

Deck 1

The Datix Report

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Introduction

You are following a **Serious Incident Investigation**.

As you progress, you will find out information, which can be added to the timeline in front of you. At the end of each deck you will be invited to share your thoughts, feelings and make notes of any questions in the **Activity Booklet**.

 **Draw the next card**

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Introduction

An investigator is first introduced to the events of a Serious Incident by reading something called a '**Datix Report**'.

This is a digital report, completed by a member of staff who was present during the incident. It contains a brief overview of what happened and who was involved.

 **Draw the next card**

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Introduction

First, let's see who was present during the incident. **Read each of the following 5 character cards and place them at the start of the timeline on the left side of the board.**

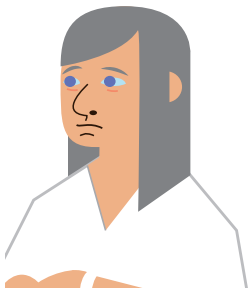
The order you place them is completely up to you. There is no wrong order.

  **Draw the next card**

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Patient



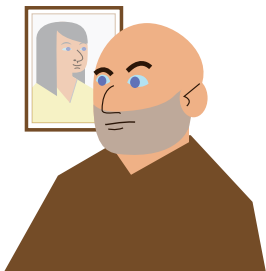
Admitted to hospital with a urinary tract infection (UTI) which is causing her a lot of pain.

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Patient's Son



He brought his elderly mother to hospital after her condition deteriorated.

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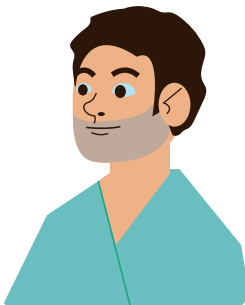
Senior nurse on the elderly acute ward. She completed the **Datix Report**.

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Nurse

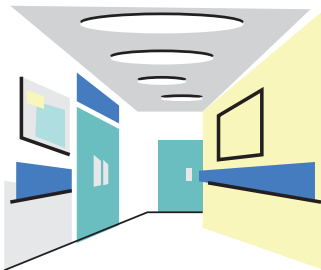


Assigned to the patient
during the night shift.

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The Hospital Trust



This character card covers the **Trust** and **ward** where the incident took place as well as **any other person** who might have been involved.

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Datix Report

The following cards contain all the information from the **Datix Report**.

We've divided it into chunks so you can create a timeline of the events. As you place cards think about **when they occur** and **who was** involved.
eg. If a card focuses on a certain character, you can place it on their timeline.

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The Datix Report

The events described in this report took place on the **Elderly Acute Ward**. The incident itself occurred **during a night shift**, between the hours of 22:30 and 23:00.

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At 18:00 the **patient's son** brought his mother to hospital and was recorded as next of kin, supplying his contact information.

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The **patient** was admitted to the **Elderly Acute Ward** suffering from a UTI infection.

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On the evening of her admission the **patient** was showing signs of distress. The **consultant** in charge of her prescribed a low dose of morphine to help make her more comfortable.

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The **nurse** collected the morphine from the Pharmacy and administered it to the **patient**.

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Whilst recording the morphine in the **patient's** notes the **nurse** realised that the dose he had given was slightly higher than the one prescribed in the notes. At this point the patient was at no immediate risk.

He alerted the **matron** and they ensured the **patient** was comfortable, agreeing to monitor her.

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Later that night, while **the matron and nurse** were both assisting other patients on the ward, they heard a loud noise from the direction of the **patient's** bed and quickly attended her.

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They found the patient on the floor, having fallen out of bed.

The **matron** and **nurse** got her back into bed. It was immediately clear that she was in a lot of pain.

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The **matron** contacted the on-call consultant who had already left for the night. The **consultant** examined the **patient** and later an x-ray confirmed a **serious hip fracture** to be the source of her pain.

The **patient** was prioritised for surgery.

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The **consultant** contacted the **patient's son** and informed him of his mother's fall and injury.

In accordance with the duty of candour it was also explained that she had been accidentally administered a slightly higher dose of morphine than she required.

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The **matron** contacted the 'Fall Coordinator' at the hospital and submitted an electronic **Datix Report** containing a summary of the incident.

(The Report contains the information on these blue cards).

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On reviewing the Datix Report, **the review committee agreed that the incident met the criteria for a serious incident investigation.**

Staff were contacted who could potentially **investigate** this incident.

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Introduction

The information you have just arranged onto the timeline represents the level of detail an investigator would have on day one.

Any further information must be found out during the process of investigation.

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Before you continue

Are you happy with the order of events on your timeline?

Once you are happy please complete **page 2 of the Activity Booklet**. This will capture your thoughts about the incident so far.



Go to booklet - page 2