NHS
National Patient Safety Agency
National Reporting and Learning Service

How do your patient safety incident reports compare with your peers'?

NHS organisation feedback report for

Any Town Trust

(Medium acute trust)

A feedback report for your organisation
on patient safety incidents reported to the
Reporting and Learning System within a cluster

Comprising incidents occurring between
October 2008 and March 2009

For any queries, please contact:
nrlsxtranet@npsa.nhs.uk

Contents

List of figures and tables

1 Your organisational feedback report

This feedback report provides a snapshot of the patient safety incidents occurring in your organisation, and your organisation's reporting culture, between 1 October 2008 and 31 March 2009, through individualised analysis of incidents reported from your organisation to the Reporting and Learning System (RLS).

The analyses presented in this report show you:

- what and where patient safety incidents occurred in your organisation between 1 October 2008 and 31 March 2009;
- how your organisation compared with other similar organisations (your cluster group, see page 2) in terms of rates of occurrence of incidents and reporting them to the RLS.

Key findings are presented in the main report, whilst detailed data (numbers, percentages, upper and lower quartiles, etc.) are given in Appendix 2.

The National Patient Safety Agency (NPSA) hopes that these analyses will stimulate your organisation's board, clinical governance or risk team, and clinical staff to have constructive discussions on how to:

- further improve the reporting of patient safety incidents in your organisation;
- provide safer care for your patients.

Improving reporting of patient safety incidents

Reporting of patient safety incidents can be improved by:

- implementing robust systems to send reports to the RLS at least monthly;
- developing an active reporting and learning culture;
- using the degrees of harm of severe or death correctly, including avoiding reporting deaths from natural causes as patient safety incidents;
- including medication name in reports of medication incidents;
- improving free text by avoiding the use of staff or patient identifiers and completing *'actions taken to prevent recurrence'*.

Note: As with all data, some analyses need to be interpreted with caution due to various reasons, for example, small numbers of incidents and incomplete reports. Throughout the report, boxes with the title *'! Interpret with care'* explain where and why caution is required while interpreting the data.

The RLS: every report helps

- Over 99 per cent of reports to the RLS are received via local risk management systems. Thus, for frontline staff, submitting a report to the RLS does not involve any additional time or effort. The NPSA is grateful to the staff in each NHS organisation who have developed and maintain their local risk management system and who regularly upload the locally reported incidents to the RLS.
- The information on patient safety incidents sent by your organisation to the RLS enables the NPSA to identify patterns and themes in patient safety, and provide feedback to the NHS on how this key component of healthcare can be improved, through a range of reports, alerts and other guidance (www.nrls.npsa.nhs.uk).
- If you have any problems with or questions regarding reporting to the RLS please call our helpdesk on 020 7927 9579 or visit the NPSA website for guidance and other sources of support (www.nrls.npsa.nhs.uk).

Who should read the feedback report?

Patient safety is at the core of delivering high-quality care to patients. Therefore, it is important that the report is circulated as widely as possible, for example to your organisation's:

- group leading patient safety;
- department patient safety leads;
- patient safety champion.

Key findings should be shared with frontline staff. To aid with this the NPSA has designed a template for local staff newsletters, which you can use to share the findings from this report with frontline staff. This can be downloaded from www.nrls.npsa.nhs.uk

The medication section should be shared with your head of pharmacy or equivalent role.

How to use the feedback report?

Throughout this report we have identified areas where your organisation may wish to make changes to further improve patient safety. We have listed the relevant NPSA products, developed using learning from the RLS, along with other sources of information, which you can use to help implement changes.

However, every organisation is different. Therefore, the key findings of this report should be shared at a board-level meeting, so that your local knowledge of the services, patients and staff can help you ask the right questions and lead to ongoing improvements in incident reporting and patient safety at your organisation. We recommend that the full report is discussed and any further action planned by the group that leads on patient safety.

You could also use this report as part of your organisation's self-assessment against the Healthcare Standards for England and the Healthcare Standards for Wales.

Data included in this report

This report presents an analysis of all patient safety incidents successfully submitted by your organisation to the RLS by 30 June 2009, where the date that the patient safety incident occurred was between 1 October 2008 and 31 March 2009.

Note that reports uploaded via your local risk management system and reports uploaded by individual staff via the RLS eform are included in the analysis in this report.

Cluster group

Your organisation's cluster group is shown on the front cover of this report. The NPSA uses standard benchmark grouping, as used by other parts of the NHS. To see the names of all organisations within your group, please visit www.nrls.npsa.nhs.uk

Terms of use

Please see the privacy statement, usage rules and disclaimer in Appendix 1.

Do you have a query about your data?

If you cannot reconcile this report with the number of incidents you believe your organisation has sent to the RLS, please see the data query section in Appendix 3.

! Interpret with care: Acute specialist organisations to note

Ideally benchmark cluster groups contain broadly similar types of organisations, so that we can compare ‘apples with apples, not apples with pears’. Clearly, many organisations that provide specialist acute care alone are very different from each other and some are unique. However, any benchmarking process relies on there being an adequate number of organisations within the cluster group: if you are the only ‘apple’ in your cluster group, you cannot be compared with other organisations in that group. Therefore, the comparison part of this report should be viewed with caution by specialist organisations.

2 Key findings

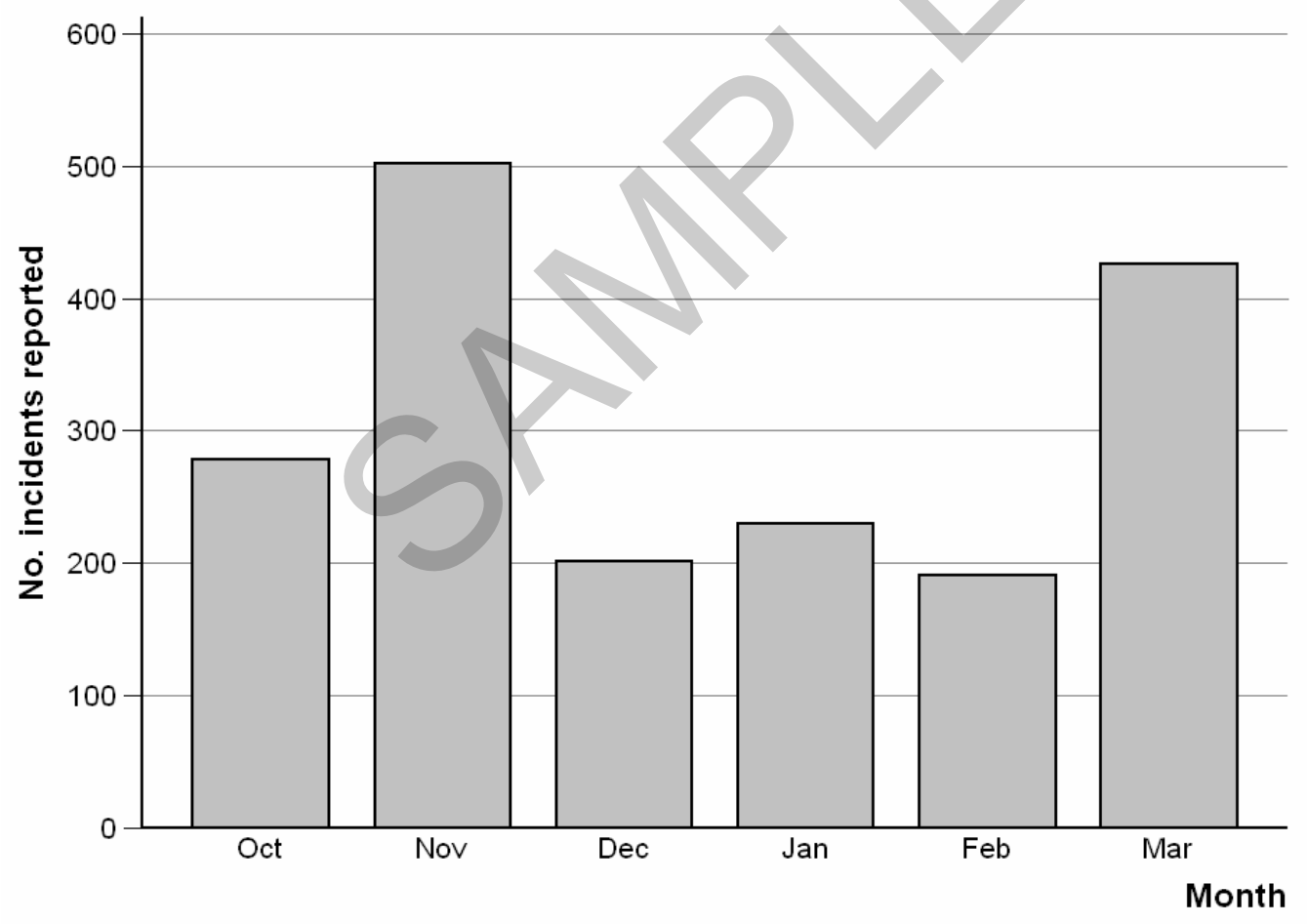
2.1 Your organisation's rate of reporting to the RLS

What we recommend:

- Each organisation should upload its latest data to the RLS at least monthly.
- If more than 50 patient safety incidents are reported in a week in your organisation then the data should be uploaded fortnightly.
- If more than 100 patient safety incidents are reported in a week in your organisation then the data should be uploaded weekly.

Figure 1 shows the pattern of uploading from your organisation from 1 October 2008 and 31 March 2009. This figure uses the date you successfully submitted incidents to the RLS rather than the date the patient safety incident occurred. We are going to be working with trusts to ensure that the most recent serious incidents are reported more quickly. Please see Section 3.8 for data on current timeliness on reporting from your trust.

Figure 1: Reports received by month from your organisation



Source: patient safety incident reports successfully submitted to the RLS during the period 1 October 2008 to 31 March 2009

How to interpret Figure 1

If the graph shows broadly similar numbers of incidents for all six months, your organisation has well-established systems for regularly reporting to the RLS, and your local risk management or clinical governance team should be congratulated.

If the graph shows large differences in numbers of incidents reported over the six months, your organisation probably has not yet established reliable systems for reporting to the RLS.

Implications of Figure 1 for your organisation

If Figure 1 indicates that your organisation is not reporting regularly, you may wish to consider some of the reasons listed below.

- Only one member of staff has responsibility for your organisation's local risk management system. So when they are absent or if they leave the organisation, reporting to the RLS is interrupted.
- Data entry into the local risk management system is irregular or interrupted owing to local resource issues, for example, the responsible staff member is on long-term leave or there are recruitment problems.
- There are problems in the link between your local risk management system and the RLS. This should be reported to the NPSA, so we can provide advice and support to help resolve the problem.
- Following a pattern of monthly reporting around the first or last day of each calendar month can lead to the appearance of less frequent reporting, for example if reports are submitted on 1 and 31 October, 30 November, 3 and 31 January.

