Procedure for the Investigation of Incidents, Complaints and Claims

1. Introduction

Future Directions CIC is committed to ensuring that the investigation of incidents, complaints and claims are thoroughly and effectively investigated. A key element of this process is to ensure that Future Directions CIC captures the opportunity to learn from adverse events, thereby ensuring the reoccurrence is minimised. Future Directions CIC is committed to utilising Root Cause Analysis Techniques (RCA) as part of incident, complaint and claim investigation. A key element of the RCA process is rather than apportioning blame the investigation process seeks to identify, understand and learn from the adverse event.

2. Purpose

This procedure provides guidance to all Future Directions CIC employees involved in the investigation of incidents, complaints and claims. Future Directions CIC is committed to the fundamental principle of organisational learning and the concept of “being open”. The procedure outlines the roles and responsibilities of staff undertaking investigations, includes the processes and tools required to undertake RCA investigations.

3. Key Issues

3.1. Why Are Investigations Necessary?

Investigations are necessary to provide a retrospective review of events in order to identify what, how and why it happened. The analysis should then be used to identify areas for change, recommendations and sustainable solutions, to help minimise re-occurrence in the future. There is an inherent need to ensure public confidence in the organisation is maintained. In instances where there is harm as a consequence of the adverse incident it is important that the affected individual(s) are given an apology and an honest and open account of what happened.

A key mechanism for ensuring the above is via investigations being undertaken by appropriately trained and competent investigators, and where appropriate in collaboration with external agencies as partners in the investigation process. Whilst professional accountability has to be acknowledged within the investigation process of equal importance is the need for identifying the root causes of the adverse incident.
3.2. Why Are Learning and Sharing Safety Lessons Important?

Learning from experience is critical to the delivery of safe and effective services. To avoid repeating mistakes Future Directions CIC recognises the need to learn from adverse events and to ensure that the lessons are communicated in order to minimise the chance for reoccurrence, and that plans for improving safety are formulated and acted upon.

3.3. The Need for Effective Communication

Future Directions CIC recognises the need to ensure that a key element of the investigation of adverse events is to ensure that communications with all those affected and involved are maintained in an open and honest manner. The Directors will in discussion with investigating officer identify who is the most appropriate employee(s) to maintain open and honest communication with all those affected and the staff involved in the adverse event. Of significant importance in this process is ensuring detailed records of all communications are maintained and available for review as part of the investigation process.

3.4. Support for Service Users/Carers/Relatives and Staff

Being involved in an incident/complaint or claim which is under investigation can be an incredibly stressful experience. Future Directions CIC will endeavour to support service users, carers, relatives and staff during this difficult time. This will be achieved by following the principles of ‘being open’.

4. Duties Within the Organisation

This section describes the individual and departmental roles and levels of responsibility for the investigation of incidents, complaints and claims within Future Directions CIC.

4.1. Chief Operating Officer

As the accountable officer for Future Directions CIC they will ensure that responsibility for management of incidents, complaints and claims is delegated to a Manager.

The Chief Operating officer is responsible for:-

- Supporting and enabling any investigation into an incident, complaint or claim.
- Undertaking the role of Senior Investigating Officer, when delegated.
- Ensuring that any affected service users/family or carer receive timely information and appropriate support including feedback on organisational learning.
- Ensuring support for staff members undertaking or involved in an investigation.
- Ensuring the safeguarding reporting and requirements have been implemented.
- Reviewing all incident reports and ensuring that the grading and assessment reflects the severity of the incident, complaint or claim.
- Management of timeframes within their scope of responsibility as part of the investigation process of incidents, complaints and claims.
- Ensuring contemporaneous records in respect of an investigation into the following:
  - All records related to the investigation.
  - All communications with affected person(s).
  - All communications with staff.
  - All communications/reports to external agencies, e.g. safeguarding, CQC and Commissioners.
- Where appropriate identify wider organisational clinical and non clinical risks and ensure they are entered on the Risk Register and assessed in line with Risk Management Procedure.

4.2. The Directors

The Directors will receive summary reports providing an overview of all incidents, complaints and claims. They will be provided with the summary findings, and actions of any incident, complaint or claim investigation that is weighted as high risk. Where organisational learning has been identified the Directors will receive assurances regarding the dissemination and implementation of these requirements.

4.3. Investigating Manager/Team

Using the Risk Matrix below an incident, complaint or claim can be graded in severity.

