

# Quarterly National Reporting and Learning System data summary

Summer 2006



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The National Patient Safety Agency (NPSA) published its first report from the Patient Safety Observatory, *Building a memory: preventing harm, reducing risk and improving patient safety*, in July 2005.<sup>1</sup> It provided analysis of incidents reported to the National Reporting and Learning System (NRLS) up to the end of March 2005, and described the role of the Patient Safety Observatory in drawing together information about patient safety from a range of sources in order to enhance our understanding of, and ability to improve, patient safety.

The second report, *With safety in mind: mental health services and patient safety*, presents an in-depth analysis of patient safety issues that are relevant to mental health services.<sup>2</sup> Alongside the second report, this summary provides an update on incidents reported to the NRLS from all sectors of the NHS up to the end of March 2006.

## The role of the NPSA

The NPSA was set up in 2001 to make changes at a national level that will improve patient safety in the NHS. The NPSA:

- identifies trends and patterns in patient safety incidents using its NRLS and data from other sources;
- provides tools for staff locally to understand underlying causes of incidents and then be able to act on them, for example the root cause analysis toolkit<sup>3</sup> and the Incident Decision Tree<sup>4</sup>;
- develops solutions at a national level, for example our national campaign to improve hand hygiene in hospitals (clean $\mathbf{y}$ ourhands<sup>5</sup>).

The NPSA is currently working on 47 projects to develop solutions to safety problems.<sup>6</sup>

In 2005, the NPSA took on new roles and is now also responsible for supporting local organisations in addressing their concerns about the performance of individual doctors and dentists; ensuring research is carried out safely; looking after the safety aspects of hospital design, cleanliness and food; and managing the contracts with the three Confidential Enquiries.

The reporting of patient safety incidents is essential to improving safety. One of the NPSA's core functions has been the development of the NRLS to collect reports of patient safety incidents and their root causes. Incident reporting enables the types and causes of safety problems to be identified so that practical solutions can be developed to prevent harm to patients.<sup>7,8</sup>

Further information about the NPSA can be found on our website at: [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

## The Patient Safety Observatory

Although incident reports are fundamental to understanding patient safety, on their own they cannot tell us all that we need to know. There are a number of reasons for this. Firstly, incident reporting systems are not comprehensive due to under-reporting, biases in what types of incident are reported, and the existence of several reporting systems. For example, in the UK, in addition to the NRLS there are separate reporting systems for medical device incidents,<sup>9</sup> adverse drug reactions,<sup>10</sup> healthcare associated infections<sup>11</sup> and suicide and homicide of people with mental illness<sup>12</sup>. Serious incidents are rare, and information on them is often distributed across the healthcare system.

In order to achieve a more comprehensive understanding of patient safety and to help reduce risk across all healthcare sectors, the NPSA has developed the Patient Safety Observatory in collaboration with a number of partners from both the NHS and elsewhere.<sup>1,13</sup>

The primary function of the Patient Safety Observatory is to quantify, characterise and prioritise patient safety issues in order to support the NHS in making healthcare safer. The Patient Safety Observatory enables us to draw upon a wide range of data and intelligence so that we can identify and monitor trends in patient safety incidents and prioritise areas for action.

## The National Reporting and Learning System

The NRLS is the primary mechanism for the NPSA to collect information on patient safety incidents from across England and Wales. The NRLS data set is designed to collect a notification report of a single patient safety incident soon after it occurs. It focuses on what happened, when and where it happened, the characteristics of the patient(s) involved (such as age, sex and ethnicity), and the outcome for the patient(s) and the staff involved in the incident and/or making the report. Additional data are collected on incidents that involve medicines and medical devices. The data set also includes contributory factors and factors that might have prevented harm. Reports also contain free text that explains what happened in varying degrees of detail.

The NRLS is the first national reporting system of its kind in the world. It collects data from across all healthcare settings and provides a springboard for developing national solutions to patient safety problems and for identifying priorities for the NPSA and the wider health service. The reports from the Patient Safety Observatory are part of a programme of work to exploit the data within the NRLS, and to provide feedback to those who report.

The NPSA is committed to undertaking thematic analyses of incidents from different sectors or topics. Alongside detailed thematic reports, the NPSA will also provide regular analysis of reports from the whole NRLS.

