

Using DATIX to report an incident on line:

A Step by Step Guide on How to Report an Incident



Brent

Working Together to
Improve Quality



Brent Community Services

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Pathway for submitting an incident on-line

Introduction

Brent Community Services and NHS Brent Staff can report incidents via the same pathway on the intranet. No password is required to submit an incident, just navigate through to the intranet and choose the option 'Reporting an incident'. This will take you directly through to the Datix Icon, our new reporting system.



This will take you through to a new screen and you will need to select 'Log a new Datix incident'. This will bring you to a blue form entitled "***Brent Community Services and NHS Brent Incident Reporting Form***".

What to expect on the incident reporting form

The form itself is simple and is structured systematically enabling you to identify the type of incident, location, category, severity and contacts. All sections with a red star are mandatory and require an entry.

The form has several drop-down boxes giving you a number of options to choose from and is no different to a form that you would use to book a holiday or anything else via a web page. There are several prompts and guidance is provided throughout the form, including signposts to relevant Trust policies.

This booklet is designed to assist you through the process of submitting an incident.

Who should I contact if I need help or have a query about Datix?

If you have a query about the type of incident that you are reporting, you should seek advice from your immediate line manager. If however, you require assistance about Datix itself (you need to contact your local Datix administrators via e-mail:

To report Datix specific issues for BCS please email

Datix.BCS@brentpct.nhs.uk and an administrator will contact you.

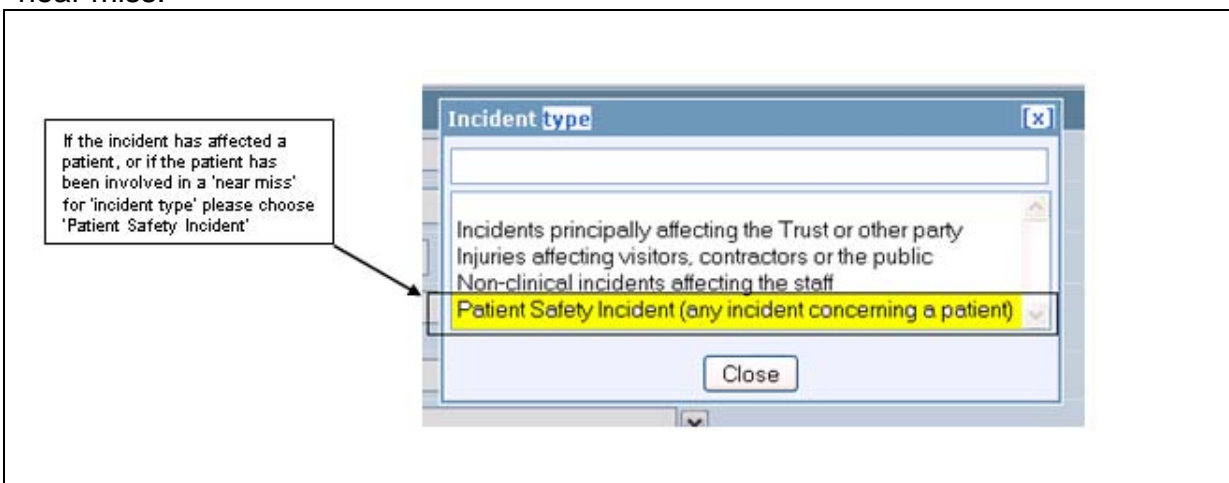
To report Datix specific issues for NHS Brent please email Datix.NHSBrent@brentpct.nhs.uk and an administrator will contact you.

NHS Brent	BCS
Bina Patel – PA to Head of Corporate Affairs	Faisal Ahmed – Clinical Governance Lead
Vanessa Fernandis - Corporate Affairs & Complaints Manager	Tammy Moorcroft – Emergency Planning and Risk Manager

