National Patient Safety Agency

Comprehensive and Independent Investigation Report Template

Summary Guidance

The following format and headings are designed to improve the recording and standardisation of information in investigation reports (including multi-incident investigations), and to facilitate collection and learning from findings. These headings will continue to be evaluated and developed over time.

1. Write your investigation report in the blank comprehensive investigation template which accompanies this guidance
   a. Refer to quick ref. guidance here in green as you go.
   b. For detailed guidance refer to the NPSA's 'RCA investigation report writing guidance'.

2. On completion of the investigation and to complete your final report
   a. Ensure all guidance (in green) is deleted
   b. Update table of contents. To do this right click mouse over the contents table, select 'update field', then click 'update entire table' and press OK.
   c. Save the document with the chosen file name. Always include a version number in the filename.

[Add trust logo]

Root Cause Analysis Investigation Report

Incident Investigation Title:	
Incident Date:	
Incident Number:	
Author(s) and Job Titles	
Investigation Report Date:	

CONTENTS:

To update contents -Right click over contents table, select 'update field', click 'update entire table', click OK

Executive Summary

AFTER E MAIN REPORT IS COMPLETED, write here a one page summary of the document, presented succinctly under the following headings:-

• **Brief incident description:** • **Incident date:** • **Incident type:** • **Healthcare Specialty:** • **Actual effect on patient and/or service:** • **Actual severity of incident:**
Level of investigation conducted
Involvement and support of the patient and/or relatives
Detection of the incident
Care and service delivery problems
Contributory factors
Root causes
Lessons learned
Recommendations
Arrangements for sharing learning

MAIN REPORT:

Incident description and consequences

Concise description of the incident.

Example only
A lady with asthma sustained brain damage following IV administration of a drug to which she was known to be allergic.

Incident date:
Incident type:
Specialty:
Actual effect on patient:
Actual severity of the incident:

Pre-investigation risk assessment

Pre-investigation

Assess the realistic severity and likelihood of recurrence, using your organisation's Risk Matrix

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C = A x B)

Background and context

A brief description of the service type, service size, clinical team, care type, treatment provided etc

Terms of reference

Guide provided below. Amend this to build your own. Add only a summary to the body of the report.

Purpose To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients
Objectives To establish the facts i.e. **what** happened (*effect*), to **whom**, **when, where**, **how** and **why** (*root causes*) To establish whether failings occurred in care or treatment To look for improvements rather than to apportion blame To establish how recurrence may be reduced or eliminated To formulate *recommendations and an action plan* To provide a *report and* record of the investigation process & outcome To provide a means of *sharing learning* from the incident To identify routes of *sharing learning* from the incident
Key questions/issues to be addressed ...specific to this incident or incident type
Key Deliverables Investigation Report, Action Plan, Implementation of Actions
Scope (investigation start & end points)

Investigation type, process and methods used • Single or Multi-incident investigation • Gathering information e.g. *Interviews* • Incident Mapping e.g. *Tabular timeline* • Identifying Care and service delivery problems e.g. *Change analysis* • Identifying contributory factors & root causes e.g. *Fishbone diagrams* • Generating solutions e.g. *Barrier analysis*
Arrangements for communication, monitoring, evaluation and action
Investigation Commissioner
Investigation team Names, Roles, Qualifications, Departments
Resources
Involvement of other organisations
Stakeholders/audience
Investigation timescales/schedule

Level of investigation

Choose from: Level 1 (Concise); Level 2 (Comprehensive); Level 3 (Independent Investigation)

Involvement and support of patient and relatives

e.g. Meetings to discuss questions the patient anticipates the investigation will address and to hear their recollection of events (anonymised in line with the patient / relatives wishes).
e.g. Family liaison person appointed, information given on sources of independent support.

Involvement and support provided for staff involved

Refer (anonymously) to involvement of staff in the investigation, and to formal & informal support provided to those involved and not involved in the incident.

