Incident Management - Guideline

Document Type	Guideline
Function	Clinical Administration, Management and Governance
Directorate(s)	All Auckland District Health Board (Auckland DHB) directorates
Department(s) affected	All Auckland DHB departments & services
Patients affected (if applicable)	All Auckland DHB patients
Staff members affected	All Auckland DHB staff members
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Contents

Content Cont'd

1. Purpose of guideline

Auckland District Health Board (Auckland DHB) recognises its responsibility in providing safe, effective and efficient healthcare for patients, and a safe environment for patients' families/whānau, staff, contractors, external personnel, students, volunteers and visitors.

The purpose of this guideline is to provide clear guidance on how to use the Auckland DHB Incident Management Framework, and outline its implications for reporting consistency with the National Reportable Events Policy, Worksafe New Zealand, Ministry of Health, ACC, the Health and Disability Commissioner and other regulatory requirements that may arise.

See Definitions and abbreviations in appendices

2. Summary

Auckland DHB is committed to ensuring a safety culture, following a systems approach that is embodied in the Incident Management Framework detailed below. In summary this will be achieved through:

1. Notifying of incidents when they occur or when they become apparent.
2. Informing patients, staff or their authorised representatives of any incident or accident which has created harm or has the potential to create harm to the patient or Auckland DHB staff.
3. Assessing each incident using the Auckland DHB Severity Assessment Code (SAC) (see appendices), excluding health and safety incidents.
4. Reporting of all incidents with a SAC of 1 or 2 to the Quality Department.
5. Immediately escalating to the appropriate manager or clinical leader an incident that is likely to result in media attention.
6. Ensuring all incidents are investigated. The nature of the investigation will be determined by the risk rating of the incident or the level of harm sustained by the person.
7. Ensuring that corrective actions and quality improvements are designed, implemented and evaluated to minimise the risk of recurrence of a similar incident.
8. Advising staff of actions taken to prevent recurrence of incidents and accidents and ensuring that these lessons are shared across Auckland DHB.

3. Scope

This guideline applies to any incident resulting in harm, loss or damage, to any person, property or environment, including near miss events occurring in any Auckland DHB-controlled site or location deemed to be an Auckland DHB 'Place of Work'.

This procedure is applicable to:

1. Any consumer or visitor within Auckland DHB places of work
2. All Auckland DHB workers (full-time, part-time, casual and temporary), and associated personnel (including contractors, students, visiting health professional etc.) working in, or contracted to provide a service on any Auckland DHB site.

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3. Any person undertaking work activity on an Auckland DHB controlled site, eg sales representative, stall holder.

Exceptions

This guideline does not apply to the management of complaints, unless an incident is identified as part of the complaint, in which case the incident will be investigated before the complaint process is completed.

1. Complaints from patients or their representatives are managed in accordance with the Consumer Complaint Management Policy (see associated Auckland DHB guidelines).
2. Staff complaints or grievances should be made in writing to the staff member's manager and not made on an Incident/Accident/Near Miss Notification Form (incident form).

4. Incident Management Framework

Incident management is a continuous process with many components. It is not simply about reporting incidents. The process involves 10 key steps - see Incident Management Framework flow diagram in appendices.

Step 1. Incident Identification

An incident is an unplanned event that results in, or has the potential to result in, injury, damage or loss. In this document the scope of an 'incident' also includes accident, and also applies to clinical and non-clinical events:

- Clinical: an event unrelated to the natural course of the illness and differs from the expected outcome of patient management.
- Product Fault: an event where a consumable product or medical device has failed in its intended purpose.
- Health and Safety: An event relating to a hazard, work injury or serious harm, involving employees, contractors, sub-contractors, students and volunteers.

An incident may be minor (eg medication error with no harm, piece of equipment goes missing, loss/unavailability of clinical record), moderate (eg additional monitoring, investigations or interventions as a result of incident, patient reacts to medication which should have been withheld) or serious (see serious adverse event/serious harm in Definitions and abbreviation).

Line managers are responsible for ensuring that staff understand what constitutes a patient "incident" and how it differs from a complication of care (see Definitions and abbreviations in appendices).

The first step in managing incidents is recognising and identifying them. Incidents may be identified:

- By direct observation or facilitated discussion
- By clinical staff or patient during or following patient care
- By a patient or family/whānau member expressing concerns or complaints to a staff member
- By the consumer liaison team when they are assessing complaints
- By the Quality Department

- From ACC reports
- From Coroner's report
- From clinical record audits
- From morbidity/mortality reviews

Note: If an incident results in, or is linked to a complaint, it must be investigated and managed in the first instance as an incident, but also responded to as per the Consumer Complaints Management Policy (see associated Auckland DHB guidelines).

If an incident is identified in the complaint, the incident must be reported in the Incident Management System by the Quality Department in conjunction with the main directorate involved.

Step 2. Immediate Action

Following identification of an incident it may be necessary to take immediate action to mitigate the harmful consequences of the incident. Such action would potentially include support for the person involved, their family and/or the staff involved in the incident. Immediate action may also be needed to make the local environment safe eg the removal of a hazardous substance. Call for assistance/advice as necessary.

On discovering an event, preventive or corrective action must be initiated immediately to ensure person(s) safety and wellbeing. This may include:

- Additional medical treatment
- Placing the patient in a safe environment
- Replacing faulty equipment
- Withdrawal of a service in the interests of patient safety

In the event of serious harm to a **staff member**, where possible the scene of the incident should be secured by the person in charge of the workplace and notified accordingly to Health and Safety policy (see associated Auckland DHB documents).

For all incidents resulting in harm or possible harm to a **patient**, the information about the event must be given to the person involved and/or carer as soon as it is practicably possible (at least within 24 hours of the event becoming known) in an open and honest manner. This process is called 'Open disclosure' and is described on the next section.

In some situations it is also appropriate to secure items such as the patient's clinical record or the equipment used as it may be required for the review of the event.

Step 3. Open Disclosure

Open disclosure of information to patients and their representatives has four key components:

1. Acknowledgement of and/or expression of regret to the person involved, family/whānau that the incident occurred,
2. An undertaking that an investigation will be done to determine why the event occurred,
3. Disclosure of the facts determined by the review to the person involved and their family/whānau where appropriate and
4. Providing support for those involved - patients, families, carers or staff - to cope with the physical and psychological consequences of what happened.

The points below should be included when communicating with the patient and/or responsible person:

- Involve a senior staff member/manager to disclose SAC 1 & 2 events. When an event is scored at 3 or 4 the health professional with overall responsibility for the consumer's care (or their delegate) must disclose the incident.
- Factual explanation of what happened.
- Explain any potential consequences for patient.
- Outline what steps have been taken to manage the event and prevent reoccurrence.
- Timeframe for investigation, type of investigation and method of feedback to patient and/or responsible person (family/6hanau member or other person).
- Contact details of staff member who will maintain ongoing relationship with patient or responsible person (family/whānau member or other person).
- Consideration to the consumer's cultural and ethnic identity and first language, and the support they require.
- For Māori, please contact He Kamaka Oranga.
- For a Pacific patient and family, please contact the Pacific Family Support Unit.
- Provide copy of '*Your Rights'* (see other resources) leaflet which includes how to make a complaint & support services available.
- Provide consumer with information on the Health and Disability Commission (HDC) advocacy service.
- Advise that they may be eligible to make an ACC Treatment Injury claim for costs related to an injury arising from an event. Provide information on the claims process and initiate medical forms (ACC45 & ACC2152 - see Forms) as appropriate, as soon as possible.
- Disclosure and subsequent action must be detailed in the patient's clinical record.
- Provide an apology for any harm suffered. This is Auckland DHB's opportunity to say "*We are sorry that this happened to you*". The apology is about acknowledging the seriousness of an incident and the distress that it caused. It is not about apportioning blame for the event happening. Further information about open disclosure is provided by the Health & Disability Commission (see also Feedback and Learning)

The focus of open communication is to answer questions in a manner that satisfies the person of the honesty of the communication. It primarily encompasses communication between health care providers and patients/carers and may include a factual explanation of what happened, the potential consequences and what steps are being taken to manage the event.

Step 4. Notification/Reporting

Any employee of Auckland DHB who identifies an incident can and should notify it by completing the Incident Form (see appendices) using the Incident Management System. The Incident Form should preferably be completed by the staff member involved in the incident, but may also be done by any staff member who becomes aware of the incident.

The Incident Form must be completed as soon as possible, preferably before the end of the working day/shift **but no longer than 24 hours**. Notifications must be legible and stated in an objective, factual and professional manner. Opinion and subjective comments should be avoided. Identification of staff involve should be avoided. If unsure, advice may be sought from the Quality Department.

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Note: An Incident Form must **not** be completed by patients, clients or visitors

Where the incident has:

- Resulted in patient harm arising from clinical treatment - an ACC Treatment Injury Form 2152 must also be completed (if relevant). The line manager receiving an incident form must review the incident and ensure that appropriate immediate interventions, open disclosure and corrective actions have been taken to minimise any further harm/loss.
- Involved a patient - documentation describing what occurred, any care provided to the patient and that the issue has been discussed with the patient/family is to be completed in the patient's clinical record, stating the number of the incident form used to notify the incident.

