



SGN-122

Safety Guidance Note

Health and Safety Incident Investigation

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Amendment Record

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Contributors	Name	Title

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1 Introduction

The purpose of this Safety Guide Note is to provide managers with a structured approach to help identify and control the underlying or root causes of all incidents in order to prevent their recurrence.

All incidents – regardless of size or impact – must be recorded (Datix – see [Appendix 04.](#)) and depending on severity, investigated. This process helps managers look beyond what happened to discover why it happened. It allows managers to identify and correct shortcomings in their local health and safety arrangements.

This guidance builds on the Trust's Incident Management Procedure and claims management policies which describe how these adverse events are identified, reported and managed.

The Trust is committed to using Root Cause Analysis (RCA) to investigate incidents. This approach is underpinned by the Trusts' commitment to working within a just and open culture in which staff are encouraged to report any errors or incidents and encourage feedback in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

2 Purpose and Scope of the Procedure

This guidance is relevant to all managers and employees. Some services in the Trust are provided on an integrated basis with other social care partners/ agencies. Staff working on behalf of the Trust is a respected part of service delivery; as members of an integrated service, staff will play an active role in delivering this policy and is likely to be part of Investigation Teams. Where appropriate this may also apply to claims relating to the Trust.

3 Definitions:

Accident: an event that results in injury or ill health

Incident: near miss: an event not causing harm, but has the potential to cause injury or ill health (in this guidance, the term near miss will include dangerous occurrences)

Undesired circumstance: a set of conditions or circumstances that have the potential to cause injury or ill health, e.g. untrained nurses handling heavy patients

Dangerous occurrence: one of a number of specific, reportable adverse events, as defined in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR).

Hazard: the potential to cause harm, including ill health and injury; damage to property, plant, products or the environment, production losses or increased liabilities.

Immediate cause: the most obvious reason why an adverse event happens, e.g. the guard is missing; the employee slips etc. There may be several immediate causes identified in any one adverse event.

Root cause: an initiating event or failing from which all other causes or failings spring. Root causes are generally management, planning or organisational failings.

Underlying cause: the less obvious 'system' or 'organisational' reason for an adverse event happening, e.g. pre-start-up machinery checks are not carried out by supervisors; the hazard has not been adequately considered via a suitable and sufficient risk assessment; production pressures are too great etc.

Examples of health and safety related incidents;

- A member of staff trips on an uneven surface
- A member of staff slips on a spillage of water
- A service user threatens a social worker (victim) with a knife
- A patient strikes out and hits a nurse (victim)
- A member of staff uses a faulty medical device potentially harming the patient
- A visitor is verbally abusive to a receptionist (victim)
- A member of staff sustains a sharps injury
- A member of staff sustains an injury from the use of an item of equipment
- A visitor falls in the car park not necessarily sustaining an injury

All incidents involving the delivery of clinical or social care are treated as a clinical incident:

- Service user self-harm incidents are considered a clinical incident
- Service user absconsion is considered a security incident
- Service user falls as a result of an underlying medical condition are considered a clinical incident (unless there was a failing in a health and safety system, i.e. equipment and/or local environment, etc.)

4 Why investigate?

Learning the lessons from what is uncovered in an investigation is at the heart of preventing incidents from re-occurring. By carrying out an investigation, the Trust is able to achieve a deeper understanding of the risks associated with its activities and improve its overall management of risk. In turn, investigations help to:

- prevent injuries and ill health
- save lives
- save money
- comply with legislation
- demonstrate a commitment to health and safety and
- promote positive workplace moral

5 Health and Safety Risk Assessment and Investigation

The completion of health and safety risk assessments is the cornerstone to successfully managing and controlling health and safety risks. Not only is it a statutory duty¹ to complete a risk assessment, it is a requirement to keep it under review, and where changes are made these are implemented and communicated to staff.

Often the findings of the incident investigation will form the basis of an action plan to prevent the incident from reoccurring and for improving the overall management of risk. The findings may also point to areas of the risk assessment that need to be reviewed.