The NPSA expects that if your organisation had not been reporting regularly to the RLS, board-level staff would have been made aware of this through internal communication before your received this feedback report, and that a plan has been put in place to establish regular reporting.

! Interpret with care: Irregular reporters to note

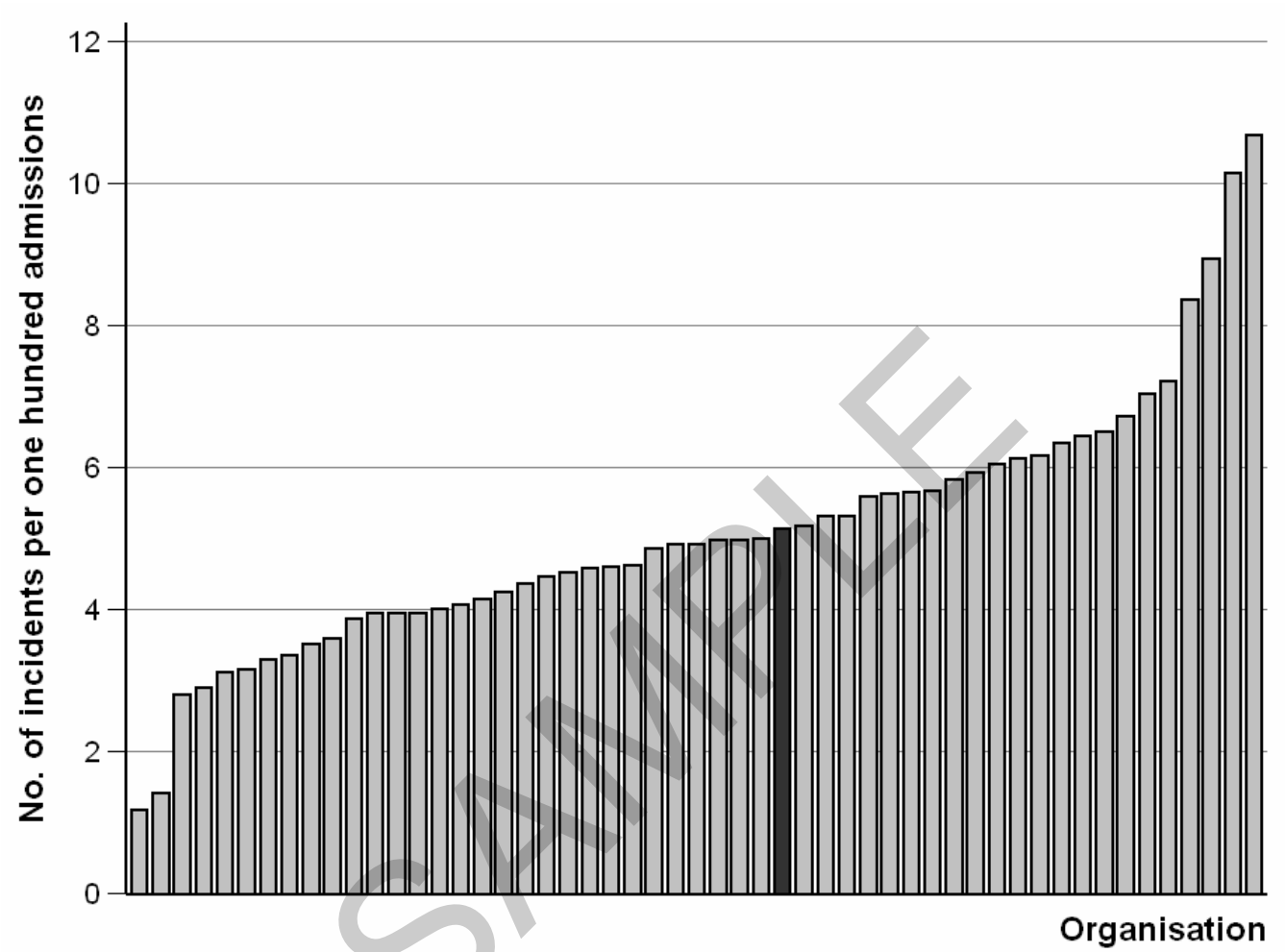
If your organisation has not reported regularly to the RLS, or did not report all incidents that occurred between 1 October 2008 and 31 March 2009 by 30 June 2009, the remainder of this feedback report should be read bearing this in mind.

If your organisation 'caught up' with reporting after 31 March 2009 but before 30 June 2009, these data are not shown in Figure 1 but have been used in the rest of this feedback report.

2.2 Your organisation's reporting culture compared with other organisations

In general, the higher the rate of incidents, the stronger the reporting culture in that organisation.

Figure 2: Incident rate per one hundred admissions



Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 2

Figure 2 shows the rates of reported patient safety incidents per 100 admissions in the organisations in your cluster group during the period 1 October 2008 to 31 March 2009. The black bar represents the data from your organisation.

A direct comparison of the number of reports from various organisations can be misleading, as even organisations within the same cluster can vary considerably in size and activity.

Implications of Figure 2 for your organisation

- If your organisation is not among the high reporters according to Figure 2: Experience in other industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents.[1] Reports of patient safety incidents are predominantly made by frontline staff. Therefore to improve your organisation's rate of reporting, ensure that frontline staff are made aware that their reports are being used to improve their patients' safety and that the staff involved in patient safety incidents are treated fairly.

- If your organisation is among the high reporters according to Figure 2: Research suggests that even in high reporting organisations, many incidents do not get reported,[2] and that organisations need to remain proactive to maintain the level of reporting. This includes ensuring that frontline staff continue to see that their reports are being used to improve their patients' safety, that the staff involved in patient safety incidents are always treated fairly, and checking that good reporting cultures continue to be maintained in all departments and all staff groups.

If Figure 2 indicates that your organisation has a low reporting culture, you may wish to consider some of the reasons listed below.

- Half of all organisations will inevitably appear in the lower half of this figure, so consider whether your organisation is already working on improving reporting rates when you look at the figure.
- Data from your organisation may be missing in the RLS database if you have not uploaded patient safety incidents regularly, so the figure may not be accurate for your organisation.
- The population your organisation serves, or the specialties you provide, may mean patient safety incidents are less likely to occur (for example, younger adult patients are less likely to fall than older patients).
- Your organisation's policy regarding the kinds of patient safety incident that should be reported may be resulting in fewer incidents being reported. The NPSA defines a patient safety incident as 'any unintended or unexpected incident which could have, or did lead to harm for one or more persons receiving NHS funded healthcare'. We have found that most organisations have a similarly wide definition, usually with an additional 'if in doubt, report' proviso, but you may need to take a second look at your local policy.

If you believe your reporting rates are below average because you have made greater improvements in patient safety than most other organisations in your cluster, you need to carry out case note reviews or observational studies to confirm that your lower rates are due to improvements in safety rather than due to under-reporting.

3 Further findings

! Interpret with care: Low reporters to note

If your organisation has reported few patient safety incidents, bear in mind that the rest of this feedback report may be affected. Small numbers of incidents can make detailed comparisons misleading, as each incident reported will then represent a greater proportion in the analysis (for example, if your organisation reported only 50 incidents, each incident will represent two per cent of the total, and make a visible difference to the figures).

3.1 How many patient safety incidents should be expected to occur in your organisation?

It is unlikely that a 'correct' level of reporting of patient safety incidents can ever be established. The development of increasingly complex treatments for previously untreatable conditions means that there are greater opportunities for error, even if safety improvements are happening at the same time.

International case note reviews suggest around one in 10 acute hospital patients suffer adverse events which resulted in some harm to the patient.[3] Although the definitions of adverse events and patient safety incidents overlap they are not equivalent, and adverse events studies do not include any no harm incidents (whilst around three-quarters of patient safety incidents reported from acute organisations are no harm incidents). As expectations and standards improve, minor delays in treatment or diagnosis that were previously accepted as normal practice will become perceived as patient safety incidents.

You may find it helpful to consider the findings of this feedback report in combination with other data sources on your organisation's safety culture. For English organisations, the Care Quality Commission's staff survey (www.cqc.org.uk) may be useful. Similar questions are included in the NHS Wales staff survey.

One study found that organisations with better scores on items in the staff questionnaire (related to fair treatment of staff reporting errors, encouraging reporting, confidentiality and preventive action taken) also had higher reporting rates per admission.[4] However, the NPSA would suggest caution in interpreting responses to question 3.4.4 (England) or questions 16a-c (Wales) (for example, *'Have staff observed an error or near miss in the past working month?'*) as a higher than average response here could indicate an organisation with staff who are more alert to patient safety incidents, rather than an organisation where more patient safety incidents occur.

Another study that compared local risk management systems with case note review, patient administration data, laboratory results, complaints, claims and inquests. It was found that all these data sources were potentially useful for identifying some reports of patient safety incidents that were not recorded by the local risk management systems.

For more details about how to triangulate data, see 'Using a broad range of data to monitor patient safety' at www.nrls.npsa.nhs.uk.

Also, organisations achieving the highest possible rating (Level 3) on their NHS Litigation Authority Clinical Negligence Scheme for Trusts assessment have significantly higher rates of reporting to the RLS.[4] We do not know whether a similar effect applies to the Welsh Risk Pool scores. It is also important to consider how your organisation's reporting changes over time: does your organisation undertake local analysis of year-on-year increases in reporting?

Can the NPSA help in improving your organisation's safety culture?

