

Patient Safety Bulletin

Emerging themes from reported incidents

January 2007

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Welcome from Lord Patel

The NHS has made an important investment in patient safety by introducing the first national reporting and learning system (NRLS), launched by the NPSA in February 2004.

Since then, thanks to the commitment of NHS staff, over one million incident reports have been collected and analysed.

The *Patient Safety Bulletin* highlights the emerging issues arising from this analysis. These issues may not immediately be subject to further detailed analysis or solution development, but nevertheless are essential to feedback to the NHS.

The content of the Bulletin is driven by, and dependent on, the consistent reporting of incidents and the quality of those reports.

We are all stakeholders in patient safety and the Bulletin illustrates how incident reports can be used to share learning and improve safety.

I hope you find this issue informative and useful.

Lord Patel
Chairman, NPSA

Quarterly summaries of data from the National Reporting and Learning System are available at: www.npsa.nhs.uk/NRLSdata

Safety improves following NHS action

Action by NHS organisations following recommendations on the storage and use of potassium chloride has significantly improved patient safety on general wards – although further action is required to protect patients in critical care areas.

General ward areas

The NPSA issued advice to the NHS in 2002 aimed at minimising the risk of wrongly selecting potassium chloride concentrate ampoules for either sodium chloride 0.9% or water for injections.¹ The recommendations included removing the concentrate from clinical areas and using ready-diluted infusions.

Evaluation of implementation in 154 trusts in England and Wales, undertaken in 2003, showed that over 97 per cent had implemented the recommendations.

Additionally, in an independent evaluation of 20 trusts by Lankshear et al in 2005, 98 per cent of trusts were found to be fully compliant with the recommendations.²

Since the recommendations were published, the NPSA has not received any reports of incidents of death or serious harm concerning maladministration of potassium chloride concentrate in general ward areas.

Critical care areas

In critical care areas it is not always

possible to remove potassium chloride concentrate products and so it was recommended that the concentrate be stored in a separate cupboard to sodium chloride and water for injections, and that additional documentation controls be introduced.

Since the recommendations were published, there have been reports of two deaths involving potassium chloride concentrate infusions in critical care areas.

These incidents involved high strength potassium chloride infusions being mistakenly administered too rapidly via a central venous catheter.

In a recent audit of 41 hospitals in the north of England, 53 different strengths of potassium chloride infusions were still being prepared and used in mainly critical care areas.³

It is recommended that NHS organisations review the range of potassium chloride infusions being used in critical care. They should reduce the range of infusions used and minimise the preparation of infusions in these areas by procuring ready-to-use/ready-to-administer formulations from hospital pharmacy manufacturing units or commercial manufacturers.

In addition, there should be written guidelines and procedures to assist in the prescribing, preparing, administering and monitoring of high strength potassium infusions in critical care units. All critical care staff should receive this training on induction and at update sessions.

Adequate safeguards need to be maintained in all areas where potassium chloride concentrate is stored and used. These products still pose a significant risk to patients and by implementing these recommendations on critical care wards, safety can be improved for all patients.

We recommend that trusts undertake an audit of practice and policy on high strength potassium chloride use in critical care areas, with reference to the original NPSA alert and the suggestions above.



1 National Patient Safety Agency. *Potassium chloride Patient Safety Alert*. July 2002. Available at: www.npsa.nhs.uk/health/alerts

2 Lankshear AJ, Sheldon TA, Lowson KV, Watts IS, Wright J. Evaluation of the implementation of the alert issued by the UK National Patient Safety Agency on the storage and handling of potassium chloride concentrate solution. *Qual Saf Health Care*. 2005; 14: 196-201

3 Hardy L. *Risk assessment of parenteral products across the North of England Phase one report*. Pharmacy Department, Seacroft Hospital, Leeds. June 2005.

Emerging safety themes

The *Patient Safety Bulletin* is an important way in which emerging safety issues, as reported by NHS staff, are shared across the service.

This key publication will now regularly disseminate news of those issues that emerge from incidents reported to the NPSA, as well as from other data sources.

The Bulletin will be made available to all NHS staff and will address a wide range of issues affecting all aspects of healthcare.