The link between investigation and risk assessment(s) is a legal one so in the event of any incident taking place (irrespective of grade) this should automatically trigger the risk assessment being reviewed.

Risk Assessments are often used to support the Trust in defending employer liability claims and investigation from enforcement and regulatory bodies. As a Risk Assessment is a statutory requirement, it is discoverable in legal proceedings and Freedom of Information requests. It is therefore important that risk assessments are accurate and up to date.

Training is also an integral part of health and safety. All training records at the time of the incident should be reviewed and where training is absent or out of date, actions should be taken to correct those gaps.

6 Process for Investigation and Reporting

6.1 Which events should be investigated?

Having been notified of an adverse event and been given basic information on what happened, you must decide whether it should be investigated and if so, in what depth.

It is the potential consequences and the likelihood of the adverse event recurring that should determine the level of investigation, not simply the injury or ill health suffered on this occasion.

For example:

- Is the harm likely to be serious?
- Is this likely to happen often?

Similarly, the causes of a near miss can have great potential for causing injury and ill health. When making your decision, you must also consider the potential for learning lessons. For example if you have had a number of similar adverse events, it may be worth investigating, even if each single event is not worth investigating in isolation. It is best practice to investigate all adverse events which may affect the public.

¹ Management of Health and Safety at Work Regulations (NI) 2000
SGN-122 Health and Safety Incident Investigation (ver. 1.02)

6.2 When should it start?

The urgency of an investigation will depend on the magnitude and immediacy of the risk involved (e.g. a major accident involving an everyday job will need to be investigated quickly).

In general, adverse events should be investigated and analysed as soon as possible. This is not simply good practice; it is common sense – memory is best and motivation greatest immediately after an adverse event.

6.3 What makes a good investigation?

It is only by carrying out investigations which identify root causes that the Trust can learn from past failures and prevent future failures.

Dealing with the immediate causes of an adverse event may provide a short-term fix, but, in time, the underlying/root causes that were not addressed will allow conditions to develop where further adverse events are likely, possibly with more serious consequences. It is essential that the immediate, underlying causes and root causes are all identified and remedied.

Investigations should be conducted with accident prevention in mind, not placing blame. Attempting to apportion blame before the investigation has started is counterproductive, because people become defensive and uncooperative. Only after the investigation has been completed is it appropriate to consider whether any individuals acted inappropriately.

Investigations that conclude that operator error was the sole cause are rarely acceptable. Underpinning the 'human error' there will be a number of underlying causes that created the environment in which human errors were inevitable, e.g. inadequate training and supervision, poor equipment design, lack of management commitment, poor attitude to health and safety.

The objective is to establish not only how the adverse event happened, but more importantly, what allowed it to happen.

6.4 Information gathering:

- explores all reasonable lines of enquiry;
- is timely;
- is structured, setting out clearly what is known, what is not known and records the investigative process.

6.5 Analysis:

- is objective and unbiased;
- identifies the sequence of events and conditions that led up to the adverse event;
- identifies the immediate causes;
- identifies underlying causes, i.e. actions in the past that have allowed or caused undetected unsafe conditions/practices;
- identifies root causes, (i.e. supervision, monitoring, training, resources allocated to health and safety etc.).

6.6 Risk control measures:

- identify the risk control measures which were missing, inadequate or unused;
- compare conditions/practices as they were with that required by current legal requirements, codes of practice and guidance;
- identify additional measures needed to address the immediate, underlying and root causes;
- provide meaningful recommendations which can be implemented. Vague recommendations such as ‘employee must take care’ show that the investigation has not delved deep enough in search of the root causes.

6.7 Action plan and implementation:

- provide an action plan with SMART objectives (Specific, Measurable, Agreed, Realistic and Time scaled);
- ensure that the action plan deals effectively not only with the immediate and underlying causes but also the root causes;
- include lessons that may be applied to prevent other adverse events, e.g. assessments of skill and training in competencies that may be needed for other areas of the organisation;
- provide feedback to all parties involved to ensure the findings and recommendations are correct, address the issues and are realistic;
- should be fed back into a review of the risk assessment.
- communicate the results of the investigation and the action plan to everyone who needs to know;
- include arrangements to ensure the action plan is implemented and progress monitored.

