

Patient safety incident  
reports in the NHS

Learning from reporting

NATIONAL REPORTING  
AND LEARNING SYSTEM  
QUARTERLY DATA  
SUMMARY

ENGLAND

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## England at a glance

**276,340** incidents were reported in England between 1 July 2009 and 30 September 2009, representing a decrease of 25,029 incidents compared to the previous quarter (301,369 incidents in April to June 2009).

**73 per cent** of reported incidents occurred in **acute/general** hospitals.

**14 per cent** of reported incidents occurred in **mental health services**.

The number of incidents reported as occurring in **general practice** settings has continued to increase per quarter to 1,027 for April to June 2009.

The three top incident types were **patient accidents** (32 per cent of all incident reports), **treatment/procedure** (10 per cent) and **medication** (10 per cent).

**67 per cent** of incidents were reported as causing '**no harm**', while 26 per cent were reported as '**low harm**' and six per cent were reported as '**moderate harm**'.

**One per cent** of all incidents were reported as '**severe harm**'. The proportion of incidents reported to have resulted in death was small (less than one per cent).

**371** NHS organisations (95 per cent) in England reported at least once in the past quarter.

**3,875,241** incidents in total have now been reported in England to the Reporting and Learning System (RLS) since its inception.

*The overall trend in reporting is upwards. This suggests much greater awareness of patient safety and openness among staff. Healthcare organisations with a high rate of reporting are much more likely to have a strong commitment to patient safety and high safety standards.*

*Trends and patterns in the RLS data show that no healthcare organisation can be complacent about patient safety – errors can and do happen everywhere.*

### About the Reporting and Learning System

Ensuring patients are treated safely is the top priority for NHS staff. When incidents do happen, it is important they are reported so lessons are learned across the NHS to prevent the same incidents occurring elsewhere.

The Reporting and Learning System (RLS) aims to help the NHS improve the safety of patient care by making risks visible and driving national learning. Reports made to the RLS are analysed with expert clinical input to identify hazards, risks and opportunities to improve safety. In short, information from reported incidents helps the NHS understand why things go wrong and how to prevent them happening again.

A patient safety incident is any unintended or unexpected incident that could have or did lead to harm for a patient receiving NHS healthcare.

The RLS is the first national level patient safety incident reporting system of its kind in the world. It provides comprehensive coverage of healthcare settings (acute, ambulance, combined, learning disability, mental health and primary care organisations) and supports direct reporting from patients. For information on how the RLS works, go to: [www.nrls.npsa.nhs.uk/report-a-patient-safety-incident](http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident)

The first reports were submitted to the RLS in November 2003. By January 2005 all NHS organisations were linked to the national system and the flow of data to the RLS continues to increase.

All healthcare staff in England and Wales providing NHS-funded care can report patient safety incidents to the RLS.

Incident reporting typically involves staff recording information about events that led to unintended or potential harm to patients. Ninety-nine per cent of the incidents reported to the RLS come through the Local Risk Management Systems (LRMS) of NHS organisations. Electronic transfer of the incident reports means that incidents reported once serve both local and national needs.

Staff, patients and the public can also report directly to the National Reporting and Learning Service (NRLS), part of the National Patient Safety Agency (NPSA), through the website: [www.nrls.npsa.nhs.uk/report-a-patient-safety-incident](http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident)

For further information on the RLS, see the appendix on page 32.

### High reporting organisations

A commitment to reporting demonstrates a commitment to patients and their safety.

Consistently high reporting levels tend to be a mark of high reliability organisations. Research shows that organisations with high and consistent levels of incident reporting are more likely to demonstrate other features of a stronger safety culture, such as high NHS Litigation Authority ratings<sup>1</sup>.

For case examples of how NHS organisations are developing a culture of high reporting, see the joint NPSA and NHS Confederation briefing, June 2008: [www.nrls.npsa.nhs.uk/management](http://www.nrls.npsa.nhs.uk/management)

### Publication of Summary Organisation Patient Safety Incident Reports

In March 2009, the NPSA began publishing summary Organisation Patient Safety Incident Reports from each NHS trust or local health board in England and Wales.

The publication of these reports aims to encourage greater awareness of patient safety and to improve the quality of local and national reporting from all healthcare staff, as part of embedding strong patient safety standards in all NHS organisations.

The latest set of Patient Safety Incident Reports was published on 7 October 2009. For more information visit [www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports](http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports)

## About this report

This Quarterly Data Summary (QDS) summarises data reported to the RLS between 1 July 2009 to 30 September 2009. It offers an overview of risks to patient safety in NHS services in England.

Two sets of data and analysis are presented in this report:

- **Section 1** describes the level of reporting to the RLS by quarter and uses data based on the date that the report was received by the RLS<sup>‡</sup>. The data cover the period from when the RLS was first set up in October 2003 until the end of September 2009.
- **Section 2** contains an overview of patterns and trends in patient safety incident reports. It uses data based on the date that the patient safety incidents were reported as having occurred. The data covers the four quarters between July 2008 and June 2009.

Data presented in Section 1 should not be compared with data in Section 2 of this report, as they are not based on the same time period. Care should also be taken when comparing data with previous issues of the QDS reports, since the RLS is a dynamic reporting system and the number of incidents reported as having occurred in each quarter may vary to some extent in the different issues of the data summaries.

This quarter we also provide specific and actionable information (*Learning from reporting* from page 9) on 'Working together to improve the quality of data'.

This report shows data for England only, with the exception of the data used in the 'Learning from reporting' section. A separate report for Wales is available at: [www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries](http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries)

## How to use this report

The data presented in this report can be used to:

- compare data reported within local organisations against national trends;
- provide data for research;
- enable triangulation with other data sources.

A data workbook to accompany this QDS report is available on the NRLS website at: [www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries](http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries). As well as containing all the data underpinning the analysis in the QDS report (frequencies and per cent), the workbook provides charts showing trends in the data on a quarterly basis. The workbook shows the data for both England and Wales separately, as well as the combined figures. Notes to aid the accurate interpretation of RLS data are provided in the appendix on page 32 of this report.

NHS boards play a key role in ensuring the care given is safe and risks are reduced. Board members can identify gaps in their safety culture, and work to improve it, by answering seven key questions set out in the joint NPSA, NHS Confederation and Appointments Commission factsheets *Questions are the answer? Seven questions every board member should ask about patient safety*.

Download the factsheets from: [www.nrls.npsa.nhs.uk/management](http://www.nrls.npsa.nhs.uk/management)

<sup>‡</sup> The date the report was received by RLS is also referred to as 'date of submission'.

### How are we learning from serious incident reports?

Every year, around 10,000 patient safety incidents coded as death or severe harm to patients are reported by NHS organisations. Each of these incident reports is reviewed by expert clinical reviewers at the NPSA to identify opportunities for national learning. Free text within the incident report is used to better understand the patient story and its clinical significance. This helps identify the contributing factors leading to the incident and wider system failures. If further information about the incident or underlying safety issues is required, the NPSA contacts the reporting organisation.

Key reports are prioritised according to their importance for national learning and action, using robust criteria and decision-making processes. This happens at a weekly multidisciplinary meeting with a range of clinical inputs. Other potential safety issues are also considered from sources such as:

- coroners' data; and
- serious untoward incidents (SUIs).

Where needed, safety recommendations are developed with input from the NHS and experts, and disseminated to providers of NHS-funded care to raise awareness of risks and inform local priorities and action. These are issued as Rapid Response Reports (RRRs), i.e. one-page guidance with timelines for action. They are issued through the Central Alerting System (CAS) in England and directly to organisations in Wales.

Some of the topics currently being scoped include:

- ECT and anaesthetic techniques;
- contrast medium and the risks of renal failure;
- problems with weighing patients (working with the Medicines and Healthcare products Regulatory Agency (MHRA) and Department of Health Estates);
- portable suction failure in ambulances.

A full list of published RRRs can be found at: [www.nrls.npsa.nhs.uk/resources/type/alerts](http://www.nrls.npsa.nhs.uk/resources/type/alerts)

Below is an example of a patient safety topic currently being explored:

#### **Failure to track intentionally retained items (swabs/packs)**

Incident report from the Strategic Executive Information System (STEIS) regarding swabs intentionally left in the wound following an aortic aneurysm repair.

The patient had a number of subsequent surgical procedures and was also transferred to a different hospital where a swab was located in the wound that had not been documented.

The main theme identified from a review of incidents extracted from the RLS was poor documentation – retained swabs not recorded in the patients notes adequately.

Other issues identified included:

- swabs/packs/ribbon gauze cut;
- swabs/packs without raytec used;
- swabs/packs not removed when planned.

All incident reports received are important and those that do not lead to an RRR inform regular and thematic reviews. For example, the NPSA has recently carried out detailed analyses of incident data on chemotherapy incidents and risks to children. Further work is exploring some of the broader themes emerging from a review of serious incidents. Details can be found at [www.nrls.npsa.nhs.uk/resources/type/signals](http://www.nrls.npsa.nhs.uk/resources/type/signals)

For further, detailed information on how we review serious incidents and identify key areas for action, download *Acting on serious risks to patient safety* from [www.nrls.npsa.nhs.uk/management](http://www.nrls.npsa.nhs.uk/management)

If you would like to share your expertise or additional information on any of the issues currently being developed, please email [rrr@npsa.nhs.uk](mailto:rrr@npsa.nhs.uk)

## About serious incidents

### Focus on serious events – this quarter

- 1,017 incidents reported to the RLS as resulting in death and 2,441 incidents reported as resulting in severe harm in England and Wales were reviewed during the period 1 July to 30 September 2009. These 3,458 serious incidents were reviewed individually by clinical experts to identify safety issues with the potential for national learning.
- Between July and September 2009, 151 new incidents were scoped with potential for national learning, together with issues from other sources including SUIs, coroners' data and other.
- All 151 incidents were explored further, either through contact with the reporting trust, advice from topic experts, or searches of the RLS and, where appropriate, the findings were shared with other organisations who could act on them.
- One RRR was issued during this period; 'Oxygen safety in hospitals'.

