

# Incident and Complaint Management Investigation Toolkit

## Purpose and Background

The Incident and Complaint Management (ICM) Toolkit is designed to help CHL staff manage incidents and complaints in accordance with the Incidents and Complaints Management Framework, as well as related policies, procedures, and work instructions. Specifically, this toolkit aims to provide practical guidance and resources for employees and managers to proactively manage incidents and complaints, ensuring the delivery of high-quality care and services through efficient systems and processes. This toolkit should be read in conjunction with the CHL Framework for Incidents and Complaints, CHL Incidents Procedures and CHL Complaints and Feedback Policy and Procedures.

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## 1. Managing an incident and complaint

### Overview of key steps to managing an incident and complaint

All consumer incidents and complaints involving care provision and services for consumers in CHL should be reported and managed in keeping with the respective [CHL - Incident Management - Consumer - Procedure](#).

The ICM Toolkit provides detailed guidelines and tools to assist in the management and investigation of consumer related incidents and complaints. This toolkit guidance should be read in conjunction with the [People - Health Safety and Wellbeing - Procedure](#) and the guidelines listed below for employee-related incidents.

[HSW.G.24 - MySafety Managers Guide - How to respond to a Safety Incident Report v1.0.pdf](#)

[HSW.G.21 - MySafety User Guide - How to complete a Safety Incident Report v1.0.pdf](#)

## 2. Detailed steps in Managing a consumer incident and complaint

An incident and complaint may be identified/reported by a consumer, visitor or any CHL employee. It is important for all staff to recognise when an incident has occurred and acknowledge when staff become aware of a complaint.

## 3. Identification

### How do we recognise that things have gone wrong?

An incident and complaint may be identified/reported by a consumer, visitor or any CHL employee. It is important for all staff to recognise when things have gone wrong/an incident has occurred/an event or activity that had the potential to cause harm to a consumer/an event or activity that led to a poor experience.

Incidents and complaints can be identified from several sources, which may include:

- Direct observation and direct conversation
- Team discussion
- Coroner's reports
- Clinical review meetings
- Death review processes
- Staff meeting discussions
- Complaints

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- Carer and family input
- Monitoring variation in clinical practice
- Audits
- Chart reviews.

Pro-active approaches such as direct observation of clinical workplaces, briefing and debriefing, and consumer, carer and family escalation processes can detect errors early or prevent them.

It is a mandatory requirement for all employees (including CHL employees and any contracted staff from external agencies) who become aware of an incident or a complaint to notify one of the following of that fact as **soon as possible**:

- a) Most senior person on duty
- b) One of the provider’s key personnel
- c) A supervisor or manager of the staff member

## 4. Immediate action

### How do we minimise the immediate risk?

When an incident or complaint is identified any immediate risk must be immediately managed and action taken to reduce and mitigate the risk. All opportunities to improve the consumer experience and the experience of any other affected persons should be swiftly actioned.

These actions include:

- Providing immediate care and response to the individuals involved – this includes consumers, carers, families, and members of the workforce
- Making a situation/scene safe
- Notifying the manager responsible and the medical team as necessary
- Notifying security and the police (as relevant to the incident)
  - If there are reasonable grounds to report the incident to the police, the notification must be completed as soon as reasonably practicable and no later than 24 hours of becoming aware of the incident
  - If reasonable grounds to notify the police come to light later, the incident must be reported to the police within 24 hours of becoming aware of those grounds
  - Removing or managing malfunctioning equipment or supplies.

Ongoing support should be offered to consumers, carers, families and members of the workforce who are involved in the incident or a complaint. The incident or complaint should be acknowledged and an outline of next steps by staff provided. Expressions of regret and an apology should also be provided to the consumer, carer or family in line with the [CHL - Open Disclosure - Policy](#)

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## 5. Report, Escalate and Notify

Do we have all the information we need?

How serious is the incident?

- Notifications should be timely
  - Complete notifications to the immediate supervisor as soon as possible.
  - Notifications for CAS 3, CAS 4 and CAS 5 incidents must be completed verbally (telephonically or face to face) within the same shift for which the incident took place or during which the complaint was received.
  - Notifications for CAS 2 and CAS 1 incidents must be completed verbally (telephonically or face to face) immediately after the immediate response has been completed.
  - Complete notifications to the authorised representative (AR)
  - Notifications to the AR must be completed verbally (telephonically or face to face) within the same shift for which the incident took place or as soon as is reasonably practicable.
  - Allocate the level of harm and severity rating (CAS rating).
  - Escalate in line with the Enterprise Risk Escalation matrix
  - Confirm the level of harm and severity rating (CAS rating).
- Overall accountability for the incidents management and complaints management rests with the Residential Managers/Service Manager. They must have complete oversight of all incidents at the Home/Service Level, and they must undertake pro-active steps to ensure that the incident management process for all incidents and complaints is in-line with the relevant CHL Frameworks, Policies and Procedures.
  - It is expected that the Residential Managers/Service Managers are closely involved in the management of CAS 3, CAS 2 and CAS 1 incidents.
  - Care Managers/Care Advisors are responsible for ensuring and/or directly managing all clinical incidents at the Home or Service Level.
  - Care Managers/Care Advisors will review trends for incidents and complaints on an ongoing and monthly basis to ensure they are managed in-line with the overarching management processes to ensure minimisation of harm and re-occurrence.  
For all CAS 1 incidents, the Incident Response Team (IRT) is convened and will determine the management response to the incident - **refer to incident response procedures**.
- Staff must establish a high-level sequence of events and known facts to complete a preliminary assessment of risk and additional actions for Legal, Media & Board escalation if necessary.
  - For employee involvement (conduct/safety), review the information and decide on whether a stand down is required in consultation with relevant stakeholders.
  - Contact security and the police (if required).

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## 6. Record and Document

The incidents are to be recorded in relevant documentation systems.

All incidents (including near misses) and complaints must be reported in relevant documentation systems (i.e. Incident and Complaints Register Applications and workforce incidents in MySafety). An option for reports to be made anonymously should be available. Consumers, carers or visitors should also be encouraged to notify staff of near misses when they encounter them. Near misses are opportunities to prevent harm and strengthen safety and quality. Staff must do all they can to recognise, report and respond appropriately to near misses.

When reporting, it is vitally important to ensure the accuracy, quality, and completeness of the report to support the follow-up incident and complaint review. Important considerations for notifiers include:

- Provide as much relevant detail as possible
- Provide **objective, accurate** and **information**. Staff must refrain from including personal opinions in an incident or complaint record. All clinical incidents should use the ISBAR framework (Introduction, Situation, Background, Assessment, and Recommendation ) as a guide.
- Report the incident within the prescribed timeline.
  - Notifications for CAS 2 and CAS 1 incidents must be completed verbally (telephonically or face to face) immediately after the immediate response has been completed.
  - Notifications for CAS 3, CAS 4 and CAS 5 incidents must be completed verbally (telephonically or face to face) within the same shift for which the incident took place or during which the complaint was received.
- Document relevant facts and complete all fields (mandatory and non-mandatory fields in the incident and complaint forms and provide detailed factual/objective information that will assist with further review and management of the incident and complaints.
- Some incidents and complaints may require notification to the regulatory bodies (Aged Care Quality and Safety Commission (ACQSC), NDIS Quality and Safeguards Commission (NDIS), Healthcare Complaints Commission (HCCC), Australian Health Practitioner Regulation Agency (AHPRA) ), and consideration should be given to completing the required notifications within the required period.

All employees must notify all incidents and complaints to the most senior person on duty immediately after becoming aware of the issue.

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## 7. Investigate and Identify the Contributing Factors

What Happened?

How and why, it happened?

What actions can be taken to prevent harm to the consumer and minimise re-occurrence?

All clinical incidents and complaints require review by the line manager/ delegated authority to determine the level of investigation required. **Not all complaints require an investigation**, and the majority can be successfully resolved at the point of receipt.

The analysis and investigation phase is used to establish the course of events and to identify the contributing factors. A standard protocol is outlined below:

CAS 1 incidents and complaints	Comprehensive or Concise Investigation (or similar methodology) to be undertaken.
CAS 2 incidents and complaints	5 Why's approach/Concise/ Comprehensive Investigation
CAS 3, CAS 4 and CAS 5 incidents and complaints	5 Why's approach

Consideration should be given to providing consumers and their families with the opportunity to contribute information about the incident or complaint to assist with the investigation process and the development of person-centred recommendations.

### Investigation principles.

#### 1. Confidentiality

- Protect the privacy and dignity of residents, families, and staff involved in the investigation.
- Ensure that information gathered during the investigation is kept confidential and shared only with those who have a legitimate need to know.

#### 2. Impartiality and Objectivity

- Investigators must remain neutral and avoid any conflicts of interest. It's important to ensure the investigation is free from bias or preconceived notions.
- The investigation should be based solely on evidence, avoiding assumptions or personal opinions.

#### 3. Evidence-Based Approach

- Collect all available evidence, including witness statements, medical records, surveillance footage, and any relevant documentation.

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- Base conclusions on verified facts and data, ensuring all evidence is considered before making a determination.

## 4. Timeliness

- Investigations should be conducted promptly to ensure the issue is addressed quickly and to prevent further harm or risk to residents.
- Timely resolution also helps maintain trust with residents, families, and staff.

## 5. Transparency

- The investigation process should be clearly communicated to all parties involved, including residents, their families, and staff. They should be informed of the process, expected timeframes, and outcomes.
- Any findings or decisions made as a result of the investigation should be clearly explained.

## 6. Legal and Regulatory Compliance

- The investigation must comply with relevant laws, regulations, and standards, including those set by government bodies such as the ACQSC.
- Ensure adherence to policies regarding mandatory reporting, especially in cases of suspected elder abuse or neglect.

## 7. Fairness

- Ensure that all parties involved have an opportunity to present their perspective and provide evidence.
- Treat all individuals with respect and reserve judgement until the investigation is complete and findings are clear.

## 8. Documentation

- Maintain comprehensive records of the entire investigation process, including interviews, findings, evidence, and any decisions made.
- Proper documentation ensures accountability and can be referred to in future disputes or regulatory reviews.

## 9. Follow-Up and Corrective Action

- After the investigation, take appropriate corrective actions to address the findings. This could include staff retraining, policy changes, or disciplinary action where necessary.
- Monitor the effectiveness of any corrective actions to ensure the issue does not recur.

## 10. Resident and witness centred Focus

- Always prioritise the health, safety, and well-being of the residents and or witnesses during and

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after the investigation. Residents' voices should be heard, and their concerns validated.

- Ensure that the investigation leads to outcomes that enhance the quality of care for residents.

By following these principles, investigators can conduct fair, transparent, and effective investigations.

## Complainant and Witness Management

It is imperative that all staff involved in the investigation process take steps to minimise harm to witnesses. This means creating supportive environments where witnesses feel safe and offering emotional support during and after the interview. It is important that witnesses have a clear understanding of their rights, including the right to have a support person present. A trauma informed approach should be used with witnesses who may have experienced or observed distressing incidents. Investigators must be sensitive to the emotional toll that recounting such events may have. Investigators must take all necessary steps to **minimise repeated interviews unless absolutely necessary**. Multiple interviews can not only lead to significant emotional distress, it can also lead to inconsistencies in witness accounts and impact the credibility of the evidence.

Multiple interviews can also erode trust. CHL has a duty of care to protect witnesses from workplace related psychological harm. After the interview, ensure that witness have access to counselling's services via EAP or support groups if they have experienced emotional distress.

