



Acacium Group

Incidents Reporting Policy

Policy Reference | ORG 04

Version | V3.2

Policy Name	Incidents Reporting Policy
Purpose of Document	This document sets out the Acacium Group policy for reporting and managing incidents.
Target Audience	All workers.
Version	V3.2
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Risk and Resource Implications	Risk: Potential communication risk as there is one generic policy but varying processes within divisions. Resources: Training.
Associated Strategies and SOPs	CLIN 07 Infection Prevention Policy CLIN 08 Safeguarding and protecting Children Policy CLIN 09 Safeguarding Vulnerable Adults Policy CLIN 14 Health Records Management Policy CLIN 19 Resuscitation Policy CORP03 Whistleblowing for Internal Employees Policy CORP04 Whistleblowing for Associate Workers and External Parties CORP10 Policy on Policies Policy CORP14 Complaint Reporting Policy ORG 03 Health and Safety Policy ORG 24 Duty of Candour Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A

Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B
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Document History			
Version	Date	Changes made/comments	By whom
Draft v 1	Jul 2011	Changes made following comments concerning font and use of colons.	K. Matthews- Shard
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1. Introduction

- 1.1 Within Acacium Group there is a culture that supports safety and openness. All workers report incidents, accidents, near misses, and potential incidents, through the DATIX risk management reporting system so that steps are taken to improve the safety of the clients and workers.
- 1.2 Through a dynamic system of reporting and managing incidents the organisation is able to identify areas of potential risk at an early stage and take action to improve working practice across the organisation.
- 1.3 Acacium Group has implemented the Patient Safety Incident Response Framework (PSIRF) which sets out the NHSE approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. This replaces the Serious Incident Framework.
- 1.4 The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.
- 1.5 Acacium Group's commitment to safety is delivered by everyone within the organisation through understanding the:
 - importance of timely incident reporting
 - significance of effective incident management
 - need to cooperate in the investigation of incidents, within the agreed timescales
 - value of incident reviews to establish the root cause and facilitate organisational wide learning
 - importance of involving clients and their families.
- 1.6 This is a group generic policy which is supported by two standard operating procedures (SOPs):
 - Acacium Group Reporting and Grading Incidents
 - TNS / SNG Reporting Incidents.
 - DOC 03 Dealing with Concerns
- 1.7 Copies of both these SOPs may be found in Appendix D and Appendix E.

2. Definitions

- 2.1 Definitions relevant to this Policy are set out in Table 1.

Table 1: Definitions

Definition	Explanation
An incident	Includes the terms 'untoward incident', 'near miss', 'adverse incident' or 'accident'. These are where an act, omission, undesired circumstance, or event, results, or had the potential to result, in an unintended or undesirable outcome, harm, loss, or damage. This may involve clients, workers, members of the client's family, property or equipment. The term 'incident' includes issues related to but not exclusively related to: • working practices • client safety • health and safety • fire • theft

	• emergency situations • loss of information or data or data security breaches • violence / aggression from clients or their family against any worker, and vice versa.
An adverse incident	Is any incident, occurrence, or accident, related to clinical or non-clinical care, which has or could have resulted in an injury, or near miss to a client, visitor, or worker. An incident may be: • a complaint related to clinical or non-clinical care • an event not in compliance with Acacium Group routine operation • property or equipment damage • equipment failure • physical aggression or verbal threats. • All workers must consider this fundamental definition when deciding whether or not to submit a report. If in doubt, the worker should report the incident.
Serious Incident (SI) or Serious Untoward Incident (SUI)	Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.
Patient safety incident investigation (PSII)	This replaces the term Root Cause Analysis (RCA) (RCA). Safety investigations are conducted to identify how and why certain patient safety incidents happen. They include data collection and analysis phases to learn more about system-based underlying factors and their interdependencies. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care (NHS England 2020)
The Serious Incident Framework (NHS England 2015)	Describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.
Internal Investigation	Method used for incidents to establish internal learnings and actions
Contributory factors	Factors, practices or influences that contributed to or had an influence on the incident occurring.
Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)	These are incidents including those involving an Acacium Group worker that result in: • death, major injury • hospital admission for over 24 hours or more than 3 days • absence from work for over 7 days.
An accident	Is commonly defined as 'an unplanned event, which may or may not result in injury or damage'. It is clear from this definition that it is not essential for injury to have been sustained or for damage to have occurred for an accident to happen. However, an accident is also defined as an unforeseen event resulting in harm or serious injury requiring a visit to the GP, Accident and Emergency, or hospital admission.
A near miss or No harm (impact prevented)	An event not causing harm, but has the potential to cause injury. These incidents should be investigated as the same immediate and patient causes of the incident are present and there is the potential for harm.
A prevented harm incident	Is an incident where a client or worker was prevented from an injury or harm by the action of another person.
A hazard	Is a general term for anything that has the ability to cause injury.

A dangerous occurrence	Is something that happened that did not result in an injury, but which clearly could have done.
Violence and aggression at work	Is defined as any incident in which a worker is verbally abused, threatened, or assaulted, by a client or member of the public, in circumstances relating to his / her employment. Violence is defined as any incident where a worker is abused, threatened, or assaulted, in circumstances relating to their work, involving an explicit or implicit challenge to their safety, wellbeing, or health.

3. Roles & Responsibilities

- 3.1 The overall organisational roles and responsibilities are set out in the policy document, CORP10 Policy on Policies for drafting, approval and review of policies and SOPs.
- 3.2 Acacium Group acknowledges that reporting and managing incidents through the DATIX system is the responsibility of all its workers. The following table outlines the responsibilities of the key people involved in the effective reporting and management of incidents.

Table 2: Roles and responsibilities relating to this Policy

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	• nominates an appropriate member of staff to lead grades 4 and 5 incident investigations. See the Acacium Group Reporting and Grading an Incident SOP • ensures all incidents are investigated within agreed timescales • ensures there are appropriate systems to undertake: ○ a monthly incident trend analysis ○ a review of serious untoward incidents (SUIs) ○ implementation of the SUI investigation recommendations ○ the approval of actions identified to reduce the likelihood and occurrence of incidents ○ the dissemination and implementation of lessons learnt ○ the monitoring of agreed actions ○ the review of the effectiveness of action taken to reduce the likelihood and occurrence of incidents • ensures a full cycle of communication in relation to the management of incidents from frontline service level to the senior management team and back to frontline workers • identifies incidents that require reporting to external bodies, such as, the Health and Safety Executive (HSE), the Care Quality Commission (CQC), the Regulation Quality Improvement Authority, Northern Ireland (RQIA), Healthcare Improvement Scotland (HIS) and the. NHS Commissioning Board • identifies when incidents require joint management, for instance, with NHS acute trusts, mental health trusts or GPs. Also identifies a nominated Acacium Group lead to undertake this joint working • monitors trends in incidents and highlights issues in relation to incidents that require escalation • ensures lessons learnt are disseminated and implemented throughout Acacium Group • monitors compliance with this Policy and associated SOPs.
Individual worker	To be aware of Acacium Group's Incident Policy to ensure compliance:

