

## INCIDENT DECISION TREE (IDT) - APPENDIX 1

The Trust's Risk Management Committee has agreed to adopt the IDT subject to the following amendments: -

- At the outset of any investigation, advise the individual of their right to consult a Staff Representative.
- The HR Adviser must be brought into the 'case' at the start of the IDT

### National Patient Safety Agency (NPSA) Incident Decision Tree

In November 2004, the Risk Management Committee approved the NPSA Incident Decision Tree (IDT), which will be used for any employee involved in a patient safety incident, whatever their professional group. Although the IDT promotes good management practice, it is not designed for use in other situations, such as poor performance or absenteeism.

## Frequently Asked Questions

### Who can the Incident Decision Tree be used by?

It is designed for use by any manager dealing with staff involved in a patient incident. This includes Clinical Directors, Divisional Managers, Heads of Nursing, Governance Facilitators and Human Resources professionals.

### When should the IDT be used?

Ideally, it should be used as soon as possible after the patient safety incident, whilst facts are still fresh in people's minds. However, this is not always possible and it can be used at any point during the investigation.

If new information comes to light, it can be worked through afresh and may or may not lead to a different conclusion.

### How does the IDT work?

Based on a flowchart (see attached), the Incident Decision Tree guides you through a series of structured questions about the individual's actions, motives and behaviour at the time of the incident.

These questions move through four sequential 'tests':-

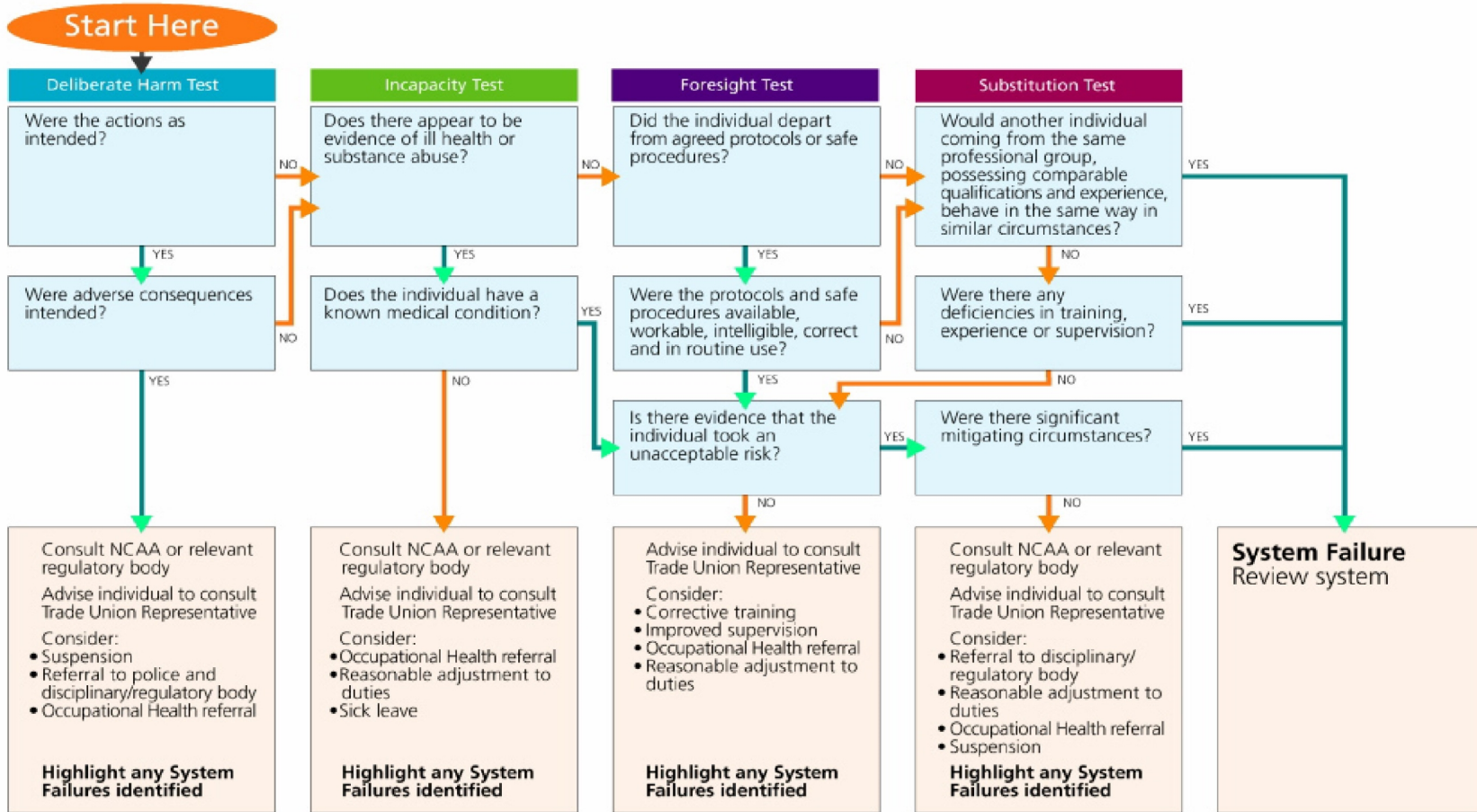
- The Deliberate Harm Test
- The Incapacity Test
- The Foresight Test
- The Substitution Test

Working through each test in turn, possible reasons for the individual's actions are reviewed and the most likely explanation identified. The responses lead to a list of recommended options for consideration.

In the majority of cases system failure turns out to be the cause of the patient safety incident.

# INCIDENT DECISION TREE\*

Work through the tree separately for each individual involved



\* Based on James Reason's Culpability Model