The NPSA has developed a variety of tools to help organisations improve their patient safety culture of reporting and learning. These include:

- Seven steps to patient safety – *advice on building a safety culture*
- MaPSaF – *a safety culture assessment tool for acute hospitals*
- The Incident Decision Tree – *to ensure fair treatment of staff involved in a patient safety incident*
- Engaging clinicians – *a resource pack to support local initiatives to increase reporting and learning*
- Medical error – *aimed particularly at encouraging reporting from junior doctors*
- Being Open – *managing communication with patients, relatives and staff when a patient safety incident has occurred*
- Chief Executives' checklist –*how leadership from the top can influence patient safety*
- Root Cause Analysis – *retrospective review of patient safety incident*
- Foresight training – *to help improve understanding of risk prone situations that could be considered as a "near miss"*

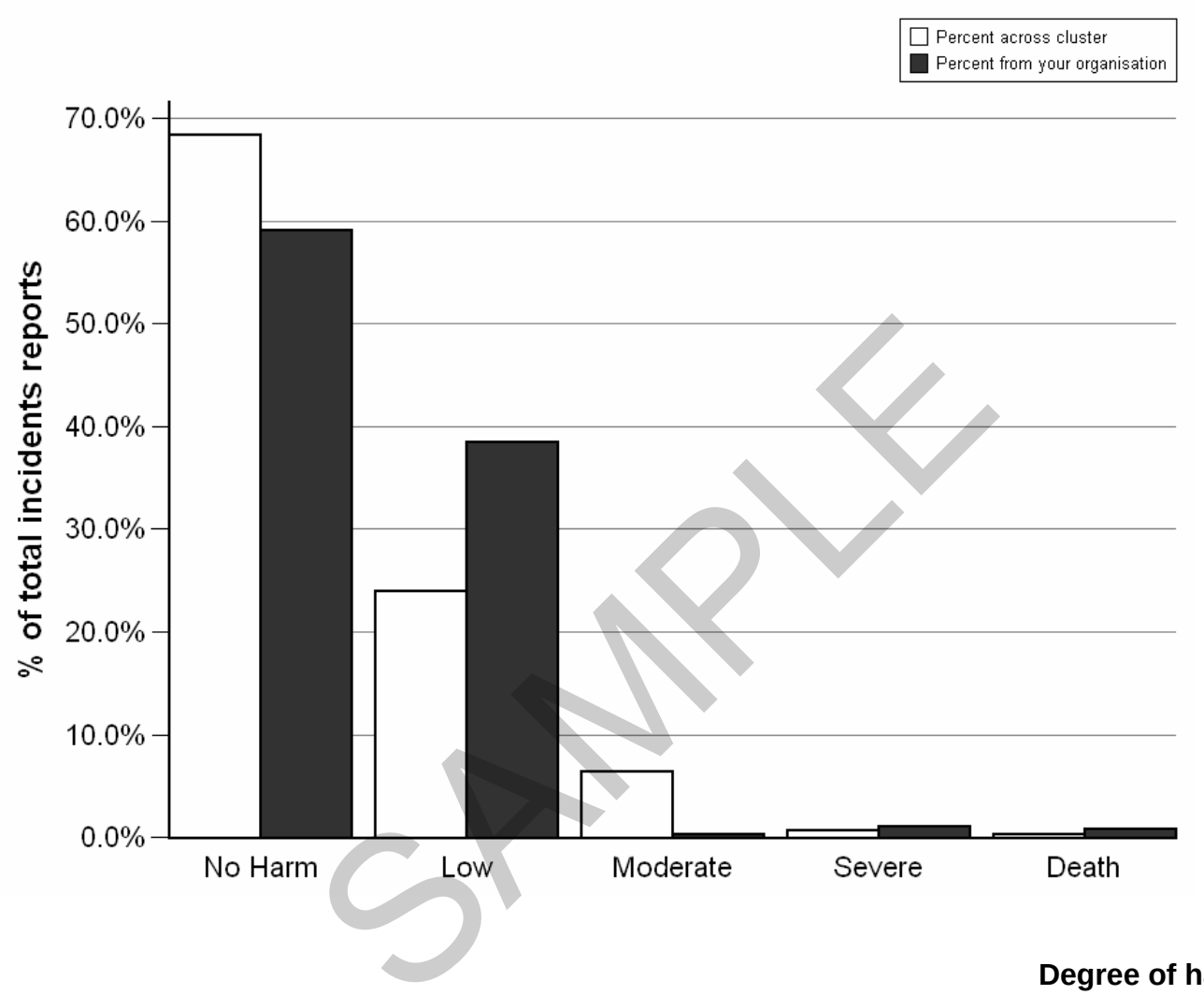
Learning from each other

Some high reporting organisations are willing to be contacted by other organisations who are seeking to improve their reporting rates, to discuss any differences in reporting systems, policy and practice. If you would like to contact any such organisations please email makingcontact@npsa.nhs.uk.

3.2 Analysis of the reported degree of harm*

Figure 3 shows how your organisation compares with other organisations in your cluster with regard to degree of harm incurred by patients in the incidents reported by your organisation.

Figure 3: Degree of harm to patients



Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

No harm	*e.g. wrong dose of aspirin given, but no harm caused*
Low harm	*- requiring extra observation or minor treatment*
	e.g. fell and grazed arm,dressing applied
Moderate harm	*- causing significant but not permanent harm*
	e.g. returned to theatre to drain wound site haematoma
Severe harm	*- causing permanent and significant harm*
	e.g. cardiac arrest after allergic reaction, anoxic brain damage
Death	*- directly attributable to the patient safety incident*
	e.g. paracetamol levels not checked in overdose patient, fatal liver failure

* Figure 3 uses abbreviated definitions; see *Seven steps to patient safety* www.nrls.npsa.nhs.uk (page 100) for full definitions

How to interpret Figure 3

The black bars in Figure 3 show the proportions of no harm and more serious incidents reported in your organisation. The white bars show the average proportion of the same incidents that occurred in all the organisations in your cluster group.

We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes, which confounds comparison of actual numbers in a meaningful way. Also, we do not assign a degree of harm to some incidents – these are incidents in which many patients were involved together. However, there were only few such incidents.

Implications of Figure 3 for your organisation

If the proportion of incidents of different degrees of harm in your organisation differs noticeably from the average of the other organisations in your cluster, you may wish to consider some of the reasons listed below.

- The coding of degree of harm in your organisation may be flawed (see the quality section below).
- Have local initiatives affected the degree of harm reported? For example, initiatives to encourage the reporting of near misses may lead to an increased proportion of no harm incidents.
- Do the kinds of service provided by your organisation mean you would expect differences in degree of harm? For example, an organisation specialising in ophthalmology might expect fewer instances of incidents leading to death than an organisation specialising in cardiac conditions.

Experience in other industries suggests as reporting cultures mature, the proportion of reports of no harm incidents increases, and the number of reports of severe harm incidents decrease.[5] However, organisations should be very cautious in applying the findings to healthcare settings. For example, in the aviation industry, as reporting of near misses increased, the number of fatal incidents reduced.[6] But aviation, unlike healthcare, was starting from a baseline where all fatal aircraft crashes were known, whilst the issues for healthcare are much more complex. For example, a wrong diagnosis leading to a potentially preventable death may only be detected if the patient's family consented to a post-mortem examination.

An analysis of high reporting organisations found no significant correlation between the number of reports made per admission and the proportions of degrees of harm.[4] Because of this, the NPSA expects organisations to continue aiming to improve local reporting levels of patient safety incidents of all degrees of harm.

At a national level, all serious incidents are reviewed to extract any learning on risks and system weaknesses which need to be shared more widely. From this issues are identified and prioritised by the NPSA. Some of these may result in Rapid Response Reports and other guidance to drive safety improvements.

Is your organisation coding incidents correctly with regard to degree of harm?

We sometimes find there is a discrepancy between the coding of degree of harm and other information in the report, such as incident type or the free text. You should be aware that inconsistent and incorrect coding of degree of harm will impact on the findings in this report and affect your ability to use your data to prioritise incidents for action.

It is important that incidents reports to the NPSA are only categorised as 'Death' if a patient died as a result of a patient safety incident. Deaths from natural causes or those that could not have been prevented are not patient safety incidents and should not be reported to the RLS.

We acknowledge that currently there are different definitions of a patient safety incident used across England and Wales, particularly in relation to serious untoward incidents. The NPSA is working to standardise these definitions. NHS organisations will be consulted in this work and the outcomes will be communicated to all organisations when the process is completed.

Some causes of incorrect coding of degree of harm:

- Confusing the potential degree of harm of an incident with actual degree of harm that occurred, for example coding near misses (where no harm resulted) as ‘severe’ harm. The NPSA requires the degree of harm to reflect the actual and not the potential degree of harm caused by the patient safety incident.

- Coding the degree of harm as ‘severe’ when the patient is expected to suffer severe but transient harm (for example severe bruising) instead of the required significant permanent harm (for example amputation, brain damage). Our recent analysis of free text suggests that only about 48 per cent of incidents reported as leading to severe harm were correctly coded by the reporting organisation.

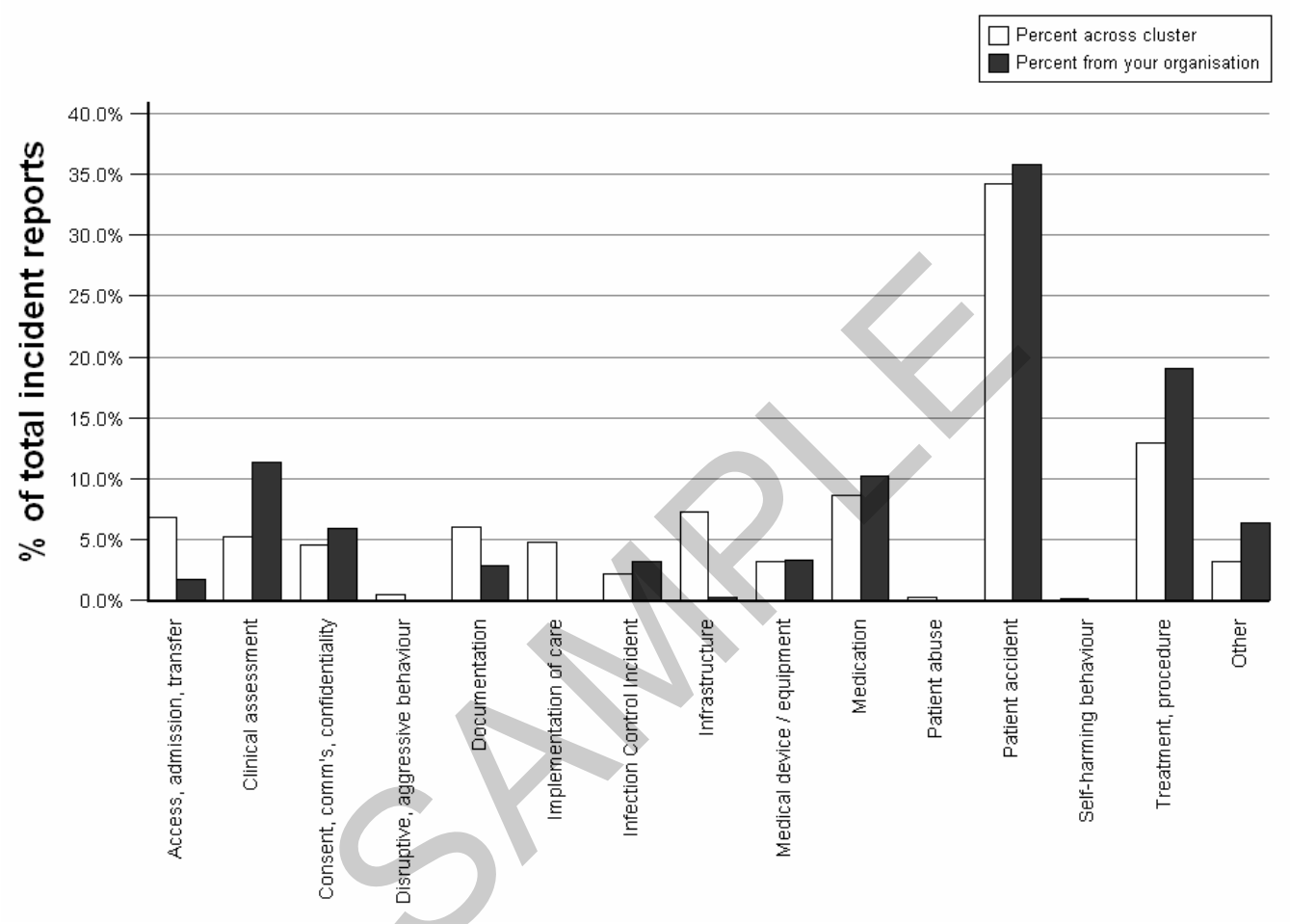
- Coding the degree of harm as ‘death’ when a patient died but the death was unrelated to the patient safety incident they had suffered, or the patient did not die but could have died as a result of the incident (recording the potential rather than the actual harm that occurred). The NPSA defines ‘death’ as the degree of harm incurred ‘where death is directly attributable to a patient safety incident’. To illustrate the problem we conducted a detailed review of all incidents reported as death. For this we examined all the free text provided to identify whether the coding of death was supported by other information in the report. We have found that in a substantial proportion of incidents the free text and other information in the report do not appear to support the coding of harm.

