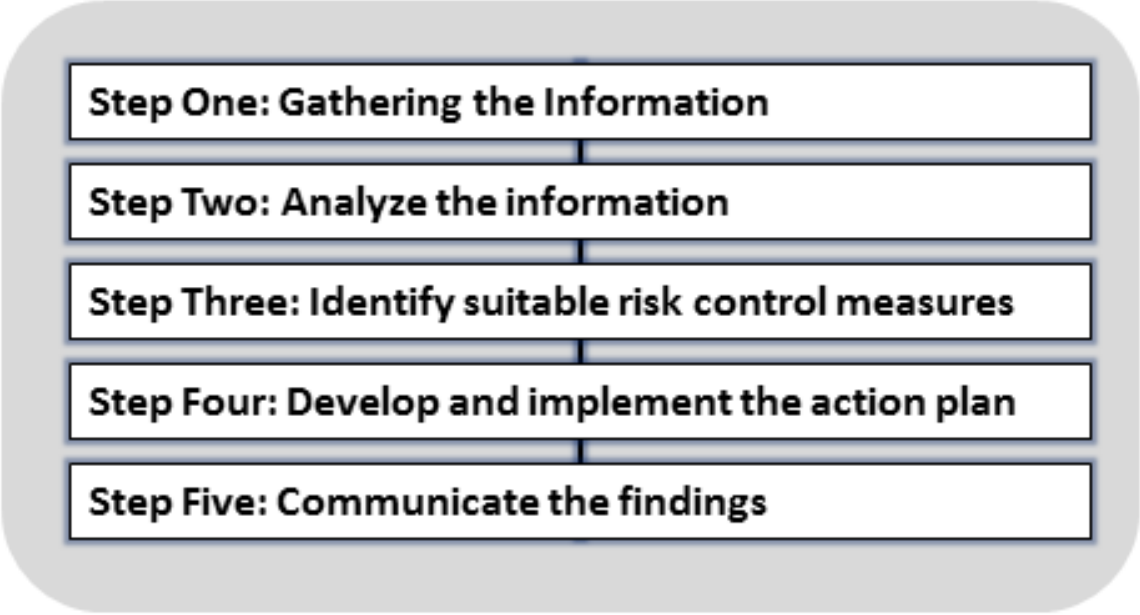
16.INVESTIGATION PROCEDURE

Listed below are a number of steps that should be considered when undertaking an investigation. Each investigation will differ and must ensure that sufficient information is gathered from each. This ensures the company is in a position to make an informed decision regarding the actual failings that led to the event.

Further, the level of investigation required will also differ depending on the severity and likelihood for reoccurrence. The entity should ensure that the level of investigation is in line with the incident.

The steps set out below, provide best practice information on area's that may have been a factor leading to the incident. Figure 1 below outlines these steps.

Figure 1 Investigation Steps



Initial steps to take following any adverse event; PRIOR to initiating a formal investigation:

- Maintain personal safety
- Take prompt emergency action
- Make the area safe
- Preserve the scene
- Notify your immediate Manager
- Note the names of the people, equipment involved and the names of the witnesses
- Complete QHSE Reporting Form
- Report the adverse event to the relevant personnel as per Appendix D

Specific events MUST be reported within specified time frames. Appendix E is an excerpt of events mandated by the OSHAD-SF Mechanisms - *Mechanism 11.0 – Incident Notification, investigation, and reporting Version 3.0* that have the highest likelihood of occurring during National Ambulance's routine operations.

Step 1: Gathering the Information

Find out what happened and what conditions and actions influenced the adverse event. Begin straight away, or as soon as practicable.

It is important to capture information as soon as possible. This stops it being corrupted, e.g. items moved, guards replaced etc. If necessary, work must stop and unauthorized access be prevented.

Talk to everyone who was close by when the adverse event happened, especially those who saw what happened or know anything about the conditions that led to it; obtain written statements as appropriate.

The amount of time and effort spent on information gathering should be proportionate to the level of investigation. Collect all available and relevant information. That includes opinions, experiences, observations, sketches, measurements, photographs, check sheets, permits-to- work and details of the environmental conditions at the time etc.

Gathering detailed information such as:

- How and what?
- What activities were being carried out at the time?
- Was there anything unusual or different about the working conditions?
- Were there adequate safe working procedures and were they followed?
- What injuries or ill health effects, if any, were caused?
- If there was an injury, how did it occur and what caused it?
- Was the risk known? If so, why wasn't it controlled? If not, why not?
- Was maintenance and cleaning sufficient? If not, explain why not.
- Were the people involved competent and suitable?
- Did difficulties using the equipment influence the adverse event?
- Was the safety equipment sufficient?
- Did other conditions influence the adverse event?

Where an accident is relatively straightforward, it may seem artificial to differentiate between the accident itself and the mode of injury, but when the accident is more complicated the differences between the two aspects become clearer and therefore precise descriptions are vital.