Note: A copy of the incident form must **not** be filed in the patient's clinical record.

- Involved a staff member, student, visitor or contractor - medical attention should be sought as required, and an incident form must be completed and sent to the Health and Safety Service at the earliest opportunity.
- Where the incident requires investigation and response from another service in Auckland DHB - the line manager receiving the incident form is responsible for:
  - forwarding to the other service(s) a copy of the incident form for their investigation and follow-up
  - forwarding to Quality and Patient Safety or Health and Safety as appropriate, documentation received should outline the other service's follow-up.

Where the other service does not respond to the line manager's request for follow-up, the line manager may elevate this request to their own manager to pursue.

Where the incident involves an external facility eg rest home and is felt to be sufficiently serious with a need to follow up, it is the line manager's responsibility to contact the facility to notify them of the issue. A copy should be sent to Planning and Funding for their information.

All incidents with a rating of SAC 1 or 2 must be notified as soon as possible (within 24 hours) to the ward/team manager and Quality Department. See Incident Management Process in appendices for the required process for SAC 1 and 2 incidents.

[1]**Note: Clinical Incidents** where serious harm has occurred must be reported to the Quality Department and **Non Clinical Incidents** must be reported to Health and Safety immediately during normal business hours and to the Clinical Nurse Manager/hospital coordinator after hours.

[2]**Note:** In case of any issue to access the Incident Management System to report an incident for more than 24 hours, a printed Incident Form (see appendices) can be filled and sent to the Quality Department during normal business hours and to the Clinical Nurse Manager/hospital coordinator after hours.

The charge nurse/midwife or the senior staff member on duty must be advised of any event involving a patient in their care which occurs outside of the patient's ward/unit.

Notification to other internal services, such as the following, may be required:

- Auckland DHB Communications
- He Kamaka Oranga (Māori Health)
- Cultural services (eg Pacific Health)
- Medicines Governance Committee
- Research Principal

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- Infection Prevention and Control/Microbiology
- Occupational Health and Safety
- Human Resources
- Legal Counsel
- Materials Management (for all device related incidents)

Step 5. Prioritisation of incidents

The notifier must make an initial assessment of the severity of the incident - as major, intermediate or minor - when the report is submitted to the line manager for confirmation. The line manager of the notifier is responsible for confirming the severity of the consequence, determining the likelihood and SAC rating.

The SAC contains four levels of severity. The definitions for consequence in the matrix must be used to ensure consistency in the rating of risk across Auckland DHB. The rating is determined by assessing the actual outcome or consequence of the incident that has been notified as far as it can be known at the time of notification (See Prioritising Matrix: Severity Assessment Code in appendices).

Each incident will be assigned a SAC score by the manager of the area concerned within three (3) working days of the incident having been reported, particularly if the SAC rating is 1.

If an incident is complex and the manager is unclear what SAC should be assigned or the type of investigation, they must escalate the case as follows:

- To the Quality Department representative (Clinical Effectiveness Advisor, Clinical Quality Facilitator) allocated to the directorate. They should advise about the SAC rating.
- If there is still a discrepancy or no clear SAC rating, the Quality Department representative should present the case in the next SAC 1-2 group meeting, asking for advice.
- If there is still a discrepancy, a clinical representative from the Directorate/Service should present the arguments at the SAC 1-2 group meeting and a final decision must be made.

Cases requiring escalation must be documented in a brief summary of the discussions and decisions. The final SAC rating must assigned within 15 working days of the incident having been reported.

Some events require mandatory external notification regardless of their risk rating. These incidents must be managed in accordance with the requirements of the policy, and must be escalated to the Quality Department and/or to OH&S if the incident is notifiable within one (1) working day to ensure appropriate external notification. Incidents requiring mandatory external notification are specified on the Severity Assessment Code and are listed in Prioritising Matrix. Severity Assessment Code (see appendices).

Step 6. Review (incidents involving patients)

It is the Director of the directorate responsibility to ensure that an appropriate review process commences as soon as possible and that preventative actions are implemented and noted on the Incident Management System. Clinical Effectiveness Advisors or Quality Facilitators are available as a resource to assist and provide advice.

When an event may involve more than one area, the Director of the area in which the event occurs must liaise with other senior staff members to ensure an appropriate review process occurs, for example when an incident involves both an operating room and a ward, or a ward area and medical staff members.

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Review Tools

There are several tools available to investigate incidents. The choice of tool will depend on the severity or outcome of the incident that is being investigated.

SAC 1 events

All events that are coded as SAC 1 will be investigated using a Root Cause Analysis (RCA), London Protocol (mental Health cases) or equivalent systematic method of review. This will be completed within 70 working days of the incident being notified, including submission to the Adverse Events Review Committee (AERC) for approval of methods, findings and recommendations. A summary report from the RCA will be forwarded to the Health Quality and Safety Commission (HQSE) i.e. Reportable Events Brief (REB) Part B (see other resources).

SAC 2 events

SAC 2 incidents must have a detailed investigation. This could take the form of a systematic review (such as RCA, Failure Mode Effect Analysis FMEA, London Protocol); however other appropriate and effective investigation methods may be used, such as a case review. It is possible to aggregate similar events and review together. The investigation must be completed within 70 working days. A copy of the report is to be sent to the Adverse Events Review Committee for approval of methods, findings and recommendations. A summary report will be forwarded to the Health Quality and Safety Commission (HQSE) i.e. Reportable Events Brief (REB) Part B (see other resources).

RCA is a mechanism to find effective solutions to identified problems, and will assist in developing an open and fair culture where the emphasis is on learning and not apportioning blame. Once root cause(s) have been established corrective action(s) must be agreed upon with a completion date and the persons responsible for the implementation of the corrective action(s).

The London Protocol differs from the Root Cause Analysis model with its emphasis on gaps and inadequacies within the system and its analysis of the chain of events and contributory factors leading to the adverse event rather than a focus on a single/small number of root cause(s). See The Principles of Root Cause Analysis (RCA) Investigation and London Protocol in appendices for more information on RCA and London protocol investigations.

Setting up a review team (SAC 1 and 2)

Review investigations must be facilitated by the lead directorate who will be responsible for its timely completion. A review leader must be provided with relevant training and/or support. Members of the Quality Department can advise on process and methods. Team members must be selected by the directorate for their expertise in the subject matter relating to the event. Directorates should consider including staff members outside the immediate clinical area, where appropriate, such as other clinical services, cultural advisors, facilities management, pharmacy, allied health and materials management. Staff members directly involved in the event (or their manager) must **not** be included in the review team. Directorate leaders must ensure team members are released from their usual work to undertake the review. The Quality Department will regularly report to the lead Director about the progress towards completion of reviews.

Final reports (SAC 1 and 2)

The final report must be agreed upon in conjunction with the key leaders in the service including the service directorates, service manager and clinical director/professional leader, prior to submission to the Adverse Events Review Committee.

The report and any associated documents such as interview notes, meeting notes, and timelines are to be stored electronically by the Quality Department.

Reports must not identify patients or staff members.

Any disagreement between the review team and key leaders in the service that cannot be resolved through the review process must be discussed at the Adverse Event Review Committee and final recommendations must be made.

SAC 3 and 4

A review of these incidents must be undertaken at the ward or service level and responsibility for their management must be assigned.

Review of these incidents must identify:

- System issues that need to be addressed
- Appropriate quality improvement action to prevent recurrence where possible

Potentially relevant tools include: barrier analysis, cause and effect diagrams, five whys, flow diagrams and change analysis.

It will not be possible to formally investigate all SAC 3 and SAC 4 events. It may be more efficient and just as appropriate to investigate multiple incidents as common incident types and to develop a common action plan.

The review, or decision to aggregate events, should be completed within 30 working days and documented in the '*outcome details*' section on the electronic reporting database.

Staff support

Ensure staff safety and support. Approaches might include defusing, debriefing and involving professional bodies as outlined in the Critical Incident Stress Management policy (see associated Auckland DHB documents).

The Employee Assistance Programme (EAP) is available to staff members for support and debriefing. See the Occupational Health & Safety intranet site.

Māori staff members may be offered whānau support throughout the process.

Protected quality assurance activity (PQAA)

Although the initial notification of an event has no special protection, some subsequent review processes (eg departmental clinical audit) may be undertaken as PQAA but protection is limited to new information regarding the clinical care provided by individual health practitioners.

Auckland DHB's primary investigation into an adverse incident, such as an RCA, will not be carried out as a PQAA.

Staff members must be well informed about the use of information provided for any review they are asked to be involved in. Staff members may be requested to write additional factual

information as part of the review process. Notes may be taken as review teams gather more information about an event, however audio-visual recording of discussions should not occur.

A staff member may seek advice from Auckland DHB Legal Counsel or their professional body. See Protected Quality Assurance Activities policy in associated Auckland DHB documents for more information.

Medico-legal involvement

Where an event has resulted in a review by the Coroner, the RCA or equivalent review may be submitted to the Coroner before the inquest. Consult with Auckland DHB Legal Counsel.

For any event that may have medico-legal implications, (i.e. there is a significant adverse outcome for the patient/client and criticism of clinicians is likely) documentation other than a factual account in the clinical record and the standard notifications should be made only with legal/professional advice.

