Portsmouth Hospitals NHS
NHS Trust

Policy for the Investigation of Incidents, Complaints and Claims

Version	2
Name of responsible (ratifying) committee	Governance and Quality Committee
Date ratified	7 February 2012
Document Manager (job title)	Head of Risk Management and Legal Services
Date issued	9 February 2012
Review date	January 2015 (unless requirements change)
Electronic location	Management Policies
Related Procedural Documents	Policy for the Management of Adverse Incidents and Near Misses Policy for the Management of Serious Incidents Requiring Investigation Policy for the Management of Complaints Policy for the Management of Claims Being Open Policy
Key Words (to aid with searching)	Incident, Serious Incident, Complaint, Claim, Investigation, Root Cause Analysis

In the case of hard copies of this policy the content can only be assured to be accurate on the date of issue marked on the document.

For assurance that the most up to date policy is being used, staff should refer to the version held on the intranet

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INTRODUCTION

Portsmouth Hospitals NHS Trust (the Trust) recognises that in a service as large and complex as the NHS incidents, complaints and claims do occur. However, the Trust has a responsibility to investigate these events to understand their root causes and to recommend actions and sustainable solutions to help minimise the chance of the same or a similar event recurring in the future.

The Trust recognises that most incidents, complaints and claims occur because of problems with systems rather than individuals. Therefore, the Trust supports the view that the response to an incident, complaint or claim should not be one of blame and retribution but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination. Therefore, the Trust is committed to developing a just culture and to encouraging a willingness to admit mistakes without fear of punitive measures.

PURPOSE

This purpose of this policy is to ensure that the appropriate level and quality of investigation takes place as a result of adverse incidents, complaints or claims and results in measurable improvement in practice.

SCOPE

This policy applies to all permanent, locum, agency, bank and voluntary staff of Portsmouth Hospitals NHS Trust, the MDHU (Portsmouth) and Carillion, whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management or chain of command will be taken into account.

'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety'

DEFINITIONS

Adverse incident: an event or omission, which caused physical or psychological injury to a patient, visitor or staff member or any event or circumstances arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage.

Serious incident requiring investigation (SIRI): one where serious actual harm has resulted (commonly classified as a 'red' incident).

'Never Event'
'Never Events' are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Near miss: a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient

Claim:
Clinical claim: a claim for compensation in respect of adverse clinical incidents, which led to personal injury.

Complaint: an expression of dissatisfaction by one or more members of the public about the Trust's action or lack of action, or about the standard of a service, whether the action was taken by the Trust itself or by somebody acting on behalf of the Trust.

Harm: an injury (physical or psychological), disease, suffering, disability or death. In most instances, harm can be considered to be *unexpected* if it is not related to the natural course of the patient's illness, treatment or underlying condition, or the natural course of events if harm occurs to someone other than a patient

Root cause analysis (RCA): a well recognised way of investigating incidents, claims and complaints, which offers a framework identifying what, how and why the event happened. Analysis can then be used to identify areas of change, develop recommendations and look for new solutions.

Investigation: a detailed inquiry or systematic examination

DUTIES AND RESPONSIBILITIES

Head of Risk Management and Legal Services has responsibility for ensuring the operational and day-to-day implementation of this policy. The Head of Risk Management leads the Risk Management and Legal Services Teams.

Risk Management Team is responsible for supporting and advising managers in the investigation of all incidents.

Lead Investigator is responsible for coordinating and leading the investigation into any event.

Risk Analyst is responsible for ensuring that the database of incidents, complaints and claims is maintained, including the outcome of any investigations.

Legal Services Manager is responsible for ensuring that all claims are investigated thoroughly, appropriately and promptly, in line with this policy and with that for the management of claims.

Patient and Customer Services Manager is responsible for ensuring that all complaints are investigated thoroughly, appropriately and promptly, in line with this policy and with that for the management of complaints.

Clinical Service Centre (CSC) Governance Leads are responsible for ensuring that investigations in their CSCs are investigated appropriately and for ensuring adherence to the timescales as set out in this and other associated policies.

All Managers will ensure that their staff are released for training, are fully assisted and supported throughout the handling of an investigation and receive feedback on the outcome. Where staff experience particular difficulties associated with an investigation, managers should consider referring the staff member or members to the Occupational Health Department, or the Director of Postgraduate Medical Education, in accordance with the Human Resources Policy for Supporting Staff

Serious Incident Review Group (SIRG), Pressure Ulcer Review Group (PURG), Venous Thromboembolism Review Group (VIRG) are responsible for providing high level forums to oversee and monitor the investigation, reporting and review of SIRIs.

