London Ambulance Service NHS Trust

Investigation of Incidents, PALs, Complaints and Claims Policy

DOCUMENT PROFILE and CONTROL

Purpose of the document: This policy aims to define the method of analysis of incidents, claims and complaints and other reportable events to be used by those investigating them.

Sponsor Department: Corporate Services

Author/Reviewer: Assistant Director Corporate Services. To be reviewed by June 2013.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
05/10/10	1.1	Governance and Compliance Manager	Reformat
04/06/10	0.5	Head of Governance	Further additions
28/05/10	0.4	Head of Governance/ Director of Corporate Services/Head of Records	Fourth draft
24/03/10	0.3	Head of Governance	Third draft
24/03/10	0.2	Head of Governance	Second draft
24/03/10	0.1	Head of Governance	First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

For Approval By:	**Date Approved**	**Version**
SMG	09/06/10	1.0
Ratification (If appropriate):		

Published on:	**Date**	**By**	**Dept**
The Pulse	08/10/10	Governance Administrator	GCT
LAS Website	08/10/10	Governance Administrator	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB	15/06/10	Records Manager	GCT

EqIA completed on	**By**
03/06/10	EqIA team (see doc)
Staffside reviewed on	**By**
	Staffside Representative

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/006	Serious Untoward Incident (SUI) Policy (TP006)	
	Disciplinary Policy	
	Dealing with Unacceptable Behaviour Policy	
	Conduct, Capability and Ill Health and Appeals Policy and Procedure	
	Capability Policy	
	Policy for Managing Concerns about the Performance of Independent Contractors	
	Independent Medical Practitioners Review Process	
TP/034	Being Open Policy	
HS/011	Incident Reporting Policy	
TP/033	Complaints Policy	12/03/10
HR07/22	Whistle-blowing Policy	
	Care Quality Commission Registration Requirements	
	NHSLA Risk Management Standards for Ambulance Trusts 2010/11. Standard 5. Criterion for Investigations.	
	London Ambulance Service Trust - Equality Impact Assessment Guidance and Form.	
TP005	Risk Management Policy & Strategy	
TP049	Risk Assessment & Risk Register Procedure	
TP013	Claims Handling Policy & Procedure, including guidance on witness statements	12/03/10
TP015	Procedure for responding to enquiries and giving evidence at coroners inquests and statements at police interviews	
TP016	Habitual or Vexatious Complaints or Enquiries Policy	25/02/10
TP055	Investigation of Incidents, PALS, Complaints and Claims Policy	
TP023	Driving and Care of Service Vehicles	
TP056	Core Training Policy (inc.TNA)	

1. Introduction

This policy demonstrates the commitment of the London Ambulance Service NHS Trust to providing high quality healthcare to all our patients, improving safety by learning lessons from the investigation and analysis of incidents, complaints and claims.

Every day incidents, complaints and claims occur which may affect individuals, specific areas of London Ambulance Service NHS Trust (from hereon referred to as 'the Trust') or the Trust as a whole. By analysing such occurrences the Trust recognises that it can identify and address areas of poor performance, system failures, violation of procedures, and ensure lessons are learnt and practice or systems are changed appropriately in both clinical and non-clinical areas.

When incidents, complaints or claims occur it is important to ensure rapid, thorough and co-ordinated follow up so that appropriate reports and/or witness statements are produced as soon as possible whilst staff can still recollect accurate details relating to a specific event.

The Trust is committed to achieving this standard as part of its overall Risk Management Policy and Strategy. Factual, comprehensive and well - formatted reviews, reports and witness statements are crucial to enabling the Trust to maximise both its opportunities for identifying and learning from root causes of problems and in providing timely, quality information for reference should they be required at a later date.

The Trust will ensure that it complies with all legislative requirements that apply to the investigation of incidents, complaints and claims.

In order to ensure that the Trust maximises the learning potential when an incident, complaint or claim occurs it will support the use of Root Cause Analysis (RCA) as an investigation technique. The times at which the Trust expects RCA to be used are identified within the Policy.

This document must be read in conjunction with the Risk Management Policy and Strategy, Incident Reporting Procedure, Complaints and Feedback Policy, and Claims Handling Policy and Procedure, all of which contain investigation details specific to that particular type of event.

The Trust is committed to treat all feedback it receives with the same degree of seriousness, with a focus on the issues raised and how these can be addressed in keeping with the Making Experiences Count Programme. The Trusts approach to feedback in relation to incidents is set out in the Complaints and Feedback policy which should be read in conjunction with this document.

2. Scope

This document describes the rationale for investigating incidents, complaints and claims and the processes through which Trust managers are required to undertake investigations, the actions which must be taken when an incident, complaint or claim occurs and the approach used by the Trust to subsequently learn from investigations. The process for the dissemination of this learning and outcomes throughout the Trust, and the wider health community where appropriate, is also addressed.

3. Objectives

1. To guide the investigation of incidents claims and complaints and other reportable events with a common approach and establish clear pathways for the dissemination of learning and best practice

2. To provide guidance for all staff so that the analysis generated by investigations enables the Trust to identify and address poor performance, system failures, violation of procedures and ensure lessons are leant and practices or systems are changed appropriately in clinical and non –clinical areas.

4. Responsibilities

4.1 Trust Board

The Trust Board must satisfy itself that appropriate steps are taken throughout the organisation to learn from investigations into incidents, complaints and claims, to minimise harm and to avoid recurrence. In pursuit of these objectives it:

- receives and reviews regular reports on SUIs that have occurred and monitors the actions which have followed;
- receives and reviews reports on the number of incidents and SUIs, PALs & complaints, and claims;
- the Trust Board will review inquests that the organisation is specifically involved in as appropriate
- approves actions that should be taken to address any issues or concerns identified

4.2 Chief Executive

The Chief Executive is responsible for:

- setting a standard for the entire organisation;

- demonstrating commitment to a patient safety culture and to the Trust's non-punitive approach;
- ensuring that all Directors demonstrate the same commitment through their own actions;
- ensuring that there is an effective system in place to ensure that all investigations are dealt with effectively and appropriately;
- confirming the need for a special investigation team.

4.3 Quality Committee

- The Quality Committee receives a report containing aggregate incident, complaints and claims data. This report identifies the 'corporate themes' of the aggregate data, as well as identification of more specific trends and assurance that lessons have been learned following an investigation.