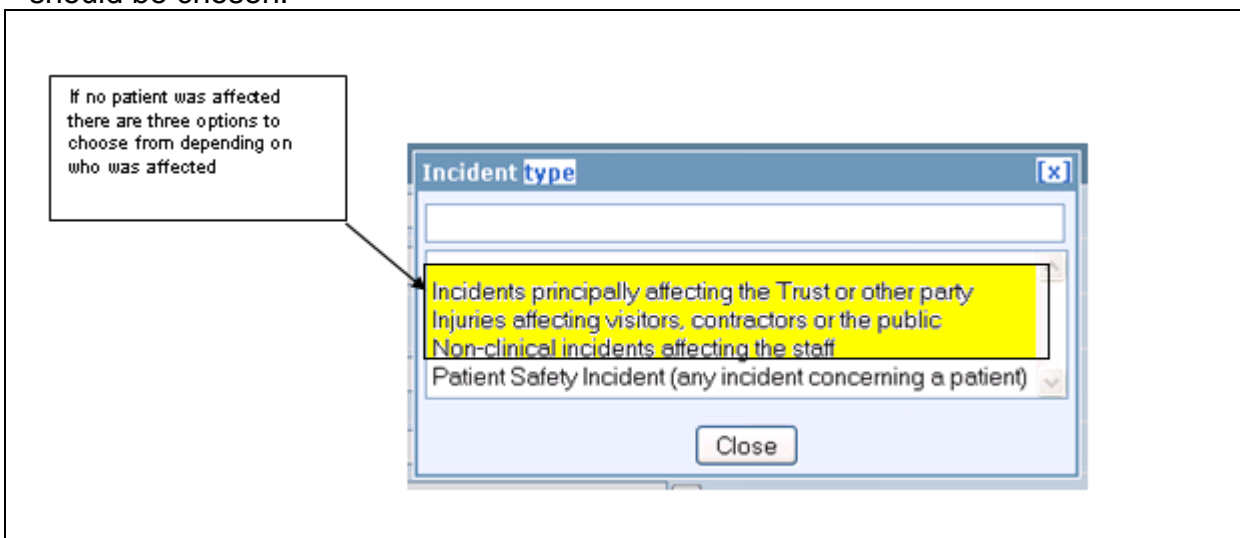
1. Incident Details

1.1 Incident Type

If the incident directly involves a patient this will need to be reported as a ‘Patient Safety Incident’ – this option should also be chosen if the patient was involved in a near miss.



If no patient was affected, it is not a ‘patient safety incident’ and the relevant option should be chosen.



1.2 Incident Date and Time

When you click on the date icon a calendar will automatically appear. The time allows you to free text and you should enter the time format using the 24 hour clock.

1.3 Organisation

Enter the organisation that you are responsible to whether NHS Brent or Brent Community Services.

1.4 Site

Choose the site where the incident actually occurred.

1.5 Location (type)

This is the general collective term for the type of place where the incident occurred. If the incident occurred on a specific ward, you should choose 'ward' under this option. If the incident occurred in the reception of a main site, you should choose 'hospital building' and so on.

1.6 Location (Exact)

This option allows you to filter to the precise location where the incident took place. Following on from the ward example, you will now be able to select the ward or specific area.

The screenshot shows a form titled 'Incident details' with the following fields and annotations:

- Incident type**: A dropdown menu. Annotation: "This opens a drop down box allowing you to identify whether it is a patient safety incident etc".
- Incident date (dd/MM/yyyy)**: A text input field with a calendar icon.
- Time of Incident (hh:mm)**: A text input field.
- Organisation**: A dropdown menu. Annotation: "If you are reporting the incident you must identify whether you work for BCS or NHS Brent so the incident can go to the correct manager".
- Site**: A dropdown menu.
- Location (type)**: A dropdown menu.
- Location (exact)**: A dropdown menu. Annotation: "These fields should identify the location where the incident occurred. So if a ward incident put 'Willesden' for site, then 'Ward' for location type, then the name of the relevant ward i.e. 'Robertson'".
- Service / Specialty**: A dropdown menu. Annotation: "For this field you should choose the service or specialty involved i.e. if a patient was in the podiatry department at the time of the incident you must choose 'podiatry' as the specialty".

1.7 Service/Specialty

This option allows you to identify the service or specialty that contributed toward the incident or 'near miss' occurring and is the main reason for you submitting the incident. Identifying the service and specialty will allow the service or specialty lead to be aware that an incident has occurred.

If a patient was receiving treatment in the Podiatry Department at the time the incident occurred, then you would choose 'Podiatry' as the specialty.