6.8 The decision to investigate

The table below will assist in determining the level of investigation which is appropriate for the adverse event. Remember you must consider the reasonably foreseeably worst potential consequences of the adverse event (e.g. an electric fault may not have caused any injuries, but it may have had the potential to cause major or fatal injuries).

Likelihood of recurrence	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (Expected to occur daily)	●	●	●	●	●
Likely (Expected to occur weekly)	●	●	●	●	●
Possible (Expected to occur monthly)	●	●	●	●	●
Unlikely (Expected to occur annually)	●	●	●	●	●
Rare (NOT expected to occur for years)	●	●	●	●	●

6.9 Investigating Green/Low Risk incidents

In a green /Low Risk incident investigation, the relevant reviewer/handler/ team will look into the circumstances of the event and try to learn any lessons which will prevent future occurrences.

All actions taken and lessons learnt should be recorded in the Investigation Section of Datix.

6.10 Investigating Yellow/Medium Risk and Amber/High Risk incidents

The Health and Safety Department must be made aware of any incident in this category and a Local Level Investigation Form must be completed and returned to the H&S Dept.

Incidents in this category should also be screened via the Directorates Incident screening procedures to determine if they meet the criteria of a Serious Adverse Incident (SAI). In the case of being an SAI, a member of the Health and Safety department should be assigned to the review team.

The investigation should commence as soon as possible completed within twelve weeks of the incident taking place. The action plan and learning points must be recorded on Datix Web.

The Head of Service and Assistant Director are responsible for the implementation of any actions and learning following the investigation. Action plans and implementation of learning should be overseen at the Directorate Governance forum by the Director.

When undertaking a review the following questions should be answered:-

- what happened?
- did what happened vary from what should have or was expected to happen?
- if so, why?
- what is the learning from this incident?

A check list detailing topics to be considered when investigating a health and safety incident can be found at [Appendix 01](#).

6.11 Investigating Red/ Extreme Risk incidents

The Health and Safety Department must be made aware of any incident in this category and a Local Level Investigation Form must be completed and returned to the H&S Dept.

Incidents in this category should also be screened through the directorate's incident screening procedures to determine if they meet the criteria of a SAI. In the case of being an SAI, a member of the Health and Safety department should be assigned to the review team.

A full investigation will be conducted and will be complete within the SAI guidelines (SAI timescales level 1 investigation is 6 weeks level 2/3 is 12 weeks). It is the responsibility of the Head of Service to inform the Assistant Director immediately. Regular updates will be provided to the lead director for Health and Safety and the Director. The investigation report and Action Plan will be forwarded to the Director for approval. The Action Plan will be implemented by the Assistant Director and overseen by the Director.

The lead for the investigation will ensure that Managers/staff are kept up to date with the progress of the action plan and any lessons learnt.

The completed investigation report should be presented to the SMT for consideration where there are recommendations for wider Organisational learning.

6.12 RIDDOR

Where the incident is deemed RIDDOR reportable, this will also trigger the need to complete a Local Level Investigation Form. This will be issued from the Health & Safety Department to be completion and returned by the incident Handler.

6.13 Local Level Investigation Form

The form is available at [Appendix 02](#).

This form must be completed for Yellow, Amber and Red Risks. When complete the form must be returned with supporting evidence (e.g. risk assessments, training records, safe systems of work) to the Health & Safety Department. Once verified by Health & Safety Department this information will be scanned and attached to the Datix record. These documents are used by the Trust to support potential Employers Liability Claims and/or other investigations and should therefore be accurate and the most up to date.

6.14 Incident Witness Statement Form

The form is available at [Appendix 03](#).

This form should be completed for Yellow, Amber and Red Risks. Those involved or have knowledge of the incident should be invited to complete an Incident Witness Statement form.