	• report incidents, as soon as they occur, or as soon as they become aware of an incident • inform their Line Manager/appropriate other as soon as possible. Prepare a statement of events for all moderate and above incidents as soon as possible after the event before the end of the working day at the latest. Report all other instances within three days. • report to their Line Manager/appropriate other if they are absent from work for more than 3 days as a result of an incident to ensure it is reported as a RIDDOR incident • take appropriate remedial action to reduce the risk and likelihood of the incident recurring, or prevent further deterioration • cooperate in identifying the root causes of an incident and the implementation of any required changes to practice • take part in training, including attending updates so that skills and familiarity with the procedures are maintained • maintain a high level of record keeping practice at all times • abide by their professional standards • access regular supervision and support in line with local procedures.
Acacium Group Incidents and Complaints Management Team	• Provide advice and support to the businesses and teams to help resolve complaints and incidents • Training of new manager's in relation to complaint and incident handling • Ensure Datix is kept updated and used in accordance with the guidelines • Regular Audit of Datix to ensure all complaints and incidents are recorded accurately and in the right category, managed within the agreed timeframes in line with group policies • Provide reports of outstanding complaints and incidents to each business • To ensure any serious, moderate, safeguarding, police risk incidents & complaints are escalated to the Group Global Clinical Director/Group Chief Nurse immediately
Clinical Advisory Group (CAG)	Review policies and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

4. Reporting and Managing Incidents Key Actions and Generic Good Practice

4.1 Equality and diversity

4.1.1 Acacium Group has a statutory duty to set out arrangements to assess, and consult, on how their policies SOPs and functions impact on all individuals in relation to the legislation set out in the Equality Act October 2010 and those of the devolved governments.

4.1.2 An Equality Impact Assessment (must be completed by the author of a Policy using the checklist provided in Appendix A). Reference Acacium Group Equality and Diversity Policy.

4.2 Best practice

4.2.1 This section sets out best practice in reporting incidents, adverse incidents, accidents, near misses, and potential incidents, whether in a clinical or non-clinical environment, a client's home, or any other establishment or setting where care is provided.

4.2.2 The NHS Patient Safety Strategy 2021.

- 4.2.3 This strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems and also includes details of the Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework.
- 4.2.4 PSIRF has four key aims with regards to patient safety incidents
- compassionate engagement and involvement of those affected
 - a system-based approach to learning
 - considered and proportionate responses
 - supportive oversight focused on strengthening response systems and improvement.
- 4.2.5 PSIRF will provide updated guidance on how NHS organisations and other stakeholders should respond to patient safety incidents and provides guidance on how to develop the cultures, systems, and behaviours necessary to respond to patient safety incidents in a way that ensures continual improvement.
- 4.2.6 Acacium Group is committed to the adoption and implementation of the PSIRF and will further review the policy and procedures as required.
- 4.2.7 Patient Safety Incident Response Plan can be found in the Knowledge Room on SharePoint. (see appendix H)

4.3 Assessment of risk

- 4.3.1 Assessment of risk and planning are integral to incident reporting and management. All workers are expected to contribute to these processes. Following an incident, a risk assessment must be undertaken, and action taken to reduce the likelihood of the incident recurring. The aim is to reduce the likelihood to the lowest, reasonably practicable category. When prioritising resource, action should be first targeted at reducing the likelihood of those incidents with the highest level of severity, or where an incident of a low severity may impact on a high number of persons.
- 4.3.2 Risks that are significant to Acacium Group and its clients, or may be difficult to manage, should be escalated to the Group Chief Nurse for inclusion on the Acacium Group Risk Register so that there is corporate awareness and monitoring.

4.4 Reporting to statutory and other bodies

- 4.4.1 Table 3 sets out a list of incidents and the appropriate reporting body to whom Acacium Group reports certain incidents in order to safeguard its clients. All external reporting must be reported to the Group Clinical Director/Chief Nurse in the first instance. This list is indicative only.

Table 3: List of incidents and appropriate reporting body.

Incident	Reported to:
Work-related accidents which cause deaths Work-related accidents which cause certain serious injuries (reportable injuries) Diagnosed cases of certain industrial diseases; and Certain 'dangerous occurrences' (incidents with the potential to cause harm) Refer to https://www.hse.gov.uk/ for guidance	Acacium Group is legally required to report all accidents and incidents defined in the regulations to the Health and Safety Executive (HSE), within ten days of the accident occurring. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR 2013) sets out the regulations for reporting to the HSE
Incidents involving failed medical devices.	Medicines and Healthcare products

	Regulatory Agency (MHRA).
In the case of commissioned or contracted services where a serious untoward incident (SUI) has occurred, the Group Clinical Director/Chief Nurse is the person responsible for informing and updating the appropriate body.	Reported to the: • commissioner • lead for the contracted service • next of kin or the client of the care package.
Incidents of known reportable diseases. The UK Health Security Agency (formerly Public Health England) publishes a list of notifiable diseases which can vary.	The UK Health Security Agency There are some reporting differences in Scotland, Wales, and Northern Ireland, so members should check the latest position with: Health Protection Scotland Public Health Wales HSC Public Health Agency
Incidents of a criminal nature.	Police.
Incidents related to poor professional performance and poor standards of quality and service in the regulated services/activities.	Professional regulatory bodies as detailed below dependant on location Care Quality Commission (CQC) Scottish Care Inspectorate The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services. The reviews undertaken by the RQIA are based on the 2006 'Quality standards for health and social care'. In 2009, the duties of the Mental Health Commission were also transferred to the RQIA. Care Inspectorate Wales 2004 (CIW) The CIW is the independent regulator of social care and nurse agencies across Wales. They regulate, inspect, and support, improvement of care, social work, and child protection services for the benefit of the people who use them.
Breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. This includes breaches that are the result of both accidental and deliberate causes.	Information Commissioners Office (ICO) All serious data breaches must be reported the ICO within 72 hours where Acacium Group acts as the data Controller, and to the data controller where Acacium Group is the data Processor within 24 hours The Group Data Protection Officer should be informed of any data breach in the first Instance

4.4.2 Types of incidents reportable under RIDDOR:

Deaths and injuries

If someone has died or has been injured because of a work-related accident this may have to be reported. Not all accidents need to be reported, other than for certain gas incidents, a RIDDOR report is required only when:

- the accident is work-related
- it results in an injury of a type which is reportable
- Types of reportable injury
- The death of any person

All deaths to workers and non-workers, with the exception of suicides, must be reported if they arise from a work-related accident, including an act of physical violence to a worker.

Specified injuries to workers

The list of 'specified injuries' in RIDDOR 2013 replaces the previous list of 'major injuries' in RIDDOR 1995. Specified injuries are (regulation 4):

- fractures, other than to fingers, thumbs and toes
- amputations
- any injury likely to lead to permanent loss of sight or reduction in sight
- any crush injury to the head or torso causing damage to the brain or internal organs
- serious burns (including scalding) which:
 - covers more than 10% of the body
 - causes significant damage to the eyes, respiratory system or other vital organs
- any scalping requiring hospital treatment
- any loss of consciousness caused by head injury or asphyxia
- any other injury arising from working in an enclosed space which:
 - leads to hypothermia or heat-induced illness
 - requires resuscitation or admittance to hospital for more than 24 hours

For further guidance on specified injuries is available at
<https://www.hse.gov.uk/riddor/specified-injuries.htm>

4.5 Record keeping

4.5.1 Accurate record keeping is vital in all elements of care provision and incident management. Effective record keeping often speeds up the sometimes stressful aspects of incident reporting and management. For full details on the requirements of record keeping, please refer to Acacium Group's Record Management Policy.

