Lincolnshire Community Health Services NHS Trust

Procedure for the Investigation of Incidents, Complaints and Claims

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Lincolnshire Community Health Services NHS Trust
Version Control Sheet

Procedure for the Investigation of Incidents, Complaints and Claims

Version	Section/Para/ Annex	Version/Description of Amendments	Date	Author/Amended by
1		New Policy	August 2012	
2		Establishment of new NHS Trust	January 2012	Bev Wormald
3		Review and Update	July 2014	D. Kitson
4		Review and Update	June 2016	K Rossington
5		Review and Update	May 2018	R. Shrimpton and J. Gooch
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Lincolnshire Community Health Services NHS Trust

Procedure for the investigation of incidents, complaints and claims

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Policy Statement

Background

Lincolnshire Community Health Services has individual policies and procedures that cover the reporting and management of incidents, complaints and claims and being open with our staff, patients, carers and the public. This document sets out the process for investigation of incidents, looking at the underlying causes and identifying actions to prevent a recurrence and understand how loss can be minimized.

Statement

The 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. This policy has been developed to demonstrate Lincolnshire Community Health Services commitment to improving safety by learning lessons from the investigation and analysis of incidents, complaints and claims.

Responsibilities

Chief Executive, all Directors, Head of Clinical Services, Quality Assurance Manager, Service Managers, Staff.

Training

All new members of staff will be introduced to the Organisation's procedures, during the Organisation Induction programme.

Dissemination

Website
Via email
Identified in the Organisation's staff newsletter

1. Introduction

Lincolnshire Community Health Services NHS 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 fair blame culture and to encouraging a willingness to admit mistakes without fear of punitive measures.

This procedure document should be read in conjunction with the Claims Policy P-CIG-02, Being Open Policy P-CIG-16, Complaints P-CIG-08 Policy, Risk Management Strategy, Incident Reporting Policy P-RM-01 and the Serious Incident Framework P-RM-06.

Procedures for the investigation of serious incidents (SI) should be in line with the provisions within the Serious Incident Policy. For ease of reference, adverse incidents, complaints and claims will all be referred to as “incidents” for the remainder of this document.

2. Purpose

The purpose of this policy is to ensure that the appropriate level and quality of investigation is carried out in respect of adverse incidents, complaints or claims and results in measurable improvement in practice. This policy has been developed to demonstrate the Trust’s commitment to improving safety by learning lessons from the investigation and analysis of incidents, complaints and claims. Lincolnshire Community Health Services NHS Trust has individual policies and procedures that cover the reporting and management of incidents, complaints and claims and being open with our staff, patients, carers and the public. This document sets out the process for the investigation of incidents, including looking at the underlying causes and identifying actions to prevent a recurrence and understanding how loss can be minimised.

3. Definitions

Direct cause is defined as the immediate cause which triggered the incident.

Contributory cause is defined as a factor which contributes to the incident but which, by itself, would not have caused the incident.

Root cause is defined as any underlying cause to which the incident can be ultimately attributed and which if corrected should minimise the risk of recurrence.

Investigation: a detailed inquiry or systematic examination to establish the facts.

External agency: any non-NHS organisation that is recognised as having an interest in the investigation e.g. Police.

National Patient Safety Agency (NPSA): An arm’s length body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and

influencing organisations and people working in the health sector.

4. Duties

Chief Executive
The CEO has overall accountability for ensuring there are appropriate processes in place for the investigation of incidents, complaints and claims but delegates this responsibility through the Director of Nursing and Operations.

Director of Nursing and Operations
The Director of Nursing and Operations has responsibility for ensuring that appropriate processes are in place for the investigation of incident, complaints and claims.

Trust Board Secretary
The Trust Board Secretary has responsibility for ensuring the implementation of this policy. The Trust Board Secretary manages the corporate assurance and claims handling function.

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

Quality Assurance Manager
Quality Assurance Manager in the Business Units have responsibility for ensuring the operational and day-to-day implementation of the policy and that incidents are investigated thoroughly, appropriately and promptly in line with this policy

Complaints Manager, Quality Assurance Manager and Corporate Assurance Manager
The Complaints Manager, Quality Assurance Manager and Corporate Assurance Manager have responsibility for ensuring that all complaints and claims are investigated thoroughly, appropriately and promptly, in line with this policy.