RRRs are available to download from: [www.nrls.npsa.nhs.uk/resources/type/alerts/](http://www.nrls.npsa.nhs.uk/resources/type/alerts/)

#### **Oxygen safety in hospitals: RRR summary**

Oxygen is indicated in many critical conditions and can save lives by preventing severe hypoxaemia. However, there is a potential for serious harm and even death if it is not administered and managed appropriately.

Common issues include:

- failure to or wrongly prescribed oxygen;
- patients not monitored properly;
- problems with administration;
- faulty and/or missing equipment.

Following 281 reports of serious incidents involving inappropriate administration and management of oxygen, the NRLS issued the RRR 'Oxygen safety in hospitals' to minimise the risks of oxygen therapy.

Download the RRR at: [www.nrls.npsa.nhs.uk/resources/type/alerts](http://www.nrls.npsa.nhs.uk/resources/type/alerts)

# Working together to improve the quality of data

Improving the quality of data submitted to the RLS is critical to creating opportunities for national and local learning. More accurate data, particularly in reporting the degree of harm to the patient, means that the NPSA can be more effective in identifying critical risks and driving learning.

Improvements in the quality of data submitted will help the NPSA to be more effective in supporting local patient safety improvement activities by providing accurate, timely data. This, in turn, will allow the NPSA to help the NHS to understand why and how patient safety incidents (PSIs) happen, to learn from these incidents and take action to prevent the occurrence of future harm to patients.

The NPSA has worked closely with NHS organisations to develop clearly defined standards for reporting and these were first published in September 2009.

## What are the standards?

The standards provide guidance to NHS organisations about the reporting of PSIs and how to improve the quality of that data. The standards request that all NHS organisations should report their PSIs to the NPSA to allow analysis for national learning. These data are published quarterly (in the Quarterly Data Summary) for use both nationally and locally; they are used to inform themed reviews of incidents in particular clinical areas; and to produce feedback reports for individual NHS organisations to allow benchmarking.

Detailed analysis of the most serious incidents, and identification of the most important safety issues through trends, leads to the development of alerts such as Rapid Response Reports (RRR) issued via the Central Alerting System (CAS).

## What are the data quality standards?

Standard	Reason/significance
NHS organisations should submit all their reported PSIs to the RLS	This is vital for any NHS care-giving organisation and will exhibit a good local safety culture and sound risk management process.
Every NHS organisation should submit reported PSIs regularly to the RLS – regularly is described as at least monthly	A monthly upload to the RLS will ensure that timely information is received and highlight good local risk processes.
Every NHS organisation should ensure that PSIs reported to the RLS do not contain person identifiable information in free text fields.	It is paramount that person identifiable information is not sent to the NPSA by inclusion in the free text of reported incident data. Any information of this nature will show non-compliance with the Data Protection Act.
Every NHS organisation should ensure that the degree of harm recorded for each PSI describes the actual harm to the patient as a direct result of the PSI.	Many trusts are tempted to report a higher severity due to the potential harm that could have occurred to the patient by the incident. This negatively affects the accuracy of data that is reporting the actual harm that occurred to the patient. Organisations should ensure that only actual harm that occurred to the patient is reported to the RLS.
Every NHS organisation should report PSIs with an actual degree of harm of either severe (permanent harm) or death to the RLS within two working days of the incident occurring	This is vital to ensuring that the national picture of severe incidents and deaths related to patient safety is both accurate and timely. All severe incidents and deaths reported to the RLS are examined by clinical reviewers, therefore the more timely the reporting of these incidents the better.

## Learning from reporting

Implementation of these standards will result in further improvements in the quality of data submitted and help the NPSA to be more effective in supporting local patient safety improvement activities.

### Action points

NHS organisations are encouraged to develop an action plan to aid implementation of these standards. Regular audit of compliance with the standards should be part of this plan.

Organisations that are unable to implement these standards should seek further assistance from the NPSA.

For more information on using the standards please contact your designated RLS Improvement Lead or Patient Safety Manager. If you do not know who your contact is please email [support@npsa.nhs.uk](mailto:support@npsa.nhs.uk)

Download a copy of the standards from: [www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/improving-reporting/](http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/improving-reporting/)

Access Organisation Patient Safety Incident Reports at: [www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/](http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/)

# How many incidents are reported?

This is an overview of the volume and frequency of patient safety incidents reported to the RLS.

## How many reports and organisations reporting?

From October 2003, when the RLS was first set up, to September 2009, 3,875,241 incidents reports were received from organisations in England (see figure 1).

In the past quarter, 1 July 2009 to 30 September 2009, 276,340 incident reports were submitted. This is a decrease of 25,029 incidents compared to the previous quarter (301,369 incidents in April to June 2009).

Of the 389 NHS organisations in England<sup>†</sup>, 371 organisations (95 per cent) reported at least once between 1 July 2009 and 30 September 2009. Of the 389:

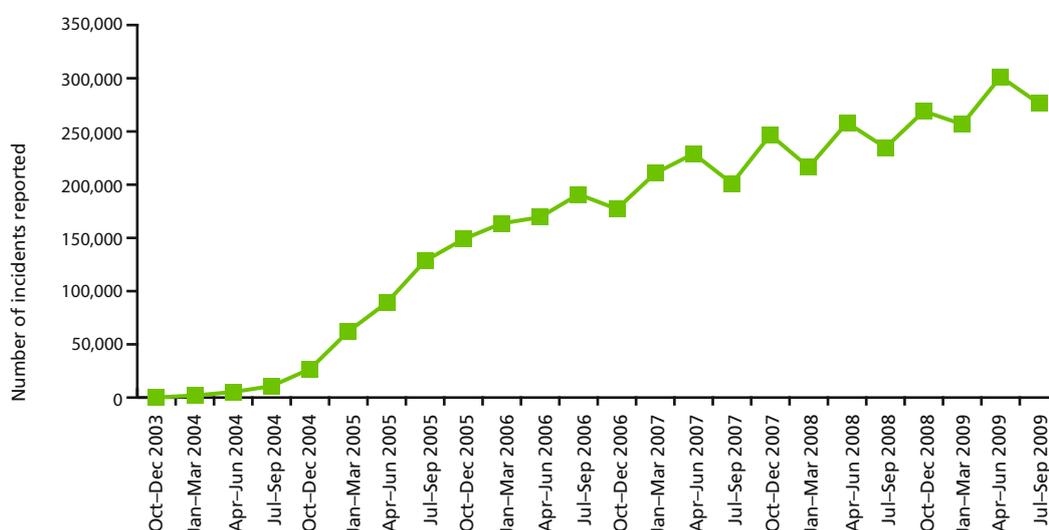
- 255 organisations (66 per cent) reported at least once every month;

- 116 organisations (30 per cent) reported at least once in the quarter but less often than every month;
- 18 organisations (five per cent) did not report at all during the quarter.

(See figure 2 on page 12)

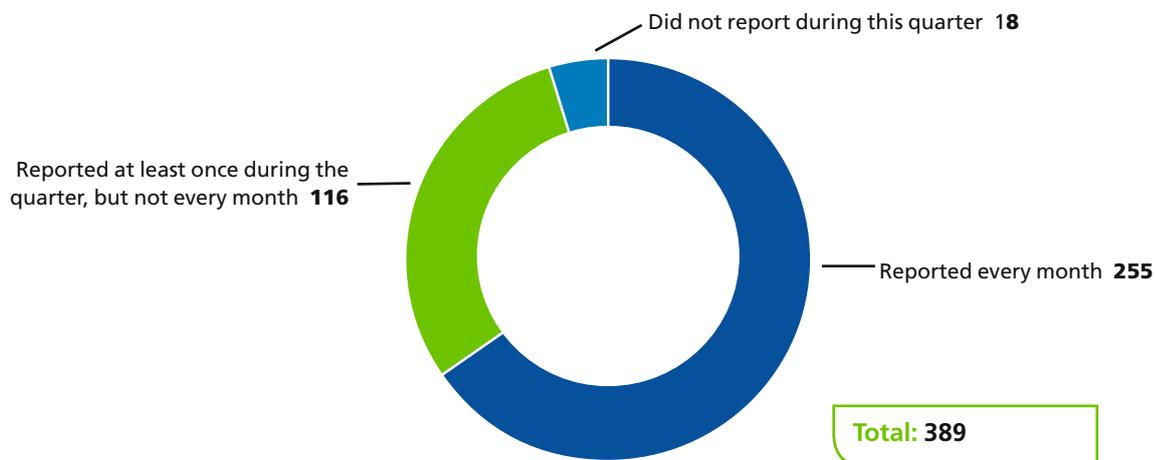
The overall trend in reporting is upwards and there has been an increase in the number of organisations reporting. This suggests much greater awareness of patient safety and openness among staff. Healthcare organisations with a high rate of reporting are much more likely to have a strong commitment to patient safety and high safety standards.

<sup>†</sup> Since the start of the quarter April to June 2009, five organisations in England merged into two, resulting in a total of 389 NHS organisations in England as of 1 April 2009. This excludes NHS Direct.



**Figure 1:**  
Number of incidents reported in England, October 2003 to September 2009

**Figure 2:**  
Timeliness of reporting among NHS organisations in England, July to September 2009



## How are reports received by the RLS?

Most reports received by the RLS come from staff working in NHS organisations and are reported via the LRMS of the NHS trust (which collates staff reports at the local level).

The source of reports to the RLS in England from 1 July 2009 to 30 September 2009 shows that the LRMS accounted for over 99 per cent of incident reports received. The proportion of reports submitted via the LRMS has not dropped below 98 per cent since the quarter January to March 2004.

The NPSA encourages staff to report via the LRMS, to avoid duplicate data entry and to facilitate learning within NHS organisations.

The remaining incidents are submitted using direct reports by NHS staff to the RLS using a specially designed electronic form (the eForm) that allows anonymous reporting. Staff reporting on eForms can choose to share their reports with their organisation and the majority do choose to do this.

## What gets reported?

This section gives an overview of the patterns and trends in patient safety incidents, focusing on incident types, care settings and degree of harm.

### How many patient safety incidents were reported as occurring between July 2008 and June 2009?

Between 1 July 2008 and 30 June 2009, a total of 945,520 patient safety incidents in England were reported to the RLS. This figure is based on the date incidents were reported as having occurred. The incidents reported in England during this period accounted for 94 per cent of all incidents reported to the RLS, while six per cent were reported to have occurred in Wales. A small proportion of incidents were reported anonymously and can therefore not be allocated to a country.

