

# The Newcastle Upon Tyne Hospitals NHS Foundation Trust

## Procedure for Incident Investigation

Effective Date: December 2007

Review Date: December 2010

### 1. Introduction

- 1.1 Many people feel that errors are random occurrences that are unpredictable and beyond control. Whilst it is true that chance will play a part in some incidents and staff may slip or fumble causing an untoward event, a large majority of incidents are caused by systemic failures that follow a recurrent pattern. Moreover, if the cause of the incident can be identified, preventative changes can take place and true learning encouraged.
- 1.2 To ensure that incidents graded moderate and above (Appendix I) are effectively investigated the following procedure has been developed.
- 1.3 Staff should remember that any incident can progress to a claim in negligence. Implementation of the following steps will allow the Trust and the National Health Service Litigation Authority to make informed decisions about the management of the claim.

### 2. Immediate Action

- 2.1 Before reviewing any incident the investigating officer must ensure their own safety and before approaching the locus of any adverse incident check that the environment is safe for them to approach.
- 2.2 All individuals involved in the incident must have their safety assured and any injuries dealt with. Where the injured person is a patient the recorded next of kin should be notified as soon as possible in accordance with the Trust policy 'Being Open'.
- 2.2 Contact the line manager/supervisor i.e. First Line Responder, who should follow procedures in the **'Policy for Management and Reporting of Accidents and Incidents'**. Trained First Line Incident Responders have access to the Incident Investigation Kits that are available from Reception at Leazes Wing, RVI and Freeman Hospital and the Security Office at the General Hospital.
- 2.3 On occasions the locus of the incident will require cordoning off to ensure that staff and visitors do not put themselves at risk. Cordon tape is available in the Incident Investigation Kit.
- 2.4 Any equipment that was involved in the incident should be isolated until it has been reviewed by either the Health and Safety Advisor or Chief Engineer- Estates Department. Photographs should be taken to support analysis of the incident. Health and Safety Advisors, Patient Safety Advisors and Patient Co-ordinators all have access to digital cameras.

2.5 Where an incident involves a piece of bio-medical equipment:

- Do not alter any dials or settings
- Record the setting for future reference
- Retain any disposables e.g. giving sets, in a yellow bio-hazard bag within a sealed and clearly labelled clear polythene bag
- Isolate the kit in an area where it can not be accessed by staff who may inadvertently put the equipment back into service
- Do not allow the kit to be returned to the manufacturer without the clear agreement of either the Works Department, Manager – Medical Electronics, Health and Safety Department or CGARD.

2.6 Ensure that there is a secure environment to store any evidence to prevent loss or tampering.

### 3. Investigation

3.1 Review the case notes (if clinical incident) and ensure that all records are completed appropriately. Staff should not record the reasons for any incident within the clinical record. The clinical record exists to record the clinical care of the patient and all other information should be recorded on the appropriate incident form and supplementary documentation.

3.2 Where a patient death or injury could be perceived as suspicious the police may seize the records. To allow the Trust to start its own investigation ensures that the senior officer on site at the time obtains a photocopy of the case notes at the outset to retain in safe keeping for future reference.

3.3 Ensure the collection of statements. In some cases staff members may need support in writing statements. Advice on completion of statements is available in the Trust “***Policy for Management and Reporting of Accidents and Incidents***’.

3.4 The investigating officer and line manager must consider if it is likely/possible that there was any negligence or deliberate/malicious intent involved, and act in accordance with Trust Policy “***Incidents, Accidents and the Trust Disciplinary Process – Guidelines for Managers, Clinical Directors and employees***”.

3.5 Serious Untoward Incidents (SUI) will be reported to the SHA and investigated as per the Trust’s SUI policy and procedure.

3.6 Where possible staff members should write statements immediately following an incident. Statements can be marked draft until the staff member is satisfied with the content.