Deputy Directors/Heads of Clinical Services/Senior Managers
Deputy Directors/Heads of Clinical Services/Senior Managers are responsible for ensuring that local analysis of trends arising from adverse incidents, complaints and claims takes place. Deputy Directors /Heads of Clinical Services/Senior Managers have delegated responsibility for the quality and effectiveness of the investigation process and subsequent appropriate analysis of all incidents, complaints and claims. They are also responsible for ensuring that local action plans are generated, implemented and delivered. Where actions cannot be completed or where they have Lincolnshire Community Health Services wide implication these should be discussed at the local Quality Assurance Meetings or Quality and Risk Committee as appropriate. Deputy Directors /Head of Clinical Services/Senior Managers will ensure that learning from the investigation, and analysis of adverse incidents, is shared with staff at local Quality Assurance Groups and cascaded from there to all staff through team meetings.

Role of clinicians/specialist advisors
Depending upon the incident it may be necessary to involve other staff within Lincolnshire Community Health Services or external experts/bodies with specialist skills and knowledge.

The Trust recognises that being involved in an adverse incident, complaint or claim can be traumatic and stressful. Managers are encouraged to refer staff to Occupational Health as appropriate to ensure that they are fully supported.

All Staff
All staff must ensure that they are aware of the contents of this policy and cooperate fully with any investigation.

Lincolnshire Community Health Services Trust Board
Lincolnshire Community Health Services Trust Board has overall responsibility for ensuring appropriate investigation processes are in place and for supporting action plans, training and opportunities for service improvement. The Lincolnshire Community Health Services Trust Board is also responsible for receiving quarterly reports so that it can be assured that lessons learned from the investigation of incidents, complaints and claims are implemented.

Committee with overarching responsibility for investigations
The Quality and Risk Committee will have overall responsibility for the management of investigations. The Quality and Risk Committee reports to the Trust Board and receives reports from the formal committees and quality assurance groups in the governance structure as detailed in the Risk Management Strategy.

The Quality and Risk Committee will receive aggregated data on a monthly basis and will consider themes and trends, causal factors and agree appropriate actions. The reporting of incidents, complaints and claims will enable trends to be identified and reported via the Quality and Risk Committee to relevant departments, individuals, groups and committees in order that appropriate action may be taken, learning disseminated and better quality services delivered.

The Quality and Risk Committee will, as a result of effective investigations and through the governance committee structure, facilitate organisational learning and service improvement. Such measures will be an intrinsic part of the action plan.

The Quality and Risk Committee will ensure continuous sustainability of risk reduction measures by receiving reports from committees and Effective Practice Assurance Group and monitoring the development of risk reduction measures.

The Quality and Risk Committee has developed terms of reference which include accountability, responsibility, authority, membership and quorum and has a schedule of meeting dates.

Quality Assurance Groups/Specialist Committees
The local Quality Assurance Groups/Specialist 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 quality assurance groups also have a responsibility to ensure that an ethos of learning is fostered within teams.

Link with incident management and complaints management
An effective interface between claims handling, complaints management and incident reporting is coordinated through the Quality and Risk Committee where reports are provided on these elements at the monthly meetings. Lincolnshire Community Health Services recognises that all these elements are important risk identification tools for the organisation.

5. Key Issues

Why are investigations necessary?
Investigations are necessary to provide a retrospective review of events in order to discover what, how and why they happened. By analysing this information Lincolnshire Community Health Services is able to identify areas for change and recommend actions and sustainable solutions to help minimise the risk of the same or similar incident recurring in the future.

Why is learning and sharing safety lessons important?
Learning from experience is critical to the delivery of safe and effective services across the NHS. To avoid repeating mistakes, organisations must learn from previous similar incidents. Effective learning cannot happen without efficient systems for communicating the outcome of investigations and team working to ensure the development of workable plans for improving safety.

The need for effective communication
As part of the investigation process it is important that Lincolnshire Community Health Services engages with patients, carers, staff and members of the public (as appropriate) in an open and honest manner. Lincolnshire Community Health Services has, through its Being Open policy, set out its commitment to this aim and the process that will be adopted to support its delivery. Discussions with those involved will be documented to demonstrate that the principles of the Being Open Policy have been followed throughout the investigation.

Support for patients/carers/relatives and staff
Being involved in an incident, complaint or claim which is under investigation can be a particularly traumatic and stressful experience. Lincolnshire Community Health Services, will actively endeavor to support patients, carers, relatives and by offering a range of counselling and support mechanisms. The arrangements adopted by Lincolnshire Community Health Services follow the principles outlined within the Being Open Policy.

6. Training

Basic information on incident reporting and investigation will be provided for all staff at induction.

All managers involved in incident investigation should attend Incident Investigation Training provided on the staff website.

Investigation training will be provided by Lincolnshire Community Health Services.

All training will be recorded on a central training database held by the Workforce Department.

7. Investigation

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

All incidents should be investigated in accordance with the relevant Lincolnshire Community Health Services policy.