The number of reported incidents was similar in all four quarters from July 2008 to June 2009. Of the reported incidents:

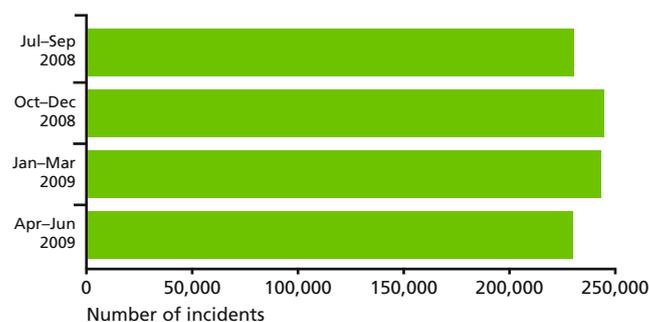
- 229,732 incidents (24 per cent) were reported as having occurred between July and September 2008;
- 243,843 incidents (26 per cent) between October and December 2008;
- 242,634 (26 per cent) between January and March 2009;
- 229,311 incidents (24 per cent) between April and June 2009.

(See figure 3)

As in the majority of previous reports, reporting levels have been broadly similar across the first three quarters with a slight decrease for the most recent quarter.

**Figure 3:**

Number of incidents reported as occurring in England, July 2008 to June 2009



#### About these data

The three-month time lag in publishing these data allows time for the majority of incidents to be reported, uploaded to the RLS and processed.

The data were extracted as of 30 September 2009. Further incidents which occurred during the period April to June 2009 that have been sent to the RLS since this date will be included in subsequent QDS reports. Accordingly, the figures presented in this report for the three quarters between July 2008 and March 2009 may also vary to a small extent compared to previous issues of the report, since additional incidents have been submitted since then.

Data in this section have been through data quality measures to eliminate duplicate data and blank reports. The data in this section are presented on a 12-month basis, which is followed, where relevant, by a description of trends and changes in the patterns seen across the four individual quarters. The primary focus in the text in this section is the data expressed in term of per cent. Figures and charts display the number of incidents while aiming to provide a visual overview of relevant patterns.

The full tables for this section as well as additional charts showing trends in the data on a quarterly basis are provided in the data workbook which accompanies this report (see: [www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries](http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries)).

## What are the main incident types?

Patient accident was the most commonly reported type of incident across all sectors, which accounted for 32 per cent of all incidents.

Following patient accidents, the next most commonly reported incident types were:

- treatment/procedure and medication (10 per cent each);
- access/admission/transfer/discharge (eight per cent);
- infrastructure (including staffing, facilities and environment) and documentation (including records and identification) (both six per cent);

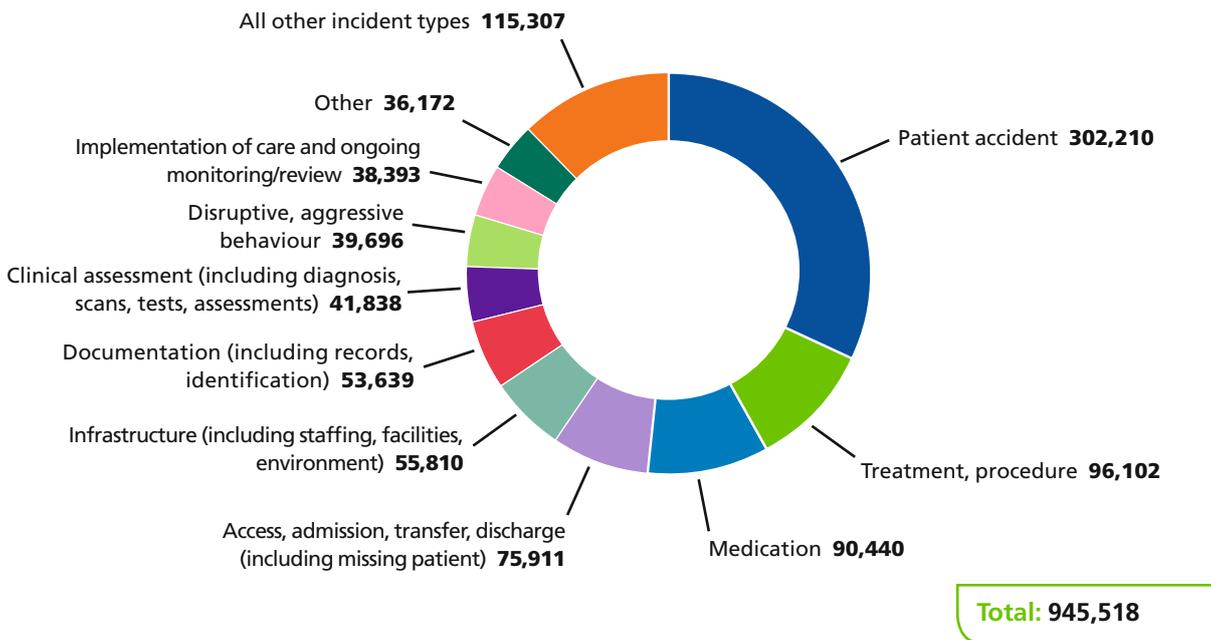
- clinical assessment (including diagnosis, scans, tests and assessments), disruptive/aggressive behaviour, implementation of care and ongoing monitoring/review and consent/communication/confidentiality (four per cent each);
- self-harming behaviour and medical device/equipment (three per cent each).

(See figure 4)

The least commonly reported incident types were infection control and abuse of patient (by staff/third party), two per cent and one per cent respectively. Four per cent of all incidents were categorised as 'other'. This pattern was very similar in all four quarters.

Figure 4:

Reported incident types in England, July 2008 to June 2009



The total figures in England are marginally lower than those shown in other tables, as there were two incidents with missing incident type. These incidents are currently being investigated.

### Examples of incident types

- **Patient accident:** 'Patient usually only mobile with assistance but walked to the toilet opposite their bed unaided. Was found behind toilet door on the floor trying to get up.'
- **Treatment/procedure:** 'SDU called theatres on the pm of [date] to inform us that a pair of mayo scissors were missing from a gynae abdo tray that had been used on the previous day for a patient having an abdominal hysterectomy.'
- **Medication:** 'A pt was given 100mg oral tramadol when the prescription was only for 50mg oral tramadol. The dose was queried by the pt mother but staff nurse told her that the dose was correct. The incident was brought to my attention 24 hours after it had occurred following the drug round that day as the mother was again checking with the staff nurse the dose of tramadol prescribed.'
- **Access/admission/transfer/discharge:** 'Details on referral difficult to read no mention that this man had ca prostate with multiple bony secondaries only when we obtained info from social worker did we realize we needed more urgent info from medical notes'
- **Infrastructure:** 'Temperature within dialysis unit particularly by the window reached 35°C. Patient and the parents feeling unwell due to heat. Staff finding it very difficult to work in these conditions. Parents wrote complaint letter.'
- **Documentation:** 'Patient arrived in theatre reception with incorrect details on labels, consent form and patient care plan. Details checked with patient and amended. Name and address of patient incorrect. Patient had moved house and married.'
- **Clinical assessment:** 'Pt arrived for scan. The wrong form was given, as there were 2 pt with the same name for the same scan on the same day. The clinical details were similar. Images were taken on the wrong pt as a result.'

### Examples of incidents classified as 'other':

'Patient had a superficial injury which was noticed to be now necrotic with an approximate size of 50p. The wound was cleaned with normal saline, dressed with Inadine and covered and secured with Melonin and micropore. Relevant staff was informed and will review. Wound had not been reviewed since [date].'

'Patient came to reception of outpatients department saying he was lost and had come from [ward], He was in his pyjamas and coat and very confused. His details were taken and reported to senior nurse who took charge of the situation.'

## Where do incidents occur?

### The majority of reported patient safety incidents occurred in acute trusts or general hospitals (73 per cent).

The second most common care setting for reported incidents was mental health services (14 per cent), followed by community services<sup>†</sup> (including community hospitals) which, combined with community pharmacy, community and general dental services and community optometry/optician services, accounted for nine per cent. Among the community services, community hospitals accounted for the majority of incidents.

Learning disabilities services accounted for three per cent of all reported incidents. Ambulance services and general practice both accounted for a small proportion of all incidents (rounded down to 0 per cent) (see figure 5).

This pattern was similar across all four quarters.

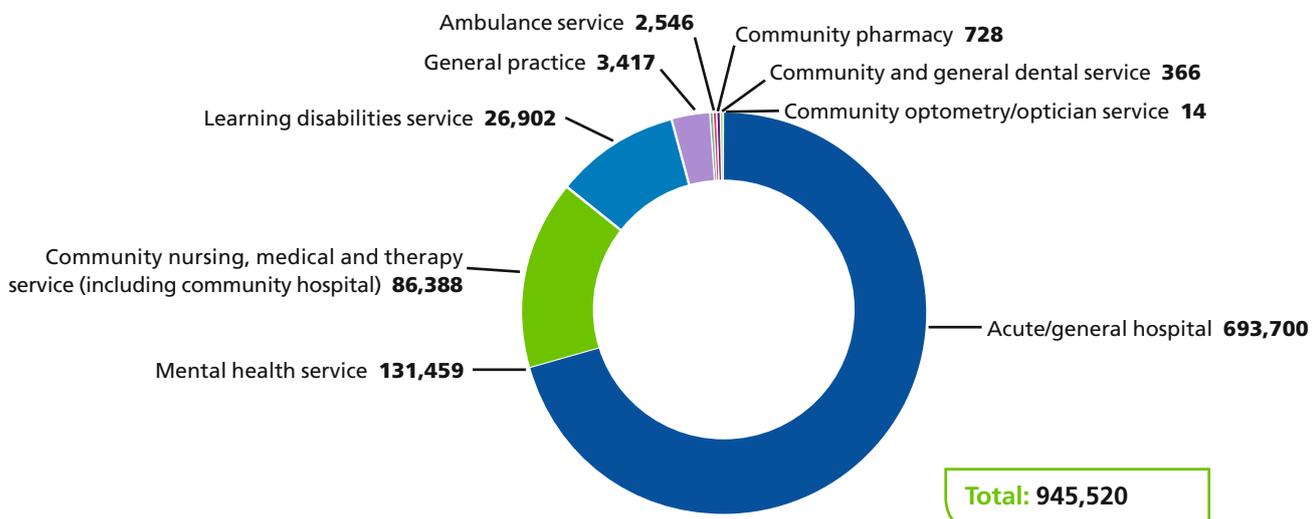
The patterns of reported incident types within each care setting during the period show that there was substantial variation across the different care settings. Patient accident was consistently the most commonly reported incident type in care settings taking inpatients, ranging from 31 per cent in acute/general hospitals to 46 per cent in community services (including community hospitals).

