**Level Two Root Cause Analysis Report - Comprehensive**

**Incident number**

**Organisation**

**Version**

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| --- |
| **Organisation Name** |
| **Health care speciality** |
| **Incident number**  | **Incident Date** |
| **Incident type** |  |
| **Detection of incident** |  |
| **Effect on patient** |  |
| **Level of investigation conducted** |  |
| **The investigation team****Declaration of interest** |
| **Investigation methods** |
| **Information and evidence gathered** |
| **Dates patient/family informed** |
| **Duty of Candour****Involvement and support of patient and relatives** |
| **Involvement and support provided for staff involved** |

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| --- | --- | --- | --- |
| **Title of the Author** | **Date of report** | **Number of pages** | **Version number** |

**Terms of Reference**

* To carry out the root cause analysis objectively and not apportion blame
* Provide a chronology of the events leading up to the incident
* Identifying care or service delivery issues, along with the factors/supplementary evidence that might have contributed to them
* Identify underlying causes
* Determine the root causes
* Establish how reoccurrence may be reduced or eliminated
* Make clear, implementable recommendations for the nursing homes in the local health community

**Clinical terminology**

Clinical terminology will beannotated with an astrisk \* indicating there is further explanation provided in the glossary on the last page of the report.

**Background and context**

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**Chronology of Events**

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| --- | --- | --- | --- | --- |
| **Date** | **Location of evidence** | **Event** | **Notable practice** | **Identified problems in care and service delivery** |
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**Glossary**

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| --- | --- |
| **Clinical terminology** | **Explanation**  |
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| **Contributory factors Frame work** |
| **Patient Factors** |  |
| **Individual staff factors** |  |
| **Task Factors** |  |
| **Communication Factors** |  |
| **Team and Social Factors** |  |
| **Education and Training Factors** |  |
| **Equipment and Resource Factors** |  |
| **Working Condition Factors**  |  |
| **Organisational & Strategic Factors** |  |

**Identified Root Causes**

**Lessons learned**

**Recommendations**

**Arrangements for shared learning**

**Good practice identified**

**Date sign off**

**Designation and signature**

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