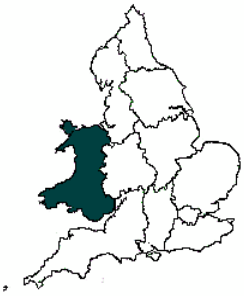


# Organisation Patient Safety Incident Report

**Caerphilly Teaching LHB**

Organisation type: **Primary care organisation without inpatient provision**

Location: **Wales**

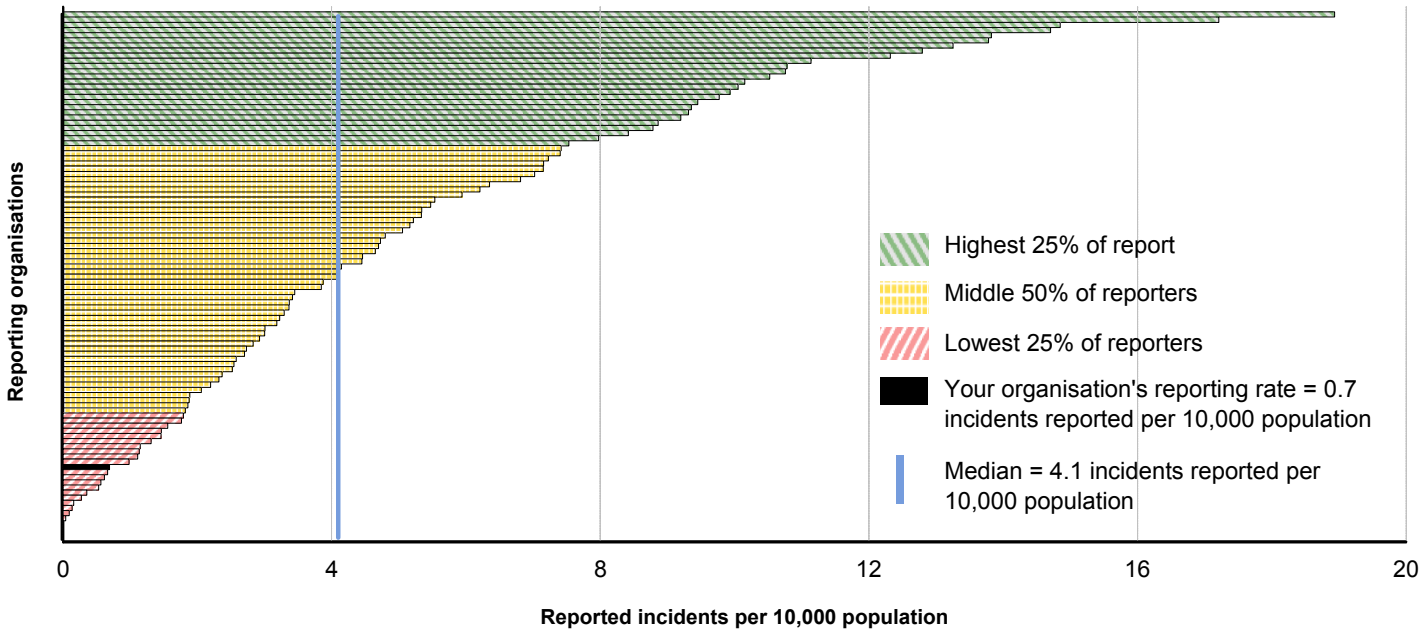
NHS
National Patient Safety Agency
National Reporting and Learning Service

YMGYRCH 1000 LIVES CAMPAIGN O FYWYDAU

## 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 (RLS) between 1 October 2008 and 31 March 2009. 12 incidents were reported during this period.

**Figure 1: Comparative reporting rate, per 10,000 population, for 104 primary care organisations with no inpatient provision.**




**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. So:**

- Encourage staff to report things that go wrong. Don't shoot the messenger!
- Make it easy to report and provide feedback. Make reporting useful!
- Use national comparative data from the RLS to better understand the reporting and learning culture in your organisation.
- Review steps your organisation can take to make reporting matter.

Tips to help you: *Act on reporting: five actions to improve reporting; Questions are the answer! Seven questions every board member should ask about patient safety at:* www.nrls.npsa.nhs.uk/

## How regularly do you report?

**Your organisation reported incidents to the Reporting and Learning System (RLS) in 4 out of the 6 months between October 2008 and March 2009.**