Incidents graded as Low, Moderate or High
These incidents should normally be investigated and reviewed locally in the ward/department/service in which they occurred. The investigation lead will be the clinical leader or department manager (or their designated deputy). The investigation should

identify learning points or safety improvements and implement control measures to reduce the risk of recurrence. Any controls identified which are not within the clinical leader or department manager's ability to implement should be communicated to more senior management for consideration.

The Duty of Candour principles should be applied to incidents graded as causing harm of moderate or above.

Incidents graded as Extreme
These should be subject to investigation and led by a suitably trained person within the ward/department/service where the incident occurred. An Initial Fact Find (IFF) will establish facts and determine the level of investigation required. The Deputy Director should decide on the appropriate person to lead the investigation. It is the responsibility of the relevant Head of Clinical Service to ensure that all learning points and safety improvements are appropriately identified. Those not within the control of the local management team should be discussed at the Safeguarding/Patient Safety Committee with a view to adding to the risk register.

Incidents classed as a Serious Incident
In accordance with the Serious Incident Policy, the incident should be subject to formal investigation using root cause analysis tools. The investigation report and improvement strategies identified should be presented to and monitored by the Quality and Risk Committee.

7.2 Investigation process

The purpose of any investigation is to identify both the immediate causes and the underlying or root causes of the incident. The investigating manager will be appointed by the Deputy Directors, or Head of Clinical Services or Senior Manager.
The investigation will need to examine Trust wide systems and local work processes to extract the maximum learning from the incident. Subsequently, learning can then be applied within the organisation and, in some cases, across other parts of the NHS.
Investigations should be completed as quickly as possible. The timescale may differ according the level of investigation.

For complaints, timescales will be agreed with the complainant. Serious Incident timescales are outlined in the SI policy P_RM_06. Recommendations and actions arising from the investigation should indicate the person responsible for implementation and the timescale for completion.

The key components of the investigation process:

- Identify people to be interviewed – those directly involved in the case or who have an expert knowledge.
- Conduct interviews in private if there is likely to be disciplinary action,
- Staff representation should be considered and clerical support would be advisable.
- Collect evidence about what happened.
- Assemble and consider the evidence and record as a "chronology of events".
- Compare the evidence with relevant standards, policies, protocols, guidelines or professional practice (local or national) to identify care management problems or system weaknesses.
- Draw conclusions about what caused the incident.
- Agree timescale for feedback with interested parties e.g. Quality Assurance Manager, Senior Team, complainant, commissioner and any other party involved in the investigation.
- Where appropriate, draw up an action plan with prioritised actions, responsibilities,

timescales, costs and ways of measuring the effectiveness of actions.
- Record findings and recommendations.
- Debrief staff.
- Draft a report/response to include all aspects of the case, the findings made as a result of the investigation, lessons learned and steps to avoid recurrence.

Lincolnshire Community Health Services will consider the need to inform external agencies such as enforcing agencies, external stakeholders, external advisors etc. as appropriate. Third party investigation could be required if there is insufficient expertise or test equipment within the organisation, political considerations, the need to eliminate bias etc.

7.3 Investigation to establish Root Causes

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

All extreme rated incidents, some high rated, and all incidents causing moderate or above harm, should be subject to an investigation following RCA principles. See Risk Matrix (Appendix 5).

The following sections provide guidance on the steps to follow to find the root causes of an incident and the appropriate learning points and recommendations.

In summary, root cause analysis is a process that involves the following steps:

- Outlining the sequence of events
- Finding and recording each pertinent event (usually by creating a tabular timeline or similar process)
- Identifying why the incident, complaint or claim occurred.
- Identifying the contributory factors and root causes, for example by using the NPSA contributory factors framework (Appendix 3).

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.

7.3.1 Gathering the information

All material facts relating to the incident must be gathered as soon as possible after the event. In determining what information to collect the investigator must consider the facts leading up to, as well as the incident itself. For complex incidents it is only by starting at the point the incident actually occurred and working back through the chronology that the “start point” for the incident can be identified.

Investigators will find it helpful to consider information from a range of sources including:

- The people involved in or witness to the incident
- The place or environment in which the incident occurred
- The equipment or objects involved in the incident
- The documentation related to the incident

All staff involved in the incident must be identified and informed an incident investigation is taking place. Staff should be encouraged to contribute to the investigation process.

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All staff involved in tragic or catastrophic incidents must be advised of the availability of

confidential support and counselling during what will be a stressful period, and told that they can have a friend or union representative with them during interviews.

All staff involved and any witnesses to the event should be requested to provide a statement (Appendix 1) and, if necessary, interviewed as soon as possible after the event (Appendix 2).

During discussions with staff it is important to try to determine custom and practice in the workplace in which the incident occurred. The information obtained can help identify the context in which risk factors exist. Where applicable, the investigator should visit the environment where the incident took place preferably before any changes are made, noting the layout and the conditions e.g. space, flooring, lighting, noise, staffing levels etc

Any piece of equipment involved in the incident should be immediately removed and preserved as evidence.