The content is generated by reports from NHS staff. To date, most of those reports come from acute trusts. In future, as reporting from other sectors continues to increase, there will be more issues that are relevant to, for example, primary and community care settings.

Articles in the Bulletin will predominantly feature issues where local action can reduce risks to patients. For example, action taken by NHS organisations has resulted in the successful reduction in incidents involving potassium chloride (page 1).

This issue features an article from the National Confidential Enquiry into Patient Outcome and Death, about the importance of raising awareness of the risk of sedation in older people having endoscopies (page 3).

A distressing report of a fatal incident involving flammable bandaging is also featured. The trust involved and the patient's family wanted to share this story so that other similar incidents might be prevented from occurring in the future (page 4).

Data from the NRLS has highlighted safety issues in maternity care. One article here provides an overview of reported incidents, and another focuses on concerns about the risks faced by mothers who have had a previous Caesarean section (pages 3 and 4).

The feedback featured in the Bulletin is dependent on the detailed reporting of incidents. There are some small changes that can be made at a local level that will make a big difference to the quality and completeness of data (page 6).

The Bulletin is a joint project between the NPSA and those who report incidents to us. If there are issues you are aware of from your experiences locally, it can make a difference if they are shared across the service.

To find out more about reporting and the solutions work of the NPSA, go to www.npsa.nhs.uk

Please contact us at: NPSA, 4-8 Maple Street, London W1T 5HD or email enquiries@npsa.nhs.uk

**Professor Richard Thomson – Clinical Editor
Director of Epidemiology and Research, NPSA**

Risk from IV infusions

A report of a fatal incident has highlighted the risks of prescribing intravenous infusions for hospital patients.

The report, made via the NPSA's anonymous online form, described how a pre-registration house officer (PHRO) got the clinical assessment of a patient wrong and inappropriately prescribed fluids. The patient died due to fluid overload.

The reporter indicated that this was just one example of a regular occurrence that is likely to be a major cause of iatrogenic avoidable deaths in NHS hospitals.

Underlying causes of this error were considered by the reporter to be: PHROs prescribing intravenous infusions in the middle of the night with little or no supervision from senior medical staff; poor training of doctors in assessing fluid balance and the dangers of excessive fluid administration; and poorly designed processes and fluid balance charts.

An analysis of data from the NRLS found very few reports of incidents involving infusion fluids; suggesting that the problem is not a well-recognised patient safety risk.

Research on the subject carried out in UK hospitals support these theories. An audit carried out in a colorectal unit in a large District General Hospital¹ found that nearly one in five post-operative general surgical patients developed intravenous fluid-associated complications.

Seventeen per cent of patients developed fluid-associated morbidity. Seven patients developed tachyarrhythmia, which were associated with the prescription of inadequate maintenance potassium. Five patients developed fluid overload, associated with excessive fluid and sodium administration.

In a telephone questionnaire of 100 PHROs and 50 senior house officers (SHOs),² only 56 per cent of respondents stated that fluid balance charts were checked each morning on the ward round, and few reported post-operative weighing as a means of measuring fluid balance.

Knowledge of electrolyte content of commonly used solutions and electrolyte and fluid requirements were also tested. Results exposed significant gaps in junior doctors' knowledge.

The report's authors concluded that protocols for management need to be reviewed, and fluid and electrolyte prescribing by junior doctors requires close supervision. They also suggest that undergraduate and postgraduate education and training in this area should be improved, with an emphasis on practical application.

¹ Walsh SR, Walsh CJ. Intravenous fluid-associated morbidity in postoperative patients. *Ann R Coll Surg Engl.* 2005; 87(2): 126-30.

² Lobo DN et al. Problems with solutions: drowning in the brine of inadequate knowledge base. *Clin Nutr.* 2001; 20(2): 125-30.

The NPSA recommends that NHS organisations take the following actions to improve patient safety with intravenous infusions:

- 1 Ensure staff are aware of the risks associated with infusion fluids and encouraged to report* patient safety incidents involving this therapy, so that the problem can be better understood and tackled.
- 2 Carry out an audit of the prescribing of infusion fluids, fluid balance and electrolyte assessment.
- 3 Review policies and procedures concerning fluid balance assessment and the prescribing of infusion fluids.
- 4 Review the competencies and training of junior hospital doctors in this area.