## How to interpret NRLS data

There are a number of notes of caution in interpreting the data from the NRLS:

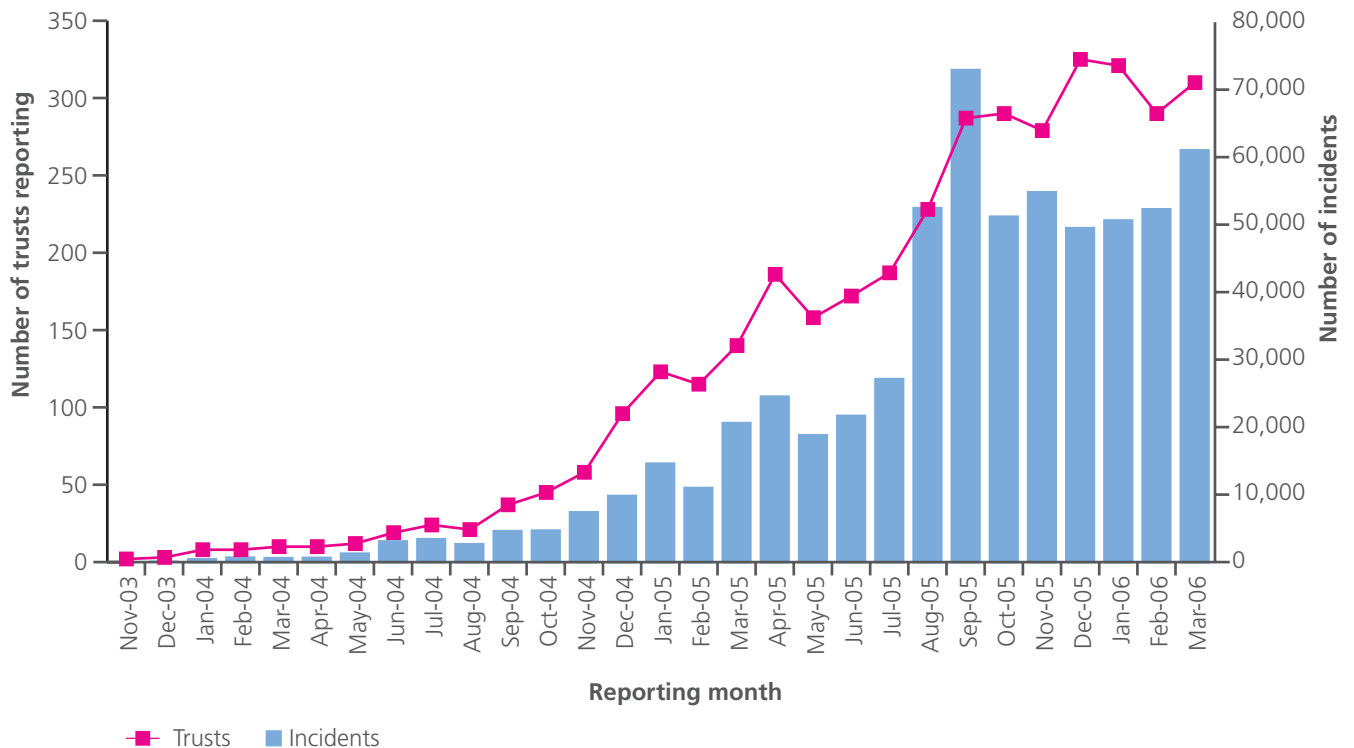
- NHS organisations have provided data to the NRLS for varying lengths of time, so data included within this report may not be representative of the rate of incidents across all of England and Wales.
- International research suggests that there is significant under-reporting of incidents.
- Reports made to local risk management systems may not capture all types of incidents that occur.
- The data are confidential. The NPSA does not seek to hold information on the identities of individual staff or patients, and this means that the data are not routinely checked with the reporter. However, steps are usually taken to maximise the quality of the data held by, for example, checking for duplicate reports and feeding back to individual trusts if there are problems with their reports.
- Incident reports are often made soon after the incident, but before the incident has been investigated locally: hence the reports to the NRLS may not contain complete information about the incident, especially findings of more detailed investigations such as root cause analysis.
- There are no reports from the public or patients included in this analysis. From April 2006, the public and patients have been able to report incidents via a dedicated reporting form.<sup>14</sup>
- A higher number of reported incidents from a trust, specialty or location does not necessarily mean that the trust, specialty or location has a higher number of incidents; it may instead reflect greater levels of reporting. Organisations reporting higher numbers of patient safety incidents may have a better developed safety culture, resulting in greater reporting and learning from reports.