**Note:** *The care setting in which incidents were reported as taking place should not be confused with organisation cluster types which are used in the QDS public workbook (S.1 Regularity of reporting) and some other publications. Organisation cluster types are directly related to the organisation which has provided an incident report (for example, large acute organisations or mental health organisations). Depending on the vendor system used by an organisation, care setting may be based on where the reporter thought the incident occurred and can include settings outside of that normally provided by an organisation. For example, an ambulance trust may report an incident which occurred in the acute/general care setting, and vice versa.*

<sup>†</sup> Community services include community nursing, medical and therapy services.

**Figure 5:**

### Care setting of incident reports in England, July 2008 to June 2009



# What type of incidents occur?

## Acute/general hospitals

The most commonly reported type of incident in acute/general hospitals was patient accident (31 per cent).

Following patient accidents, the next most commonly reported incident types were:

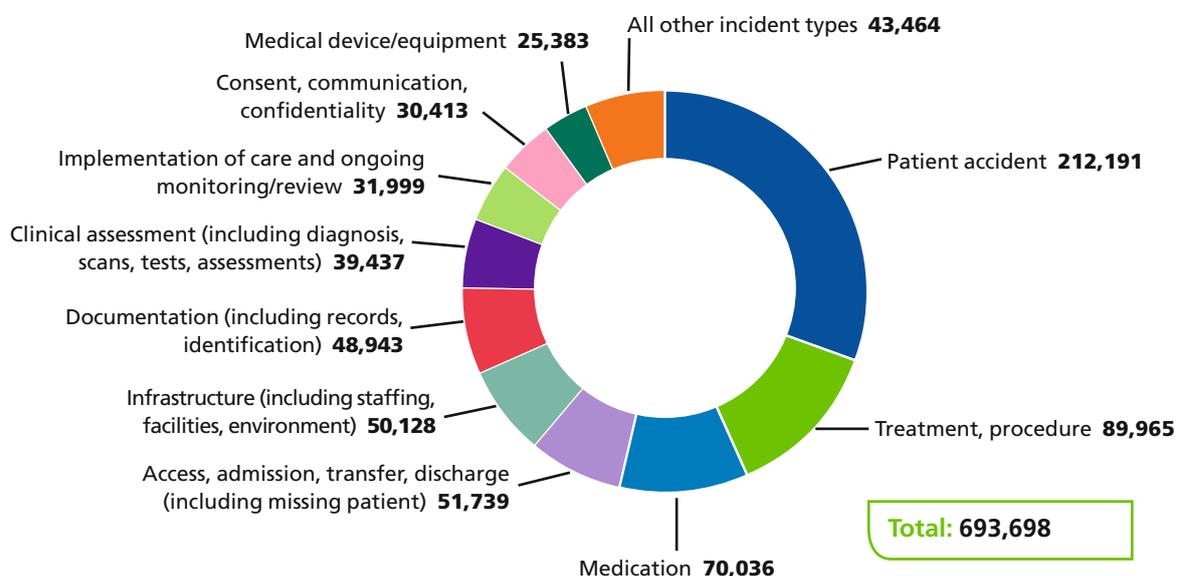
- treatment/procedure, the second most commonly reported incident type (13 per cent);
- medication (10 per cent);
- access/admission/transfer/discharge (including missing patient), infrastructure (including staffing, facilities, environment) and documentation (including records, identification) (seven per cent each);

- clinical assessment (including diagnosis, scans, tests, assessments), implementation of care and ongoing monitoring/review, consent/communication/confidentiality and medical device/equipment incidents (between six per cent and three per cent);
- incidents categorised as infection control (two per cent).

The remaining incident types disruptive/aggressive behaviour, patient abuse (by staff/third party) and self-harming behaviour each accounted for a negligible proportion (each rounded down to 0 per cent). Three per cent of incidents were classified as 'other' (see figure 6).

**Figure 6:**

Reported incident types in acute/general hospitals in England, July 2008 to June 2009



The total figures in England marginally lower than those shown in other tables, as there was an incident with missing incident type. This is currently being investigated.

**Examples of incidents occurring in acute/general hospitals****Care setting:** Acute/general hospital**Incident type:** Consent, communication, confidentiality**Reported degree of harm:** Low**Incident description:** Mum and child arrived for appt in paediatric dermatology. The appt had been cancelled due to educational 1/2 day. Another appt letter to see another consultant on [date] sent to mum but letter did not state that this appt had been cancelled. Apologises made. Mum cross.**Care setting:** Acute/general hospital**Incident type:** Medication**Reported degree of harm:** No harm**Incident description:** Patient prescribed Solostar Apidra (Glulysine) pharmacy dispensed solostar lantus (Glargine) in error (label was correct). Error came to light following day during a random stock check.**Care setting:** Acute/general hospital**Incident type:** Patient accident**Reported degree of harm:** No harm**Incident description:** Relative of another patient came and said to the staff patient had fall. Found him on the floor on his front. No injury noticed. Used the full hoist and transferred him back to bed. Observations done which is recorded. Informed the on-call Doctor on [number] bleep. Patient said he started walking with stick and had fall.**Care setting:** Acute/general hospital**Incident type:** Self-harming behaviour**Reported degree of harm:** Low**Incident description:** Patient on ward who has history of mental illness and self harm, obtained a razor and removed blade. Proceeded to slash her left forearm. She reported it to nursing staff straight away.**Care setting:** Acute/general hospital**Incident type:** Treatment, procedure**Reported degree of harm:** Low**Incident description:** Patient was admitted for elective bilateral pinnoplasty. This was completed on Friday [date]. Patient was to discharge following day [date] but with no ENT cover to assess patients dressing a small bleed to right ear. Called [Hospital] and spoke to ENT Consultant who said he would not come over as it was not an emergency but would speak to his Registrar and call back.

## Mental health and learning disabilities services

The pattern of incident types in mental health services was different compared to other care settings, although patient accidents still accounted for the largest proportion of incidents (32 per cent).

In mental health services, the next most commonly reported incident types were:

- disruptive/aggressive behaviour – this was the second most commonly reported incident type (21 per cent), in contrast to other care settings;
- self-harming behaviour (17 per cent);
- access/admission/transfer/discharge (including missing patient) (11 per cent);
- medication (seven per cent);
- 'other' incidents (six per cent).

The remaining incident types accounted for two per cent or less. This pattern was similar in all four quarters.

(See figure 7)

Similar to mental health services, in learning disabilities services the most commonly reported incident types were:

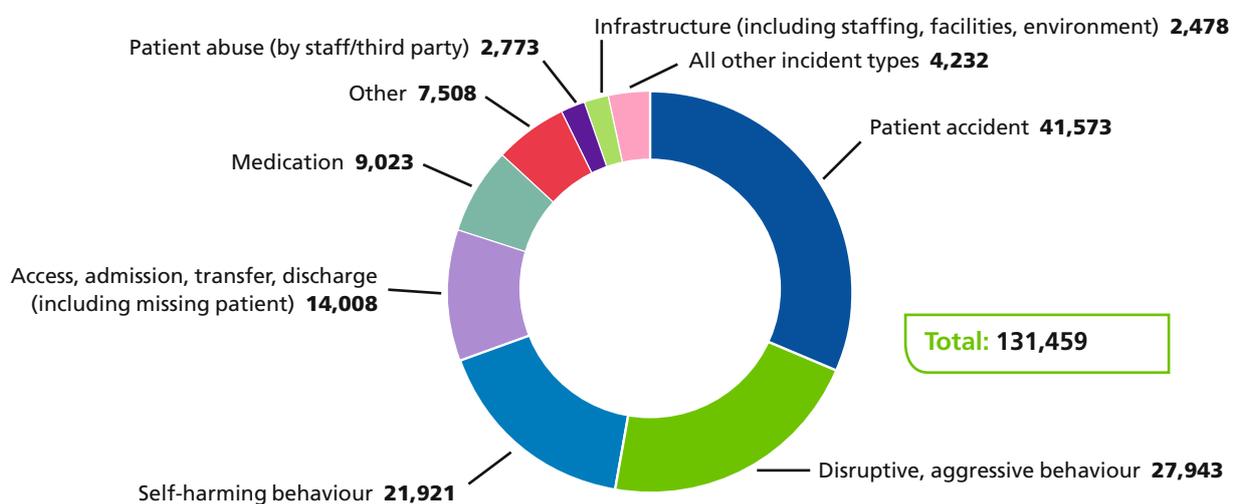
- patient accidents (31 per cent);
- disruptive/aggressive behaviour (27 per cent);
- self-harming behaviour (21 per cent);
- incidents coded as 'other' (eight per cent);
- medication (six per cent).

The remaining incident types accounted for two per cent or less.