The mode of injury concerns two different aspects:

- the harmful object (known as the 'agent') that inflicted the injury
- the way in which the injury was actually sustained

Step 2: Analysing the information

An analysis involves examining all the facts, determining what happened and why. All the detailed information gathered should be assembled and examined to identify what information is relevant and what information is missing. The information gathering and analysis are actually carried out side by side. As the analysis progresses, further lines of enquiry requiring additional information will develop.

To be thorough and free from bias, the analysis must be carried out in a systematic way, so all the possible causes and consequences of the adverse event are fully considered. QHF305 Root Cause Analysis (RCA) Form is available to aid this approach and should be used.

The analysis should be conducted with employee representatives and other experts or specialists, as appropriate. This team approach can often be highly productive in enabling all the relevant causal factors to emerge.

It is only by identifying the immediate, underlying, and root causes that lessons can be learned from past failures and therefore prevent future repetition.

The causes of adverse events often relate to one another in a complex way, sometimes only influencing events and at other times having an overwhelming impact, due to their timing or the way they interact. The analysis must consider all possible causes. Keep an open mind. Do not reject a possible cause until it has been given serious consideration. The emphasis is on a thorough, systematic and objective look at the evidence.

What happened and why?

The first step in understanding what happened and why is to organize the information that has been gathered. This guidance uses the simple technique of asking 'Why' over and over, until the answer is no longer meaningful.

For each of the reasons identified ask 'Why?' and set down the answers. Continue down the page asking 'Why' until the answers are no longer meaningful.

Do not be concerned at the number of times the question, 'Why?' is asked because by doing so you will arrive at the real causes of the adverse event. Some lines of enquiry will quickly end, e.g. 'Why was the hazard of falling present?' Answer: 'Gravity'.

Having collected the relevant information and determined what happened and why, the company can now determine the causes of the adverse event systematically.

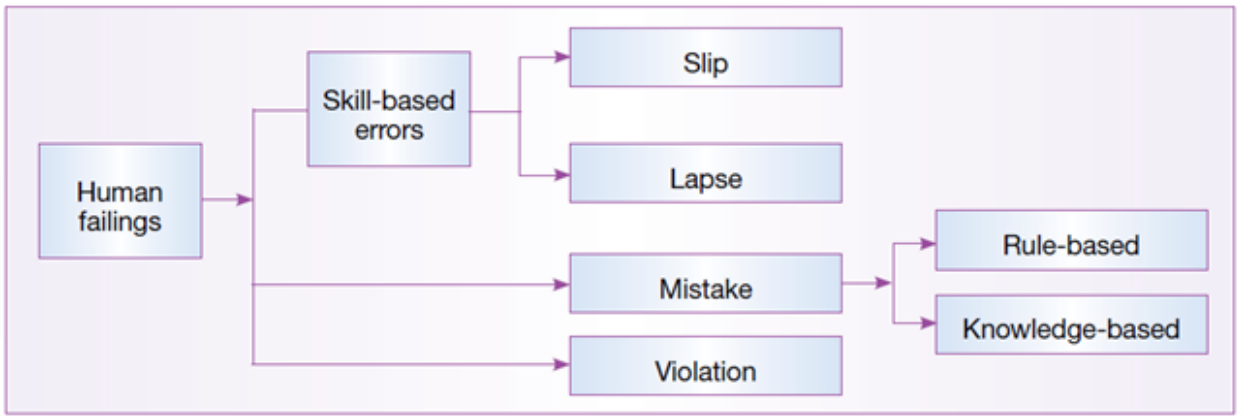
What if 'human failings (errors and violations)' are identified as a contributory factor?

If the investigation concludes that errors or violations contributed to the adverse event, consider carefully how to handle this information.

Not addressing the 'human' factors greatly reduces the value of the investigation. The objective of an investigation is to learn the lessons and to act to prevent recurrences, through suitable risk control measures. The entity will not be able to do that unless the workforce trusts them enough to co-operate with them.

Human failings can be divided into three broad types and the action needed to prevent further failings will depend on which type of human failing is involved.

Figure 2 Human failings



Skill-based errors: a slip or lapse of memory

- Slips happen when a person is carrying out familiar tasks automatically, without thinking, and that person's action is not as planned
- Lapses happen when an action is performed out of sequence or a step in a sequence is missed. These types of error can be foreseen and measures can be taken to prevent or reduce their likelihood.

Mistakes: errors of judgment (rule-based or knowledge-based):

- Rule-based mistakes happen when a person has a set of rules about what to do in certain situations and applies the wrong rule
- Knowledge-based mistakes happen when a person is faced with an unfamiliar situation for which he or she has no rules, uses his or her knowledge and works from first principles, but comes to a wrong conclusion.

Training, comprehensive safe working procedures, and equipment design are most important in preventing mistakes.