CSC Governance Committees
The Committees are responsible for monitoring the action plans and recommendations arising from investigations and ensuring learning and the implementation of any changes in practice required in the light of those recommendations. The Committees also have a responsibility to ensure dissemination of the investigation outcome

PROCESS

Deciding the level of investigation required

It is unrealistic to suggest that all incidents, complaints or claims should be, or need to be, investigated to the same degree or at the same level. The Trust uses the principles of the NPSA guidance to ensure the investigation is conducted at a level appropriate and proportionate to the incident, complaint or claim. Whilst the principles of any investigation remain the same the level of detail will be determined by the type, severity and potential for learning. Details of the investigation process for complaints and claims are included in the relevant policies.

1.1.1. Level 1: Concise Investigation

This type of investigation is most commonly used for incidents, complaints and claims or concerns that resulted in no, low or moderate harm to the patient.

It will normally:

- Be conducted by one or more people who:
  - Are local to the event
  - Have knowledge of investigative procedures
- Involve completion of a summary or short report(s);
- Include the essentials of a thorough and credible investigation conducted in the briefest terms;
- Involve the use of at least one RCA tool e.g. timeline, 5 why's;
- Include recommendations or changes already made in the light of the event; and
- Include an action plan to ensure implementation of any recommendations or changes

1.1.2. Level 2: Comprehensive Investigation

This type of investigation is normally used for incidents, complaints and claims (including 'Never Event's) when the outcome has been actual harm or has the potential to cause, severe harm or death.

It will normally:

- Require input from a multi-disciplinary team
- Require input from staff not involved in the event or the specialty or CSC where the event occurred;
- Be led by someone experienced and/or trained in RCA;
- Be conducted to a high level of detail, including all the elements of a thorough investigation;
- Include the use of appropriate analytical tools e.g. tabular timeline, 5 why's;
- Involve the patient/relative/carer, including the offer of support / independent representation; and
- Involve communication with the Trust's communications team, to ensure any media enquiries are appropriately managed.

It must include:

- A full report with an executive summary and appendices
- Robust recommendations and time targeted action plan
- Process for shared learning: locally / nationally

It may require management of the media via the Trust's communications team

1.1.3. Level 3: Independent Investigation

This is commonly considered for incidents, complaints or claims of high public interest or those with the potential to attract considerable media attention. It is similar to level 2 but must be commissioned and conducted by those independent to the provider service and the Trust e.g. the PCT or the Strategic Health Authority

Why investigate

The primary reason for undertaking an investigation is not to set out to find someone to blame. It is to identify what, how and why the event happened and to learn and change where the need for this is identified. Whilst acceptance of accountability for one's actions is an integral part of every employee's life, individuals rightly expect to be treated fairly and equitably and do not expect to be used as scapegoats for organisational failures.

The purpose of any investigation

The purpose of any investigation is to:

- Find out the full facts, with respect to the sequence of events that led to the event occurring;
- Determine what, if anything, went wrong and identify issues of concern;
- Identify the root causes of any error or concern;
- Determine what was managed well;
- Identify the actions required to prevent a recurrence; and
- Inform local and national learning

The investigation process

The Trust uses the Root Cause Analysis methodology and investigation tools developed in line with the recommendations of the National Patient Safety Agency. The methodology and tools do not attempt to supplant clinical expertise: the aim is to utilize that expertise and experience to the fullest extent. The structured, systematic approach means that the ground to be covered in any investigation is, to a significant extent, already mapped out and the methods used are designed to promote a greater climate of openness and to move away from routine assignment of blame. The methodology also enables a process of analysis, investigation and organisational and individual learning. Further information can be obtained at www.npsa.nhs.uk/nrls

1.1.4. Nominating a lead investigator / investigating team

All investigations must have a lead investigator who is trained or experienced in root cause analysis to a level proportionate to the event. Appendix A offers guidance on grading an event.

