### Root Cause Analysis Investigation Report

### National Patient Safety Agency

### RCA Investigation Report Template - Guidance

The following headings are designed to improve the recording of information currently considered good practice for investigation reports. These headings will be evaluated over time to confirm or challenge that understanding.

**PLEASE READ - Instruction for use of this RCA Report Template**

1. **Determine the level of investigation to be undertaken**

Refer to the NPSA’s ‘Three Levels of investigation’ (Level 1 = Concise; Level 2 = Comprehensive; Level 3 = Independent), to the NPSAS’s ‘Triggers for Investigation’, and to your own organisational policy and terms of reference.

1. **Delete all ROWS not required for the level of investigation being undertaken**

The investigation level numbers in the middle column provide a guide to which rows are needed for which level of investigation. (i.e. for a Level 1 - Concise investigation you only need rows which have the number 1 in the ‘Level’ column)

1. **Write your investigation report in the right hand column**

* Delete examples (in green), and refer to summary guidance in the left hand column as you go. For detailed guidance refer to the NPSA’s ‘Guide to RCA investigation report writing’.
* If an investigation produces no information against a heading, add an explanation on why this is the case.
* If issues arise which require a new heading this can be added as a new row

1. **On completion, delete the guidance to produce your final report**

* Delete all guidance both here and in the template below (i.e. all green and red type, all green coloured rows and all green coloured columns)
* Realign the remaining table containing your own report, so that it fits the whole page.
* Save the document with the chosen file name for each individual investigation report.