- 3.7 Staff must be supported in statement writing following an incident. All statements must be dated and signed with the name clearly printed in black ink on Trust headed paper. As staff may be traumatised having witnessed, or been involved in, a SUI it is not always possible to obtain immediate statements, in such cases they will need to return to undertake supported statement writing at a later time. In extreme cases it may be necessary to visit a member of staff at home, with their agreement, to assist in statement provision. If this is necessary it is essential that consideration is given to who should undertake this task.
- 3.8 Arrange interviews with all key staff involved in the incident. If investigating a SUI involving death or serious harm, all staff who was involved at the time must be interviewed.
- 3.9 Involvement in a critical incident can be extremely upsetting for staff and the emotional state of the employee must be considered at all times. Support by Staff Counsellors can be arranged through Occupational Health if required. Please refer to Trust document "**Supporting Staff Involved in Traumatic/Stressful Incident or Claims Policy**". Early implementation of this process will demonstrate strong support for staff involved
- 3.10 Prior to the interviews the investigating officers should meet to agree the areas of information to be obtained and the methods of discussion. An interview preparation form may be used (Appendix II).
- 3.11 Ensure staff members are supported and that they are informed that they may bring a supportive friend, professional advisor or union representative to the interview if they wish.
- 3.12 The investigator may find the use of a Cause and Event chart beneficial (Appendix III).
- 3.13 The following may be required:
- i. Incident Form and relevant appendices
  - ii. Other relevant written documentation as appropriate/ available at the time (e.g. patients case notes or written policy documents)
  - iii. Staff statements from all relevant staff immediately following incident (availability will depend on nature of Incident).
- 3.14 Determine where the beginning of the investigation should be and ensure that, where utilized, the Cause and Event chart is completed appropriately. This chart will visually represent the timeline for the incident being investigated and is the core tool used. There will be multiple events within the one scenario and it may be necessary to look further back than the time of the incident being investigated.

- 3.15 Having developed the Cause and Event chart the investigators should identify the Causal Factors. A Causal Factor is *“any event or condition that, had it been prevented or changed, would have either stopped the incident happening or have reduced the amount of associated damage.”* On the Cause and Event chart, causal factors are noted as black triangles. There will usually be more than one Causal Factor identified during the investigation of an incident.
- 3.16 Each Causal Factor should be analysed to identify the Root Cause of the incident being investigated using a Why analysis (Appendix IV).
- 3.17 Following the analysis the investigator should identify an Action Plan for remedial action and suggest methods for assuring the remedial action is working.
- 3.18 The investigator should prepare the final Trust Report inclusive of responses to any external peer reviews.
- 3.19 On line training in Incident Investigation is provided by the National Patient Safety Agency at [http://www.npsa.nhs.uk/health/resources/root\\_cause\\_analysis](http://www.npsa.nhs.uk/health/resources/root_cause_analysis).

#### **4. Closing the Investigation**

- 4.1 Senior Officers from the department/s involved should agree the factual basis of the report and remedial action required.
- 4.2 Inform the members of staff involved that the investigation is closed, bearing in mind that this is likely to be a difficult time for some and that support may be required.
- 4.3 **It is the responsibility of the Clinical Director of the department where the incident occurred to ensure, with the support of the Directorate Manager and Matron that the remedial action is implemented and that learning from the incident is shared over the organisation.** This will be achieved by taking the findings to the Clinical Risk Group.
- 4.4 Ideally it is good practice to share lessons with the whole group of staff involved.
- 4.5 It must be remembered that the report can be disclosed during litigation.
- 4.6 Where necessary ongoing audit of the proposed changes should be agreed at this point and written into the report and forward planning implemented.

