

Guidance Notes

How do I...

...access IRMIS?

- Go to <http://medusav2.wales.nhs.uk> and log into the site using your IRMIS username and password.
- You will then be taken to the Medusa Welcome page.
- Using the menu bar on the left hand side of the screen, go to IRMIS.

...enter an incident (near miss/error)?

- Using the menu bar on the left hand side of the screen, go to **Incident entry**.
- First select whether this is an incident related to the [enquiry answering process](#) or related to a [publication/pro-active work](#).

...amend, delete or print an incident?

...produce reports for my MI centre?

...access IRMIS quarterly reports from UKMi?

...access IRMIS annual reports from UKMi?

...obtain a username and password?

References

Incidents related to the Enquiry Answering Process

Title of enquiry

- Enter the relevant title from in-house enquiry answering database, e.g. MiDatabank.
- This is to ensure that the incident and enquiry may be easily matched.
- **To maintain anonymity the enquiry title will not be included in any UKMi reports.**

Enquirer status

- Select the enquirer status from the drop down menu (N.B. This is the list used for national statistics).
- If the enquirer does not appear on the list, select 'Other' and state their role in the box that appears to the right.

Enquiry number

- Enter the relevant number from enquiry answering database, e.g. MiDatabank.
- This is to ensure that the incident and enquiry may be easily matched.
- **To maintain anonymity the enquiry number will not be included in any UKMi reports.**

Summary of incident and enquiry

- There is no limit on the amount of text that can be added.
- Include all relevant clinical details as well as the exact details of the incident being reported.
- Also include any other pertinent details not covered elsewhere.
- **DO NOT** use opinions, **USE** facts.
- **DO NOT** mention names, **USE** job titles or the words 'colleague' or 'patient' to define people involved/affected.

Enquiry category

- Select the category or categories that best describe the nature of the enquiry, using the check boxes.
- You may select one or more categories (N.B. This is the list used for national statistics).

Was the enquiry about the care of a specific patient?

- Select the option that best answers this question.
- If you are not sure, then please select 'Don't know'.

Incident category

- Select **Near miss** or **Error** from the drop down menu.
- Definitions are as follows:

Near miss

When wrong, misleading or incomplete information or advice was detected in a completed enquiry before the response was given to the enquirer.

*NB. This **should not** include anything picked up whilst processing the enquiry. If the incident is identified once an answer has been formulated, but before the answer was given, this should be classified as a near miss.*

Error

When wrong, misleading or incomplete information or advice is given to the enquirer.

NB. These definitions may differ slightly from the NPSA definitions¹

[Return to Contents Page](#)

Date of incident

- Enter the date the incident occurred (not when it was detected).
- Please use the format dd/mm/yy.

Incident type

- Select from the drop down menu, the option that best describes the incident that occurred.

'Data' is defined as factual information that has not been interpreted.

'Advice' is where we have interpreted the factual information and/or provided an opinion.

Incident point

- Use the drop down menu to select the point at which the incident was most significant.

| Option | The incident was most significant when the... |
|-------------------------|---|
| Receiver of enquiry | enquiry was being taken in. |
| Processor of enquiry | enquiry was being researched. |
| Checker of enquiry | enquiry was being checked. |
| Giver of enquiry answer | answer to the enquiry was being given. |

Click on the **NEXT** button when you have completed the fields above, click this button to take you to the next page (you can return to this page if necessary later on).

Detected by

- Select from the drop down menu, the option that describes who detected the incident. This will be either the enquirer or somebody else.
- If the enquirer detected the incident select enquirer from the list.
- If somebody other than the enquirer detected the incident, select his or her status from the drop down list.

Note: If a member of MI staff detected the incident, ensure you select the correct option.

| Option | Detected by a member of staff... |
|-------------------------|---|
| MI staff – audit | during an audit of enquiries. |
| MI staff – other | not directly involved in the enquiry, e.g. peer review, colleague overhears conversation. |
| MI staff – processor | who was processing the enquiry. |
| MI staff – checker | who was checking the enquiry. |
| MI staff – answer giver | who was giving out the answer to the enquirer. |
| Other (please specify) | who was not the enquirer or MI staff |

Enquiry received in MI by

- Select from the drop down menu, who in MI received the enquiry (i.e. who took in the enquiry and obtained background information etc.).

Frequency

- Select from the drop down menu how often the individual normally receives MI enquiries.

Enquiry Processed by

- Select from the drop down menu, who in MI processed the enquiry (i.e. who researched and gathered the information to answer the enquiry).