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

### Incident reports

The number of trusts reporting, and the number of reports, have continued to increase rapidly as more local risk management systems have become connected to the NRLS. By the end of March 2006, all NHS organisations have reported to the NPSA, and a total of 611,331 reports had been received.

**Diagram 1: roll out of the NRLS – reported incidents and number of reporting trusts**



Source: reports to the NRLS database up to the end of March 2006.

Incident reports reach the NRLS electronically via local risk management systems, and directly from staff completing electronic forms. The vast majority of reports continue to come from local risk management systems: between April 2005 and March 2006, 99.3 per cent of reports came via local risk management systems.

The majority of reports (71 per cent from April 2005 to March 2006) continue to come from acute trusts, which tend to have more well established incident reporting systems and a more active reporting culture (Table 1). However, the proportion of reports from other care settings is increasing over time. In particular, reports from mental health, learning disabilities and community services have increased rapidly between April 2005 and March 2006. The number of reports from community pharmacy settings is expected to increase rapidly in coming months, with the new requirement for community pharmacists to report serious incidents being part of their contract. The NPSA is working with the major pharmacy chains to connect their risk management systems directly to the NRLS. The NPSA is also preparing to launch a campaign directed at primary care practitioners, to boost reporting from this sector.

**Table 1: care setting of incident reports**

Care setting	Up to the end of March 2005		April 2005 to March 2006		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Acute/general hospital	66,931	79.0	374,588	71.1	441,519	72.2
Ambulance service	395	0.5	1,961	0.4	2,356	0.4
Community and general dental service	11	0.0	168	0.0	179	0.0
Community nursing, medical and therapy service (incl. community hospital)	5,609	6.6	51,420	9.8	57,029	9.3
Community optometry/optician service	1	0.0	7	0.0	8	0.0
Community pharmacy	54	0.1	1,319	0.3	1,373	0.2
General practice	437	0.5	2,199	0.4	2,636	0.4
Learning disabilities service	798	1.0	18,736	3.6	19,534	3.2
Mental health service	10,489	12.5	76,208	14.5	86,697	14.2
<b>Total</b>	<b>84,725*</b>	<b>100.0</b>	<b>526,606</b>	<b>100.0</b>	<b>611,331</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* Since the first report from the Patient Safety Observatory was produced, more duplicates have been identified in the NRLS database. The number of incidents shown up to the end of March 2005 in the table above is therefore slightly different from that reported in the first report.

The majority of reports continue to result in no harm (69 per cent). The proportion resulting in severe harm or death is about one per cent. Note that an incident can affect more than one patient so the total number of patients affected is greater than the number of incidents.