4.5.2 All incidents should be logged onto the DATIX system. In case of litigation, incident records must be retained for a period of ten years following the closure of an incident.

4.6 Recourse to disciplinary procedures

4.6.1 Acacium Group put emphasis on discovering and addressing the root causes of an incident through thorough analysis of all the contributory factors. There may be instances where recourse to the disciplinary process is required if:

- there is a deliberate failure to report or an unreasonable delay in reporting an incident
- misconduct and serious misconduct i.e. fraud, physical assault, corruption, breach of confidentiality, or where the incident is repeated on several occasions
- during an incident investigation there is evidence that the incident was due to an action deemed reckless, deliberate or as a result of gross negligence
- there is an attempt to deliberately mislead an incident investigation.

4.6.2 If punitive action is necessary, as a result of a disciplinary investigation, it must be seen to be fair and reasonable. It must not be influenced by the outcome of the incident, or the position or profession of the worker. No disciplinary action will be taken as a result of incident reporting against workers who have followed Acacium Group policies and procedures, and exercised reasonable judgement. Where disciplinary procedures are required, the Employer Relations/People Team will be involved at the earliest opportunity. The disciplinary procedure will not be used as part of any investigation process unless there is:

- clear evidence of blatant malpractice
- breaches of professional standards of conduct
- grossly unprofessional errors
- a complete disregard for the safety of others
- malicious intent to harm
- theft
- fraud or any other criminal, or malicious acts.

4.6.3 Follow up action may take the form of retraining, disciplinary procedures or reporting to a professional regulatory body.

4.7 Immediate actions following an incident

4.7.1 Actions are as follows:

- prevent a recurrence of the incident, which may include an item of equipment being removed, or the client being removed from the area of the incident in order to create a safe environment
- provide or arrange any first aid, or medical care, as needed
- retain and keep all evidence, preferably in the same condition as it was at the time of the incident
- if help is required it must be called for as soon as possible. This may include the police, the fire brigade, the ambulance service and / or a Line Manager / appropriate other
- if an incident has occurred to a client that they are unaware of then they should be advised sensitively, as soon as possible, after the incident. Workers who feel they need the support of their Line Manager / appropriate other to do this should call their Line Manager / appropriate other as soon as possible and wait for them to attend the incident, prior to discussing this information with the client
- statements must be taken as soon as possible after the event and before the end of the shift. See Acacium Group's Record Management Policy for guidance.

4.8 Reporting, timescales and grading of incidents

4.8.1 There are two different approaches to reporting, timescales, and grading of incidents, one for Acacium Group workers and one for TNS/SNG workers. The SOPs that support this Policy are set out in Appendix D: Acacium Group Reporting and Grading of Incidents SOP and in Appendix E: TNS Reporting Incidents SOP.

4.9 Appeal

4.9.1 If an individual is dissatisfied with the investigation process and outcome an appeal can be lodged with the Group Clinical Director by emailing appeals@acaciumgroup.com.

4.9.2 Clinical Governance will allocate the appeal to the most appropriate person within the group, once the appeal outcome is shared with the complainant there are no further avenues for appeal with Acacium Group and appeal to external bodies will be necessary, if the complainant continues to be dissatisfied with the outcome.

5. Acacium Group Investigation of Incidents

- 5.1 This section applies to incidents categorised in Appendix D: Reporting and Grading of Incidents SOP for Acacium Group workers.
- 5.2 Some investigations into incidents such as TNS/SNG, Bank or Agency will be carried out, in partnership, with the client's organisation, and in line with their policies and SOPs.
- 5.3 All investigations should be undertaken by a person that has received training for investigations and is competent to investigate. Patient Safety Incident Investigations (PSII formally Root cause analysis) must be led or undertaken by a senior suitably trained and qualified person who has received up to date training on incident investigations and where necessary in partnership with the client or outside agencies such as LADO, ICB, CQC, RQIA etc.
- 5.4 The selection of incidents for local patient safety incident investigation is based on the:
- actual and potential impact of the incident's outcome (harm to people, service quality, confidence)
 - likelihood of recurrence (including scale, scope and spread)
 - potential for new learning and improvement in terms of:
 - knowledge and understanding of underlying factors
 - opportunity to influence efficiency and effectiveness
 - opportunity to influence wider system improvement.
- 5.5 The aim of the investigation is to understand what happened, ensuring both the voice of the worker and patient/client is listened to. Identify how future incidents may be prevented and ensure that the conclusions in the final report are fair, evidenced, and reasoned. The investigation is intended to:
- find out all the facts regarding the sequence of events that led up to the incident
 - determine what was well managed
 - determine what (if anything) went wrong and identify any issues of concern
 - identify the 'root causes' that led or contributed to the incident occurring
 - make recommendations to address the root causes identified.
- 5.6 All aspects of the investigation must be recorded on DATIX. The timeframe for incident investigation will be flexible and set in consultation with the those involved but should not exceed 6 months (Patient Safety Incident Response Framework guidelines).
- 5.7 PSIRF supports the Acacium Group to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.
- 5.8 **Assessing whether an incident triggers a PSII**
- 5.8.1 In many cases it will be immediately clear that a serious incident has occurred and further investigation will be required to discover what exactly went wrong, how it went wrong (from a human factors and systems-based approach) and what may be done to address the weakness to prevent the incident from happening again.
- 5.8.2 Where it is not clear whether or not an incident fulfils the definition of a serious incident, Acacium Group will engage in open and honest discussions to agree the appropriate and proportionate response.
- 5.9 For non-serious Incidents, or those where the investigation is undertaken by another body, Acacium Group will undertake an internal investigation to identify any learnings the organisation needs to

action. This level of investigation is not a Root cause analysis investigation and should be undertaken for all incidents moderate and below. The template for this investigation is in Appendix G.

5.10 This level of investigation will establish the facts, collate the evidence and identify learnings for the organisation and will be in line with National standards for patient safety investigation (NHS England March 2020).

5.11 Patient Safety Investigation (Formally Root Cause Analysis)

5.11.1 The primary aim of a good quality patient safety incident investigation is to accurately and thoroughly identify what happened (problems arising) and why (contributory and causal factors); and recommend strong/effective systems-based improvements to prevent or significantly reduce the risk of a repeat incident Acacium Group will follow the National standards for patient safety investigation (NHS England march 2020) based upon the following principles:

- strategic
- preventative
- collaborative
- fair and just
- expert/credible
- people focused.

5.11.2 The PSII is a structured investigation that aims to identify the true cause of a problem, and the actions that are necessary to either eliminate or significantly reduce the risk. The six steps involved in undertaking an investigation include:

- identify the scope of the investigation and gather Information
- prepare a chronology of events
- problem identification
- problem exploration
- identify safety and quality improvements
- generate the PSI Report, Improvement Plan and sharing the lessons learnt.

5.11.3 Acacium Group ensure that the PSII report Identifies system strengths as well as problems (together with their associated mitigating and contributory factors).

5.11.4 A PSII must be undertaken for all incidents moderate and above. As part of the investigation, contributory factors will be analysed. See Table 4: Factors to be considered. The template for RCA reports is in Appendix H.