Violation (rule breaking):

- Deliberate failure to follow the rules, cutting corners to save time or effort, based on the belief that the rules are too restrictive and are not enforced anyway

This type of behaviour can be foreseen. The provision of training, simple practical rules, and routine supervision and monitoring of performance will reduce this type of behaviour.

Step 3: Identifying suitable risk control measures

The methodical approach adopted in the analysis stage will enable failings and possible solutions to be identified. These solutions need to be systematically evaluated and only the optimum solution(s) should be considered for implementation. If several risk control measures are identified, they should be carefully prioritized as a risk control action plan, which sets out what needs to be done, when and by whom. Assign responsibility for this to ensure the timetable for implementation is monitored.

WHAT RISK CONTROL MEASURES ARE NEEDED/RECOMMENDED?

- The analysis of the adverse event will have identified a number of risk control measures that either failed or that could have interrupted the chain of events leading to the adverse event, if they had been in place. The company now needs to draw up a list of all the alternative measures to prevent this, or similar, adverse events.
- Some of these measures will be more difficult to implement than others, but this must not influence their listing as possible risk control measures. The time to consider these limitations is later when choosing and prioritizing which measures to implement.
- Evaluate each of the possible risk control measures on the basis of their ability to prevent recurrences and whether or not they can be successfully implemented.

In deciding which risk control measures to recommend and their priority, choose measures in the following order, where possible:

- Measures which eliminate the risk
- Measures which combat the risk at source
- Measures which minimize the risk by relying on human behaviour

In general terms, measures that rely on engineering risk control measures are more reliable than those that rely on procedures and people.

DO SIMILAR RISKS EXIST ELSEWHERE? IF SO, WHAT AND WHERE?

Having concluded the investigation of the adverse event, consider the wider implications: could the same thing happen elsewhere in the company? What steps can be taken to avoid this?

HAVE SIMILAR ADVERSE EVENTS HAPPENED BEFORE?

- If there have been similar adverse events in the past why have they been allowed to happen again? The fact that such adverse events are still occurring should be a spur to ensure that action is taken quickly.
- Remember that there is value in investigating near-misses and undesired circumstances: it is often only a matter of luck that such incidents do not result in serious injuries or loss of life.

Step 4: Develop and implement the action plan

An action plan for the implementation of additional risk control measures is the desired outcome of a thorough investigation. The action plan should have SMART objectives, i.e. Specific, Measurable, Achievable, Realistic, and Time-bound.

Deciding where to intervene requires a good knowledge of the entity and the way it carries out its work. For the risk control measures proposed to be SMART, management, safety professionals, employees and their representatives should all contribute to a constructive discussion on what should be in the action plan.

Not every risk control measure will be implemented, but the ones accorded the highest priority should be implemented as soon as possible. In deciding the priorities, be guided by the magnitude of the risk rating

The company must either reduce the risks to an acceptable level, or stop the work that creates the risk.

For those risks that are not high and immediate, the risk control measures should be put into an action plan in order of priority. Each risk control measure should be assigned a timescale and a person made responsible for its implementation.

A specific person must be responsible for ensuring that the action plan as a whole is put into effect. This person doesn't necessarily have to do the work himself but they should monitor the progress of the risk control action plan.

Progress on the action plan should be regularly reviewed. Any significant departures from the plan should be explained and risk control measure rescheduled, if appropriate. Employees should be kept fully informed of the contents of the risk control action plan and progress with its implementation.

WHICH RISK ASSESSMENTS AND SAFE WORKING PROCEDURES NEED TO BE REVIEWED AND UPDATED?

The findings of the investigation should indicate areas of the risk assessments that need improving. It is important to take a step back and ask what the findings of the investigation identify about the risk assessments in general.

HAVE THE DETAILS OF ADVERSE EVENT AND THE INVESTIGATION FINDINGS BEEN RECORDED AND ANALYSED?

The investigation findings and recommendations need to be analysed as above but also in the context of other events. This is done specifically to find trends so the controls can be put in place (i.e. different equipment sourced, additional training offered) to prevent further occurrences.

The records of events and subsequent investigations are retained for several reasons. This enables the company to monitor the QHSE performance and detect trends, identify deficits, and document improvements. This improves the overall understanding and management of risk.

It is also useful to estimate the cost of adverse events to fully appreciate the true cost of accidents and ill health to the entity.

Step 5: Communicate the findings

The final step in the investigation process is the communication of relevant findings to the appropriate staff. While specific information, such as names and medical treatments, may need to remain confidential, it is essential that the findings and controls are shared with the staff.

Appendix E of outlines these reporting requirements.

17. RELATED FORMS

List related policies and procedures to the created/updated policy.