- The Quality Committee does not have a responsibility to monitor that specific actions arising following an investigation into an SUI have been completed, as this will be overseen by the Clinical Quality Safety & Effectiveness Committee or the Risk Compliance & Assurance Group. It is responsible for ensuring that the relevant committee is monitoring the action plan and will therefore need to receive regular updates regarding the progress made.

4.4 Designated Board Member

The Director of Corporate Services has delegated responsibility for corporate governance and risk management. The Director of Corporate Services will report to the Trust Board on matters relating to this policy.

4.5 Medical Director/Deputy Chief Executive/Director of Finance

The above post-holders will:

- ensure root cause analysis is undertaken for all SUIs, and for others where appropriate, and will support the staff and those involved in any incident, complaint or claim through the process;
- prepare the report following any root cause analysis undertaken and ensure any risks identified are reassessed and reviewed, and recommendations are implemented and monitored;
- provide support and guidance for any manager undertaking an investigation, or any member of staff involved in an investigation, as appropriate;
- ensure that learning from incidents, complaints and claims is shared throughout the organisation, as agreed by the Learning from Experience Group or a risk management committee;

4.6 Learning from Experience Group

The role of the group is to provide a co-coordinated and focussed approach to the review of incidents, PALs, complaints and claims thereby ensuring the

Trust learns from these resulting in improvements for patients, carers and staff.

4.7 Senior Management

The Assistant Director of Corporate Services (Governance and Compliance) has responsibility for implementing this policy.

Day to day implementation of this policy is delegated to the Head of Legal Services, the Head of Patient Experiences and the Head of Safety and Risk.

4.8 Head of Patient Experiences/Head of Legal Services/Head of Risk & Safety

The above post-holders will:

- ensure root cause analysis is undertaken for all SUIs, and for others where appropriate, and will support the staff and those involved in any incident, complaint or claim through the process;
- prepare the report following any root cause analysis undertaken and ensure any risks identified are reassessed and reviewed, and recommendations are implemented and monitored;
- provide support and guidance for any officer undertaking an investigation, or any member of staff involved in an investigation, as appropriate;
- ensure that learning from incidents, complaints and claims is shared throughout the organisation, as agreed by the Learning from Experience Group or a risk management committee;

4.9 Role of designated managers and officer

Designated managers will:

- receive training in the role of investigating officer and the management of SUIs;
- act as investigating officer, or will designate another manager to assume this role;
- ensure that staff involved in an investigation are made aware of the process that will be followed and the support that is available to them, should they require it;
- identify possible areas of improvement or any corrective action required;
- draw up and/or approve the action plan(s) arising from the findings or recommendations of investigations;
- take the necessary steps to ensure that recommendations following investigation are implemented and that learning is shared across Complexes/throughout the Trust.

4.10 Role of Heads of Department

Heads of department and local managers must ensure full cooperation with investigations and lead on investigations at the request of the designated manager/investigating officer. They would normally be expected to undertake investigations for incidents with a risk rating of 6 or less.

4.11 Lead teams

As the lead teams the Governance and Compliance, Safety and Risk, Legal Services and Patient Experience departments are responsible for:

- making sure that appropriate competent investigating officers are appointed to investigate all untoward events;
- producing aggregated data relating to untoward incidents, complaints and claims is analysed and any trends or themes identified and communicated to all relevant individuals or groups
- supporting the development of appropriate action plans are by respective directorate/departments and monitored effectively
- communicating all organisational learning points to internal and external stakeholders.

4.12 All Staff

- are responsible for highlighting any risk issues which could warrant further investigation;
- must co-operate with investigations, by providing information requested from them to the investigator in a timely manner, and respond openly;
- must maintain confidentiality in relation to incidents, complaints and claims and their subsequent investigation;

4.13 Clinicians/Specialist Advisers

Clinicians and specialist advisers:

- will be approached at the request of the investigating manager/team;
- will have as much information communicated to them as is necessary to facilitate an adequate response;
- will be requested to provide explanations of terms or scenarios as part of the investigation process and are required to respond in a timely manner using terminology in their responses that can be interpreted by the investigating manager/team;
- must maintain confidentiality in relation to incidents, complaints and claims which they are being consulted about, unless they are asked to discuss the issue with a wider audience;

5. Definitions

Investigation: an authorised, systematised, detailed examination or inquiry to uncover facts and determine the truth of a matter. This may include collecting, processing, reporting, storing, recording, analysing, evaluating, producing and disseminating the authorised information. The purpose of an investigation is to determine:

- the full facts, with respect to the sequence of events that led to the incident;
- what was well-managed;
- what, if anything, went wrong and to identify issues of concern;
- the 'root causes';
- the actions required to prevent recurrence;

Root cause analysis: a structured investigation that aims to identify the true cause of a problem and the actions to eliminate it;

External agency: statutory and non-statutory bodies with a legitimate interest in the Trust.

6. INVESTIGATION AND ROOT CAUSE ANALYSIS

6.1 Identifying which incidents, complaints or claims need to be investigated

6.1.1 The Trust recognises and accepts the benefits that effective investigation into incidents, complaints and claims has. However, it does not have the resources to undertake a full root cause analysis for every investigation that is required, therefore a system exists which enables the Trust to adjust the level of investigation required based on the risk rating.

6.1.2 Table 1 overleaf identifies the level of investigation required and the person responsible for either assigning the lead investigator or undertaking the investigation. The Risk Scoring Matrix, which is used to identify levels of risk that are faced by the Trust, is shown in Appendix 1.

6.1.3 Specific timescales for the completion of investigations into incidents, complaints and claims can be found in the relevant policies (full titles shown in Section 1).

Table 1

Risk Rating	SUI[1] Status	Responsibility for Investigation			Level of Investigation Required
		Incident	Complaint	Claim	
High Risk (score 15-25)	SUI	Lead investigator to be appointed by the Chief Executive/Deputy Chief Executive/ Director of Corporate Services/Medical Director/Director of Operations (also known as the SUI Group)			Root Cause Analysis
Significant Risk (score 8-12)	Not an SUI	AD Corporate Services or Head of Safety & Risk	AD Corporate Services or Head of Patient Experience	AD Corporate Services or Head of Legal Services	Root Cause Analysis to be considered
Moderate Risk (score 4-6)	Not an SUI	AD or Senior Manager	ADO or Senior Manager	ADO or Senior Manager	Standard investigation
Low Risk (score 1-3)	Not an SUI	Head of Services or Senior Manager	Head of Services or Senior Manager	Head of Services or Senior Manager	Standard investigation

7. Key Issues

7.1 Why is investigation necessary?

Investigations are necessary to provide a retrospective review of events to find out what, why, how, and when they happened. This analysis enables the Trust to identify areas for change and recommend actions and sustainable solutions to help minimise re-occurrence in the future.