Table 4: PSII factors to be considered

Factors to be considered in all clinical reports	Other factors to be considered as appropriate
Client/patient factors	Task
Communication factors	Engagement
Organisational/strategic/policy/care coordination, record keeping	Environmental factors - working conditions
Individual/professional	Education and training
Team and social	
Equipment and resource	

5.12 Patient Safety Investigation of an incident

5.12.1 Acacium Group adopt the 7 key principles in the management of all incidents in line with The Patient Safety Incident Response Framework (NHS England 2020).

- Open and transparent
- Collaborative
- Proportionate
- Systems based
- Timely
- Responsive
- Objective

5.12.2 Investigation of an incident may include some or all of the following processes:

- interviews with the key individuals involved to ensure they are heard.
- interview with the person affected (where appropriate)
- interview with any witnesses
- inspection of the location of the incident
- inspection of any equipment involved
- examination of any physical evidence available
- review of appropriate policy or standard operating procedure (SOP)
- review of the personnel healthcare records.

5.12.3 All interview transcripts should be uploaded to DATIX.

5.12.4 If it becomes clear that an incident is in relation to safeguarding vulnerable adults or children, the incident must be referred to the local safeguarding teams for further investigation, and action. All investigations must be completed and attached as a linked document to the Datix incident report within two months. Less complicated incidents are expected to be completed within a shorter period of time.

5.13 **Communication with and the support for Acacium Group workers**

5.13.1 Acacium Group is committed to developing a culture which allows workers to raise concerns through appropriate channels, particularly in relation to client safety. Where workers wish to raise concerns about client safety they must consult Acacium Group Whistleblowing Policy. Following a reported incident, regardless of severity level, it is essential that the workers are appropriately supported by the Line Manager/appropriate other, involved in any subsequent investigation. Acacium Group workers should also be made aware of the investigation outcomes and any recommended changes to practice.

5.14 **Communicating with and the support for victims, clients, families, and perpetrators**

5.14.1 Acacium Group expects that following any incident those involved in the incident, workers, and clients, will be offered information and support commensurate with the level of the incident. Where applicable, and with the consent of the client, families, and carers, the perpetrator is also offered the relevant level of support and information.

5.14.2 The NPSA guidance to the NHS, to which Acacium Group is committed, 'Being open' means communicating client safety incidents with clients and their carers, and informing all third party contacts following an incident. The basic principles underlying any communications are the principles of Duty of Candour and follow the Acacium Group Duty of Candour Policy.

5.14.3 Acacium Group seek feedback from individuals, families and carers to determine how well they are upholding the principles of openness and transparency and respect confidentiality and protect data but not allow these concerns to unnecessarily undermine openness and transparency.

5.14.4 Information and support will be provided by the Line Manager / appropriate other but in the event of moderate and above incidents, the Global Clinical Director will identify a designated lead, to support the family.

5.15 Learning from incidents

5.15.1 It is essential that all workers feel able to report incidents openly and feel supported during incident management so that lessons can be learnt. Learning from incidents is disseminated in a number of ways, depending on the level of urgency. Some learning is provided through the dissemination of alerts via the managers. Other methods of dissemination are made via posting information on the intranet, publishing a newsletter or holding training events.

5.15.2 All learnings must be action planned with named people and timeframes for completion of the action to ensure that we reduce the likelihood of a similar incident occurring again. If there is an action plan from a PSII then this should follow the lessons learned framework from the Patient Safety Incident Reporting Framework (PSIRF).

5.16 Media management

5.16.1 In the event that an incident occurs that attracts media attention the process of liaising with the media is undertaken by the Group Clinical Director. Under no circumstances should any worker enter into discussions with the media unless they have been nominated by the Chief Executive or Group Clinical Director.

5.17 Incidents which involve care partners

5.17.1 There may be an occasion when there is an incident which involves more than one care provider. When this occurs, there will be full partnership working to enable the other care providers to learn from incidents as well. Information will be shared on a need to know basis and according to Acacium Group Records Management Policy.

5.18 Governance

5.18.1 All incidents are reported monthly to the Board and on a Bi-monthly basis to the senior management team.

5.18.2 Clinical quality and safety meetings are held across the business, for group discussion on Risks, incidents and feedback, lessons learnt, and dissemination of information.

5.19 Investigation of workers

5.19.1 Workers involved in an incident are required to participate in an investigation and, if necessary, could be subject to a disciplinary or breach of contract process. If the worker requires investigation this is managed separately under the HR process.

5.19.2 The process required will depend on the type of worker that was involved in the incident. In Acacium Group there are two types of worker:

- workers on an employment contract PAYE
- workers on a terms of engagement contract: LTD company, agency workers, self-employed.

5.19.3 Acacium Group have different responsibilities for the different types of workers. Therefore, some of the terminology used throughout the investigation process is different. The table below illustrates the differences required.

Stage (if applicable)	Workers on employment contract	Workers on terms of engagement
-----------------------	--------------------------------	--------------------------------

Stop the workers working (if applicable).	Suspend workers pending investigation.	Remove/Restrict workers from all future shifts pending investigation.
Investigation Stage.	Invite workers to investigation meeting.	Invite workers to investigation meeting.
Disciplinary Stage.	Workers to attend disciplinary meeting.	Workers to attend 'Breach of Contract' meeting. If the worker is paid by an Umbrella company then a BOC would not occur. If appropriate we would inform the worker and the Umbrella company that we will no longer be offering them work and it would be for the Umbrella Company to investigate as they are the employer.

5.20 A just culture

5.20.1 In line with the NHS A Just Culture guide, Acacium Group ensure workers involved in a patient safety incident re treated in a consistent, constructive and fair way. Acacium Group ensure that their investigation process guards against:

- bias: all workers involved in similar actions or decisions leading to a patient safety incident should be treated in the same way, irrespective of whether the patient was or was not harmed (outcome bias) and their grade or professional group.
- risk of discrimination, by ensuring that those involved in making decisions about referring staff for disciplinary, professional, regulation or individual training and reflection are trained in equality and diversity and the risks of unconscious bias.

5.20.2 Policies and procedures are consistently reviewed in line with the Acacium Group Policy on Polices, and steps taken to understand and resolve inequality and potential unfair treatment.

For further information see https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

6. Training

6.1 Acacium Group will enable their workers to participate in training in the effective management of incidents and the use of the Datix Cloud system, this is provided by the Clinical Governance team. This is a mandatory requirement upon commencement of employment with Acacium Group if the worker requires access to the Datix system. Group workers are also expected to attend regular updates. The training will be proportionate, and relevant to the roles and responsibilities of each worker.

6.2 It is the responsibility of the business divisions to request, where appropriate, the training required for their workers in lie wot their job role.

7. Implementation Plan

7.1 For **consultation, ratification and dissemination** of this Policy see the Policy on Policies for drafting, approval and review of policies and SOPs.

7.2 This Policy will be implemented through:

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- communication of the Policy to all relevant workers
- communication of the Policy to all stakeholders
- raising awareness and understanding of the Policy and related processes throughout the organisation through committee meetings, Acacium Group workers' meetings, Acacium Group Intranet, the website and general communication
- through Acacium Group induction programmes and related training.

7.3 The Group Clinical Director will ensure the dissemination of this Policy across the organisation.

7.4 Audit and monitoring

7.4.1 The Group Clinical Director will monitor compliance with this Policy. See also the policy author's responsibilities in Table 2 of Acacium Group Policy on Policies for drafting, approval and review of policies and SOPs.

7.4.2 Processes for monitoring the effectiveness of this Policy include:

- audits of specific areas of practice
- evidence of learning across the organisation
- incidents reporting procedure
- appraisal and Personal Development Plans (PDP).