Policy & Procedure /Form
QHF201 QHSE Reporting Form
QHF205 Health and Safety Risk Assessment Form
QHP201 QHSE Report Register
QHF802 BC Treat and Vulnerability Assessment Form
QHF414 Suggestion, Risk Assessment and Audit Register
ITP125 IT Operations Policy for IT incidents
QHF305 Root Cause Analysis (RCA) Form
QHP401 Customer Enquiries and Feedback Policy & Procedure
COP401 Organizational Change Management Policy and Procedure
QHF233 Failure Mode and Effects Analysis Register
QHF702 Risk Assessment Register
QHF703 Risk and Opportunity Register

18.FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to

qhse@nationalambulance.ae

19. DOCUMENT CONTROL

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- QHSE & BC Manager

This controlled document is managed / overseen by [Procurement and Tendering Committee and/or Audit and Risk Management Committee and/or HR and Compensation Committee]

Change Brief

Version No.	Date	Changes
2.0	June 2012	New Document
3.0	August 2012	Update to include integration of HSE requirements. Update to new controlled document code. Risk scale updated to align with EHSMS. This replaces NACRIS01 and NACRIS02
4.0	August 2012	Adjusted steps for QHSE Reporting
5.0	September 2012	Added risk assessment for special events
6.0	12 June 2013	A process for action plans with ASANA
7.0	January 2016	Minor update
8.0	February 2017	Review of policy: added in risk appetite, business continuity references, review and consolidation of responsibilities, updating of procedures, reordering of document and reformatting.
9.0	August 2017	Changes of procedures in reporting
10.0	February 2021	Merge with QHP203 Hazard Near Miss and Incident Policy and Procedure Removal of DPE and Business Continuity Specialist Added responsibilities to table A Broke down the risk management policy to Quality, Health & Safety, and Environmental management system Merged the quality with the health and safety risk assessment procedure Added FMEA under section 4.4 QHSE Management System Moved the action plan procedure to section 7.5 Added criteria for determining significant aspects removal of Business Continuity content except the risk matrix rearrange and rewrite of the other procedures Other minor changes Added the QHF702 Risk Assessment Register Added the QHF703 Risk and Opportunity Register

CEO Approval

Board Member Verification

APPENDIX A – Risk Assessment Reference Tables

Table 1: Likelihood

Descriptor	Likely Frequency			
	Quality	**Health and Safety**	**Environment**	**Business Continuity**
Rare (1)	Never occurred	Never occurred	Less than once every five years.	Never occurred
Possible (2)	Has occurred	Has occurred	Once every 5 years.	Has occurred
Likely (3)	Has occurred more than once	Has occurred more than once	1 – 5 times per year.	Has occurred more than once
Often (4)	Occurs several times per year	Occurs several times per year	5 – 12 times per year.	Occurs several times per year
Frequent (5)	Occurs frequently	Occurs frequently	Continuous or will happen frequently.	Occurs frequently

Table 2: Consequence / Severity

	Service Quality and Complaints	Health Losses, and Business Impacts	Health and Safety of Patients, Staff or the Public	Environmental and Cultural	Business Continuity
Insignificant	Unsatisfactory service or experience not directly related to patient care *Unsatisfactory service or experience related to patient care but with a single resolvable issue* Incident event without causing Service loss *No reasonable potential for litigation* *No media involvement*	An event, the impact, of which can easily be resolved promptly by day to day management processes. *Unlikely to result in adverse regulatory response or action.* Little or no stakeholder interest *Financial loss (compensation, fines, cost to repair) of less than AED5,000.*	Minor injuries, which may require self-administered first aid. *Injured personnel can continue to perform normal duties.* May include substantial stress event reducing work effectiveness without lost time. *No time off work*	Insignificant environmental impact. *Occasional damage by erosion, or disruption to aquatic flora and fauna.* Temporary nuisance from noise, odor, dust, other air emissions, greenhouse gases, vibration, visual impact. *Some disruption to flora or fauna habitats.* Minor use of water, fuels and energy and other natural resources	No noticeable impact on delivery of NA priority activities, supporting activities or resources required (as identified in the business impact analysis) to carry out supporting activities.
Minor	Unsatisfactory service or experience related to patient care with a multiple resolvable issues *Some potential for litigation* Minor, adverse local public or media attention and complaints. *Service loss or delay up to one week.*	An event, the consequences of which can be absorbed but management effort is required to minimize impact. *Reputation is adversely affected with a small number of affected people.* Incident reportable to regulatory authorities. *Financial loss (compensation, fines, cost to repair,) of AED5,000 - AED50,000.*	Injuries requiring on-site treatment by medical practitioner. Personnel unable to continue to perform duties. *May include substantial stress event requiring professional clinical support.*	Minor impacts on fauna/flora and habitat, but no negative impacts on ecosystem function. *Minor repairable damage to items of cultural significance, or minor infringements of cultural values.* Minor impact due to contained release of pollutant (including odor, dust and noise), fire or explosion with no lasting detrimental effects. No outside	Minor interruption to supporting activities or availability or required resources, which does not impact ability to meet in emergency medical treatment, patient transport times, or ability to act as lead medical agency during an MCI in the Northern Emirates.