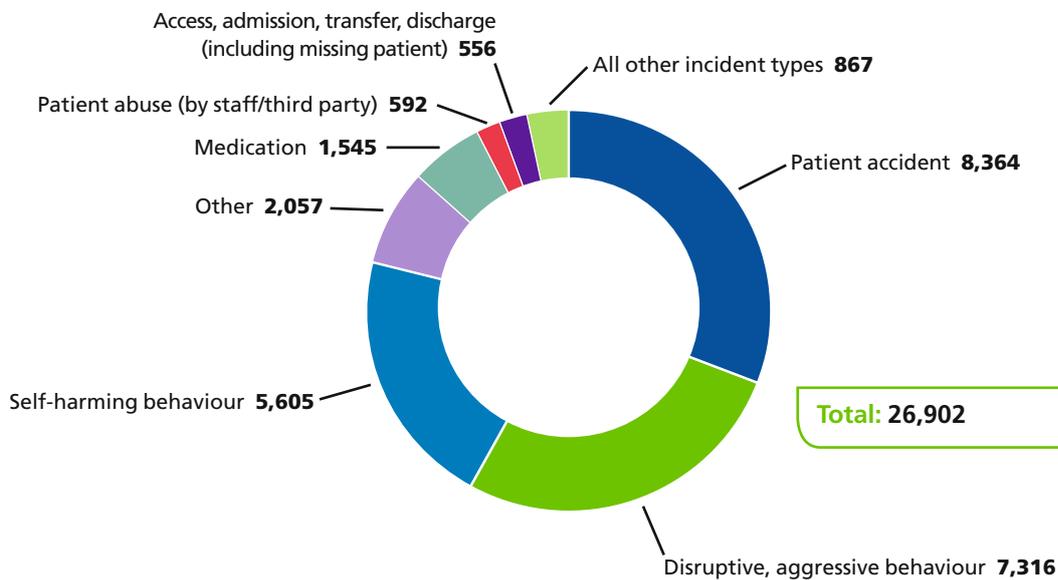
(See figure 8 on page 20)

**Figure 7:**

Reported incident types in mental health services in England, July 2008 to June 2009



**Figure 8:**  
 Reported incident types in learning disabilities services in England, July 2008 to June 2009



**Examples of incidents occurring in mental health**

**Care setting:** Mental health service

**Incident type:** Access, admission, transfer, discharge (including missing patient) – absconder/missing patient

**Reported degree of harm:** No harm

**Incident description:** Pt has been settled and appropriate in his interaction with staff and other pt on the ward. No concerns observed in him prior to leaving the ward. Client returned by police on [date] at 04:15. See incident forms [number] and [number].

**Care setting:** Mental health service

**Incident type:** Self-harming behaviour – self-harm

**Reported degree of harm:** No harm

**Incident description:** The patient banged several times with some force on the window of her bedroom using both fists. Alerted by the noise, staff quickly arrived and prevented her from continuing. The patient sustained slight abrasions across knuckles of her R hand which were cleaned and covered with plaster. Staff remained with the patient for the remainder of the evening to maintain safety and offer distraction.

**Care setting:** Mental health service

**Incident type:** Medication

**Reported degree of harm:** No harm

**Incident description:** Pt found box of leave medication in the laundry room belonging to Pt. The box contained lorazepam tablets with two take out. Pt said they were from her leave when she was first admitted. Pt handed medication to staff.

Community services (including community hospitals), community pharmacies, community and general dental services, and community optometry and optician services

The most commonly reported type of incident in community services<sup>†</sup> (including community hospitals) was patient accident, which alone accounted for 46 per cent of all incidents.

None of the remaining categories accounted for more than 10 per cent of reported incidents, these were:

- access/admission/transfer/discharge (including missing patient) and medication (10 per cent each);
- incidents coded as implementation of care and ongoing monitoring/review (six per cent);
- incidents coded treatment/procedure and 'other' (five per cent each);
- documentation and consent/communication/confidentiality incidents (including records, identification) (four per cent each).

The remaining categories each accounted for between one per cent and three per cent. They were:

- infrastructure (including staffing, facilities, environment);
- medical device/equipment;
- clinical assessment (including diagnosis, scans, tests, assessments);
- infection control incidents;
- disruptive/aggressive behaviour;
- patient abuse (by staff/third party) and self-harming behaviour.

The pattern of incident types in community services (including community hospitals) was similar in all four quarters.

In community pharmacies, the vast majority of reported incidents related to medication (91 per cent). None of the remaining incidents types accounted for more than four per cent of the incidents. It is important to note that it was not possible to attribute a country to a large proportion of incidents classified as occurring in the community pharmacy care setting. Please refer to the QDS workbook on the NRLS website for further information ([www.nrls.npsa.nhs.uk/resources](http://www.nrls.npsa.nhs.uk/resources)).

In community optometry/optician services:

- four incidents were reported to have occurred in England in the quarter from April to June 2009;
- the overall number of incidents received between July 2008 and June 2009 remained very low (n=14).

Therefore, no conclusions can be drawn with respect to incident patterns in this care setting.

In community dentistry access/admission/transfer/discharge (including missing patient) was the most commonly reported type of incident (22 per cent). The other most commonly reported incident types were:

- treatment/procedure (18 per cent);
- patient accident (13 per cent);
- medical device/equipment (11 per cent);
- incidents coded as 'other' (nine per cent).

The remaining incident types accounted for five per cent or less.

(See figure 9 on page 22)

There was some fluctuation in the pattern of incident types in community dentistry. However, the number of reported incidents in each quarter remains low, meaning that small changes in the number of reported incidents can produce an inconsistent pattern.

<sup>†</sup> Community services include community nursing, medical and therapy services.

### Example of an incident occurring in community services

**Care setting:** Community nursing, medical and therapy service (including community hospital)

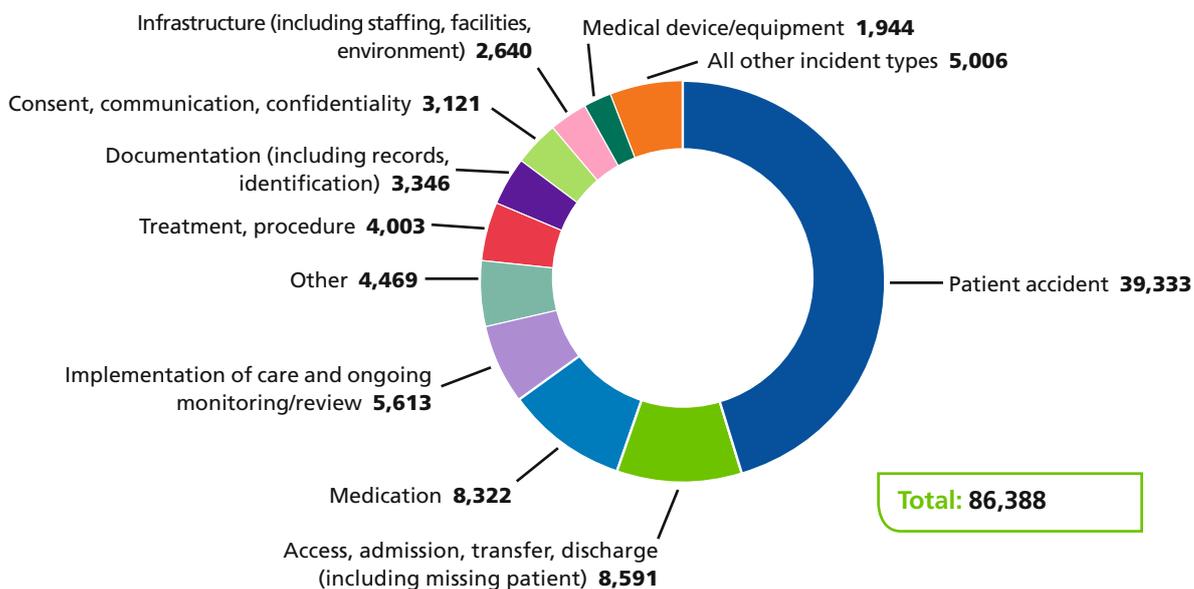
**Incident type:** Access, admission, transfer, discharge (including missing patient)

**Reported degree of harm:** No harm

**Incident description:** Case referred for transfer of care – assessments sent [Date]. Repeated contacts to Rehabilitation Hospital – informed on waiting list. Contact today [Date] – advised to re-fax details. Informed patient on list but other patients have taken the 5 beds available today.

**Figure 9:**

Reported incident types in community nursing, medical and therapy services in England, July 2008 to June 2009



## Ambulance services<sup>†</sup>

The most commonly reported incident type in ambulance services was access/admission/transfer/discharge (including missing patient), which accounted for 23 per cent of all incidents.

In ambulance services other reported incident types were:

- patient accident (20 per cent);
- medical device/equipment (15 per cent);
- treatment/procedure (10 per cent);
- incidents coded as 'other' (eight per cent);
- consent/communication/confidentiality (six per cent);
- infrastructure (including staffing, facilities, environment) and clinical assessment (including diagnosis, scans, tests, assessments) (five per cent each).

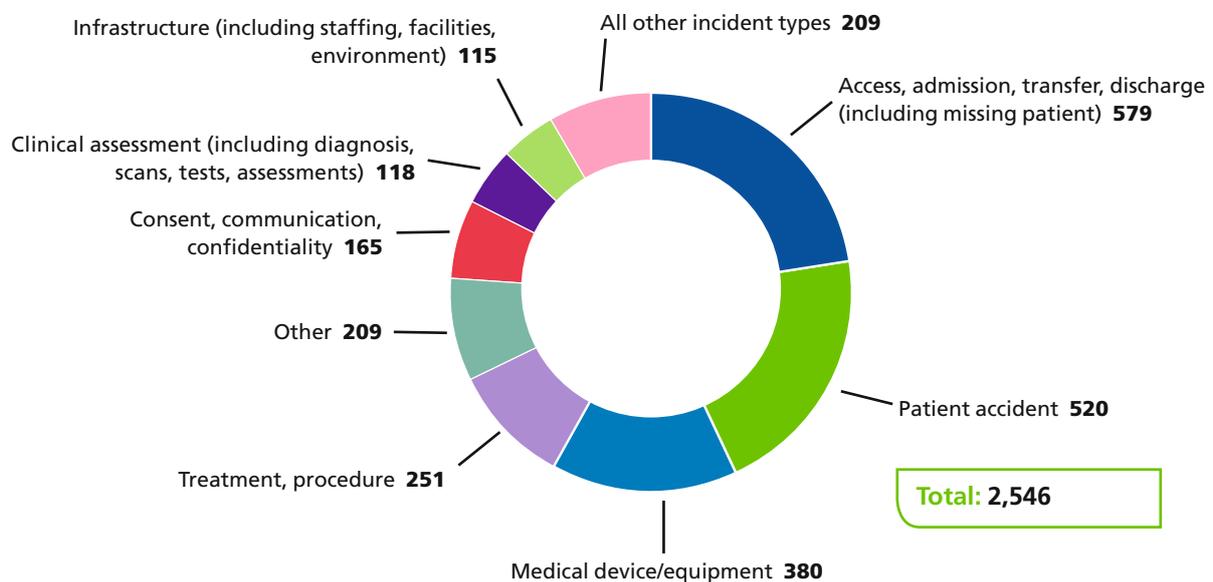
The remaining incident types accounted for four per cent or less.