Medical defence organisations and/or professional indemnity insurers require notification of potential claims. This is the responsibility of the individual professional involved.

Advice can also be sought from Auckland DHB Legal Counsel. Legal advice must not delay submission of the event via Incident Management System.

Performance Issues

Although the review process seeks for to identify systems and process gaps, it may in the process find potential performance issues. In this case, the team review could discuss any concerns with the Clinical Effectiveness Advisor allocated to the case and then with the Quality Manager who will be manage this with the directorate lead. The final report must not refer/describe any performance issue

Step 7. Coding

This is a process of capturing relevant information about the incident to ensure that the complete nature of the incident is documented and understood. The electronic Safety Management System provides a coding system for incident categories i.e. location of the incident, responsible manager, causal and contributing factors, actions to develop and lessons to be learnt from the incident.

This information is recorded using different sources of classification that is normally validated.

Converting relevant information in to categories or codes allows for easy analysis and facilitates reports and dashboards.

Step 8. Analysis

The Incident Management System provides the ability to summarise events occurring within a service, directorate or within Auckland DHB.

The following types of analysis should be considered:

- Summary of the frequency of incidents - allows prioritisation for the allocation of resources
- Descriptive summaries
- Trend analysis can identify changes that suggest new problems (or, if improving, that safety measures are working). A cluster of events that suddenly arises suggests a need for inquiry and immediate action

- Identify correlations eg causal factors such as communication, workloads, teamwork, equipment, environment and staffing

Monthly service level reports are to be discussed at service/quality meetings and other relevant forums to discuss trends and identify where further action is required.

Step 9. Action

Implementation of recommendations from the reviews are required to develop better systems to ensure improved practice. The Adverse Events Review Committee will review the reports from SAC 1 and SAC 2 investigations and decide whether they should be accepted in conjunction with the directorate. The directorate will consider the allocation of appropriate resources to implement the agreed recommendations. The acceptance of the recommendations is recorded in the minutes of the Adverse Events Review Committee.

Recommendations from SAC 1 and SAC 2 reviews must include timeframes for completion and must have an assigned person(s) responsible for the implementation of recommendations. The recommendations are added to the Auckland DHB-wide corrective action database for tracking of implementation. An audit of recommendations must occur 90 days after the completion of the RCA or formal review. A report showing progress will be submitted by the Quality Department to the relevant Directorate(s) and the Auckland DHB Clinical Board quarterly.

The Adverse Events Review Committee is a sub-committee of the Auckland DHB Clinical Board. It provides organisational governance of all Auckland DHB SAC 1 and 2 events to ensure:

- Appropriate investigation options are implemented
- Process is clear and transparent
- Reporting is accurate and timely
- Implementation of recommended actions from all SAC 1 & 2 occurs
- External reviews are appropriately commissioned and executed
- Organisational learning is facilitated

Step 10. Feedback and Learning

To staff members

Feedback must be provided to relevant staff members on the results/outcomes of investigations for all events. This must occur in a timely manner. For a SAC 1 event the feedback must be undertaken by senior staff and be based on the final RCA report. The RCA report must be provided to the relevant clinical team and presented at relevant staff meetings.

Directorates should provide ward staff members/clinical and management teams regular reports on aggregated data and outcomes of reviews. Feedback should include the changes made and the improvements achieved as a result of these changes.

To patient/responsible person (family/whānau member or other person)

Patients or family members must be provided with an opportunity to discuss the outcome of the investigation unless there are exceptional reasons for not doing so. The meeting should be face to face if possible and may include the provision of the report and other summary material. The patient/family should be provided with an opportunity to meet again to discuss any questions they may have as a result of the outcome meeting or reading the report.

Feedback should usually be made to the individual patient and/or responsible person (family/whānau member or other person). This must occur formally for SAC 1 and SAC 2 events. When discussion with the consumer is not possible or appropriate - such as when they have died or been significantly compromised - his or her next of kin, designated contact person, or representative must be informed.

Cultural support and processes and/or emotional support must be considered when arranging the feedback meeting for patients or families. Details about the incident and any harm experienced and any other subsequent clinical actions must be fully documented in the patient's clinical record.

If not previously, notified consumers must be advised at this point that they may be entitled to compensation through the ACC Treatment Injury claims process. Appropriate medical forms (ACC45 & ACC2152 - see Forms) must be initiated.

Directorate leaders must be involved in decisions on who provides feedback to patients and their families and on when and what information is to be provided. Details of staff members involved in the event must **not** be included in any feedback. The Consumer Liaison Department may be asked to facilitate feedback to the patient or family.

5. Incident Management Timelines

	Milestone	Working days	Accumulate working days	Directorate accountability	Quality Department accountability	Team review accountability
1.	**Incident identification**			Mitigate/control risks, communicate with the patient, family and other stake holders		
2.	**Incident reporting**	0	0	To report the incident in the Incident management system	Provide access to the safety management system	
3.	**Incident SAC rating**	5	5	Determine the SAC score, for complex cases seek advice from the Quality Department	In cases where the directorate seeks clarification/advice on the SAC rating, the case would be presented at the next SAC1-2 meeting. This will be presented by the CEA allocated for that directorate. All CEAs by directorate oversee incident forms for their directorates. If a CEA finds that a serious or major event is not classified correctly, it can be presented at SAC 1-2 - the directorate is then informed of any changes	

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4.	**REB A sign off**	3	8	Director to sign off the REB A form and send it to the CEA	Once the SAC score is confirmed as 1-2, the CEA prepares the REB Part A form and sends it to the directorate for sign off	
5.	**Team confirmation**	5	13	Director to confirm the names of the clinical team involved in the review	CEA will request names from the directorate for the review team	
6.	**First meeting**	10	23		Prepare the timeline for the case. Send invitation of participation to the review team members. Book meeting room laptop and projector. Prepare the slides for the first meeting. Make contact with the team members to allow an opportunity to respond to questions before the meeting. CEA to send the RMPro incident form, timeline, terms of reference and agenda to the review team before the meeting	Participation/ engagement in the meeting. Contribution of material relevant to the case. Discussion and correction of the timeline. The aim of meeting one is to complete the simple flow diagram, agree on the actions (eg interviews, data analysis, etc.) and agree on dates for the next meeting
	Time between 1st and 2nd meeting				Collect information sent by the team members. Configure templates for the detailed flow diagram and causation flow diagram. Book meeting room, laptop and projector. Prepare slides for the second meeting and ensure contact is made with members of the team in order to help and support with the interviews.	Interview staff as agreed. Research relevant issues and other relevant analyses. Locate policies/ procedures
7.	**Second meeting**	15	38		Facilitate in the development of the detailed flow diagram and on the causation flow diagram. Allocate sections of the report (findings) to each team member	Participation/ engagement in the meeting. Contributes with material relevant for the case eg interviews notes, policies, data, processes etc. Develop and contribute to the detailed flow diagram and to the causation flow diagram

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	Time between 2nd and 3rd meeting				Start report writing for sections: details of the incident, brief description of the case, insert the detailed flow diagram, insert the causation diagram if completed. Book meeting room , laptop and projector, prepare slides for the third meeting	Contribute to the report by completing the allocated report findings
8.	**Third meeting**	5	43		Develop and complete the causation diagram. Develop recommendations and discuss residual risk	Participation in the meeting. Complete the causation flow diagram, contribute to the discussion on recommendations
	Draft 1	5	48		Collect all the information from the review team and put together all a first draft of the report. Send the draft to the team for their first review	Review the draft and contribute while ensuring all changes are tracked
	Final draft approved	15	63			Approve the final draft
	Send draft report to the staff involved and to the services involved				Send the approved draft to the staff involved for errors of fact and then to the service clinical directors for comments	Comment on feedback received from the draft report
	Send to the directorate for Pre - approval	5	68	Pre-approve the case/send comments or feedback to the review team.	Send to the director (others involve in the assessment at the directorate level) for analysis and pre-approval	To revise and review the report if requested by the director/ directorate level. In cases where the team do not agree with the comments (or some of them) the case shall be presented and discussed (points of disagreement in the AERC)
	Ready to include in the next AERC agenda pack	2	70	To be present during the presentation, and be accountable for the implementation of the actions	Include the case in the next AERC agenda pack	To present the case at the AERC meeting and to respond to any questions received from the committee

6. Supporting evidence

1. Vincoli, J. W. (2014). *Basic guide to system safety* (3rd Ed.). John Wiley & Sons.
2. Backlund, A. (2000). The definition of system. *Kybernetes, 29*(4), 444-451.
3. Miller, J. G. (1995). *Living systems*. University Press of Colorado.
4. Marx, D. A. (2001). *Patient safety and the" just culture": a primer for health care executives*. Columbia University, New York.
5. McKinnon, R. C. (2012). *Safety Management: Near Miss Identification, Recognition, and Investigation*. CRC Press.
6. Meadows, S., Baker, K., Butler, J. & Agency FOR Healthcare Research Quality Rockville MD. (2005). *The Incident Decision Tree: Guidelines for Action Following Patient Safety Incidents*.