## 5 Final Report for major incidents - content and structure

- 5.1 Cover Sheet. The cover sheet should include the following information:
  - 5.1.1 Trust Reference Number from the Incident Form.
  - 5.1.2 Name of Investigating Officer
  - 5.1.3 Designation of Investigating Officer
  - 5.1.4 Date
- 5.2 Contents page
- 5.3 Introduction
  - 5.3.1 Brief summary of what the incident was and the outcome of the incident
  - 5.3.2 The specific Terms of Reference for the Investigation (if applicable)
  - 5.3.3 Outline the methodology of the investigation
  - 5.3.4 List of statements taken (if applicable)
  - 5.3.5 List documentation used
  - 5.3.6 List staff/ persons involved in incident, for purposes of confidentiality. it may be necessary to anonymise the names of staff
  - 5.3.7 List of staff/persons from whom statements were taken if different to above list
  - 5.3.8 Interview information (timescale, how conducted, different interview methodologies, repeat interviews undertaken)
  - 5.3.9 In depth causal analysis for all incidents involving death or serious harm
  - 5.3.10 Details of meetings /group discussions held with staff involved
  - 5.3.11 Provide details of internal/external peer reports requested (if applicable)
  - 5.3.12 Level of involvement/communication with patients/carers/relatives etc.
- 5.4 Body of the Report:
  - 5.4.1 Factual account of the findings of the incident
  - 5.4.2 Analysis/interpretation of the cause and effects of the incident
  - 5.4.3 Detailed actions taken since time of incident (changes to practice / service delivery)
  - 5.4.4 Details of lessons learned and to be shared.
- 5.5 Conclusions of the Report.
- 5.5 Recommendations.
- 5.6 Action Plan with timescales and monitoring arrangements.
- 5.7 Identify the members of the Review Team / Investigating Officers if more than one person was involved.
- 5.8 References and supporting documentation.

## 6. Review of Procedure

- 6.1 This procedure will be reviewed on a three yearly basis by the Manager – Clinical Governance and Risk. This review will consist of an audit of ten reports supplied following a formal incident investigation in the previous year to ensure that the correct procedures have been followed.
- 6.2 Reports of this Audit will be reviewed at the subsequent Clinical Risk Group meeting to identify any remedial action required and to ensure adherence to the procedure.

<b>Author; Manager Clinical Governance and Risk</b>	<b>Accountable Director: Medical Director</b>
<b>Approved by: Clinical Policy Group</b>	<b>Area of Reference: Trust wide</b>
<b>Linked Documents: Incidents, Accidents and the Trust Disciplinary Process- Guidelines for Managers, Clinical Directors and Employees Supporting Staff involved in Traumatic/Stressful Incidents, Complaints or Claims Policy Policy for the management and reporting of accidents and incidents</b>	<b>Further Advice:  Clinical Governance and Risk Department</b>

Incident Grading Table taken from 'Policy for Management and Reporting of Accidents and Incidents'

Level	Descriptor	Actual/ Potential Impact on Individuals	Actual/ Potential Impact on Organisation	Number of persons affected at one time
5	Catastrophic	Suicide or homicide or a death that would generate immediate media attention Any alleged rape or other serious violent assault on an NHS patient or member of staff Infant abduction	National adverse publicity NHS Investigation STEIS Healthcare Commission Visit Criminal Prosecution, RIDDOR Extended service closure Cost greater than £500K Litigation Expected	Excess of 50 e.g. cervical screening disaster, evacuations etc
4	MAJOR	Invasive procedures being carried out on the wrong patient or body part. Any unexpected death of a patient whilst under the direct care of a health care professional or within one month of being seen by a health care professional Haemolytic transfusion reaction; Removal of wrong body part. Infant discharge to the wrong family Permanent injury Loss of body part, Mis-diagnosis – poor prognosis. Patient receiving radiation dose much greater than intended whilst undergoing a medical exposure	Service closure, H&S Investigation reportable, Long term sickness. Claim expected – indefensible. Temporary service closure. Increased Pt. Stay >15 days Cost greater than £250K RIDDOR reportable injury MHRA reportable STEIS reportable	16 - 50 Moderate number – e.g. loss of specimens, vaccination problem
3	MODERATE	Semi-permanent Injury/ Damage e.g. injury takes up to one year to resolve Short term sickness more than 3 days	Needs careful PR, Local Adverse publicity RIDDOR reportable MHRA reportable Hospital stay increased < 15 days	Small number 3-15
2	LOW	Short term Injury/ Damage e.g. injury that has been resolved within one month	Minimal risk to the organisation	One
1	INSIGNIFICANT	No injury or adverse outcome Near Miss	No Risk at all to the organisation	None