**Table 2: degree of harm to patients**

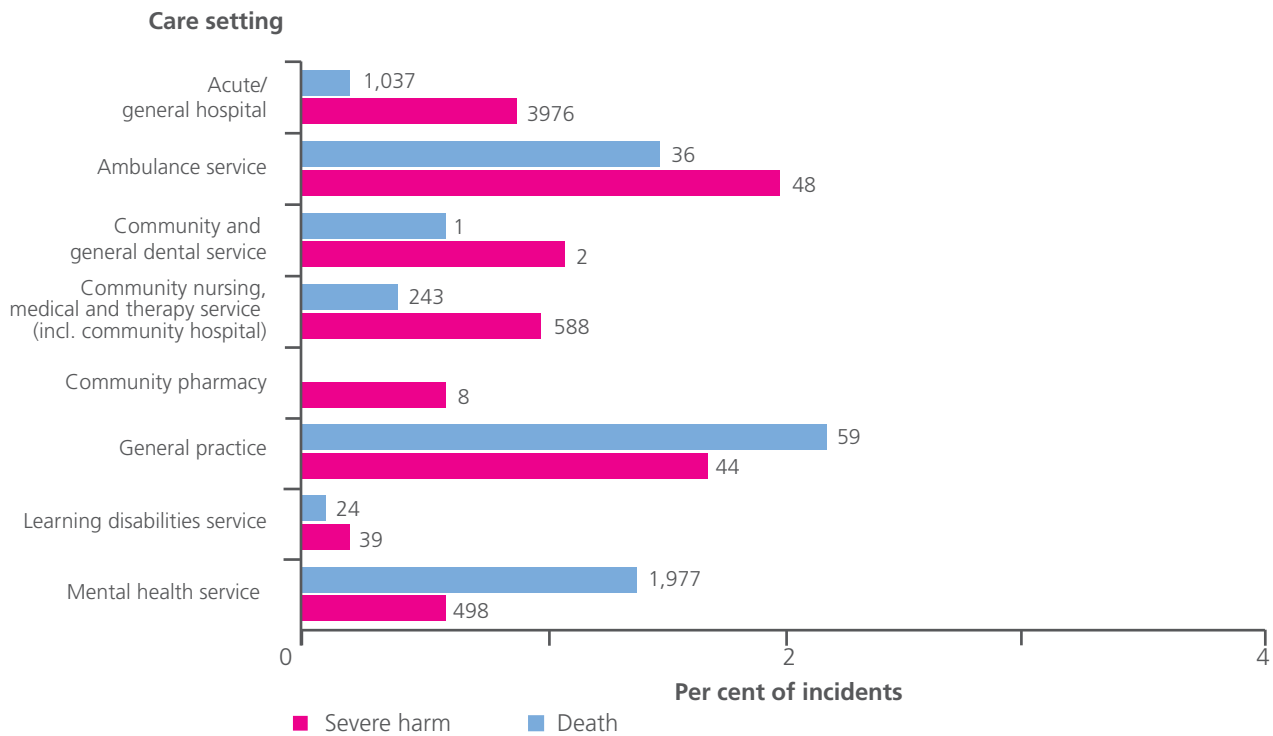
Degree of harm	Up to the end of March 2005		April 2005 to March 2006		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
No harm	58,064	67.9	361,464	68.6	419,528	68.5
Low	21,573	25.2	130,086	24.7	151,659	24.8
Moderate	4,794	5.6	28,361	5.4	33,155	5.4
Severe	675	0.8	4,529	0.9	5,204	0.9
Death	418	0.5	2,159	0.4	2,577	0.4
<b>Total</b>	<b>85,524*</b>	<b>100.0</b>	<b>526,599</b>	<b>100.0</b>	<b>612,123</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\*Since the first report from the Patient Safety Observatory was produced, more duplicates have been identified in the NRLS database. The number of incidents shown up to the end of March 2005 in the table above is therefore slightly different from that reported in the first report.

The severity of incidents shows variation by care setting (Diagram 2). The proportion of reported incidents resulting in severe harm or death is highest in ambulance and general practice settings (excluding community optometry due to an insufficient number of incidents), and this reflects differences in reporting culture: fewer incidents are reported overall (Table 3), but incidents that result in severe harm or death are most likely to be reported. The reporting of incidents from mental health settings that result in severe harm or death is discussed in the second report from the Patient Safety Observatory.

**Diagram 2: severity of incidents by care setting**



Source: reports to the NRLS database up to the end of March 2006.

Across the whole database, the most frequently reported incidents are patient accidents (Table 3). However, the type of incidents most frequently reported varies by care setting. For example, the most frequently reported incident type in general practice is incidents related to medication, and from ambulance trusts it is incidents involving medical device/equipment.

**Table 3: reported incident types for all incidents**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	46,684	7.6
Clinical assessment (including diagnosis, scans, tests, assessments)	26,021	4.3
Consent, communication, confidentiality	24,420	4.0
Disruptive, aggressive behaviour	30,180	4.9
Documentation (including records, identification)	30,554	5.0
Implementation of care and ongoing monitoring/review	11,373	1.9
Infection control incident	6,602	1.1
Infrastructure (including staffing, facilities, environment)	39,620	6.5
Medical device/equipment	19,749	3.2
Medication	50,516	8.3
Patient abuse (by third party)*	3,074	0.5
Patient accident	239,574	39.2
Self-harming behaviour	19,917	3.3
Treatment, procedure	49,676	8.1
Other	13,215	2.2
Unknown	156	0.0
<b>Total</b>	<b>611,331</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

In acute/general hospital settings, the most frequently reported incident type is patient accident; accounting for 38 per cent of reports from this sector. The remaining incidents are split between a range of types including treatment/procedure, infrastructure, access/discharge, clinical assessment and documentation.