Other information sources include evidence of:

- Guidelines, policies and procedures
- Clinical records
- Incident reports
- Risk assessments
- Maintenance records
- Clinical audits
- Training records

7.3.2 Mapping the event

Once all the information has been gathered and collated you will have to make sense of it all by ordering it in some way. This is particularly important when the event is complex and a large amount of notes and records have been gathered. 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:

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

7.3.3 Analysing the information

Mapping the chronology of events will start to identify gaps in knowledge and/or systems.
Gaps and problems can arise in the process of care, usually actions or omissions by staff e.g. care deviated beyond safe limits of practice, failure to monitor, observe or act.

Gaps and problems can also be associated with procedures and systems that are part of the process of service delivery and not direct care, e.g. training process, human factors, maintenance systems, environmental conditions and communication strategies.
For each gap/problem identified there will be a number of contributory/influencing factors and root causes.

There are a number of analysis tools which can be used including:

- Fishbone
- Five whys
- Brainstorming
- SHELL

7.3.4 Barrier analysis

An alternative technique 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, help evaluate proposed corrective actions by assessing the strengths of the current controls.

7.3.5 Developing solutions and an action plan for implementation

For all investigations a final report should be completed and an action plan developed to address any recommendations. Recommendations should be designed to address the root causes i.e. the conclusions of the investigation
It is the responsibility of the lead manager/clinical leader for that area to ensure action plans are completed.

Recommendations should:

- Be clearly linked to and address all identified root causes or key learning points

- Be designed to significantly reduce the likelihood of recurrence and/or severity of outcome.
- Be Specific, Measureable, Achievable, Realistic and Timed (SMART).
- Be prioritised wherever possible.
- Be categorised as those:
    - Specific to the area where the incident 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 incident if applicable

Action 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 for the implementation of each action point as well as a named individual with responsibility for sign off of completion.

7.4 Completing an investigation report

All Root Cause Analysis reports and recommendations will be monitored by the local quality assurance group/ Specialist Governance Groups. Investigations that identify possible performance issues should have that element investigated according to the Investigation Policy.

Any risks that remain unresolved after completion of the action plan will be reviewed in line with the risk management strategy.

8. Performance Management and Data Collection

Details of all reported adverse incidents (including no harm events), concerns, complaints and claims are recorded onto a central database. Aggregated analysis of incidents, complaints and claims is undertaken monthly and reported to the Quality and Risk Committee. This analysis allows for identification of trends and themes across service areas in order to drive changes in practice and quality improvement.

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

9. Sharing The Lessons

Lincolnshire Community Health Services supports a culture of open reporting where investigation and follow up will be fair, equitable and focused on learning and change. The Effective Practice Assurance Group provides a forum where lessons learned from local investigations can be shared and discussed in a supportive environment. It is the responsibility of the Quality and Risk Committee to make sure that an effective system of incident reporting and investigation is in place and that lessons learned through incidents/ near misses, complaints, PALS and claims investigation are shared and disseminated across the Trust via the Quality Assurance Groups.

Incidents reported by external stakeholders e.g. other healthcare organisations, social services, Coroners, members of the public will be investigated in accordance with standard procedures. Upon receipt, details of the reported incident will be forwarded to the manager of the most relevant area/department. The lead manager will be required to complete the necessary level of investigation and produce a report for the Effective Practice Assurance Group. A letter of feedback to the initial external stakeholder will share details of lessons learned and actions.

10. Local Feedback

The results of an incident investigation (or complaint/claim investigation) should be discussed with relevant staff. It is the responsibility of the investigating manager to ensure that feedback is provided to all relevant persons.

On occasions managers may need to provide feedback to other departments involved in the initial incident report.

11. Monitoring

This document will be monitored to ensure it is effective and to assure compliance.

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit	Responsible individuals/ Group/ committee (multidisciplinary) For review of results	Responsible individuals/ group/ committee for development of plan	Responsible Individuals/ Group/ Committee for Monitoring of Action plan
Percentage of investigations completed by trained investigators	Audit	Quality Assurance Manager/ Complaints Manager/ Corporate Assurance Manager	Annually	Quality and Risk Committee	Quality Assurance Manager/ / Corporate Assurance Manager/ Quality and Risk Committee	Quality and Risk Committee
The number of serious incident reports returned for further work by the Trust	Audit	Quality Assurance Manager/	Annually	Quality and Risk Committee	Quality Assurance Manager/ Quality and Risk Committee	Quality and Risk
Percentage of investigations completed per grade	Audit	Quality Assurance Manager/ Complaints Manager/ Corporate Assurance Manager	Annually	Quality and Risk Committee	Quality Assurance Manager/ Complaints Manager/ Corporate Assurance manager/ Quality and Risk Committee	Quality and Risk Committee
Percentage of investigations with completed action plans	Audit	Quality Assurance Manager/ Complaints Manager/ Corporate Assurance Manager	Annually	Quality and Risk Committee	Quality Assurance Manager/ Complaints Manager/ Corporate Assurance Manager/ Quality and Risk Committee	Quality and Risk Committee