### INTERVIEW PREPARATION FORM

Notes

- Complete as much of the following information as possible before the interview takes place
- Introduce yourself and explain purpose of interview
- Stress fact finding nature, looking for facts pertaining to the incident
- Inform employee about how the information will be used and what will be done with the notes taken
- Commence interview by asking for general information about employee's work history, allow them time to relax
- Using open questioning techniques to find out what they – heard, saw, felt, smelled, tasted from the start of the incident to the end
- Allow the interviewee to talk –**Do not interrupt**
- Clarify any unclear points and ask if there is anything they would like to say
- Close by offering contact details so that they can contact you should they remember any other facts.

**Interviewers:**

**Interviewee:**

**Department:**

**Job Title:**

**Experience:**

**Address:**

**Email:**

**Telephone**

**Main Points to cover in the interview**

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Date .....

## CAUSE AND EVENT CHART

### 1. Introduction

A Cause and Event chart is a diagram of the sequence of events of an incident. Its purpose is to:

- To organise the information collected
- Identify missing or conflicting information or topics for greater analysis
- Improve the understanding of the information by graphically showing the relationship between the information and the sequence (timeline) of the incident
- To identify what are often multiple incident causes rather than just focusing on a single, prominent cause
- Present findings to others and focus discussions about the incident on the facts and the actual sequence, rather than on opinions and rumours.

### 2. Building a Cause and Event Chart

2.1 Identify the incident to be examined and write a short description in a circular symbol.

2.1.1 The incident is the most serious event that took place. It is an event and should be recordable in an objective manner i.e. a distinct action.