**Table 4: reported incident types in acute/general hospitals**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	31,583	7.2
Clinical assessment (including diagnosis, scans, tests, assessments)	24,699	5.6
Consent, communication, confidentiality	21,118	4.8
Disruptive, aggressive behaviour	2,603	0.6
Documentation (including records, identification)	28,465	6.5
Implementation of care and ongoing monitoring/review	10,028	2.3
Infection control incident	6,129	1.4
Infrastructure (including staffing, facilities, environment)	34,900	7.9
Medical device/equipment	17,679	4.0
Medication	40,298	9.1
Patient abuse (by third party)*	1,178	0.3
Patient accident	167,728	38.0
Self-harming behaviour	1,744	0.4
Treatment, procedure	47,129	10.7
Other	6,136	1.4
Unknown	102	0.0
<b>Total</b>	<b>441,519</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

The most commonly reported incident types from mental health settings are patient accidents, disruptive/aggressive behaviour, self-harming behaviour and access/discharge; which between them account for 84 per cent of reported incidents reported from this setting.

**Table 5: reported incident types in mental health services**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	9,666	11.2
Clinical assessment (including diagnosis, scans, tests, assessments)	180	0.2
Consent, communication, confidentiality	606	0.7
Disruptive, aggressive behaviour	20,218	23.3
Documentation (including records, identification)	299	0.3
Implementation of care and ongoing monitoring/review	262	0.3
Infection control incident	92	0.1
Infrastructure (including staffing, facilities, environment)	2,246	2.6
Medical device/equipment	118	0.1
Medication	3,385	3.9
Patient abuse (by third party)*	1,330	1.5
Patient accident	29,622	34.2
Self-harming behaviour	14,466	16.7
Treatment, procedure	487	0.6
Other	3,703	4.3
Unknown	17	0.0
<b>Total</b>	<b>86,697</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

The predominant incident type reported to the NRLS from community services is patient accident, which accounts for 61 per cent of reported incidents.

**Table 6: reported incident types in community nursing, medical and therapy services (including community hospital)**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	4,444	7.8
Clinical assessment (including diagnosis, scans, tests, assessments)	823	1.4
Consent, communication, confidentiality	2,021	3.5
Disruptive, aggressive behaviour	1,470	2.6
Documentation (including records, identification)	1,344	2.4
Implementation of care and ongoing monitoring/review	933	1.6
Infection control incident	328	0.6
Infrastructure (including staffing, facilities, environment)	1,916	3.4
Medical device/equipment	1,336	2.3
Medication	4,043	7.1
Patient abuse (by third party)*	293	0.5
Patient accident	34,572	60.6
Self-harming behaviour	565	1.0
Treatment, procedure	1,647	2.9
Other	1,283	2.3
Unknown	11	0.0
<b>Total</b>	<b>57,029</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

The most commonly reported incident types from learning disabilities services are patient accident and disruptive/aggressive behaviour, followed by self-harming behaviour.

**Table 7: reported incident types in learning disabilities services**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	299	1.5
Clinical assessment (including diagnosis, scans, tests, assessments)	5	0.0
Consent, communication, confidentiality	39	0.2
Disruptive, aggressive behaviour	5,864	30.0
Documentation (including records, identification)	16	0.1
Implementation of care and ongoing monitoring/review	55	0.3
Infection control incident	18	0.1
Infrastructure (including staffing, facilities, environment)	163	0.8
Medical device/equipment	26	0.1
Medication	701	3.6
Patient abuse (by third party)*	241	1.2
Patient accident	6,944	35.6
Self-harming behaviour	3,099	15.9
Treatment, procedure	88	0.5
Other	1,970	10.1
Unknown	6	0.0
<b>Total</b>	<b>19,534</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

Medication incidents account for nearly a quarter of reported incidents from general practices. Other frequently reported incident types are documentation, consent/communication/confidentiality and access/disclosure.

**Table 8: reported incident types in general practices**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	278	10.6
Clinical assessment (including diagnosis, scans, tests, assessments)	250	9.5
Consent, communication, confidentiality	404	15.3
Disruptive, aggressive behaviour	17	0.6
Documentation (including records, identification)	409	15.5
Implementation of care and ongoing monitoring/review	68	2.6
Infection control incident	15	0.6
Infrastructure (including staffing, facilities, environment)	111	4.2
Medical device/equipment	44	1.7
Medication	597	22.7
Patient abuse (by third party)*	16	0.6
Patient accident	179	6.8
Self-harming behaviour	35	1.3
Treatment, procedure	135	5.1
Other	77	2.9
Unknown	1	0.0
<b>Total</b>	<b>2,636</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

The most frequently reported incident types from ambulance services are medical device/equipment, patient accident and access/discharge; which between them account for 60 per cent of incidents reported to the NRLS from this setting.

