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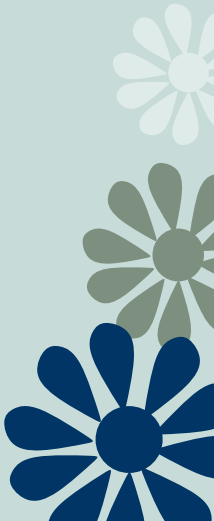
How do we investigate serious incidents?

Root Cause Analysis



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What is a Root Cause Analysis (RCA) investigation?

Our RCA Leads are responsible for investigating serious incidents. They look into how and why things have happened and see if there are lessons to be learned that will enable us to provide better, safer care.

The RCA process is neutral and does not seek to apportion blame. It uses a number of approaches to examine and understand how systems, processes and human factors may have contributed to an incident taking place.

Who is involved and how?

Most importantly the investigation, where possible, will involve working with the person involved, their carers and family so that their experiences, concerns or views can be considered and reflected in the investigation report. In the first instance, and where appropriate, when there has been a bereavement, we will normally contact the identified next of kin to agree how they or others may want to be involved.

When families do wish to be involved in the RCA process an RCA Lead will:

- Make contact with the family / carers early on and arrange for a meeting (or other method) for them to be involved
- Provide a point of contact for the family
- Be open and honest about what has happened, share this with family members and address any specific issue that the family have
- Know the details of the case
- Offer meaningful involvement in the production of the RCA report
- Be professional.

If a carer or family member chooses not to be directly involved in the investigation, we will always offer them the chance to receive a copy of the final investigation report for their information.

When the RCA investigation begins, the RCA Lead will identify the staff that were involved, either directly in the incident, or in the care that was being provided at the time. They will also work with other specialists depending on the type of incident.

As part of the investigation the RCA Lead may contact other agencies that have provided care to the person involved, this may include the family doctor, Social Services or other care providers. If a number of different agencies have been involved in providing care to the person, a joint agency RCA investigation may be undertaken. Once the investigation is completed the report is shared with the organisation that commissions the service(s) involved. They are responsible for reviewing the report and agreeing the actions that have been suggested.

What sort of incidents lead to an RCA being carried out?

Serious incidents in health care are adverse events, where the consequences for people using our services, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a detailed response is justified.

The 'Serious Incident Framework' is published by NHS England and describes the circumstances in which a serious incident investigation may be required. It provides details about how this should be done to ensure that incidents are identified correctly, investigated thoroughly and, most importantly, that organisations are able to learn from incidents to minimise the risk of something similar happening in the future.

There is no definitive list of events or incidents that constitute a serious incident.

Serious incidents include acts or omissions in care that result in:

- Unexpected or avoidable death
- Unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm
- Abuse
- 'Never Events' (a nationally agreed list of incidents that should never take place)
- Incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in health care services.

How do we decide what will be investigated?

Every incident that is reported is reviewed by the relevant service manager and our Experience, Safety and Risk Team. The Director or Deputy Director of Nursing and Practice can also be involved in this review.

Where an incident appears to require further investigation, for example where it has resulted in a high level of harm, it will be reported as a 'Serious Incident Requiring Investigation' to our commissioners and the Care Quality Commission and an RCA will be recommended.

There may be occasions where the RCA investigation has to be delayed. This could be until the end of another process such as a police investigation, Coroner's inquest or safeguarding enquiry. If this happens we will look at the outcome of these processes and then reassess whether the RCA investigation is still needed.

Who carries out the investigation?

We have a team of RCA investigators who are independent from our clinical services who complete most RCA investigations. Each of these investigators is a clinically qualified, senior mental health practitioner from a clinical background and has significant experience of working within mental health services.

There may be occasions when it is indicated that an external independent investigator should be asked to complete the investigation - particularly where the RCA investigation requires the review of a number of organisations.

What is the process and timescale for the investigation?

The RCA investigation should normally be completed and ready to be submitted to the commissioners for review and closure within 60 days of the incident being reported. If there are delays in the investigation those involved will be contacted by the RCA Lead to explain the reasons.

The RCA process is as follows:

1. The terms of reference for the investigation are developed, this identifies what will be included
2. Information is gathered and reviewed; the investigator will review the clinical records, policies and procedures and any relevant guidance
3. The RCA Lead will contact the identified person / next of kin to make arrangements for meetings with them or other family members, or carers if desired. Meetings with staff involved in the care are arranged.
4. The RCA Lead will contact other agencies and services involved in the care provided
5. The RCA Lead will review all of the information gathered and will draft their investigation report. The draft report is shared for consideration with the family, staff and others involved in the investigation and their managers. They are asked to check the facts in relation to the recommendations and learning identified in the report
6. The draft report is shared with the senior managers in the service involved, this includes the Clinical Director; they are asked to review the report, agree or amend the suggested actions and approve the report
7. Any comments received or amendments suggested are considered and the report is updated as appropriate
8. The final draft report is sent for review and approval to the Director or Deputy Director of Nursing and Practice
9. The approved report is sent to the commissioner for the service involved for review, approval and monitoring of the action plan. The commissioner may ask for further information before approving the report
10. Once the report has been approved by the commissioner a copy is shared with everyone involved including the person or their next of kin. If requested the RCA Lead may arrange to meet with the person affected, the family and staff from the services involved to discuss the report.

What happens once the investigation is completed?

Every investigation produces an RCA report which provides a summary of the information about the incident, what was involved in the investigation process and the outcome of the investigation.

The purpose of the report is to provide:

- a formal record of the investigation process
- an opportunity to share the lessons learned.

The report will explain

- what happened (a chronology of events)
- who it happened to
- when it happened
- where it happened
- how it happened (what went wrong)
- why it happened (what underlying, contributory or 'root cause' caused things to go wrong)
- what can be done to minimise the risk of it happening again.

How do services change after an investigation?

Each service named in the report is expected to review it, share the lessons learned across their services and complete all the actions that the report identifies as needing to be carried out.

The actions identified in the report are monitored by our Experience, Safety and Risk Team, reminders are sent to all identified action leads, their managers and the services involved to make sure that they are completed and evidence is provided that it has been done.

The commissioners regularly request updates and provide assurance that all necessary actions have been taken and will only close the action when they are satisfied with the progress made.

The learning and themes from all investigations are shared across the organisation in particular through our Learning from Experience Groups, our Quality and Safety Committee and other forums. Copies of anonymised reports are made available to staff for wider learning on our intranet.

What if someone is not happy with the outcome of the investigation?

We would always hope to resolve any concerns that people have about the investigation or report through the investigation process. However if, once the investigation report is completed, someone is unhappy with the outcome they may choose to raise their concerns as a complaint. They can do this by contacting our Patient Advice and Liaison Team.

Contact details are on the back of this booklet.

Reference: 515/05/17

Your feedback

If you would like to know more about us, need information in a different language or format or have a concern, compliment or complaint, then please contact our PALS Team:

PALS Team
Devon Partnership NHS Trust
Wonford House, Dryden Road
Exeter EX2 5AF

Freephone: 0800 0730741
Email: dpn-tr.pals@nhs.net

You will also find useful information about our services and issues related to mental health and wellbeing on our website.

www.dpt.nhs.uk