Frequency

- Select from the drop down menu how often the individual normally researches and gathers the information to answer an enquiry.

Enquiry Checked by

- Select from the drop down menu, who in MI checked the enquiry before the answer was given to the enquirer.

Frequency

- Select from the drop down menu how often the individual normally checks an enquiry before the answer is given to an enquirer.

Enquiry Answer given by

- Select from the drop down menu, who in MI gave the answer to the enquirer.

Frequency

- Select from the drop down menu how often the individual normally gives an answer to an enquirer.

Incident cause(s)

- Select the check box or boxes that describe the reason(s) that the incident occurred.
- **One or more boxes may be selected.**

Click on the **NEXT** button when you have completed the fields above, click this button to take you to the next page (you can return to this page if necessary later on).

Potential risk to patient(s)/organisation

(Hold your mouse over the term for the definition but also listed below)

- Select from the drop down menu, the potential risk to the patient.
- This should be an estimate of the risk to the patient(s) as a result of the incident, which is being reported.
- The estimate should be based on the specific clinical circumstances, factual information and clinical judgement/interpretation.

| Potential Risk | Examples |
|---------------------|--|
| Negligible | Minimal injury requiring no/minimal intervention or treatment, or informal complaint/inquiry, or potential for public concern. |
| Minor | Minor injury or illness requiring minor intervention, or formal complaint, or local media coverage - short-term reduction in public confidence. |
| Moderate | Moderate injury requiring professional intervention, or formal complaint, or local media coverage – long-term reduction in public confidence. |
| Major | Major injury leading to al long-term incapacity/disability, or mismanagement of patient care with long-term effects, or multiple complaints/independent review, or national media coverage with < 3 days service well below reasonable public expectation. |
| Catastrophic | Incident leading to death, or inquest/ombudsman inquiry, or national media coverage with > 3 days service well below reasonable public expectation, or total loss of public confidence. |

For further examples, see the [NPSA Risk Matrix for Managers](#) ³

Actual outcome to patient(s)/organisation

(Hold your mouse over the term for the definition)

- Select from the drop down menu, the actual outcome.
- This should be what actually happened to the patient as a result of the incident, which is being reported.
- For near misses, select the “Near miss” option from the drop down menu.
- See above for definitions.

Likelihood of recurring





(Hold your mouse over the term for the definition but also listed below)

| | |
|-----------------------|---|
| Rare | This will probably never happen/recur. |
| Unlikely | Do not expect it to happen/recur but it is possible it may do so. |
| Possible | Might happen or recur occasionally. |
| Likely | Will probably happen/recur but is not a persisting issue. |
| Almost certain | Will undoubtedly happen/recur, possibly frequently. |

Risk Score

- This is displayed once the actual outcome and likelihood of the incident recurring has been completed.

| Likelihood score | Likelihood | | | | |
|-----------------------|------------|----------|----------|--------|----------------|
| | 1 | 2 | 3 | 4 | 5 |
| | Rare | Unlikely | Possible | Likely | Almost certain |
| 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| 4 Major | 4 | 8 | 12 | 16 | 20 |
| 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| 2 Minor | 2 | 4 | 6 | 8 | 10 |
| 1 Negligible | 1 | 2 | 3 | 4 | 5 |

| | | |
|---|---------|---------------|
|  | 1 - 3 | Low risk |
|  | 4 - 6 | Moderate risk |
|  | 8 - 12 | High risk |
|  | 15 - 25 | Extreme risk |

Actions taken to prevent recurrence

- The field has no limit on the amount of text that can be added.
- Include any systems, procedures etc. that have been put in place as a direct result of the incident being reported, with the aim of preventing a recurrence.

Other comments

- This field is not mandatory.
- The field has no limit on the amount of text that can be added. Include any other relevant information not included elsewhere within the record.
- For example, any extenuating circumstances that may have contributed to the incident.

N.B. If you wish to amend any of the details on previous pages, you can do so by clicking on Back (see bottom of web page).

[Return to Contents Page](#)

Click on the **FINISH** button when you have completed the fields above. The site will then display an incident number (which may be recorded although recording the incident number is not essential) and the following message:

Thank you for submitting your incident about your enquiry entitled [enquiry title]. Your entry will be kept anonymous in any national UKMi reports. Summaries of the incidents are reported every quarter and can be used as a learning tool. These summaries will be circulated by UKMi to all centres for this purpose.