Significant new information for reportable incidents must be notified:

(1) CHL must notify the Aged Care Quality and Safety Commissioner (the Commission) of significant new information relating to a Priority 1 reportable incident under section 15NH (1) of the Quality-of-Care Principles 2014

(2) The notification must:

- be in writing
- be in the approved form
- be provided as soon as practicable - most cases a day 5 update is recommended followed by further updates as required and/or as significant new information comes to light.

## 8. Findings and Recommendations

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Investigations into incidents and complaints can be carried out by different roles within CHL. The personnel could range from clinical team members to specialists and trained (internal or external) investigators. At the completion of the investigation, a final report or analysis is prepared with recommendations for consideration. A corrective action plan or a plan for continuous improvement is then developed to ensure the execution of all recommendations at the operational level to ensure minimisation of harm and reoccurrence.

For CAS 1 and CAS 2 incidents and complaints, it is usually the decision makers who would be the recipients of the final investigation report. Any additional updates or final notifications for reportable incidents are provided to the regulatory bodies. The findings are then communicated with the key stakeholders internally and externally as required by the investigation lead. Considerations are also made for external notifications to other regulatory bodies such as AHPRA. It is at this point that the closure criteria for the incident are determined.

CAS 1 and CAS 2 incidents and complaints may require a comprehensive or concise investigation.

The development of recommendations is a fundamental component in the management of incidents and complaints. Recommendations provide the framework for action in strengthening quality and safety and preventing adverse events from occurring.

All incidents and complaints should have recommendations that are:

- Based on contributing factors aimed at preventing or minimising the occurrence of similar events.
- Clearly define a recommendation/s with timeframes for completion
- Include measurable outcomes to monitor the progress and the impact of recommendations.
- Identify individual(s) responsible for implementing and monitoring the recommendations.

## Final report about reportable incident must be given if required/ requested by ACQSC

- (1) If required by the Commission under subsection 95E(1) of the Commission Rules, CHL must give the Commissioner a final report about a reportable incident.
- (2) The final report must:
  - a) be in writing; and
  - b) be in the approved form; and
  - c) contain the information specified by the Commission under subsection 95E(1) of the Quality Safety Commission Rules.
- (3) Under 95G(1)(c)(i) and (ii) of the Commission Rules 2018 the Commission may also require CHL to carry out an internal investigation into the incident and submit an investigation report to the Commission.

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## 9. Share Learning and Improvement

Feedback to the consumer and nominated relative/carer should occur throughout the management and resolution of the incident and complaint and as part of the Open Disclosure Process. A follow-up post-resolution of the incident and complaint is required with the consumers and the nominated relative/carer to capture satisfaction with the overall incident management process.

For all CAS 4 and CAS 5 incidents and complaints the relevant manager or their delegate involved in the management of the incident and complaint is usually the best person to support open disclosure.

For all CAS 3 incidents the relevant manager involved in the management of the event is the best person to support open disclosure.

For CAS1 and CAS 2 incidents, additional support may be provided to the team as determined by the relevant Chief Officer.

The success of incident and complaints management also depends on the prompt feedback to all staff on the recommendations/outcome of investigation. Failure to provide feedback can undermine staff confidence in the process, so managers must always follow through with feedback and close the loop.

## 10. Implementation of Recommendations

Recommendations arising from incident and complaint investigations are to be implemented as soon as possible and no later than 12 months after the investigation has been finished.

## 11. Monitoring of Recommendations

The Practice Quality and Risk (PQR) Team will work closely with Homes/Services to support effective management and end-to-end resolution of CAS 1 incidents and complaints. The PQR Team will request information from Homes/Services regarding the implementation of CAS 1 incident and complaint recommendations on a six-monthly basis.

Similarly, the PQR Team will conduct reviews into the management of all CAS 2 incidents and complaints to ensure conformance with the relevant frameworks, policies and procedures. The Quality Assurance and Clinical Governance team will carry out level 2 assurance activities monthly by reviewing trends and associated risks to monitor practice.

Overall accountability for incident and complaint management rests with the Residential/Service Managers.

## 12. Evaluation of Recommendations

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When all recommendations have been appropriately implemented (e.g. six months post-implementation) the Home/Service should evaluate the effectiveness of the strategies in order to validate that improvements have been made. This is to ensure that:

- The systemic problems identified have been addressed
- Recurrences have been reduced or eliminated
- Lessons have been learnt and communicated
- Identified barriers to change have been removed
- Loop is closed to ensure organisational learning

Once all recommendations are implemented and evaluated the incident and complaint is considered closed.

## 13. Overview of investigation methods and tools

Incidents and complaints classified as CAS 1 or 2 may be due to a single event in connection with the provision of care and services, that caused or had the potential to cause significant or serious harm, or impact upon the delivery of safe care and services to a Consumer.

CAS 1 and CAS 2 incidents and complaints may also occur or have the potential to occur because of serious systemic problems. As a result, there are occasions when a CAS 1 or 2 incident requires a deeper examination of causes. When responding to a CAS 1 incident, the IRT will determine who leads the investigation and when required the methodology to be followed.

## 14. Incident and Complaint Investigation

The Comprehensive and Concise investigation methodology is designed to support organisational learning and quality improvement.

The approach moves beyond a linear representation of analysis by introducing concepts related to complexity theory and depicting contributing factors as clusters within a constellation, rather than as part of direct one-to-one cause-and-effect relationships.

Investigations highlight the importance of recognising that many sources of information flowing through the organisation can clarify risks to the safety of Consumers (e.g. recommendations from accreditation, complaints, etc.).

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The investigation methodology provides an approach to incident and complaint analysis. The analysis can either be concise or comprehensive. In some instances, a concise event analysis may generate information that may prompt the need for a comprehensive event analysis.

1. **Comprehensive investigation** is used for complicated and complex incidents. Multiple sources of information are consulted, including interviews with those directly or indirectly involved in the incident and complaints as well as experts, and may be supplemented by a literature review. A significant amount of time and resources (human and financial) can be invested to conduct the investigation.
2. **Concise investigation** is a succinct, yet systematic way to review incidents and complaints. The sources of information consulted are the available reports, supplemented with a small number of select interviews and a targeted review of other sources of information. The analysis is completed in a short interval of time by one or two individuals.

The methodology **used is the same for both** Concise and Comprehensive investigations. The key difference is **in the resources and skill sets** required in the more complex incidents and complaints that require a comprehensive review.

Investigations into incidents and complaints are underpinned by:

- A just culture – when an incident occurs, individuals are treated fairly and not held accountable for system failings over which they have no control
- Focus on systems and not people – review processes and consider the conditions under which individuals work, considering the complexity and interdependencies
- Regardless of the methodology used, the incident and complaint investigation always focuses on answering the following questions:
  - What happened?
  - Why did it happen?
  - What can be done to prevent it from happening again?

It is important that we acknowledge that no one comes to work to do a bad job. Front-line staff need to be supported by managers and leaders who have a focus on **reducing preventable harm**, supporting a safety culture with accountability, and strengthening the capability of their staff.

This toolkit provides guidance for teams undertaking an investigation. It includes the tools and processes that will assist a team in answering the three questions. It is divided into three sections:

1. Comprehensive incident investigation
2. Concise incident investigation

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3. Five Why's approach to investigation.

## 15. CAS 1 incidents and complaints investigations

A comprehensive investigation may be required for CAS 1 incidents and complaints or other incidents and complaints that may be due to serious systemic issues. The IRT convened by the Chief Quality Officer (CQO), Chief Residential Officer (CRO) or Chief Communities Officer (CCO) determines the investigation methodology for CAS 1 incidents and complaints. There may be occasions where the IRT engage an external and independent company to complete the investigation.

## 16. Privilege

The need for statutory privilege is assessed by the IRT in consultation with the Chief Legal Counsel (CLC). If privilege is a consideration in any investigation advice from the CLC must be obtained as soon as possible.

## 17. Before the Investigation Lead and the Investigation Team are appointed

When an incident or complaint is identified there are a series of processes that take place prior to the commencement of the investigation. These include:

1. Clinician disclosure – the relevant clinician shares what they know about the incident with the consumer, carer and/or family
2. Establish a high-level sequence of events and known facts to complete a preliminary assessment of risk and additional actions for Legal, Media & Board escalation
3. A dedicated family contact is appointed. This staff member is the main contact for the family during the management and resolution of the incident and complaint

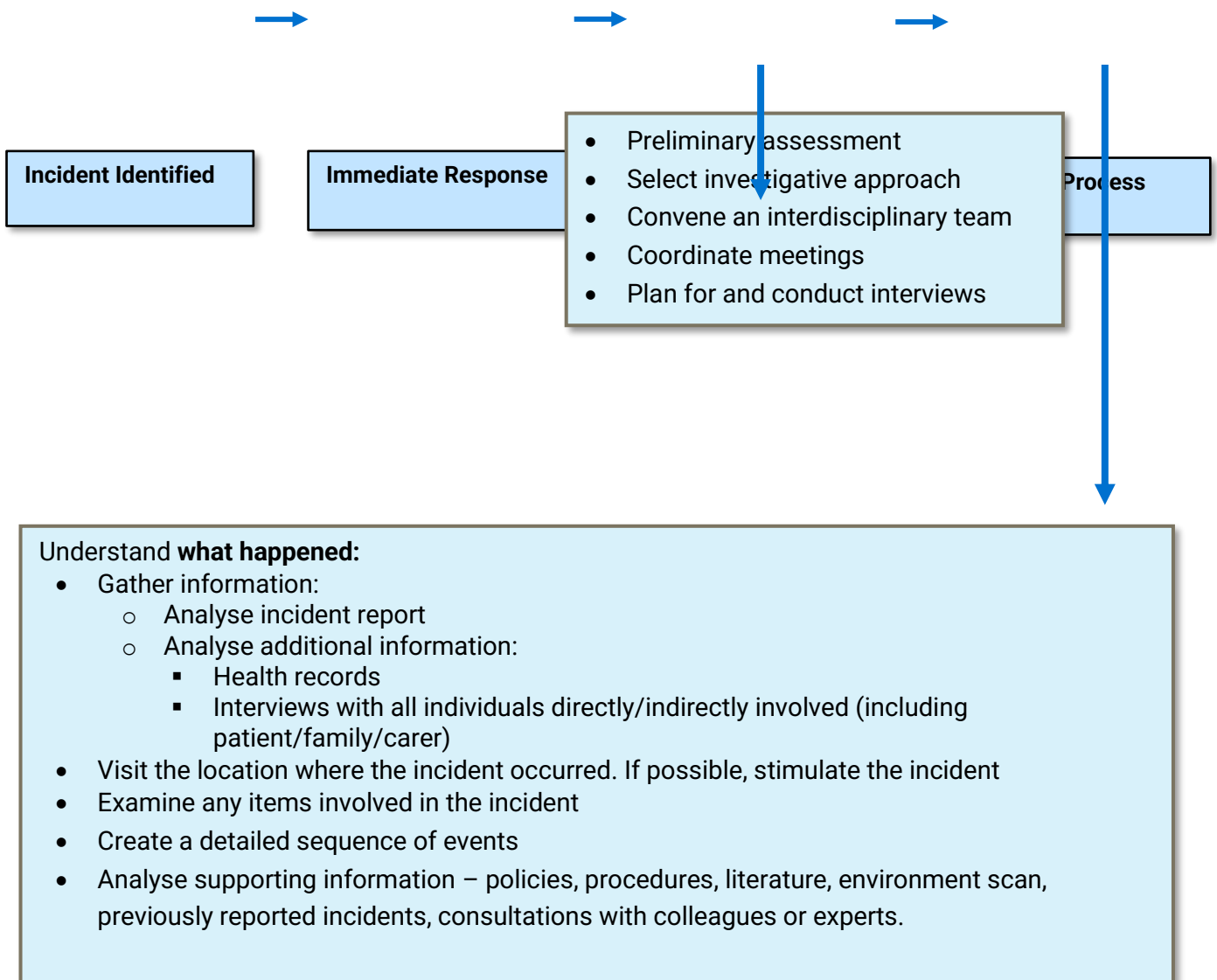
## 18. Comprehensive and Concise Investigative Approach

A Comprehensive or Concise investigation of a single incident is generally undertaken when permanent harm or death has occurred (or a significant risk thereof), the incident is complicated or complex, the area impacted is at micro, meso, or macro level, and/or the contextual pressures are high.