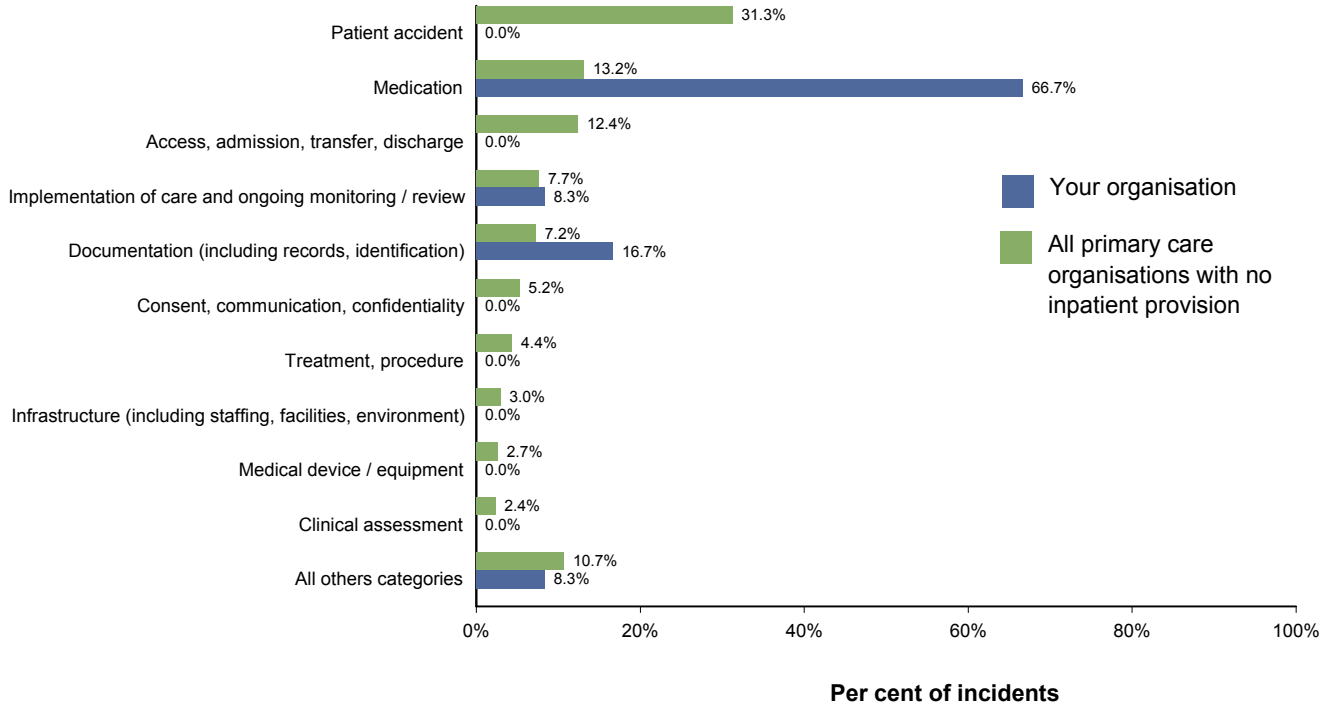
**Report regularly:** Incident reports should be submitted to the RLS at least monthly.

Fifty percent of all incidents were submitted to the RLS more than 57 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 72 days after the incident occurred.

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

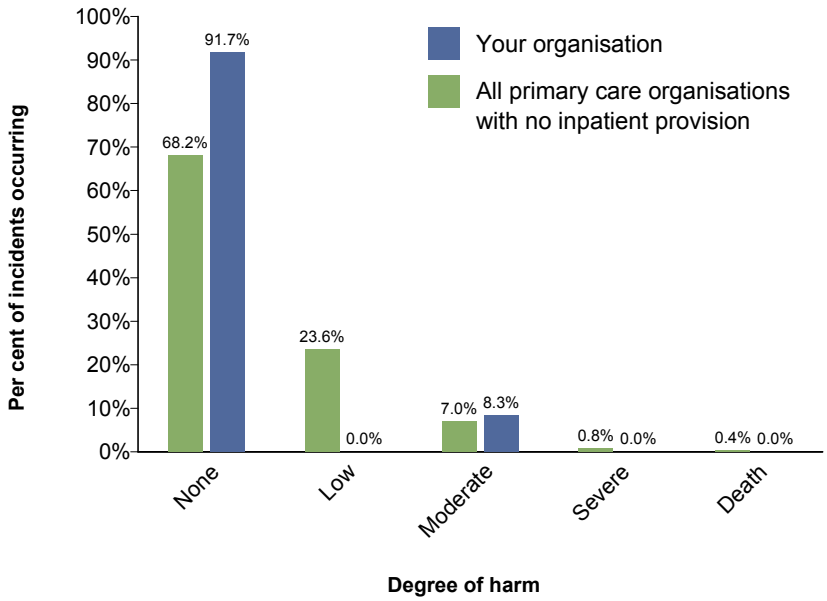
## What type of incidents are reported in your organisation?

**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 primary care organisations with no inpatient provision**




| Your figures: | None | Low | Moderate | Severe | Death |
|---|---|---|---|---|---|
| | 11 | 0 | 1 | 0 | 0 |

## Do you learn from patient safety incidents?

- Investigate incidents thoroughly so that you can identify contributing factors, identify root causes and successfully implement recommendations.
- Train staff on investigation techniques such as root cause analysis or significant event audit.
- Provide board members should receive regular reports of investigations and implementation plans.
- Go to www.nrls.npsa.nhs.uk/ references, tools and guidance on how to deliver patient care safely.

## Do you understand harm?

Nationally, 66 per cent of incidents are reported as no harm, and just over 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.

- A consistent approach to coding of degree of harm ensures that we can compare and analyse data in order to set clear priorities for national learning.
- Organisations should record actual harm to patients rather than potential degree of harm.

## Further information for you

We help 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 RLS can be found at: www.nrls.npsa.nhs.uk/organisationdata/.