**Table 9: reported incident types in ambulance services**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	408	17.3
Clinical assessment (including diagnosis, scans, tests, assessments)	49	2.1
Consent, communication, confidentiality	217	9.2
Disruptive, aggressive behaviour	6	0.3
Documentation (including records, identification)	7	0.3
Implementation of care and ongoing monitoring/review	26	1.1
Infection control incident	15	0.6
Infrastructure (including staffing, facilities, environment)	258	11.0
Medical device/equipment	527	22.4
Medication	130	5.5
Patient abuse (by third party)*	14	0.6
Patient accident	501	21.3
Self-harming behaviour	8	0.3
Treatment, procedure	153	6.5
Other	19	0.8
Unknown	18	0.8
<b>Total</b>	<b>2,356</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

As might be expected, almost all incidents reported from community pharmacies relate to medication.

**Table 10: reported incident types in community pharmacies**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	0	0.0
Clinical assessment (including diagnosis, scans, tests, assessments)	4	0.3
Consent, communication, confidentiality	4	0.3
Disruptive, aggressive behaviour	0	0.0
Documentation (including records, identification)	8	0.6
Implementation of care and ongoing monitoring/review	0	0.0
Infection control incident	0	0.0
Infrastructure (including staffing, facilities, environment)	2	0.2
Medical device/equipment	3	0.2
Medication	1,343	97.8
Patient abuse (by third party)*	1	0.1
Patient accident	2	0.2
Self-harming behaviour	0	0.0
Treatment, procedure	2	0.2
Other	3	0.2
Unknown	1	0.1
<b>Total</b>	<b>1,373</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

The number of reports from community and general dentist services is still small and reporting patterns may change as the number of reports increases. To date, treatment/procedure, patient accident, infrastructure and medication are the most commonly reported incident types.

**Table 11: reported incident types in community and general dentist services**

Incident type	Number	Per cent of total
Access, admission, transfer, discharge (including missing patient)	5	2.8
Clinical assessment (including diagnosis, scans, tests, assessments)	7	3.9
Consent, communication, confidentiality	11	6.2
Disruptive, aggressive behaviour	2	1.1
Documentation (including records, identification)	5	2.8
Implementation of care and ongoing monitoring/review	1	0.6
Infection control incident	5	2.8
Infrastructure (including staffing, facilities, environment)	24	13.4
Medical device/equipment	16	8.9
Medication	18	10.1
Patient abuse (by third party)*	1	0.6
Patient accident	25	14.0
Self-harming behaviour	0	0.0
Treatment, procedure	35	19.6
Other	24	13.4
Unknown	0	0.0
<b>Total</b>	<b>179</b>	<b>100.0</b>

Source: reports to the NRLS database up to the end of March 2006.

\* This category covers a wide range of incidents, from verbal remarks to physical contact.

Only eight incidents have been reported from community optometry/optician services, so the breakdown by incident type is not shown.

## Summary

This report provides an overview of all data reported to the NRLS up to the end of March 2006, and provides an update on the analysis presented in the first report from the Patient Safety Observatory. The major change from April 2005 to March 2006 has been the rapid increase in incidents reported to the NRLS, as more organisations are connected via local risk management systems; by the end of March 2006, 611,331 incidents had been reported. The pattern of incident types and severity of incidents has remained broadly consistent with reports up to the end of March 2005. Future reports will examine trends in more detail, once the flow of reports from across all sectors of the NHS is more stable.

## References

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- 14 National Patient Safety Agency. *Please ask.* [www.npsa.nhs.uk/pleaseask](http://www.npsa.nhs.uk/pleaseask)

## **The National Patient Safety Agency**

We recognise that healthcare will always involve risks, but that these risks can be reduced by analysing and tackling the root causes of patient safety incidents. We are working with NHS staff and organisations to promote an open and fair culture, and to encourage staff to inform their local organisations and the NPSA when things have gone wrong. In this way, we can build a better picture of the patient safety issues that need to be addressed.

## **The National Patient Safety Agency**

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