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Diagram 1: Flow diagram for Comprehensive and Concise Investigations.



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**Determine how and why it happened:**

- Analyse information to identify contributing factors and the relationship/s among them:
  - Use systems theory and human factors
  - Use diagramming:
    - Describe the incident and outcome
    - Identify potential contributing factors
    - Define relationships between and among potential contributing factors
    - Identify the findings (can be highly relational)
    - Confirm the findings with the team
- Summarise findings
- Develop and manage recommended actions

**What can be done to reduce the risk of reoccurrence and make care safer?**

- Develop recommended actions
- Suggest an order of priority
- Prepare and hand-off report for endorsement by leadership as appropriate
- Allocate timeframes and individuals responsible for each recommended action
- Include an evaluation strategy for each recommended action



**Follow through – implement, monitor, assess**



**Close the loop – share what was learned (internally and externally)**

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## Investigation Process – Detailed Steps

**Step 1: Approvals, appointment of the Investigation Lead/ team and scope.**

The use of Comprehensive/Concise investigative methodology within the current CHL operating environment will be rare. It will be confined to the most serious of incidents and complaints where there is death or serious harm caused to a consumer in circumstances where the incident was preventable. Despite this, the steps in the tool kit provide a resource that can be applied to all investigations, and the domains of factors in the guiding questions are highly relevant to all operating environments.

For a comprehensive investigation, approval is required from the IRT to ensure that the Chiefs:

- are aware of and endorse the investigation team, **scope**, and approach.
- have decided if the incident and/or complaint investigation is to be undertaken utilising qualified privilege or without qualified privilege.
- are committed to providing resources required for the effective conduct of the investigation.
- For comprehensive investigations, the IRT **should appoint the lead investigator and investigation team members**.

The **lead investigator** should be experienced and/or trained in Systems Analysis or similar methodology.

The lead investigator is responsible for:

- facilitating the investigation process, arranging team meetings.
- ensure all documentation is completed and retained in a secure location.
- ensuring the investigation is completed within the required time frame (where possible).
- completing the final report and providing it to the decision-makers to review.
- developing learnings to be shared within the organisation.

**Investigation teams** can be multi-disciplinary and may consist of:

- staff with expertise in the clinical specialties involved in the event.
- staff familiar with the area in which the incident occurred.
- a person from outside the Home/Service who has expertise in a relevant clinical area, health service management or in the relevant investigation methodology.

For **Concise Investigations**, the lead investigator may be appointed by the CRO, or the CCO) in consultation with the CQO.

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The Five Why's investigative approach is also suitable for all CAS 2-5 incidents and complaints and a flexible and pragmatic approach must be applied on a case-by-case basis to our response to all incidents and complaints, ensuring proportionality responses commensurate to risk and harm caused.

## Check Point!

Before moving to the next step, as the appointed Lead Investigator, have you:

- ensured the investigation has been scoped and the approval is documented?
- confirmed if the review is being performed with qualified privilege or without qualified privilege?
- established a team that has an appropriate balance of experience for the circumstances?

## Step 2: Construct Incident chronology.

Documentation and material related to the incident and complaint should be collected as soon as possible to:

- make sure the information is available for use in the investigation.
- allow the development of a description of the sequence of events (chronology) leading up to the incident and/or complaint.

Information that may be relevant includes:

- health records from all relevant service providers.
- relevant physical evidence (packaging, equipment) observations and evidence from employee/s/ witnesses involved.
- comments and information from the Consumer and authorised representatives as appropriate, information about the environment and conditions (e.g., staff roster).
- Photographic evidence, CCTV, Call data.

Information collected should be organised and logged for ease of future reference. The investigation team develops a chronology of events based on all information gathered. The chronology may be documented using the template in the Comprehensive/ Concise investigation template.

Obtaining information from employee/s should focus on gaining information about their recollection of:

- the sequence and timing of events
- their involvement
- any difficulties or problems they experienced or observed.

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The investigation team will determine who needs to be formally interviewed and conduct the interviews.

## Interview Guidelines (see section 19, templates :

- At the time an interview is arranged, interviewees should be given a clear explanation of the topic and purpose of the discussion, how the information will be used and if using qualified privilege explain any constraints, including protection from discovery.
- Interviewees should be offered the opportunity to bring a colleague with them. The above information should be explained to anyone participating in the discussion.
- Interviews should be held in a private place without interruptions.

## Interview Guidelines:

- It may be helpful to have two interviewers so one is able to record comments whilst the other maintains the dialogue. Interviews **may be recorded with consent**.
- Records made should be legible and accurate (objective rather than subjective notetaking). Information collected in interviews is for the purpose of the investigation only. Investigation material and interview notes are confidential and must be kept in a secure location.
- Interviews should be held in a supportive and understanding spirit.
- If the Lead Investigator or any other person forms the opinion that an incident may involve potential professional misconduct or impairment by an individual staff member or clinician/s, they must notify the **IRT in writing**. For concise investigations, the notifications should be in writing to the CQO. The CQO will liaise with the CRO or CCO or the Chief Peoples Officer (CPO) to determine appropriate actions.
- Staff should be offered ongoing support and counselling via EAP services in circumstances where a notification is made to the CQO about their conduct.

## Check Point!

Before moving to the next step, have you:

- gathered all relevant documentation?
- identified and interviewed relevant staff?
- provided all relevant information to team members for investigation?

## Check Point!

Before moving to the next step, have you:

- reviewed the information gathered and documented the sequence of events?
- gained agreement from relevant I investigation team members regarding the accuracy of the sequence of events?

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## Step 3 Identify Contributory Factors.

### Apply guiding questions:

The information gathered is used to identify key factors that contributed to the incident. Two key questions that will help this process are: **“How did this happen?”** and **“What else influenced the circumstances?”** The lead investigator should continue to ask “how” and “what influenced it” questions until no further information can be generated for the key contributing factors.

A set of guiding questions is provided below to guide the identification of contributing factors, hazards, and mitigating factors during the “how and why did it happen” stage of the investigation.

They are intended to assist with checking the availability and strength of safeguards at all levels in the organisation and guide the investigation towards the identification of system vulnerabilities that aligned in such a way that allowed for the incident or complaint to take place. Teams are encouraged to note, analyse and report the system barriers that worked well (mitigating factors) and therefore should be reinforced and recognised so they will continue to prevent future harm.

The questions are grouped around categories of factors designed to focus the analysis on the interaction between humans and the system, and in this way, help identify system-level contributing factors at various levels in the organisation.

Use the guiding questions in the table below to briefly explore each domain (task, equipment, work environment, consumer characteristics, care team, organisation, other) of factors that may have contributed to the incident and /or complaint. For domains that are relevant to the incident and complaint, further explore each specific question.

When identifying potential contributing factors, focus on systems-based factors, and not people-focused ones to ensure that likewise, the recommended actions are not people-focused. Keeping in mind human factors principles and systems theory, an analysis should focus on **“how”** certain human actions occurred, not just that they occurred.

For example, in the course of analysing an incident in which an incorrect medication was administered, it was determined that the nurse was in a hurry. The fact that the nurse was in a hurry is a factual detail of what happened and not a contributing factor. The contributing factor(s) are those that may have caused them to be in a hurry.

Examples could include too many tasks were assigned (the nurse was assigned too many complex patients); or the patient’s medication needs conflicted with shift change (the patient was admitted right

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before the shift ended and the nurse wanted to give the patient their pain medications so that they did not have to wait until after the shift change). By focusing on the systems-based contributing factors, the investigation team will be able to identify higher-leverage solutions. Recommended actions should be consistent with **one of the main tenets of human factors: fit the task or system to the human, not the other way around.**

## Instructions

- i. The Investigation team reviews each domain of the guiding questions to determine whether it is relevant to the incident and complaint.
- ii. For domains that have been identified as relevant, the team explores each question to identify contributing factors.

## Domains of factors in guiding questions

<b>Consumer (s) characteristics:</b> Considered in the context of how well the system identified, understood and acted upon these factors. It should not be the only factor considered.
<b>Task</b> (care/work process)
<b>Care Team, Care Givers</b> (Human Factors). Work Environment/Scheduling
<b>Care Team – Supporting TEAM</b> (all involved in care process).
<b>Equipment</b> (including materials, fixtures, information and communication systems safety mechanisms)
<b>Organisation</b> : Policies and priorities.
<b>Organisation</b> – Culture
Other relevant factors.

## Guiding questions

Domain/category of contributing factors	Relevant?
Consumer (s) characteristics: (Considered in the context of how well the system identified, understood, and acted upon these factors. It should not be the only factor considered)	
Did the consumer (s) have the information to assist in avoiding the incident?	
If not, what would have supported the resident/client in assisting their care team?	
Did factors like age, sex, medications, allergies, diagnosis, and other medical conditions, contribute to the incident? How did they contribute?	
Did any social or cultural factors contribute to the incident?	

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Was language a barrier?	
Other?	
<b>Task (care/work process)</b>	
Were there previous or predicted failures for this task or process?	
Were specialised skills required to perform the task?	
Was a fixed process or sequence of steps required (e.g. order sets, checklists)?	
If a fixed process existed, was it followed?	
Was a protocol available, was it up-to-date, and was it followed in this case?	
Were there constraints or pressures (e.g. time, resources) when performing the task?	
Was the information required to make care decisions available and up to date (e.g. test results, documentation, patient identification/ care plans up to date)?	
Was there a risk assessment/audit/quality control program and in place for the task/process?	
Other?	
<b>Care Team/Care Givers (Human Factors)</b>	
Were the education, experience, training, and skill level appropriate?	
Was fatigue, stressors, health or health factors an issue?	
Was the workload appropriate?	
Was appropriate and timely help or supervision available?	
Other?	
<b>Care team – Supporting team (all involved in care process)</b>	
Was there a clear understanding of roles and responsibilities?	
Was the quality and quantity of communication (verbal and/or written) between team members appropriate (clear, accurate, free of jargon, relevant, complete, and timely)?	
Were there regular team briefings/debriefings about important care issues?	
Was team morale good? Did team members support each other?	
Were the communication channels available and appropriate to support the needs of the team	
Other?	
<b>Equipment (including materials, fixtures, information and communication systems)</b>	
Were the displays and controls understandable?	
Did the equipment automatically detect and display problems?	
Was the display functional?	
Were the warning labels, reference guide, and safety mechanisms functional and readily visible/accessible?	
Were the maintenance and upgrades up to date?	
Was the equipment standardised?	
Would the users describe this equipment as easy to use?	
Were the communication systems (phone, pager, software, hardware, etc.) available and operational?	
Other?	
<b>Organisation - Policies and priorities</b>	

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Were the relevant policies and procedures available, known, and accessible, and did they meet the needs of users?	
Were there workarounds to the documented policy/procedure?	
Was there a mechanism in place to identify and resolve gaps between policy and practice?	
Were the strategic priorities of the organisation clear to all?	
Other?	
<b>Organisation – Culture</b>	
Was everyone (patients, clinicians, other staff) comfortable to speak-up about safety concerns?	
Was there visible support from leadership and the board for safe patient care?	
Was communication between staff and management supportive of day-to-day safe patient care?	
Were incidents viewed as system failures with a mechanism/transparent process for fair and just review of actions by individuals where indicated?	
Other?	
Did scheduling influence the staffing level, or cause stress, or fatigue?	
Was there sufficient capacity in the system to perform effectively (e.g., access to resources)?	
Other?	
<b>Other – consider</b>	
Are there any factors that prevented this event from happening on a more regular basis?	
Where there any factors or actions taken that mitigated the severity of the event?	
Were there any local conditions or circumstances that may have influenced the incident and/or an outcome?	
Were there any other contextual conditions or circumstances that may have influenced the incident and/or outcome?	
Other?	