7.2 Why is learning and sharing lessons important?

Learning from experience is vital for delivery of safe and effective care to all our patients. To avoid repeating mistakes the Trust must learn from previous similar events. Effective learning is only properly delivered using all trust communication systems (i.e. Intranet, LAS News, Staff conferences, Chief Executive's consultation meetings) to relay the outcome of investigations and team working to ensure the development of practical plans for improving safety.

7.3 The need for effective communication

As part of the investigation process it is important for the Trust to engage with patients, staff and the public (as appropriate) during the investigation in an open and honest manner (see TP/034 Being Open Policy).

7.4 Supporting patients, carers, relatives and staff

Being involved in an incident, complaint or claim which is under investigation can be an incredibly stressful experience. The Trust has a range of counselling and support mechanisms (LINC support scheme, staff support team) that actively help patients, carers, relatives and staff during this difficult time.

8. Staff Training

8.1 All new staff will be given risk awareness training as part of their induction programme. This includes risk assessment, incident reporting and investigation as appropriate. Refresher training will be given as detailed in the Training Needs Analysis (TNA).

8.2 Additional training will be provided as set out in the TNA, to managers and team leaders on conducting investigations of incidents, complaints and claims. This training will be provided with input from the Patient Experiences, Safety and Risk and Governance and Compliance teams and include the following: Statement taking; Investigation techniques; Root case analysis and Report writing.

9. Key components of a standard investigation

9.1 Investigation process

See Appendix 2 (Process for Investigating Incidents, Complaints and Claims).

- Establish and record the basic facts about the incident and collect evidence.
- Identify the names of the people present at the time of the incident (including contact details), so that statements can be obtained (at the earliest opportunity).
- Identify all equipment that was potentially involved in the incident (equipment should be taken out of use if safe and appropriate to do so);

- If possible, and where appropriate, take photographs or make sketches of the incident scene (as this will provide a permanent record of the scene).
- Identify people to be interviewed, e. g., those directly involved in the case, witnesses or those who have expert knowledge, and conduct interviews (See Appendix 3).
- Assemble and consider the evidence and record as a “chronology of events”.
- Analyse all the facts and evidence against relevant standards, policies, protocols, guidelines or professional practice (local or national).
- Draw conclusions about what caused the incident, looking past the immediate causes or active failures and digging deeper for the underlying or latent failures.
- Agree timescale for feedback with interested parties, e. g., claimant, patient, other stakeholders and all those involved in the investigation.
- Review the need to inform external agencies, such as enforcing agencies e.g. NPSA, CQC, SHA, NHSLA etc., as appropriate in an investigation.
- Record findings and recommendations on the Incident Investigation Form (See Appendix 4).
- Draft a report dealing with all aspects of the case, the findings made as a result of the investigation, lessons learnt and steps to avoid reoccurrence.
- Develop action plans with timescales and responsibilities.
- Debrief staff.

9.2 Root Cause Analysis

Root Cause analysis is the process of examining what happened in order to establish how and why it occurred. It should result in preventative measures to ensure that it does not happen again and that the risk is removed or reduced.

All “High Risk” rated incidents should be subject to Root Cause analysis and it should be considered for “Significant Risk” (See Appendix 1 Risk Matrix).

Use the Root Cause Analysis Flowchart (Appendix 5), with the following stages:

- Information Gathering
- Information Mapping
- Identifying problems
- Identifying contributing factors (use Appendix 6 NPSA contributory factors framework)

- Agreeing root cause
- Recommending and reporting

By taking into account the above issues the investigation should highlight where there are areas of poor performance/practice, system failures, violation of procedures or the need for change in clinical or non-clinical practice.

9.3 Gathering the Information

The first stage of the investigation process is to establish the basic facts (appendix 2). This will help to identify, at an early stage, whether or not specialist advice or guidance may be required from either internal or external sources.

Factual information should be gathered as soon as possible after an event, whilst people can still accurately recollect what happened and when.

9.3.1 From people:

- Witness statements (see Appendix 7 for guidance) should be obtained from all those who were involved in the incident, complaint or claim.
- It may be appropriate to interview people involved in an incident, complaint or claim (see Appendix 3 for guidance on conducting an interview). All staff must be advised of the availability of support (e.g. from a Union Representative) during the interview process.
- Statements should be obtained from anyone present, whether they saw the incident/circumstance about which a complaint is being made or not, if appropriate.
- Statements should be obtained from other relevant persons who may have information that influences the investigation (e.g. external contractors).

9.3.2 From the environment:

Records should be made about the physical environment at the time of the incident, where appropriate (e.g. lighting, temperature, available space, positioning of relevant equipment, road conditions).

9.3.3 Documentary evidence

Examples of documentary evidence that should be collected are policies and procedures, pre- and post-risk assessments, patient records, training records, relevant incident forms, maintenance records, safe systems of work, correspondence.

9.4 Mapping the events

9.4.1 It is important to gather the facts as soon as possible after an incident, claim or complaint has happened.
Mapping the chronology of events will start to identify gaps in knowledge and/or systems.

9.4.2 A timeline should be used to document this chronology, as it will also allow for the identification of information gaps and any critical problems that arose.

9.4.3 Information should be sort to clarify what actually happened and not to allocate blame.

9.4.4 Where the investigator identifies any information gaps or critical problems they should be followed up and included in the final investigation report.

9.5 Identifying and analysing contributory factors to the Incident/Complaint/Claim

9.5.1 When all of the relevant sources of evidence have been gathered then the contributory factors, including 'root causes', must be identified.

9.5.2 At this stage of the investigation the aim is to identify what, where, why and how the incident occurred, looking at the fundamental causes of the incident, complaint or claim and not just the obvious causes (that can simply be attributed to human error).

- Identify the organisational, management and institutional factors that may have contributed to the event (e.g. lack of documents to guide practice, lack of risk assessments, lack of equipment, lack of training);
- Identify any error producing conditions (e.g. staff shortages, poor working conditions, poor communication);
- Identify any violation producing conditions (e.g. poor management culture (violations occurring without being addressed), lack of supervision of untrained staff);
- Identify any unsafe acts completed that conflicted with Policy, procedures, training or best practice;

9.5.3 The purpose of the subsequent analysis is to identify what happened, why it happened, how did it happen and how can it be prevented from happening again. The aim of the analysis is to determine what lessons can be learned for the Trust and what changes will be made to improve practice and reduce future risks or reoccurrence.