7. Legislation

- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health Practitioner Competence Assurance Act (2003)
- Health and Safety Employment Act 1992
- Health and Safety at Work Act (2015)

8. Associated Auckland DHB documents

- ACC Treatment Injury
- Adverse Event Review Committee
- Child Abuse Neglect, Care & Protection
- Critical Incident Stress Management
- Deceased (Tupapaku) +/- Referrals to the Coroner for an Adult, Child, Infant, Neonate or Stillbirth
- Documents & Records Retention
- Health and Safety
- Health Practitioner's & Registered Social Worker Competence & Reporting Obligations
- Open Disclosure following an Adverse Event
- Protected Disclosures
- Protected Quality Assurance Activities
- Security
- Sexual Misconduct Allegation from a Patient against an Auckland DHB Employee - AED/APU Initiated

9. Other resources

- Health and Disability Commissioner *'Your Rights'* leaflet
- Kiosk - A Quick Reference Guide for Staff
- Learn from Adverse Events (Quality Department)

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- New Zealand Health and Disability Services. *National Reportable Events Policy 2012*. Retrieved http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/320/
- New Zealand Medicines and Medical Devices Safety Authority (Medsafe)
- Occupational Health & Safety
- Office of the Health and Disability Commissioner. *Open Disclosure*. Retrieved http://www.hdc.org.nz/decisions--case-notes/open-disclosure
- Reportable Event Brief (REB)
- Root Cause Analysis (RCA)
- Severity Assessment Code (Includes Matrix)
- Worksafe New Zealand. Retrieved http://www.worksafe.govt.nz/worksafe/

Patient information

- Your Rights when receiving a Health or Disability Service (HDC)

Forms

- Medsafe Serious Harm Form
- ACC forms ACC45
- ACC2152: Treatment Injury Claim

10. Disclaimer

No guideline can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

This guideline will align with the Health Quality & Safety Commission (HQSC) National Reportable Events Policy therefore this guideline will be updated as and when HQSC update their National Reportable Events Policy.

11. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed before the scheduled date, they should contact the owner or the Clinical Policy Facilitator without delay.

12. Appendices

12.1 Definitions and abbreviations

Accident	Referred to in this policy as an incident. An accident is an event that causes any person to be harmed or in different circumstances, might have caused any person to be harmed (referred to as a near miss)
Adverse event	An incident that has resulted in unanticipated death or loss of function not related to the natural course of a consumer's illness or condition
Apology	An expression of regret
Clinical leader	Clinical leader in this document refers to the role in its broadest sense: a clinician who has designated responsibility and accountability for clinical professional leadership. For example: Level 2 and 3 leadership positions for medical staff members Level 2 and 3 leadership positions for nursing staff members Level 3 Allied Health Professional Leaders Other designated roles
Consumer	A person receiving care/treatment from Auckland DHB
Contractor/Sub-contractor	Person engaged by Auckland DHB (other than a Auckland DHB employee) to do any work for gain or reward
Contributing factor	This is a circumstance, action or influence (such as availability of staff members or increased workload) which is thought to have played a part in the origin or development of an incident, or increase the risk of an incident
Handler	The person responsible for confirming the SAC rating in the case and for completing the management section of the incident report into the Incident Management System
Harm	Refers to illness, injury or both and includes physical or mental harm caused by work-related stress
Hazard	It is a potential source of harm or adverse health effect on a person or persons
Health Practitioner	A registered doctor, nurse or allied health professional
Incident	In this guideline the term "incident" is used generically to refer to incident or accident. An incident is an unplanned event that results in or has the potential to result in injury, damage or loss. This applies to clinical and non-clinical events. • **Clinical:** an event unrelated to the natural course of the illness and differs from the expected outcome of patient management • **Product Fault:** an event where a consumable product or medical device has failed in its intended purpose • **Health and Safety:** An event relating to a hazard, work injury or serious harm, involving employees, contractors, sub-contractors, students and volunteers

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	An incident may range from minor (eg medication error with no harm, piece of equipment goes missing, loss/unavailability of clinical record), moderate (eg additional monitoring, investigations or interventions as a result of incident, patient reacts to medication which should have been withheld) or serious (see serious adverse event/serious harm in Definitions and abbreviations)
Incident Management System	This is the Auckland DHB electronic reporting system available to staff members to report an event or incident
Incident with harm	An unplanned event that results in injury, or loss. This applies to clinical and non-clinical events
Incident with no harm	An unplanned event that reaches the patient, employee or organisation without any injury, or loss but has the potential to result in injury, or loss
Intentionally unsafe acts	Events related to patients that result from any act or omission with intention to cause harm or with reckless disregard for the safety of others. This includes assault, abuse or deliberate neglect
Just Culture	A just culture approach recognises that even competent professionals make mistakes and acknowledges that they can develop shortcuts, workarounds and routine violations - yet declares intolerance for reckless behaviour. The approach sometimes distinguishes between human error, at-risk behaviour, and reckless action - three categories which involve increasing degrees of wilfulness and disregard (Marx, 2001)
Licensed user	This is a senior staff member that is responsible for the follow-up of events in their area and has full access to the Auckland DHB electronic reporting system (Risk Monitor Pro)
London Protocol	An incident investigation model developed by the Clinical Risk Unit, University College, London, which starts by examining the chain of events that led to an accident or adverse outcome and considering the actions of those involved. It then looks further back at the conditions in which staff members were working and the organisational context in which the incident occurred.
Near miss	An unplanned event with the potential to result in injury, or loss but was timely stopped before it reached the patient, employee or organisation. Any event that could have had adverse consequences but did not and is indistinguishable from an actual incident in all but outcome. A near miss may occur when a sequence is interrupted hence no actual incident eventuates. The difference between the accident and the near miss incident is purely a matter of chance as the outcome of a near miss incident cannot be determined and is very difficult to predict (McKinnon, 2012, p.98)
Notification	Completion of the Auckland DHB Incident Form following identification of an incident and sending it to the Quality and Patient Safety, Product Coordinator or Health and Safety Service as appropriate.
Notifiable event	Any events that arise from work that results in the death of a person, a notifiable injury/illness or a notifiable incident
Open disclosure	Timely and transparent approach to communicating, engaging with, and supporting consumers and their families (whānau) when things go wrong - refer to the Open Disclosure following an Adverse Event Policy in

	associated Auckland DHB documents An apology is made and, if an investigation is to take place, those concerned are advised. An open disclosure approach also includes support for staff members and the development of a culture where staff members are confident that the associated investigations will have a quality improvement rather than a punitive focus
Reportable event	Any event that must be reported to the Health Quality & Safety Commission (HQSC) for (national) aggregation, analysis, and action. This includes SAC 1 and SAC 2 events. All reportable events require a Reportable Event Brief (REB) to be completed.
Reported severity	The first assessment of the severity of a reported event, done by the staff member completing web based form (Risk Monitor Pro).
Review methods	**Root Cause Analysis (RCA)** A systematic, no blame process whereby factors that led to an incident are identified in order to establish the contributing factors/ hazards/ causes. **London Protocol** This outlines a process of incident investigation and analysis. It is designed to be a structured process of reflection on incidents, providing insight to the health care system and can be adapted for use in many contexts, and used either quickly for education and training or in substantial investigations of serious incidents
Risk	The possibility (likelihood) of suffering harm or loss (consequence) from a hazard
Risk Monitor Pro (RMPro)	This is the Auckland DHB electronic reporting system available to staff members to report an event or incident
Root cause analysis (RCA)	Root Cause Analysis is defined as a systematic iterative process whereby the factors which contribute to an incident are identified by reconstructing the sequence of events and repeatedly asking '*why?*' until the underlying root causes (contributing factor/hazards) have been elucidated
Serious harm	An event related to staff, visitor or contractor that amounts to or results in permanent loss of bodily function, or temporary severe loss of bodily function or as outlined in the HSE Act 1992: 1. respiratory disease, noise-induced hearing loss, neurological disease, cancer, dermatological disease, communicable disease, illness caused by exposure to infected materials, decompression sickness, poisoning, vision impairment, chemical or hot-metal burn of eye, penetrating wound of eye, bone fractures, laceration, crushing 2. Amputation of body part 3. Burns requiring referral to a specialist registered medical practitioner or specialist outpatient clinic 4. Loss of consciousness from lack of oxygen 5. Loss of consciousness, or acute illness requiring treatment by a

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	registered medical practitioner, from absorption, inhalation, or ingestion of any substance 6. Any harm that causes the person harmed to be hospitalised for a period of 48 hours or more commencing within seven days of harm occurrence
Serious Adverse Event Review Committee	Auckland DHB has a Serious Adverse Event Committee. This panel review and approve recommendations from RCAs and provide a report to the Clinical Board and/or other relevant committees
Serious adverse event & Sentinel event	An event has resulted in, or has the potential to result in, serious lasting disability or death, not related to the natural course of the consumer's illness or underlying condition
Serious Incident Review	A process followed by Mental Health to review serious incidents involving mental health and addiction service consumers
Severity Assessment Code (SAC)	A numerical rating allocated to an event based on the type of event, the actual outcome or consequence of the event and the likelihood or recurrence of a similar event
Serious harm to employees	See Occupational Health & Safety Intranet site
System	A system is a set of interacting units with relationships among them (Miller, 1995, p. 17; Backlund, 2000)
System failure	A fault, breakdown or dysfunction within the system
System safety	It is an specific, driving purpose to eliminate system faults or failure risk and subsequent recognised accident/incident and/or hazard potential through design and implementation of controls (Vincoli, 2014, p.9)
Staff/employee	Refers to all staff covered under the Health and Safety Employment Act 1992. This includes all employees, loaned employees, students and contractors working in Auckland DHB
Worker	Any person who carries out work in any capacity for CM Health (fulltime, part-time, casual and temporary), including associated personnel (contractors, students, visiting health professional etc.) working in, or contracted to provide a service on any Auckland DHB site
Workplace	Any place where work is carried out for or on behalf of Auckland DHB whilst a person is deemed at work

12.2 Mandatory External Reporting Responsibilities

External Reporting to Auckland DHB

- **Health Quality and Safety Commission HQSC:**

SAC 1 & 2 events are required to be reported to the HQSC within 15 working days of being reported or within five working days of the SAC score being confirmed. Any matter that requires direct notification to a national agency under existing legislative reporting requirements or policy directive, regardless of its SAC rating, is to continue being reported to that agency.

