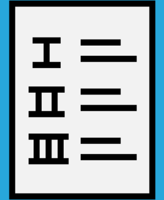
NCISH

10 standards for investigating serious incidents

1 Specific terms of reference

Are there clear terms of reference (ToR), specific to the individual patient/incident, which set out the scope of the investigation and the timescale for conducting the review?

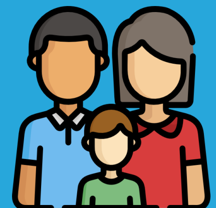


2 Clearly independent investigators

Was the investigation conducted independently of the treating team?

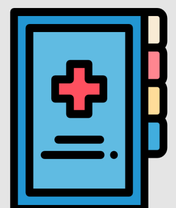
3 Contacting family

Were family members given the opportunity to contribute to the investigation?



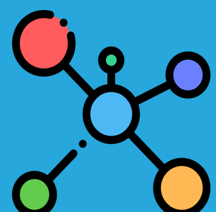
4 Accessing full case records

Is it clear whether the investigation acquired access to full case records detailing the patient's clinical history? If there are records missing is this clearly stated?



5 Contributory factors

Are the contributory factors leading to the incident presented (rather than a single root cause)?



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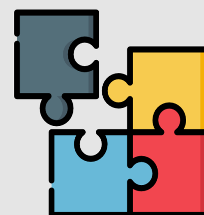
6 Sufficient information for understanding what happened

Is there sufficient information to enable a thorough understanding of the circumstances of the death/incident, as well as the activity of the services involved?

7 Report coherence

Is the serious incident report coherent? Is there a clear and logical pathway from the ToR to the contributory factors to the recommendations? Is it clear how the recommendations could be used in prevention?



8 Accessibility to a lay reader

Is the serious incident report accessible to a lay reader? Is the report not too lengthy and written in plain English with all specialist vocabulary explained?

9 Action plan

Does the serious incident report have an associated action plan with a timescale for review?

10 Learning

Does the serious incident report provide details of what needs to change in the service(s) and is there evidence of how learning will occur internally?