9.5.4 The person investigating the incident, complaint or claim should aim to ask the question 'why (did something happen)' until the answer is no longer meaningful. Each stage of the analysis should be recorded.

9.5.5 The analysis is only complete when the investigator has identified both the obvious causes (for an action or event) and the contributory underlying (root) causes to be identified. The root causes will typically be management factors.

It must be recognised that the cause of an incident, complaint or claim cannot usually be attributed to one particular cause or event.

9.5.6 Barrier Analysis

An alternative technique to Root Cause Analysis is "Barrier Analysis" which can be used to establish what barriers, defences or controls should have been in place to prevent the accident or could be installed to increase system safety. Examples of Barrier Analysis questions are "Why did the barrier fail? Was it natural, physical, human action or administrative barrier? What else could be put in place?" Barrier analysis can offer a structured way to visualise the events related to system failure, help identify missing or failed barriers, and help evaluate proposed corrective actions by assessing the strengths of the current controls.

9.5.7 Developing solutions and an action plan for implementation

- The investigation process will include making recommendations. These recommendations focus on reducing the level of risk identified.

- Each recommendation will be supported as part of an action plan with the person responsible for taking the action identified, a date for completion and a director or committee for monitoring the implementation.

- In the case of an SUI the Assistant Director of Corporate Services/Head of Patient Experiences/Head of Legal Services (on a daily basis)/Learning from Experience Group/Risk Compliance and Assurance Group/Clinical Quality, Safety & Effectiveness Group, as appropriate, will be responsible for monitoring the implementation of the action plan.

- Where the incident is not deemed to be an SUI then it will be the responsibility of the Assistant Director of Corporate Services or Head of Patient Experience/Head of Legal Services to monitor implementation of the action plan and to report progress and outcomes to the Learning from Experience Committee.

9.5.8 Completing a Report

The investigation report should be a document that identifies all of the factors involved in an incident. The document should encompass all the information that has been collated during the investigation

including, for example, photographs, training records, maintenance records.

The final document could be used as evidence at a later date and may be requested by enforcing authorities, such as the Health and Safety Executive or the Health Service Ombudsman.

The investigation report must include the following details as a minimum requirement:

- Purpose of the report;
- Author of the report;
- A list of staff, patients and anyone involved in the incident;
- Full factual account of the incident, including a detailed chronology of events;
- Background information about the affected person (e.g. patient's clinical details, staff history);
- Findings of the root cause analysis (both positive and negative);
- Recommendations and action plans;
- How the root cause analysis reports and recommendations will be monitored by the Learning from Experience Group/Clinical Quality, Safety & Effectiveness committee or the Risk Compliance & Assurance Group
- How the Board will be given assurance that remedial actions are being taken.

The timescales for completion of investigation reports are identified in the Serious Untoward Incident Policy, Incident Reporting Procedure, Complaints and Feedback Policy, and Claims Handling Policy and Procedure.

10. Risk Assessment and Risk Register.

Risks identified during the investigation process should be individually risk assessed. This is done on the basis that until the action plan that is developed following the investigation is implemented, a potentially unacceptable level of risk exists.

Risks that are assigned a risk rating of 15 or above must be included on the Corporate Risk Register and notification of this must be made to the Governance & Compliance Manager. In the case of an SUI it is likely that the

SUI will appear on the Corporate Risk Register as an entity, until such time that the entire action plan has been implemented.

Risks with a rating of below 15 identified during any investigation, regardless of the level of investigation, must be included on the relevant local risk register until such time that the action plan has been fully implemented.

11. Performance management and data collection

Details of all reported adverse incidents (including no harm events), informal and formal complaints and claims are recorded onto central database (DATIX). Aggregated analysis of incidents, complaints and claims is undertaken monthly and reported to the appropriate group or committee, e. g., Clinical Quality Safety and Effectiveness committee, Learning from Experience group, Quality Committee. This analysis allows for identification of trends and themes for areas where changes in practice and organisational culture must be implemented.

12. Reports to the Nominated Committee and the Board

Ad hoc reports may be submitted to the Quality Committee and/or the Risk Compliance & Assurance group where trend analysis has identified a significant risk. Significant trends or individual cases will be reported immediately to the Quality Committee and the Trust Board.

13. Learning from Experience

All SUIs will be reported to the Quality Committee, who will be ultimately responsible for ensuring that action plans are implemented and that learning is being shared throughout the organisation. Investigation reports will be shared with North West London Commissioning Partnership, who will provide onward notification to NHS London, and the investigation reports for SUIs that have been declared following an incident will also be shared with the Trust from which the patient has been referred.

Learning from experience is only effective when staff feel safe and supported in reporting risks, incidents and adverse events. This will allow issues to be openly investigated, lessons learned and promptly applied.

The Trust supports a culture of open reporting where investigation and follow up will be fair, equitable and focussed on learning and change. The Learning from Experience Group (Terms of Reference in the Risk Management Policy and Strategy) is responsible for ensuring that where lessons are identified the necessary changes are put into practice.

The Trust shares learning from its analysis of adverse events and safety information received through:

- Dissemination of external and internal safety alerts.
- Discussion of complaints, claims and incident data with staff at appraisal.
- Debriefings following an investigation.
- Rolling programme of audit and monitoring to evaluate if this and other related policies are being implemented effectively.
- Dissemination of reports and action plans to appropriate external bodies and agencies.
- Publicity of information on the intranet.
- Providing reports to the Staff Council and Corporate Health & Safety Group.
- Providing reports to Directors and SMC.
- Team Briefings
- Staff newsletters

14. Involving external agencies

The trust will provide information and reports on root cause analysis trends, themes and outcomes and learning actions to external bodies.

During the course of an investigation into an incident, complaint or claim it may become apparent that the involvement of a specialist external agency (e.g. the Health and Safety Executive) is necessary in order to progress with and inform the investigation. Approval must be sought from the Director of Corporate Services or Deputy Chief Executive prior to the involvement of such agencies.

Root cause analysis, trends, themes, outcomes and learning actions will be monitored by the Learning from Experience Group. They will be shared with the wider public using internet and membership communication. They will also be described using al trend and theme update within the Trust's annual report. These processes will be conducted in accordance with the Trust's Being Open Policy.