Following the identification of a SAC 1 or a SAC2 event the Quality Department representative completes a Reportable Event Brief (REB) (see other resource) in conjunction with the Directorate leader(s). The Quality Department forwards the REB to the Health Quality and Safety Commission.

- **Department of Labour and WorkSafe**

Serious harm to employees:
Service or clinical manager notifies OH&S and Dept of Labour, verbally as soon as possible, and completes a serious harm form and submits to OH&S (see Occupational Health and Safety intranet site).

Serious harm to patients (not related to treatment eg fall):
Clinical manager or Quality Department representative (as agreed with service) highlight the case to Quality Department and Auckland DHB OH&S. OH&S must review the case and will discuss the case with the Chief Professional Officer and Legal Advisor before completing the online Worksafe New Zealand serious harm form.

- **Perceived breach of professional standards:**

Director of the Directorate must report to professional body as outlined in Health Practitioners Competency Assurance Act 2003 (see Legislation)

- **Director of Mental Health, Ministry of Health:**

All Mental Health SAC 1 & 2 events are sent to - the Director Mental Health Services Auckland DHB

- **Centre for Adverse Reactions Monitoring (CARM or Medsafe)**

Medicine related SAC 1 & 2 events are sent to by the pharmacy manager

- **Ministry of Health – Medsafe**

Medical Device SAC 1 & 2 events related to a medical device eg material, instrument, machine, appliance, implant are reported to the Materials Management who notify the Ministry of Health - Medsafe (see other resources)

- **National Radiation Laboratory**

Radioactive Materials SAC 1 & 2 events related to incorrect administration of radioactive materials/radiation therapy are reported by the Principal Licensee Radiology/Radiation Oncology Manager

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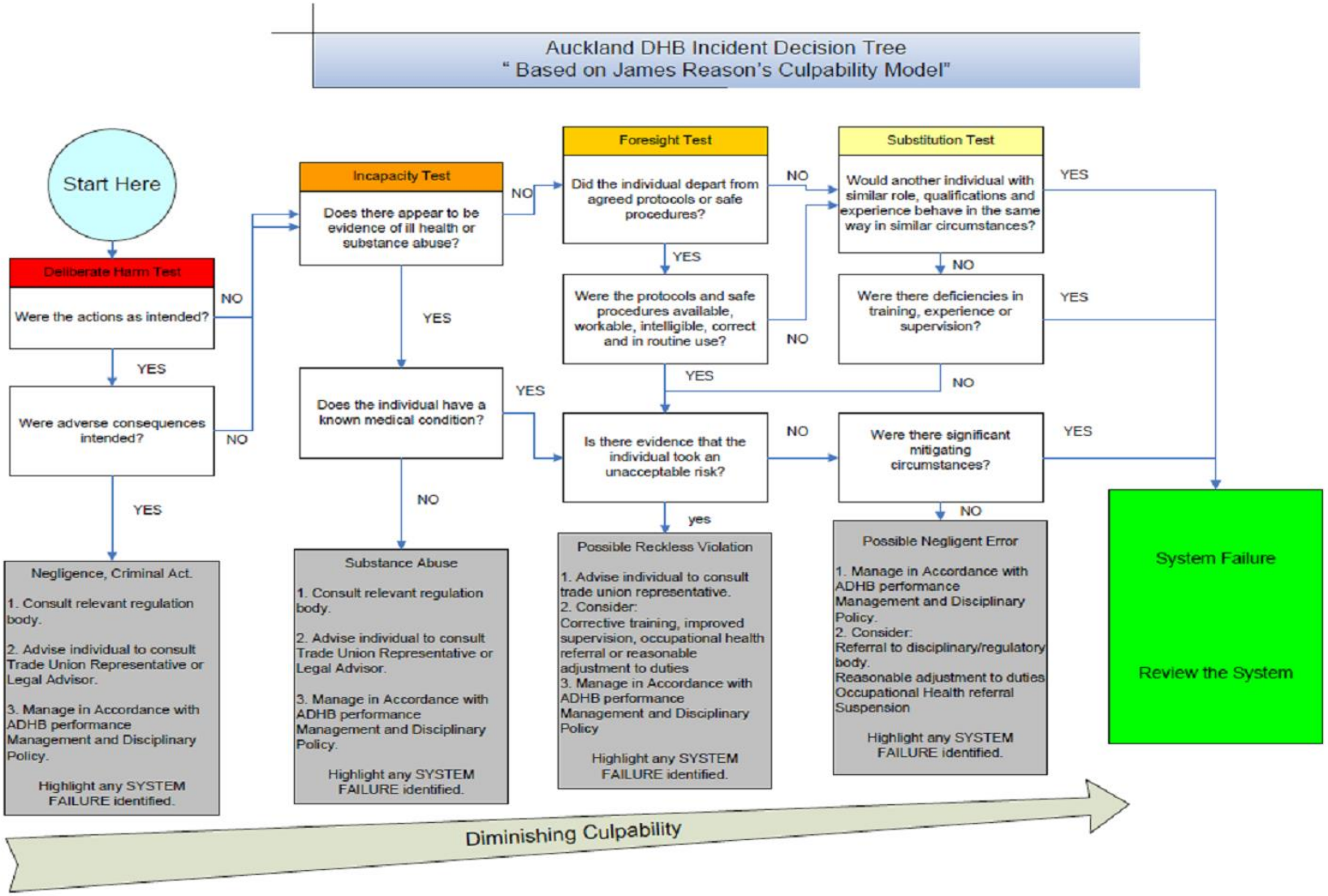
- **Coroner Office**

If a patient has died as a result of the adverse event, the case must be discussed by a senior doctor with the on call coroner

- **Insurance Brokers**

Auckland DHB Legal Counsel must report all potential/actual claims to the Insurance Brokers. Individual health professionals are responsible for reporting issues/incidents to their professional indemnity insurers or professional defence organisations.

12.3 Incident Decision Tree



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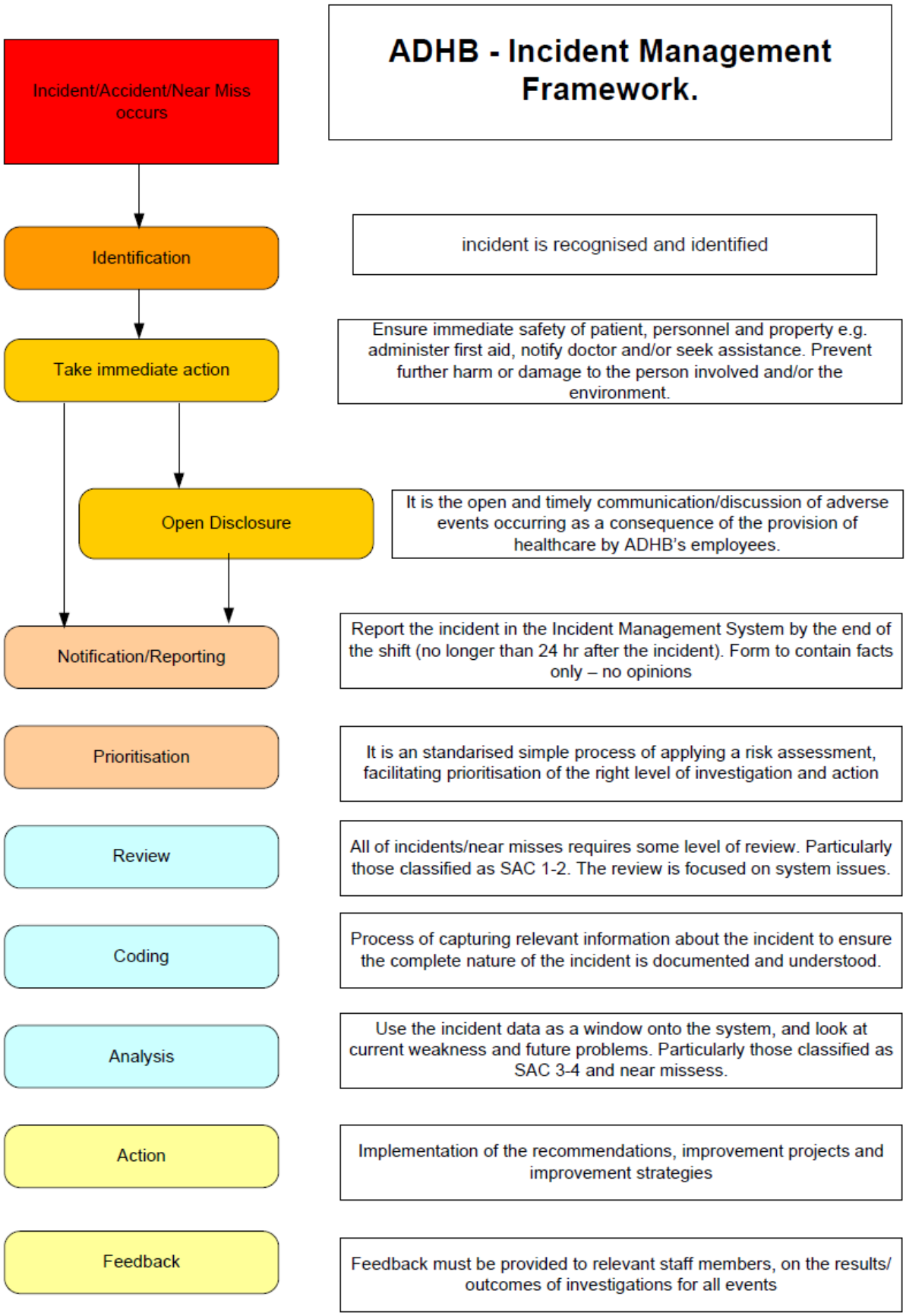
12.4 Incident Management Framework