APPENDIX 1

GUIDANCE TO STAFF REGARDING WRITING A STATEMENT OR REPORT

This guideline sets out the principles of effective statement / file note writing and should be used to ensure that information documented is standardised in such a way to ensure that:

- Information is available for all investigative processes e.g. RCA
- If there is a requirement for information to leave the organisation this is presented in a standardised way to underpin the organisations reputation
- As an organisation being in a position to provide an efficient response to requests for information i.e. information is collected only once in a standardised way which is fit for purpose

You may be asked to provide a statement as a result of an untoward incident, a complaint, a root cause analysis, or for a coroner's inquest. If you are requested to do this then you are required by the organisation to complete this task without delay.

1. **DO NOT PANIC.** It is recommended that you write your statement as soon as possible following the incident; this is because your recollection of events is likely to be more accurate. Your statement ***must*** be an accurate story line and ***must*** be supported by written/electronic records. It is also recommended that your statement is typed, signed and dated by yourself once completed.

2. Make sure you understand the task; if you are unsure about what you are being asked to do, seek guidance from:
   - Line Manager
   - Practitioner Performance Manager
   - Quality Assurance Manager
   - Profession or Trade Union representative

3. Using the templates available on the LCHS website you must complete your;
   - Full name
   - Qualifications
   - Details of the post you hold and a brief description of the significance of your role in relation to the incident in question.

4. Write in the first person as this provides an easier picture of who did what, when, why and to whom e.g. "I visited", "I performed", "I assessed".

5. Be clear about why you are writing the statement. Assume that the reader has no background knowledge of the case and/or healthcare settings.

6. Write simply and avoid jargon or abbreviations.

7. Write numbered, brief paragraphs, listing the events in the order they occurred; giving precise dates and times.

8. Within your report, state which details are based from ***your memory***; the contemporaneous records, what others wrote and your usual or normal practice. For example if it was normal for there to be no service as the incident happened at a weekend then state this.

9. Concentrate on ***your*** observations and understanding, provide a factual account, not supposition or opinions. Include ***your*** interpretation of events and information and the history given to you by the patient or from what you have read in the records and correspondence. Demonstrate that your history and examination were thorough; include not only what you found but what you looked for and failed to find.

9. If normal procedures were not followed, state what the normal procedures are and why these were not followed.

10. When referring to other people, be precise in their full name and title.

11. When mentioning procedures, describe them clearly. If you mention a drug, explain what type it is e.g. antidepressant, its full name, dosage and route of administration.

12. Always check your typed statement thoroughly and keep a copy for your reference.

13. The final paragraph of the statement should read:

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

14. The statement should be signed and dated.

15. Name and job title should be printed under the signature.

This can be found on the *Clinical Statement and Report Writing Guideline.*

Link to page:
https://staff.lincolnshirecommunityhealthservices.nhs.uk/patient-safety/practitioner-performance

APPENDIX 2

GUIDELINES ON CONDUCTING INTERVIEWS WITH STAFF INVOLVED IN AN INCIDENT INVESTIGATION

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 just 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 Practitioner Performance Team if required.

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.

Establishing the facts:

- Ask the staff member to describe the sequence of events before, during and after the incident.
- Ask the staff member 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.

APPENDIX 3:

Root Cause Analysis Investigation tools
Contributory Factors Classification Framework

Patient Factors	Components
Clinical condition	❑ Pre-existing co-morbidity ❑ Complexity of condition ❑ Seriousness of condition ❑ Limited options available to treat condition ❑ Disability
Physical Factors	❑ Poor general physical state ❑ Malnourished ❑ Dehydrated ❑ Age related issues ❑ Obese ❑ Poor sleep pattern
Social Factors	❑ Cultural / religious beliefs ❑ Language ❑ Lifestyle (smoking/ drinking/ drugs/diet) ❑ Sub-standard living accommodation (e.g. dilapidated) ❑ Life events ❑ Lack of support networks / (social protective factors -Mental Health Services) ❑ Engaging in high risk activity
Mental/ Psychological Factors	❑ Motivation issue ❑ Stress / Trauma ❑ Existing mental health disorder ❑ Lack of intent (Mental Health Services) ❑ Lack of mental capacity ❑ Learning Disability
Interpersonal relationships	❑ Staff to patient and patient to staff ❑ Patient engagement with services ❑ Staff to family and family to staff ❑ Patient to patient ❑ Family to patient or patient to family ❑ Family to family (Siblings, parents, children)

