

3/7 Day Report Template

CPG3 – Appendix 9

This report should be completed using the principles of Root Cause Analysis. The report will seek to investigate the initial facts as found within 3/7 days of the incident determining reasons as to why the incident occurred and immediate actions necessary to reduce the likelihood of the incident recurring.

Incident Overview					
Local SI ref.:		StEIS ref.:		CCG Ref:	
7 day report due:		Final report due:		SI Level:	
Incident date:		Speciality:		Ward/Location:	
If this is an information governance SI please provide the report reference from the IG Toolkit					

Summary of Incident
Brief description of Incident (what/when/how)
<p style="font-size: 48px; opacity: 0.5; transform: rotate(-30deg);">SAMPLE - DO NOT USE</p>
Description of the circumstances leading to the detection of the incident
<p style="font-size: 48px; opacity: 0.5; transform: rotate(-30deg);">SAMPLE - DO NOT USE</p>
Using a timeline, provide a detailed chronological account of events leading up to the incident, the incident itself and actions taken immediately after to manage the incident

Date/time	
-----------	--

Initial understanding of possible contributory factors (why)

SAMPLE - DO NOT USE

Please describe the staffing establishment at the time of the incident versus template and describe skill mix/training level of staff on duty

SAMPLE - DO NOT USE

Initial understanding of effect on patient(s)

Ultimate effect on patient(s) *if known*

Initial communication with patient/family re Being Open / Duty of Candour

--

Initial Analysis

Please consider factors relating to the care and treatment of the service user, taking in to account potential problems/deficiencies initially identified: For Instance

- What exactly was the level of involvement of services
- Was there a failure to adhere to/apply any Trust policies
- Was the risk assessment and management of the individual involved in the incident appropriate and robust? When was the last review or assessment – had frequent reviews been undertaken?
- Were adequate treatment and equipment arrangements in place?
- Was there adequate communication between the service user, their carers and the Trust, health professionals and external agencies (if applicable)?
- How compliant was the service user with their treatment plan?

In addition to the above considerations please also highlight any good practice identified at this stage

SAMPLE - DO NOT USE

If at this stage you are able to identify the root causes and lessons learned please state below:

Root Causes:

Lessons Learnt:

Immediate Actions taken/to be taken

Has the immediate risk been assessed for impact and likelihood of recurrence? Yes / No

If Yes, what measures if any have been put in place to minimise risk of reoccurrence?		
Measure/Action	Who is Responsible for Action	Completed (Please Mark)

Incident Report completed by:			
Name:		Designation:	
Telephone:		E-mail:	

RETURN YOUR COMPLETED REPORT TO YOUR LOCAL CCG CLINICAL QUALITY TEAM

SAMPLE - DO NOT USE

7-Day Report Guidance

Thank you for agreeing to write a 7-Day Report; please find below guidance notes:

General

- 1) For the purpose of anonymity and to assist external reporting, the name of the patient, relative or staff is **not** to be included in the report. Initials should be used or in the case of staff, job titles (including their role and grade)
- 2) The 7-Day report must be completed and submitted electronically.
- 3) Any acronyms should be explained and the report should be easy to read and understood; in exceptional circumstances the report may be disclosed externally
- 4) Proof read the report before submitting it, or ask a colleague to read, in order to avoid omissions or typing errors
- 5) Do not include unnecessary text, summarise, particularly in relation to details of incident, service user profile and chronology
- 6) Retain appendices, do not submit them with the report electronically
- 7) Ensure that your Senior Manager has agreed the content of the final report before it is submitted

Analysis and Findings

- 8) If the incident related to a patient consider **all** factors relating to the care and treatment of the service user or , taking in to account the following:
 - Was there a failure to adhere to PCT policy? If so, which one and how?
 - Was the management of the individual involved in the incident appropriate and robust? When was the last review or assessment
 - Was adequate treatment and equipment arrangements in place?
 - Was there adequate communication between the service user, carers / family, the PCT and other health and social services.(if applicable)?
 - Was their treatment plan adequate?
 - Please identify any good practice which has emerged during your investigation.
- 9) Please investigate and identify whether there were any issues with training, supervision and resourcing.

The Report

- 10) The nature and severity of the incident will inform the type and level of investigation, the data gathered and Root Cause Analysis Tools used (state what documents have been reviewed for the purpose of your investigation)
- 11) When detailing findings, avoid generalisations, include facts and not opinion and ensure that factual information is evidenced
- 12) If a problem is identified a problem, explain what best practice is expected and what the policy or protocol states should happen
- 13) Evidence what support has been provided to patients, victims, families and staff following the incident
- 14) Identify good practice as well as poor
- 15) Recommendations must be actionable statements and should derive from evidence presented within the body of the report i.e. **recommendations must relate to the findings of the investigation**
- 16) Summarise all the recommendations under the final section of the report and ensure they do no duplicate or replicate others – do not feel obliged to make unnecessary recommendation