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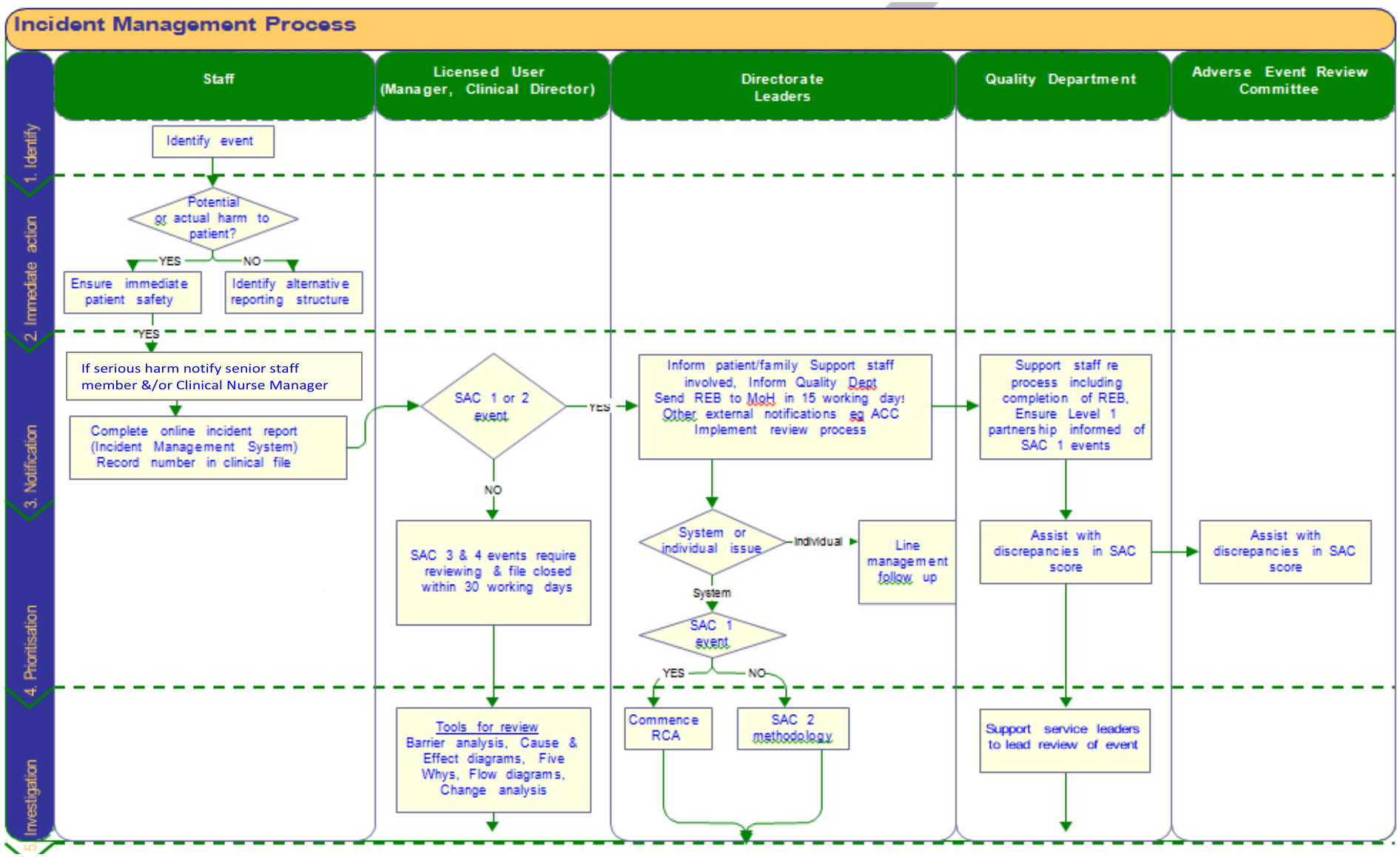
12.5 Incident Management Process



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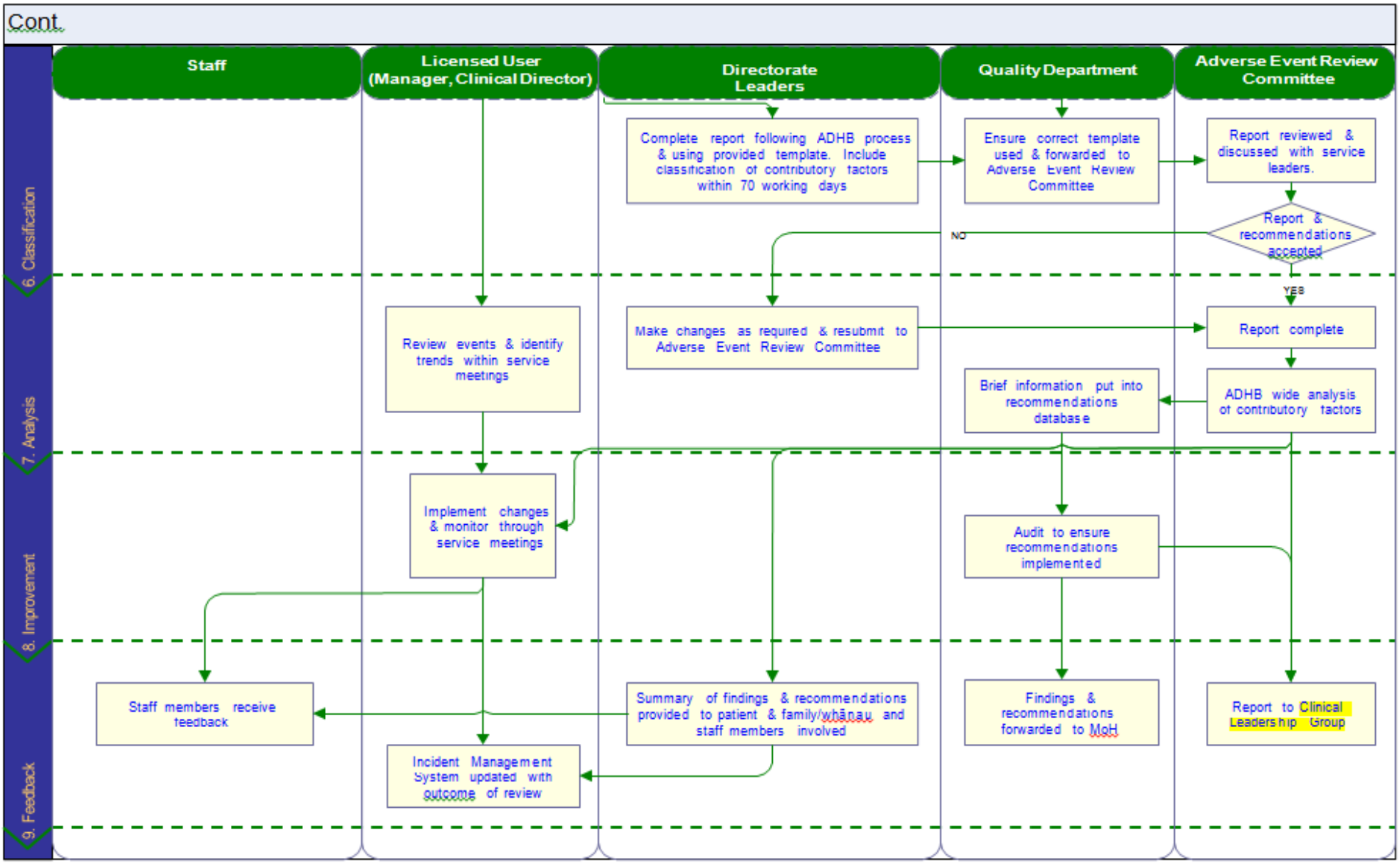