(See figure 10)

The pattern of incident types fluctuated notably during the four quarters between July 2008 and June 2009, which may be explained by the relatively low number of total incident reports received from this care setting.

<sup>†</sup> Issues 11 and onwards of the QDS show data reported from the ambulance services separately for England and Wales. Issues 1–10 display English and Welsh data combined.

**Figure 10:**  
Reported incident types in ambulance services in England, July 2008 to June 2009



## General practice

The incident types reported in general practices showed a markedly different pattern compared to care settings that take inpatients.

Between July 2008 and June 2009 the most commonly reported incident type in general practice was medication (21 per cent), followed by:

- documentation (including records, identification) (15 per cent);
- consent/communication/confidentiality (11 per cent);
- clinical assessment (including diagnosis, scans, tests, assessments) and access/admission/transfer/discharge (including missing patient) (both 10 per cent);
- treatment/procedure and 'other' (both seven per cent);
- patient accident and implementation of care and ongoing monitoring/review (five per cent each).

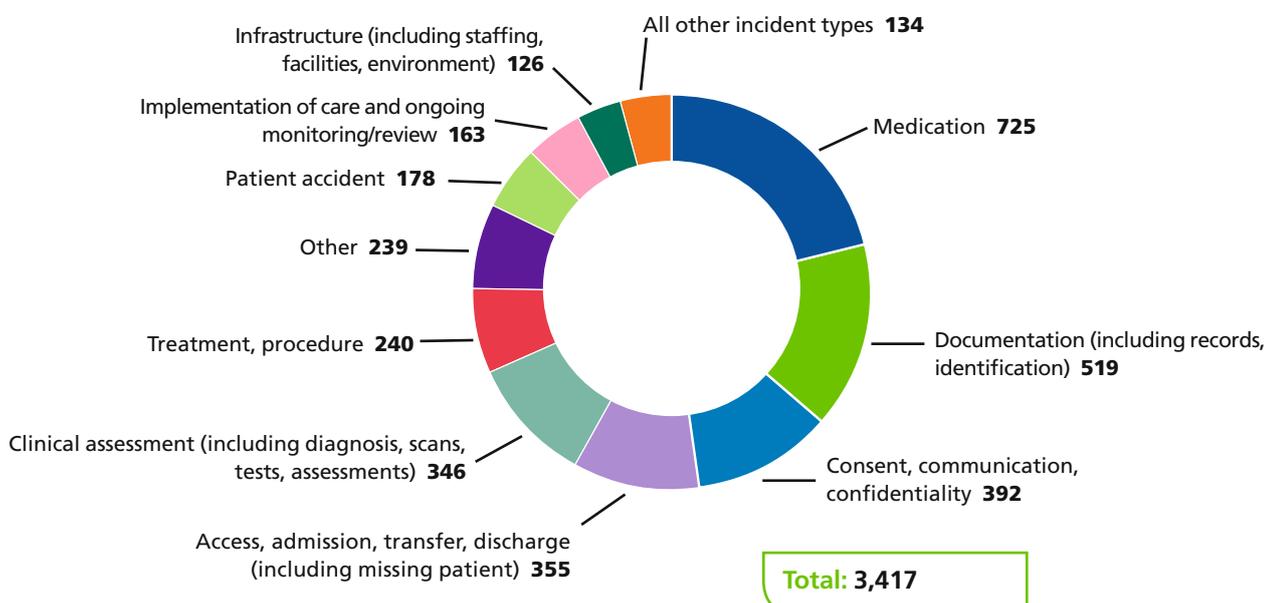
The remaining incident types each accounted for four per cent or less.

(See figure 11)

The number of incidents reported from this care setting has increased over the last four quarters from 706 in July to September 2008 to 1,027 in April to June 2009.

Some variation was seen across the four quarters in the pattern of incident types, although no consistent trends were evident. The fluctuations are likely to be the result of the relatively low number of total incident reports submitted by general practices.

**Figure 11:**  
Reported incident types in general practice in England, July 2008 to June 2009



## Improving reporting and learning in primary care

Primary care is the cornerstone of the NHS: each year in England alone there are approximately 300 million consultations in general practice with nearly 800 million prescriptions dispensed in the community.

Studies have identified that incidents occur between five and 80 times per 100,000 consultations, mainly related to the processes involved in diagnosis and treatment. Incidents have been identified to occur in up to 11 per cent of all prescriptions, mainly related to errors in dose.

The NPSA is committed to promoting safe practice in primary care and is currently working on a number of initiatives to support this aim, for example **Seven steps to patient safety in general practice**.

This quick reference guide describes the key steps for a general practice to keep safe the patients they care for, including activities that can be taken to develop policies, strategies and action plans. There are also practical hints and techniques that can be used to promote quality care.

A series of webinars dealing with each of the seven steps in general practice is being hosted by the NPSA. For more information and details on how to register, or to download a recording, visit [www.nrls.npsa.nhs.uk/resources/?entryid45=61598&q=0%C2%ACseven+steps%C2%AC](http://www.nrls.npsa.nhs.uk/resources/?entryid45=61598&q=0%C2%ACseven+steps%C2%AC)

We are committed to **making reporting easier**, more relevant and accessible to frontline healthcare staff. To help this process, we are currently revising the electronic form used to report incidents from general practice; this builds on an earlier feasibility study with a volunteer sample of 14 practices and four out-of-hours services, which found that the service specific eForm was usable and took less time to complete than the standard NRLS eForm. We aim to make the eForm available to all staff later this year.

**Significant Event Audits (SEA)** are also particularly important to primary care as they involve systematically investigating and reviewing incidents of both good and bad practice that have been reported by primary care teams.

The process offers the chance to hold regular structured meetings to discuss recent practice, as well as identify individual and organisational learning needs. Last year, the NPSA released guidance on how to conduct SEAs, including a template data collection tool to extract learning from SEAs that can then be shared across organisations.

We are currently working with primary care trusts (PCTs) in one Strategic Health Authority (SHA) to use the template and will continue to promote the guidance throughout the year. In addition, the NPSA is working with a PCT in the north east to develop and test thematic reporting of patient safety incidents, and will be working closely with two SHAs to undertake patient safety collaboratives designed to support clinical staff in identifying local patient safety risks as well as working to design and test solutions.

### Example from general practice:

*'Tried to contact patient regarding medication request query – phone number not available. Patient had left new telephone number with reception six weeks previously but it hadn't been changed on the computer.'*

See: [www.nrls.npsa.nhs.uk/resources/clinical-specialty/primary-care](http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/primary-care)

## How seriously harmed are patients?

Between July 2008 and June 2009, 67 per cent of incidents in England were coded by local reporters as resulting in no harm to patients.

Twenty-six per cent were reported as causing low harm and six per cent were reported as causing moderate harm. One per cent of all incidents were coded by the reporter as resulting in severe harm or death, with the majority of these incidents being classified as severe harm rather than death. This pattern was similar across the four quarters.

(See figure 12)

### Definition of degree of harm

#### No harm

Impact prevented: any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm.

Impact not prevented: any patient safety incident that ran to completion but no harm occurred.

#### Low harm

Any patient safety incident that required extra observation or minor treatment and caused minimal harm.

#### Moderate harm

Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.

#### Severe harm

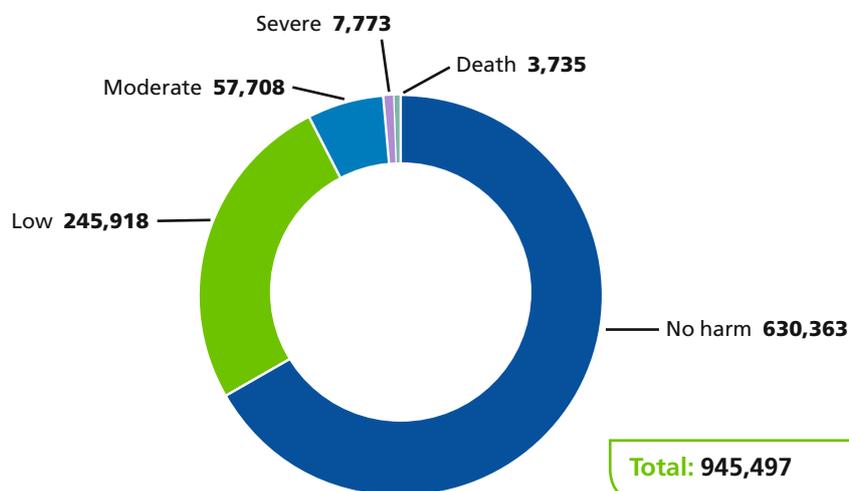
Any patient safety incident that resulted in permanent harm.

#### Death

Any patient safety incident that directly resulted in the death of the patient.

**Figure 12:**

Reported degree of harm to patients in England, July 2008 to June 2009



Total excludes incidents for which degree of harm was not available, thus total may differ from other figures.

## Severe harm or death by care setting

The proportion of incidents associated with severe harm or death in England showed some variation across care settings (see figure 13 on page 28). The proportion of incidents reported as leading to either severe harm or death of patients between July 2008 and June 2009 was highest from general practice (2.8 per cent)<sup>†</sup>, followed by:

- ambulance services (2.4 per cent);
- mental health services (1.5 per cent);
- community services (including community hospitals) and community and general dental services (1.4 per cent each);
- acute/general hospital (1.2 per cent);
- community pharmacy (0.7 per cent);
- learning disabilities service (0.3 per cent);

It is likely that the relatively high proportion of incidents reported as resulting in either severe harm or death in general practice reflects a different reporting culture compared to other care settings: fewer incidents are reported overall but incidents that result in severe harm or death are more likely to be reported.

In almost all care settings, the proportion reported as leading to severe patient harm was higher than the proportion reported as causing death. For example, in general practice the proportion resulting in severe harm was 1.7 per cent, whereas the proportion causing death was 1.1 per cent. In community services (including community hospitals) the equivalent proportions were 1.0 per cent and 0.4 per cent, respectively. The exception to this pattern was mental health services where 0.9 per cent of incidents were reported to have resulted in death, compared to 0.6 per cent of incidents resulting in severe harm. This pattern was largely similar in the four quarters.