- Other exclusions include some duplicate reports which only become apparent from the free text of incidents, cases where there is insufficient or inadequate information or detail provided; and cases which are not about patients receiving NHS funded care (for example visitor incidents).

3.3 Comparison of the types of incident that occurred in your organisation and in other organisations in your cluster

Figure 4 shows how your organisation compares with other organisations in your cluster group with regard to each category of patient safety incident reported by your organisation.

Figure 4: Incident type



(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 4

For each category of patient incident type, the black bars in Figure 4 show the proportions of incidents reported in your organisation. The white bars show the average proportion of the same incidents that occurred in all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes, which confounds comparison of actual numbers in a meaningful way.

Implications of Figure 4 for your organisation

The analysis of incident type can provide useful context for the earlier analysis of reporting culture: if your organisation is a high (or low) reporter, does that hold true over all incident types, or is your organisation's higher (or lower) reporting rate arising mainly from one or two incident types? Small variations between organisations are expected due to differences in categorisation and subcategorisation of incidents between your local risk management system and the others. However, if any incident types appear markedly more common or less common in your organisation than in other organisations of your type, you may find it useful to consider some of the reasons listed below.

- Differences in inpatient population: for example, a higher proportion of older patients may be reflected in an increased risk of patient accidents.
- Local risk management system is less successful at capturing some types of incident: for example, do the anaesthetists or pharmacists in your organisation maintain a separate reporting system that does not feed into your main local risk management system?
- A higher proportion of incidents coded as 'other': this may indicate problems with the incident categories that you use, or with the mapping of your local risk management system to the RLS.

Note: this comparison of incident types is intended to complement, not replace, the extensive local analysis carried out to prioritise and target efforts to improve patient safety, and understand trends.

Taking action: using NPSA's resources

The NPSA has developed a range of resources to help you reduce the incidence of the specific incident types that are relevant to acute organisations. These include areas such as:

- Bedrail safety
- Blood transfusion safety
- Cleaning safely
- Correct site surgery
- Crash calls and patient deterioration
- Intravenous infusions in children
- Radiological reports
- Reducing dosing errors with opioid medicines
- Risks of chest drain insertion
- Risks with intravenous heparin flush solutions
- Spinal injury and bowel management
- Problems with infusions and sampling from arterial lines
- Emergency care for neck breathers
- Emergency support for haemorrhage
- Epidural injections and infusions
- Falls prevention
- Hand hygiene
- Healthcare risk assessment made easy
- Latex allergy
- Nasogastric feeding
- Neonatal nasogastric feeding
- Patient identification
- Hospital at night

Rapid Response Reports:

- Minimising risks of suprapubic catheter insertion (adults only)
- Preventing delay to follow up for patients with glaucoma
- Female urinary catheters causing trauma to adult males
- Problems with infusions and sampling from arterial lines
- Mitigating surgical risk in patients undergoing hip arthroplasty for fractures of the proximal femur

Visit the 'Improving Patient Safety' section on the NPSA website (http://www.nrls.npsa.nhs.uk) for links to the detailed guidance in all the above and other areas. For resources and advice on medication safety, please see the medication section later in this report.

3.4 Where did the incidents that were reported from your organisation occur?

Some of the patient safety incidents reported by your organisation may not have occurred within the organisation. As patients move across healthcare services, patient safety incidents which occurred outside your organisation may be reported within your organisation.

For example, a patient safety incident that caused harm which needed acute hospital treatment, or because checks on transfer of care led to an earlier patient safety incident being detected: 'Patient admitted … drowsy and unresponsive with respiratory rate of 8 breaths per minute. Patient documented as having possible opioid toxicity … Accompanying GP letter stated patient takes 10mg Oramorph before removal of dressings … on investigation found prescription for 100mg had been written and dispensed.'

Table 1 compares the locations where incidents reported from your organisation and those reported from other organisations in your cluster occurred.

Table 1: Incident location

Incident location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Ambulance (including call / control centre)	35	<0.1%	0	0.0%
Community hospital	630	0.7%	0	0.0%
General / acute hospital	90,527	97.1%	1,287	99.0%
Mental health unit / facility	275	0.3%	0	0.0%
Not applicable	33	<0.1%	0	0.0%
Primary care setting	237	0.3%	0	0.0%
Public place	54	<0.1%	1	<0.1%
Residence / home	661	0.7%	12	0.9%
Social care facility	94	0.1%	0	0.0%
Other	662	0.7%	0	0.0%
Unknown	60	<0.1%	0	0.0%
Total	93,268	100.0%	1,300	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Table 1

Cross-reporting happens in both directions, for example, a primary care organisation reporting a patient safety incident that occurred whilst the patient was admitted in an acute hospital but was detected after the patient had been discharged.

From this table you can also find out how the services offered by your organisation compare with the services in other organisations in your cluster: any differences here will make a difference to the comparison and also to the type and number of patient safety incidents reported.

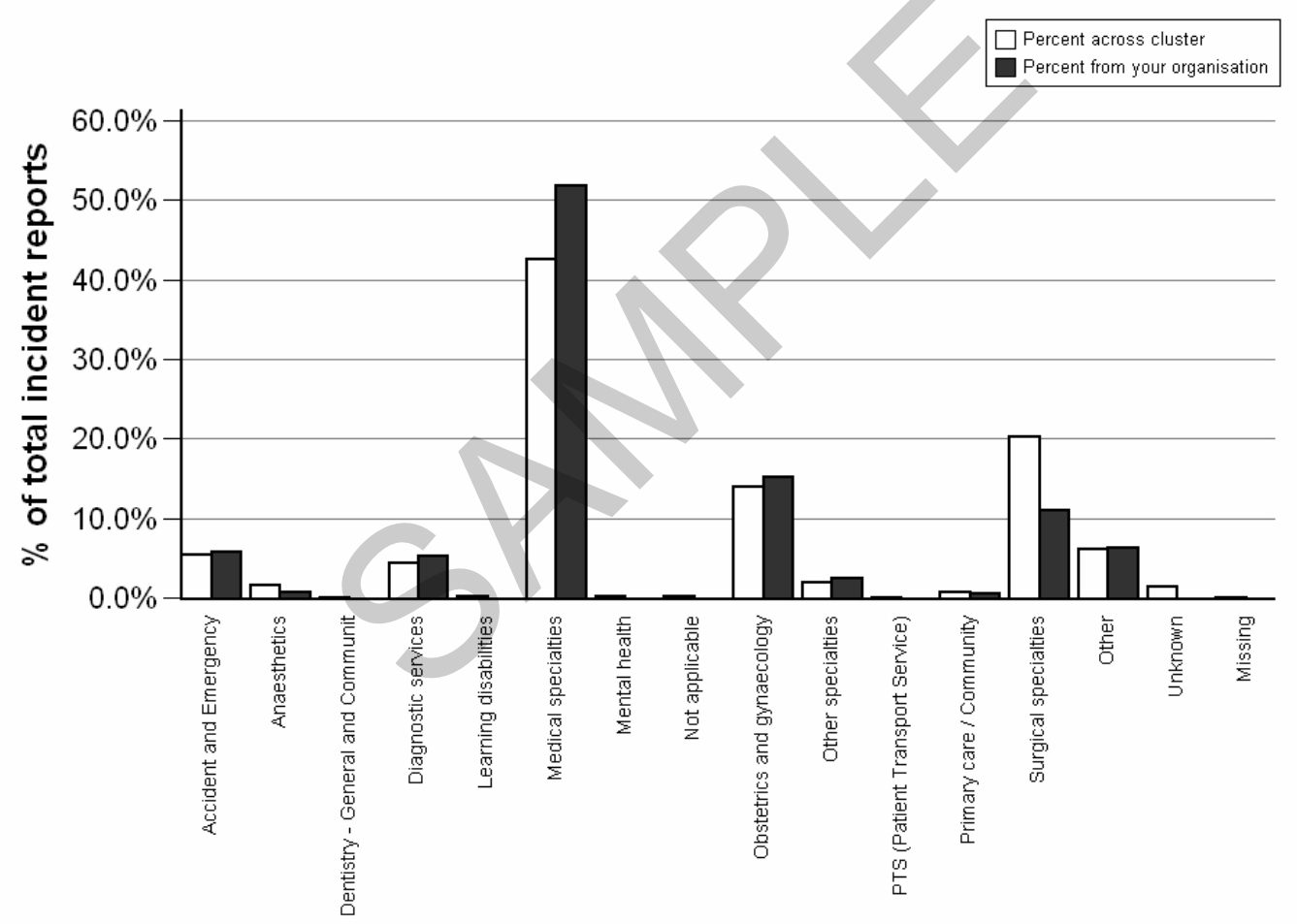
3.5 Breakdown of incidents by specialty

Figure 5 shows how the specialties in your organisation compare with those in other organisations in your cluster group with regard to the proportion of incidents occurring in each specialty.