An incident witness statement is a factual synopsis of the alleged incident. A statement should provide a factual account of the individual staff member's involvement in an incident, to include their direct knowledge of the involvement of others and any other information that they felt may be relevant

6.15 Final Approval / Closing of an incident

The incident Handler or reviewing team must ensure that all actions arising from the investigation are complete; for example training, risk assessment review and that staff have received feedback before Finally Approval of the incident. Further guidance is available in [Appendix 04](#).

7 Key Contacts:

An up-to-date Contacts List is available on the Health and Safety SharePoint site – search for "[Health and Safety](#)" and select [Contacts](#)

Direct Dial Number	Extension	Office
028 375 64156	64156	H&S Admin' Office

Appendix 01

Investigation Checklist

Investigation Check List

This list is to be used as a prompt to consider certain areas and or item to be gathered as evidence.

This is not meant to be an exhaustive list.

All incident

- Incident report form completed – Datix
- Incident witness statements taken (Appendix 03)
- Review of similar incidents in the same area
- Current/relevant Risk Assessments
- Relevant training records
- Relevant Policies
- Relevant internal memos/communication
- Details of Personal Protection Equipment being worn

Slips/Trips/Falls

- All maintenance and inspection records in relation to the accident location
- Relevant written instructions in relation to the cleaning and inspection system
- Records of any relevant complaints in relation to the condition of the floor
- Records of any relevant complaints in relation to the cleaning of the floor
- Maintenance, inspection or repair records in relation to any equipment which was involved in the incident
- Details of wet floor signs in place at the time of the incident, including their precise location and who placed them
- Sketch/photographs of the warning signs
- Details of the footwear worn at the time of the incident, note if special footwear is required
- Details of contractors undertaking work in the area at the time

Manual Handling

- Manual handling training records
- Written instructions given in respect of the lifting task
- A copy of the patient care plan
- Details of mechanical aids or hoists available at the time of the incident
- Documentation in respect of Manual Handling Risk Assessment – service records and statutory inspections
- Weight of the item being moved or lifted

Incidents involving a contractor

- Tender documents
- Contract between Trust and Contractor

- Snagging lists
- Details of Contractor's insurance (if known)

Incidents involving equipment

- Asset id of the equipment
- Serial number of the equipment
- Maintenance reports
- Statutory inspection reports

Manufacturer's instructions

- Training records/material
- PPE required when using the equipment

Road Traffic Incident

- Copy of motor insurance claim form

Burns/scalds

- Details of PPE require
- Details if PPE worn
- Details of First Aid treatment

Sharps

- Details of device used – make, product number, lot number

Assault

- Relevant training given to victim
- Records of prior violence relating to the assailant
- Patient's risk assessment or similar
- Details of other available staff able to assist
- Details of relevant personal alarms/panic buttons in use

Slips/Falls on Ice

- Salting/gritting schedule for relevant area

Asbestos

- Copy of the relevant Register
- Copy of the relevant asbestos survey
- Records of accessing the Asbestos Register

Appendix 02

Local Level Investigation Form

LOCAL LEVEL INVESTIGATION FORM

If an incident occurs that is graded as green (insignificant harm or very low risk) or yellow (low risk), it should be investigated at local level by the ward/department/facility manager or frontline staff. This form has been developed to record the findings of your investigation. Investigation can be delegated but the ward/department/facility manager has overall responsibility for the outcome and that appropriate remedial action has been taken.

Date of Incident:		Datix ref:					
Name of ward/department/facility manager:							
Name of person investigating the incident:							
Job role:			Department:				
Email Address:							
Contact Number:			Date of investigation:				
Grading as per incident form:	Very Low (Green)		Low (Yellow)		Moderate (Amber)		High (Red)

Investigation	
Safety Precautions/Control measures current in place for this activity <i>(please tick all that apply)</i>	
Risk Assessment <input type="checkbox"/> Training/Instruction <input type="checkbox"/> Supervision <input type="checkbox"/>	Procedure of safe system of work <input type="checkbox"/> PPE <input type="checkbox"/>
What do you think contributed to the incident? <i>(eg premises defect, faulty equipment, weather conditions (describe), unsafe work methods, inadequate training) Please retain any equipment involved for inspection</i>	
What action requires/has been taken to prevent a recurrence? <i>(eg revised maintenance regime, training, review risk assessment, review system of work/standard operating procedures)</i>	
Signature of ward/department/facility manager:	Date:

Appendix 03

Incident Witness Statement

Incident Witness Statement

Frequently Asked Questions

What is an Incident Witness Statement

- An incident witness statement is a factual synopsis of the alleged incident.
- A statement should provide a factual account of the individual staff member's involvement in an incident, to include their direct knowledge of the involvement of others and any other information that they feel may be relevant.
- Why have I been asked to provide an Incident Witness Statement?
- The Trust requests a statement from all involved staff in order to gather information to assist with the investigation of the incident and possibly to defend a claim being made against the Trust.
- Sometimes the Trust will request a statement from Managers, Head of Service, Directors etc. even though they are not directly involved in the incident. This can provide an overview of the local implementation of the health and safety management system

How will my incident witness statement be used?

- Your statement will be attached to the incident and will be used to build a clear picture of the events that took place leading up to, during and after the incident. This will allow the Trust to investigate the incident and may form part of any legal proceedings.

If I provide an Incident Witness Statement will I have to attend court?

- Once the Trust's investigation of the incident is complete the incident will be closed. If a civil claim or criminal prosecution is taken against the Trust in relation to an incident any evidence gathered will be requested by the Trust's legal team. The Trust will receive legal advice in relation to the strengths and weaknesses of the Trust's defence and recommendations regarding the progression or settlement of the claim.
- If the Trust chooses to defend a claim, then the case will be listed at Court and the Trust legal team will confirm the witnesses that are required to attend Court. Therefore if you have provided a statement you may be called to give evidence at Court.
- If you are required to give evidence at Court, you will be notified by the Litigation Department and invited to attend consultations with the Trust's legal advisers and other involved staff to discuss the case, review your statement and ask any questions you may have in relation to the case and the court process.

Dos and Don'ts

Do

- Record the; name, job title, service area, date and time of the incident, Datix reference (if known)
- If more than one sheet is use, number and sign all the sheets
- Write clearly and well-spaced
- Keep the statement simple. Record – actions, dates, times, etc. as clearly as possible.
- Only record what you remember.
- If you are unsure of certain aspects of the incident or situation then state this
- Place the events in the order that the happened
- If referring to individuals; state their full names and job titles
- Double check your statement before signing it
- If you require assistance in recording your statement, you should contact your line manager or your union representative
- Keep a copy of your signed statement

Do Not

- Do not file incident witness statements in patient/client records
- Avoid abbreviations or jargon
- Avoid copying verbatim form other notes or records – the statement should read as a narrative

Health and Safety Incident Witness Statement

(Use blocked capitals)

Staff Name:

Job Title:

Employer:

Datix Reference:

I declare that this statement consisting of () pages, each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence at a preliminary enquiry or at the trial of any person, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Signature of
Witness:

Date of
Statement:

/ /

Page: of

Appendix 04

A Managers guide to Reviewing and Investigating Datix Incidents

Training - Corporate Mandatory Training modules:

This Clinical and Social Care Governance (CSCG) training is divided into three areas; Incident Management Awareness, Demonstration of reporting an Incident on Datix and Service User Feedback Awareness

- Incident Management Awareness
- Demonstration of reporting an Incident on Datix
- Service User Feedback Awareness

All SHSCT staff are expected to complete this training (this forms part of your Corporate Mandatory Training which must be completed by everyone, regardless of your role).

Direct link to training below;

[CSCG Training – Incident Management & Service User Feedback Awareness \(SHSCT/CSCG\)](#)

Other guidance;

[Safety Guidance Note: SGN-105 Reporting Incidents & Near Misses Using Datix](#)

The review process ensures that all parts of the incident form are completed correctly, and identifies what level of further investigation resulting management action/preventative measures need to be undertaken.