* Staff can report incidents using their local reporting forms, or they can report online and anonymously (with the option of sharing their report with their trust) to the NPSA at: www.npsa.nhs.uk/staffreports

Elderly patients vulnerable to sedative overdose



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New findings have shown that elderly patients are at risk of being given excessive doses of sedatives for gastro-intestinal (GI) endoscopy.

As a result, advice is being issued to the NHS on recommended doses of sedative drugs.

This issue first became an area of concern following a report of a serious incident in dental anaesthesia, which has been followed up with the Chief Dental Officer.

People over the age of 70 are more sensitive to many drugs than younger people. It is well established that the dose of Midazolam they require is usually half or less of that required by younger patients. Midazolam is an intravenous (IV) benzodiazepine routinely used for procedures requiring IV sedation.

A 2004 report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), *Scoping our practice*,¹ found that there have been 1,818 deaths

after therapeutic GI endoscopic procedures between 1 April 2002 and 31 March 2003. NCEPOD advisors judged that the sedation given was inappropriate in 14 per cent of these cases, usually because an overdose of benzodiazepine had been administered. The use of flumazenil, a benzodiazepine antagonist, usually indicates that the patient has been given a relative overdose of benzodiazepine.

Detailed analysis of NCEPOD data has shown that patients who were given flumazenil died two days sooner after their endoscopy than patients who did not receive flumazenil.²

Analysis of NRLS data has shown that there have been 349 reports of incidents involving Midazolam or Pethidine between 24 November 2003 and 30 September 2005.

Monitoring and safety guidelines for sedating patients have been issued in the past; particularly in light of a 1991 audit³ of over 14,000 patients that had an upper GI endoscopy. The audit found that over 100 patients died within 30 days of the procedure. Several of these patients died as a result of being given too large a dose of either IV Midazolam or Diazepam.

Previous guidelines have all stressed the importance of not exceeding the dose of IV benzodiazepine recommended by the manufacturer, and of reducing the dose sufficiently in elderly, frail or at-risk patients.

Recent audits of endoscopic procedures such as colonoscopy have shown improved monitoring of endoscopy patients.⁴ However, the NCEPOD study shows that some endoscopists continue to use excessive doses of sedatives in elderly patients.

The British Society of Gastroenterology (BSG) issued guidelines in 2003 on doses of Midazolam and Pethidine in vulnerable, at-risk and elderly patients⁵ and the NPSA fully endorses these.

It is recommended that all endoscopy units adopt the following dosing policy with immediate effect. This dosing policy should also be considered for other procedures requiring IV sedation:

- 1 In patients over the age of 70, no more than 2mg of Midazolam or 25mg of Pethidine should be drawn up into any syringe prior to the procedure. In most instances, the maximum dose of sedative should be 2mg of Midazolam or 25mg of Pethidine. It is, however, recognised that this group of patients exhibit a wide spectrum of baseline physiology and medical conditions, and that occasionally it may be appropriate to exceed this dose. This will depend upon the procedure being undertaken, and the degree of sedation achieved once the effect of the initial dosing has been observed.

2 In patients under the age of 70, no more than 5mg of Midazolam or 50mg of Pethidine should be drawn up into any syringe prior to the procedure.

3 The practice of routinely drawing up 10mg of Midazolam or 100mg of Pethidine should cease for all patients.

4 The drugs should be given slowly into an indwelling plastic cannula and flushed through with sterile saline. Further 'top-up' doses of Midazolam or Pethidine should only rarely be required.

The NPSA will approach drug manufacturers to explore whether ampoules containing Midazolam 2mg in 2ml and 5mg in 5ml can be made available in the UK in addition to the present standard Midazolam 10mg in 5ml. A similar approach will be taken concerning Pethidine 25mg in 1ml.

