

Risk Incidents and Complaints Management



Identification and Analysis of Evidence

Instructions:



This handout contains instructions and a worked example to help create an Evaluation Matrix Analysis tool. The NDIS Commission requires you to have a way to conduct an investigation into an incident to identify what caused it and how to prevent it from happening again. This resource is intended for senior staff with formal responsibility for conducting investigations as part of role on behalf of their service.

This handout is general in nature and to be used as a guide to suit the size of your service and the supports it provides.



Identification and Analysis of Evidence - Instructions and example

An Evaluation Matrix Analysis is a useful tool to assist with setting out evidence and analysis in a clear and coherent way. The technique lists issues, evidence collected and its source, analysis and findings in a matrix. It illustrates the logic used to reach conclusions and communicates that logic to others. It is a valuable tool for resolving conflicting evidence. It also provides a record of the analysis used to examine the facts to ensure the validity and repeatability of tracking all the facts through analysis and on to conclusions.

It is critical to identify what evidence may be important to the investigation early on in the process. This could include work rosters, progress/case notes, medical records, photographs etc. Ensure that all relevant logs, records, and other evidence are collected and stored securely.

Instructions to complete the Evaluation Matrix Analysis

1. First list issues/incidents on the matrix worksheet (see worked example below).
 - *These will either be not substantiated or will change to findings and conclusions as information is gathered.*
2. List all important findings or conclusions, including positive ones to help assure that good things in the system are not changed while correcting problem areas.
 - *This can also serve as a process to facilitate positive feedback that might arise out of the process.*
3. List all evidence whether it supports your finding or is contrary to it.
 - *If this is not done, the investigation may appear biased in that it only looked at supporting evidence for the findings. Listing contrary evidence illustrates that all relevant evidence was gathered and considered.*
4. Clearly specify the source of evidence.
 - *Avoid broad statements such as, "Operation's personnel knew the valve was faulty." Any statement made in a report that is analysis should always be clearly supported by evidence, and it must be clear exactly where the evidence has come from. A specific and detailed evidence-based report is a reliable and credible report.*
5. Include any remarks that would be beneficial to the board or others, e.g., the location of the evidence.
6. Include all types of evidence, i.e., physical, paper and software, and witness evidence.
 - *Be thorough in ensuring each finding is supported by documented evidence.*
7. Give enough detail that the findings are clearly supported and reasoned for the final report.
 - *You should not have to fill in any gaps, all evidence relied upon to make a finding should be clearly laid out in the report and discussed in the analysis. The report should stand alone as a document and should be able to withstand scrutiny.*



Analysis of the evidence and list of the findings

Provide an analysis of all the evidence gathered that demonstrates how you have reached a finding. Highlight any conflicting, contradictory, or exculpatory evidence. Exculpatory evidence refers to evidence that clears a person of wrongdoing. For example, someone not being on staff the day an alleged incident occurred.

In your report, your evidence section should be free from analysis. This means you might write in your evidence “the rosters for May have been obtained by the investigation and indicate that Jenny was on annual leave from 1 to 15 May”. They would not follow on with “it follows that Jenny cannot have been present during the incident as alleged” This is analysis and does not belong in your evidence section.

Likewise, no new evidence should be introduced in analysis. If you find that in your analysis you need to mention something that has not been laid out in your evidence section, go back and put it in.

Analysis is where you tell the story of how you have come to your finding. Don't just re-state your evidence, you need to talk about how and why you are weighting some evidence over other evidence; what the investigation accepts and does not accept; and what the policies say and how they should be implemented.

There should be separate analysis for each issue or allegation leading to each separate finding.

Findings and recommendations

A finding should clearly state the outcome of a particular issue, allegation or line of enquiry. Different types of investigations will have different types of findings, and it's important to know that your findings are distinct from your recommendations.

A finding might say whether or not an allegation has been substantiated, it might say that there is no evidence of any deviation from policy or procedure, it might say that a particular root cause has been established. A finding should be clear and short. The lengthy analysis has told the story, the finding is just where you state, very clearly, what the end product of the investigative process is.

Your findings may form the basis of your recommendations. For example, you may make a finding that on a particular issue, staff have not been checking the risk register on a weekly basis as required by policy. Your recommendation then will be something to assist in addressing the issue, such as retraining, a toolbox talk, a new process to support the task, and so on. Recommendations should be clear, direct and based on the findings of the investigation.



Issue requiring investigation:

Resident (M) choked on sandwich at lunch in the dining room on the 2/3/22, which he took from another resident (L).