To review and investigate incidents, a separate level 2 form is used. This form is also referred to as the Datix Incident Review/Approval Form (IR2). IR2 form can only be used by logged in application users.

The review process will typically begin with the identified manager or handler receiving an automated email notification informing them that a new incident has been submitted. It is the responsibility of the manager or handler to log into the Datix application, and review and complete the IR2 form, to:

- Ensure all parts of the form are completed correctly. As a manager/handler with access to the IR2 form, you may amend incidents if there are errors or inadequacies, for example, the description of the incident is factually incorrect, or does not provide adequate information, names of staff have been included in free text fields, wrong incident classification has been applied and so on. Typically, any material amendments, such as description of incident needs to be discussed and agreed with the incident reporter. When editing the incidents, make sure to follow your organisation’s policy.
- Complete or update the severity and risk grading matrix.
- Identify the root cause of the incident and remedial actions to prevent similar incidents from occurring.
- Initiate further investigation where appropriate.

Datix application has an audit trail function which identifies amendments made, when and by whom. You can also view the original IR1 submission data to see the changes.

About the Incidents Dashboard

The **Incidents Dashboard** contains all the tools necessary to report and review an incident, and produce statistical and listing reports.



Left-handed Navigation Menu.

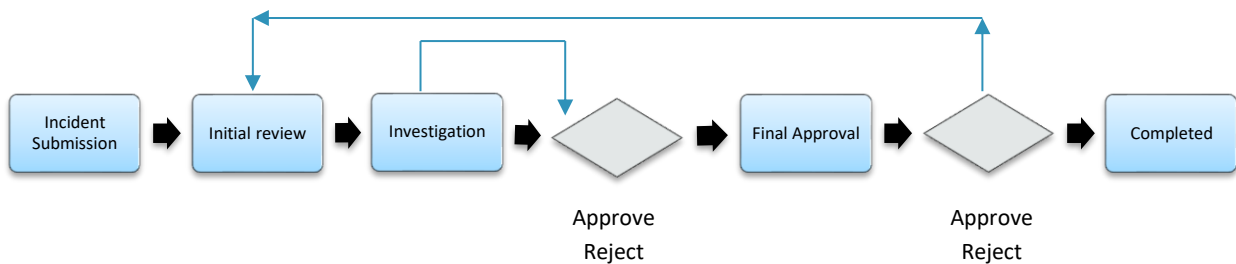
- **My Reports.** Run saved custom reports and packaged reports.

- **Design a Report.** Create custom reports.
- **New Search.** Search for incident records.
- **Saved Queries.** Open searches saved as queries for re-use.
- **Help.** Access additional support with the application.

Workflow Review Statuses. The workflow features various holding areas, or statuses. Records sit in each of the holding areas until they are pushed into the next area.

Managing Incident Review Workflow

The incident workflow is designed to take incident records through predefined stages in an incident management process.



Once submitted, incident records go through an initial review process and investigation before being passed on to final approval. Having received final approval, the incident records remain in the application. Authorised application users can continue to access these records and use them to support new investigations and safety learning.

Statuses		
■ In the holding area, awaiting review	1140 records	940 Overdue
■ Being reviewed	4177 records	3824 Overdue
■ Finally approved	195395 records	
■ Rejected	938 records	

In Datix, there are several predefined workflows that can be used to track the status of an incident record. The exact workflow will depend on your organisation's requirements. After each stage of the

workflow process is completed, the incident record must be manually updated to indicate the new status. This mechanism is used to move the record through the workflow to a status of final approval or rejection. If records are not acknowledged within the number of days determined by the Trust, they become overdue and will be displayed as overdue in the holding area. Clicking the record number in a holding area allows you to quickly access the listing page with the corresponding records.

To Assign an Incident Handler

Use this procedure to assign a record to a handler.

1. On the top application menu, click **Incidents**.
2. Open an incident record.
3. Click the **Handler** drop-down list and select the name of the record handler.

