Cannock Chase Clinical Commissioning Group

Stafford & Surrounds Clinical Commissioning Group
Working Towards Excellence

NHS
Cannock Chase Clinical Commissioning Group
Stafford & Surrounds Clinical Commissioning Group

Root Cause Analysis Toolkit

for

Nursing Homes

Contents page

Introduction

This tool kit has been designed to support nursing homes when carrying out a Root Cause Analysis (RCA) investigation for serious incidents that involve residents that are NHS funded, commissioned by the Staffordshire and Surrounds and Cannock Chase Clinical Commissioning Groups (SAS/CC CCG).

The toolkit has been written in line with the Serious Incident Framework, supporting learning to prevent reoccurrence (NHS England, 2015)

Nursing homes that are commissioned to provide care are responsible for the safety for service users and must ensure that there are robust systems in place for reporting and responding to serious incidents, arranging and resourcing investigation.

Serious incidents that involve NHS funded residents commissioned by SAS/CC CCG must be reported through the usual arrangements and also reported to the CCGs. In some instances the CCGs may require an RCA to be undertaken.

The commissioner must be assured that the nursing home has undertaken a robust investigation and developed and implemented a responsive action plan to prevent a recurrence of similar incidents.

The sections of the tool kit Include:-

- Reporting of incidents
- The RCA process
- Templates to use when carrying out an RCA
- Check lists that can be utilised for conducting different types of “harms” of serious incidents i.e. pressure ulcers.

Support utilising the toolkit can be obtained from:-

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Quality Improvement Manager for Nursing Homes

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Please note the tool kit and templates will continually be updated as required.

Incident Reporting

Serious Incidents can be:-

- Acts or omissions in care that result in; unexpected or avoidable death
- Unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse
- Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services
- An incident that indirectly impacts on patient safety or an organisation's ability to deliver ongoing healthcare
- Actual or alleged abuse
- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services
- Security breach concern

Please note there is no definitive list that constitutes a serious incident, every incident must be considered using the descriptors below.

- Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care);
- Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).

As soon as a serious incident occurs, appropriate action must be taken to ensure the safety of the affected person(s), other service users, staff and visitors.

Nursing homes will have a procedure and arrangements in place for reporting serious incidents internally and to other regulatory, statutory, advisory and professional bodies as appropriate.

In line with the NHS serious incident framework, a serious incident must be disclosed to the affected person/patients and where applicable families/carers must be notified immediately o when reasonably practicable but must be within 10 working days .

The National NHS Contract for nursing homes also requires nursing homes to provide information in relation to incidents to the commissioning CCG within 2 working days. To report a serious incident the nursing home reports to the CQC in addition the incident needs to be reported directly to the Risk team by email via your NHS net account or password protect the document. The address is scsu.riskteam@nhs.net

If an incident has occurred via another provider of care then the incident needs to be reported to scsu.riskteam@nhs.net to record as intelligence and reported back to the previous provider of care and the Quality Improvement Manager for Nursing Homes copied into the email for monitoring purposes.

Notify the CCG immediately if the incident:-

• will be of significant public concern:
• will give rise to significant media interest or will be of significance to other agencies such as the police or other external agencies

In line with the Serious Incident Framework, Root Cause Analysis must be applied to the investigation of serious incidents.

What is Root Cause Analysis

RCA is a methodical process that seeks to identify the root causes that led to a serious incident happening and the actions required to prevent the incident from reoccurring.

There are three levels of RCA investigation:-

1. Concise investigation for less complex serious incidents - must be completed within 60 days
2. Comprehensive investigation for more complex serious incidents (these must be managed by a multidisciplinary team that involve experts and /or specialist investigators – must be completed within 60 days.
3. Independent investigations - the investigator is independent to the organisation i.e. the police – must be completed within 6 months of being commissioned.

Please note that the safe guarding team take the lead on the investigation of serious incidents that require safeguarding input.

The Root Cause Analysis process for nursing homes

Identifying the lead investigator

The nursing home are responsible for identifying an investigation team that identifies a lead investigator. The lead investigator must have knowledge and the skills/ competencies to lead and deliver the RCA investigation. Training events and support is provided by the Quality Improvement Manager for Nursing Homes (QIMNH). This link will also connect you to an online RCA guidance resource.

https://report.npsa.nhs.uk/rcatoolkit/course/iindex.htm

The QIMNH will support the lead investigator where necessary.