1 *Scoping our practice*. Available at: www.ncepod.org.uk

2 Lord DA et al. *Sedation for Gastrointestinal Endoscopic Procedures in the Elderly: Getting Safer but Still Not Nearly Safe Enough*. Available at: www.bsg.org.uk/pdf_word_docs/sedation_elderly.pdf

3 Quine MA et al. Prospective audit of upper gastrointestinal endoscopy in two regions of England: safety, staffing and sedation methods. *Gut*, 1995; 36(3): 462-7

4 Bowles CJA et al. A prospective study of colonoscopy practice in the UK today: are we adequately prepared for national colorectal cancer screening tomorrow? *Gut*, 2004; 53(2): 277-83

5 *Safety and Sedation During Endoscopic Procedures*. 2003. Available at: www.bsg.org.uk/bsgdisp1.php?id=58f1bad2cab34caa44ac&h=1&sh=1&i=1&b=1&m=00023

info@ncepod.org.uk

Increase in incidents of postpartum haemorrhage

Analysis of reports made by NHS staff has shown an increase in incidents of postpartum haemorrhage associated with Caesarean section.

Postpartum haemorrhage is a significant cause of maternal mortality and morbidity, and has generally been associated with vaginal delivery, but NRLS data show that there is now also a significant link to Caesarean section. In some cases, postpartum haemorrhage can result in hyster-

ectomy. From November 2003 to February 2006, there were 52 incidents reported of hysterectomies following deliveries associated with postpartum haemorrhage. Of these, 32 were associated with Caesarean section. Half of these women had either a low lying placenta and or a placenta that was invading through the uterine wall (placenta accreta) which is often associated with a previous Caesarean section.

Research suggests that the risk of hysterectomy following Caesarean section for a low lying placenta is about one in 400. But the risk rises dramatically to at least one in 65 if the woman had also previously had a Caesarean section. Therefore women having a Caesarean delivery who have had a previous Caesarean and have a low lying placenta have been identified as at higher risk of postpartum haemorrhage and associated hysterectomy.

This increased risk is also ratified by the Confidential Enquiry into Maternal and Child Health (CEMACH). CEMACH also suggest that the risk of maternal death in a woman with a low lying

placenta who had previously had a Caesarean section may be as high as one in 200.

More accurate data will soon be available from the UK Obstetric Surveillance System (UKOSS) which has looked at 200 cases of hysterectomy at the time of childbirth. Since assessing this information, the Royal College of Obstetricians and Gynaecologists have been developing guidance for clinicians in the management of these cases in order to reduce the morbidity and mortality related to this procedure.

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Focus on safety in maternity care

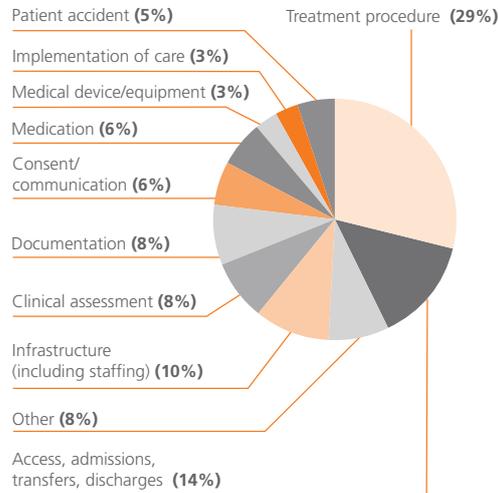
Over 60,000 patient safety incidents associated with maternity care have been reported from November 2003 to the end of June 2006.

Most women receive safe and high quality maternity care, but when things go wrong, the outcome can be catastrophic for the woman and her baby. Many of the incidents reported to the NPSA are related to delays in treatment and the failure to recognise complications.

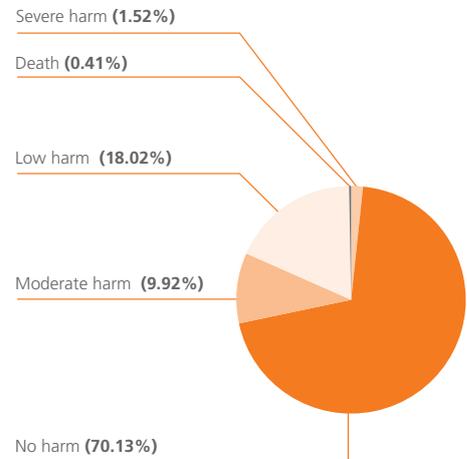
These incidents support the findings of other organisations (the NHS Litigation Authority, the Healthcare Commission, the Confidential Enquiry into Maternal and Child Health (CEMACH) and the Institute for Healthcare Improvement) that suggest that many of the factors that contribute to patient safety problems in maternity care are to do with systems, including:

- staff having inadequate experience and/or skills;
- leadership and management issues;
- delayed or inappropriate decision-making;
- lack of consultant involvement;
- equipment problems;
- poor team work;
- inadequate support services, (for example, interpreters, advocacy);
- problems with fetal surveillance;

Categories of maternity patient safety incident reports



Degree of harm of maternity patient safety incident reports



- lack of staff or the wrong mix of skills.