	Service Quality and Complaints	Health Losses, and Business Impacts	Health and Safety of Patients, Staff or the Public	Environmental and Cultural	Business Continuity
				assistance required. Temporary damage (<1 mth) to habitats.	
Moderate	Unsatisfactory service or experience related to patient care with a multiple resolvable issues involving multiple staff *Critical service interruption not back in contractual timeframe.* Heavy local media coverage, Reputation impacted with some stakeholders. *Service loss or delay of one week to one month.*	Significant event, which can be managed under special circumstances. *Financial loss (compensation, fines, cost to repair,) of AED50,000 - AED500,000* Serious breach of Act, Regulation or consent conditions with potential for regulatory action such as issuance of a formal notice, a fine or prosecution.	Serious injuries requiring off-site treatment by medical practitioner or immediate evacuation to hospital. Potential long-term or permanently disabling effects. *Hospital treatment injury less than 3 days lost time* Serious temporary disability.	Significant localized impacts but without longer-term impact on aquatic ecosystems, and/or short term impacts on water resources. *Disruption to, or some death of, rare flora or fauna, but not resulting in eradication of endangered species.* Non- persistent but possibly widespread damage to environment: damage that can be remediated without long-term loss; localized persistent damage; or significant temporary damage (<1 year) to ecosystem. *Creation of noise, odor, dust, other controlled/ uncontrolled air emissions, greenhouse gases, vibration, and visual impact at significant nuisance levels.* Results in the generation of significant quantities of hazardous wastes.	Incident which will causes inability to carry out supporting activities up to 1 day, and impacts directly upon NA priority activities. Requires modification to existing workloads, staffing and procedures to continue supporting frontline ambulance service and activities until return to normal operations. Frontline operations will notice reduced availability of normal resources, or depletion of standby stock.

	Service Quality and Complaints	Health Losses, and Business Impacts	Health and Safety of Patients, Staff or the Public	Environmental and Cultural	Business Continuity
Major	Significant issues regarding standards, quality of care and safeguarding of or denial of rights *Major breach of Act, Regulations or consent conditions that is expected to attract regulatory attention* Complaints with clear quality assurance or risk management issues that may cause lasting harm *Significant adverse national media/ public coverage with reputation impacted with a significant number of stakeholders* Service loss or delay for over one month.	Major event that with prioritized and focused management will be endured *Financial loss (compensation, fines, cost to repair, plant damage) of AED500,000 - AED10M.* Significant adverse national media/ public coverage with reputation impacted with a significant number of stakeholders	Single fatality. *Single long (>15 days) term hospitalization.* Permanent disabilities (1-4 persons)	Significant widespread impact on protected wildlife (e.g. migratory shorebirds, marine plants, fish breeding grounds), or aquatic ecosystems of moderate duration *Continuous and serious damage by erosion or to flora or fauna. Major disruption to, or frequent death of, rare flora or fauna.* Moderate damage to structures/ items of cultural significance, or significant infringement of cultural values/ sacred locations. *Major damage to structures/items of cultural significance, or major infringement of cultural values/ sacred locations*	Significant incident which will causes inability to carry out business continuity supporting activities for an extended period of time, and impacts directly upon NA priority activities. Results in adverse patient outcomes and possible deaths. Requires involvement of other medical service providers to help cover shortfall in company service delivery during recovery. Requires significant changes to existing workload and procedures to continue supporting frontline service until return to normal ops. Inability to act as lead medical agency in the Northern Emirates during an MCI for 1 day - 1 week.

	Service Quality and Complaints	Health Losses, and Business Impacts	Health and Safety of Patients, Staff or the Public	Environmental and Cultural	Business Continuity
Catastrophic	Serious issues that may cause long term harm which will require immediate and in depth investigation *May result in significant litigation, including class actions.* Reputation and standing affected nationally and internationally; reputation impacted with majority of key stakeholders.	Extreme event with potential to lead to failure of most objectives or collapse of part of the business. *Critical infrastructure service loss for <1 month.* Severe financial penalties or legal liabilities. Financial loss (compensation, fines, cost to repair, plant damage) of greater than AED10M. *Loss of license to operate or ability to produce indefinitely*	Multiple fatalities. *=/>5 persons with permanent disability*	Long-term and significant change in population (e.g. eradication of endangered species) or habitat with negative impact on ecosystem function. *Widespread destruction to a significant area of land, rare flora and fauna and/or groundwater resource.* Major destruction of significant habitat. *Results in the generation of significant quantities of intractable wastes.* Irreparable damage to highly valued structures/ items/ locations of cultural significance or sacred value.	Long lasting complete or near complete interruption to priority or supporting activities. Company's ability to recover from major interruption to priority activities or supporting activities will take 4 weeks or more. Likely to result in serious adverse impacts on patient outcomes including deaths, for a period of at least 2 weeks or more. Inability to act as lead medical agency in the Northern Emirates during an MCI for 1 week or more.