7.4.3 The audit will:

- identify areas of operation that are covered by this Policy
- set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance
- highlight where non-conformance to the procedures has occurred and suggest a tightening of controls, and adjustment to related procedures
- report the results to the Governance Committee via the Clinical Director.

7.4.4 Specific elements for audit and monitoring are the:

- investigation of incidents in a manner appropriate to their severity
- standard of documentation
- completion of relevant action plans
- aggregation of incidents and claims
- frequency and appropriateness of logging incidents
- management of incidents according to timescales
- evidence of structured learning across Acacium Group

7.4.5 Acacium Group will regularly audit its incident reporting and management for compliance with this Policy.

7.4.6 This Policy replaces all other 'incident recording and management' policies within Acacium Group.

8. Associated Policies / SOPs

Policies

CLIN 07 Infection Prevention Policy

CLIN 08 Safeguarding and protecting Children Policy

CLIN 08-S Safeguarding And Protecting Children Policy (Scotland)

CLIN 09 Safeguarding Vulnerable Adults Policy

CLIN 09 -S Acacium Group Safeguarding and Protecting Adults At Risk Policy (Scotland)

CLIN 14 Health Records Management Policy

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CLIN 19 Resuscitation Policy
 CORP03 Whistleblowing for Internal Employees Policy
 CORP04 Whistleblowing for Associate Workers and External Parties
 CORP10 Policy on Policies Policy
 CORP14 Complaint Reporting Policy
 ORG 03 Health and Safety Policy
 ORG 24 Duty of Candour Policy
 SNG CLIN 08-ROI Protection and Welfare of Children Policy (ROI)
 SNG CLIN 09-ROI Safeguarding and Protecting Adults at Risk Policy (ROI)

9. References

- Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 1995 – updated 2013 (RIDDOR). Health and Safety Executive.
- Department of Health, 2000. *An organisation with a memory*. National Patient Safety Agency (NPSA).
- National Patient Safety Agency, 2004. *Seven steps to patient safety*.
- National Patient Safety Agency, September 2005. *Being Open*.
- Data Protection Act 2018. HMSO.
- National Patient Safety Agency, 2004. *Seven steps to patient safety*.
- National Patient Safety Agency, 2001. *Doing less harm*.
- National Patient Safety Agency, September 2005. *Being open when patients are harmed*. London: NPSA.
- National Patient Safety Agency, 2004. Seven steps to patient safety: full reference guide. Available at: <http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/>
- [Accessed 27 July 2017].
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Northern Ireland 1997 (RIDDOR).
- Health and Safety at Work Act 1974 (HASAWA). England, Scotland, Wales and Northern Ireland & Health and Safety at Work 1998 (Amendment) Northern Ireland.
- Data Protection Act 2018 (DPA).
- NHS Quality Improvement Scotland, 2006. *Safe Today – Safer Tomorrow*.
- Care Quality Commission, March 2010. *Essential standards of quality and safety*. CQC.
- Regulation and Quality Improvement Authority Northern Ireland 2005, 2009 (RQIA).
- Social Care and Social Work Improvement Scotland 2011 (SCSWIS).
- Northern Ireland Adverse Incident Centre, March 2015. Safety Notice. 200810.23 - *Raising concerns: Guidance for nurses and midwives*.
- Disclosure and Barring Service, 2012. *Guidance on how to make a referral*.
- The Equality Act October 2010 <http://www.legislation.gov.uk/ukpga/2010/15/contents>
- The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 https://www.legislation.gov.uk/wsi/2011/1064/pdfs/wsi_20111064_mi.pdf
- Outline of Scottish Government's duties under the Equality Act 2010. <https://www.gov.scot/publications/scottish-governments-equality-duties/>
- Patient Safety Incident Response Framework <https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#supporting>

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

 Part of Acacium Group	 Part of Acacium Group	 Part of Acacium Group
		 multistaffing one solution
 Part of Acacium Group	 Part of Acacium Group	 Part of Acacium Group
 Part of Acacium Group	 Part of Acacium Group	 Part of Acacium Group
 Part of Acacium Group	 Part of Acacium Group	 Part of Acacium Group
 Part of Acacium Group		

Appendix B: Legislation

- This Policy is supported by legislation and national guidance as set out in the table below.

National policies, guidance, and legislation, supporting reporting and managing incidents.

Act, policy, guidance	Explanation
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) – updated 2013. England, Scotland and Wales. Refer to https://www.hse.gov.uk/	These health and safety regulations require employers to report certain occupationally acquired injuries and diseases to the Health and Safety Executive. Certain workplace occurrences must also be reported. The regulations include strict timescales for reporting and failure to comply is an offence. See 'section 5.4.1' for a list of RIDDOR reportable incidents.
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.	Places a legal duty on: - employers - self-employed people - people in control of premises. To report work-related deaths, major injuries or over-three-day injuries, work related diseases, and dangerous occurrences (near miss accidents).
Health and Safety at Work Act 1974 (HASAWA). England, Scotland, Wales and Northern Ireland.	All workers have the right to work in places where risks to their health and safety are properly controlled. The Health and Safety at Work Act creates legal obligations for staff and employers to ensure this, including the undertaking of risk assessments to identify risks in order to put in place preventative measures.
Health and Safety at Work (Amendment) Northern Ireland 1998.	As above.
Data Protection Act 2018 (DPA)	The DPA provides a framework that governs the processing of personal information in relation to living individuals. It identifies eight data protection principles that set out standards for information handling. A breach of the DPA constitutes a serious incident.
Safe Today – Safer Tomorrow (NHS QIS 2006) Scotland	Sets out suggestions for an effective incident reporting system.
Care Quality Commission (CQC), March 2010. Essential standards of quality and safety – updated 2015 to Fundamental Standards	Regulator standards. The CQC 13 Fundamental standards are the standards below which care must never fail
Regulation and Quality Improvement Authority Northern Ireland 2005, 2009 (RQIA)	'The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services'. The reviews undertaken by the RQIA are based on the 2006 'Quality standards for health and social care'. In 2009, the duties of the Mental Health Commission were also transferred to the RQIA.
Social Care and Social Work Improvement Scotland September 2011 (SCSWIS) (known as the Care Inspectorate).	SCSWIS is the independent regulator of social care and social work services across Scotland. They regulate, inspect, and support, improvement of care, social work and child protection services for the benefit of the people who use them.

Northern Ireland Adverse Incident Centre (NIAIC Safety Notice 2008.	Guidance for reporting adverse incidents is contained in this safety notice, distributed in Northern Ireland only.
Care Inspectorate Wales (CIW)	The CIW is the independent regulator of social care and nurse agencies across Wales. They regulate, inspect, and support, improvement of care, social work and child protection services for the benefit of the people who use them.
CIW Regulation 28	Guidance for employers on the 'Notification of serious injury and other incidents.
NMC Raising concerns: Guidance for nurses and midwives, March 2015.	This document provides guidance for nurses and midwives in raising concerns (including whistleblowing) and the process to follow.
Disclosure and Barring Service (DBS) - 2012	This service helps employers and managers to understand their legal duty in making a referral to the Disclosure and Barring Service (DBS) when one of their workers or volunteers has harmed, or poses a risk of harm, to a child or vulnerable adult.

2. **Equality and diversity**

Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.