15. Special investigation team (see appendix 8)

15.1 Only the most serious incidents are likely to require a Chairperson from outside the Board or the Senior Managers Group. Incidents involving clinical matters will require the inclusion of appropriate senior clinical staff who are not closely associated with that aspect of the service under scrutiny. Where legal matters are raised in the initial report, the Trust's legal advisors should be consulted. Decisions also need to be taken at this stage on the level of support required for all involved in what is often a traumatic and stressful process. The need for Involvement of the Police and/or the Health

and Safety Executive, in accordance with the Memorandum of Understanding, must be considered.

15.2 Terms of reference for the investigation must be produced in writing. Guidance for Special Investigation Teams is set out in Appendix 8. The investigating panel should be the minimum size necessary to do the job, but this will depend on the breadth and scope of the enquiry set out in the Terms of Reference, and the need to co-ordinate with other agencies.

15.3 The panel may call witnesses to give evidence and/or require staff to submit statements. Some may already exist from the prima facie report. Expert witnesses will be called and appropriate consultation with professional bodies, defence societies and Trade Unions will be taken. Staff may be accompanied by a representative or other person not connected with the incident if they so wish.

15.4 All deliberations of the panel will be conducted in the strictest of confidence and fully documented. Any decision to reveal any aspect of the findings or recommendations ahead of the final report should have the full agreement of the panel and the executive to whom they are reporting. This might include information to patients or relatives or advice to staff to seek legal or other advice, or some immediate remedial action.

16. Support for staff, patients, relatives/carers

16.1 It is recognised that being involved in an incident, complaint or claim which is under investigation may be an incredibly stressful experience.

16.2 It is the duty of the manager of any staff member involved in an investigation to support that staff member and to ensure that they are aware of other sources of support which they may access. The ADO or Senior Manager is responsible for ensuring that this information has been communicated in the case of more serious incidents or complaints. Occupational Health will be able to see staff that wish to self-refer for health advice. The Human Resources Department should be contacted in the first instance in order for members of staff to have full information regarding such support.

16.3 Managers who have concerns about a staff member's fitness to work may wish to formally refer the individual to Occupational Health for advice and possible recommendations. Staff counselling, Occupational Health and Personnel Department are able to assist with support following a significant traumatic event.

16.4 Independent support may be obtained through the Atos Healthcare Counselling Service and staff can access this service without a referral from their line manager. Additionally, staff may wish to seek the advice of any professional organisation of which they are a member.

16.5 Support to patients and or their relatives/carers should be provided in accordance with the Being Open Policy.

Implementation Plan

IMPLEMENTATION PLAN	
Intended Audience	All LAS Staff
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.
Communications	Policy and Procedure to be announced in the RIB and a link provided to the document.
Training	Training on investigation forms part of the 'Incident Reporting for Managers' course. Requirements for attendance at this course are identified in the Mandatory Skills and Knowledge Matrix. In addition to this the Trust provides ad-hoc RCA training sessions, which are facilitated by an external training provider. There is no formal requirement for all managers to be trained in RCA methodology. Where an investigation needs to use RCA a suitably trained person will be appointed as lead investigator.
Monitoring	The Learning from Experience Group and the Quality Committee will be responsible for monitoring compliance with this Policy. The effectiveness of this Policy will be monitored through the following: Undertaking a periodic review of a random selection of incidents, complaints and claims to verify that the level of investigation is suitable; Following up the action points identified in a random selection of incidents, complaints and claims to verify that they have been effectively implemented and that there is demonstrable change; Confirming that risk management committees have reviewed relevant incidents and the investigation outcomes; Undertaking a thorough review of the process for investigating SUIs when one occurs and identifying any policy improvements that need to be made. Quality Committee will monitor the full implementation of recommendations from SUI reports and any other incident reports related to risks that are included on the corporate risk

register.

Learning from Experience Group is responsible for the integrated review of incidents, complaints, and claims, in order to identify actual and emerging risk themes and to recommend changes to practice, and has a direct relationship with clinical audit and research. The committee will have delegated responsibility for a number of the CQC regulation outcomes.

Undertaking a periodic review of a random selection of incidents, complaints and claims to verify that the level of investigation is suitable;

Following up the action points identified in a random selection of incidents, complaints and claims to verify that they have been effectively implemented and that there is demonstrable change;

Confirming that risk management groups (Clinical Quality, Safety & Effectiveness; Learning from Experience; Risk Compliance & Assurance Group) have reviewed relevant incidents and the investigation outcomes;

Undertaking a thorough review of the process for investigating SUIs when one occurs and identifying any policy improvements that need to be made.

Standards/Key Performance Indicators

The Trust will use the following auditable standards and key performance indicators to monitor the effectiveness of this Policy:

- Number of untoward events per 100 staff.
- Comparison of numbers reported and seriousness of incidents
- Percentage of recommendations outstanding from incidents reported per quarter
- Number of root cause analyses completed within agreed time scales.
- Compliance with minimum criteria from relevant NHSLA Level One and Two standards

The Policy will be approved by the Learning from Experience Group and then ratified by the Quality Committee. The Clinical Quality, Safety & Effectiveness and Risk Compliance and Assurance groups will also incorporate the policy within their terms of reference.

Appendix 1

Risk Matrix

The purpose of scoring or grading incidents is to establish the potential future risk to people and the organisation. If the risk is "high" (even though the actual consequences of the incidents are minor) it is important that the contributory factors and root causes are established to prevent recurrences.

Instructions for Use of Matrix

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use **Table 1** to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use **Table 2** to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Use **Table 3** to calculate: I (Impact) x L (Likelihood) = R (risk score).
5. Use **Table 4** to obtain the risk grading.

Table 1 Impact Score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Domains	**Impact score (severity levels) and examples of descriptors**				
	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large

Domains	Impact score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
			4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients.	Mismanagement of patient care with long-term effects	number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Domains	Impact score (severity levels) and examples of descriptors				
	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
Descriptor	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk Score = Impact x Likelihood (I x L)

			Likelihood Score				
			1	2	3	4	5
			Rare	Unlikely	Possible	Likely	Almost certain
Impact Score	5	Catastrophic	5	10	15	20	25
	4	Major	4	8	12	16	20
	3	Moderate	3	6	9	12	15
	2	Minor	2	4	6	8	10
	1	Negligible	1	2	3	4	5

Table 4 Risk Grading

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

Risk Score	Risk Grading
1-3	Low risk
4-7	Moderate risk
8-14	Significant risk
15-25	High risk

