



Department of
**Health, Social Services
and Public Safety**

An Roinn
**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports

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Working for a Healthier People

Introduction

This work has been commissioned by the DHSSPS Safety in Health and Social Care Steering Group as part of the action plan contained within “*Safety First: A Framework for Sustainable Improvement in the HPSS*” (under 5.1.2 Agreeing Common systems for Data Collection, Analysis and Management of Adverse Events). The following work forms part of an on-going process to develop clarity and consistency in conducting investigations and reviews. This is an important aspect of the safety agenda.

This template and guidance notes should be used, in as far as possible, for drafting all HSC incident investigation/review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports. It should assist in ensuring the completeness and readability of such reports. The headings and report content should follow as far as possible the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

All investigations/reviews within the HSC should follow the principles contained within the National Patient Safety Agency (NPSA) Policy documents on “*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*”.

http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

It is also suggested that users of this template read the guidance document “*A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises*” – Regional Governance Network – February 2007.

http://www.dhsspsni.gov.uk/microsoft_word_-_hss_sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

This template was designed primarily for incident investigation/review however it may also be used to examine complaints and claims.

The suggested template can be found in the following pages.

Template Title Page

Date of Incident/Event

**Organisation's Unique Case Identifier (for
tracking purposes)**

Introduction

The introduction should outline the purpose of the report and include details of the commissioning Executive or Trust Committee.

Team Membership

List names and designation of the members of the Investigation team. Investigation teams should be multidisciplinary and should have an independent Chair. The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident. However, best practice would indicate that investigation / review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice. In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered. There may be specific guidance for certain categories of adverse incidents, such as, the Mental Health Commission guidance http://www.dhsspsni.gov.uk/mhc_guidance_on_monitoring_untoward_events.pdf

Terms of Reference of Investigation/Review Team

The following is a sample list of statements of purpose that should be included in the terms of reference:

- To undertake an initial investigation/review of the incident
- To consider any other relevant factors raised by the incident
- To agree the remit of the investigation/review
- To review the outcome of the investigation/review, agreeing recommendations, actions and lessons learned.
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the investigation.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

Summary of Incident/Case

Write a summary of the incident including consequences. The following can provide a useful focus but please note this section is not solely a chronology of events

- Brief factual description of the adverse incident
- People, equipment and circumstances involved
- Any intervention / immediate action taken to reduce consequences
- Chronology of events
- Relevant past history
- Outcome / consequences / action taken

This list is not exhaustive

Methodology for Investigation

This section should provide an outline of the methods used to gather information within the investigation process. The NPSA's "Seven Steps to Patient Safety" is a useful guide for deciding on methodology.

- Review of patient/ service user records (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
 - Organisation-wide
 - Directorate Team
 - Ward/Team Managers and front line staff
 - Other staff involved
 - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Engagement with patients/service users / carers / family members
- Review of Trust and local departmental policies and procedures
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

Analysis

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care provided.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors investigated and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful.

www.npsa.nhs.uk/health/resources/7steps

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

Conclusions

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any ongoing engagement / contact with family members or carers.

Involvement with Patients/Service Users/ Carers and Family Members

Where possible and appropriate careful consideration should be made to facilitate the involvement of patients/service users / carers / family members.

Recommendations

List the improvement strategies or recommendations for addressing the issues above. Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions. Recommendations should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions.

- Local recommendations
- Regional recommendations
- National recommendations

Learning

In this final section it is important that any learning is clearly identified. Reports should indicate to whom learning should be communicated and copied to the Committee with responsibility for governance.

Further Reading

A Protocol for the Investigation and Analysis of Clinical Incidents. Clinical Risk Unit, University College London and ALARM (September 1999).

A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises – Regional Governance Network – February 2007
http://www.dhsspsni.gov.uk/microsoft_word_-_hss_sqsd__18-07_patient_service_review_guidelines_-_final_feb07.pdf

Being Open. Communicating Patient Safety Incidents with Patients and their Carers. The National Patient Safety Agency, 2005.
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

Circular HSS (PPM) 06/2004 -Reporting and Follow-up on Serious Adverse Incidents: Interim Guidance

Circular HSS (PPM) 05/2005 – Reporting of Serious Adverse Incidents

Circular HSS (PPM) 2/2006 – Reporting and Follow-up on Serious Adverse Incidents.

Circular HSS (MD) 12/2006 – Guidance Document – How to classify Incidents and Risk

SAI Reporting Template from 1st April 2007 (PDF 20 KB) - Reporting and Follow-up on Serious Adverse Incidents
<http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm>

Confidentiality: Protecting and Providing Information. General Medical Council 2004

Decision making tool to reduce unnecessary suspensions and support a safety culture – The National Patient Safety Agency
www.npsa.NHS.uk/idt

Dineen, M 2002, Six Steps to Root Cause Analysis, *Consequence UK Ltd.* Oxford.

Doing Less Harm; Improving the Safety and Quality of Care through Reporting, Analysing and Learning from Adverse Incidents, Department of Health and The National Patient Safety Agency, 2001

Mental Health Commission for Northern Ireland: Monitoring of Untoward Events by the Mental Health Commission (Revised Guidance) S6/2006 April 2006.

Managing risk and minimising mistakes in services to children and families, (SCIE: Children and Families' Services Report 6) 2005, <http://www.scie.org.uk/publications/children.asp>

Memorandum of Understanding Investigating patient or client safety incidents (Unexpected death or serious untoward harm) DHSSPS, PSNI, Coroners Service and HSENI, February 2006

Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults DHSSPS & PSNI 2003

Protocol for Joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – NI September 2004

Root Cause Analysis: Simplified Tools and Techniques, Anderson B, Fagerhaug T Quality Press, Milwaukee, 2000.

Seven Steps to Patient Safety A guide for NHS staff SSG/2003/01 - The National Patient Safety Agency, April 2004 (including the RCA tool kit) www.npsa.nhs.uk/health/resources/7steps

Managing risk and minimising mistakes in services to children and families, (SCIE: Children and Families' Services Report 6) 2005, <http://www.scie.org.uk/publications/children.asp>

Milne R and Bull R (2000) Investigative Interviewing, Psychology and Practice, Wiley J and Sons, Chichester, 1999

Taylor-Adams S.E et al, *Long Version of the CRU/ALARM Protocol: Successful Systems Event Analysis* (2002)