Appendix C: Reporting and Grading Incidents SOP

1. Reporting and Grading Incidents Standard

- 1.1 Within the organisation there is a culture that supports safety and openness. All Acacium Group workers report incidents, accidents, near misses, and potential incidents, so that steps are taken to improve the safety of service users and workers.
- 1.2 Acacium Group's commitment to safety is delivered by everyone within the organisation through understanding the:
 - importance of timely incident reporting
 - significance of effective incident management
 - need to cooperate in the investigation of incidents, within the agreed timescales
 - value of incident reviews to establish the root cause and facilitate organisational wide learning
 - importance of involving service users and their families.

2. Reporting and Grading Incidents SOP – General Points

- 2.1 An incident includes the terms 'untoward incident', 'near miss', 'adverse incident' or 'accident'. These are where an act, omission, undesired circumstance, or event, results, or had the potential to result, in an unintended or undesirable outcome, harm, loss, or damage. This may involve service users, Acacium Group workers, members of the service user's family, property or equipment. The term "incident" includes issues related to but not exclusively related to:
 - working practices
 - service user safety
 - health and safety
 - fire
 - theft
 - emergency situations
 - loss of information or data or data security breaches
 - violence / aggression from service users or their family against a Acacium Group worker, and vice versa.
- 2.2 **Assessment of risk**
 - 2.2.1 Assessment of risk and planning are integral to incident reporting and grading. All workers are expected to contribute to these processes. Following an incident, a risk assessment must be undertaken and action taken to reduce the likelihood of the incident recurring. The aim is to reduce the likelihood to the lowest, reasonably practicable category. When prioritising resource, action should be first targeted at reducing the likelihood of those incidents with the highest level of severity, or where an incident of a low severity may impact on a high number of persons. See the Acacium Group Risk Assessment SOP.
 - 2.2.2 Risks that are significant to Acacium Group workers and / or service users, or may be difficult to manage, should be entered on the risk register (DATIX) by the Group Chief Nurse and individual business divisions risk holders so that there is corporate awareness and monitoring.
3. **Reporting an Incident**
 - 3.1 Table 1 sets out a summary flowchart of the required action for Acacium Group workers to follow in the event of an incident, adverse incident, accident, near miss, and potential incident, whether in a clinical or non-clinical environment, in a service user's home, or any other establishment that provides care.

Table 1: A summary of the required action for Group workers to report an incident

1. Prevent a recurrence of the incident
2. Provide or arrange any first aid or medical care as needed
3. Retain and keep all evidence
4. If help is required it must be called for as soon as possible. This may include the police, fire brigade, ambulance service and/or Line Manager or appropriate other
5. If the client is unaware of the incident then they should be advised sensitively, and as soon as possible after the incident
6. All incidents are classes according to 5 levels of severity. An immediate assessment of the incident grade must be undertaken to allow Acacium Group Workers to progress the incident. See Table 2: Incident Grading
7. Incidents must be logged on Datix within 3 working days of the incident except those that are graded moderate and above must be reported within 1 working day of the incident
8. Incidents assessed as moderate or above must be reported immediately to the Group Clinical Director through the line manager/appropriate other or out of hours to the on call manager.
9. Reporting incidents on Datix is not dependent on the time of day. Therefore, accurate reporting is expected at all times. If Datix is not available, see below for a copy of the template. Only facts are to be recorded, including dates and times. Do not record opinions.
10. Accurate record keeping is vital in all elements of care provision and incident management
11. Incident report forms must not be kept in the Client/patient/service user's clinical notes. These should be held centrally in Datix. In case of litigation, incident forms must be retained for a period of 10 years following the closure of an incident.

4. Classification / Grading of Incidents

- 4.1 The classification of an incident by severity and/or consequence determines the procedure for reporting and investigating. All incidents are classified according to five levels of severity. An immediate assessment of the incident grade must be undertaken to allow Acacium Group workers to progress the incident. If in doubt, Acacium Group workers should classify the incident at the higher level. The incident may be reclassified following further assessment, as set out in Table 2: Incident classification/grading

Table 2: Incident classification / grading

Grade	Severity	Description
1	Insignificant	- incidents that have the potential to cause an unintended or undesirable outcome, harm, loss, or damage, are classified as near misses. They are to be investigated and managed by frontline Acacium Group workers - any identified contributory factors and actions taken are recorded, with subsequently identified root causes and actions recorded on Datix. - the person signing off the incident is responsible for ensuring that all actions are completed. Uncompleted actions are reported to the Group Clinical Director - the potential for learning lessons to prevent similar near misses across the organisation must be considered, and disseminated, as appropriate.
2	Minor	- incidents that result in a minor unintended or undesirable outcome, or have no serious consequence, are investigated and reviewed by Acacium Group workers - any identified contributory factors and actions taken are recorded. The identified root causes and actions are then recorded on Datix - the person signing off the incident is responsible for ensuring that all actions are completed and reported to the Group Clinical Director - the potential for learning lessons, to prevent similar occurrences across the organisation are considered, and disseminated, where appropriate.
3	Moderate	- incidents that result in a moderate unintended or undesirable outcome, with no serious consequence, are investigated by the Line Manager / appropriate other. They are then reviewed by the Group Clinical Director - any identified contributory factors and actions taken are recorded. The identified root causes and actions are then logged on Datix. - the Group Clinical Director delegates actions to appropriate personnel who report back when actions are completed. An action plan is drawn up with dates for completion. Uncompleted actions are reported to the business review meetings - lessons learnt to prevent similar occurrences across the organisation are disseminated.
4	Major	- incidents which are serious in nature, or consequence, will be investigated and reviewed by the Group Clinical Director. Any identified contributory factors and actions taken are recorded. The identified root causes and actions are then logged on Datix - the Group Clinical Director delegates actions to appropriate personnel who report back when actions are completed. An action plan is made with dates for completion. Uncompleted actions are reported to the business review meetings - the Group Clinical Director ensures that lessons are learnt to prevent similar occurrences and disseminated across the organisation. All 'Major' incidents are reported to the Board via the Group Clinical Director.

		- incidents graded at level 4 will be graded as a serious untoward incident (SUI) at the discretion of the Group Clinical Director. All level 4 incidents are coordinated by the Group Clinical Director - the Line Manager / appropriate other monitors completion of action plans at a local level and informs the Group Clinical Director on completion.
5	Catastrophic	- incidents that are catastrophic in nature, or consequence, are classified as a SUI. SUIs are investigated and coordinated by the Group Clinical Director - any identified contributory factors and actions taken are recorded. The identified root causes and actions are then logged on Datix - the business review meetings ensures the dissemination of lessons learnt - the Line Manager / appropriate other completes the action plans at a local level and informs the Group Clinical Director on completion - Acacium Group may commission an independent review by an external organisation in order to gain objective learning.

5. Investigation of an Incident

5.1 All Acacium Group workers are expected to support an investigation into an incident as appropriate. Incident investigations must be carried out according to the classification/grading of the incident, which may include some or all of the following processes:

- interviews with the key individuals involved
- interview with the person affected (where appropriate)
- interview with any witnesses if applicable
- inspection of the location of the incident if applicable
- inspection of any equipment involved if applicable
- examination of any physical evidence available if applicable
- review of the appropriate policy or SOP
- review of the personnel healthcare records if applicable

5.1.2 If it becomes clear that an incident is in relation to safeguarding vulnerable adults or children, the incident must be referred to the local safeguarding teams for further investigation, and action. All investigations must be completed and attached as a linked document to the Datix incident report within two months. Less complicated incidents are expected to be completed within a shorter period of time.