The lead investigator must ensure that the investigation is conducted thoroughly and

- Is in line with the severity and nature of the event;
- Follows the principles of root cause analysis;
- Is completed within the required timescales and where this is not possible notify the appropriate responsible manager e.g. the Patient and Customer Services Manager for complaints and the Legal Services Manager for claims;
- Leads to a comprehensive written report, including recommendations for actions taken or to be taken to address any identified areas for improvement;
- Ensure any areas identified as requiring immediate action (e.g. a specific safety issue) or a different or additional investigation process (e.g. safeguarding) are reported to the appropriate manager; and
- Will present the report and its findings to the relevant Group, as appropriate

Depending on the severity of the event it may be advisable to appoint a small investigating team. The make up of the team can be flexible but must include:

- A person with specialist / clinical knowledge of the event
- An 'independent' member, who knows nothing about the work or specialty involved in the event. This person can think laterally about the problem and challenge the status quo, without any preconceptions
- Someone involved in the event

For SIRIs the lead/team will be nominated by the Medical Director or Director of Nursing at the initial panel meeting. For all other adverse incidents the CSC

Governance Lead will ensure an appropriate the lead/team is nominated. The Legal Services Manager and the Patient and Customer Services manager will be responsible for ensuring a lead is nominated for the investigation of claims and complaints respectively

1.1.5. Gathering the information

Information is the cornerstone of any investigation. Obtaining full and accurate accounts of an event may determine whether or not the Trust is able to identify the key problems and issues that have occurred and this, in turn, will affect the quality and effectiveness of any actions/recommendations that emerge from the investigation. Gathering information is such an important stage in the investigation process that around 60% of the time, particularly for a full root cause analysis, may be spent collecting and collating the information you are going to use.

Therefore, one would expect some, or all, of the following processes to occur, depending upon the severity of the event:

- Interviews with/obtaining statements from key individual(s) involved
- Interviews with the patient(s) involved, where appropriate
- Interviews with/obtaining statements from any witnesses
- Examination of the physical location of the event, where appropriate: this may include the taking of photographic evidence
- Examination of any equipment involved
- Examination of any physical evidence
- Review of healthcare records
- Review of any appropriate policies/guidelines/protocols

1.1.6. Mapping the information

Once all the information has been gathered and collated it will need to be ordered in some way, so that sense can be made of all the elements. This is particularly important when the event is complex and a large amount of notes and records have been gathered or when a full root cause analysis is being carried out. The chronology of events is of the utmost importance and should be mapped to allow you to identify problems and good practice in the sequence of events. There are four common methods of mapping. (Appendix B provides more information):

- Narrative chronology
- Tabular timeline
- Time person grid
- Cause and effect chart

1.1.7. Problem identification and prioritisation: root cause analysis

Having gathered all the relevant information about the event it is now possible to explore the unanswered questions and problems. A fundamental component of this is the identification of the contributory and causal factors that led to the event. The significance of these factors will vary from being highly to mildly significant to the chain of events. However, gauging their importance can help identify the development and implementation of recommendations and the person(s) who should take responsibility for addressing them.

There are a number of tools that can be used to help to identify and reach a consensus about the problems that occurred during the event

- Brainstorming
- Brainwriting
- The five why's
- Fishbone diagrams

More information on these tools can be found at Appendix C

1.1.8. Barrier analysis

A barrier is a control measure designed to prevent harm to e.g. to people, buildings, organisational reputation or the wider community. Barrier analysis establishes what barriers (controls or defences) should have been in place to prevent the event or could be installed to increase safety. For further details see Appendix B

1.1.9. Recommendations

Recommendations should be designed to address the root causes i.e. the conclusions of the investigation. For shorter, less complex investigations recommendations and solutions may be developed at the same time. For more detailed investigations, recommendations may inform action planning and solutions development carried out at a later date by a different or reconstituted team.

However they are developed, recommendations and actions plans should:

- Be clearly linked to identified root causes or key learning points: to address the problems rather than the symptoms
- Address all of the root causes and key learning points
- Be designed to significantly reduce the likelihood of recurrence and/or severity of outcome
- Be Specific, Measurable, Achievable, Realistic and Timed (SMART)
- Be prioritised wherever possible
- Be categorized as those:
- Specific to the area where the event happened
- That are common only to the Trust
- That are universal to all and, as such, have national significance
- Include the ongoing support of patients and staff affected by the event, if appropriate

1.1.10. Action planning

Actions plans will set out how each of the recommendations will be implemented and follow the same principles as set out above for recommendations. A named lead will be nominated and a target date set for the implementation of each action point.