Table 3: Risk Matrix

This risk matrix is used to determine the risk rating, by considering the combination of the 'likelihood' (probability) and the 'consequence' (severity) of a particular hazard/risk occurring.

Likelihood	Consequence				
	Insignificant (1)	**Minor** (2)	**Moderate** (3)	**Major** (4)	**Catastrophic** (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Possible (2)	**2**	**4**	**6**	**8**	**10**
Likely (3)	**3**	**6**	**9**	**12**	**15**
Often (4)	**4**	**8**	**12**	**16**	**20**

Frequent / Almost Certain (5)	5	10	15	20	25

Table 4: Risk Rating Interpretation

The risk rating estimated previously is interpreted according to Table 4.

Risk Rating		Interpretation of Risk Rating
1-3	Low Risk	No action required, unless escalation of risk is possible
4-6	Moderate Risk	Activity can operate subject to controls
8-12	High Risk	Activity should be modified to include remedial planning and action and be subject to detailed QHSE assessment.
15-25	Extreme Risk	Activity should not proceed in current form.

Table 5: Notifications

Risk Level	Authority to Accept Residual Risk	Notification Requirements	Documentation Distribution List	Residual Risk Review Requirements
Low	All employees	Managers via Reporting Register	Reporting Register and Monthly Reports	None
Moderate	Manager / QHSE	Director via Reporting Register	Reporting Register and monthly reports	Prior to undertaking actives creating hazard Formally- Annually
High	Director	Executive Management Team Representative	Reporting Register, To be included in Risk Assessments and Corporate Risk Register	Prior to undertaking actives creating hazard Formally-Semi-Annually
Extreme	Executive Management Team Representative	Executive Management Team Representative and Chief Executive Officer	Reporting Register, To be included in Risk Assessments and Corporate Risk Register	Prior to undertaking actives creating hazard Formally- Monthly

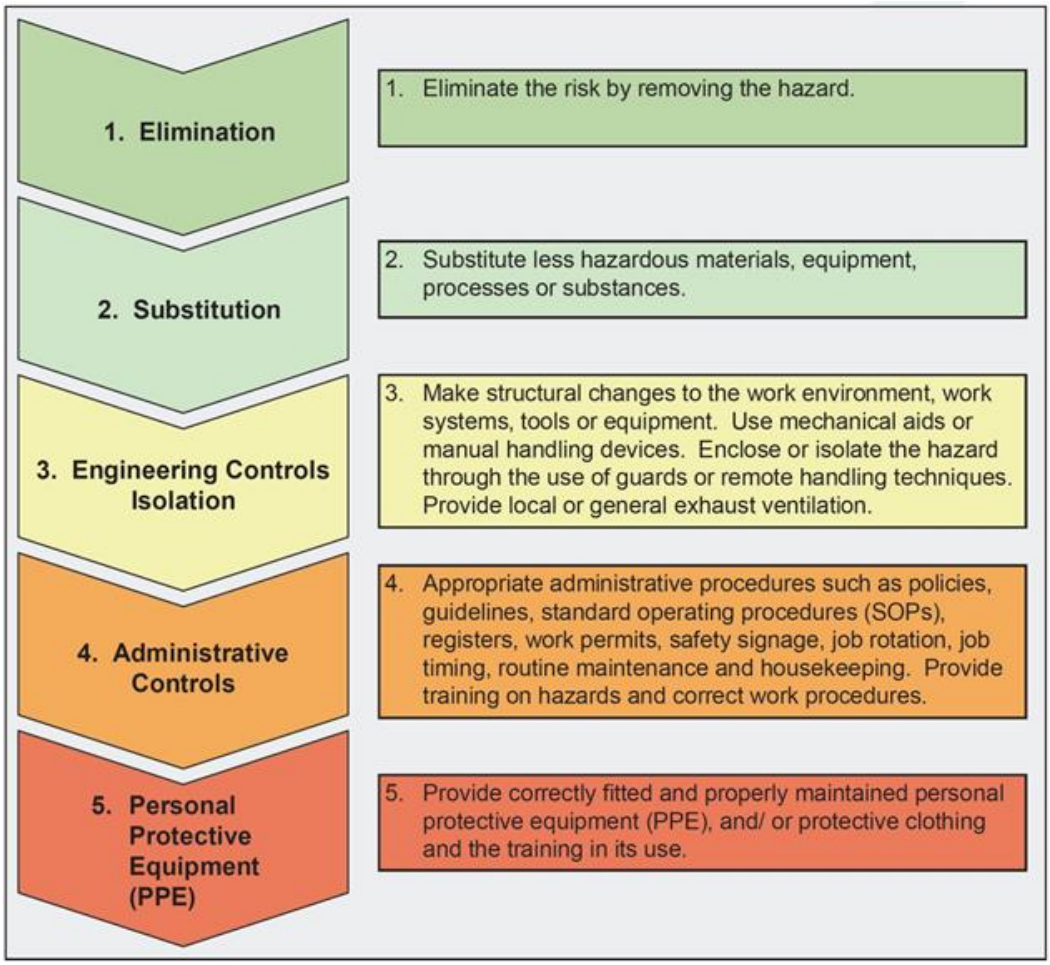
APPENDIX B - Occupational Health and Safety Control Hierarchy

Hazards and risks must be controlled in a systematic manner with the requirement to eliminate the hazard or risk wherever practicable.