Staff Factors	Components
Physical issues	❑ Poor general health (e.g. nutrition, hydration, diet, exercise, fitness) ❑ Disability (e.g. eyesight problems, dyslexia) ❑ Fatigue ❑ Infected Healthcare worker
Psychological Issues	❑ Stress (e.g. distraction / preoccupation) ❑ Specific mental illness (e.g. depression) ❑ Mental impairment (e.g. illness, drugs, alcohol, pain) ❑ Lack of motivation (e.g. boredom, complacency, low job satisfaction)
Social Domestic	❑ Domestic problems (e.g. family related issues) ❑ Lifestyle problems (e.g. financial/housing issues) ❑ Cultural beliefs ❑ Language
Personality Issues	❑ Low self confidence / over confidence (e.g. Gregarious, reclusive, interactive) ❑ Risk averse / risk taker ❑ Bogus Healthcare worker

Cognitive factors	❑ Preoccupation / narrowed focus (Situational awareness problems) ❑ Perception/viewpoint affected by info. or mind-set (Expectation/Confirmation bias) ❑ Inadequate decision/action caused by Group influence ❑ Distraction / Attention deficit ❑ Overload ❑ Boredom

Task Factors	Components
Guidelines, Policies and Procedures	❑ Not up-to-date ❑ Unavailable at appropriate location (e.g. Lost/missing/non-existent/not accessible when needed) ❑ Unclear/not useable (Ambiguous; complex; irrelevant, incorrect) ❑ Not adhered to / not followed ❑ Not monitored / reviewed ❑ Inappropriately targeted/focused (i.e. not aimed at right audience) ❑ Inadequate task disaster plans and drills
Decision making aids	❑ Aids not available (e.g. CTG machine; checklist; risk assessment tool; fax machine to enable remote assessment of results) ❑ Aids not working (e.g. CTG machine, risk assessment tool, fax machine) ❑ Difficulties in accessing senior / specialist advice ❑ Lack of easy access to technical information, flow charts and diagrams ❑ Lack of prioritisation of guidelines ❑ Incomplete information (test results, patient history)
Procedural or Task Design	❑ Poorly designed (i.e. Too complex; too much info.; difficult to conceive or remember) ❑ Guidelines do not enable one to carry out the task in a timely manner ❑ Too many tasks to perform at the same time ❑ Contradicting tasks ❑ Staff do not agree with the 'task/procedure design' ❑ Stages of the task not designed so that each step can realistically be carried out ❑ Lack of direct or understandable feedback from the task ❑ Misrepresentation of information ❑ Inappropriate transfer of processes from other situations ❑ Inadequate Audit, Quality control, Quality Assurance built into the task design ❑ Insufficient opportunity to influence task/outcome where necessary ❑ Appropriate automation not available

Communication	Components
Verbal communication	❑ Inappropriate tone of voice and style of delivery for situation ❑ Ambiguous verbal commands / directions ❑ Incorrect use of language ❑ Made to inappropriate person(s) ❑ Incorrect communication channels used
Written communication	❑ Inadequate patient identification ❑ Records difficult to read ❑ All relevant records not stored together and accessible when required ❑ Records incomplete or not contemporaneous (e.g. unavailability of patient management plans, patient risk assessments, etc.) ❑ Written information not circulated to all team members ❑ Communication not received ❑ Communications directed to the wrong people ❑ Lack of information to patients ❑ Lack of effective communication to staff of risks (Alerts systems etc.)
Non verbal communication	❑ Body Language issues (closed, open, body movement, gestures, facial expression)
Communication	❑ Communication strategy and policy not defined / documented

Management	❑ Ineffective involvement of patient/carer in treatment and decisions ❑ Lack of effective communication to patients/relatives/carers of risks ❑ Lack of effective communication to patients about incidents (being open) ❑ Information from patient/carer disregarded ❑ Ineffective communication flow to staff up, down and across ❑ Ineffective interface for communicating with other agencies (partnership working) ❑ Lack of measures for monitoring communication

Equipment	Components
Displays	❑ Incorrect information / feedback available ❑ Inconsistent or unclear information ❑ Illegible information ❑ Interference/unclear equipment display
Integrity	❑ Poor working order ❑ Inappropriate size ❑ Unreliable ❑ Ineffective safety features / not designed to fail safe ❑ Poor maintenance programme ❑ Failure of general services (power supply, water, piped gases etc)
Positioning	❑ Correct equipment not available ❑ Insufficient equipment / emergency backup equipment ❑ Incorrectly placed for use ❑ Incorrectly stored
Usability	❑ Unclear controls ❑ Not intuitive in design ❑ Confusing use of colour or symbols ❑ Lack of or poor quality user manual ❑ Not designed to make detection of problems obvious ❑ Use of items which have similar names or packaging ❑ Problems of compatibility

