Standard operating procedure (SOP) · INC-SOP-001 · Version 1.1 · Approved by the ASF Expert Committee

Supports: 2A.6

At a glance

- Classify the incident as serious (death, severe harm, or a near miss with high potential) within 2 working days.
- Form a review team with no one directly involved in the event.
- Find the causes, not the person to blame: use the root-cause method.
- Write actions with owners and dates. Track them until closed.
- Share the findings with staff and, where appropriate, with the patient or family.
- Stop and get help straight away if: a serious incident is not reviewed within the time set, or the review blames an individual without looking at the system.

1. Purpose

To find out why a serious incident happened, change the system so it does not happen again, and track the change until it is complete [EC].

2. Scope

Applies to	All serious incidents, including death, severe harm and high-potential near misses
Locations	All services at the facility
When	Within 2 working days of classification; review completed within 45 days (EC)
Does not apply to	Minor incidents, which are handled through the incident policy (INC-POL-001)

3. Definitions

Term	Meaning
Serious incident	An event that caused or could have caused severe harm or death
Root cause	The underlying system factor that, if corrected, would prevent recurrence

Action tracker	A log of every action, owner, due date and status

4. Background

A brief description of what happened does not explain why. Root-cause analysis looks at systems, processes, equipment, staffing and communication to find the causes. It is what criterion 2A.6 requires.

5. Responsibilities

Role	Responsibility	Competence
Quality lead	Leads the review; keeps the tracker; reports to governing body	RCA training
Review team	Gathers evidence, interviews, finds causes, writes actions	RCA training
Chief executive	Classifies serious incidents; approves the report	Executive leadership
Action owners	Complete actions by due date; report progress	Competence for their action

6. Materials and equipment

Item	Requirement	Condition
RCA record (INC-FRM-001)	Current version	Complete
Action tracker (INC-REG-001)	Current	Updated monthly

7. Safety

- Protect the confidentiality of staff and patients in the review. Share findings in anonymised form.
- Staff involved must be supported, not punished for honest reporting.

8. Before you start

- Preserve records, equipment and logs related to the event.

- Inform the patient or family of the review (see the disclosure procedure).

9. Procedure

Step 1. Classify and register the incident.

- Within 2 working days, the chief executive or delegate classifies the event as serious or not.
- Enter it on the incident log with the date, the classification and the reviewer.

Key point: Classification decides the level of review. Make it early.

Step 2. Form the review team.

- Include a clinician, a manager from another service, a quality lead and, where possible, a patient representative.
- No one directly involved may lead the review.

Key point: Independence is what makes the findings believable.

Step 3. Gather the facts.

- Collect the records, timeline, equipment logs, rotas and communications.
- Interview the people involved, one at a time, in a neutral setting, and record what each person says.
- Build a timeline of events with times.

Key point: A timeline shows what happened in order. Gaps in it are questions to answer.

Step 4. Find the root causes.

- Use the five whys or a fishbone diagram to move from what happened to why.
- Ask whether the system allowed the error, made it likely, or failed to catch it.
- Agree the root causes as a team and record them on INC-FRM-001.

Key point: Stop when you reach a system cause. Blaming a person is the end of the analysis, not the start of the fix.

Step 5. Write actions.

- For each root cause, write one or more actions that change the system: a checklist, a redesign, training with a check, a change of equipment or staffing.

- Give each action an owner, a due date and a measure of success.
- Rank actions by strength. Prefer changes that remove the hazard over warnings and training alone (EC).

Key point: Training alone is the weakest action. Make the safe choice the easy choice.

Step 6. Track and close actions.

- Enter each action on the tracker (INC-REG-001).
- Review overdue actions monthly with the governing body.
- Close an action only when the measure of success is shown.

Key point: An action is complete when it works, not when it is written.

Step 7. Share and report.

- Share the findings and lessons with staff in the affected service.
- Report the outcome to the governing body and, where appropriate, to the patient or family.

Key point: The lessons only help if people hear them.

10. Decision points

- If the review finds a possible criminal or professional misconduct, refer it to the relevant authority through the chief executive, separately from the learning review (EC).

11. Special situations

Situation	Action
Death of a patient	Notify the coroner or prosecutor where the law requires; follow the legal procedure (EC).

12. Escalation

- Serious incidents are reported to the governing body within 24 hours of classification.
- Overdue actions are escalated to the chief executive after 30 days.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Serious incidents with a completed root-cause review within 45 days	100%	Monthly	Quality lead	Escalate to governing body
Actions completed by due date	90% (EC)	Monthly	Quality lead	Escalate to owner’s manager
Actions verified as effective	100% of closed actions	Quarterly	Quality lead	Re-open action

14. Records

Record	Kept in	Retention
RCA record (INC-FRM-001)	Quality file	the period set by the facility’s records policy years
Action tracker (INC-REG-001)	Quality file	the period set by the facility’s records policy years

15. Training

- Quality leads and senior managers are trained in root-cause methods before leading a review (EC).
- Staff involved in a review receive feedback on the findings.

16. Related documents

ID	Title	Use
INC-FRM-001	Root Cause Analysis Record	Used in steps 3 to 5
INC-REG-001	Incident Action Tracker	Used in step 6
INC-POL-001	Incident Reporting and Management	Incident classification
GOV-PLN-002	Quality Improvement Plan	Actions feed the plan

17. Evidence

Reference	Note

E-009	ASF Expert Committee consensus. Timeframes (2 days, 45 days, 24 hours) are EC decisions.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	Approved by the ASF Expert Committee
1.1	the date of approval	Internal quality review: corrected cross-references, status wording and document control	Approved by the ASF Expert Committee

E-learning for this document

- **Incident Reporting, Just Culture and Open Disclosure** (T-09)
- **Nonconformity, Corrective Action and Risk** (T-04)

References

- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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