[Return to Contents Page](#)

Incidents related to Publication/Pro-active Work

Title of publication

- Enter the title of the publication so that the incident and publication may be easily matched.
- **To maintain anonymity the publication title will not be included in any national UKMi reports.**

Date of Publication

- Enter the date of the publication
- Please use the format dd/mm/yy.
- This is the date that the incident occurred.

Target audience of publication/pro-active work

- Select the relevant option.

Type of publication/pro-active

- Select the relevant option
- N.B. Examples of presentations include posters and teaching; examples of Medicines management/formulary work include bulletins, new drugs reviews, injectable medicine guidelines.

Method of dissemination of publication/pro-active work

- Select the category or categories that best describe the method of dissemination using the check boxes.
- You may select one or more categories.

What is the estimated size of the audience?

- Select the estimated size of the target audience for the publication/pro-active work.

Summary of incident and publication

- There is no limit on the amount of text that can be added.
- Include all relevant details as well as the exact details of the incident being reported.
- Also include any other pertinent details not covered elsewhere.
- **DO NOT** use opinions, **USE** facts.
- **DO NOT** mention names, **USE** job titles or the words 'colleague' or 'patient' to define people involved/affected.

Click on the **NEXT** button when you have completed the fields above, click this button to take you to the next page (you can return to this page if necessary later on).

Incident category

- Select Near miss or Error from the drop down menu, where the following definitions apply:

Near miss

Any situation where wrong, misleading or incomplete information or advice is contained in a document but this was detected before the document was published and available to the intended audience.

*NB. This **should not** include anything picked up whilst processing the document. If the incident is identified while the document is being prepared, but before the document is published, this should be classified as a near miss.*

Error

Any situation where wrong, misleading or incomplete information or advice is contained in a document that is published and available to the intended audience.

NB. These definitions may differ slightly from the NPSA definitions¹

Date incident identified

- Enter the date the incident was identified, i.e. when it was detected.
- Please use the format dd/mm/yy.

Incident type

- Select from the drop down menu, the option that best describes the incident that occurred.

Data is defined as factual information that has not been interpreted.

Advice is where we have interpreted the factual information and/or provided an opinion.

Incident point

- Use the drop down menu to select the point at which the incident was most significant.

| Option | The incident was most significant when the publication was being... |
|---|---|
| Author of publication/pro-active work | written. |
| Checker of publication/pro-active work | checked. |
| Second checker of publication/pro-active work | second checked. |

Detected by

- Select from the drop down menu, the option that describes who detected the incident.
- This will be either a member of the MI team or someone who had read/used the publication/pro-active material.

Note: If a member of staff detected the incident, ensure you select the correct option.

| Option | Detected by a member of staff... |
|----------------|--|
| Author | who wrote the publication/pro-active work. |
| Checker | who checked the publication/pro-active work. |
| Second checker | who second checked the publication/pro-active work . |

Author

- Select from the drop down menu, who wrote the publication/pro-active work.

Frequency

- Select from the drop down menu how often the individual normally writes publications/pro-active work.

Publications/Pro-Active Work Checked by

- Select from the drop down menu, who checked the publication/pro-active work before it was disseminated.

Frequency

- Select from the drop down menu how often the individual normally checks a publication/pro-active work before it is disseminated.

Publications/Pro-Active Work Second Checked by

- Select from the drop down menu, who second checked the publication/pro-active work.

Frequency

- Select from the drop down menu how often the individual normally second checks publications/pro-active work.

Incident cause(s)

- Select the check box or boxes that describe the reason(s) that the incident occurred.
- One or more boxes may be selected.

Click on the **NEXT** button when you have completed the fields above, click this button to take you to the next page (you can return to this page if necessary later on).

Potential risk to patient(s)/organisation

(Hold your mouse over the term for the definition but also listed below)

- Select from the drop down menu, the potential risk to the patient.
- This should be an estimate of the risk to the patient(s) as a result of the incident, which is being reported.
- The estimate should be based on the specific clinical circumstances, factual information and clinical judgement/interpretation.

| Potential Risk | Examples |
|---------------------|---|
| Negligible | Minimal injury requiring no/minimal intervention or treatment, or informal complaint/inquiry, or potential for public concern. |
| Minor | Minor injury or illness requiring minor intervention, or formal complaint, or local media coverage - short-term reduction in public confidence. |
| Moderate | Moderate injury requiring professional intervention, or formal complaint, or local media coverage – long-term reduction in public confidence. |
| Major | Major injury leading to a long-term incapacity/disability, or mismanagement of patient care with long-term effects, or multiple complaints/independent review, or national media coverage with < 3 days service well below reasonable public expectation. |
| Catastrophic | Incident leading to death, or inquest/ombudsman inquiry, or national media coverage with > 3 days service well below reasonable public expectation, or total loss of public confidence. |

For further examples, see the [NPSA Risk Matrix for Managers](#) ³

Actual outcome to patient(s)/organisation

(Hold your mouse over the term for the definition)

- Select from the drop down menu, the actual outcome.
- This should be what actually happened to the patient as a result of the incident, which is being reported.
- For near misses, select the “Near miss” option from the drop down menu.
- See above for definitions.