In many cases, it will be necessary to involve frontline staff, to ensure the solutions are realistic, accepted and owned by the service or services involved.

1.1.11. The investigation report

The investigation report represents the culmination of all the work undertaken. It conveys all the necessary information about the event, the investigation process and outcome and should be clear, logical and demonstrate that an open and fair approach has been taken.

The purpose of the report is to provide a:

- Formal record of the investigation
- Means of sharing the investigation

The report should explain:

- What happened
- Who it happened to
- When it happened
- Where it happened
- How it happened
- Why it happened
- The root causes
- Actions to be taken to significantly reduce the likelihood of recurrence and/or severity of outcome

Further information can be obtained from the NPSA document: *Root Cause Analysis Investigation Tools. Guide to investigation report writing following Root Cause Analysis of Patient Safety Incidents (2008)* www.npsa.nhs.uk

Monitoring action plans

1.1.12. Action plans associated with 'Never Events' or are monitored by SIRG through quarterly presentation by relevant healthcare professional

1.1.13. Action plans associated with other adverse incidents, complaints and claims are monitored monthly at CSC Governance Committees

Communicating with and supporting staff

Where an incident, complaint or claim has occurred all members of staff directly involved must be kept informed and appropriately communicated with: this is crucial to the development of an open and honest reporting culture. The communication will be through the CSC structure and should include information about the investigative process, the likely timeframe for completion and, most importantly the outcome of the investigation and any actions that will be taken to prevent a similar incident happening again.

Where staff experience particular difficulties as a result of any event, it is essential that they feel supported. Support for staff can take a number of forms: what is right for one member of staff or one situation may not be right for another. Managers should also be aware that staff needs change over time and as they come to terms with events. Sensitive and ongoing communication will ensure that needs are identified and addressed wherever possible. As well as personal support through the line management structure, managers should also consider referring the staff member or members to the Occupational Health Department, or the Director of Postgraduate Medical Education, in accordance with the relevant Human Resources Policy.

Continued support for military personnel will come in the first instance from their respective single Service lead in partnership with their Floor Liaison Manager and civilian Line Manager. It should be noted that these arrangements can be flexible and adapt to the individual's needs. However the single Service lead will retain overall responsibility for the support and an open dialogue between respective parties should be maintained to support this direction.

Communicating with and supporting patients, carers and relatives

When things go wrong one of the biggest concerns for patients, relatives and carers who have been affected by any event is lack of information. Providing factual information in a sensitive way is helpful and is not an admission of liability for the incident itself.

Communication may be through the appropriate healthcare professional or through the use of a facilitator, a patient advocate or a national organisation or charity who will be responsible for identifying the patient's needs and communicating them back to the healthcare team. More information and advice on support for patients, families and carers can be obtained from the Trust's Being Open Policy, the Patient Advice and Liaison Service (PALS) or from Patient UK on www.patient.co.uk

Organisational Learning

There is no value in undertaking an investigation unless there is organisational learning and feedback on the lessons learned and any required changes in practice implemented. The Trust has introduced a number of processes to enable learning and feedback, which include:

Internal

- A systematic approach to the recording and analysis of incidents, complaints and claims through the use of an electronic database;
- Monthly Quality Exception reports to the Trust Board;
- Monthly Business Intelligence reports to the Trust Board;
- Quarterly Quality Report to the Trust Board and Governance and Quality committee. The report provides an aggregated view of issues concerning patient safety, patient experience and clinical effectiveness
- CSC Members of the Governance and Quality Committee will ensure the relevant section of the quarterly quality report is disseminated to CSC staff
- Monthly CSC Performance Reviews, at which the status of complaints and SIRIs is monitored;
- Production of reports specifically tailored to the needs of various groups e.g. pressure ulcer working group, falls group;
- Monitoring of action plans at monthly at CSC Governance Committees;
- Monitoring of SIRI action plans at SIRG;
- Sharing of relevant SIRI reports with the Learning and Development Team and Deteriorating Patient Group; and
- A Risk Management intranet site that can be accessed by all staff and that holds all relevant documents and reports, including: incident reports; legal updates from solicitors; NPSA updates;