Midwives, obstetricians and others working in maternity care are familiar with many of these issues. The NPSA is working with organisations such as the royal colleges, the Northern Regional Maternity Survey Office and CEMACH to address these issues.

This work includes:

- combining root cause analysis and anonymised case review to evaluate incidents involving women who become seriously ill due to complications during pregnancy;
- scoping work on the use of

obstetric 'bundles' to improve safety in intrapartum care;

- identifying the specific patient safety issues for vulnerable groups of women known to be at higher risk of maternal death;
- preventing wrong route errors with epidural infusion;
- sharing information about locally developed solutions, for example, in some maternity units, a simple sticker, based on the National Institute for Health and Clinical Excellence cardiotography (CTG) interpretation algorithm, is being used to ensure that CTGs are reviewed regularly, decisions

made and recorded, and an action plan formulated.

The NPSA is collaborating with the Patient Safety Research Programme which has commissioned research on:

- obstetric drills and simulation;
- reviewing obstetric litigation data;
- reviewing the incidence of neonatal encephalopathy.

Through reports of incidents to the NRLS and other data sources, causal factors of patient safety incidents can be identified and advice developed to help the NHS improve the safety of maternity care.

Skin treatment fire risk

The death of a patient undergoing treatment for psoriasis has highlighted the fire risk associated with a commonly used topical dermatological product.

The fatal incident occurred when the patient was receiving treatment for an acute exacerbation of psoriasis that included the application of an ointment containing 50/50 white soft and liquid paraffin with coal tar, and covering the affected areas of the body with gauze bandaging.

After the treatment, the patient walked out onto a fire escape, lit a cigarette and the bandages ignited.

The intensity and immediacy of the fire caused the patient to suffer 90 per cent burns and die. Similar incidents have been reported with, in one case, the patient suffering 12 per cent burns.¹

Following the incident, the trust involved has recommended that:

- all patients and carers must be informed of the potential fire

risk of this treatment due to the combustible property of the ingredients, and the advice given should be documented;

- the use of non-flammable clothing for patients receiving this treatment should be explored;
- all patients who smoke should be offered help, advice and support to help them stop smoking;
- trusts should consider the impact of their 'No Smoking

in Hospital and Grounds' policies as the risk of this type of incident happening within the hospital environment may be increased as patients try to find somewhere to smoke.

No further similar incidents have been reported to the NRLS. However, this is an important issue to raise and the hospital involved and the patient's family have shared details of this incident in the hope that others can learn from this experience and prevent similar incidents from happening in the future.

¹ Allan SJR, Tidman MJ. Dermatology dressings: an incendiary potential. *British Journal of Dermatology*. 2001; 144: 649-650

Rise in community pharmacy reports

Including the reporting of patient safety incidents to the NPSA within the community pharmacy contract has had a significant impact on the number of incidents being reported from this sector.

This has arisen through proactive consideration and prevention of potential risks, and analysis of critical incidents by the whole pharmacy team to inform individual and organisational learning.

Initially it is only serious incidents which have to be reported, but it is expected that this requirement will, in the future, be expanded to include all incidents.

From November 2003 to the end of June 2006, there were 2,041 reports received from the commu-

nity pharmacy sector; of which one resulted in the death of a patient and 26 resulted in moderate harm to the patient.

Most of the errors (92 per cent) reported from this sector involve dispensing errors, rather than errors occurring during other parts of the pharmaceutical process, such as prescribing or administration.

It is expected that the range of errors reported will increase as pharmacists become more comfortable with the reporting process.

