Nosocomial COVID-19 Patient Safety Incident[1]

Investigation Proportionality Decision Tool

INVESTIGATION STAGE 1

Identification of Patients (Including post discharge from hospital)

Non-Healthcare Acquired	Healthcare Acquired
Completion of Datix Record outlining investigation findings. **Stop here[2]**	Datix Report ↓

INVESTIGATION STAGE 2

Clinical Assessment to Determine Level of Harm (see section 4.1 of Framework)

No Harm / Low Harm	Moderate Harm	Severe Harm	Death – Medical Examiner and/or Universal Mortality Review[3]			
			No contribution:	Contributing Causation:	Part of Causal Sequence:	Sole Contribution:
Completion of Datix Record outlining investigation findings. **Stop here[4]**	↓	↓	HAI did not contribute to the death or the contribution was redundant, i.e. the patient would have died anyway	HAI was a contributory cause but not related to the disease or condition causing the death	HAI was part of the causal sequence of events that led to death but not sufficient on its own ↓	HAI was the sole cause of death – no other disease or condition causing the death was present (sufficient condition) ↓
			Completion of Datix Record outlining investigation findings. **Stop here[4]**			

<u>Communication with patient / family or representative should occur at this stage</u> (See section 7 of the Framework)

INVESTIGATION STAGE 3

Continue to undertake proportionate investigation as to determine any care and service delivery issues and causal factors[5]

No care and service delivery issues	Care and service delivery issues
Completion of Datix record to detail investigation outcome. • Communicate outcome of investigation • **Stop here[4]**	• Complete investigation report • Local scrutiny panel • Liaise with Legal and Risk Services (where applicable) • Follow PTR requirements

[1] Patient Safety Incident, or an incident concerning patient safety, means any unexpected or unintended incident which did lead to or could have led to harm for a patient (The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011).

[2] Health Bodies should record details of patients who are considered within this category but no investigation is required, except to manage any associated processes such as individual concerns or inquest process, in keeping with local and national regulations and guidance.

[3] Health Bodies can use the outcome of mortality to reviews to help inform this decision, and/or referral to the Medical Examiner Service in the event of new cases. Note however, that mortality reviews, nor the Medical Examiner process, constitute an 'investigation' under the investigation requirements of regulation 23 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

[4] Health Bodies can make an operational decision to commission further investigation in the absence of any individual concerns raised.

[5] Health Bodies can choose the appropriate method by which to investigate based on the degree of harm.

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