|  |  |  |
| --- | --- | --- |
| **Quick reference guide** | **Level** | **Type your investigation report in this column** |
| **Cover page**   * Organisation name and / or logo * Title or *Brief* outline of incident * Incident date * Incident number * Author(s) * Report date * Page numbers * Document version * Computer File Path | 2 + 3 |  |
| **Contents page** | 2 + 3 | **CONTENTS**  Executive summary  Incident description and consequences  Pre-investigation risk assessment  Background and context  Terms of reference  The investigation team  Scope and level of investigation  Investigation type, process and methods used  Involvement and support of patient and relatives  Involvement and support provided for staff involved  Information and evidence gathered  Chronology of events  Detection of incident  Notable practice  Care and service delivery problems  Contributory factors  Root causes  Lessons learned  Recommendations  Arrangements for shared learning  Distribution list  Appendices |
| **Executive summary** | 2 + 3 | **EXECUTIVE SUMMARY** |
| A one page summary of the main report | 2 + 3 | **Brief Incident description** |
| presented succinctly under the following | 2 + 3 | * **Incident date:** |
| headings:- | 2 + 3 | * **Incident type:** |
|  | 2 + 3 | * **Healthcare specialty:** |
|  | 2 + 3 | * **Actual effect on patient and/or service:** |
|  | 2 + 3 | * **Actual severity of the incident:** |
|  | 2 + 3 | **Level of investigation conducted** |
|  | 2 + 3 | **Involvement and support of the patient and/or relatives** |
|  | 2 + 3 | **Detection of Incident** |
|  | 2 + 3 | **Care and Service Delivery Problems** |
|  | 2 + 3 | **Contributory Factors** |
|  | 2 + 3 | **Root Causes** |
|  | 2 + 3 | **Lessons Learned** |
|  | 2 + 3 | **Recommendations** |
|  | 2 + 3 | **Arrangements for Sharing Learning** |
| **Main Report** | 1, 2 +3 | **MAIN REPORT** |
| **Incident description and consequences**   * Concise incident description | 1, 2 +3 | **Incident description and consequences**  **Example only (please delete and add your own findings)**  A lady with asthma sustained brain damage following IV administration of a drug to which she was known to be allergic. |
| * Incident date | 1, 2 +3 | Incident date: |
| * Incident type | 1, 2 +3 | Incident type: |
| * Healthcare speciality involved | 1, 2 +3 | Specialty: |
| * Actual effect on patient and / or service | 1, 2 +3 | Effect on patient: |
| * Actual severity of incident | 1, 2 +3 | Severity level: |
| **Pre-investigation risk assessment**  Assess the realistic likelihood and severity of recurrence, using your organisation’s Risk Matrix | 2 + 3 | **Pre-investigation risk assessment**   |  |  |  | | --- | --- | --- | | **A**  **Potential Severity**  **(1-5)** | **B**  **Likelihood of recurrence**  **at that severity (1-5)** | **C**  **Risk Rating (C = A x B)** | |  |  |  | |
| **Background and context to the incident**  A brief description of the service type, service size, clinical team, care type, treatment provided etc. | 2 + 3 | **Background and context** |
| **Terms of reference -** Outline :-   * Specific problems to be addressed * Who commissioned the report * Investigation lead and team * Aims, Objectives and Outputs (see examples opposite) * Scope, boundaries and collaborations * Administration arrangements (accountability, resources, monitoring) * Timescales | 2 + 3 | **Terms of reference**  **Example only (please amend to build your own aims)**  To establish the facts i.e.:- **what** happened (the *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* as a record of the investigation process  To provide a means of *sharing learning* from the incident |
| **Investigation team**  Names, Roles, Qualifications, Dept.’s | 2 + 3 | **The investigation team** |
| **Scope and level of investigation**   * State level of investigation   (NPSA -1.Concise; 2.Compre.; 3.Independent)   * Describe the start and end points * List services & orgs involved   NB: for Level 3 ‘Independent’ Investigations ‘scope’ could be included under Terms of Reference | 1, 2 +3 | **Scope and level of investigation** |
| **Investigation type** (i.e. Single / Aggregation / Multi-incident)**, process, and methods used**   * 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. *Fishbones* * Generating solutions e.g. *Barrier analysis* | 2 + 3 | **Investigation type, process and methods used** |
| **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/relative wishes).  e.g. Family liaison person appointed, information given on sources of independent support. | 1, 2 +3 | **Involvement and support of patient and relatives** |
| **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. | 2 + 3 | **Involvement and support provided for staff involved** |
| **Information and evidence gathered**  A summary list 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) | 2 + 3 | **Information and evidence gathered**  **Example only (please delete and add 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 |
| **Chronology of events**  For complex cases any summary timeline included in the report should be a summary | 1, 2 +3 | **Chronology of events**  See table below |
| **Detection of incident**  Note at which point in the patients treatment the error was identified. i.e.   * At risk assessment of new/changed service * At pre-treatment patient assessment * Error recognition pre-care/treatment * Error recognition post-care/treatment * By Machine/System/Environ. change/Alarm * By a Count/Audit/Query/Review * By Change in patient’s condition | 1, 2 +3 | **Detection of incident**  Select from the list on the left  Add additional information |
| **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) | 2 + 3 | **Notable practice**  **Example only (please delete and add 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 of the *key* problem points. (Where many problems have been identified the *full* list should be included in the appendix) | 1, 2 +3 | **Care and service delivery problems**  **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**  A list of significant contributory factors (where many contributory factors are identified a full list or ‘fishbone diagrams’ should be included in the appendix) | 1, 2 +3 | **Contributory factors**  **Example only (please delete and add 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** (numbered)  These are the most fundamental underlying factors contributing to the incident that can be addressed. Root causes should be meaningful, (not sound bites such as communication failure) and there should be a clear link, by analysis, between root CAUSE and EFFECT on the patient. | 1, 2 +3 | **Root causes**  **Example only (please delete and add 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** (numbered)  Key safety and practice issues identified which may not have contributed to this incident but from which others can learn. | 1, 2 +3 | **Lessons learned**  **Example only (please delete and add your own findings)**  1. A distinction should be made between essential and desirable documentation in clinical records |
| **Recommendations**(numbered and referenced) Recommendations should be directly linked to root causes and lessons learned, They should be clear but not detailed (detail belongs in the action plan). It is generally agreed that key recommendations should be kept to a minimum where ever possible. | 1, 2 +3 | **Recommendations**  **Example only (please delete and add your own findings)**  1. Ensure allergy records and other priority assessment sheets  are routinely filed prominently for ease of completion  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, NPSA, etc.) | 1, 2 +3 | **Arrangements for shared learning**  **Example only (please delete and add your own findings)**   Share findings with other departments caring for short stay patients and include them in piloting solutions   Share findings with patient Safety Action Team 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 | 2 + 3 | **Distribution list** |
| **Appendices**  Include key explanatory documents. e.g. Tabular timeline, Cause + effect chart, Acknowledgements to patients, family, staff or experts etc. | 2 + 3 | **Appendices** |
|  |  | **Author:** |
|  |  | **Job Title:** |
|  |  | **Date:** |

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