NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Risky Business

Reviewing incidents

It is really important that incidents reported on to Datix are reviewed.

Every Care Group have incidents in the holding area in Datix, please work with us to reduce these. If you require assistance please ring the Patient Safety Team on 642277.

Receiving incident feedback

To encourage staff to report incidents and continue to do so, they need to receive feedback on the incidents they have reported in the past.

Please when reviewing an incident fill in the datix feedback field so the reporter finds out what has happened.

Datix for positive reporting

There is always a positive atmosphere and all of the staff are approachable even during busy periods.

The handover of patients demonstrated how well staff knew those in their care and really helped me to be able to prioritise the list. I was teaching a new Physiotherapy Assistant and used the handover as an example of a good detailed handover.

I think that ward 18 are setting an excellent example of how an effective team can ensure the best patients care.

This is a story about four people named: **Everybody**, **Somebody**, **Anybody** and **Nobody**. There was an important job to be done and **Everybody** was sure that **Somebody** would do it. **Anybody** could have done it but **Nobody** did it. **Somebody** got angry about that, because it was **Everybody's** job. **Everybody** thought **Anybody** could do it but **Nobody** realised that **Everybody** wouldn't do it. It ended up that **Everybody** blamed **Somebody** when **Nobody** did what **Anybody** could have done.

The **team**

Head of Patient Safety & Experience
Louise Povey: *642277*

Legal Services Manager
Michele Corbett: *642167*

Patient Experience Team Leader
Joanne Blockley: *642768*

System Analyst and Admin (Datix)
Tracy Evans-Philips: *642275*

Patient Safety Leads
Debbie Swift: *642274*
Mark Race: *642273*
Linda Mcloughlin: *644647*
Maggie Gregory: *642719*
Emma-Louise Drabble: *642719*

Risk Management Co-ordinator
Diane Crozier: *642276*

Legal Services Admin
Angela Giblin: *642272*

Patient Safety Facilitator
Rachel Robert: *642272*

Patient Experience Officers
Gary Metcalfe: *642766*
Jenny Olma: *642765*

Patient Experience Admin
Sarah Maye: *642764*
Elaine Green: *642764*
Deborah Cummins: *642764*
Amy Farrington: *642764*

Risk **training**

Sessions will cover the Datix system, key principles of risk management, risk ratings and risk registers.

Thursday 14 September 2017, 12 to 1.30pm, Education Centre, Room 2, DRI
Friday 22 September 2017, 2 to 3.30pm, Boardroom, Bassetlaw Hospital
Wednesday 27 September 2017, 3 to 4.30pm, South Block Meeting Room, DRI
Monday 2 October, 2.30pm to 4pm, Boardroom, DRI
Wednesday 18 October, 2 to 3.30pm,Boardroom, Montagu Hospital
Wednesday 1 November, 2.30 to 4pm,Boardroom, Bassetlaw Hospital

Please register your attendance at the sessions with jane.shaw2@dbh.nhs.uk.

How to **identify the degree of harm**

When completing the incident staff should consider the harm level is actual and not potential!

No harm (impact prevented)

Any incident that had the potential to cause harm but was prevented, resulting in no harm (near miss).

No harm (impact not prevented)

An incident that happened but no harm occurred.

Low

An incident that required extra observation or minor treatment and caused minimal harm (for example cuts, bruises, fractured fingers/ toes, some skin tears and grade two pressure ulcers).

Moderate

An incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment (due to incident) or transfer to another area which caused significant but not permanent harm (for example grade three pressure Ulcers, fractured arm/leg, unintended injury during surgical procedure). Ask yourself: "If this had happened at home, would you have had to come into hospital for treatment?". If you answer 'yes' then the harm is considered 'Moderate' in the first instance.

Severe

an incident that appears to have resulted in permanent harm (for example: Fractured skull/neck of femur, grade four pressure ulcer).

Death

An incident that appears to have resulted in permanent harm (for example, fractured skull/neck of femur, grade four pressure ulcer).

Near miss

When an incident has occurred and it is a near miss there is a reason why it is a near miss and we need to learn from this.

Remember: Report, report and report.