5.2 Communication with and the support for Acacium Group workers

5.2.1 Acacium Group is committed to developing a culture which allows Acacium Group workers to raise concerns through appropriate channels, particularly in relation to service user safety. Where Acacium Group workers wish to raise concerns about service user safety they must consult the Acacium Group Policy on Whistleblowing. Following a reported incident, regardless of the severity level, it is essential that Acacium Group workers are appropriately supported by the Line Manager / appropriate other, involved in any subsequent investigation. Acacium Group workers should also be made aware of the investigation outcomes and any recommended changes to practice.

5.3 Communicating with and the support for victims, service users, families, and perpetrators

5.3.1 Acacium Group expects that following any incident those involved in the incident, Acacium Group workers, and service users, will be offered information and support commensurate with the level of

the incident. Where applicable, and with the consent of the service users, families, and carers, the perpetrator is also offered the relevant level of support and information.

Reporting and Grading Incidents

Incident reporting form

This form should only be used for reporting any incidents and accidents, including near misses, when the electronic version of the form, via Datix, is not available.

Once Datix is available online, please ensure all the details of this form are transferred immediately.

Part A – Reporter	
Full Name	
Job Title	
Telephone Number	

Part B – Incident Details	
Date & Time	
Location	
Service	
Description of the incident	
Person Affected	
Worker Details	
Witnesses	
Outcome	
Immediate action	

Who has been informed?	
Who is investigating?	
Name of the manager responsible for managing this incident	

Additional information	
-------------------------------	--

Signature:
Date:

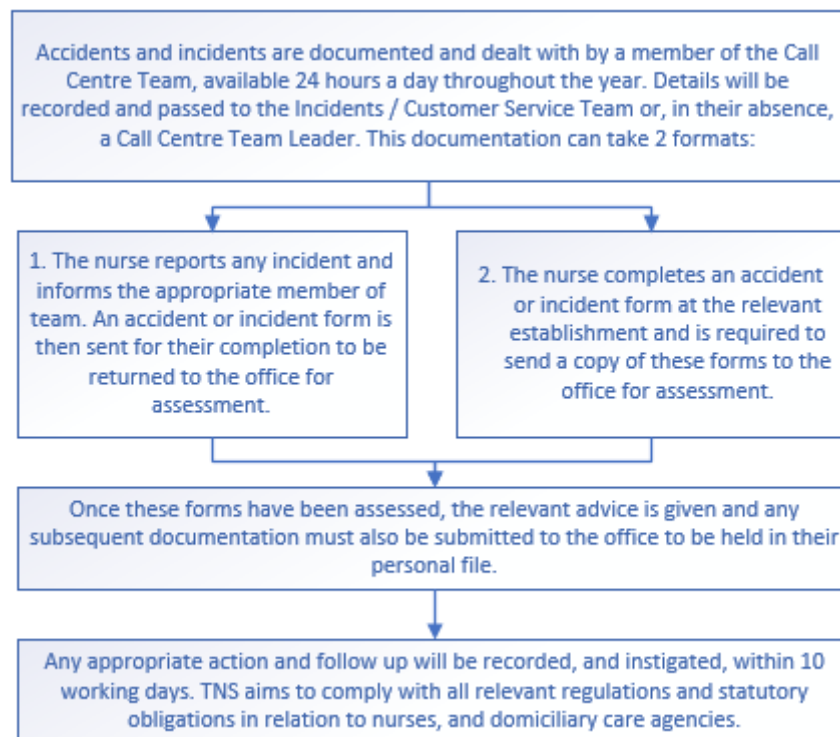
Appendix D: TNS / SNG Reporting Incidents (SOP)

1. Reporting an Incident

1.1 Reporting incidents process and timescales

1.1.1 This process sets out a series of actions to be taken to achieve a consistent approach to the reporting of incidents. This process is a formal document and must be complied with by all TNS / SNG workers. It **must** be read in conjunction with Acacium Group Reporting and Managing Incidents Policy ORG: 05. The flowchart in Table 1 sets out the process of reporting incidents and timescales.

Table 1: Process for reporting incidents and timescales



Appendix E: Regulatory bodies and their role in reported incidents

Regulatory body	Contact details	Role in reported complaints
Care Quality Commission (England)	CQC National Customer Service Centre Citygate Gallowgate Newcastle upon Tyne NE1 4PA Tel: 03000 616161 Email: enquiries@cqc.org.uk Website: www.cqc.org.uk	Although unable to investigate individual incidents, they are keen to hear from people who are not happy about the care that has been provided.
Care Inspectorate (Scotland)	Care Inspectorate Headquarters Compass House 11 Riverside Drive Dundee DD1 4NY Tel: 0845 600 9527 Fax: 01382 207288 Email: enquiries@careinspectorate.com Website: www.scswis.com	If someone is unhappy with the quality of a registered care service and doesn't think it meets the National Care Standards, they will deal with that incident / complaint.
The Regulation and Quality Improvement Authority (Northern Ireland)	RQIA 9th Floor Riverside Tower 5 Lanyon Place Belfast BT1 3BT Tel: 028 9051 7500 Fax: 028 9051 7501 Email : info@rqia.org.uk	Incidents should not be referred to RQIA but to the Ombudsman (www.ni-ombudsman.org.uk) except: • if the agency has failed to comply with the regulations or standards • when there is police involvement • for medication incidents • for safeguarding incidents. A summary of all incidents, outcomes and actions taken will be made available to RQIA upon request.
Care and Social Services Inspectorate Wales	National Office Welsh Government Rhydycar Business Park Merthyr Tydfil CF48 1UZ Tel: 0300 062 8800 Email: ciw@wales.gsi.gov.uk	Although unable to investigate incidents linked to individual circumstances, they are keen to hear from users of services about their experiences and any concerns they may have about the services that are regulated by them. They will direct the complainant to the organisation which is best placed to help.

Information Commissioner's Office	Information Commissioner's Office Wycliffe House Water Lane Wilmslow Cheshire SK9 5AF Telephone: 0303 123 1113 Fax: 01625 524510 ico.org.uk	The ICO is the UK's independent body set up to uphold information rights.
NHS Digital		Data security and protection related incidents. The incident reporting tool for data security and protection incidents (which replaces the IG SIRI reporting tool in the previous information governance toolkit) should be used to report all data security and protection incidents.
Professional regulators Professional misconduct/fitness to practise/competency concerns		There are nine professional regulators: General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, General Pharmaceutical Council, Health and Care Professions Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland.
Health and Safety Executive		Incidents may need to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
Medicines and Healthcare products Regulatory Agency (MHRA)		Incidents related to medicines and medical devices or to blood and blood components Any suspected problems with a medicine or medical device should be to the MHRA using the Yellow Card Scheme.
Care Quality Commission (CQC), March 2010. Essential standards of quality and safety – updated 2015 to Fundamental Standards		Regulator standards. The CQC 13 Fundamental standards are the standards below which care must never fail