Of the dispensing errors reported, the majority (63 per cent) involved picking errors related to drugs with similar names, or the wrong strength of the correct drug. Drugs such as amitriptyline, atenolol,

amlodipine and amiloride were commonly involved in patient safety incidents.

The high incidence of errors with certain drugs could be due to their high usage within the community, or the fact that the drugs implicated (for example, cardiovascular drugs, antiepileptics, insulins, antipsychotics) have greater capacity for causing harm than some others, and therefore incidents are more readily reported by staff.

The tables below show the number of reports of incidents from community pharmacy relating to the stage in the process where the error was deemed to have occurred (table 1), and the nature of the error (table 2).

As staff working in community pharmacy continue to increase their reporting, and to develop a reporting culture, themes can be identified and solutions found to those issues specific to this sector.

Table 1

Stage in process that error occurred	Number of reports
Administering and supplying	34
Prescribing	79
Preparing medicines in all locations/dispensing in a pharmacy	1,885
Monitoring/follow up of medicine use	6
Advice	3
Supply/use of over-the-counter medicines	19
Other	13
Unknown	2
Total	2,041

Table 2

Type of error	Number of reports
Adverse drug reaction when used as intended	2
Contra-indication in relation to drugs or conditions	11
Mismatching between patient and medicine	111
Omitted medicine/ingredient	27
Patient allergic to treatment	6
Wrong/omitted/passed expiry date	42
Wrong/omitted patient information leaflet	5
Wrong/omitted verbal patient directions	3
Wrong/transposed/omitted medicine label	102
Wrong/unclear dose/strength	612
Wrong drug/medicine	672
Wrong formulation	180
Wrong frequency	31
Wrong method of preparation/supply	19
Wrong quantity	128
Wrong route	1
Wrong storage	4
Unknown	58
Other	27
Total	2,041

MRI scanners – magnetic element risk

MRI scanners are powerful diagnostic tools used for a variety of conditions. The powerful magnet in the scanners, however, can cause risk to patients and staff.

These risks include:

- metal within the body, such as pacemakers, shrapnel or aneurysm clips becoming displaced or malfunctioning;
- metallic equipment attached to the patient, such as intravenous pumps and syringe drivers, malfunctioning;

- loose metal objects becoming projectiles, with potential for fatal injury if a patient or staff member is in the pathway of a large metallic object (for example an oxygen cylinder).

These risks are well known; guidelines for magnetic resonance equipment in clinical use were produced by the Medicines and Healthcare products Regulatory Agency (MHRA) in 2002.¹

Although incidents are very rare in the context of the high number of investigations carried out in MRI units, one death is known to have occurred in the UK through scanning with an undetected pacemaker, and nine deaths have been reported in the USA, including the death of a child through a projectile oxygen cylinder.

Patients who are confused, of low literacy, or who do not speak fluent English, may be

particularly at risk of harm, as they may not be able to identify lifetime risks (for example, having worked with metal, or been injured by shrapnel) or recall their full medical history.

MRI units also have to manage risks related to contact burns and contrast reactions, and the management of very sick patients away from the ward environment

After concerns raised by a manager working in an MRI unit, NPSA patient safety managers visited several MRI units to explore the safety issues. There was considerable variation in safety practice between units, for example, in how entry to the unit was restricted, how patients were prepared for examination, how information was provided to patients on possible risks, and how patients too ill to complete a safety form were managed. (*continued on page 6*)

(continued from page 5)

How to reduce risks

- Whether providing or commissioning services, there must be effective reporting systems in MRI units linking to local risk management systems and the NRLS.
- Audit local compliance with MHRA guidance.
- Review patient information – leaflets, safety questionnaires, posters and notices – for ease of understanding, especially for patients with low literacy.
- Review the effectiveness of safeguards for patients unable to complete their own safety questionnaire.

- 1 MHRA. *Guidelines for Magnetic Resonance Equipment in Clinical Use. 2002.* Available at: www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON007427&ssTargetNodeId=575

What does NRLS data show?

Analysis of reports to the NRLS has shown that 1,262 patient safety incidents concerning MRI units have been reported from November 2003 to June 2006.

Of these, 77 were directly related to metallic objects or implants. Whilst none resulted in serious harm, 18 pacemakers, two implantable defibrillators, two heart valves and five aneurysm clips went undetected through initial safety checks and harm was only prevented by staff vigilance.