Appendix 2

Process for Investigating Incidents, Complaints and Claims

In summary

- Request investigation
- Appoint investigation team
- Nominate support for the staff involved
- Keep the patient / relatives / staff informed
- Gather relevant data – health records / policies / duty rosters
- Map information / generate chronology of events
- Identify problems / barriers / areas for exploration
- Request statements from and interview relevant staff
- Analyse problems
- Agree root causes and safety improvements with the team
- Generate conclusions and recommendations
- Compile draft report
- Share relevant extracts (where appropriate) with individual staff for comment
- Finalise report
- Submit report to appropriate directorate / committee
- Generate action plan for implementation of recommendations, with specific timescales and responsibility
- Share findings and learning with patient / relatives / staff / other relevant stakeholders

Good Investigation:

Focuses On:	Avoids:
▪ Structured analysis ▪ Openness and fairness ▪ Professional accountability ▪ Learning and sharing ▪ A recognition that things go wrong ▪ Good practice identified ▪ Minimising future risk ▪ Appropriate staff support	▪ Pre-judging the outcome ▪ Personal bias ▪ Naming and shaming ▪ Looking for a quick fix ▪ Recommending solutions that create new risks ▪ A negative culture of fear ▪ Inappropriate use of the disciplinary process

Key Questions to Ask

- What happened?
- How did it happen?
- Why did it happen?
- What was the impact?
- What can we learn?

- What action is needed to reduce recurrence?

The Investigation Process

Charting the Event with Current Knowledge

1. The first stage of the investigation process is to establish the basic facts. This will help to identify, at an early stage, whether or not specialist advice or guidance may be required from either internal or external sources. The following should be identified:
    - who was affected by/involved in the incident;
    - a summary of what happened;
    - a list of the names of all present at the time of the incident (including
    - contact details) so that statements can be obtained (at the earliest opportunity);
    - a list of all equipment that was potentially involved in the incident (equipment should be taken out of use if safe and appropriate to do so);
    - if possible, and where appropriate, take photographs or make sketches of the incident scene (as this will provide a permanent record of the scene).

2. Where an SUI is being investigated this information will be required for inclusion in the report to NHS London.

Gathering Evidence

1. **Factual** information should be gathered as soon as possible after an event, whilst people can still accurately recollect what happened and when.

From People

- Witness statements (see Appendix 7 for guidance where appropriate) should be obtained from all those who were involved in the incident, complaint or claim.
- It may be appropriate to interview people involved in an incident, complaint or claim (see Appendix 3 for guidance on conducting an interview). In appropriate cases staff must be advised of the availability of support (e.g. from a Union Representative) during the interview process.
- Statements should be obtained from anyone present, whether they saw the incident/circumstance about which a complaint is being made or not, if appropriate.
- Statements should be obtained from other relevant persons who may have information that influences the investigation (e.g. maintenance staff, external contractors), where appropriate.

From the Environment

- Records should be made about the physical environment at the time of the incident, where appropriate (e.g. lighting, temperature, available space, positioning of relevant equipment).

Documentary Evidence

- Examples of documentary evidence that should be collected are policies and procedures, pre- and post-risk assessments, patient records, training records, relevant incident forms, maintenance records, safe systems of work, correspondence.

Mapping the events

1. The information gathered should be used to establish the chronology of events (i.e. when specific events occurred and in what order).

2. The preferred Trust tool for documenting the chronology is a timeline, as it will also allow for the identification of information gaps and any critical problems that arose.

Identifying and analysing contributory factors to the incident/complaint/claim

1. Having gathered all of the relevant sources of evidence, the nest stage of the investigation is to identify the contributory factors, including 'root causes'.

2. The aim of this stage of the investigation is to identify the fundamental causes of the incident, complaint or claim and not just the obvious causes (that can simply be attributed to human error).
    - List the organisational, management and institutional factors that may have contributed to the incident/complaint/claim (e.g. lack of documents to guide practice, lack of risk assessments, lack of equipment, lack of training);
    - List any error producing conditions (e.g. staff shortages, poor working conditions, poor communication);
    - List any violation producing conditions (e.g. poor management culture (violations occurring without being addressed), lack of supervision of untrained staff);
    - List any unsafe acts completed that conflicted with Policy, procedures, training or best practice;

3. The purpose of the subsequent analysis is to identify what happened, why it happened, how did it happen and how can it be prevented from happening again. The aim of the analysis is to determine what lessons can be learned and what changes can be made to improve practice and reduce future risks. The person investigating the incident, complaint or claim should aim to ask the

question ‘why (did something happen)’ until the answer is no longer meaningful. Each stage of the analysis should be recorded.

4. Full analysis of the gathered evidence will enable the obvious causes (for an action or event) and the contributory underlying (or root) causes to be identified. The root causes will typically be management factors.

5. ***It must be recognised that the cause of an incident, complaint or claim cannot usually be attributed to one particular cause or event.***

Action planning

1. The investigation process will have identified a series of recommendations which could be implemented to reduce the level of risk identified.

2. Recommendations that are supported need to be identified within an action plan, with a responsible person identified and a target completion date assigned.

3. In the case of an SUI the Head of Patient Experiences, Head of Safety & Risk /Head of Legal services (on a daily basis) and the Clinical Quality Safety & Risk Committee/Risk Compliance and Assurance group will be responsible for monitoring the implementation of the action plan. Where the incident is not deemed to be an SUI then it will be the responsibility of the ADO or relevant senior manager to monitor implementation of the action plan and to report progress and outcomes to the relevant Committee.

Completing a report

1. The investigation report should be a document that identifies all of the factors involved in an incident. The document should encompass all the information that has been collated during the investigation including, for example, photographs, training records, maintenance records.

2. The final document could be used as evidence at a later date and may be requested by enforcing authorities, such as the Health and Safety Executive or the Health Service Ombudsman.

3. The investigation report must include the following:
    - Purpose of the report;
    - Author of the report;
    - A list of staff, patients and visitors;
    - Full factual account of the incident, including a detailed chronology of events;
    - Background information about the affected person (e.g. patient’s clinical details, staff history);
    - Findings of the root cause analysis (both positive and negative);
    - Recommendations/action plan;

4. The timescales for completion of investigation reports are identified in the Incident Reporting Policy, Complaints Policy and Claims Policy.

Appendix 3

Guide to Interview Techniques

Listening to the first-hand accounts from those involved in an incident, as soon as possible after it has happened, is vital. The optimum time for holding an interview is between 2 and 72 hours after the event.

The interviewee should be made aware that, during the interview, notes will be taken for the purpose of informing the investigation. These notes are not act a formal witness statement and therefore do not need the interviewees signature. Following the interview, the interviewer may decide that a formal, signed written statement is required.