Information and evidence gathered

A summary of relevant local and national policy / guidance in place at the time of the incident, and any other data sources used:-
(Include:-Title and date of Guidance, Policies, Medical records, interview records, training schedules, staff rotas, equipment, etc)

Example only (please delete and use your own findings)
Interviews with the four staff on duty - 01.02.08
Interviews with patient relatives - 05.02.08
A visit to the location of the incident -14.02.08
The patient's clinical records

FINDINGS:

You may prefer to summarise findings as a whole, in a narrative style. If so, in order to facilitate collation, sharing and learning from investigations, findings should then also be segregated into the following headings (Detection, Notable practice, Care and service delivery problems, Contributory factors, Root causes, Lessons learned, and Post investigation Risk assessment). For definitions of each please refer to the NPSA's RCA Investigation Report Writing Guidance at: www.npsa.nhs.uk/rca

Chronology of events

Any timeline included in the report should be a summary. It may be valuable to include a fuller timeline as an appendix

Chronology (timeline) of events	
Date & Time	**Event**

Detection of incident

Note the point in the patient's treatment AND the method by which the incident was identified. See NPSA 'Detection Factors' tool for a list of options. www.npsa.nhs.uk/rca

Notable practice

Points in the incident or investigation process where care and/or practice had an important positive impact and may provide valuable learning opportunities.
(e.g. Exemplar practice, involvement of the patient, staff openness etc)

Example only (please delete and use your own findings)
Actions taken to inform the patient and relatives of the error in an open and honest way, and to subsequently involve them in the RCA process was valued by all and greatly enhanced the investigation.

Care and service delivery problems

A themed list or description of the *key* problem points, expressed as care and service problems, (example here in green).

Example only (please delete and add your own findings)
Nurses on the short stay ward routinely failed to complete the section in the patient notes to highlight the existence of known allergies

Contributory factors

List or describe significant contributory factors. See the NPSA 'CF Classification Framework' tool for list of options. www.npsa.nhs.uk/rca (The Contributory Factors Grid could be used in the report or appendix as an alternative to 'Fishbone diagrams', as appropriate to the case.) Include narrative on deliberation as appropriate.

These may ultimately be termed 'associated factors' in Mental Health cases, where lessons learned rather than root causes are identified.

Example only (please delete and use your own findings)
Over years numerous assessments for nutrition, pressure ulcers, falls risk etc. had been added, causing short stay wards to see the completion of all documentation as impossible.

Root causes

These are the most fundamental underlying Contributory Factors that led to the incident. They should be addressed or escalated. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link (by analysis) between the root CAUSE and the EFFECT on the patient. Include narrative on deliberation / rationalisation involved in arriving at these.

Example only (please delete and use your own findings)
1. When adding or updating patient assessments and care plans, risk assessment of the wider implications of their use should be conducted and acted upon to reduce the risk of impact on patient safety

Lessons learned

Key safety and practice issues identified which may not have directly contributed to this incident but are significant and will be useful learning for others.

Example only (please delete and add your own findings)
1. A distinction should be made between essential and desirable documentation in clinical records

Post-investigation risk assessment

Re-assess the realistic severity and likelihood of recurrence in light of your findings

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C = A x B)

CONCLUSIONS:

Recommendations

Recommendations should numbered and referenced and be directly linked to root causes and lessons learned. They should be clear but not detailed (detail belongs in the action plan). To focus effective action it is generally agreed that recommendations should be kept to a minimum where ever possible.

Example only (please delete and use your own findings)

1. Ensure allergy records and other priority assessment sheets are routinely filed prominently.
2. Ensure essential assessment criteria are set as mandatory fields in new electronic record development.

Arrangements for Shared Learning

Describe how learning has been or will be shared with staff and other organisations (e.g. through bulletins, PSAT/Regional offices, professional networks, Reporting to NPSA, etc.)

Example only (please delete and add your own findings)

- Share findings with other departments caring for short stay patients & include them in piloting solutions
- Share findings with NPSA, SHA & PCT to identify opportunities for sharing outside the organisation

Distribution List

Describe who (e.g. patients, relatives and staff involved) will be informed of the outcome of the investigation and how

Appendices

Include key explanatory documents. e.g. Tabular timeline, Fishbone diagrams, Cause + effect chart, Acknowledgements to patients, family, staff or experts etc

Action Plan

With Action plan, see also 'Types of Preventative Actions Planned'- tool at www.npsa.nhs.uk/rca

	Action 1	Action 2	Action 3
Root CAUSE			
EFFECT on Patient			
Recommendation			
Action to Address Root Cause			
Level for Action (Org, Direct, Team)			
Implementation by:			
Target Date for Implementation			
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion			
Monitoring & Evaluation Arrangements			
Sign off - action completed date:			
Sign off by:			