If it is not practicable to eliminate the risks, then the risks need to be reduced through substitution and/or engineering control measures and/or administrative control measures. The last level of control is to provide personal protective equipment (PPE) against the risk.

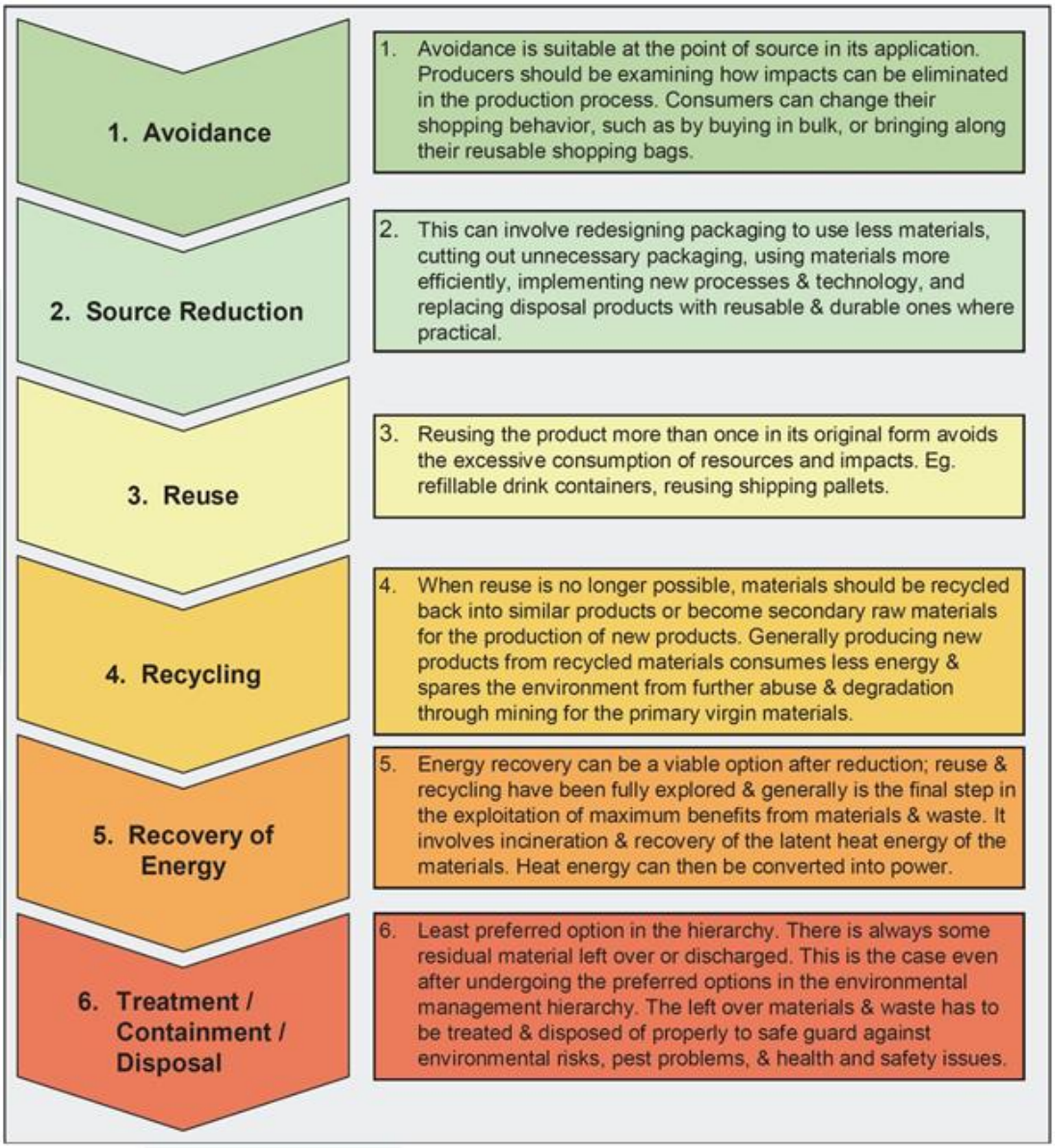
This latter approach does nothing to minimize or alter the original risk, and any failure of the PPE exposes the wearer to the full hazard potential. This is why the control measures are referred to as a hierarchy, as one must start with the first control measure of elimination, and work downwards only if it is not reasonably practicable to implement that control measure.