1. Interview Preparation

- Arrange a definite time for the interview. This allows staff to make arrangements for appropriate cover and to gather their thoughts in advance.
- Provide the staff member with the section of the Incident Reporting Policy that indicates the Trust aims for a fair blame culture and a learning environment. This section indicates disciplinary action will not form part of the response to an incident, except in certain circumstances.
- Inform the staff member of their right to bring a colleague or trade union representative for support.
- Seek advice from Human Resources if required.

2. Interview Technique

- Undertake the interview in private and, if at all possible, away from the immediate place of work.
- Explain that the purpose of the interview is to find out what happened. The style adopted should be supportive and understanding – any adverse comment/judgment may lead to demoralisation and defensiveness.
- If it becomes apparent that there has been professional shortcoming, this should not be extracted by cross-examination. It should be allowed to develop naturally from the conversation.
- Staff should be provided with support (even if this momentarily detracts from the purpose of the interview). This may be especially necessary if a staff member recognises that their actions contributed to an incident/complaint.

3. Establishing the facts

- Ask the interviewee to describe the sequence of events before, during and after the incident.
- Ask the interviewee to identify what they consider to be the key issues.
- Ask where the care provided can be considered to have gone outside acceptable limits made explicit in guidelines, protocols or pathways.

4. Concluding the interview

Thank interviewee for their contribution and ask if they have any further questions or comments to make. Explain the next stage of the investigation process. The interviewer must ensure that the interviewee feels appropriately supported and that any further support required is organized.

INTERVIEWEES SHOULD BE PROVIDED WITH A COPY OF THEIR INTERVIEW NOTES

Further information can be found in the document 'Investigative interview guidance (cognitive type interview): taking a first-hand account of individuals' involvement in a patient safety incident', NPSA, 2008

Appendix 4

LA311

Incident Investigation Form

Ref No:	
Name of Investigating Officer:	
Date and Time of Incident:	
Date Incident was reported:	
Date Investigation to be completed by:	
Type of Incident (circle): Complaint Incident Claim	
Name of Patient: **DoB of Patient:**	**Patient address:** **Patient phone number:**
Name, address and phone number of person reporting incident:	**Does the patient or person reporting incident require communication assistance?** **Please describe what is required**
Names & Department of all Staff members involved:	**Names, address and phone number of all witnesses:**

Sketch of incident scene (if applicable):
Photos of incident scene (if applicable), including location where original digital files are saved:
List of equipment involved (if applicable):
Key Issues to be investigated:

Please log all conversations, interviews, telephone calls etc, carried out during the investigation of the incident:

Actions / recommendations identified as a result of investigating the incident:	Timescales for completion of actions:	Lead person identified to implement the recommendations:
Full name of Investigating Manager **Print:** **Signature:**		
Position:	**Tel No:**	
Date:	**Base:**	

State the number of 'Incident Supporting Statement Forms' attached in this box

Appendix 5 Root Cause Analysis Process Flowchart

A. Information Gathering From:

- People
- Site
- Policies and procedures
- Patient Records
- Other Sources including witness statements, rotas etc

This will also help put together a chronology of events

B. Information Mapping:

Organising the information so it is easier to analyse.

There are several methods available to map the information.

C. Identifying Problems:

This involves identifying where things went wrong.

These can be split into Care Delivery Problems or Service Delivery Problems.

Some problems will be identified at an early stage, other will be found through discussion and the emergence of more evidence.

There are several methods available to identify the problems.

D. Identifying the Contributory Factors:

These are looked at through nine categories. There are several methods for drawing these out.

E. Agreeing the Root Cause:

Process of deciding which contributory factors are root causes of the incident, that must be addressed to help prevent the incident happening again.

F. Recommending and Reporting:

Looking to ensure that the recommendations prevent similar events happening in the future – whilst keeping an eye on the bigger picture

Appendix 6

NPSA Contributory Factors Framework - A Root Cause Analysis Checklist

Individual Factors	
Physical issues	□□ Fatigue □□ Stress/pressure □□ Excessive Workload
Team and Social Factors	
Role Congruence	□□ Role definitions not correctly understood □□ Roles not clearly defined
Leadership	□□ Leadership responsibilities are unclear □□ There is inadequate supervision and support
Support and cultural factors	□□ Staff are not aware of support networks □□ Team communication/openness is poor
Perception	□□ Not a Multi-professional team, professional barriers exist
Communication Factors	
Verbal	□□ Poor verbal commands and or directions ambiguous □□ Style of delivery inappropriate to situation □□ Incorrect use of language/ terminology □□ Inadequate communication
Written	□□ Records are unclear / not easy to read □□ Relevant records are not stored together □□ Relevant records are inaccessible when required □□ Records are incomplete □□ Communications are not directed to the right people
Task Factors	
Guidelines, Procedures and Policy	□□ Not up-to-date □□ Not available at appropriate location (e.g. not accessible when needed) □□ Unclear, ambiguous □□ Too complex □□ Outdated; unavailable/missing, unrealistic □□ Not adhered to / followed □□ Inappropriately targeted (i.e. not aimed at right audience)
Decision Making Aids	□□ No risk assessment □□ No clear pathway, flow charts, diagrams or protocols □□ Incomplete information available
Procedure or task Design	□□ Guidelines do not enable one to carry out the task in a timely manner □□ Stages of the task are such that each step can not be realistically carried out

Education & Training Factors	
Competence	□□ Inadequate knowledge to perform task □□ Inadequate skills to perform task □□ Inadequate experience to perform task □□ Unfamiliar with task
Supervision	□□ Inadequate supervision
Availability	□□ Inadequate induction training □□ Inadequate mandatory training □□ Inadequate Core Skills training
Suitability	□□ Training content inadequate/ incomplete □□ Training not provided frequently/enough □□ Training not recorded
Equipment Factors	
Design	□□ Not available □□ Difficult to use □□ Poor ergonomic design (e.g. shape, size) □□ Out of date □□ Non compatible with other equipment in use □□ Not standardised
Use	□□ Poor working order □□ Unreliable □□ Inadequate safety features □□ Inadequate maintenance programme □□ Inadequate storage □□ Unfamiliar equipment
Work Environment Factors	
Administrative Factors	□□ Inadequate systems for requesting medical records □□ Inadequate systems for ordering drugs □□ Insufficient administrative support
Environment	□□ Housekeeping issues – poor cleanliness □□ Inadequate temperature control □□ Poor lighting □□ Distracting noise levels □□ Insufficient space
Staffing	□□ Inadequate skill mix □□ Inadequate staffing numbers (staff to patient ratio) □□ Poor retention/high staff turnover □□ High workload / dependency factors □□ High/over reliance on temporary (locum, agency) staff

Hours	□□ Shift related fatigue □□ Insufficient breaks during work hours □□ Time pressures
Organisational Factors	
Structure & Culture	□□ Hierarchical structure, not conductive to discussion, problem sharing, etc. □□ Tight boundaries for accountability and responsibility □□ Poor safety awareness and culture
Patient Factors	
	□□ Pre-existing co-morbidity □□ Complexity of condition □□ Culture /religious beliefs □□ Lifestyle (smoking, drinking, diet) □□ Language □□ Mobility □□ Inappropriate (V&A) behaviour

Appendix 7

Guide for Writing Statements

Written evidence, in the form of statements, will be obtained as part of an investigation. Statements provide an opportunity for staff involved to record all possible factual information relating to an incident. This will help to prevent detail from being forgotten.

