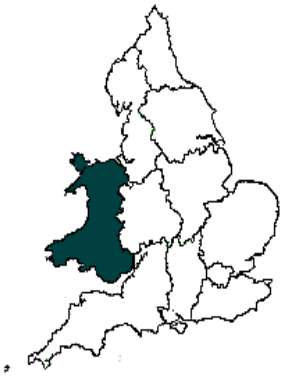


Organisation Patient Safety Incident Report

1 April 2011 to 30 September 2011

Velindre NHS Trust

Organisation type: **Acute specialist organisation**

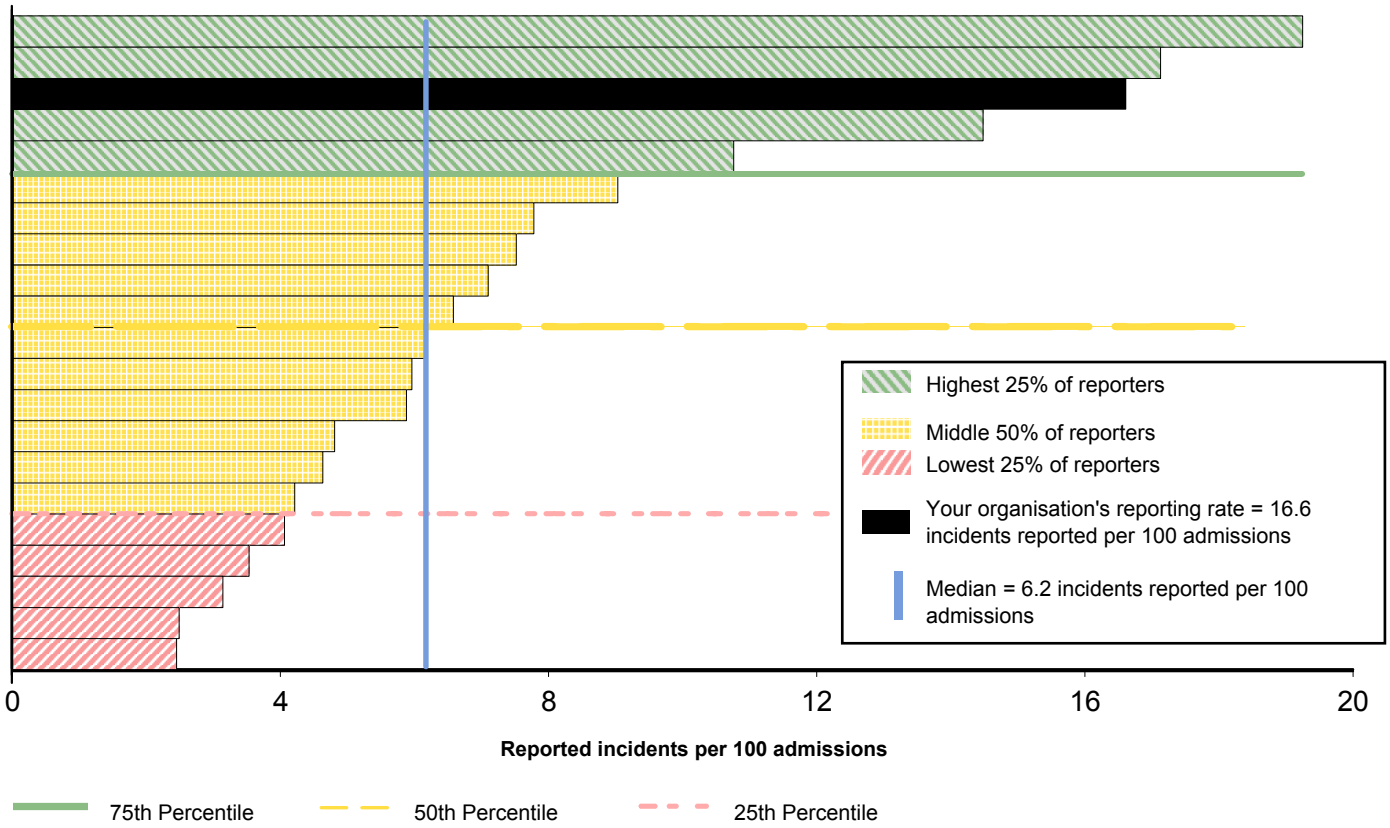
Location: **Wales**

NHS
National Patient Safety Agency

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLS) between 1 April 2011 and 30 September 2011. 303 incidents were reported during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 21 acute specialist organisations.



Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between April 2011 and September 2011.