Level of investigation

There are three levels of investigation detailed in the table below

Level	Application	Product/ outcome
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at a local level	Concise/ compact investigation report which includes the essentials of a credible investigation
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report including all elements of a credible investigation
Level 3 **Independent investigation**	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved.	Comprehensive investigation report including all elements of a credible investigation

(Taken from Serious Incident Framework supporting learning to prevent reoccurrence 2015, NHS patient safety domain)

The level of investigation must be agreed with the nursing home and the commissioning CCG, however as new information/evidence emerges the investigation team may need to change level of investigation in response. Nursing homes may have their own templates for undertaking and writing up an RCA, RCA templates for level one and level 2 investigations are included in section 3 and can be used if your nursing home does not have any.

It must be noted that patients and their families/carers must be involved and supported throughout the investigation process.

The RCA must be supported by a clear RCA management plan that must be developed at the start of the process to avoid delay and can be used to keep patients, staff, families and CCG up to date with the process.

Gathering the information

The first step of the process is to gather the information, this can be collected from a variety of sources:-

- Witness statements or interviews from those directly involved in the incident
- Policies and procedures in place at time of incident and were they followed
- Medical and Health Care documentation.
- The site were the incident occurred- photographs of the site may be required

As you work through the investigation other sources of information may be required which include:-

- Training records
- Staff rotas
- Maintenance records for equipment

Checklists have been supplied via hyperlinks in section 2 that can be used as guidance as to what information must be included in relation to the type of incident harm. For example a pressure ulcer checklist can be used to ensure all the information is gathered when investigating the development of a pressure ulcer incident.

Writing up the RCA report

There are report templates for a concise or comprehensive investigation in section 3 there are also examples of what information must be included in the templates in section 4.

The templates have been designed in line with the Serious incident framework supporting learning to prevent reoccurrence 2015 document. The report requires a narrative chronology of events to be produced, this hyperlink provides more information on writing a narrative chronology Tools_Narrative_Chronology.doc

The narrative chronology is a straightforward account, or story, of what happened, in date and time order. It is constructed using information that has been collected during the data gathering phase of the investigation which is then aggregated into a seamless account. Supplementary and contributory factor information is often also recorded within this format and is useful for identifying issues that may have influenced the occurrence of the incident.

Completing a narrative chronology of events provides the investigation review team with straightforward account that is in a chronological order.

https://report.npsa.nhs.uk/rcatoolkit/course/iindex.htm

The report needs to be written so that the persons involved are unidentifiable, disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest.

Quality team review

Once the investigation is completed the RCA document must be submitted to the QIMNH for scrutiny via the quality team based in the CCG. Any queries or challenges will be conveyed back to the investigator if further investigation is required by the QIMNH.

The Multi-professional review meeting

An RCA will require additional scrutiny from a multi-professional review panel which should be organised by the lead investigator in the nursing home. The review panel should include key personnel who have been involved in the care of the patient and the QIMNH from the CCG.

The functions of the review meeting is to ensure that no critical issues have been overlooked, provide analysis of the identification of problems, establish the root causes and put forward recommendations to reduce the likelihood of the incident reoccurring.

It is important to ensure all the nursing/health care notes are available for the meeting in case questions are asked for example a review panel member may query what medication the patient was taking on admission to the home. Arrangements must be made to ensure any documentation is out of archive and available for the review meeting.

The meeting must be minuted for audit purposes, a template has been provided for this in the tool kit, it may be beneficial to organise that another employee minutes the meeting.

The RCA facilitator must chair the meeting and guide the reviewing panel through the documentation.

When the RCA documentation has been reviewed satisfactorily, the panel must identify any amendments/required information to be added to the RCA documentation, contributory factors, root causes, gaps in care that will require actions and suggest recommendations to close the gaps.

Post review meeting, the lead investigator must ensure that the minutes are an accurate reflection of the meeting and make the appropriate suggested amendments to the RCA documentation and circulate both documents to the RCA panel members to ensure accuracy and to check the minutes are agreed as a true reflection of the meeting.

The Action plan

The nursing home is responsible for formulating the action plan and can use their own templates or the template supplied in the templates section of this pack.

The action/gap analysis plan must be formulated by the lead investigator that includes that the agreed gaps in care identified at the review meeting. The lead investigator and nursing home manager must identify the actions to close the gaps to lessen the risk/potential risk of

the incident occurring again. It is important to agree on realistic timescales and identify the person who is responsible for ensuring the action is completed.

The QIMNH will ensure the action plan is followed up and the incident is closed down. The nursing home will receive communication to inform when this has happened.