! Interpret with care: Specialist acute organisations to note

Specialist acute organisations differ greatly from each other in the specialties they provide, and they tend to have more highly specialised sub-specialties, which are not included in our dataset. Therefore, comparing incidents by specialty across the specialist acute organisation cluster may be misleading.

Figure 5: Top level specialties within the cluster



(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 5

The black bars in Figure 5 show in which specialties the patient safety incidents reported in your organisation occurred. The white bars show the average proportion of incidents that occurred in the same specialties across all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes which confounds comparison of actual numbers in a meaningful way.

For acute organisations providing a range of different specialties and sub-specialties: this figure shows top-level specialties offered by organisations within your cluster. For more detailed sub-group breakdowns please see Appendix 2 (Tables 7a and 7b).

Implications of Figure 5 for your organisation

A degree of variation between your organisation and other organisations in your cluster in the proportion of incidents reported by specialty is expected due to differences in local service provision. However, if there is a marked difference in the proportion of incidents occurring in a specialty in your organisation and the cluster average, you may wish to consider some of the reasons listed below.

- Are there differences in service provision that explain differences in reporting?
- Does the reporting from any specialty in your organisation appear to be lower than in other organisations?
- If so, do they have a specialty reporting system that is not connected to your local risk management system, or do they need support to improve reporting and learning?

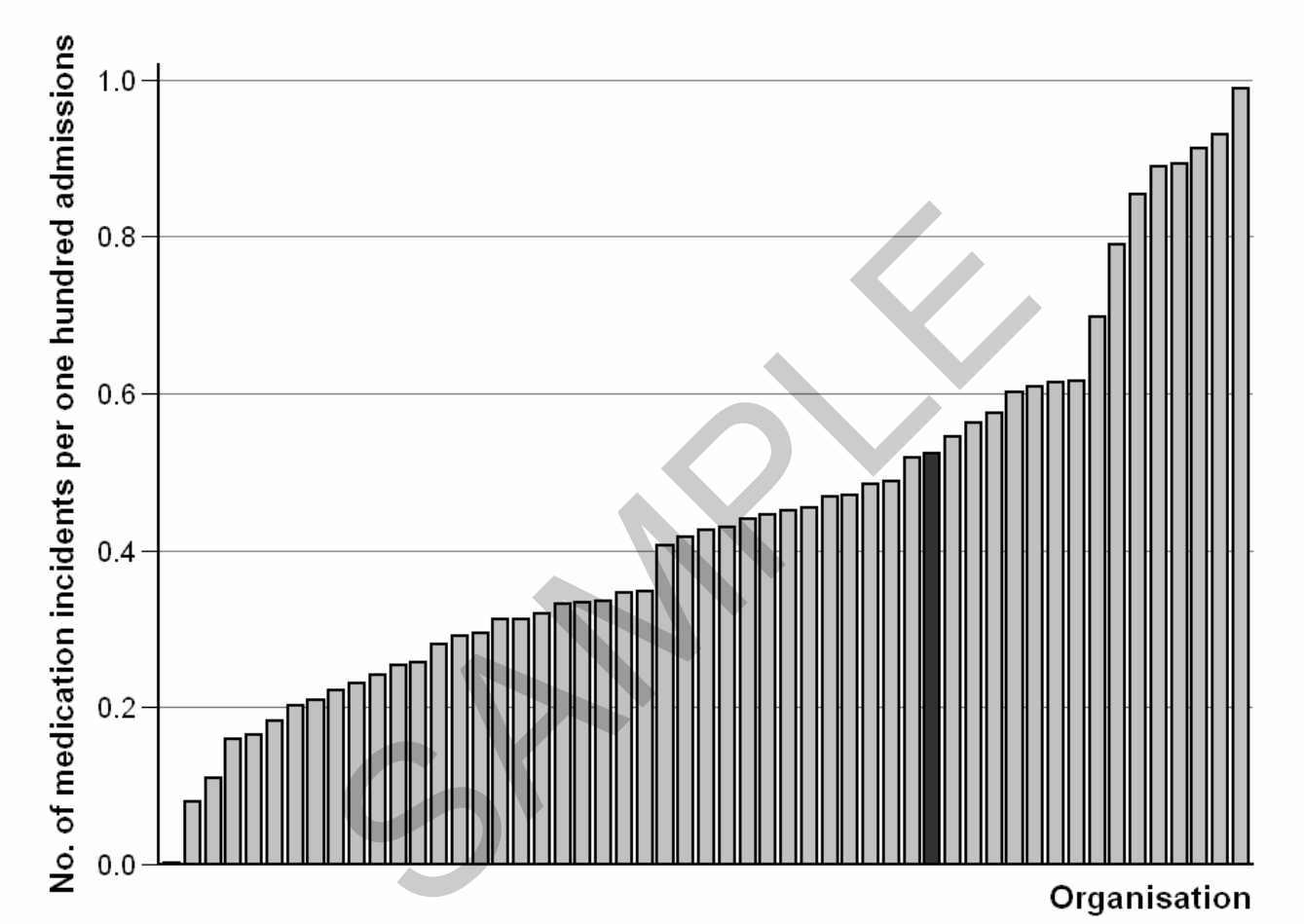
The comparison of specialties' reporting patterns from your organisation with reporting patterns from specialties in other organisations in your cluster is intended to complement, not replace, the extensive local analysis carried out to understand and act on the particular patient safety challenges within different specialties.

3.6 Analysis of medication incidents

3.6.1 How does your organisation's reporting of medication incidents compare with other organisations in your cluster?

Figure 6 shows how your organisation compares with other organisations in your cluster group with regard to the reporting of medication incidents.

Figure 6: Medication incident rate per one hundred admissions



Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 6

Figure 6 shows patient safety incidents involving medication per 100 admissions, reported from the organisations in your cluster group during the period 1 October 2008 and 31 March 2009. The black bar represents the data from your organisation. We have shown the rate of reported medication incidents per 100 admissions to allow meaningful comparison as the organisations within the cluster vary considerably in size and activity.

Implications of Figure 6 for your organisation

- If your organisation is among the high reporters according to Figure 6: Research suggests that even in high reporting organisations, many medication incidents do not get reported.[2] Therefore regardless of their position in the figure, all organisations should be aiming to further increase their reporting rates, and checking that good reporting cultures exist in all departments and all staff groups involved in medication processes.

- If your organisation is among the low reporters according to Figure 6: Whatever efforts are being made locally to improve reporting and learning from medication incidents, half of all organisations will inevitably appear in the lower half of this figure.

If your organisation is in the lower half of the figure, you may wish to consider some of the reasons listed below.

- Are all reports of medication incidents being entered on your local risk management system? Or are the pharmacists in your organisation reporting to a separate system?
- Do you enter enough information on medication incidents to successfully upload them to the RLS? (see the quality section below).
- Does your medicines management policy include strategies for encouraging reporting and learning from medication incidents?

If you believe your reporting rates are below average because you have made greater improvements in medication safety than most other organisations in your cluster, you need to carry out prescription card reviews or observational studies to confirm that your lower rates are due to improvements in safety rather than to due under-reporting. It would also be useful to check that you have implemented all the safety improvements recommended.

3.6.2 How many medication incidents should you expect?

International studies on medication error are complex to interpret. The most conservative estimates from international studies focused on medication errors in acute care rather than adverse effects suggest between one and two significant medication errors occur per 100 occupied bed days.[7] Specialist settings such as paediatrics and intensive care have higher rates.[8] To explore this in more detail see the NPSA's patient safety observatory's report on medication safety 'Safety in doses' at www.nrls.npsa.nhs.uk. Even in organisations that are high reporters of medication incidents compared with other organisations in their cluster, there is scope to further increase reporting.

Can the NPSA help improve your organisation's medication safety?

The NPSA has developed a range of resources to help organisations improve medication safety, these can be found in the 'Medication Zone' and the section on 'Alerts, directives, tools & guidance' at http://www.nrls.npsa.nhs.uk. Some examples are:

Rapid Response Reports:

- Reducing risk of harm from oral bowel cleansing solutions
- Reducing risk of overdose with midazolam injection in adults

Patient Safety Alerts:

- Actions that can make anticoagulant therapy safer
- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes
- Promoting safer use of injectable medicines
- Safer practice with epidural injections and infusions
- Reducing the risk of hyponatraemia when administering intravenous infusions to children

Themed Reviews:

- Safety in Doses - Medicines related patient safety incidents and actions to prevent harm

3.6.3 Completion of mandatory fields relating to medication

Is your organisation reporting medication incidents correctly?

The stage of the medication process at which a medication error occurred and the type of medication incident are mandatory fields that need to be entered when reporting medication incidents to the RLS. If your organisation does not record this information, you will not be able to successfully upload reports of medication incidents to the RLS. The reports will bounce back.

We have found that descriptions of medication incidents submitted to the RLS do not always contain the name of the medication involved. Ideally the reporter should use the specific field to enter the medication name that is provided in most local risk management systems. If this is not possible, the name of the medication – with checked and correct spelling – should be included in the free text description of the medication incident. Correctly recording the medication name is vital for national learning, and is also essential for local understanding of what your highest-risk medications are, so that local medication safety improvements can be appropriately targeted. Do you know which five medication types are the most likely to be involved in medication errors in your organisation?