Management of Incident

Handler

Enter the manager who is handling the review of the incident

Additional/dual handler

If it is practice within your team for two managers to review incidents together use this field to record the second handler

Escalate

You can use this field to note the incident has been escalated to a more senior manager within your Service/Division- select the manager from this list and send an email via the Communication section to notify the manager the incident has been escalated to them.

Approval status (update at each save)

Before navigating away from an incident update the approval status in this field to reflect which stage of the review process has been reached

Date of final approval (closed date) (dd/MM/yyyy)

5. Click **Save**. An email is sent to the new handler.

To Assign an Incident Investigator

Use this procedure to assign a record to an investigator.

1. On the top application menu, click **Incidents**.
2. Open an incident record.
3. Click **Investigation** in the left-hand navigation menu.
4. Click the **Investigator** drop-down list and select the name of the record investigator.

Investigation

Investigator

Date started (dd/MM/yyyy)

Actual Impact/Harm

This has been populated by the reporter. To be quality assured by the investigating manager.

Risk grading

Click here

Consequence:

Likelihood of recurrence:

Grade:

When the incident has a Severity (actual impact/harm, grading of insignificant to moderate, you need to plot on the matrix opposite the Potential impact/harm. Deciding what are the chances of the incident happening again under similar circumstances. (Likelihood) and multiply that by the potential impact if it were to reoccur (consequence) The overall risk grading for the event will be determined by plotting; consequence multiplied by likelihood = risk rating. Refer to impact table here.

5. Click **Save > Back to Record**. An email is sent to the new investigator.

The **Communication** section on IR2 form is used to send emails directly from Datix

This saves you time as you don't have to switch between different applications. Emails which are sent from Datix will be logged directly in the record in as the message history.

1. **Recipients.** Area where you add the users who will receive your email.
2. **Message.** Area where you add the contents of your email. This email will include some default text, which you can edit as required.
3. **Message History.** Area where previous messages can be viewed.

To Add Documents to an Incident Record

Use this procedure to add documents to an incident record.

1. On the top application menu, click **Incidents**.
2. Open an incident record.
3. Click **Documents** in the left-hand navigation menu.

Click **Attach A New Document**.

5. Select a format from the **Link As** drop-down list.
6. Type a description of the document in the **Description** field.
7. Click **Choose File** from the **Attach This File** field and navigate to the file on your computer.

8. Select the file and click **Open**.
9. Click **Save**. The file is now attached to the record you are working with. If you see an error message and cannot upload a document, contact your administrator for further guidance.

To Update the Approval Status of an Incident Record

Use this procedure to update the status of an incident record following review.

1. On the top application menu, click **Incidents**.
2. Open an unapproved incident record.
3. Click **Name and Reference** in the left-hand navigation menu.
4. Click the **Approval Status (update at each save)** drop-down list and select the new status.

The screenshot shows a web form titled "Management of Incident". It contains several fields: "Handler", "Additional/dual handler", "Escalate", "Approval status (update at each save)", and "Date of final approval (closed date) (dd/MM/yyyy)". The "Approval status" dropdown menu is open, showing four options: "In the holding area, awaiting review", "Being reviewed", "Finally approved", and "Rejected". A red arrow points to the dropdown menu. At the bottom right of the form, there are "Search" and "Cancel" buttons.

5. Click **Save > Back to Record**.

Summary of Manager's role of a Datix Incident

The line manager will review the Datix (IR1). Managers will be responsible for completing and recording the incident investigation within 31 days of receipt and taking all necessary steps to escalate and mitigate risk associated with the incident or its aftermath. The line manager should move the Datix from 'In the holding area, awaiting review' Approval Status to 'Being reviewed' upon receipt and having read through it.

Datix Incident Investigation should be completed by the appointed investigator. The investigators will review the grade of all incidents as soon as possible after the event. The grading will reflect the actual impact of the incident and the risk to the organisation (likelihood x outcome). The level of local investigation and analysis will be dependent upon this grading and the potential for learning.

Incidents will be closed off in Datix once there is no further benefit in them being kept open. This will usually be when the investigation has been completed, the lessons or improvement measures identified and the action plan to address the lessons and improvements agreed.