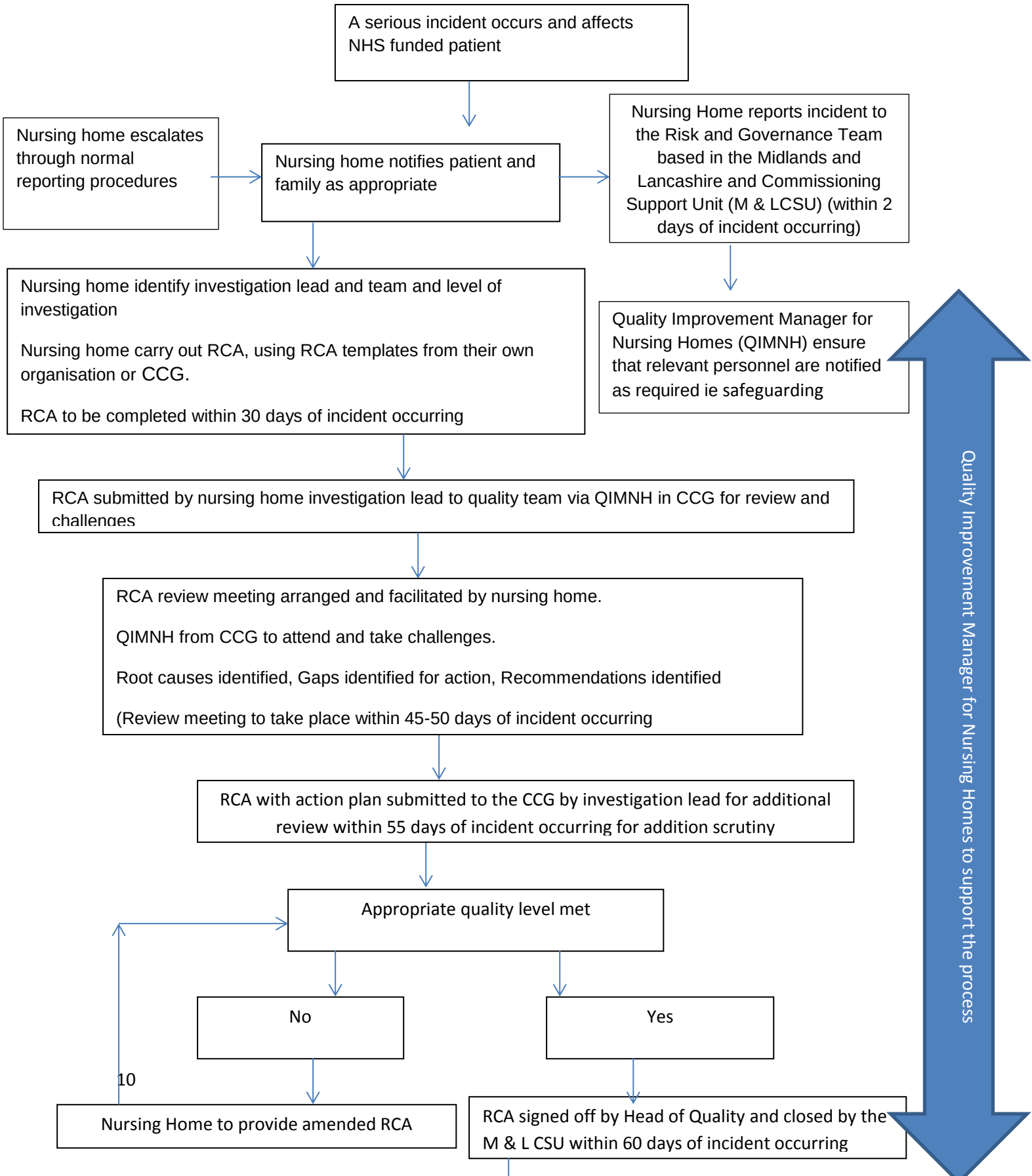
Lessons learned

Lessons learned must be distributed internally within the nursing home by the home manager and to senior management for circulation to other nursing homes within the organisation. Lessons learned will be distributed via the QIMNH for Nursing Homes as appropriate to other nursing homes within the health economy.

Further learning regarding the RCA process can be accessed via the following link

https://report.npsa.nhs.uk/rcatoolkit/course/iindex.htm

The RCA process



Section Two

Check lists to aid RCA

Incident harm/ type	
Pressure ulcers	To be put on the website
Falls	Currently under development
Medication	Currently under development

Section three

Templates	
Concise level one	Hyperlink to be inserted
Comprehensive level 2	Hyperlink to be inserted