## Examples of contributory factors and how to frame them.

Some contributory factors are likely to be present in future situations (e.g. medication labels of similar colour and design) and some are likely to have been specific to the event under investigation (e.g. a one-off communication problem between staff). Contributory Factors likely to be present in future situations can be recorded on a contributory factors statement . Contributory factor statements need to focus on process and system vulnerability rather than the actions of individuals.

## Examples of contributory factors

1. Show the link between the contributory factor and the outcome. Example:

*X A doctor was fatigued.*

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✓ *The level of fatigue experienced by the doctor increased the likelihood that he/she missed the instructions which led to incorrect insertion.*

2. Use specific and accurate descriptions of what occurred. Avoid negative and vague descriptors such as “poorly, inadequately, carelessness.” These do little to describe the actual conditions or behaviors that lead to an event. Example:

✗ *Poorly trained nurse.*

✓ *The level of the nurse’s training increased the likelihood that he/she misunderstood the IV pump controls which contributed to missing steps in the programming of the dose and rate.*

3. Identify factors that preceded human error. Example:

✗ *The doctor did not review the discharge summary.*

✓ *The level of staffing meant there were extra demands on the doctor that resulted in the doctor rushing the discharge and the patient being sent home with the wrong discharge summary.*

4. Identify factors that preceded a procedural error. The goal is to identify the positive and negative incentives that created the informal ‘norm’ or accepted way of doing things. Example:

✗ *The pharmacy technician did not follow the correct dispensing procedure.*

✓ *Due to staffing shortages, routine checking by two persons was bypassed resulting in the incorrect dispensing of medications.*

5. Include failure to act as a contributory factor only if there is a pre-existing duty to act. Such a duty may arise from practice standards and guidelines or other duties to provide patient care. Example:

✓ *Failure to prescribe a cardiac medication after a myocardial infarction can only be used if the medication was required as part of an agreed guideline.*

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## Step 5 Identify Contributory Factors.

Develop a visual description of the contributory factors (fishbone and/or constellation diagrams may be used).

A constellation diagram provides a visual description of the non-linear cascading aspects of each contributing factor. In addition, the unique visual representation of the constellation diagram encourages and facilitates the identification of interconnections and the sphere of influence among contributing factors, which will assist in identifying the contributing factors with the biggest impact on consumer safety.

Improving safety and quality of care in complex adaptive healthcare systems is dependent on the ability to see how the parts of the system influence each other so the limited resources available can be focused with more precision to where the greatest risks are identified.

### Instructions

Describe the incident. Briefly summarise the incident and harm/potential harm in the centre of the diagram (typically fewer than 10 words).

- 1) Identify potential contributing factors.
  - a) Add the contributing factor categories (task, equipment, work environment, patient, care team, organisation, etc.) to the diagram in a circle around the incident/outcome description
  - b) Use the guiding questions provided to identify potential contributing factors.
  - c) Place each potential contributing factor on a sticky note and group the factors near the category title
  
- 2) Define inter-relationships between and among contributing factors.
  - a) For each potential contributing factor ask, "How and why did this happen? "What was this influenced by?" and "What else influenced the circumstances.
  - b) Add the answers to these questions to develop "relational chains." Some contributing factors may be directly linked with each other, within the same category to create a chain. Some answers may come from different contributing factor categories; if so, show the linkage by drawing lines.
  - c) Continue to ask "why" and "what influenced it" questions until no further information can be generated.
  
- 3) Identify the findings that are central to the incident. The team should expect to identify several findings – there is seldom, if ever, **only a single reason why an incident occurred.**

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Findings will be identified in three categories:

- i) Factors that, if corrected, **would likely have prevented the incident, or mitigated the harm** – these will be the basis for developing recommended actions (note that these factors may require actions at different levels of the system).
- ii) Factors that, if corrected, would not have prevented the incident, or mitigated the harm but are important for patient/staff safety or safe patient care in general.
- iii) These issues should be included in the team’s findings and brought to the attention of the appropriate individuals for follow-up and documented in the analysis report for future review and action as appropriate.
- iv) Mitigating factors – factors that did not allow the incident to have more serious consequences and represent solid safeguards that should be kept in place.

The question to be asked is: “If this factor was eliminated or corrected, would it have likely reduced the risk of incident recurrence and/or harm?”

While it is possible that many contributing factors will be identified in the analysis, certain factors, if corrected, they have the greatest probability to prevent the incident altogether or mitigate harm from the incident. It is common for these factors to be “**highly relational**,” in other words, relationships, or potential relationships between a number of the identified factors appear to have combined to enable an incident to occur, and there is a sphere of influence amongst them.

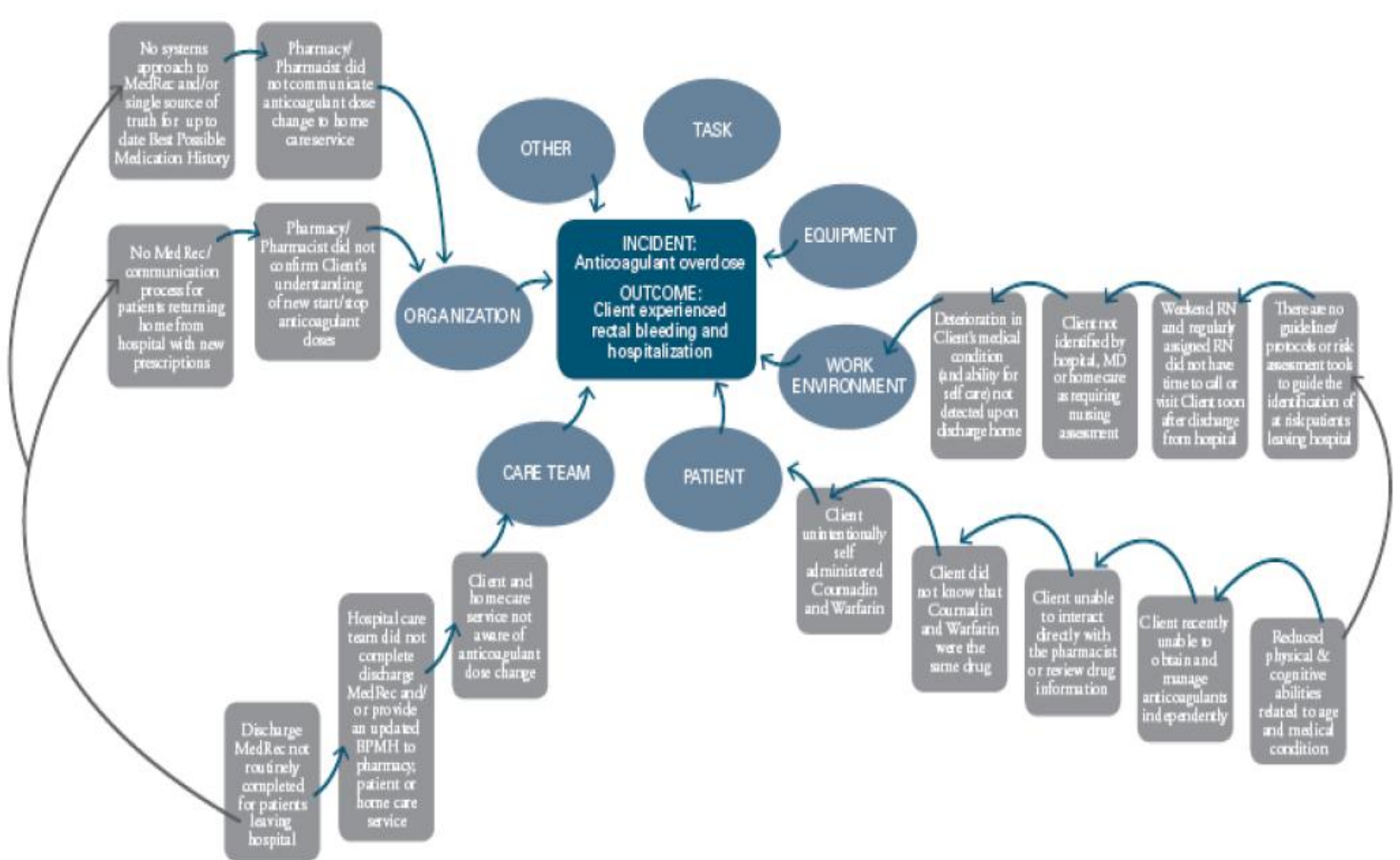
These findings will be the basis for developing recommended actions (note that actions may be required at different levels of the system).

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See the below for an example of a constellation diagram/fishbone/cause and effect diagram:

