Full Investigation and Analysis

The purpose of the process is to implement changes that will make the system safer, which is primarily done by identifying the most important contributory factors .

Reviewing the Case Records

Make an initial summary of the principal events as recorded in the notes. List the key staff involved and decide who to interview.

Framing the Problem

Decide which section of the process of care to examine. Analysis should initially focus on the time period where problems were most apparent.

Interviews

While analyses can be conducted from statements and case records, talking to staff involved provides hugely important additional information. There are several distinct phases to the interview:

- Establishing the role of that member of staff and their view of the sequence of events
- Explain the concept of CMP. Ask them to identify CMPs in the process of care
- For each CMP ask specific questions about each level of contributory factors: patient, task, individual, team, working conditions and, if relevant, higher level factors
- For important contributory factors ask whether this is a general problem on the unit
- Ask about impact on patient, family and staff

Analysis of the case

The core of the process is to ask: What happened? How did it happen? Why did it happen? What can we learn from this and what changes should we make, if any? The analysis follows the same sequence as the interviews:

- Establish the chronology: an agreed history of events, specifying any important areas of disagreement between accounts
- List the principal CMPs identified from records, statements and interviews
- For each CMP identify the principal contributing factors.
- Note those contributory factors that are thought to be general problems in the unit. These are the targets for action and implementation

Reporting and Acting on the findings

- Summarise the chronology
- Identify the care management problems and their contributory causes, giving most emphasis to general contributory factors
- Emphasise positive features of the care given
- Recommend action for each of the general factors requiring attention.

Some incidents may have immediate implications for action. Substantial change will usually only be implemented when a clear pattern of problems and contributory factors is seen in several incidents and the potential impact of any proposed changes is fully considered.

On the Spot Investigation

The method can be used for immediate reflection on any incident or near miss in any formal or informal group by carrying out a brief interview or structured discussion in the time available.

- Determine what happened and who was involved
- Impact on patient and staff
- Most important CMPs
- Most important contributory factors
- How those involved think future similar incidents might be prevented

Proceed to a full investigation if the incident is either very serious or has high potential for organisational learning.

Further reading

Full protocol and case examples available at www.patientsafety.ucl.ac.uk See also:

Vincent CA, Adams S, Stanhope N (1998). A framework for the analysis of risk and safety in medicine. BMJ 316 1154-7

Vincent CA, Adams S, Hewett DH et al. (2000) How to investigate and analyse clinical incidents: CRU & ALARM protocol. BMJ320,777-781. http://www.bmj.com

Authors: Charles Vincent, Sally Taylor-Adams, David Hewett, Jane Chapman, Sue Prior, Pam Strange & Anne Tizzard. Thanks to Allan Frankel and Tejal Gandhi for their on the spot ideas and to Richard Cook for the `2 sides of A4' inspiration.