External

- Reporting of patient safety incidents, including SIRIs, to the National Patient Safety Agency (NPSA), as part of the Reporting and Learning System (RLS). The reports produced by the NPSA, are then used for both benchmarking and learning across the Trust;
- Reporting of all patients safety incidents to the Care Quality Commission, via the RLS;
- Receipt by the Commissioners of the quarterly Quality Report and the monthly Quality Exception and Business Intelligence reports; used to inform the Commissioner's targets for the Trust;
- Review of all SIRIs by the Commissioners;
- A monthly meeting with the Commissioners at which various aspects of incidents, complaints and claims handling are discussed, to provide assurance on organisational learning;
- Review of all SIRIs by the Commissioners and the Strategic Health Authority; and
- Reporting of any relevant event to external agencies, as necessary

Risk

The process for implementing risk reduction measures is described in the Board approved Risk Management Strategy, including the management and monitoring of those risks through the risk registers and Assurance Framework. Any risks identified as a result of an incident, complaint or claim are considered by the CSC Governance Committees for potential inclusion on the CSC risk register. The CSC Governance Leads ensure any risks that they consider appropriate are presented to the Risk Assurance Committee, for discussion and potential transfer to the Trust Risk Register or Assurance Framework.

The CSC risk registers are monitored by the CSC Governance Committees and the Trust risk register is monitored by the Risk Assurance Committee, to ensure appropriate actions are taken and lessons learned to address any identified risks.

TRAINING REQUIREMENTS

Training forms part of the Trust's Essential Skills and Training Requirements as identified in the Training Needs Analysis. It is included in mandatory Corporate Induction and in Essential Updates.

Staff attend classroom delivered Essential Update training every three years and undertake refresher training via the Electronic Staff Record (ESR) system in the intervening.

All training is recorded on the ESR from which the Learning and Development Team provide a monthly heat map to each CSC, to enable monitoring of compliance.

Compliance is further monitored through the CSC performance reviews with the Executive Team.

REFERENCES AND ASSOCIATED DOCUMENTATION

External

- National Patient Safety Agency, July 2005. *Building a Memory: preventing harm, reducing risks and improving patient safety*www.npsa.nhs.uk
- National Patient Safety Agency, 2009, *RCA Toolkit* www.npsa.nhs.uk
- National Patient Safety Agency, 2009 *Root Cause Analysis Investigation Tools* www.npsa.nhs.uk
- National Health Service Litigation Authority, April 2011/12, *Risk Management Standards,* www.nhsla.com
- National Patient Safety Agency, 2009. *Being Open: Patient Safety Alert NPSA/2009/PSA/003,* www.npsa.nhs.uk
- National Health Service Litigation Authority, April 2011/12, *Clinical Negligence Scheme for Trusts - Clinical Risk Management Standards – Maternity* www.nhsla.com
- Department of Health, 2010, *Checklist for reporting, managing and investigating information governance SUIs.* www.dh.gov.uk

Internal

- *Policy for the Reporting of Adverse Incidents and Near Misses*
- *Policy for the Management of Complaints and Plaudits*
- *Policy for the Management of Claims*
- *Being Open Policy*
- *Risk Management Strategy*
- *Maternity Risk Management Strategy*
- *Supporting Staff Involved in an Incident, Complaint or Claim*

EQUALITY IMPACT STATEMENT

Portsmouth Hospitals NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy has been assessed accordingly

MONITORING COMPLIANCE

As a minimum the following will be monitored to ensure compliance.

Element to be monitored	Lead	Tool	Frequency of Reporting of Compliance	Reporting arrangements	Leads for acting on recommendations
Different levels of investigation appropriate to the severity of the event: 100% of investigations have appropriate level of investigation	Head of Risk Management and Legal Services	Random audit of 10 • Incident files • Complaint files • Claim files	Annually	Policy audit report to: • Patient Safety Working Group	Head of Risk Management and Legal Services / Patient and Customer Services Manager / Legal Services Manager
Process for following up relevant action plans. 100% of actions are completed within the designated time frame	Head of Risk Management and Legal Services	Random audit of 10 • Incident files • Complaint files • Claim files	Annually	Policy audit report to: • Patient Safety Working Group	Head of Risk Management and Legal Services / Patient and Customer Services Manager / Legal Services Manager

Appendix A: Guidance on Grading Events

All incidents and complaints must be graded. Claims are slightly different, as each one undergoes a similar investigation process. The grading will help you to determine the significance of any event and the required management actions. That is events graded green, yellow, amber or red will have differing levels of investigation requirements and/or urgency

How to Grade Events

The Trust has a standardised process for assessing and grading risks and this has been adapted to grade incidents, complaints and claims. An event is made up of two components: likelihood and consequence/seriousness

The consequence, or potential consequence, of the event and the likelihood of it happening again are scored separately and the values are multiplied to produce the final event grading. So for example, if the event likelihood is scored as '3' which is 'possible' with a consequence (seriousness) rating of '2' which is 'minor', then the final score would be '6' and the event graded yellow. Similarly, if the event likelihood is scored as '5', which is almost certain, with a consequence (seriousness) rating of '4', which is major, then the final score would be '20' and the incident graded red.