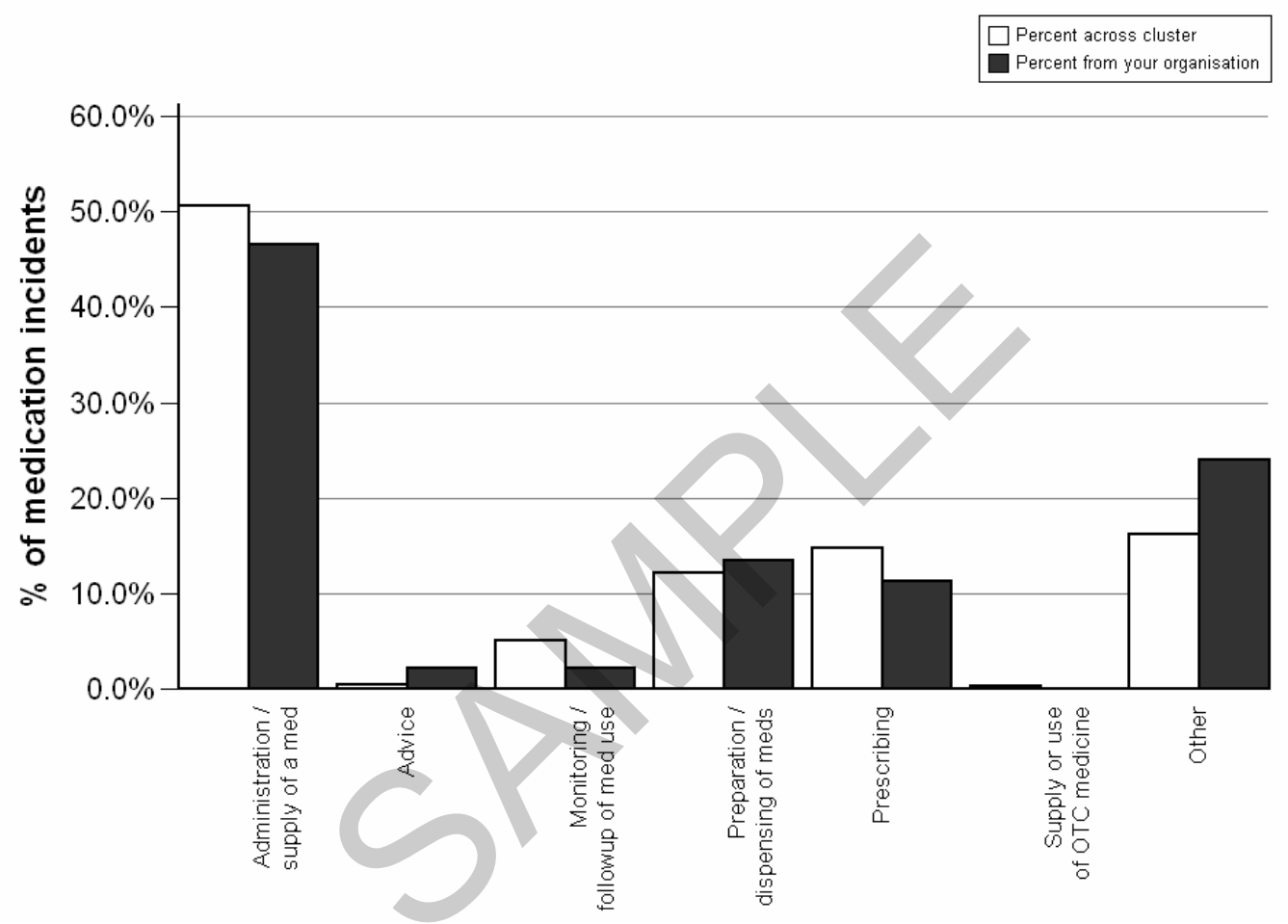
! Interpret with care

If your organisation has reported few medication incidents to the RLS as shown in Figure 6, bear in mind that the remainder of this feedback report may be affected. Small numbers of medication incidents can skew the appearance of Figures 7 and 8 as visible differences in proportions could be attributed to just a single medication incident report.

Comparing the rate of medication incidents by stage in the medication process and the type of medication incident

Figures 7 and 8 show how your organisation compares with other organisations in your cluster with regard to the stage of the medication process at which patient safety incidents occurred and the type of medication incidents reported by your organisation, respectively.

Figure 7: The stage of the medication process at which the incident occurred



(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

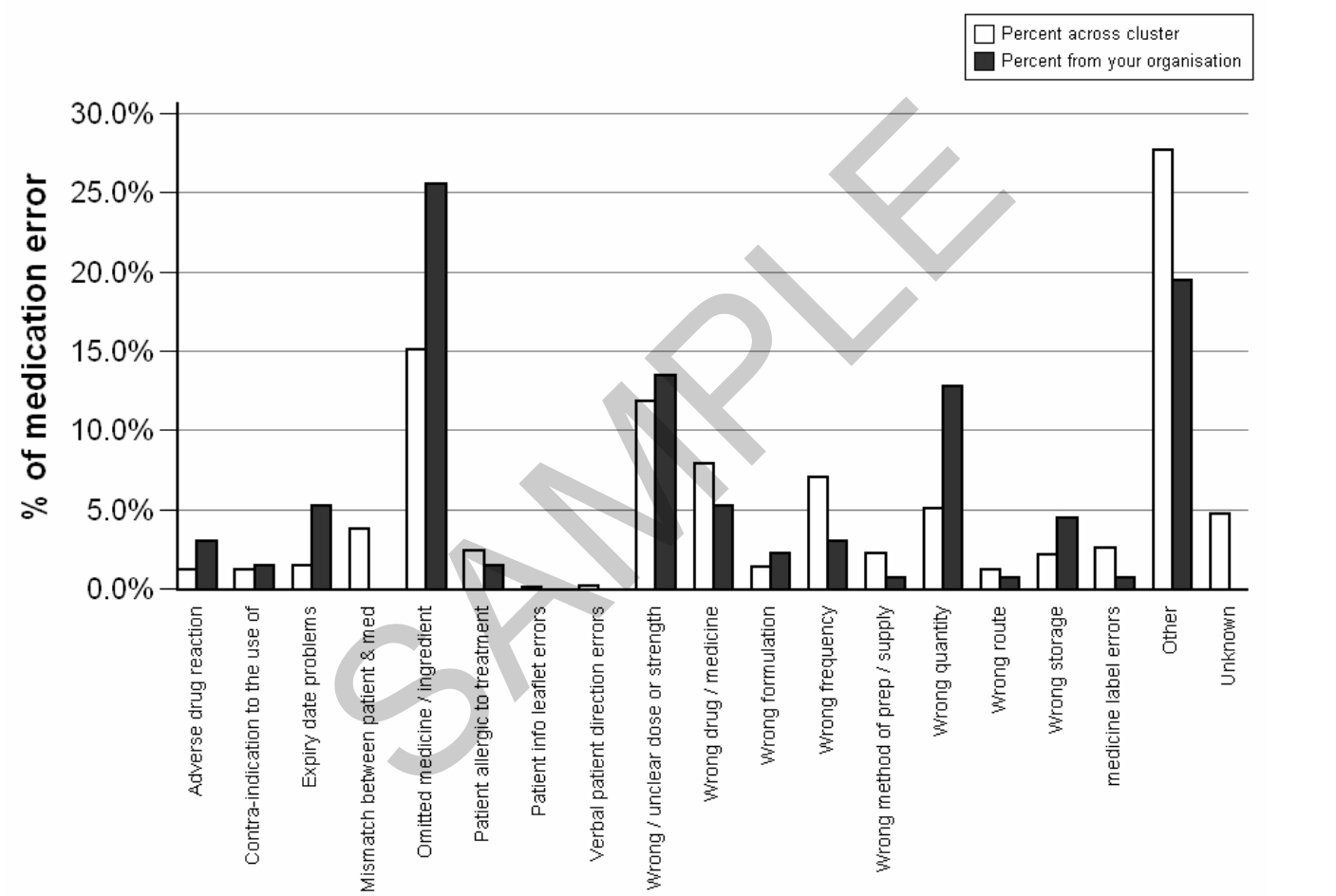
How to interpret Figure 7

The black bars in Figure 7 show the proportions of medication incidents that occurred in your organisation at each stage of the medication process. The white bars show the average proportion of incidents at the same stages that occurred in all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes which confounds comparison of actual numbers in a meaningful way.

Implications of Figure 7 for your organisation

Small variations between organisations are expected due to differences in their services and in local risk management systems. However, if medication incidents at any stage of the medication process appear markedly more common or less common in your organisation than in other organisations in your cluster, it may be useful to question why this is so. For example, a higher proportion of errors occurring at the prescribing stage could indicate you have excellent systems for pharmacists to detect, correct and report prescription errors before they reach the patient, or this could indicate you provide fewer resources to support prescribers.

Figure 8: Types of medication error



(Note: for full data labels please refer to Appendix 2)
Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

How to interpret Figure 8

The black bars in Figure 8 show the proportions of the different types of medication incident that occurred in your organisation. The white bars show the average proportion of the same types of incident that occurred in all the organisations in your cluster group. We have used percentages rather than actual numbers for this figure as the organisations in your cluster group are of different sizes which confounds comparison of actual numbers in a meaningful way.

Implications of Figure 8 for your organisation

Small variations between organisations are expected due to differences in their services and in local risk management systems. However, if any type of medication incident appears markedly more common or less common in your organisation than in other organisations in your cluster, it may be useful to question why. For example, a higher proportion of errors where the patient was allergic to treatment might indicate local problems with how allergy status is documented and checked.

3.7 Reporting information that could identify individuals

The NPSA screens free text fields to find information that may potentially identify individuals. This information is then removed. Table 2 shows the proportion of incidents reported by your organisation that had person identifiable data removed by the NPSA. The table shows the proportions of incidents that contain patient information (address, name, patient number or date of birth), proportions of incidents that contained staff information and the proportion of incidents that contain other identifiable information (third-party information or information we cannot determine the nature of).

Note: no screening process is totally accurate, so the number of incidents below may be an under-estimation of the actual number of incidents that contain person identifiable information sent by your organisation.

Table 2: Percentage of reports from your organisation that included person identifiable data

Type of person identifiable data	Oct-08 to Mar-09	Apr-08 to Sep-08
Incidents including patient identifiable information	9.6%	14.9%
Incidents including staff identifiable information	6.9%	9.8%
Incidents including other identifiable information	0.7%	0.0%
Total incidents with identifiable information	14.6%	20.5%

(Note: an incident can contain patient, staff and other identifiable information. Therefore, the total number of incidents with person identifiable data is unlikely to equal the sum of the other figures in the table, in most cases it will be lower.)

Source: patient safety incident reports successfully submitted to the RLS during the period 1 October 2008 to 31 March 2009

Implications of Table 2 for your organisation

Every organisation, including NHS organisations, is required by common law duty of confidentiality and the Data Protection Act[9] not to send any person identifiable data to third parties, including the NPSA, without the consent of the individual concerned.

The NPSA can only hold person identifiable information with that person's consent. The reporting mechanism does not include a facility to obtain patient consent. Therefore, the RLS is designed not to capture patient identifiable data in its reporting dataset.

However, as shown in Table 2, your organisation, among others, has been including person identifiable information in the free text fields of the RLS. Although we make every effort to remove person identifiable information from incident records, this cannot be guaranteed. Therefore, we request that your organisation should avoid including person identifiable data in all fields where free text can be entered, such as the description of the incident, minimising actions and actions taken to prevent reoccurrence. This can be successfully avoided by using descriptors rather than names (for example the patient, staff nurse A) at the point of data entry, even if staff used real names in the original handwritten report.