*** Service / Specialty**
Which Service does the incident relate to?

Service / Specialty [x]

- Optometry Contract
- Other general query
- Partnership / JC Children and families
- Partnership/Joint Commissioning - adults and older people
- Performance
- Performance
- Pharmacy Contract
- Phlebotomy Services
- Physiotherapy
- Podiatry**
- Psychology
- Query about complaints procedure
- Query about registration procedure
- Residential care
- Respiratory Services
- Retinal Screening
- Smoking Cessation
- Stoma Care
- Strategic and Planning
- Substance Misuse

Close

Please do:

A Further example:

if a visitor fell in the car park then 'Estates' needs to be selected

1.8 Description of Incident

This is a free text field which allows you to type freely. It is very important that you do not enter details that enable the identification of a patient or member of staff.

It is also important that the information you provide is concise and tells the reader what happened clearly and succinctly.

For example:

'The patient fell out of bed and hit his leg on the floor'

Instead of:

'I was attending to another patient when I heard a noise and saw that Mr Another was on the floor crying. I shouted for Staff Nurse Xample to help me. When we reached the bay there was such a commotion as the patient was clearly upset and complained that he hit his leg and was in a lot of pain.'

It should appear on the form like this:

*** Description of incident**
Please:
do not:

- Use any Personal Details.
- Use Abbreviations.
- Use Obscene language.

Please do:

- Enter facts - not opinions.
- Give a brief and concise account.

The patient fell out of bed and hit his leg on the floor

Always be clear and give enough information to that allows the reader to identify the incident.

1.9 Immediate action taken

Here you should indicate what actions were taken in order to safely manage the situation.

For further information and to report when necessary please click [here](#)

*** Immediate action taken**
Enter action taken at the time of the incident.

Please:
do not:

- Use any Personal Details.
- Use Abbreviations.
- Use Obscene language.

Patient assisted back to bed. Observations taken, doctor informed

Describe what you did to manage the situation at the time

1.10 Is this incident reportable to RIDDOR?

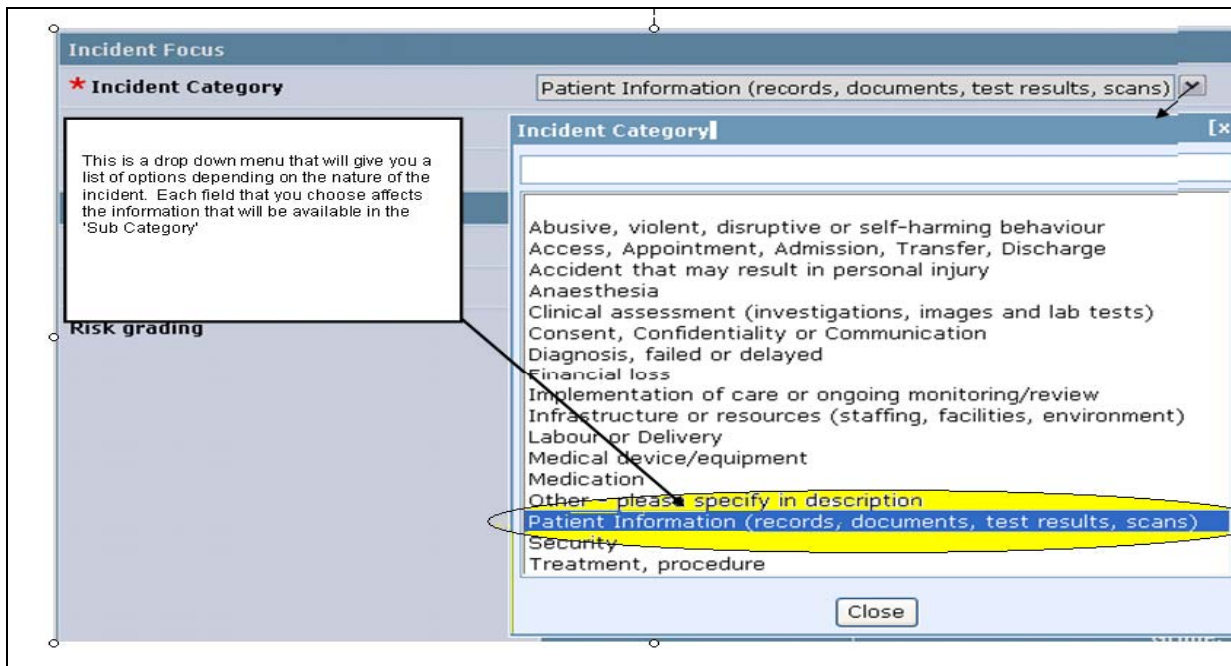
RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations in accordance with legislation. More information can be found on the link via the section of the form where it says '[click here](#)'. If you are unsure, please contact your line manager. Don't worry if you click the incorrect answer as the form will be reviewed by an appropriate governance lead who will allocate the correct answer.