However, the matrix is only an aid to decision making, and whilst it is a robust system it is not meant to replace clinical or management judgment in regard to the significance of individual events. For example, an incident with a catastrophic consequence (such major permanent harm or affected multiple patients) but which is considered rare would still be reported as a 'red' event simply because of the catastrophic outcome for the individual(s) and the potential for litigation and adverse impact on the Trust.

If you are concerned that a low or medium rated event could also be determined as a significant incident then contact your line manager to discuss the apparent circumstances and remedial actions to be taken.

Likelihood	Consequence				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
(1) Rare / impossible (Can't believe this will ever happen again)	1	2	3	1	5
(2) Unlikely (Do not expect it to happen again, but it is possible)	2	4	6	8	10
(3) Possible (May recur occasionally)	3	6	9	12	15
(4) Likely (Will probably recur, but it is not a persistent issue)	4	8	12	16	20
(5) Almost certain (Almost undoubtedly occur, possibly frequently)	5	10	15	20	25

1 – 3 Low Risk

4 – 6 Moderate Risk

8 – 12 High Risk

15 – 25 Extreme Risk

For complaints, it may also be appropriate to consider the following

Seriousness	Description
Low	Unsatisfactory service or experience, not directly related to care. No impact or risk to the provision of care OR Unsatisfactory service or experience related to care. Usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No risk of litigation
Moderate High	Service or experience below reasonable expectation in several ways, but not causing lasting problems. Has the potential to impact on service provision. Some potential for litigation
Extreme	Significant issues regarding standards, quality of care, safeguarding or denial of rights. Complainants with clear quality assurance or risk management issues that may cause lasting problems for the organisation and so require full investigation. Possibility of litigation and adverse local publicity OR Serious issues that may cause long term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues and may require a serious untoward incident investigation along side the complaints investigation. A high probability of litigation and strong possibility of adverse national publicity.

Appendix B: Mapping Tools

1. NARRATIVE CHRONOLOGY

What is a Narrative Chronology?
Most learners will be familiar with the narrative chronology. In simple terms, this is the "story" of the incident. However for clarification purposes it is included here. The narrative chronology is a straightforward account, or story, of what happened, in date and time order. It is constructed using information that has been collected during the data gathering phase of the investigation which is then aggregated into a seamless account. Supplementary and contributory factor information is often also recorded within this format.

When to Use a Narrative Chronology
This approach is best suited for compact and non-complex incidents, where the amount of detail regarding problems, good practice and contributing factors is compact. It is also an approach that fits well at the start of a more complex investigation report to give a concise overview of what happened. It can also be used as an integral part of the report as the summary of the incident "story" where it may be easier to read than a simple list of events

How to Complete a Narrative Chronology
Exactly the same as for a timeline (see Resource Centre) except that instead of placing event information in time stamped boxes the information is listed in narrative form. The key difference to note is that the supplementary information is incorporated in the body of the text.

Positive Aspects of the Narrative Chronology

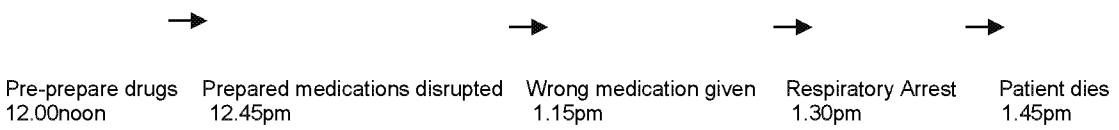
- Is a well-accepted format for presenting information.

Negative Aspects of the Narrative Chronology

- Can be difficult to pick out the salient points from a narrative chronology
- Can also be difficult to form a complete understanding of what happened in the case when using this format especially where multiple directorates or agencies are involved.