Diagram 2: Constellation diagram

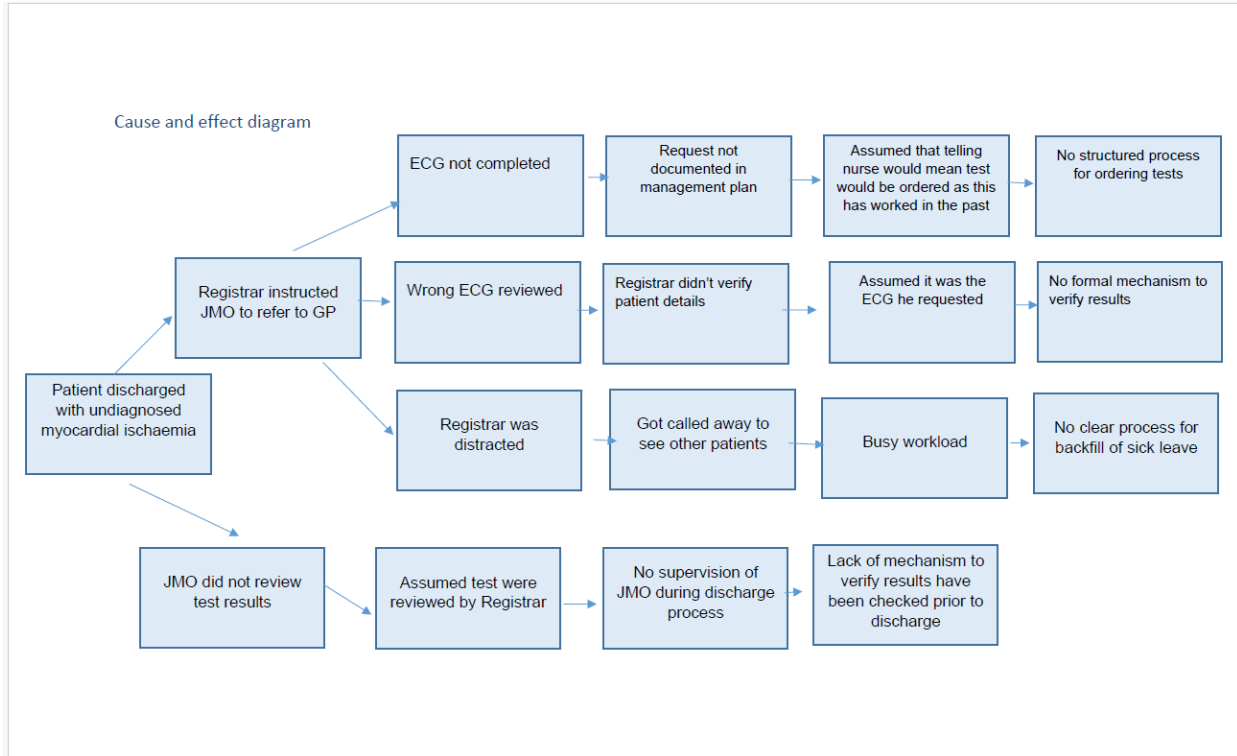


Source: US Department of Veterans Affairs, 2005

Diagram 3: Cause and effect diagram

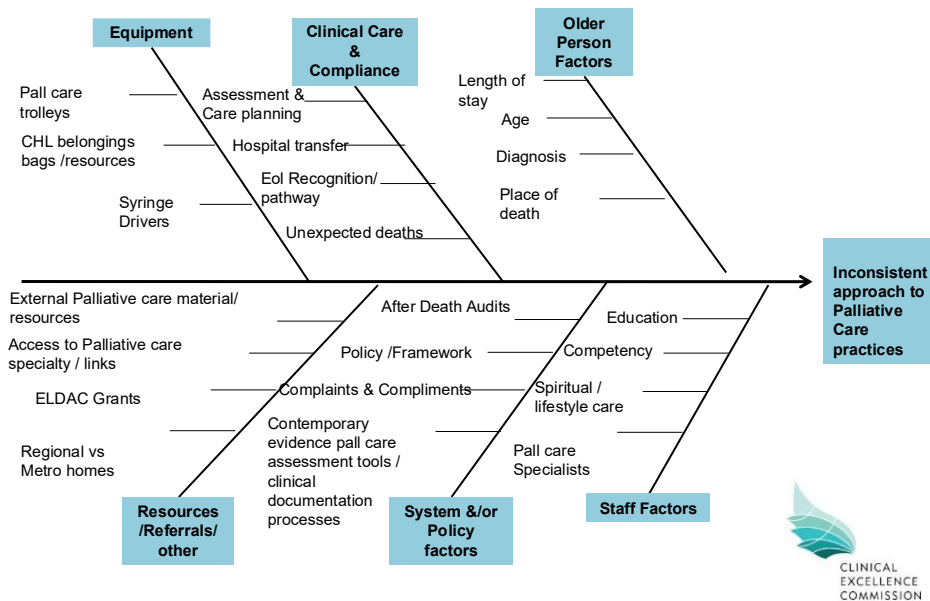
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Source: US Department of Veterans Affairs, 2005  
 Diagram 4: Cause and effect diagram template

## Cause & Effect Diagram Template



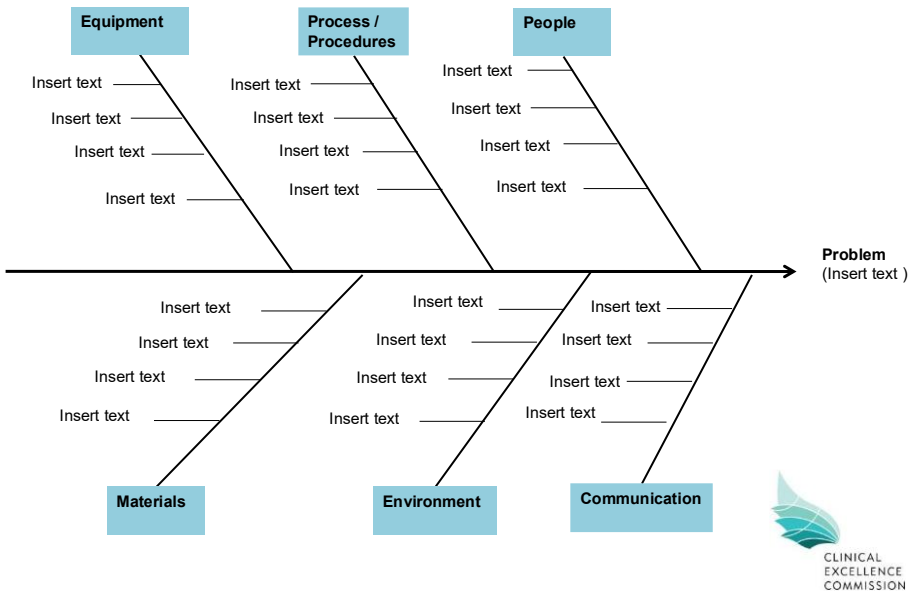
Source: NSW Health, 2003

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Diagram 5: Cause and effect diagram- typical headings

## Cause & Effect Diagram – Typical Headings



Source: NSW Health, 2003

### Step 6 Write up factors linking them to outcome

A summary of what was found is prepared to define the contributing factors related to the incident. This summary is provided as a series of “statements of findings. (The statements of findings have been adapted from “causal statements”)

The statements of findings describe the relationships between the contributing factors and the incident and/or outcome. The statements focus on the contributing factors and should be as specific as possible (note that there could be a group of factors that together contributed to the incident or outcome).

The suggested statement format is as follows: *The contributing factor(s), within the context of the incident, increased/decreased the likelihood that this outcome would occur.* A well-constructed constellation diagram will assist in the development of summary statements, working from the outside of the diagram back towards the centre.

#### Instructions

The team review the constellation diagram and work from the outside of the diagram back towards the centre to develop draft summary statements. The review team identified the following findings:

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## *Task*

No key findings

## *Equipment*

No key findings

## *Work environment.*

The lack of a standardised community health risk assessment tool or protocol increased the likelihood that clients discharged from hospital back to the community would not be accurately triaged to ensure appropriate and timely home care services are provided.

## *Consumer (s)*

The deterioration in the consumer's physical and cognitive abilities increased the likelihood of a medication error in his self-medication management.

## *Care team and organisation.*

The lack of a formalised, system-wide and communicated Discharge Medication Reconciliation process (including an updated Best Possible Medication History) decreased the likelihood that the client would receive the appropriate and timely support required for safe medication management.

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## Check Point!

Before moving to the next step, have you:

- convened the team meeting to identify contributory factors?
- reviewed relevant policies and procedures?
- reviewed relevant literature?
- identified contributory factors likely to be present in future situations?
- completed a contributory factors statement?

## Step 7 Develop Recommendations

A summary of what was found is prepared to define the contributing factors related to the incident. This summary is provided as a series of “statements of findings. (The statements of findings have been adapted from “causal statements”)

Recommendations are developed for actions to address contributory factors (see summary template in section 19). Recommendations should aim to prevent or minimise future adverse events or near-miss complaint and/or incidents.

The team recommend actions that are aimed at preventing or mitigating the factors that caused or contributed to the incident.

The success of the recommended actions is dependent on the quality of findings (how and why it happened).

Using human factors to identify contributing factors facilitates the identification and evaluation of the effectiveness of recommended actions. In other words, correctly identifying systems-based contributing factors should lead to systems-based solutions.

In some instances, review processes may not generate any new recommended actions.

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The team:

- a) Examine the findings report, particularly factors that caused or contributed to an incident and the areas for review findings.
- b) Brainstorm actions that could prevent the incident or mitigate the harm should a similar incident occur.
- c) Consider any suggested recommendations from the family.
- d) Assess the strength of each action against the Action Hierarchy (see below). Ensure at least one strong or intermediate action relevant to each factor.
- e) For each proposed action, the team ask if this recommendation was implemented, would it have prevented the incident or mitigated the harm?

Recommendations may be considered **strong** if the tasks require less reliance on humans to remember to perform the task correctly. For example:

- Introduce a forcing function (e.g., a unique connector to allow only the correct assembly of equipment).
- Remove the opportunity for potential medication errors, (e.g., ensure all high-risk medications are packed separately).
- Standardised equipment used throughout the organisation to eliminate confusion (e.g. purchase only one type of full sling lifter for all RAC Homes).
- Simplify and integrate processes.
- Introduce a physical barrier to prevent harm (e.g., nonslip floor coverings).
- Remove a hazard (e.g., fix or replace a piece of equipment).
- Examples of **intermediate actions** used for the development of recommendations include:
  - The use of checklists, protocols, and reminders (cognitive aids) to reduce reliance on memory.
  - The elimination of the use of 'sound-alike or look-alike' names. Increase staffing levels during periods of peak demand /improved allocations in-line with resident needs and staff skill mix.
  - Enhancement/modification of software.
  - Standardise documentation and communication, particularly handovers Elimination/reduce distractions for nurses when programming PCA pumps, checking schedule 8 medications.

Recommendations may be considered **weaker** if these tasks require more reliance on humans to remember to perform the task correctly. Weak recommendations include those that:

- Rely on documentation that may be difficult to access or compete with other information (e.g., policies and procedures).
- Rely on training that may take time to provide to all necessary parties and may not be retained fully.

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Weaker recommendations will be more helpful if they are specific and clear.

Example:

✗ Provide training.

✓ Implement a training module on medical emergency procedures for all ED staff by dd/mm/yyyy.

Recommendations should be recorded in an Investigation Recommendations Summary ( see template provided).

## Check Point!

Before moving to the next step, have you:

- convened the review team to develop recommendations (where appropriate)?
- ensured the recommendations directly address the why and the how?
- identified positions responsible for each recommendation (in consultation with relevant staff)?
- identified proposed time frames and owners for implementation of each recommendation?
- completed an Investigation Recommendations Summary?

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## Step 8 Report on Investigation

The investigation lead and/or team provides a final report of the investigation to the relevant decision-makers.

The decision-makers may refer recommendations back to the review team for clarification or further discussion before rejecting/approving them and endorsing/assigning responsibility for implementation.

After endorsement by the decision-makers:

Feedback on the recommendations from the review should be provided to the staff involved in the incident, other relevant providers, and the resident or family, as appropriate. Site/service-specific risks identified from the investigation should be referred to the Home/Service risk register and plans for continuous improvements. A schedule of follow-up on the implementation of recommendations should be established by the relevant Regional Manager/Regional Business Manager.

### Check Point!

Before moving to the next step, have you:

- Prepared and submitted to the relevant decision makers the investigation report
- If a CAS 1 or relevant CAS 2, provide the review findings report to the Chief Quality Officer, Chief Residential Officer/ Chief Communities Officer/ Chief People Officer.
- Obtained a copy of endorsed recommendations signed by the Chief Quality Officer,
- Provided feedback regarding endorsed recommendations to: staff involved in the incident?
- Staff involved in the incident analysis review.
- Other relevant providers
- The resident or family?
- Referred identified risks to the site / service risk register?
- Established a schedule for follow up of implementation of recommendations?

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## Step 9 Monitor Implementation of Recommendations

The implementation of approved recommendations should be monitored by the appropriate home/service. Staff (positions) assigned responsibility for implementing recommendations should contact their PQR Team representative to verify the frequency of their local reporting requirements. Additionally, a final report should be submitted to the CQO,CRO or CCO within 12 months of the reporting date.

The Practice Quality and Risk (PQR) Team will work closely with Homes/Services to support effective management and end-to-end resolution of CAS 1 incidents. The PQR Team will request information from the Homes/Services regarding the implementation of CAS 1 incident and complaint recommendations on a six-monthly basis.