2. Incident Focus

This is how Datix classifies what the incident is. There are a number of options that may seem overwhelming at first and it may appear that one or more of the categories apply. Don't worry, you will get used to the format and how by choosing one option will help you filter down into the main event that occurred.

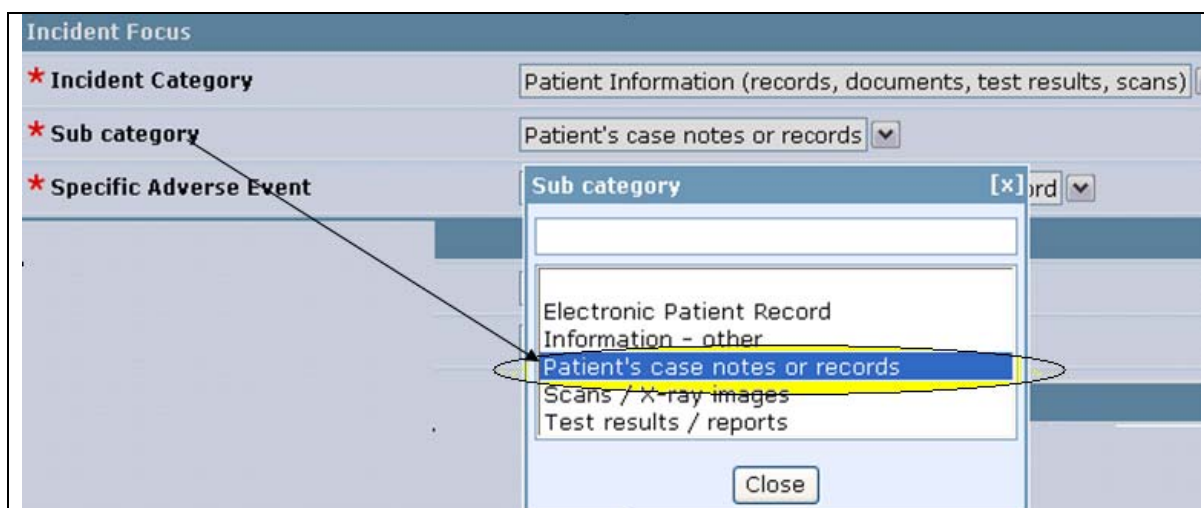
2.1 Category

If a patient was not seen because medical records not available you should indicate 'patient not seen' or words to that effect in the 'description' section. You then need to ensure the category reflects that information for a safe consultation was not available. You should do this by choosing 'Patient Information (records, documents..)'.