2. TIMELINES

What is a Timeline?
A timeline is a method for mapping and tracking the chronological chain of events involved in the incident. It allows the investigator(s) to identify information gaps and also to identify critical problems that arose during the process of care delivery. The usual presentation of the timeline is via the diagrammatic format detailed below. You will see that the data confines itself to the critical path, and does not detail any of the other salient points that might give an indication of the prevailing circumstances at the time. This supplementary information can be added once the critical path has been mapped.



When to Use a Timeline

- When undertaking any incident investigation, either as an individual or a team, where it is anticipated that the incident contains more than one isolated episode of procedural failure
- When the timeline (chronology) needs to be mapped prior to a Root Cause Analysis meeting with those involved in the incident, so that the way that the incident unfolded can be shown in an easily accessible format
- Useful to map an incident when you have multiple specialities or agency involvement, as it allows the systematic mapping of a variety of narrative chronological reports as well as mapping the

interface between the various agencies involved in the care or case management. However in such cases modifications to the timeline will be required.

How to Complete a Timeline
A timeline should either begin at the point at which the chain of events leading to the incident started, or at the point of incident occurrence and work backwards to the agreed start point. Whichever method is used, it is easier for potential readers of the timeline to have it presented in chronological order leading up to the incident. For most acute secondary care cases the time frame will span at least the period of admission to incident occurrence, though there will be occasions where the pre-treatment period needs to be included. It is important to be realistic when deciding how far back to go and, you will need to apply the principle of what is reasonable and what may be helpful in terms of the investigation.

Owing to the nature of data collection you do not have to wait until you have complete information before starting to map your timeline, as information can be added to the timeline as and when it becomes available to you.

Mapping the Incident
Each event identified, including the date or time of its occurrence should be placed in a box in chronological order. Arrows indicating the direction of time should link the boxes. Any supplementary information can be linked to the primary time-stamped event box.

Positive Attributes of the Timeline
- This approach will give you greater clarity about the key components of the incident chain, along with the supporting contextual information than some other techniques
- It will allow you to view the whole incident in one diagram
- It helps you identify information gaps and questions needed for interviews
- Experience suggests that investigators and staff using timelines are better able to identify the CDPs/SDPs (Care Delivery Problems/ Service Delivery Problems) that may require further causal analysis
- It enables you to make sense of complex and convoluted data.

Negative Attributes of the Timeline
- For some cases, which span a long period of time e.g. mental health cases, timelines can become very long and unwieldy
- Depending on your level of computer literacy, it can be difficult to integrate timelines into final reports easily.

3. TABULAR TIMELINE

What is a Tabular Timeline?
This is a development of the simple timeline, which includes more than just the basic facts. For each event, as well as its nature, date and time, there are three other fields that can be completed if the team has this information. These are Supplementary Information; Good Practice; and Care Delivery Problem/Service Delivery Problem. The table allows more detail to be recorded, but retains the discipline of the timeline type chronology.

When to Use a Tabular Timeline
A tabular timeline can be used for any type of incident. However, experience has shown that it is particularly useful for incidents that involve a long time. It is also useful when multiple agencies are involved and/or where you have a lot of information to cross-reference.

How to Complete a Tabular Timeline
A tabular timeline will initially be completed in exactly the same way as a diagrammatic timeline, where the event date and time are completed in the first two boxes of the table. Please note that date and time can be supplemented with a generic term like day or month if it is considered more appropriate. You may also find this is more practical when reviewing events over long periods of time.

Once the core information has been plotted, any other supplementary information, good practice or Care Delivery / Service Delivery Problems can be recorded in the dedicated rows assigned to them. See below: NPSA example

Event Time and Date	18 March 2002: 19.15	18 March 2002: 20.00	19 March 2002: 07.30
Event	The patient was seen on ward by the consultant anaesthetist	The patient was seen by the Senior House Officer (SHO) who applied the operation site mark	The SpR2 went to the ward and checked consent, notes and x-rays prior to operating list of patients
Supplementary Information	Pt declined a regional anaesthetic. Anaesthetic preassessment information is recorded in a log-book and the information then transferred to the anaesthetic record on the day of the procedure, although this transfer of information did not take place. This practice was adopted as the medical and anaesthetic record frequently got lost	SHO in her first SHO job and first rotation in orthopaedics. SHO applied the mark to an unusual part of the shin with a skin pencil, rather than the thigh or knee. Below knee anti-embolic stockings were then put on by the patient which covered the mark. No guidance or training is given to the SHOs on marking operative sites	
Good Practice			
Care Delivery / Service Delivery Problem	Failure to document planned procedure in the anaesthetic record	Operative site incorrectly marked	

Positive Attributes of the Tabular Timeline

- Allows you to map the chronology in a diagrammatic format, but allows additional information (e.g. supplementary information and good practice) to be mapped at the appropriate point on the chronology, making it easier to read and identify gaps quickly
- Additional information can be added where needed, without the need of reformatting.