Work Environment	Components
Administrative factors	❑ Unreliable or ineffective general administrative systems (Please specify e.g.: Bookings, Patient identification, ordering, requests, referrals, appointments) ❑ Unreliable or ineffective admin infrastructure (e.g. Phones, bleep systems etc) ❑ Unreliable or ineffective administrative support
Design of physical environment	❑ Poor or inappropriate office design (computer chairs, height of tables, anti-glare screens, security screens, panic buttons, placing of filing cabinets, storage facilities, etc.) ❑ Poor or inappropriate area design (length, shape, visibility, provision of space) ❑ Inadequate security provision ❑ Lack of secure outside space ❑ Inadequate lines of sight ❑ Inadequate/inappropriate use of colour contrast/patterns (walls/doors/flooring etc)
Environment	❑ Facility not available (failure or lack of capacity) ❑ Fixture or fitting not available (failure or lack of capacity) ❑ Single sex accommodation limitation/breach ❑ Ligature/anchor points ❑ Housekeeping issues – lack of cleanliness ❑ Temperature too high/low ❑ Lighting too dim or bright, or lack of ❑ Noise levels too high or low ❑ Distractions
Staffing	❑ Inappropriate skill mix (e.g. Lack of senior staff; Trained staff; Approp. trained staff) ❑ Low staff to patient ratio ❑ No / inaccurate workload / dependency assessment ❑ Use of temporary staff ❑ High staff turnover

Work load and hours of work	❑ Shift related fatigue ❑ Excessive working hours ❑ Lack of breaks during work hours ❑ Excessive of extraneous tasks ❑ Lack of social relaxation, rest and recuperation
Time	❑ Delays caused by system failure or design ❑ Time pressure

Organisational	Components
Organisational structure	❑ Hierarchical structure/Governance structure not conducive to discussion, problem sharing, etc. ❑ Tight boundaries for accountability and responsibility ❑ Professional isolation ❑ Clinical versus the managerial model ❑ Inadequate maintenance ❑ Lack of robust Service level agreements/contractual arrangements ❑ Inadequate safety terms and conditions of contracts
Priorities	❑ Not safety driven ❑ External assessment driven e.g. Annual Health checks ❑ Financial balance focused
Externally imported risks	❑ Unexpected adverse impact of national policy/guidance (from Department of Health / Health authorities /Professional colleges) ❑ Locum / Agency policy and usage ❑ Contractors related problem ❑ Equipment loan related problem ❑ Lack of service provision ❑ Bed Occupancy levels (Unplanned bed opening/closures) ❑ PFI related problems (Private Finance Initiative)
Safety culture	❑ Inappropriate safety / efficiency balance ❑ Poor rule compliance ❑ Lack of risk management plans ❑ Inadequate leadership example (e.g. visible evidence of commitment to safety) ❑ Inadequately open culture to allow appropriate communication ❑ Inadequate learning from past incidents ❑ Incentives for 'at risk'/'risk taking' behaviors ❑ Acceptance/toleration of inadequate adherence to current practice ❑ Ignorance/poor awareness of inadequate adherence to current practice ❑ Disempowerment of staff to escalate issues or take action

Education and Training	Components
Competence	❑ Lack of knowledge ❑ Lack of skills ❑ Inexperience ❑ Inappropriate experience or lack of quality experience ❑ Unfamiliar task ❑ Lack of testing and assessment
Supervision	❑ Inadequate supervision ❑ Lack of / inadequate mentorship ❑ Training results not monitored/acted upon
Availability / accessibility	❑ Training needs analysis not conducted/acted upon ❑ On the job training unavailable or inaccessible ❑ Emergency Training unavailable or inaccessible ❑ Team training unavailable or inaccessible ❑ Core skills training unavailable or inaccessible ❑ Refresher courses unavailable or inaccessible
Appropriateness	❑ Inappropriate content ❑ Inappropriate target audience ❑ Inappropriate style of delivery

	❑ Time of day provided inappropriate

Team Factors	Components
Role Congruence	❑ Lack of shared understanding ❑ Role + responsibility definitions misunderstood/not clearly defined
Leadership	❑ Ineffective leadership – clinically ❑ Ineffective leadership – managerially ❑ Lack of decision making ❑ Inappropriate decision making ❑ Untimely decision making (delayed) ❑ Leader poorly respected
Support and cultural factors	❑ Lack of support networks for staff ❑ Inappropriate level of assertiveness ❑ Negative team reaction(s) to adverse events ❑ Negative team reaction to conflict ❑ Negative team reaction to newcomers ❑ Routine violation of rules/regulations ❑ Lack of team openness/communication with colleagues ❑ Inadequate inter-professional challenge ❑ Failure to seek support ❑ Failure to address/manage issues of competence (whistle blowing)