The majority of person identifiable information is found in the free text variable 'Actions preventing reoccurrence' (IN10). If you have high percentages in Table 2 you should check that the text in this field is being anonymised.

3.8 Improving the quality of the data submitted to the RLS

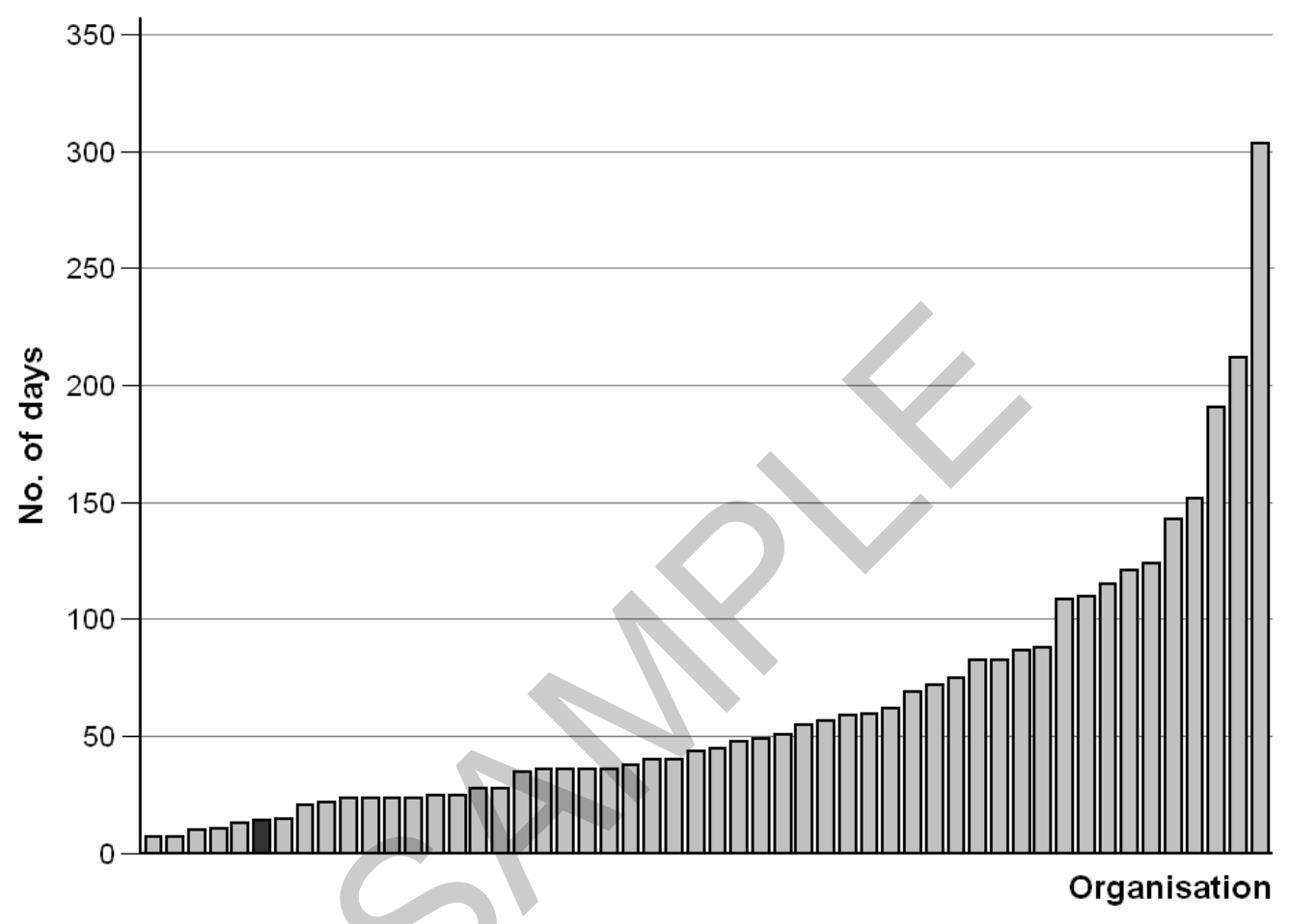
We recognise that all organisations have to balance between the amount of information they request when a patient safety incident has occurred, and making reporting easy and straightforward as far as possible for frontline staff. Because of this, the RLS has only a limited number of mandatory fields (failure to complete these fields means the report cannot be successfully uploaded). However, more detailed information adds considerably to the value of reports, both for your local learning and for the effectiveness of the RLS. We therefore suggest that your organisation consider the following points as the highest priorities for improving data quality:

- including the medication name in reports of medication incidents;
- including the date of incident in the report (see below);
- coding the degrees of severe harm and death correctly, including avoiding reporting deaths from natural causes as patient safety incidents and reporting the actual and not the potential degree of harm;
- avoiding the use of staff or patient identifiers within the free text;
- increasing the proportion of reports where the free text section of ‘actions taken to prevent reoccurrence’ is completed.

Timeliness of reporting

The time between an incident occurring and being reported to the RLS is important for the information to be useful for identifying and acting on patient safety incidents quickly.

Figure 9: Median time difference between incidents occurring and being reported to the NPSA



Source: Incidents reported to the NPSA between 1 October 2008 to 31 March 2009

How to interpret Figure 9

Figure 9 shows the median number of days between an incident occurring and the incident being reported to the RLS in the organisations in your cluster group. Your organisation is represented by the black bar.

Note: The median is used because the data distributions used in the above figure are skewed (that is, they have some incidents with very large values, but the majority are much smaller); a small number of incidents with a long time-delay would make the average much higher.

Implications of Figure 9 for your organisation

At present the median time taken for incidents to reach the NPSA is 57 days, with the reports of deaths and severe harm taking 51 days. Timeliness of reports to the NPSA affects how quickly we can provide you with benchmarking reports and also how quickly we can review and respond to the most serious incidents.

In response to requests from trusts, we base these reports on incidents occurring within a given time period, but with a two-month delay in incidents being sent to the NPSA, there is a corresponding time lag before we can start the analysis to provide these reports.

One of the key benefits of a national system is to be able to spot new issues and trends quickly, so that information about risks and remedial actions can be disseminated quickly to prevent further incidents.

In accordance with *Safety first* the NPSA has established a new response unit to ensure the most serious of incidents can be reported and addressed quickly and has been piloting new ways of working with 38 trusts. The pilot has been evaluated and findings will be published in the Autumn on the NPSA website. At this time we will also begin to roll out rapid reporting nationally and will be requesting all trusts to upload their most serious incidents much more quickly (within 36 hours of local notification). Details on how to send update reports following initial reports will be provided.

For more details on how your organisation can rapidly report more serious incidents see http://www.nrls.npsa.nhs.uk.

4 Next steps: reviewing the learning, taking action

The NPSA hopes that these analyses will stimulate your organisation's board, clinical governance or risk team, and clinical staff to have constructive discussions on how to:

- further improve the reporting of patient safety incidents in your organisation;
- provide safer care for your patients.

Reporting of patient safety incidents can be improved by:

- implementing robust systems to send reports to the RLS at least monthly;
- developing an active reporting and learning culture;
- using the degrees of severe harm or death correctly, including avoiding reporting deaths from natural causes as patient safety incidents.

5 Contact us

We hope this feedback report will stimulate your board, risk and integrated governance team, and clinical staff to have constructive discussions on whether local reporting of patient safety incidents could be further improved, and that you will be able to use the resources this report signposts to help your organisation improve patient safety.

Feedback on previous reports had requested help with the interpretation of some of the data. We have expanded on the explanation of the data, and also added prompts for interpretation. If you need further help to interpret the data, you can contact your SHA's Patient Safety Action Team (England), Patient Safety Manager (Wales), or use the feedback link and send an email to the NPSA on NRLSxtranet@npsa.nhs.uk. If you send an email, please ensure that you include details of your query in addition to your own contact details. This will help us to make sure that the most appropriate person in the team at the NPSA responds to you.

Appendices

APPENDIX 1: Terms of use

The extranet information service website is hosted by the NPSA. It enables you to access aggregated data on patient safety incident reports that have been submitted to the RLS. Your use of this information is governed by the following privacy statement, usage rules and disclaimer.

Privacy statement

The RLS does not seek to collect information on the names of patients or staff involved in an incident, and takes steps to remove person identifiable data that are inadvertently included in descriptions of the incident as far as possible. The data presented in this and future reports will not contain any information that could directly identify an individual patient or staff member involved in an incident.

The NPSA will regularly publish statistics and analyses of patient safety incident data to promote a learning culture and the development of patient safety improvements in the NHS. The NPSA operates under the principle that it will share information with partner organisations where this is beneficial to patient safety, but will inform your chief executive first of its intention, and ensure your organisation has first sight of any data.

Usage rules

Our aim is to provide you with a report focused on your organisation. We will provide notes on interpretation, including where organisations should interpret with caution. Your organisation is responsible for the use of the data and the communication of the information to your staff.

The data are made available to you through a secure website with password protection. It is the responsibility of your organisation to ensure that login details and passwords are restricted to authorised users only. You are responsible for authorising the appropriate people within your organisation to access the site.

Disclaimer

The incidents summarised in this report have been drawn from the RLS, which supports the goal of the NPSA to make patient care safer. These incidents have been reported to the RLS by NHS organisations across England and Wales, and are reported through a variety of routes by individual NHS staff through local risk management systems and web-based eforms (including an open access eform). The individual reports are not investigated or verified by the NPSA. These incidents are self-reported and so are not necessarily representative of the NHS across England and Wales and therefore should be interpreted with care.

APPENDIX 2: Detailed data

The following tables provide back-up detail for the figures and tables in the main report. All the caveats and cautions which apply to the figures apply to these tables, and they should be read in conjunction with the text supplied within the main report.

Table 3 provides summary statistics on the number of safety incident reports. The cluster information relates to incidents that occurred during the period between 1 October 2008 and 31 March 2009.

Table 3: Summary statistics for the number and rate of incidents reported

From your organisation	**Incidents occurring (1Oct2008 - 31Mar2009)**	1,300
	Incidents reported (1Oct2008 - 31Mar2009)	1,830
	Admissions*	25,327
Across your cluster	**Minimum number of reports**	564
	Lower quartile	1,198
	Median	1,783
	Upper quartile	2,134
	Maximum	3,864
	Total number of reports	93,268

Please note: the most-up-to date avaliable admissions data were used in the report.

* Provisional admissions submitted by the organisation for the period 01/10/2008 to 31/03/2009. English data were provided by HES. Welsh data were provided by HSW. Please see FAQ and data quality note for more information.