Appendix F: Internal Investigation report template

Internal Investigation Report

Author

Date

1.0 Background and Context

2.0 Detection of the incident

3.0 Investigation Team

4.0

Organisation	Name	Job Title

5.0 Scope of the Investigation

6.0 Chronology of Events

7.0 Investigation Findings

8.0 Conclusion

9.0 Notable Practice

10.0 Lessons Learned

11.0 Recommendations

12.0 Action Plan for Recommendations

13.0 Arrangements for sharing learning from the investigation

18.0 Action plan

Action	Evidence	By whom	By when	Date completed

Appendix G: Patent Safety Investigation Report template

Investigation Report

Author

Date

1. Background and Context

2. Investigation

Investigator qualifications and experience

Investigation

3. Documents

	Document title	Sourced by	Doc ID

4. Investigation Team

Organisation	Name	Job Title

5. Scope and Level of Investigation
6. Investigation Methodology
7. Involvement and Support of Patients / Relatives
8. Chronology of Events
9. Detection of incident
10. Investigation Findings
11. Outcome
12. Conclusion
13. Notable Practice
14. Lessons Learned

15. Care Delivery Problems, Learning and Recommendations

Care delivery problem: They arise in the process of care, usually actions or omissions by members of staff. They have two essential features a) care deviated beyond safe limits of practice b) the deviation had at least a potential direct or indirect on the eventual adverse outcome for the patient, member of staff or "general public"

Care Delivery Problem 1	
Detail	Learning
Recommendation(s)	

Care Delivery Problem 2	
Detail	Learning
Recommendation(s)	

Care Delivery Problem 3	
Detail	Learning
Recommendation(s)	

Care Delivery Problem 4	
-------------------------	--

Detail	Learning
Recommendation(s)	

Care Delivery Problem 5	
Detail	Learning
Recommendation(s)	

16. Contributory factors, Learning and Recommendations

Definition of a contributory factor:

Contributory factors may be considered to either influence the occurrence or outcome of an incident, or to actually cause it. Generally speaking, the removal of the influence may not always prevent incident recurrence but will generally improve the safety of the care system; whereas removal of 'root causes' will be expected to prevent or significantly reduce the chances of recurrence.

Contributory Factor 1	
Detail	Learning
Recommendation(s)	

Contributory Factor 2	
Detail	Learning
Recommendation(s)	

17. Root Causes. Learning and Recommendations

Definition of root cause:

The prime reason(s) why an incident occurred. Removal of these will either prevent or reduce the chances of a similar type of incident from happening in similar circumstances in the future.

Root Cause	
Detail	Learning

Recommendation(s)			
Root Cause			
Detail			Learning
Recommendation(s)			

18. Arrangements for sharing learning from the investigation

19. Action Plan

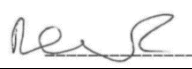
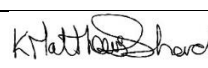
Action	Evidence	By whom	By when	Date completed

Appendix H: PSIRF Plan

Patient safety incident response plan

Effective date: 01 May 2024

Estimated refresh date: 01 May 2025

	NAME	TITLE	SIGNATURE	DATE
Author	Anna Langthorne	Group Deputy Chief Nurse		22 April 2024
Reviewer	Jo Cousins	Group Chief Nurse	JmCousins	22 April 2024
Authoriser	Karen Matthew-Shard	Global Clinical Director		1 May 2024

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1. Introduction

This patient safety incident response plan sets out how Acacium Group intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. Patient safety investigations are carried out to identify circumstances and systemic causes and casual factors that contribute to a patient safety incident.

We will integrate the 4 aims of the Patient Safety Investigation Framework: -

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

Our commitment is to ensure that we will provide a systematic, compassionate and timely response.

2. Our services

Acacium Group is a leading global healthcare delivery system with over 35 years' experience. Acacium Group has a purpose focused on improving people's lives through expert healthcare, social care and life sciences. Acacium Group's vision is to become the leading global healthcare solutions partner, differentiated in the way we combine our scale and insight in deploying temporary workforce, with technology, process management and clinical oversight to deliver the right outcomes for clients, patients and service users alike.

3. Defining our patient safety incident profile

Acacium Group has implemented the Patient Safety Incident Response Framework (PSIRF) which sets out the NHSE approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety. This replaces the Serious Incident Framework.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Responses to PSIRF follow a systems-based approach. This recognises that patient safety is a complex response. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of PSIRF.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as require.

5. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Our plan sets out how Acacium Group intends to respond to patient safety incidents. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected.

6. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every year to ensure our focus remains up to date; with ongoing improvement work to our patient safety incident profile.

We will do this by

- Focussing on the quality-of-service delivery by the adherence to local and national quality standards
- Protecting the rights, dignity and confidentiality of our patients, service users, customers and staff
- Providing person centric care and treatment that is relevant to individual needs
- Engaging with our service users/patients and customers to deliver a positive experience.
- Provide the best possible outcomes through the delivery of clinical excellence.
- Protect the health and safety of our service users/patients, customers and employees.
- Deliver the service with respect and empathy.
- Complying with relevant regulatory and governing bodies.
- Continually monitor by means of feedback and audit.
- Preventing incidents through proactive risk management.

To achieve this Acacium Group will ensure that:

- Our leadership team have an unwavering commitment to improving quality
- That we have a culture of improvement, encouraged by leaders at all levels
- We will systematically give people the skills to deliver improvement
- We put patients, service users, customers and staff at the centre of improvement

Our key priorities:

- Putting patient experience more clearly at the heart of what we do
- Improving client, patient, and service user experience

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- Securing outstanding reputation with the regulators
- Developing robust clinical pathways as our business evolves

Our quality improvement approach has six core elements that underpin the strategy. This is how we deliver on our priorities. They are:

- Understanding what is happening in our organisation
- Giving people the skills to enable improvement
- Working collaboratively within the organisation
- Embedding an empowered culture of quality
- Clear priorities and plans for improvement
- The right leadership

When defining new contracts as part of this all stakeholders are involved in agreeing KPI's that must be met and these are measured in contract review meetings.

Each business has a Quality and Safety Meeting that is chaired by either the Group Chief Nurse, or in their absence the Group Deputy Chief Nurse. The output of these meetings is then feedback to the Global Clinical Director and then to the Board during the Governance Review.

Within each business the Clinical Lead/Chief Nurse has a separate clinical improvement plan based on their incident and complaint data. This is also discussed at the Quality and Safety Meetings and is a standing agenda item.

7. Defining our patient safety improvement profile

Patient Safety Incident	Where monitored	Anticipated improvement route
Individual Businesses report their incident and complaint date	Quality and Safety Meetings	Improvements or assurances would be reported and provided during these meetings
Monitoring of quarterly trends and themes	Quality and Safety Meetings	Assurance around themes and trends would be given through the Quality and Safety Meetings and then within the Governance Report to the Global Clinical Director and Board
PSIRF knowledge for staff	PSIRF training is available both face to face and via the E-Learning Platform	
Local Templates for PSIRF Improvement Plans	Each business will have their own plan	This will be monitored through the Quality and Safety Meetings
Monthly Complaints and Incidents meetings held	Monthly meeting with the complaints and incident team to ensure any issues/themes are picked up in between Quality and Safety Meetings	

Patient safety incident type or issue	Planned response	Anticipated improvement route
Pressure Damage reported within Community Business	Quality Assurance report	Reported through the Business Review Meetings and the Quarterly Quality Review Meetings

Admission to Hospital	Quality Assurance Report	Reported through the Business Review Meetings and the Quarterly Quality Review Meetings
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