Information required to clarify issue	Evidence	Source of evidence	Comments	Evidence concurs/ inconsistent	Finding
<p>Did/does M have a choking risk? How do we know that?</p> <p>Has any choking risk been identified and documented by the service? If so, by whom, where and when?</p>	<p>M has a meal-time management plan (MTMP) dated 12/12 2021 developed by a speech pathologist Bill Smith, which includes not to leave unattended around food, including other residents' food as M has a choking risk with some foods including bread.</p> <p>M's risk profile includes choking risk.</p>	<p>M's file.</p> <p>Interview with House Manager (BK) .</p>	<p>MTMP observed to be in M's file by Investigation lead on 10/3/2022.</p> <p>MTMP refers to choking risk and food to be prohibited, for M's consumption, including bread.</p> <p>Record of interview in Investigation file.</p>		<p>Choking risk identified for participant M with current management plan developed and on file.</p>
<p>What was in place for staff in terms of daily care plan instructions for M?</p>	<p>Daily care plan includes ADLs, behaviour support plan. No mealtime management requirements.</p> <p>Staff interview confirms they were unaware of the MTMP for M or any risks for other residents aside from the behaviour support plan.</p> <p>Policy on induction for casual/ agency staff of duties with regard to individual residents.</p>	<p>M's daily care plan.</p> <p>Interview with Staff present at choking incident. (EP)</p> <p>Casual/Agency staff site induction policy and records.</p>	<p>Record of interview in Investigation file.</p> <p>Policy for casual staff of duties and awareness of individual resident needs in Operational procedures manual version dec. 2019</p>		<p>No requirement for casual/agency staff to be familiar with all risks to each resident prior to commencing shift.</p>

Information required to clarify issue	Evidence	Source of evidence	Comments	Evidence concurs/ inconsistent	Finding
<p>How are resident risks communicated to staff/how do staff make themselves aware?</p>	<p>M's choking risk was raised with staff on shift at training conducted by speech pathologist at the house on 18/12/2021.</p> <p>Only rostered staff attended training. M's key worker was responsible for ensuring mealtime practices reflected the MTMP were implemented by other staff. It was documented in the house communications book which permanent staff are required to read and sign coming onto a new shift.</p>	<p>Staff meeting minutes 18/12/2021. Record of staff attendance.</p> <p>M's file review.</p> <p>Interview with House Manager (BK) and M's Key worker (CC).</p> <p>House Communications Book for December 2021.</p>			<p>Process for permanent staff to learn about resident risks is in place however not for casual/agency staff.</p>
<p>Did this awareness process occur for all staff?</p>	<p>Staff member (EP) present at incident unaware of M having a choking risk.</p> <p>Agency staff are not routinely shown participants file or notified of any risks to M, aside from the Behaviour support plan.</p> <p>Permanent staff receive information on all residents' risks and if anyone has a mealtime management plan, they are required to monitor mealtime practices for the participant.</p>	<p>Interview with Staff (EP) present at choking incident.</p> <p>Interview with House Manager (BK).</p> <p>Staff training records December 2021 and memo's.</p>	<p>Record of interview in Investigation file.</p> <p>Permanent staff had signed they had read M's MTMP in December 2021.</p> <p>Agency staff may miss this if key worker is not available to monitor and other staff do not prompt their actions.</p>		<p>Failure to ensure all relevant staff (including agency staff) are aware of M's MTMP and choking risk and how to mitigate this risk.</p>

Information required to clarify issue	Evidence	Source of evidence	Comments	Evidence concurs/ inconsistent	Finding
<p>Events of the actual incident</p>	<p>M had finished her lunch, but she took food from Resident P.</p> <p>The Casual staff member present at the incident had not worked with this house or resident M prior.</p> <p>Resident (P) stated they are aware that resident M is not allowed to eat bread and needs to be supervised with his meals and this was followed but then the staff member left the dining room and M stole my sandwich put it all in his mouth at once and then choked.</p>	<p>Interview with staff (EP) and House Manager (BK).</p> <p>Staff roster for w/e 5/3/2022.</p> <p>Interview with Resident P.</p>	<p>Record of interviews in Investigation file.</p> <p>Staff Rosters from HR M's file.</p>		<p>Failure of staff to continue to monitor M near any food, outside his own mealtime management.</p>
<p>Was the incident reported immediately?</p>	<p>Report of incident immediately to house manager (who was off site). Record of incident made by staff in file. GP called to conduct examination of M.</p>	<p>House communications book. Incident report in M's file.</p> <p>Interview with House Manager.</p>			<p>Response to incident was appropriate.</p>
<p>Were there any factors that prevented the mitigation?</p>	<p>Procedures for inducting agency staff or 'borrowed staff in COVID circumstances' only required ADLs and behaviour management support plan to be reviewed at beginning of shift.</p>				<p>Induction for casual staff coming onto shift during COVID is inconsistently conducted. There are no records kept to record completion and depends on what is happening at the house at the time they commence a shift.</p>

Information required to clarify issue	Evidence	Source of evidence	Comments	Evidence concurs/ inconsistent	Finding
<p>How could the incident have been avoided?</p>	<p>House Manager suggests a review of induction for all staff entering the house to work for the first time be allocated time to ensure they are adequately informed of potential risks for all residents and strategies to manage these.</p>	<p>Interview House Manager</p>			<p>Induction for casual staff coming onto shift during COVID is inconsistently conducted. There are no records kept to record completion and depends on what is happening at the house at the time they commence a shift</p>