Once the primary control measure has been selected, then the use of various other control measures may be utilized to further reduce the risk so far as is reasonably practicable.



APPENDIX C - Environmental Control Hierarchy

The management hierarchy concept can be viewed as a straightforward set of management plans. The hierarchy sets forth several management strategies or options according to importance and preference in a descending order. The aim is to extract the maximum practical benefits from the products and manage impacts in the best possible manner, so that the minimum amount of waste and discharges is generated.



APPENDIX D – QHSE REPORTS INVESTIGATION AUTHORITY

Risk Level	Authority to Designate Investigation Team	Authority to Accept Investigation Findings	Mandatory Notification of NA Personnel	Mandatory Notification of NA Personnel Timeframe
Low	N/A	N/A	N/A	N/A
Moderate	Manager	Manager	Manager	48 hours
High	Director	Chief Executive Officer	Chief Executive Officer	24 hours
Extreme	Executive Management Team Representative	Chief Executive Officer	Chief Executive Officer	24 hours

APPENDIX E – REPORTABLE OCCURANCES AND SERIOUS INJURIES

Schedule A - List of Reportable Dangerous Occurrences (Maximum 24 hours)

Explosion or Fire	Failure and/or Collapse of Equipment	Machinery Damage	Biological Agent	Penetration (Sharps) Injury
Electrical short circuit or failure of electrical machinery, plant or apparatus, which results in an explosion, fire or structural damage and involves its stoppage or disuse for at least 5 hours. Explosion or fire affecting any site in which persons are at work and causing complete suspension of ordinary work in the site for at least 24 hours.	The collapse, overturning, failure or malfunction of, or damage to, any plant/equipment that the employee is in contact with that had the potential to cause injury / illness / environmental damage. Failure of breathing equipment while in use or during testing immediately before use	Explosion or failure of the structure of a steam boiler, receiver or any container used for the storage at a pressure greater than atmospheric pressure of any gas or gases (including air) or any liquid or solid resulting from the compression of gas.	Any incident which resulted in or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness.	When a person is injured by a sharp known to be contaminated with a blood borne virus (BBV) e.g. Hepatitis B or C or HIV

Schedule B - List of Reportable Serious Injuries (Maximum 24 hours)

Fatality within 24 hours of the incident
Serious injury within 3 days from the incident date
Person(s) requiring medical treatment within 48 hours of exposure to a substance
Person(s) requiring immediate treatment as an in-patient in a hospital
Person(s) requiring immediate medical treatment for:
Fracture (not including fingers and toes)
The loss of a distinct part or organ of the injured person's body, including the amputation of any part of an employee's body
Loss of consciousness and/or requiring resuscitation
A serious head injury
A serious eye injury, including loss of sight (temporary or permanent)
Exposure to a hazardous material
The separation of skin from any underlying tissue (such as scalping or de-gloving)
Electric shock or electrical burn
Serious burns due to thermal and chemical agents
Entrapment of any part of a person in machinery/equipment
A spinal injury
Dislocation of the shoulder, hip, knee or spine
The loss of bodily function
Serious laceration

Schedule C - List of Reportable Occupational Illness / Diseases (Maximum 24 hours)

Occupational Illness / Disease	Occupational Exposure
Occupational noise induced hearing loss	Any work involving exposure to the impact of noise, as well as drugs and chemicals that have an effect on hearing
Tuberculosis	Any work involving exposure to the tuberculosis microbe such as dealing with patients in hospitals or work in laboratories or handling of infected animals
Brucellosis	Any work involving exposure contact with infected people or infected animals or animal products
Hepatitis A and B	Any work involving exposure to infected people or contaminated blood such as in hospitals and laboratories
HIV/AIDS	Any work involving exposure to infected people or contaminated blood such as in hospitals and laboratories
Tetanus	Any work involving exposure to sewage and agricultural works
Extrinsic Allergic Alveolitis	Any work involving exposure to fungus, spores, plants seeds and some animals such as working in animal farms, with birds and in agriculture
Poisoning caused by exposure to petroleum and distillates	Any work involving the use or handling of petroleum and its gases or products or derivatives and any work involving exposure to such substances in solid liquid or gaseous form as in oil industry operations
Conditions caused by exposure to bromomethyl and chloromethyl	Any work involving the use or handling or exposure to fumes or gases of bromomethyl and chloromethyl as in fire extinguishers, air conditioning, and pesticides
Poisoning caused by exposure to halothanes	Any work involving the use or handling or exposure to halothanes in health sector (Anesthetics)
Conditions caused by exposure to carbon monoxide	Any work involving exposure to carbon monoxide in incomplete combustion processes, as in furnaces and maintenance of power generators