Statements should contain as much relevant detail as possible, including times, circumstances leading up to the event, people involved and action taken.

Statements are disclosable in the event of subsequent legal action.

The following points should be used as guidance when writing statements:

1. All statements should be legible, signed dated and timed. If a typed statement is presented it must be accompanied by an original signature. Photocopies or illegible statements should not be accepted.

2. Each page should be numbered consecutively in the right hand corner and all of the pages should be securely fastened together.

3. Each page should be headed with the incident/complaint/claim reference number.

4. The statement should be clear in respect to timeline. Events should be put in the order in which they happened giving precise dates and times (using am or pm or the 24 hour clock).

5. The statement should include the names of any other witnesses who were present. Give full names and job titles.

6. Only record fact - only include facts or conversations actually witnessed or participated within. The following should not form part of the official statement:
    - Speculation or hypothesis
    - Views on causes
    - Opinions of the role or quality of work provided by other staff
    - Derogatory comments about what occurred

7. Avoid using jargon or abbreviations – e.g. IVAC when it is meant “infusion pump”

8. All numbers, including dates, should be expressed in figures, not words.

9. Statements should be written in the first person e.g.: “I was asked by Staff Nurse ENE Body to record Mr. X’s blood pressure.”

10. Draw a single line through any alterations to a statement and then initial the alteration.

11. Any person providing a statement should be provided with a copy.

The following summarises the layout and contents of the relevant sections of a statement:

Section 1: Brief Introduction

This statement refers to an incident that took place in (ward/department) on (date).

Section 2: Personal Details

- Name
- Professional Grade
- Role within Trust
- Status (permanent staff or locum/agency)
- Length of service

Section 3: Facts relating to the incident

Provide a detailed chronological account of what happened, including your involvement in the incident and what happened. Include reference to times, other people, locations and case notes.

Section 4: Conclusion

The final paragraph of the statement should read:

"*This statement is true to the best of my knowledge and belief."*

The statement should be signed and dated, with name and job title should be printed under the signature.

Appendix 8

Guidance for Special Investigation Teams

Choosing the Investigation Team

Dependent on the nature of the incident, the inquiry panel could be internal, external or a mixture of both. In all these cases the team will function more effectively if the guidelines set out are followed:

Chairperson

Should be skilled and independent of the issues being investigated. The Chairperson needs to be able to co-ordinate impartially the various investigative activities, run meetings, lead a decision making progress, report writing and presentation to the client groups.

Team Members

They need the skill and specific knowledge to contribute to the investigation, so that their role in the enquiry team can be clearly defined. They need also to be capable of playing a team role when it comes to analysing, agreeing decisions and making recommendations. They need to be able to, and be prepared to, give the necessary time.

Involving Others

The Chairperson will need to recognise the need to co-opt and call upon other skills, either initially or as the investigation ensues.

Training/Briefing Session

It should not be assumed that an enquiry team is instantly capable of carrying out its role. Ideally, its first meeting should, at least in part, be a training session. As a minimum, an hours briefing by the Chairperson should happen before starting the investigation itself. The briefing should cover:-

- gaining understanding of the aims
- agreeing the style and process of the investigation
- sharing expectations of each role and each other
- agreeing key milestones and how the various investigative strands will be brought together

Establishing Terms of Reference

Terms of Reference should be produced in writing and shared with all those involved. They should also include:

- *Aims*
  These should be expressed in neutral language to encourage problem solving rather than blame allocation. The remit should be broad enough to cover both the circumstances around the incident and any other relevant factors raised by the incident. A historical perspective should be encouraged to seek patterns or trends.

- *Enquiry Team*
  Chairperson name and role in co-ordinating the investigation
  Team Members names and roles/specific contributions as appropriate

- *Time Commitment*
  It is likely that dedicated and intensive periods of time will be necessary to achieve the enquiry efficiently and expeditiously and this should be clearly identified.

- *Secretarial Support*
  What clerical support will be available; where will it be located?

- *Authority*
  What authority is vested in the team and who is the person designated to receive the report?

- *Timescales*
  Following the initial 72 hour investigation, it should be possible to estimate the time required to carry out the enquiry. One month would provide sufficient time for most incident enquiries, whilst providing an appropriate sense of urgency. The key milestones should be indicated in the Terms of Reference.

- *Enquiry Process*
  This part should include the investigation process to be undertaken, the meetings schedule, how findings will be brought together, recommendations agreed, how the report will be presented and whether it should be/has to be made public. These aspects should not be left to chance. It should also indicate the decision making progress by which any alterations to Terms of Reference, timescales etc., will be made in light of the progress.

ENQUIRY REPORT

- *Structure*
  The structure of reports should be broadly consistent. The following headings should suffice for most reports:-

- Introduction
- Terms of Reference – including membership of panel
- Enquiry Process
- Background – history of events
- Description of Incident and its Handling
- Comments on Incident Handling (Enquiry Team)
- Conclusions
- Recommendations
- Implementation Process
- Tracking

- *Recommendations*

  These could usefully be presented under three headings:-

  Policy and Procedure
  Resources and Assets
  Staff Performance and Capability

  They should be prioritised in terms of **MUST** and **COULD** do. Wherever costs are entailed, these should be itemised along with the benefits anticipated from accruing such costs.

- *Implementation Process*

  This should be in the form of an action chart, showing who, how and When by including key review points. The plan should include communications activity and show how support for those involved in the implementation process would be provided wherever this is likely to be personally stressful.

- *Tracking*

  Ownership for tracking agreed recommendations must be decided. A pro-forma for progress reports is attached. These should be presented at key review points, and at least monthly, so that actions can be signed off and any additional action can be identified.