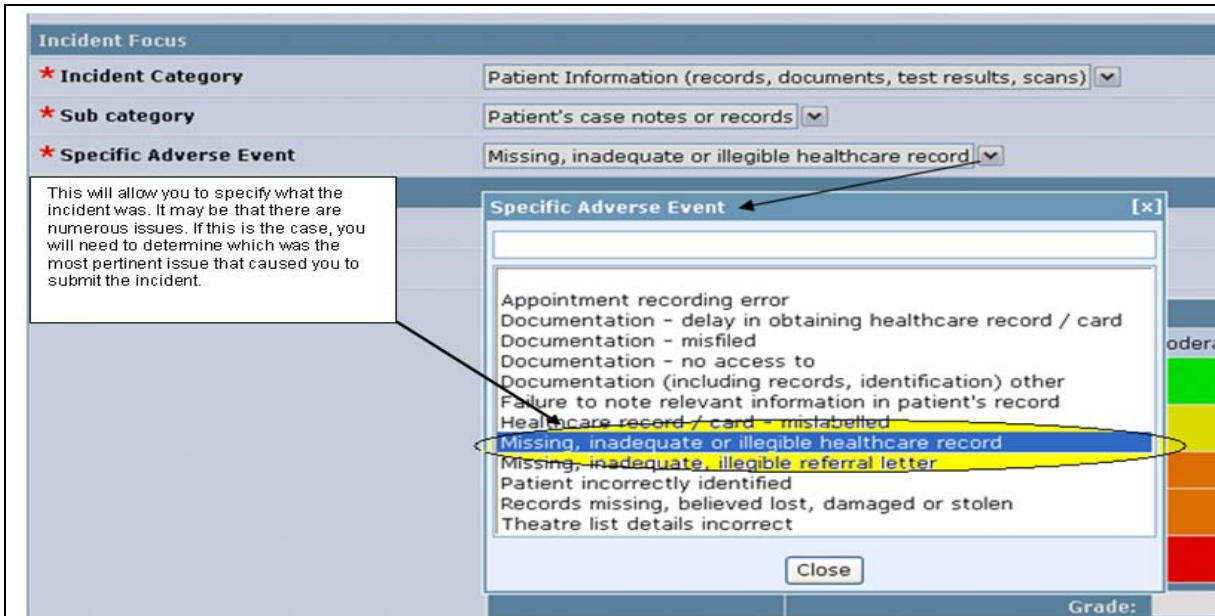
2.2 Sub-Category

The option chosen in 2.1 will determine the options that are available in the sub-category section. It helps to filter down and assist you in correctly allocating information applicable to this incident. For ease of reference we shall continue to use the previous example of unavailability of medical records. By choosing 'Patient Information' the sub-category will define and allow you to choose from possible options that relate to 'Patient Information';



2.3 Specific Adverse Event

This option should allow you to identify what caused the event to occur, in this example it should read 'missing, inadequate....healthcare record'

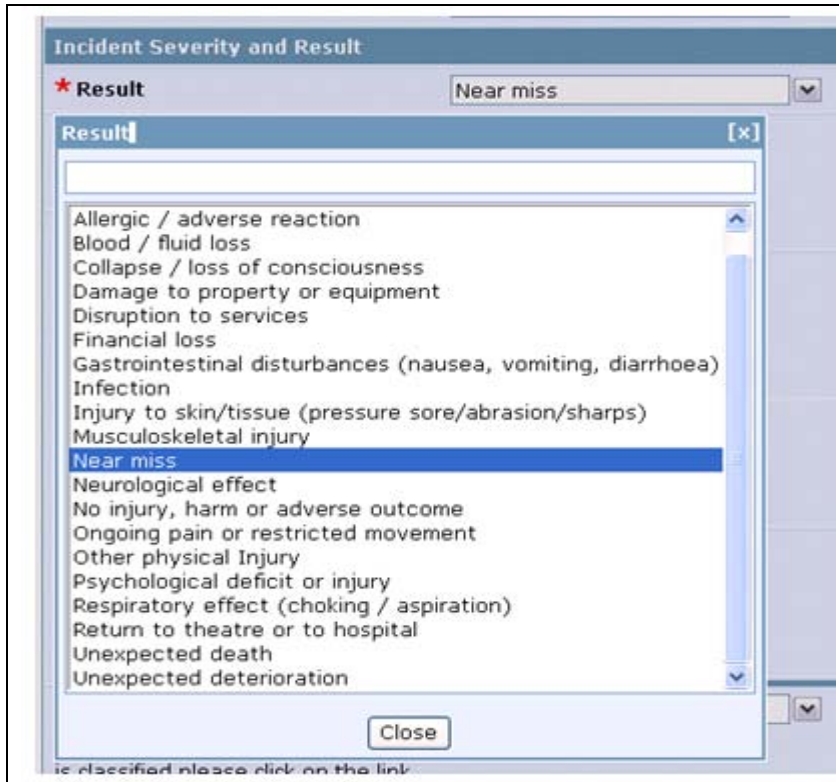


3. Incident Severity and Result

Here you select what happened to the patient as a result of the incident for example, a fall, infection or mostly no harm. You can also attempt to give the incident a risk grading based on the degree of harm and likelihood of it occurring again.

3.1 Result

We are required to report incidents that occur and also when they have been avoided (classified as near misses). There are also options to indicate what type of harm the patient sustained.