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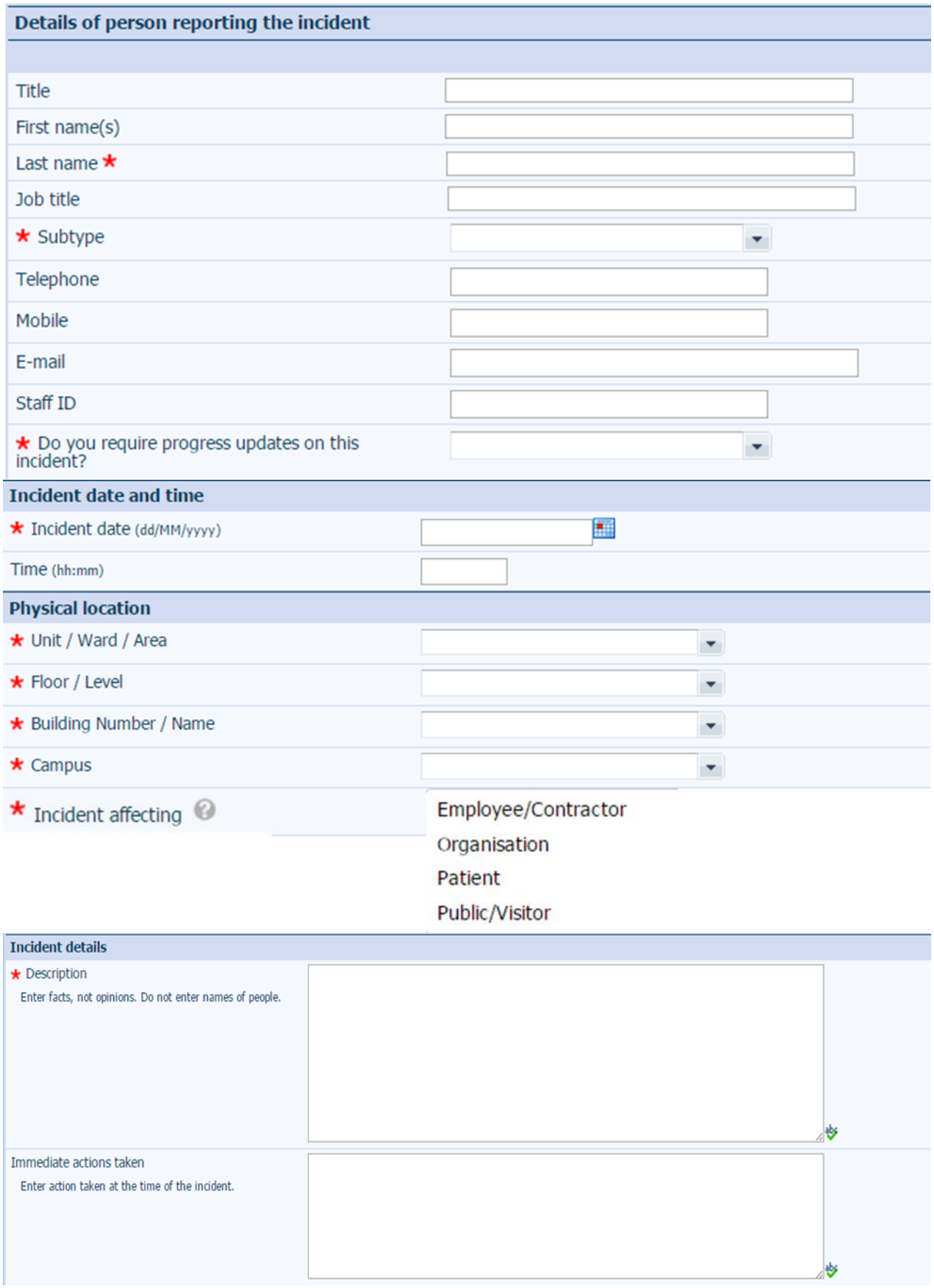
12.6 Incident Form (Hard Copy)



Details of person reporting the incident

Title

First name(s)

Last name *

Job title

* Subtype

Telephone

Mobile

E-mail

Staff ID

* Do you require progress updates on this incident?

Incident date and time

* Incident date (dd/MM/yyyy)

Time (hh:mm)

Physical location

* Unit / Ward / Area

* Floor / Level

* Building Number / Name

* Campus

* Incident affecting

Employee/Contractor
Organisation
Patient
Public/Visitor

Incident details

* Description
Enter facts, not opinions. Do not enter names of people.

Immediate actions taken
Enter action taken at the time of the incident.

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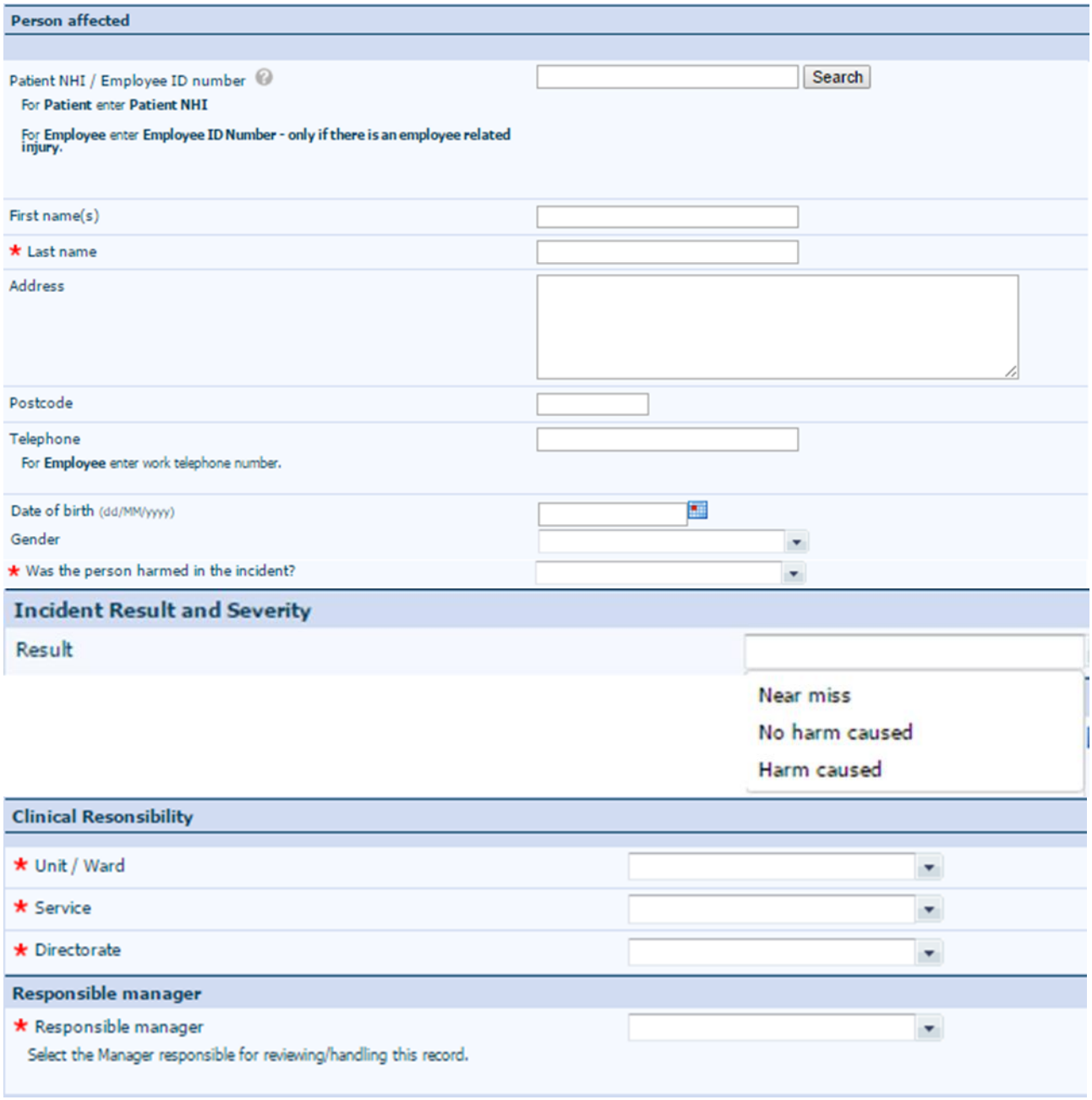

Please complete and sent to the Quality Department

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12.7 Prioritising Matrix: Severity Assessment Code

Step 1. Determine the consequences or outcome of the incident.