<table>
<thead>
<tr>
<th>Probability</th>
<th>Insignificant 1</th>
<th>Minor 2</th>
<th>Serious 3</th>
<th>Major 4</th>
<th>Catastrophic 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Certain - 5</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Likely - 4</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Possible - 3</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Unlikely - 2</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Remote - 1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Table Detailing Investigation Response

<table>
<thead>
<tr>
<th>Grading</th>
<th>Risk Level</th>
<th>Level of Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td>High</td>
<td>Includes incidents that require a comprehensive RCA investigation that can be either an internal or external review. May require Safeguarding or Commissioner liaison. Investigating Officer for internal review will be appointed by Chief Operating Officer and will be RCA trained. The investigation team will also include the Manager and other persons with specialist knowledge or experience as required. In the event of an external inquiry this will be set up in accordance with the guidance from external agencies.</td>
</tr>
<tr>
<td>YELLOW</td>
<td>Medium</td>
<td>Local investigation by Operation or Operational Network Manager appointed by Chief Operations Officer or Director investigation report using RCA tools (as appropriate) requiring detailing findings, actions, lessons learnt and recommendations which will be processed through the appropriate communication forums and monitored via Governance Meetings.</td>
</tr>
<tr>
<td>GREEN</td>
<td>Low</td>
<td>Local investigation by Team Manager responsible for outcomes and actions recorded within PRISM any wider lessons communicated through appropriate communication forums and monitored via Governance meetings.</td>
</tr>
</tbody>
</table>

It is acknowledged that the investigation of incidents, complaints and claims may in some instances be subject to the completion of Police investigation prior to Future Directions embarking its own internal/external investigation.

4.4. Role of Specialist Advisors

With regards to the investigation of incidents, complaints or claims the Management Team in consultation with the appointed investigator officer will determine if the investigation process requires additional specialist advisor membership or consultation.

The investigation team appointment and membership will include individuals with appropriate underpinning knowledge and skills base to undertake and advise on the investigation. These individuals may be either external or internal professionals.

4.5. All Staff

All Future Directions CIC have staff have a responsibility to report any adverse event or near miss which could warrant further investigation. Staff are required to be fully open and co-operative with all aspects of the investigation process.

4.6. Link with Incident Management and Complaints Management

It is acknowledged by Future Directions CIC that an effective interface between incident, complaint and claim investigation are undertaken in a timely and coordinated manner. Future Directions CIC Procedures:-

- Complaints
5. Investigation

5.1. Identifying Which Incidents, Complaints or Claims Need to be Investigated

The level of managerial authority to undertake an incident complaint or claim investigation is outlined within section 5.9. There are two main considerations when making this decision:-

- The level of severity of harm to service user/carer/relative or staff member.
- The potential for organisational learning (which may include incidents, complaints or claims of high frequency but low severity).

It is acknowledged within this procedure that all high risk incidents, complaints and claims investigations will be conducted using RCA processes “Incident Investigation Reporting Format and RCA tools may also be used in both low and medium risk investigations where appropriate.

5.2. Investigation Process

This section outlines the investigation process for all incidents, complaints and claims. The investigation process will be underpinned by the principles of ‘being open’. In addition to which all investigations will be mindful of the need, as appropriate, to provide support to those affected by the adverse or untoward event

The investigation process involves:-

- The appointment of an investigating manager;
- The identification of people to be interviewed;
- Conducting of interviews;
- The timescales for feedback
- The involvement of any external agencies;
- The production of the investigation report including organisational learning;
- The development of action plans including timescales and lead responsibility;
The debriefing of staff.

5.3. **External Stakeholder Involvement**

The investigation process may involve external agencies including those with enforcement, inspection or advisory responsibilities.

Examples of these include:-

- Police – Criminal offences investigation.
- Local Authority – Safeguarding.
- Commission for Social Care Inspectorate – Care quality concerns.
- Care Quality Commission (from April 2009) – Statutory regulation breaches and care quality concerns.
- Health Protection Agency – Infection control issues.
- Commissioners – Care quality and performance issues.
- Health and Safety Executive – Breach of health and safety at work legislation.
- Environmental Health - Contamination or outbreak e.g. food poisoning.

6. **Procedure for the Root Cause Analysis of Serious Untoward Incidents, Complaints and Claims**

6.1. **Introduction**

Root Cause Analysis (RCA) aims to assist nominated lead investigators to successfully investigate and resolve serious incidents, complaints and claims, as defined by the risk matrix (*see Section 5.9*). It allows the investigator to systematically identify the direct, contributory and root causes associated with the incident.

The information obtained from the investigation can then be analysed and the common causes and trends highlighted to the organisation via the risk management process (*see Risk Matrix example section 7.2*). By analysing such occurrences Future Directions CIC can ensure lessons are learnt and practice is changed appropriately, the investigation will help address areas of poor performance, systems failures, violations of procedures, and the need for changes in both clinical and non clinical practice.

6.2. **Undertaking the Investigation**

Future Directions CIC RCA investigations will incorporate the following key actions:-
- Identify lead investigator
- Agree terms of reference for the investigation.
- Assign a team, which ideally should be between 2–5 individuals
- Utilise other individual’s skills and knowledge as appropriate
- Outline the sequence of events – physically chart sequence e.g. timeline
- Collect and collate all the documentary evidence
- Methodology may need to include a variety of approaches, interviews, statement writing, review of documentation and direct observation (see Appendix A).
- Avoid early judgements, blame or attribution.
- Concentrate on the facts/evidence avoiding subjectivity.
- Identify the causal factors leading up to each pertinent event.
- In most cases the event does not result from one single event, but is more likely to have sequence of events (latent conditions) which in isolation may have had no effect, but when they occur in the event chain may be serious or catastrophic in nature.
- Analyse the causal factors.
- Provide a report using the guidance templates provided including recommendations (see Appendix B).
- Identify the associated risks
- Following completion of the root cause analysis investigation the original grading of the event should be reviewed and if necessary re-graded. This must be clearly recorded and signed on PRISM.