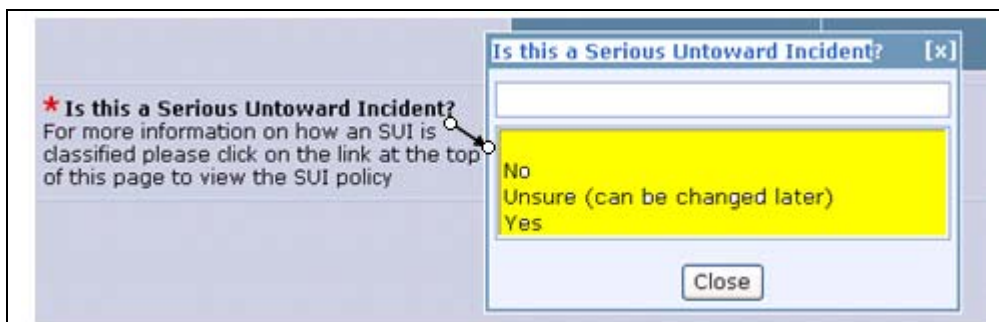


3.2 Risk Grading (See risk grading tool on page 14)

- The impact relates to the outcome of the incident on the individual:
- No Harm
- Minor – Extra observation, short term discomfort, minor loss
- Moderate – Further procedure, extended length of stay
- Major –Permanent or long term harm, major financial, shut down of service
- Extreme – Death, permanent closure service

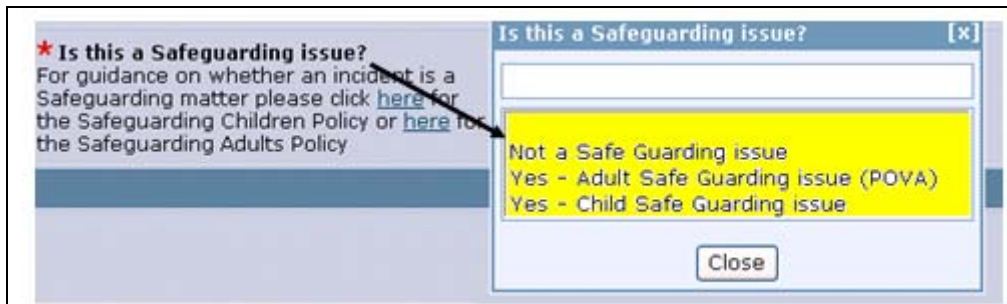
3.3 Is this a Serious Incident (SI)?

Your response should be a simple **'yes'** or **'no'** answer. Information about what constitutes an SI can be found on page 4/38 in the Trust SI policy; 'The principle definition of an (SI) is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS Brent premises or in the provision of an NHS Brent or a commissioned service. The form signposts you to the correct policy when clicking on the relevant link - All potential SI's should be escalated to the service director before being formally declared.



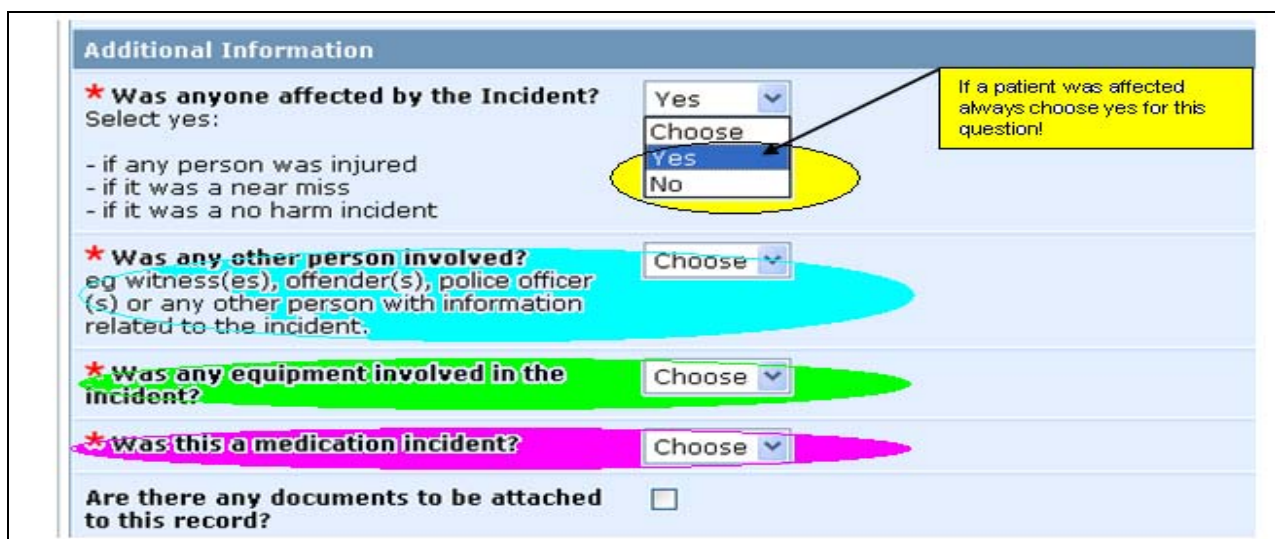
3.4 Is this a Safeguarding Incident?