Table 4: Incident type

Incident type	Incidents across cluster	% incidents across cluster	Incidents from your organisation	% incidents from your organisation
Access, admission, transfer, discharge (including missing patient)	6,308	6.8%	23	1.8%
Clinical assessment (including diagnosis, scans, tests, assessments)	4,896	5.2%	147	11.3%
Consent, communication, confidentiality	4,207	4.5%	77	5.9%
Disruptive, aggressive behaviour	430	0.5%	0	0.0%
Documentation (including records, identification)	5,669	6.1%	37	2.8%
Implementation of care and ongoing monitoring / review	4,458	4.8%	0	0.0%
Infection Control Incident	2,073	2.2%	42	3.2%
Infrastructure (including staffing, facilities, environment)	6,793	7.3%	3	0.2%
Medical device / equipment	2,950	3.2%	43	3.3%
Medication	8,076	8.7%	133	10.2%
Patient abuse (by staff / third party)	195	0.2%	0	0.0%
Patient accident	31,916	34.2%	466	35.8%
Self-harming behaviour	178	0.2%	0	0.0%
Treatment, procedure	12,112	13.0%	247	19.0%
Other	3,007	3.2%	82	6.3%
Total	93,268	100.0%	1,300	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 5: Incident location

Incident Location	Incident Location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Ambulance (including call / control centre)	**In vehicle / in transit**	35	<0.1%	0	0.0%
Community hospital	**Day care services**	11	<0.1%	0	0.0%
	General areas	27	<0.1%	0	0.0%
	Inpatient areas	514	0.6%	0	0.0%
	Outpatient department	64	<0.1%	0	0.0%
	Support Services	8	<0.1%	0	0.0%
	Other	6	<0.1%	0	0.0%
General / acute hospital	**Accident (A) / minor injury unit / medical assessment unit**	5,168	5.5%	107	8.2%
	Ambulatory care treatment centre	62	<0.1%	0	0.0%
	Day care services	1,282	1.4%	14	1.1%
	General areas	2,140	2.3%	4	0.3%
	Inpatient areas	71,560	76.7%	1,031	79.3%
	Outpatient department	3,945	4.2%	22	1.7%
	Support Services	4,966	5.3%	89	6.8%
	Other	1,382	1.5%	20	1.5%
	Missing	22	<0.1%	0	0.0%
Mental health unit / facility	**Day care services**	15	<0.1%	0	0.0%
	General areas	67	<0.1%	0	0.0%
	Inpatient areas	193	0.2%	0	0.0%

Table 5: Incident location (Continued)

Incident Location	Incident Location	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Not applicable		33	<0.1%	0	0.0%
Primary care setting	**Community pharmacy**	1	<0.1%	0	0.0%
	Dental surgery	6	<0.1%	0	0.0%
	GP Surgery	61	<0.1%	0	0.0%
	Health centre / out-of-hours centre	165	0.2%	0	0.0%
	Other	4	<0.1%	0	0.0%
Public place	**Missing**	54	<0.1%	1	<0.1%
Residence / home	**Hospice**	21	<0.1%	0	0.0%
	Nursing home	19	<0.1%	0	0.0%
	Private house / flat etc.	607	0.7%	12	0.9%
	Other	10	<0.1%	0	0.0%
	Missing	4	<0.1%	0	0.0%
Social care facility	**Residential care home**	89	<0.1%	0	0.0%
	Other	5	<0.1%	0	0.0%
Other		662	0.7%	0	0.0%
Unknown		60	<0.1%	0	0.0%
Total		93,268	100.0%	1,300	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 6: Degree of harm to patients

Degree of harm	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
No Harm	63,772	68.4%	769	59.2%
Low	22,381	24.0%	500	38.5%
Moderate	6,070	6.5%	5	0.4%
Severe	717	0.8%	15	1.2%
Death	328	0.4%	11	0.8%
Total	93,268	100.0%	1,300	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 7a: Top level specialties within the cluster

Specialty Level 1	Incidents across cluster	% Incidents across cluster	Incidents From your Organisation	% Incidents From your Organisation
Accident and Emergency	5183	5.6%	76	5.8%
Anaesthetics	1564	1.7%	11	0.8%
Dentistry - General and Community	5	<0.1%	0	0.0%
Diagnostic services	4103	4.4%	70	5.4%
Learning disabilities	298	0.3%	0	0.0%
Medical specialties	39822	42.7%	674	51.8%
Mental health	317	0.3%	0	0.0%
Not applicable	178	0.2%	0	0.0%
Obstetrics and gynaecology	13131	14.1%	199	15.3%
Other specialties	1859	2.0%	34	2.6%
PTS (Patient Transport Service)	23	<0.1%	0	0.0%
Primary care / Community	771	0.8%	8	0.6%
Surgical specialties	18904	20.3%	144	11.1%
Other	5763	6.2%	84	6.5%
Unknown	1346	1.4%	0	0.0%
Missing	1	<0.1%	0	0.0%
Total	93268	100.0%	1300	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 7b: Level 1 and 2 specialty split by paediatric/adult

Specialty levels 1 and 2		Total clust	Total Org	Adult / Paediatrics Specialty					
				Adult		Missing		Paediatrics	
				N Cluster	N Org	N Cluster	N Org	N Cluster	N Org
Anaesthetics	**Other**	1,528	2	1,528	2				
	Remainder grouped	36	9	33	9			3	0
Diagnostic services	**Chemical pathology**	502	10	502	10				
	Haematology	621	10	621	10				
	Histopathology	357	7	357	7				
	Radiology	1,693	30	1,693	30				
	Other	490	0	490	0				
	Remainder grouped	440	13	410	10	8	0	22	3
Medical specialties	**Cardiology**	1,902	24	1,902	24				
	Care of older people	11,827	91	11,827	91				
	Endocrinology	458	0	458	0				
	Gastroenterology	1,792	11	1,792	11				
	General medicine	14,729	405	14,729	405				
	Medical oncology	954	0	954	0				
	Neonatology	419	0					419	0
	Nephrology / renal	549	0	549	0				
	Neurology	387	2	387	2				
	Rehabilitation	1,882	0	1,882	0				
	Thoracic / respiratory medicine	1,089	93	1,089	93				
	Other	1,828	0	1,828	0				
	Remainder grouped	2,006	48	1,321	47	213	0	472	1

Table 7b: Level 1 and 2 specialty split by paediatric/adult (Continued)

Specialty levels 1 and 2		Total clust	Total Org	Adult / Paediatrics Specialty					
				Adult		Missing		Paediatrics	
				N Cluster	N Org	N Cluster	N Org	N Cluster	N Org
Accident and Emergency	**Missing**	5,119	64	5,119	64				
	Remainder grouped	64	12			2	0	62	12
Obstetrics and gynaecology	**Gynaecology**	1,682	42	1,682	42				
	Obstetrics	10,263	157	9,834	150			429	7
	Other	801	0	801	0				
	Remainder grouped	385	0	177	0	193	0	15	0
Other specialties	**Pharmacy (inpatient)**	884	22	884	22				
	Physiotherapy	359	10	359	10				
	Remainder grouped	616	2	474	1	32	0	110	1
Surgical specialties	**ENT**	455	0	455	0				
	General surgery	6,196	47	6,196	47				
	Ophthalmology	587	0	587	0				
	Trauma and orthopaedics	7,325	78	7,325	78				
	Urology	944	16	944	16				
	Other	2,290	0	2,290	0				
	Remainder grouped	1,107	3	992	2	16	0	99	1
Other		5,763	84	3,442	30	26	0	2,295	54
Unknown		1,346	0	1,344	0	1	0	1	0
Other low frequency specialties	**Other low frequency specialties**	1,593	8	848	8	705	0	40	0

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 8: The stage of the medication process at which the incident occurred

Stages of medication incidents	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Administration / supply of a medicine from a clinical area	4,095	50.7%	62	46.6%
Advice	41	0.5%	3	2.3%
Monitoring / follow-up of medicine use	416	5.2%	3	2.3%
Preparation of medicines in all locations / dispensing in a pharmacy	988	12.2%	18	13.5%
Prescribing	1,195	14.8%	15	11.3%
Supply or use of over-the-counter (OTC) medicine	31	0.4%	0	0.0%
Other	1,310	16.2%	32	24.1%
Total	8,076	100.0%	133	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

Table 9: Types of medication error

Medication Errors	Incidents across cluster	% Incidents across cluster	Incidents from your organisation	% Incidents from your organisation
Adverse drug reaction (when used as intended)	102	1.3%	4	3.0%
Contra-indication to the use of the medicine	99	1.2%	2	1.5%
Mismatching between patient and medicine	306	3.8%	0	0.0%
Omitted medicine / ingredient	1,220	15.1%	34	25.6%
Patient allergic to treatment	197	2.4%	2	1.5%
Wrong / omitted / passed expiry date	124	1.5%	7	5.3%
Wrong / omitted patient information leaflet	13	0.2%	0	0.0%
Wrong / omitted verbal patient directions	20	0.2%	0	0.0%
Wrong / transposed / omitted medicine label	210	2.6%	1	0.8%
Wrong / unclear dose or strength	957	11.8%	18	13.5%
Wrong drug / medicine	639	7.9%	7	5.3%
Wrong formulation	113	1.4%	3	2.3%
Wrong frequency	570	7.1%	4	3.0%
Wrong method of preparation / supply	183	2.3%	1	0.8%
Wrong quantity	413	5.1%	17	12.8%
Wrong route	102	1.3%	1	0.8%
Wrong storage	179	2.2%	6	4.5%
Other	2,241	27.7%	26	19.5%
Unknown	388	4.8%	0	0.0%
Total	8,076	100.0%	133	100.0%

Source: patient safety incident reports successfully submitted to the RLS where the incident occurred during the period 1 October 2008 to 31 March 2009

APPENDIX 3: Queries about your data?

Figure 1 and Table 2 refer to the month in which you submitted reports to the RLS. All other figures and tables in this feedback report use patient safety incidents successfully reported to the RLS by 30 June 2009, where the date that the patient safety incident occurred falls between 1 October 2008 and 31 March 2009. Details of how we calculate rates can be found at www.nrls.npsa.nhs.uk

The numbers of reports here might not exactly match the number you believe you have submitted. Differences occur because reports where essential data fields are missing are automatically rejected, and we seek to delete reports affecting staff or visitors, and multiple reports of the same incident. For more information, including how to make a query if you cannot reconcile the number of reports we received with the number of reports you believe you have sent, go to www.nrls.npsa.nhs.uk

The NPSA no longer manually recodes incidents reported as 'other' categories by organisations where possible. Because of this process change you may find your proportion of incidents or specialties coded as 'other' has increased between this and previous feedback reports.

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