Similarly, the PQR Team will oversee the end-to-end resolution of all CAS 2 and reportable incidents and provide support as required. The PQR Team will request information from Homes/Services regarding the implementation of CAS 2 and reportable incident and complaint recommendations on a six-monthly basis. For all CAS 3, CAS 4 and CAS 5 incidents and complaints the responsibility for monitoring the implementation of recommendations is managed at the Home/Service level.

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Incident Investigation – Information sheet for interviewers

## Before the Interview:

At the time an interview is arranged, give the interviewee a clear explanation of the topic and purpose of the discussion, how the information will be used and the constraints of qualified privilege (if applicable) including protection from discovery.

Provide the interviewee with the incident review Information Sheet for Interviewees. Offer the interviewee the opportunity to bring a friend or colleague with them. The above information should be explained to anyone participating in the discussion.

Consider arranging for two interviewers to attend so one can record comments whilst the other maintains the dialogue. With permission, interviews can be recorded. Organise a private place without interruptions for the interview.

## At the Interview:

Interviews should be held in a supportive and understanding spirit. If it becomes clear that a professional shortcoming or error has occurred, this should be discussed without judgment or adverse comment. Staff should be offered ongoing support and counselling if they become distressed about the content of the interview. If an interview is conducted in circumstances where the staff member is a respondent and allegations have been made, the appropriate letters from HR must have been issued before the interview commences.

Observations and comments should be recorded legibly and accurately (objective rather than subjective note taking).

Ask the interviewee to describe the sequence of events and their role in events.

Ask the interviewee to describe any issues, problems, or difficulties they experienced or observed during the sequence of events.

Ask the interviewee to comment on any factors they think contributed to the issues, difficulties or problems identified. If necessary, prompt about contributory factors such as:

- communication between staff and with the patient
- knowledge skills and competence of staff
- the environment, work conditions and scheduling
- equipment and technology policies, procedures and guidelines safety mechanisms.
- procedures and guidelines safety
- mechanisms

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Ask the interviewee if they have any other comments to make or questions to ask. Close the interview with thank you.

If during the interview it is suspected that the incident may contain elements of misconduct, the review team should refer the matter to the CQO for consideration of further action.

The investigation should continue separately to any misconduct processes unless advised by the CQO, CRO or CCO.

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## Incident Investigation Information sheet for interviewees

The (site/service insert name) Executive has requested a comprehensive/ Concise Incident investigation into **xxxxx** (add as appropriate) . You have been identified as someone who may be able to add important information and insights about the circumstances and events.

The goal of this investigation is to find out:

- What happened?
- Why it happened?
- What can we do to prevent it from happening again?

This method of investigation is an integral part of our effort to build a culture of safety and move beyond the tradition of blame by focusing on what happened rather than who was involved.

Your assistance in meeting with a member of the investigation team would be greatly appreciated.

### Who will be involved?

One or two members of the team appointed to investigate this incident will meet with you. If you would like to have a colleague attend as a support for you just let the team member know when the meeting is arranged.

### What will be discussed?

Please ensure that the information provided is FACTUAL and DOES NOT APPORTION BLAME on staff associated with the incident.

You will be asked about:

- Your understanding of the circumstances and sequence of events leading up to the complaint and/or incident.
- Your role in the situation.
- Issues, problems, or difficulties you observed.
- Factors that may have contributed to the issues, problems or difficulties observed. These contributory factors may include:
  - communication between staff and with the patient knowledge skills and competence of staff
  - the environment, work conditions and scheduling patient factors
  - equipment and technology policies, procedures and guidelines safety mechanisms
  - Any other comments you wish to make.

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## What will be recorded?

The investigation team members will take informal notes to help them remember pertinent comments for analysis with other information collected in relation to this complaint and/or incident. With your consent the interview may also be recorded.

## How will the information be used?

Your comments and views will be analysed along with information from other interviews, the patient health record, and other relevant documents to help identify the contributory factors most relevant to the complaint and incident and actions that are likely to reduce the likelihood of complaints and/or incidents recurring.

If you have questions about the complaint and incident investigation process, please do not hesitate to contact:

Name:

Position:

Telephone:

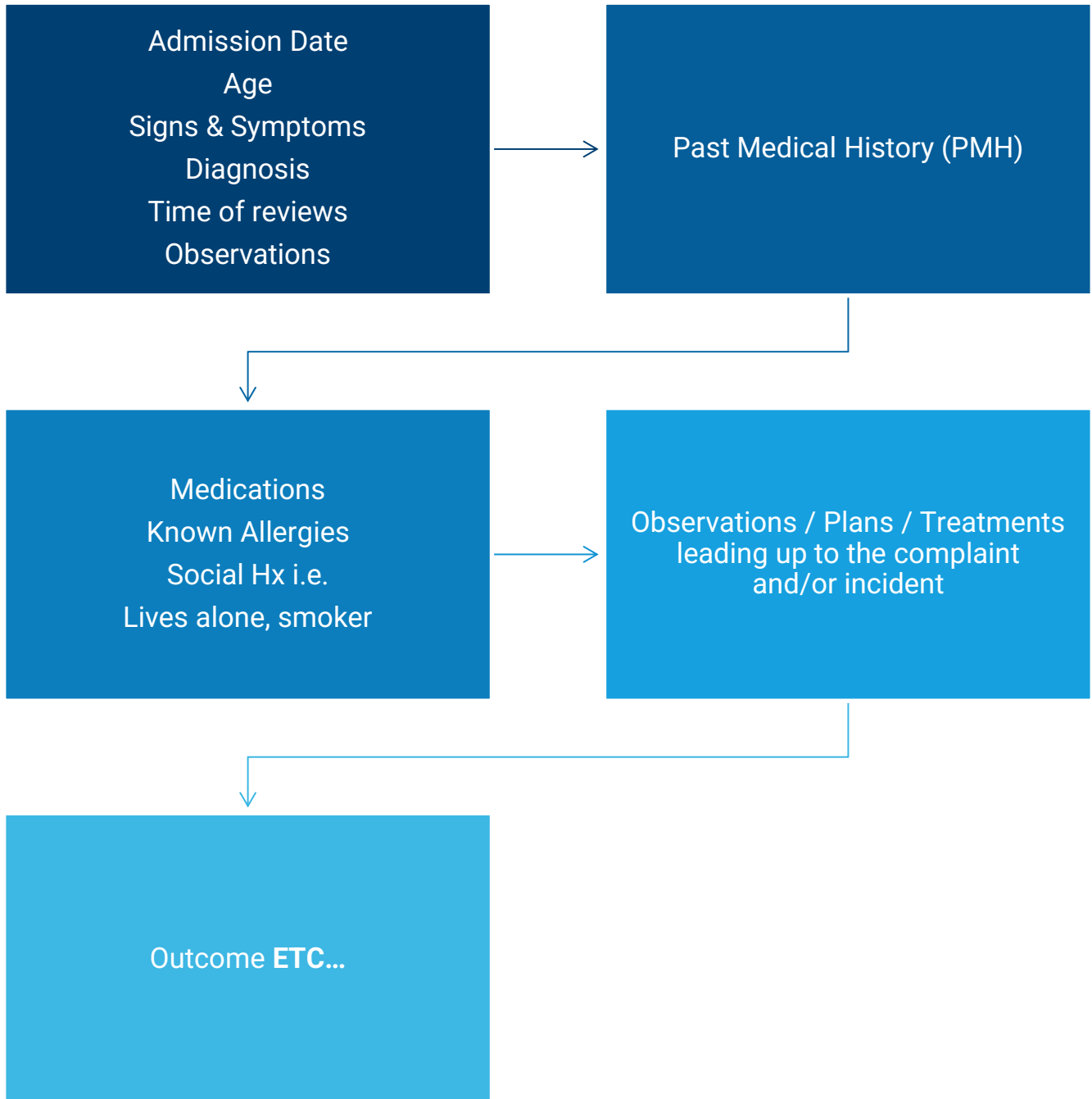
Email:

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Source: CHL Investigation Toolkit, 2024

## Contributory factors statement

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Use this template to identify any contributory factors that will require further consideration.

Contributory Factor	Category							Organisation – Capacity (resources)
	Consumer characteristics	Task (care/work process)	Care Team/Care Givers (Human Factors)	Care team – Supporting team (all involved in care process)	Equipment (including materials, fixtures, information and communication systems)	Organisation - Policies and priorities	Organisation – Culture	
1								
2								
3								
4								

## 20. The 5 Whys process and templates

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This variation of “the 5 Whys” has been adapted from the NSW Health Easy Guide to Complaint and/or Incident Management. It applies the same systems-based approach to incident reviews in a more streamlined process. It is particularly applicable to the investigation of individual events.

## The 5 Whys – Steps

### Step 1 Gather Information

- Documentation and material related to the incident should be collected as soon as possible to make sure the information is available for use in the investigation
- allow development of a description of the sequence of events leading up to the complaint and/or incident.
- Information that may be relevant includes making sure the information is available for use in the investigation.
- allow the development of a description of the sequence of events (chronology) leading up to the incident and complaint.

Information that may be relevant includes:

- health records from all relevant service providers.
- relevant physical evidence (packaging, equipment) observations and evidence from employee/s/ witnesses involved.
- comments and information from the Consumer and authorised representatives as appropriate, information about the environment and conditions (e.g., staff roster).
- Photographic evidence, CCTV, Call data.

### Step 2 Determine the Sequence of Events

The sequence of events leading up to the complaint and incident or near miss is documented in a chronology of flow chart

### Step 3 Determine Points of Variation

A comparison is made between what happened with what should have happened. Reference to policies and procedures and a review of current literature may assist in this analysis. The steps that happened and the steps that did happen may be documented in different colours on a flow chart.

For each point where actual events deviated from expected events ask the question **‘Why’ five times** (or more if necessary) until the basic contributory factors are identified.

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Some contributory factors are likely to be present in future situations (e.g. medication labels of similar colour and design) and some are likely to have been specific to the event under investigation (e.g. a one-off communication problem between staff).

Contributory factors likely to be present in future situations are noted on the Investigations Recommendation Summary .

## Step 4 Develop Recommendations

Recommendations are developed for actions to address each of the contributory factors.

Recommendations may be considered strong if they are highly likely to reduce risk by making it very easy for staff to do the right thing. Strong recommendations include the that:

- Introduce a forcing function (e.g., unique connectors to allow only correct assembly of equipment).
- Remove the opportunity to do the wrong thing (e.g., remove all potassium chloride from wards).
- Standardise to reduce confusion (e.g., purchase only one type of IV pump for a hospital).
- Simplify processes (e.g., provide direct contact numbers for high-risk patients to access expert advice from home).
- Introduce a physical barrier to prevent harm (e.g., nonslip floor coverings, bed rails).

Examples of **intermediate** actions used for the development of recommendations include:

- The use of checklists, protocols and reminders (cognitive aids) to reduce reliance on memory.
- The elimination of the use of 'sound-alike or look-alike' names.
- Increase staffing/decrease workload.
- Enhancement/modification of software.
- Improvements in documentation/ communication/handover. Elimination/reduction in distractions.

Recommendations may be considered weak if they are less likely to reduce risk. Weak recommendations include those that:

- Rely on documentation that may be difficult to access or compete with other information (e.g., policies and procedures).
- Rely on training that may take time to provide to all necessary parties and may not be retained fully.

Strong recommendations should be developed wherever possible.