CONSEQUENCE TABLE

Rate all adverse events on ACTUAL OUTCOME Rate all near misses on the most likely potential outcome Incidents with a high POTENTIAL SAC rating can be notified to the Central Repository (HQSC) via REB at the discretion of the organisation				
Severe	**Major**	**Moderate**	**Minor**	**Minimal**
Generic Consequences (applicable to all health and disability services)				
Death or permanent severe loss of function that is related to the process of health care and differs from the expected outcome of that care.	**Permanent major or temporary severe loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Permanent moderate or temporary major loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Permanent minor or temporary moderate loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Temporary minor loss of function.**
Specific Incidents/Consequences				
• Wrong consumer or wrong procedure with risk of or actual severe harm • Suicide as inpatient • Blood component given to wrong consumer • Retained item with delayed removal • Child/infant abduction or discharge to the wrong family • Failure of essential service with risk of severe consumer consequences	• Wrong consumer or wrong procedure with risk of or actual major harm • Retained item with immediate removal • Misadministration of radioactive materials • Unanticipated cardio-pulmonary resuscitation resulting from the process of health care • Community suicide by current mental health consumer within 28 days of contact with service • Missing person with a risk of serious harm to self or others	• Wrong consumer or wrong procedure with risk of or actual moderate harm • Fall resulting in fracture Any of the following as a result of the incident: • Transfer to higher level of care, including hospitalisation • Increased length of stay (>1 day) • Surgical or other significant intervention required	• Wrong consumer or wrong procedure with risk of or actual minor harm • Additional monitoring, investigations or minor interventions as a result of the incident	• Medication error with no harm

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Step 2. Determine the frequency or likelihood of recurrence

Rate all adverse events on ACTUAL OUTCOME

Rate all near misses on the most likely potential outcome

Incidents with a high POTENTIAL SAC rating can be notified to the Central Repository (HQSC) via REB at the discretion of the organisation

Including equipment/non-patient related.

Severe	Major	Moderate	Minor	Minimal
• **Services:** Failure of essential service with risk of severe consumer consequences • **Environment:** Toxic release offsite with detrimental effect that caused death • Fire requiring evacuation • **Staff, contractor or visitor:** Death(s) of staff member contactor or visitor • **Equipment:** Major disruption to services due to break down or unavailability, with the risk of consumer harm	• **Services:** significant ongoing disruption to a key service; • **Environment:** Off-site release with no detrimental effects e.g. Ammonia gas leak that causes illness, medical treatment in neighbouring property • Fire that grows larger than an incipient stage • **Staff, contractor or visitor** Permanent disability or loss of function to staff member, contactor or visitor; requires major additional medical or surgical intervention • **Equipment:** Significant disruption to services due to break down or unavailability	• **Services:** Disruption to a key service • **Environment:** Off-site release contained with outside assistance e.g. Ammonia gas leak is an odour nuisance on neighbouring property • Fire at incipient stage or less • **Staff, contractor or visitor** Staff member, contactor or visitor requires extended treatment • **Equipment:** Disruption to key services due to break down or unavailability, causing delay to	• **Services:** Disruption to service • **Environment:** Off-site release contained without outside assistance e.g. Ammonia gas leak that can be contained or repaired by on site staff or an off site contractor • **Staff, contractor or visitor** Staff member or contractor requires short term treatment only with no lost time or restricted duties. Visitor requires short term treatment • **Equipment:** Minor disruption to services, due to break down or unavailability	• **Services:** Minimal disruption to service • **Environment:** Nuisance releases e.g. Ammonia gas leak that has been reported but is not serious enough to repair immediately, to be addressed at next scheduled maintenance. • **Staff, contractor or visitor** Minimal injury to staff member, contactor or visitor; first aid required • **Equipment:** No disruption to services, due to break down or unavailability

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Likelihood Table

LIKELIHOOD CATEGORY	DEFINITION	CONSEQUENCE				
		Severe	Major	Moderate	Minor	Minimal
Almost Certain	Almost certain to occur at least once in next 3 months	1	1	2	3	4
Likely	Will probably occur at least once in the next 4-12 months	1	1	2	3	4
Moderate	Is expected to occur within the next 1 to 2 years	1	2	2	3	4
Unlikely	Event may occur at some time in the next 2 to 5 years	1	2	3	4	4
Rare	Unlikely to recur – may occur only in exceptional circumstances ie >5 years	1	2	3	4	4

Review Process	
SAC 1 SAC 2	• Complete REB Part 1 and send to HQSC within 15WD • Formal review using RCA methodology / London Protocol • Complete REB Part 2 and send to HQSC within 70WD
SAC 3 SAC 4	• Review of incident within 30WD • May complete REB Part 1 and Part 2 and send to HQSC if considered relevant eg. Health sector issue or learning

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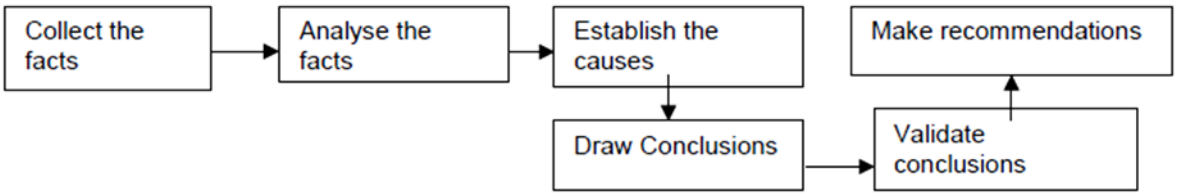
12.8 The Principles of Root Cause Analysis (RCA) Investigation and London Protocol



What happened? How did it happen? Why did it happen? Recommendations

Root Cause Analysis (RCA) is a problem solving methodology for discovering the real cause(s) of the problems, or difficulties identified. It fosters a systems based approach to the analysis rather than person centered approach, and has been shown to provide a means for identifying effective solution strategies to a broad range of problems.

The adoption of the RCA approach is a mechanism to find effective solutions to identify problems, and will assist in the development of an open and fair culture where the emphasis is on learning and not apportioning blame. Once root causes have been established corrective action(s) must be agreed upon with a completion date and persons responsible identified for the implementation of the action/recommendation.

The London Protocol differs from the Root Cause Analysis model with its emphasis on gaps and inadequacies within the system and its analysis of the chain of events and contributory factors leading to the adverse event rather than a focus on a single/small number of root cause(s).

All Severe/Major severity rated incidents and some moderate events should be subject to comprehensive investigation. The following sections provide guidance on the steps to follow when carrying out a RCA or London Protocol investigation.

STEP ONE: COLLECTING 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 events it is only by starting at the point the incident occurred and working backwards that the 'start point' for the incident can be identified. For some incidents the start point will be identified as the patient's admission to hospital (or even before).

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

- The people involved in or witnessing the event
- The place or environment in which the event took place
- The equipment or objects involved in the event
- The paper work related to the event

All staff involved in the incident event must be identified and informed that an incident investigation is taking place. They must be informed that their assistance in investigating the incident would be appreciated and that the purpose of the investigation is to identify areas where systems failed rather than to focus on human error.

All staff involved in tragic or catastrophic incidents must be advised of the availability of confidential support (via the Employee Assistance Programme EAP) and counselling during what

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will be a stressful period, and told they can have a friend or union rep with them during interviews.

All staff involved and any witnesses to the event should be requested to provide a contemporaneous written record of what occurred and, if necessary, interviewed as soon as possible after the event.

During discussions with staff it is also 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 eg 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

STEP TWO: COLLATING INFORMATION INTO A NARRATIVE CHRONOLOGY

The simplest way of collating data about an incident is to construct a Timeline.

STEP THREE: IDENTIFYING GAPS

Mapping the chronology of events will start to identify Care Delivery Problems and Service Delivery Problems (CDP).

Care Delivery Problems are problems that arise in the process of care - usually actions or omissions by staff eg care deviated beyond safe limits of practice, failure to monitor, observe, act.

Service Delivery Problems are acts or omissions identified during analysis but not associated with a direct care provision i.e. associated with procedures and systems that are part of the process of service delivery eg failure to implement safe systems of work or environmental standards etc.

Further examples include:

- Delay in diagnosis
- Incorrect risk assessment (for example, of suicide or self-harm)
- Inadequate handover
- Failure to report faulty equipment
- Failure to carry our pre-operative checks
- Not following an agreed protocol (without clinical justification)
- Not seeking help when necessary
- Failure to supervise adequately a junior member of staff
- Incorrect protocol applied
- Treatment given to incorrect body site
- Wrong treatment given

STEP FOUR: EXPLORING PROBLEMS and IDENTIFYING CONTRIBUTORY FACTORS

The simplest way of identifying the principle contributory factors in any investigation is use of the '*Five Why's'* technique. It involves delving deeper into a problem asking '*why?*' for each primary cause identified, then asking '*why*' again in response to each answer until there are no more causes forthcoming. It is best suited for exploring simple non-complex problems. As a brief rule of thumb, it usually takes about five rounds of asking '*why?*' to identify the root cause of a problem. It may be necessary, however, to ask '*why?*' more or less than five times. Other tools which can be used to explore more complex problems further are the fish bone diagram, and reactive barrier analysis (all tools are available on the Quality and Patient Safety section of the Intranet).

STEP FIVE: GENERATING SOLUTIONS

For all root cause analysis investigations a final report should be completed and an action plan identified to reduce any highlighted risk(s).

Recommendations must be specific, measurable, attainable, realistic and timely i.e. SMART.

Any unresolved risks should be discussed at the relevant service quality committee and outstanding issues placed on the service Risk Register as appropriate.