RCA literature indicates that approximately 80% of all the incidents are attributable to 20% of probable causes, and these causes.
6.3. Root Cause Analysis Pathway (Summary)

Collect the facts → Analyse the facts → Integrate evidence and establish causes → Make recommendations

What Happened
- Witnesses
- Physical evidence
- Sketches or photographs
- Records and documentation
- Medical evidence etc.

How did it happen?
- Casual factors
- What happened throughout the chain of events
- Focus on problem solving not on blame.
- System and process based – do not concentrate on the individual.

Why did it happen?
- Findings
- Probable causes
- Errors or Violations

Recommendations
- Appointment of lead implementer and timeframes for completion.

6.4. Action Plans

Incident, complaints and claims investigation reports where appropriate will detail recommendations and organisational learning. These recommendations/action plans with the report will be reviewed approved by the Chief Operations Officer.

The Directors Meeting will receive update reports regarding action plan progress/completion provided by the Quality Assurance lead.

7. Learning from Incidents, Complaints and Claims

A key function of the RCA investigation report is to identify opportunities for organisational learning. This process serves to reduce the likelihood of adverse events reoccurring.

The Quality Assurance lead will take responsibility for the dissemination as appropriate, and monitor the resultant changes in organisational culture and practice through the feedback received from the relevant personnel.

7.1. Learning from Incidents, Complaints and Claims – Implications for Organisational

Where appropriate identify wider organisational risks and ensure they are entered onto Risk Register and assessed in line with procedure on Risk Management.
Example of a Completed Root Cause Matrix

<table>
<thead>
<tr>
<th>Number</th>
<th>Identified Root Cause</th>
<th>Probability of Re-occurrence (1-5)</th>
<th>Severity if Re-occurs (1-5)</th>
<th>Overall Risk Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Communication issues between departments</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Training needs re evaluation</td>
<td>5</td>
<td>4</td>
<td>20</td>
</tr>
</tbody>
</table>

8. **Complaints**

All complaints across Future Directions CIC will be entered into a database and replies completed on at least a three monthly basis. The minimum content of the report includes both qualitative and quantitative analysis in respect numbers, trends and cause for concerns, focusing on the following areas:

- Performance management of complaints handling across Future Directions CIC
- Method of Reporting
- Category of Complainant
- Service Area
- Source of Complaint
- Nature of Complaint
- Lessons Learnt

Reports on the analysis and aggregation of complaints will be made available through the Executive Directors to the Heads of Service (as appropriate) for discussion/action as required within their operational teams.

9. **Training**

All training will be delivered in line with Future Directions CIC Training Needs Analysis as detailed contained in _____________________________.

10. **Monitoring Compliance with the Implementation of Lessons Learnt**

The Quality Assurance lead and Chief operations Officer will monitor the feedback from identified leads for implementing the “lessons learnt” and provide feedback to the directors (see Section 8).

The management of the risks associated with RCA investigations are monitored through Work place risk assessments by the appropriate identified Manager.
GUIDANCE ON MAKING A STATEMENT

Guidelines for Staff

Please use these guidelines when preparing a statement with respect to a complaint

In all cases the aim of the statement is not only to preserve the information contained in the medical records, but also to preserve information that is not immediately apparent from the medical records. This information is recorded in a form that can be used to formulate a response from Future Directions CIC as a result of a complaint and, where appropriate, it will be utilised within the disclosure of evidence to a formal hearing such as an Independent Review Panel or Ombudsman’s Enquiry.

The following guidelines should assist in the preparation of all statements

- Write your full name, place of work and brief CV details such as qualifications, current job, grade, speciality and your role in the service user’s complainant’s care.

- Remind yourself of the case by making a thorough and careful review of the relevant Medical/Paramedical/Nursing/PAM Records. It may also help to refer to any relevant policies or procedures at this time.

If there are medical records NEVER make a statement from memory

- Answer in point form the specific concerns of the complainant addressing the issues in which you were involved. Give details of precisely what you recall of the events, what you did and did not do, whom you spoke with, whom you called and at what stage you ceased to be involved in the case. Use and explain the words that you recorded in the service user’s record.

- Where you were not involved in an aspect of the complaint, state this fact clearly in your statement.

- If you discover any inaccuracies in the service user’s records then explain these as part of the statement and prepare an amendment note for the records, which must be signed and dated.

Under no circumstances alter the records after the event

- Write reasons for your actions and omissions.

- Do not include hearsay or opinion. State only the facts.

- When you are happy with the statement, sign and date it (if you use more than one sheet of paper ensure that your name is on each and each is signed and dated).
Although desirable, it is not necessary for your statement to be typed. If handwritten, please ensure that it is legible and written in black ink so that it can be easily photocopied.