2.1.2 The description should be concise and objective.

#### 2.2 Build the sequence of events (actions) on a horizontal axis.

2.2.1 The events are in order from left to right, built from start to finish.

2.2.2 Each event is recorded in a solid line box/rectangle.

2.2.3 Each box should record the date and/or time of the event.

2.2.4 Horizontal arrows are used to denote the sequence of events and will connect one box to the next.

2.2.5 There is one action per event box.

2.2.6 To ensure confidentiality, individuals are identified by an initial only.

2.2.7 Event descriptions should be in a "*Who did what*" or "*The equipment then ...*" format.

2.2.8 The record should be objective, non- judgemental and precise.

2.2.9 Build the event sequence before starting to add conditions.

2.2.10 If an event is not known or requires further information the box/rectangle is made of dotted lines.

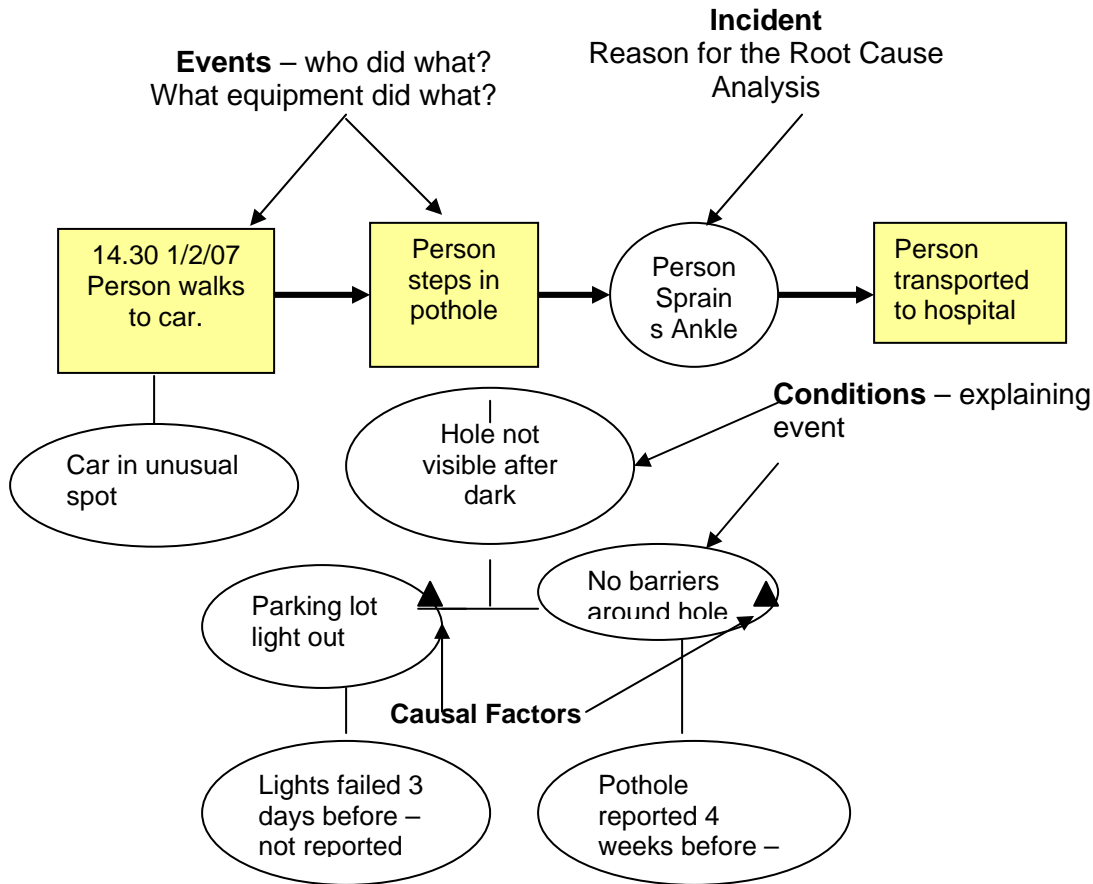
## **2.3 Add conditions to events**

- 2.3.1 Conditions are descriptors of events and are recorded in ovals.
- 2.3.2 These ovals are connected to the related event by a straight line and lie below the event on the chart.
- 2.3.3 Where conditions are not known or require further investigation, they are recorded in a dotted oval.
- 2.3.4 Conditions may be arranged in a cause /effect hierarchy i.e. one condition may be related to another.

## **2.4 Causal Factors**

- 2.4.1 Causal factors are conditions or events that, if eliminated, could have prevented the incident from occurring or reduced the damage associated with the incident.
- 2.4.2 Causal factors can be events or conditions and are designated by black triangles.
- 2.4.3 Causal factors are incorrect actions or equipment functioning in an unintended way.
- 2.4.4 There will often be several causal factors related to once incident.

## Example



The Causal Factors for this incident are that the parking lot light was out and there were no barriers around the hole.

Each of these Causal factors would be analysed to identify the root cause of the problem

## WHY ANALYSIS

### The Five Why's

The nature of the 5 Whys technique is to delve deeper into a problem. It first asks why the incident happened and then continues to ask "Why?" for each causal factor identified from the Cause and Event chart. This may take up to 5 rounds of asking the rhetorical "Why?" for each event. It is essential to remember that only one causal factor should be explored at any given time and it is better to continue with each chain until the end before considering another causal factor.

Work from the top of the chart downwards

#### **Causal Factor description:-**

*Example*

*There have been an increasing number of medication errors on ward X*

**Why? –** *Prescriptions have been incorrectly written*

**Why – Have prescriptions been written incorrectly?**

*Doctors have not been trained in writing prescriptions and there is no audit of the quality of prescription writing ( Auditing system should be analysed under another why analysis)*

**Why- Have doctors not been trained to write prescriptions?**

*Medical staff in the Unit thought that junior doctors were taught prescription writing in first year at medical school. The system has now been changed and the medical school ask that doctors be taught prescription writing in the clinical environment.*

**Why – Did medical staff in the Unit not know that training systems have been changed?**

*The Associate Dean – Clinical Practice should have set up systems to communicate educational issues with the operational medical staff but he did not know that this was part of his job*

**Why – Did the Associate Dean not know that communication with operational medical staff was part of his job?**

*It had not been written into the Associate Dean's job description and he had had no clear induction*

**Root Cause Identified: -**

- i) The Associate Dean – Clinical Practice had no job description*
- ii) The Associate Dean – Clinical Practice had had an incomplete induction programme*