Incompatible medical equipment was taken into the scanner on 10 occasions, with both projectile risk and potential disruption to therapy. On five occasions this resulted in objects actually being pulled into the magnet. No patients were harmed, although on one occasion a baby was inside the scanner at the time. Projectiles included a mirror, tweezers, keys, a sprung pillow, monitor and syringe driver.

Improving data quality



By reporting incidents that occur, NHS staff are contributing to the crucial process of identifying issues that can cause harm to patients, so that solutions can be developed and implemented.

Comprehensive and systematic analysis of the more than one million reports in the NRLS database is a vital part of this process. However, as with any system that collects significant volumes of data, analysis has identified issues to do with reporting levels, frequency of reports and data quality that may impact on the conclusions drawn from the data.

There are several key issues surrounding incident reporting:

Actual and potential harm

It is good local risk management practice to collect information on the degree of actual harm/severity as well as the potential for harm should the incident happen again. However, the NRLS only collects information about actual harm.

Some organisations use the potential outcome to classify incidents in their reports, as extrapolated using their risk assessment matrix (such as a 5x5 grid), rather than the actual outcome. For example, an incident that did not result in any harm may be classified as severe harm or even death if it had the potential to produce that outcome.

Data on actual harm should be collected and submitted when uploading data to the NRLS.

Definitions and examples of levels of severity are on the NPSA website: www.npsa.nhs.uk/health/reporting

Patient and staff names

In keeping with data protection principles, the majority of NHS organisations avoid entering the

names of patients or staff in the incident description field when reporting incidents. However, a minority of organisations do include names in the free text of incident reports.

The NPSA does not hold data on patient or staff names, and seeks to anonymise reports as far as is practicable by removing any names in the free text field. However, this cannot always be guaranteed.

To support confidentiality, reports should not include any names of patients or staff in the free text section of incident reports.

Detailed reports

The precise details of what happened during a patient safety incident is invaluable information when trying to understand the nature and causes of incidents.

Those reporting incidents should include in the free text section a clear description of what happened, including perceived causes and contributory factors.

Use of 'Other' category

Incidents that are categorised as 'Other' in any of the fields restrict the level of useful analysis of the information.

Those reporting incidents should review the way they classify incidents when inputting them into their risk management system, and seek to minimise the use of 'Other' wherever possible.

Frequency of reporting

To help those reporting incidents, the following is basic guidance on how often they should upload their incident reports to the NRLS (if reporters wish to input their data more often than this, they should do so):

- if you input **more than 150** incidents per week, upload weekly;
- if you input **between 50 and 150** incidents per week, upload fortnightly;
- if you input **less than 50** incidents per week, upload monthly;
- if you have **a very small number** of incidents, for example one or two a month, upload as soon as they are inputted;

It may be useful to set up a reminder system to ensure that incidents are uploaded to the NRLS on a regular basis (at least monthly).

Drug names

Medication errors make up over eight per cent of all reports. The inclusion of the specific drug or medication name involved in the incident is vital. This will become a mandatory NRLS field in the future and it is good practice to include these detail in incident reports.

Space should be designated on incident report forms for the collation of medication error details, including drug name, which should be entered into local risk management systems.

Ethnicity details

The Race Relations (Amendment) Act 2000i places a duty on public authorities to promote equality and good relations between persons of different racial groups and to work towards the elimination of unlawful racial discrimination. Public bodies must record ethnicity data consistently and accurately so that health planning and policy are effective and properly targeted.

The ethnicity of patients involved in incidents should be included in reports. Reporting forms must enable staff to record these details. The information must also be entered into local risk management systems.

Classifying patient safety incidents

Local risk management systems capture details of a range of different types of incidents. However, the NRLS only collects information about patient safety incidents.

There should be mechanisms in place for screening out reports that are not patient safety incidents, such as those solely involving staff, or theft, property and security.

By improving the quality of incident reports, specific safety issues can be identified. The NPSA is working with NHS staff to develop the reporting culture within organisations so that we can work together to improve safety. Local NPSA patient safety managers can help and advise organisations on reporting of incidents.