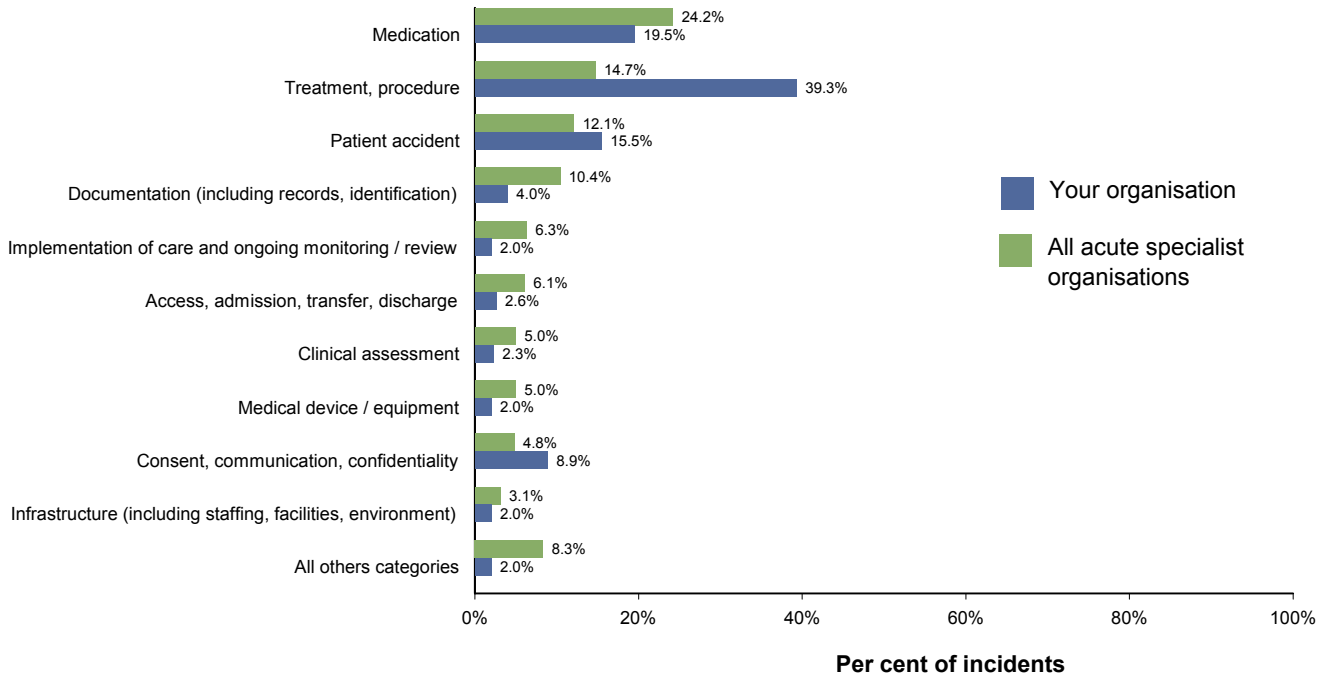
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty percent of all incidents were submitted to the NRLS more than 36 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 40 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

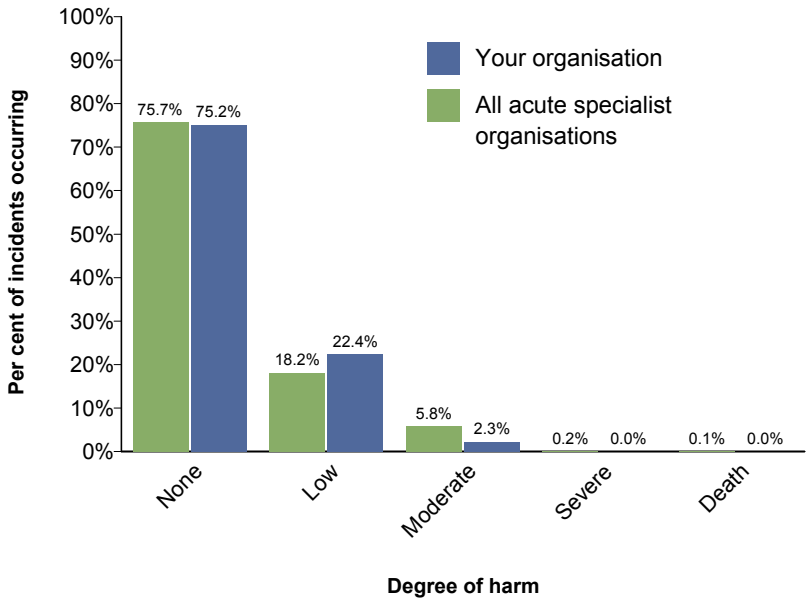
What type of incidents are reported in your organisation?

Figure 2: Top 10 incident types



If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for acute specialist organisations



Your figures:	None	Low	Moderate	Severe	Death
	228	68	7	0	0

Do you understand harm?

Nationally, 68 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Further information for you

The NPSA helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. National data from the NRLS can be found at: www.nrls.npsa.nhs.uk.