## Learning from severe harm incidents

The NPSA works closely with NHS organisations to individually review all incidents where the harm to a patient is reported as death or severe harm to identify opportunities for national learning.

Analysis of incidents reported as resulting in death suggests that this is a complex area. Some incidents may be coded based on the potential harm to the patient, rather than the actual harm.

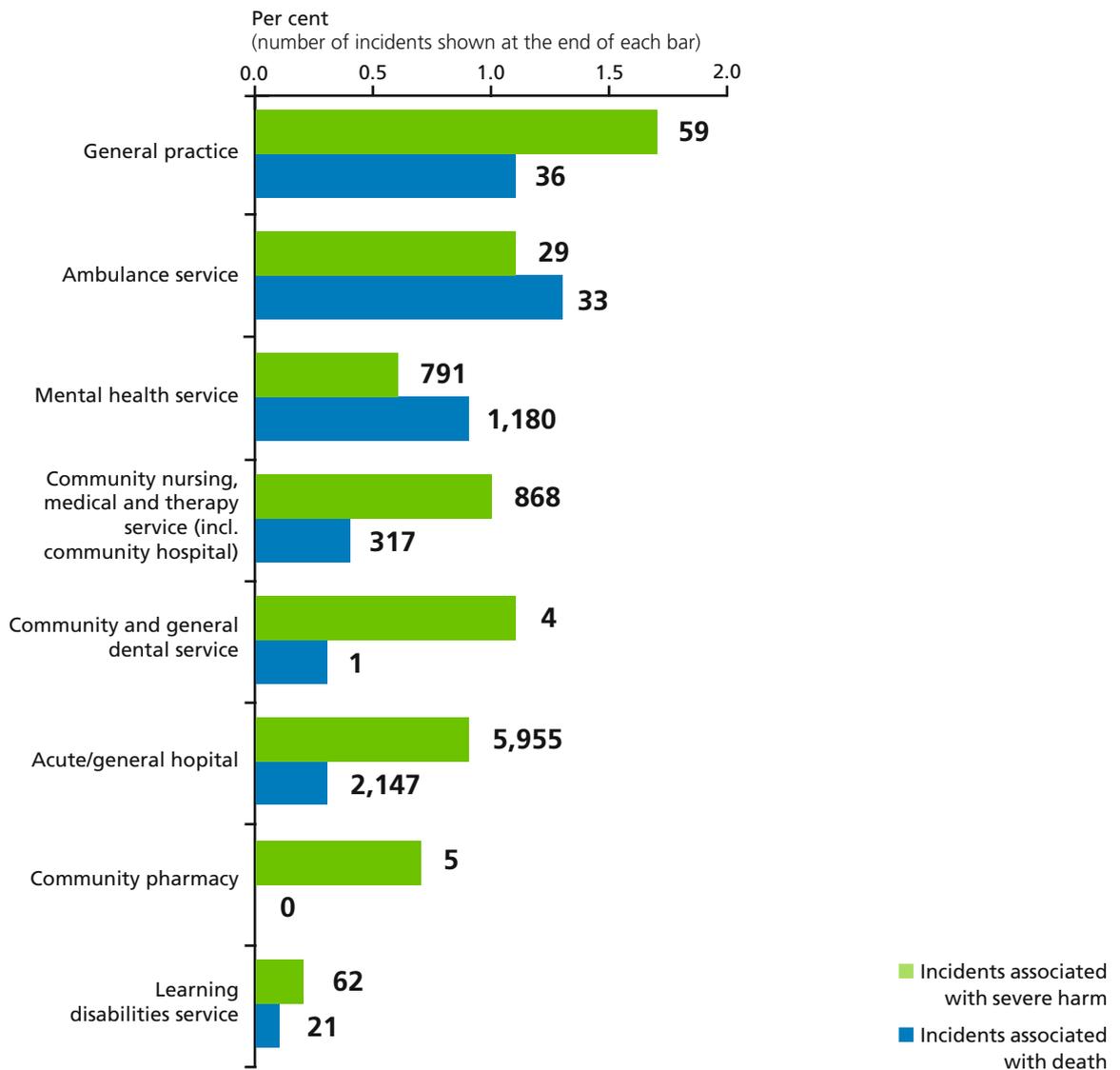
Often it is unclear whether the death of the patient was, or might have been, directly related to a patient safety incident. Organisations often capture events in the LRMS where patients have died, even if there was no patient safety incident, for example, still births, neonatal deaths and outpatient suicides. Even following investigation, the relationship between any incident which occurred and the outcome for the patient is often unclear, as some incidents may happen during the care of patients with life threatening illness.

Improving the coding of degree of harm to patients is an important aspect of data quality which the NPSA is working with NHS organisations to improve.

The fifth report from the Patient Safety Observatory, *Safer care for the acutely ill patient: Learning from serious incidents*<sup>2</sup>, shares learning about two related patient safety issues in acute care settings which were identified as themes from analysis of death reports; deterioration not recognised or acted on, and resuscitation. For further information on incidents reported as deaths from maternity services, see the *Quarterly Data Summary* Issue 6<sup>3</sup>.

<sup>†</sup> Since the proportion of incidents resulting in either severe harm or death is very low, the proportions discussed in this section are referred to using one decimal point.

**Figure 13:**  
 Reported incidents associated with severe harm or death by care setting in England, July 2008 to June 2009



## Severe harm or death by incident type

The proportion of incidents reported as severe harm or death varies between incident types (see figure 14). The combined proportion of severe harm or death incidents was highest among incidents categorised as 'other' (6.7 per cent), followed by infection control incidents (6.4 per cent) and implementation of care and ongoing monitor/review (2.9 per cent).

Among incidents categorised as self-harming behaviour 2.7 per cent were coded as severe harm or death. Between 2.0 and 1.0 per cent of incidents were coded as severe harm or death among the following incident types:

- treatment/procedure;
- clinical assessment (including diagnosis, scans, tests, assessments);
- patient abuse (by staff/third party);

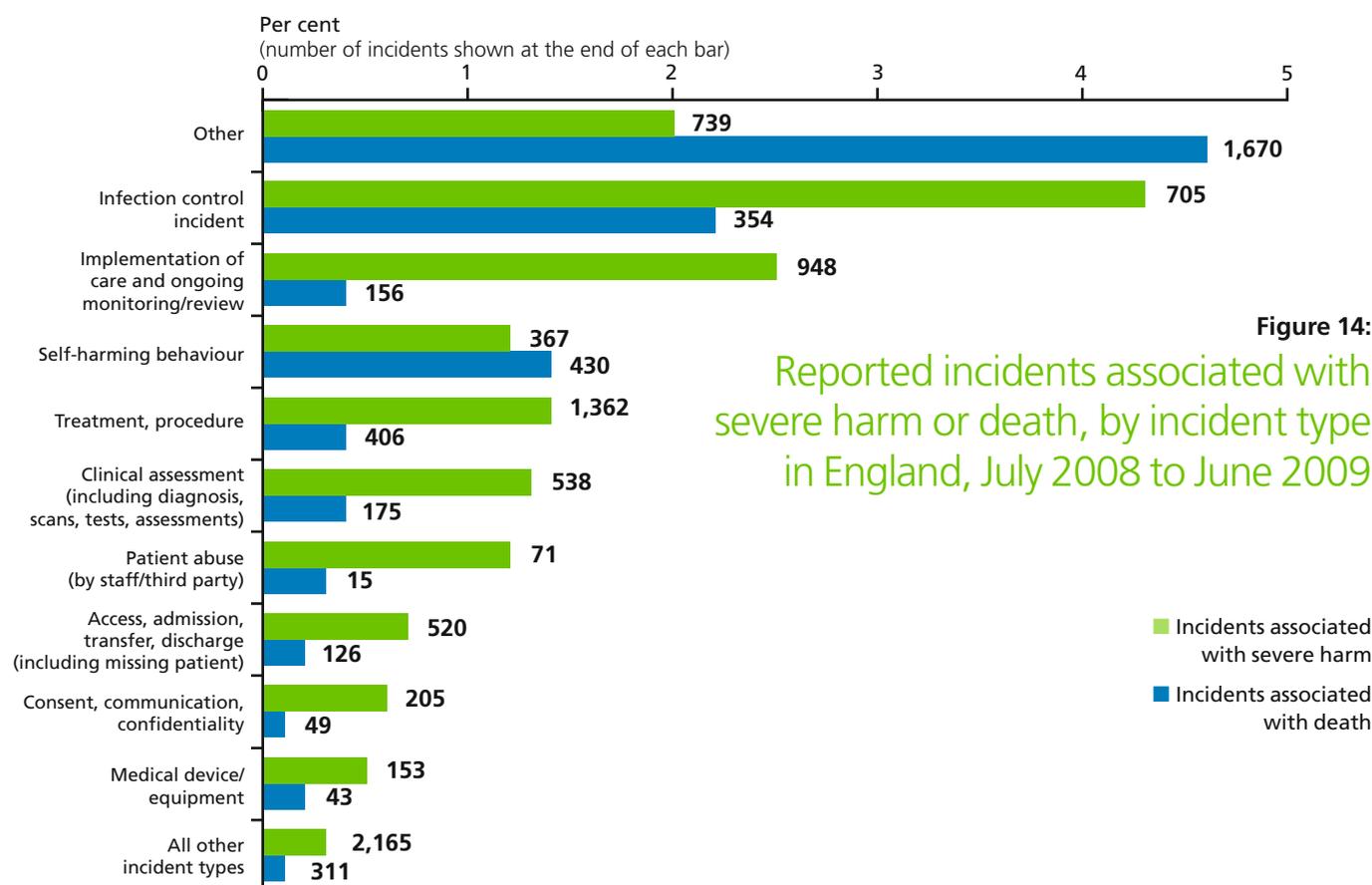
Less than 1.0 per cent of the remaining incident types were coded as either severe harm or death.

While a larger proportion of incidents tended to be coded as severe harm rather than death among most incident types, the exceptions were incidents categorised as 'other' (2.0 per cent severe harm, 4.6 per cent death) and self harming behaviour (1.2 per cent severe harm, 1.4 per cent death).