Likelihood of recurring





(Hold your mouse over the term for the definition but also listed below)

| | |
|-----------------------|---|
| Rare | This will probably never happen/recur. |
| Unlikely | Do not expect it to happen/recur but it is possible it may do so. |
| Possible | Might happen or recur occasionally. |
| Likely | Will probably happen/recur but is not a persisting issue. |
| Almost certain | Will undoubtedly happen/recur, possibly frequently. |

Risk Score

This is displayed once the actual outcome and likelihood of the incident recurring has been completed.

| | Likelihood | | | | |
|-----------------------|------------|----------|----------|--------|----------------|
| Likelihood score | 1 | 2 | 3 | 4 | 5 |
| | Rare | Unlikely | Possible | Likely | Almost certain |
| 5 Catastrophic | 5 | 10 | 15 | 20 | 25 |
| 4 Major | 4 | 8 | 12 | 16 | 20 |
| 3 Moderate | 3 | 6 | 9 | 12 | 15 |
| 2 Minor | 2 | 4 | 6 | 8 | 10 |
| 1 Negligible | 1 | 2 | 3 | 4 | 5 |

| | | |
|---|---------|---------------|
|  | 1 - 3 | Low risk |
|  | 4 - 6 | Moderate risk |
|  | 8 - 12 | High risk |
|  | 15 - 25 | Extreme risk |

• Actions taken to prevent recurrence

- The field has no limit on the amount of text that can be added.
- Include any systems, procedures etc. that have been put in place as a direct result of the incident being reported, with the aim of preventing a recurrence.

Other Comments

- This field is not mandatory.
- The field has no limit on the amount of text that can be added. Include any other relevant information not included elsewhere within the record.
- For example, any extenuating circumstances that may have contributed to the incident.

N.B. If you wish to amend any of the details on previous pages, you can do so by clicking on Back (see bottom of web page).

[Return to Contents Page](#)

Click on the **FINISH** button when you have completed the fields above. The site will then display an incident number (which may be recorded although recording the incident number is not essential) and the following message:

Thank you for submitting your incident about your publication entitled [publication title]. Your entry will be kept anonymous in any national UKMi reports. Summaries of the incidents are reported every quarter and can be used as a learning tool. These summaries will be circulated by UKMi to all centres for this purpose.

How do I amend, delete or print an incident?

- Using the menu bar on the left hand side of the screen, go to Incident Selection.
- A table listing all the incidents entered onto IRMIS under the username and password used to log in will be displayed.
- Use the amend, delete or print link as required.

How do I produce reports for my MI centre?

Incident List Report

- Produces a summary of incidents from the chosen selection criteria in date order.

Incident Stats Report

- Produces a count of incidents for the chosen selection criteria.

Cause Stats Report

- Produces a count of incidents for the chosen selection criteria.

Category Stats Report

- Produces a count of incidents for the chosen selection criteria.

Incident Point Report

- Produces an incident count grouped by the Incident Point with totals based on chosen selection criteria.

Detected by Report

- Produces an incident count grouped by the Detected By field with totals based on chosen selection criteria.

How do I access IRMIS quarterly reports from UKMi?

- These are circulated by the regional MI centres to all MI centres. The summary is taken from these reports and made available on the UKMi website. To maintain anonymity the enquiry/publication title or enquiry number related to the reported incident will not be included in any national UKMi reports.

How do I access IRMIS annual reports from UKMi?

- These are made available on the UKMi website.

How do I obtain a username and password?

- User names and passwords may be obtained by contacting: simon.watkins@wales.nhs.uk

References

1. National Patient Safety Agency. [Seven steps to patient safety Step 4: promote reporting](#); 2004.
2. National Patient Safety Agency. [NRLS Service Dataset Acute/General Hospital](#); 2003/4 Release 1.2.0.
3. National Patient Safety Agency. [A risk matrix for risk managers](#); January 2008

[Return to Contents Page](#)