This is asking whether the issue raised should be considered as a safeguarding issue for a child or adult. The option chosen will alert the safeguarding team to the incident and will ensure that the correct process for investigation is followed as this and the SI investigation process is different to an incident investigation. There are two Trust policies for reference, click on the links for access. Please note if you have chosen yes to 2.4 and 2.5; please communicate this to your manager or department head as soon as possible.



4. Additional Information

There are five tick boxes to choose from. Tick the first box to enter details of the patient/person involved in the incident. This box should always be ticked for all incidents unless there were no patient/persons affected or involved in an incident. If **equipment** was involved in the incident then tick this box. If it was a **medication** incident tick this box. If you would like to enter details of any **witnesses** to the incident then tick this box. If you select yes for any of these boxes, an additional section will appear for you to complete.



In addition, if you wish to attach something, such as a statement or anything to support the incident investigation, you can attach them if you choose to by ticking the last box. You will be able to upload an attachment in the same way that you would attach a document to an e-mail.

4.1 Person Affected (Details of Patient/Person)/ Was any other person involved?

When you tick this box a drop down screen will appear, just follow the prompts to provide the appropriate information.

Other people with information/involved	
Other Contact	
Type	<input type="text"/> ▼
Subtype	<input type="text"/> ▼
* Contact role	<input type="text"/> ▼
First names	<input type="text"/>
Surname	<input type="text"/>
E-mail	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Gender	<input type="text"/> ▼
Contact telephone number	<input type="text"/>
Ethnicity	<u>Type of Person</u> Choose from the list whether the person affected by the incident was a patient or staff member i.e. nurse, doctor, pharmacist etc.
Language	
Disabilities	<u>Job Role If Staff</u> If person affected by incident was staff choose from this list their role i.e. staff nurse, sister etc. <u>Patient/Staff No</u> If person affected by incident was a patient enter the hospital number, if person is a member of staff put in their staff number if known.
Notes	<u>Job Title</u> Enter if applicable <u>Contact No/Bleep No</u> This primarily applies if the person affected by incident was a member of staff.

4.2 Equipment Details

If the incident involved equipment enter the details here.

Equipment Type

Choose from the list

Equipment Description

Enter description of equipment

Manufacturer

Enter the name of the manufacturer of this

4.3 Medication Incident Details

If the incident involved medication enter the details.

Stage of Medication Incident

Choose from the list

Type of Medication Incident

Choose from the list

Drug administered

Indicate here if the medication was given or

<p>equipment here. <u>Serial No/Trust ID no</u> Enter the serial number of trust ID no of the faulty equipment here. <u>Description of defect</u> Give a brief description of the problem here.</p> <p>Equipment details Please retain all faulty equipment for the investigation</p> <p>* Product type <input type="text"/></p> <p>Brand name <input type="text"/></p> <p>Serial no. <input type="text"/></p> <p>Manufacturer <input type="text"/></p>	<p>omitted. <u>Format administered</u> Indicate whether it was tablet/capsule/liquid etc.</p> <p>Medication incident details</p> <p>Stage of medication error <input type="text"/></p> <p>Medication error <input type="text"/></p> <p>Drug administered <input type="text"/></p> <p>Correct drug <input type="text"/></p> <p>Form administered <input type="text"/></p> <p>Correct form <input type="text"/></p>
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Complete the rest of sections including name, title, ethnicity, gender etc. if known.