Negative Attributes of the Tabular Timeline

- Some people prefer to map a case in a more fluid and dynamic way than this format allows.

4. TIME PERSON GRIDS

What is a Time Person Grid?

A time person grid is a tabular mapping tool that enables you to track the movements of people (staff, patients, visitors, contractors) before, during and after an incident, therefore enabling the investigator to clarify where all persons were at key points in the incident.

When to use a Time Person Grid

- You have a number of personnel involved in an incident and you need to ascertain where they were as the incident was occurring. (e.g. child abduction, absconsion, unexpected clinical emergency, violence and aggression)
- It is particularly useful for short time frames when a lot seems to be going on and many people are involved in the delivery of care. This tool enables you to clarify timings and placement of people and identify areas requiring clarification
- Can be mapped onto a timeline to examine a specific time frame in more detail. It is unlikely that you would use a time person grid for the whole of an incident, unless it is very short e.g. less than 30 minutes.

How to complete a Time Person grid

- Create a table composed of a number of rows and columns, see Figure 1 below.
- In the furthest column on the left list all the staff involved in the incident. Title this column "staff involved" or something similar.
- The following column headings should be time stamped e.g. 9.00, 9.05. 9.10, etc. These must run for the duration of your incident, or for the period you have decided to analyse using this technique.

- At each point in time, ascertain where each member of staff was e.g. at 9.10, anaesthetist was in the anaesthetic room.

Staff Involved	**9.02am**	**9.04am**	**9.06am**	**9.08am**
SHO	With patient	At Dr's station	At Dr's station	With patient
Ward Manager	In office	In office	With patient	With patient
Nurse	With patient	With patient	With patient	With patient

Positive Attributes of the Time Person Grid

- Quick and efficient tool to identify where all staff were when events within an incident were happening
- A useful mechanism for identifying where you have data or information gaps
- Maps onto a timeline effectively.

Negative (Challenging) Attributes of the Time Person Grid

- Can only be used for short timeframes
- People cannot always remember where they were at specific times, especially if the case did not seem particularly significant to them at the time
- Focuses on individuals.

Appendix C: Problem identification

TOOL	WHEN TO USE	DESCRIPTION	ATTRIBUTES
Brainstorming	To generate a list of problem areas that can be improved. Identify possible contributory factors. Consider what error reduction strategies or recommendations the Trust should instigate	Mechanism to generate as many ideas as possible around a given topic	Quick and simple. Does n have to involve detaile case review. Allows fre thought and considerati of unusual ideas
Brainwriting	To protect the anonymity of participants. There is a mixture of senior / junior staff in the group. Complex ideas are expected / fears that some people may dominate the brainstorming	Essentially the same as brainstorming but allows the group to generate ideas anonymously and in a short time frame	Retains anonymity individual. Encourages participants to take pa Effective if sensitive issue are to be discusse Structured approach
Five Whys	To question each identified primary cause of a problem: to identify if this is a symptom, an influencing factor or a root cause	Allows deeper questioning as to the cause of a problem and identify whether it is a symptom or a root cause	Allows individuals / group to drill down the caus pathway. Simple ar effective tool. Works well a group or individually
Fishbone	To represent contributory factor information related to a single problem	Diagrammatic tool used to capture causes contributing to a single problem	Diagrams are eas constructed. Based verified causal factor Provides a basis for reliab improvement plans
Barrier Analysis	Can be used proactively and retrospectively to identify missing or failed barriers. Evaluate proposed corrective actions by assessing the strength of each action and selecting the strongest ones	Critical analysis of the defence or control measures in place. Identifies missing or failed defences or controls	Unbiased analysis of contr measures in plac Identification of addition control measures that ma have prevented the eve from occurring. Assists the identification of caus factors