### Cleanyourhands

The NPSA has been working to reduce the number of infection control incidents through a variety of methods, including the cleanyourhands campaign. This aims to help the NHS in England and Wales to reduce the spread of healthcare associated infection by supporting NHS trusts to improve the hand hygiene of their staff. The campaign uses a multimodal approach to facilitate, educate, prompt and enable healthcare workers to clean their hands at the right time, every time during patient/service user care.

Find out more at [www.npsa.nhs.uk/cleanyourhands](http://www.npsa.nhs.uk/cleanyourhands)



**Figure 14:**  
Reported incidents associated with severe harm or death, by incident type in England, July 2008 to June 2009

# Patient safety highlights

This section highlights recent, selected published literature on patient safety issues.

## **A survey on patient safety culture in primary healthcare services in Turkey**

S Bodur and E Filiz. *Int J Qual Health Care*. 2009; 21: 348–355

The purpose of this survey was to evaluate the patient safety culture in primary healthcare units. A cross-sectional study was carried out utilising the Turkish version of the Hospital Survey on Patient Safety Culture, developed by the Agency for Healthcare Research and Quality, and a demographic questionnaire.

The study was carried out across 12 primary healthcare centres in the center of the city of Konya, Turkey. Participants consisted of 180 healthcare staff, including general practitioners (GPs), nurses, midwives and health officers.

The main outcome measure was the patient safety culture score, including subscores on 12 dimensions and 42 items; patient safety grade and number of events reported.

Fifty-four (30 per cent) of the participants were GPs, 48 (27 per cent) were nurses, 51 (28 per cent) were midwives and 27 (15 per cent) were health officers. The mean overall score for positive perception of patient safety culture in primary healthcare units was  $46 \pm 20$  (43–49 CI). No differences were found by staff members' profession. Among the dimensions of patient safety, those with the highest percentage of positive ratings were teamwork within units (76 per cent) and overall perceptions of safety (59 per cent), whereas those with the lowest percentage of positive ratings were the frequency of event reporting (12 per cent) and non-punitive response to error (18 per cent). Reporting of errors was infrequent with 87 per cent of GPs, 92 per cent of nurses and 91 per cent of other health staff indicating that they did not report or provide feedback about errors.

The important message that improving patient safety culture should be a priority among health centre administrators. Healthcare staff should be encouraged to report errors without fear of punitive action.

## **Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people**

ND Barber, DP Alldred, DK Raynor et al, *Qual Saf Health Care*. 2009; 18: 341–346

Care home residents are at particular risk from medication errors, and the objective of this study was to determine the prevalence and potential harm of prescribing, monitoring, dispensing and administration errors in UK care homes, and to identify their causes.

This was a prospective study of a random sample of residents, within a purposive sample of homes in three areas. Errors were identified by patient interview, note review, observation of practice and examination of dispensed items. Causes were understood by observation and from theoretically framed interviews with home staff, doctors and pharmacists. Potential harm from errors was assessed by expert judgement.

The 256 residents recruited in 55 homes were taking a mean of 8.0 medicines. One hundred and seventy-eight (69.5 per cent) of residents had one or more errors. The mean number per resident was 1.9 errors. The mean potential harm from prescribing, monitoring, administration and dispensing errors was 2.6, 3.7, 2.1 and 2.0 (0=no harm, 10=death), respectively. Contributing factors from the 89 interviews included doctors who were not accessible, did not know the residents and lacked information in homes when prescribing; home staff's high workload, lack of medicines training and drug round interruptions; lack of team work among home, practice and pharmacy; inefficient ordering systems; inaccurate medicine records and prevalence of verbal communication; and difficult to fill (and check) medication administration systems.

The authors concluded that two thirds of residents were exposed to one or more medication errors is of concern. The will to improve exists, but there is a lack of overall responsibility. Thus action is required from all concerned.

### Factors associated with system-level activities for patient safety and infection control

H Fukuda, Y Imanaka, M Hirose and K Hayashida. *Health Policy*. 2009; 89: 26–36

This study examined the relationship between hospital structural characteristics and system-level activities for patient safety and infection control, for use in designing an incentive structure to promote patient safety.

The study utilised a questionnaire to collect institutional data about hospital infrastructure and volume of patient safety activities from all 1,039 teaching hospitals in Japan. The patient safety activities were focused on meetings and conferences, internal audits, staff education and training, incident reporting and infection surveillance. Generalised linear modelling was used.

Of the 1,039 hospitals surveyed, 418 (40.2 per cent) hospitals participated. The amount of activities significantly increased by over 30 per cent in hospitals with dedicated patient safety and infection control full-time staff ( $P < 0.001$  and  $P < 0.01$ , respectively). High profit margins also predicted the increase of patient safety programs ( $P < 0.01$ ). Perceived lack of administrative leadership was associated with reduced volume of activities ( $P < 0.05$ ), and the economic burden of safety programs was found to be disproportionately large for small hospitals ( $P < 0.05$ ).

Hospitals with increased resources had greater spread of patient safety and infection control activities. To promote patient safety programs in hospitals, it is imperative that policy makers require the assignment of dedicated full-time staff to patient safety. Economic support for hospitals will also be required to assure that safety programs are sustainable.

### Medication errors: how reliable are the severity ratings reported to the national reporting and learning system?

SD Williams and DM Ashcroft. *Int J Qual Health Care*. 2009; 21: 316–320

The objective of this study was to examine (1) the reliability of the severity rating scale used by the NRLS in England and Wales for medication errors; and (2) the likelihood of reporting medication errors among healthcare professionals.

The study was carried out in a 900-bed acute university teaching hospital in the North West of England. Participants consisted of 40 healthcare professionals (10 doctors, 10 nurses, 10 pharmacists and 10 pharmacy technicians).

Participants were asked to complete a self-administered questionnaire containing nine medication error scenarios on two separate occasions. They were asked to rate the severity of each incident using the NRLS severity rating scale and also the likelihood of reporting the incident via the hospital incident reporting system. The main outcome measures included comparisons of severity ratings and likelihood of reporting by the four health professional groups. Test–retest reliability of the severity ratings was also examined within and between professional groups.

Pharmacists and nurses were significantly more likely to report the errors if they had witnessed them (mean scores 36.3 and 36.2, respectively, compared with 27.9 for doctors,  $P, 0.001$ ). Nurses and pharmacy technicians assigned higher severity ratings for medication errors (mean scores 23.6 and 25, respectively) than pharmacists or doctors (both 19.4). Both within and between healthcare professional groups, there was wide variation in the assignment of medication error severity ratings.

There are marked differences in the severity ratings for medication errors graded against the NRLS severity criteria between different health professional groups and at different time points rated by the same individuals.

# The Reporting and Learning System

The RLS aims to help the NHS improve the safety of patient care. Reports made to the RLS are analysed with expert clinical input to identify hazards, risks and opportunities to improve safety. Information from reported incidents helps the NHS understand why things go wrong and how to stop them happening again.

A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

The NPSA encourages the reporting of all patient safety incidents. This includes:

- incidents you have been involved in;
- incidents you may have witnessed;
- incidents that caused no harm or minimal harm;
- incidents with a more serious outcome;
- prevented patient safety incidents (known as 'near misses').

The information from reports feed into the RLS. All this information helps us to identify trends and patterns in patient safety and helps in our work to develop solutions. The aim is to help the NHS to learn from things that go wrong.

The NPSA provides regular feedback reports to NHS organisations on the incidents that have been sent to us.

## Interpreting RLS data

The following notations are used when per cent is shown in the report and accompanying workbook:

- '0' is used for percentages that are rounded down to 0;
- '-' is used for a true 0 in a row/column showing per cent, i.e. when there are no cases in a category;
- '\*' is used when the base number is deemed too small to provide reliable percentages ( $n < 30$ ). This notation may differ compared to that used in QDS reports and workbooks prior to Issue 6.

**Note:** *Rounded figures are presented in this report. Therefore totals may differ marginally compared to the sum of figures as stated in the text. The exact figures can be found in the workbook.*

- There are a number of notes of caution in interpreting the data from the RLS:
- A higher number of reported incidents from a trust, specialty or location does not necessarily mean that the trust, specialty or location has a higher number of incidents; it may instead reflect greater levels of reporting.
- NHS organisations have provided data to the RLS for report may not be representative of the rate of incidents across all of England and Wales.
- Reports made to LRMS may not capture all types of incidents that occur.
- The data are confidential. The NRLS does not seek to hold information on the identities of individual staff or patients and this means that the data are not routinely checked with the reporter. Steps are taken to maximise the quality of the data held by, for example, checking for duplicate reports and feeding back to individual trusts if there are problems with their reports.
- Incident reports are often made soon after the incident occurs but before the incident has been investigated locally. Therefore, reports to the RLS may not contain complete information about the incident, especially findings of more detailed investigations such as root cause analysis.
- No reports from the public or patients are included in this analysis, although since April 2006 patients and the public have been able to report incidents via a dedicated reporting form.

- Some incidents recorded in LRMS and subsequently forwarded to the RLS may not be patient safety incidents. For example, deaths from natural causes which occurred in hospital and also deaths where patients died unexpectedly are sometimes reported to LRMS for local audit purposes and then uploaded to the RLS.
- The data are likely to include incidents where the impact on the patient or whether the incident could have been avoided is not clear. For example, suicides are often reported to LRMS in cases where the event could not have been prevented by health services.
- The level of detail collected varies locally. For example, some organisations and local data collection systems do not currently collect contributing factors or the ethnicity of the patients involved. At the present time, there is insufficient information on the age and gender of patients involved in incidents to allow analysis of this information, but the quality of demographic data is improving.

Although incident reports are fundamental to understanding patient safety, on their own they cannot tell us all that we need to know. There are a number of reasons for this. Incident reporting systems are not comprehensive due to under reporting, biases in what types of incident are reported and the existence of several reporting systems. For example, in the UK, in addition to the RLS there are separate reporting systems for medical device incidents<sup>4</sup>, adverse drug reactions<sup>5</sup>, healthcare associated infections<sup>6</sup> and suicide and homicide of people with mental illness<sup>7</sup>.

## References

- 1** Hutchinson A et al. Trends in healthcare incident reporting and relationship to safety and quality data in acute hospitals: results from the National Reporting and Learning System. *Qual Saf Health Care*. 2009; 18:2
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