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If an investigation finds that best possible care has been provided, there may be no useful recommendations for action.

Positions responsible for implementing recommendations should be identified/negotiated by the investigator along with proposed implementation time frames.

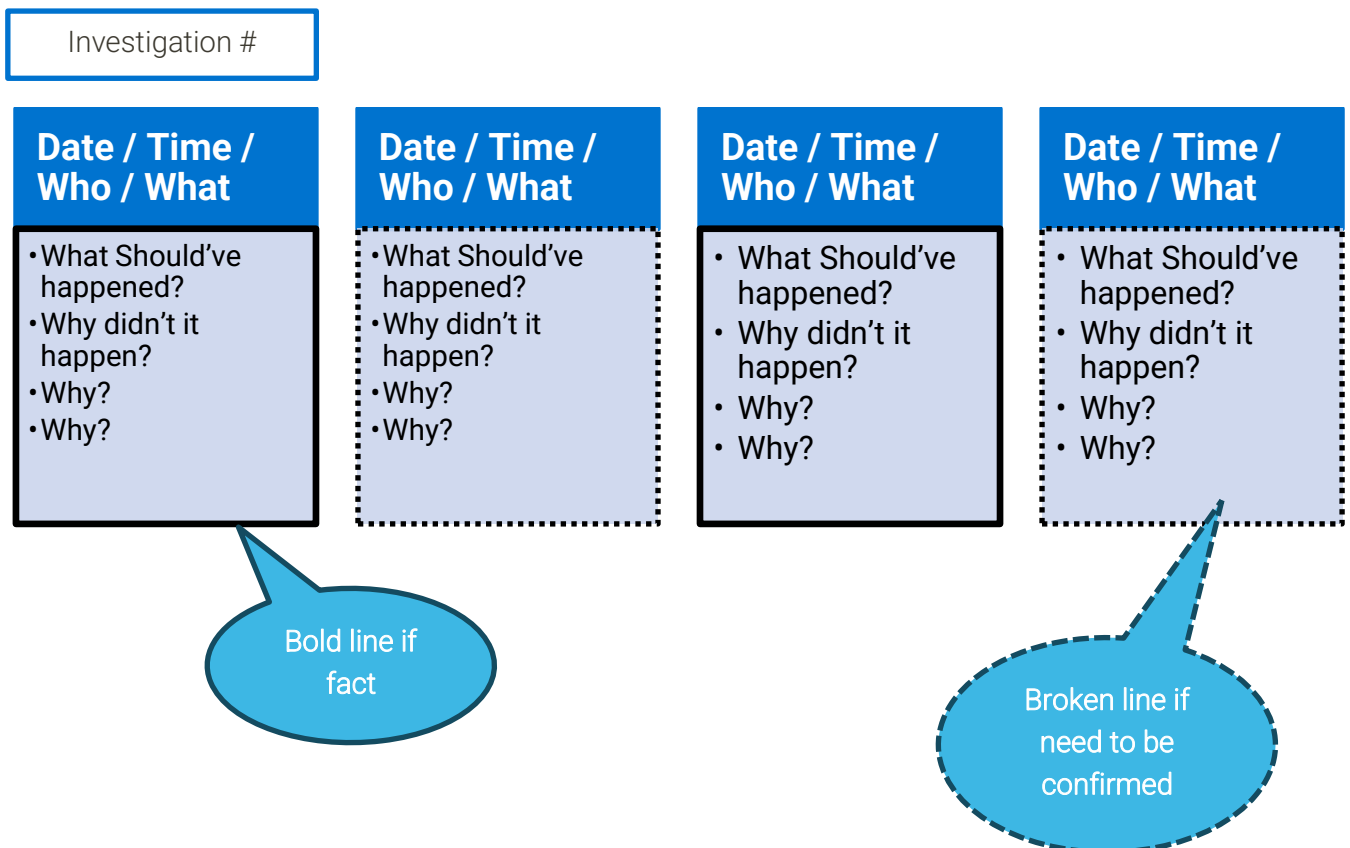
Each contributory factor should be risk rated and referred to the site/service risk register. Recommendations are recorded.

## Recommendations Summary

The implementation of recommendations should be monitored. Relevant roles should be assigned responsibility for implementing recommendations within an agreed timeframe.

Progress toward completion can be noted on the Investigation Recommendation Summary.

## 21. The 5 Whys – Flow Chart – The Story



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## 23. The 5 Whys – Investigation Recommendations Summary

Investigation #

Contributory Factor	Action							
	Recommended Action	Action E = eliminate C = control A = accept	Position Responsible	Planned Completion Date	Outcome measure	Risk Rating	Review Date	Progress
1								
2								
3								
4								
5								

# Incident and Complaint Management Investigation Toolkit

REPORT

## 26. Comprehensive/Concise Investigation Report Template

Incident Date:	
Home/Service Details:	

# Incident and Complaint Management Investigation Toolkit

REPORT

## 29. Report Incident/Complaint Overview

RESIDENT / CLIENT INFORMATION	Resident/Client: XX DOB & Age: XX Deceased (if applicable when & where): XX Date of Admission: XX	SIRS P1 <input type="checkbox"/> OR SIRS P2 <input type="checkbox"/> SIRS Report ID: XX Date of SIRS Report: XX SIRS Report Closed: Y <input type="checkbox"/> /N <input type="checkbox"/> Date: XX	Date of Incident: XX Severity Rating (CAS): • CAS 1 <input type="checkbox"/> • CAS 2 <input type="checkbox"/>
	Home/Service: XX Rm no (if applicable): XX Client Address (if applicable):	NDIS Participant: Y <input type="checkbox"/> /N <input type="checkbox"/> NDIS Mandatory Report: Y <input type="checkbox"/> /N <input type="checkbox"/> Date: XX NDIS Mandatory Report ID: XX NDIS Report Closed: Y <input type="checkbox"/> /N <input type="checkbox"/> Date: XX	Coroners: Y <input type="checkbox"/> /N <input type="checkbox"/> Date: XX Reported to Police: Y <input type="checkbox"/> /N <input type="checkbox"/> Event No.: Date: XX Comments: XX
Investigation Lead	NAME/POSITION		
Investigator Team	NAME/POSITION		NAME/POSITION
Dates	Report Completed: XX	Panel Review (if applicable): XX	
Type of Incident/Complaint	Consumer/Resident	Critical assessment Score (CAS) Category:	
Incident/Complaint Overview	• "Summarise objective FACTS of the event: what happened?"		
Issues identified			
Documents Reviewed:	Examples (guide only) 1) Statements or records of conversations e.g.: Witness (statements of staff, family and AR, guardian, family etc.) 2) Interviews with staff members Other applicable documentation (Enter information) 3) (Enter information) 4) (Enter information) 5) (Enter information) 6) (Enter information) 7) (Enter information)	8) (Enter information) 9) (Enter information) 10) (Enter information) 11) (Enter information) 12) (Enter information) 13) (Enter information)	

# Incident and Complaint Management Investigation Toolkit

REPORT

## 31. Report Background

*\*Include information that provides context to the event/incident/complaint i.e. diagnoses, medications, authorized representative and family background etc.*

## 32. Report Executive Summary

*\*Include the background, purpose, summary finding, contributing factors (Primary and Secondary) and the recommendations*

## 33. Report Chronology of Events

*\*Consider information from 3 to 7 days leading up to the event/incident, the sequence of the incident and how individual/s are involved in the process.*

Date/ Time	Summary of Events	Staff/ Person Involved	Comments

# Incident and Complaint Management Investigation Toolkit

## REPORT

### 34. Report Summary of key evidence

\*Witness evidence, clinical advice, P&P, clinical documents

### 35. Report Contributing Factors

*\*Guide: Not every single domain/category would be applicable. Consider the cause and effect of the factor/s relevant to your analysis. Do NOT make assumptions unless you have supportive evidence.*

Domain/category of contributing factors	Relevant?	Comments
<b>Consumer (s) (resident/client) characteristics: (Considered in the context of how well the system identified, understood, and acted upon these factors. It should not be the only factor considered)</b>	Yes/No	
Did the resident/client (s) have the information to assist in avoiding the incident?	Yes/No	
If not, what would have supported the resident/client in assisting their care team?	Yes/No	
Did factors like age, sex, medications, allergies, diagnosis, other medical conditions, contribute to the incident? How did they contribute?	Yes/No	
Did any social or cultural factors contribute to the incident?	Yes/No	
Was language a barrier?	Yes/No	
Other?	Yes/No	
<b>Task (care/work process)</b>		
Were there previous or predicted failures for this task or process?	Yes/No	
Were specialised skills required to perform the task?	Yes/No	
Was a fixed process or sequence of steps required (e.g., order sets, checklists)?	Yes/No	
If a fixed process existed, was it followed?	Yes/No	
Was a protocol available, was it up-to-date, and was it followed in this case?	Yes/No	
Were there constraints or pressures (e.g., time, resources) when performing the task?	Yes/No	

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Was the information required to make care decisions available and up to date (e.g., test results, documentation, resident/client identification/ care plans up to date)?	Yes/No	
Was there a risk assessment/audit/quality control program and in place for the task/process?		
Other?		
<b>Care Team/Care Givers (Human Factors)</b>		
Were the education, experience, training, and skill level appropriate?	Yes/No	
Was fatigue, stressors, health or health factors an issue?	Yes/No	
Was the workload appropriate?	Yes/No	
Was appropriate and timely help or supervision available?	Yes/No	
Other?	Yes/No	
<b>Care team – Supporting team (all involved in care process)</b>		
Was there a clear understanding of roles and responsibilities?	Yes/No	
Was the quality and quantity of communication (verbal and/or written) between team members appropriate (clear, accurate, free of jargon, relevant, complete, and timely)?	Yes/No	
Were there regular team briefings/debriefings about important care issues?	Yes/No	
Was team morale good? Did team members support each other?	Yes/No	
Were the communication channels available and appropriate to support the needs of the team	Yes/No	
Other?	Yes/No	
<b>Equipment (including materials, fixtures, information and communication systems)</b>		
Were the displays and controls understandable?	Yes/No	
Did the equipment automatically detect and display problems?	Yes/No	
Was the display functional?	Yes/No	
Were the warning labels, reference guide, and safety mechanisms functional and readily visible/accessible?	Yes/No	
Were the maintenance and upgrades up-to-date?	Yes/No	
Was the equipment standardised?	Yes/No	
Would the users describe this equipment as easy to use?	Yes/No	
Were the communication systems (phone,	Yes/No	

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pager, software, hardware, etc.) available and operational?		
Other?	Yes/No	
<b>Organisation - Policies and priorities</b>		
Were the relevant policies and procedures available, known, and accessible, and did they meet the needs of users?	Yes/No	
Were there workarounds to the documented policy/procedure?	Yes/No	
Was there a mechanism in place to identify and resolve gaps between policy and practice?	Yes/No	
Were the strategic priorities of the organisation clear to all?	Yes/No	
Other?	Yes/No	
<b>Organisation – Culture</b>		
Was everyone (resident/client, clinicians, other staff) comfortable to speak-up about safety concerns?	Yes/No	
Was there visible support from leadership and the board for safe resident/client care?	Yes/No	
Was communication between staff and management supportive of day-to-day safe resident/client care?	Yes/No	
Were incidents viewed as system failures with a mechanism/transparent process for fair and just review of actions by individuals where indicated?	Yes/No	
Other?	Yes/No	
<b>Organisation – Capacity (resources)</b>		
Did scheduling influence the staffing level, or cause stress or fatigue?	Yes/No	
Was there sufficient capacity in the system to perform effectively (e.g., access to resources)?	Yes/No	
Other?	Yes/No	
<b>Other – consider</b>		
Are there any factors that prevented this event from happening on a more regular basis?	Yes/No	
Were there any factors or actions taken that mitigated the severity of the event?	Yes/No	
Were there any local conditions or circumstances that may have influenced the incident and/or an outcome?	Yes/No	
Were there any other contextual conditions or circumstances that may have influenced the incident and/or outcome?	Yes/No	
Other?	Yes/No	