5 Your details

The good news is that you have almost completed the form; all you have to do is complete all of your details

Details of person reporting the incident	
Reporter	
Job role	<input type="text"/>
* First names	<input type="text"/>
* Surname	<input type="text"/>
NHS email address If you enter your email address you will receive an email acknowledging you have reported this incident	<input type="text"/>
* Contact telephone number	<input type="text"/>
Your Manager	
Your Manager	<input type="text"/>

Then click Submit and you're done!

<input type="text"/>
<input type="button" value="Submit"/> <input type="button" value="Submit and print"/> <input type="button" value="Cancel"/>

6 Useful Reading

Incident Reporting Policy

Serious Incident Policy

Being Open Policy

Risk Grading Tool

END

Risk Grading Tool

The risk-grading tool (also known as risk matrix / risk assessment tool) is used by the NHS Brent for all risk processes (risk assessment, Risk Register, incident reporting and near miss assessment) and risks are measured according to the following formula. The tool can be used as the basis for identifying acceptable and unacceptable risks.

For some risks there may be physical as well as financial consequences. When assessing the score for the consequences of such a risk, the clinical assessment (e.g. serious injury or death) will always take precedence over the financial assessment.

Level of Risk = Consequence * Likelihood.

Likelihood:

Q: How likely is the risk to occur?

E.g. how likely is it that there *could be a breach of patient confidentiality due to information being stored on computers without passwords?*

Choose the most appropriate level from the categories below:

Qualitative Measures of Likelihood		
LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	Can't believe the risk will ever happen
2	Unlikely	Do not expect the risk to happen but it is possible
3	Possible	The event may occur occasionally
4	Likely	The event will probably occur but is not a persistent issue
5	Almost Certain	The event will undoubtedly occur, possibly frequently

Consequence:

Q: What is the consequence (impact) of the risk?

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Q: What is the level of the risk?

Level of Risk					
	Most likely consequence (if in doubt grade up, not down)				
Likelihood of occurrence	None (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost certain (5)	5	10	15	20	25

Combining consequences and likelihood to assess the level of each risk. The risk rating score is where the likelihood (bottom left of the above level of risk table) meets with the consequence (top) on the 5x5 matrix.

Risk Key

Red (15-25)	Extreme risk
Amber (8-12)	High risk
Yellow (4-6)	Moderate risk
Green (1-3)	low risk

Risk Treatment

The above four categories of risk provide an initial prioritisation for management action. The precise timing of actions will be set out in the Action Plan. In general, the four categories of risk will be treated as follows:

Further Action Required Based on the Risk Grading

Risk Level	Further Action	By Whom
Extreme (RED)	<p><i>Significant risk:</i></p> <ul style="list-style-type: none"> Immediate action required Director must be informed and he/she to take responsibility for immediate action planning Report to Board identifying treatment options (use action plan template) Quarterly report to the Board monitoring progress on treatment action plans 	Director
High (AMBER)	<ul style="list-style-type: none"> Urgent senior management attention required Agree action point within 1 month with deadline for completion of no more than 6 months Report to Governance Committee identifying treatment options Quarterly report to Governance Committee monitoring progress on treatment action plans 	Senior Management
Moderate (YELLOW)	<ul style="list-style-type: none"> Specific responsibility for risk assessment and action planning must be allocated to a named person Deadline for completion will be within 6 to 24 months and will depend on resource availability Discuss whether any further action should be taken to reduce future risk 	Team Leaders
Low (GREEN)	<p><i>Acceptable Risk.</i> Can be managed by routine procedures</p> <ul style="list-style-type: none"> Record on risk register Inform all appropriate stakeholders 	All staff

Low (YELLOW)	<ul style="list-style-type: none"> • Specific responsibility for risk assessment and action planning must be allocated to a named person • Deadline for completion will be within 6 to 24 months and will depend on resource availability • Discuss whether any further action should be taken to reduce future risk 	Team Leaders
Very Low (GREEN)	<i>Acceptable Risk.</i>	All staff
	<ul style="list-style-type: none"> • Can be managed by routine procedures • Record on risk register • Inform all appropriate stakeholders 	