Appendix 4

RCA Timeline

SI declared

Day 1 - author to be identified by HOCS/CGM/LL or Matron, author to be notified by CGM. Panel dates arranged for day 15, actual dates fixed on timeline, CGM inputs incident on to STEIS. NN/DNN notified if safeguarding incident

Day 1 - team advised that RCA is to be completed – LL or Matron

Day 1/2 – author makes immediate investigation date with team/individuals, DNN and CGM – support from LLor Matron to release time with support from service colleagues/ neighbouring corporate team if necessary.

Day1/2 meeting/teleconference to define and agree Terms of Reference between author, HOCS/CGM plus NN Safeguarding/VCYP if incident is safeguarding or if subject of RCA has a known safeguarding history; eg CIN,CP or LAC

Day 2/3 author request records/notes and any other documentation

Day 2 – 10 (as soon as possible, but no later than 10 days) CGM and author (plus DNN and Specialist Nurse for VCYP as required)) meet team and begin investigation

Day 2/15 author provides interim progress reports to CGM, author to alert CGM if safeguarding issues emerge from the review to ensure specialist advice and involvement from NN Safeguarding/VCYP

Day 15 RCA completed by author supported by CGM

Day 15 Draft RCA presented to panel for first line scrutiny – panel comprising HOCS, CGM, NN Safeguarding/VCYP as required. If approved will progress as below, if not returned for further work with 2 day deadline date

Day 15 (17) CGM and author share report with GM.

If safeguarding incident, reviewed RCA presented to next Safeguarding Governance Group (will need to have agreement for document to be tabled if necessary)
Day of SGG or next day - Reviewed RCA to Head of Safeguarding and Chief Nurse/Medical Director for sign off

< day 45 Report to next Q&R Committee for agreement (date of Q&R committee predetermined as the one prior to the day 60 deadline)

N.B. papers due 1 week before date of meeting

If approved at Q&R, CGM to submit to NHSL and request closure on STEIS. If not approved, Q&R to detail changes required and ratify subject to these. The Panel reconvenes (by email/teleconference) to discuss and make changes as required.

Progress against action plans monitored through monthly BU Scrutiny Group meetings and with DNN/Matron in the case of individual actions. Lessons learned also shared through this group with evidence of cascade to teams

Appendix 5

Incident Definitions/Risk Management Matrix – Consequence

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**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 4-15 days RIDDOR/ agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large 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 of 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 breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
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 of0.5-1.0 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

Likelihood score (L)

What is the likelihood of the consequence occurring?

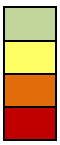
The frequency based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Amost certain**
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

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



1-3 Low risk
4-6 Moderate risk
8-12 High risk
15-25 Extreme risk

Appendix 6

MAPPING TOOLS

1. NARRATIVE CHRONOLGY

What is 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 con-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

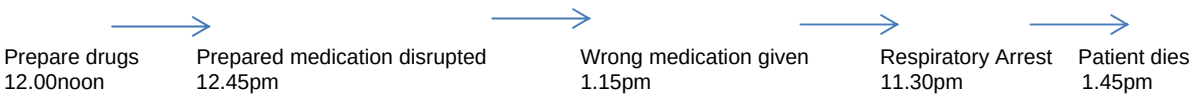
- It is a well–accepted format for presenting information

Negative aspects of the Narrative Chronology

- It can be difficult to pick out the salient points from a narrative chronology
- It 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 modification 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 accurate secondary cases the time frame will span at least the period of admission to incident occurrence, through 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 Cree 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 was 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 log0book 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 skin pencil, rather than the thigh or knee. Below knee anti-embolic stockings wear 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 that this format allows

4. TIME PERSON GRID

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 peoples 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 into 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
- It maps onto a timeline effectively

Negative (challenging) Attributes of the Time Person Grid

- It 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 7

Name of Policy/Procedure/Function*
Procedure for the investigation of incidents, complaints and claims
P_RM_05

Equality Analysis Carried out by:K Rossington
Date: 08/06/16
Equality & Human rights Lead: Rachel Higgins

Director\General Manager: Lisa Stalley Green

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	The 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. This policy has been developed to demonstrate Lincolnshire Community Health Services commitment to improving safety by learning lessons from the investigation and analysis of incidents, complaints and claims.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	This policy has an impact for all staff and users of LCHS services		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Keith Rossington		
Date:		8th June 2016		