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REPORT

## 36. Report Summary of Contributing Causes & Issues

No.	Contributing Factor/ Issue Identified	Rationale
<i>Provide a dot point summary here by reflecting on the issues that you have identified in the analysis/review completed earlier in the document.</i>		
1.	<i>ENTER Primary Contributing Factor</i>	a) b) c)
2.	<i>ENTER the secondary contributing factor</i>	a) b) c)
3.		a) b) c)
4.		a) b) c)
5.		a) b) c)
6.		a) b) c)

# Incident and Complaint Management Investigation Toolkit

REPORT

## 37. Report Recommendations

Contributory Factor	Action							
	Recommended Action	Action E = eliminate C = control A = accept	Position Responsible	Planned Completion Date	Outcome measure	Risk Rating	Review Date	Progress
1								
2								
3								
4								
5								

# Incident and Complaint Management Investigation Toolkit

## REPORT

### 38. Report 5 WHYs Investigation Report Template

<p><b>Brief description of the Incident/Complaint</b></p> <p>Provide a brief and specific title for the issue being investigated</p>	
<p><b>CAS Rating</b></p>	
<p><b>Date of occurrence/receipt</b></p>	
<p><b>Report Prepared by</b></p> <p>Provide a brief and specific title for the issue being investigated</p>	
<p><b>Manager's Review Executive Summary</b></p> <p>Provide a concise overview of the incident/complaint, key findings, and recommended actions. This section should be brief and accessible to senior management.</p>	

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<p><b>Issue Identification:</b></p> <p>Clearly define the issue being investigated. Include details about how and when the issue was first identified/discovered.</p>	
<p><b>Description/determination of incident:</b></p> <p>A detailed description of what happened, including any immediate impacts.</p>	
<p><b>Outline the sequence of events</b></p> <p>What happened? When did it happen? Where did it happen? Who was involved? How did it happen?</p>	
<p><b>What should have happened?</b></p> <p>Refer to relevant policies, procedures, current literature</p>	
<p><b>5 WHYS Analysis</b></p> <p>For each point where actual events deviated from expected events ask the question 'Why' five times (or more if necessary) until the basic contributory factors are identified.</p>	

# Incident and Complaint Management Investigation Toolkit

<p><b>Contributing Factors</b></p> <p>Identify and describe the fundamental cause(s) of the incident based on the investigation's finding</p>	
<p><b>Recommendations:</b></p> <p>Provide strategic recommendations for systemic improvements to prevent future incidents. This section should offer advice on policy changes, training needs, process updates, or other organizational improvements.</p>	<p>Use 'The 5Whys – Investigation Recommendations Summary template' provided in the incident and complaints management and investigation tool kit</p>
<p><b>Responsible Person(s):</b></p> <p>Names of individuals or departments responsible for implementing corrective actions and recommendations.</p>	
<p><b>Completion Date:</b></p> <p>Target dates for when the corrective actions and recommendations should be completed</p>	
<p><b>Follow-up and Review:</b></p> <p>Plan for how the effectiveness of the corrective actions and recommendations will be monitored and evaluated over time.</p>	

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## 40. References

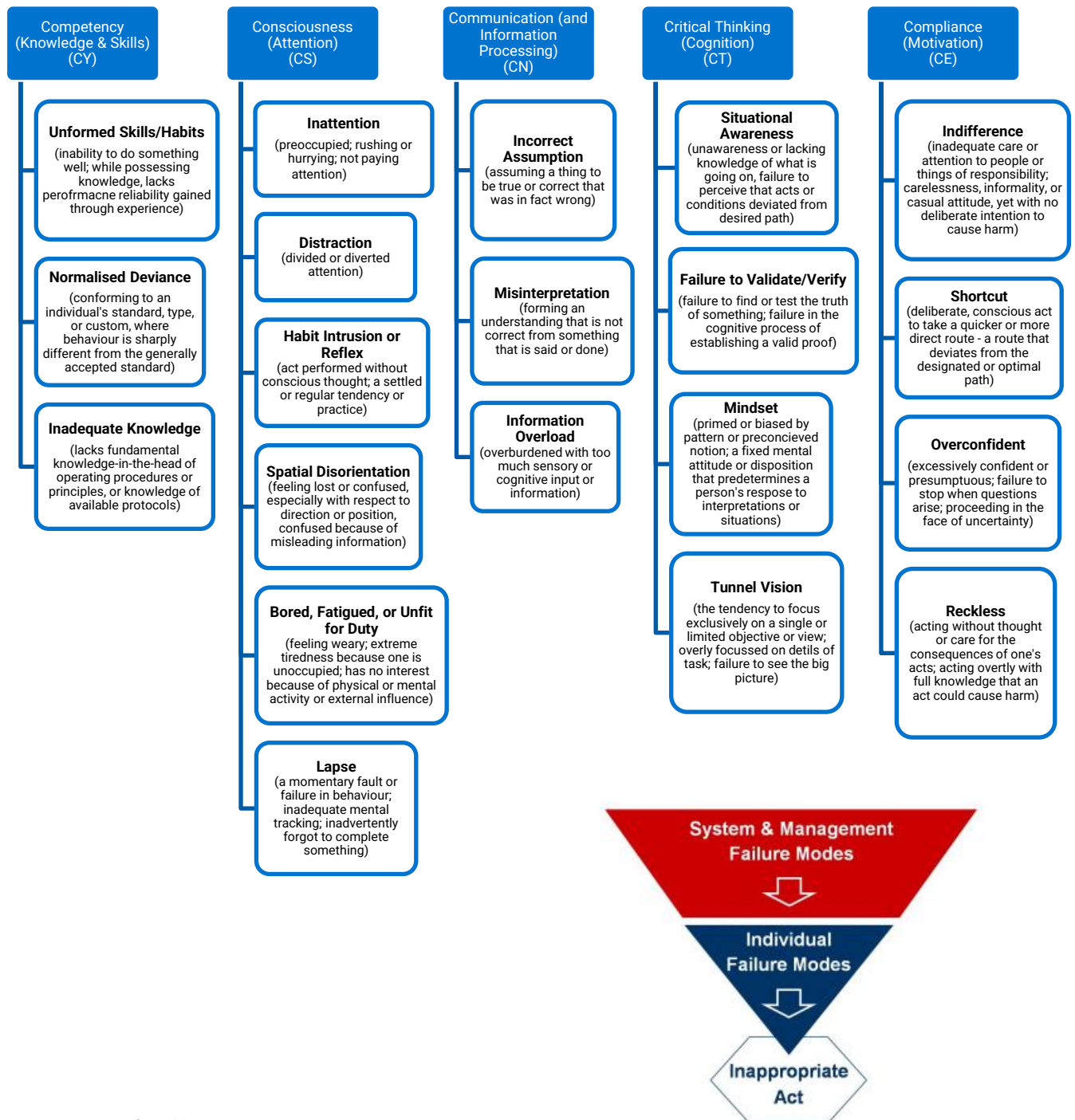
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## 41. Taxonomy of Individual Failure Modes

Diagram 7: Taxonomy of Individual Failure Modes



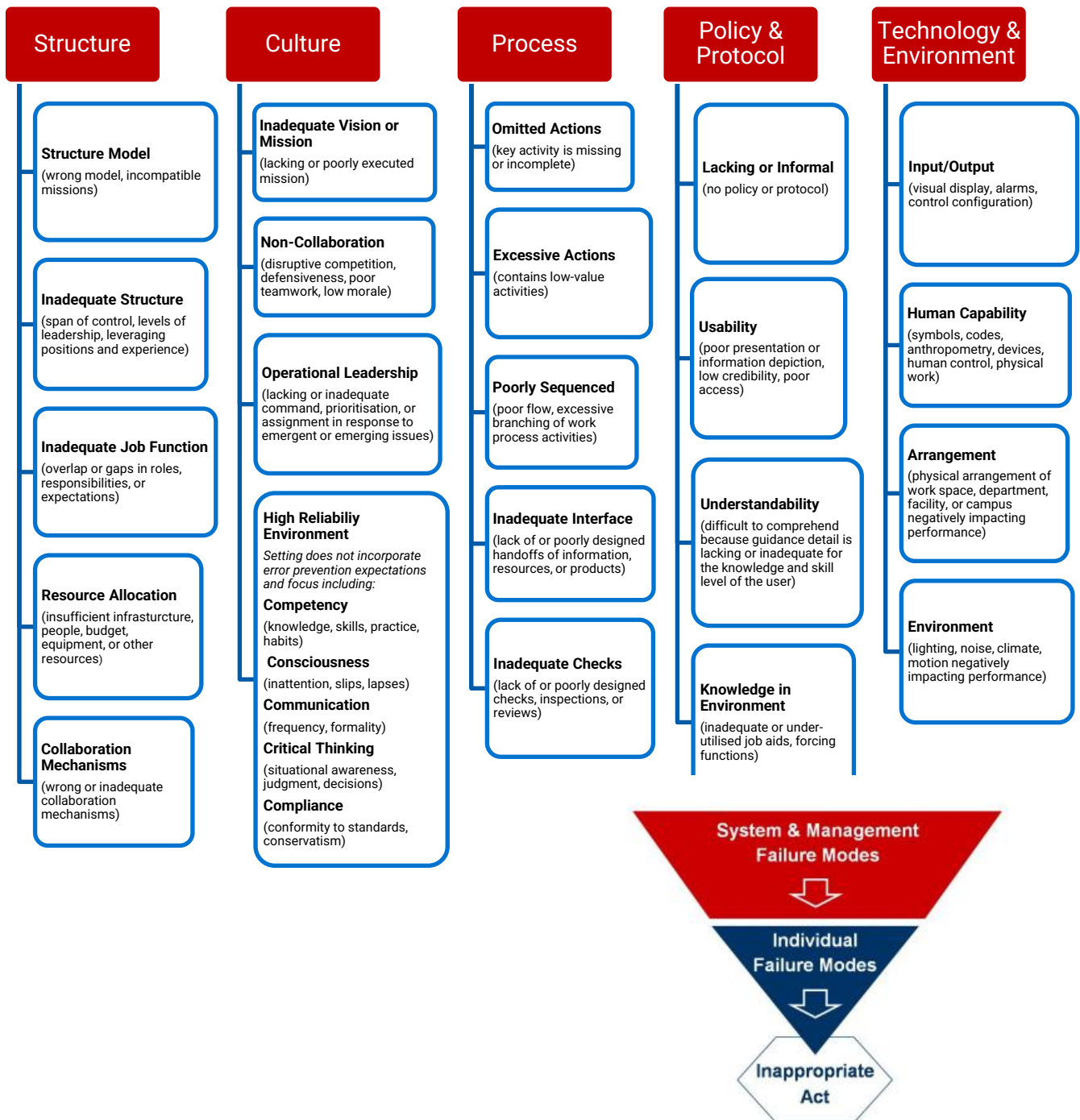
Source: Institute of Healthcare Improvement, 2010.

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## 42. Taxonomy of System Failure Modes

Diagram 8: Taxonomy of System Failure Modes



Source: Institute of Healthcare Improvement, 2010

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