National Reporting and Learning System

Organisation Patient Safety Incident Report

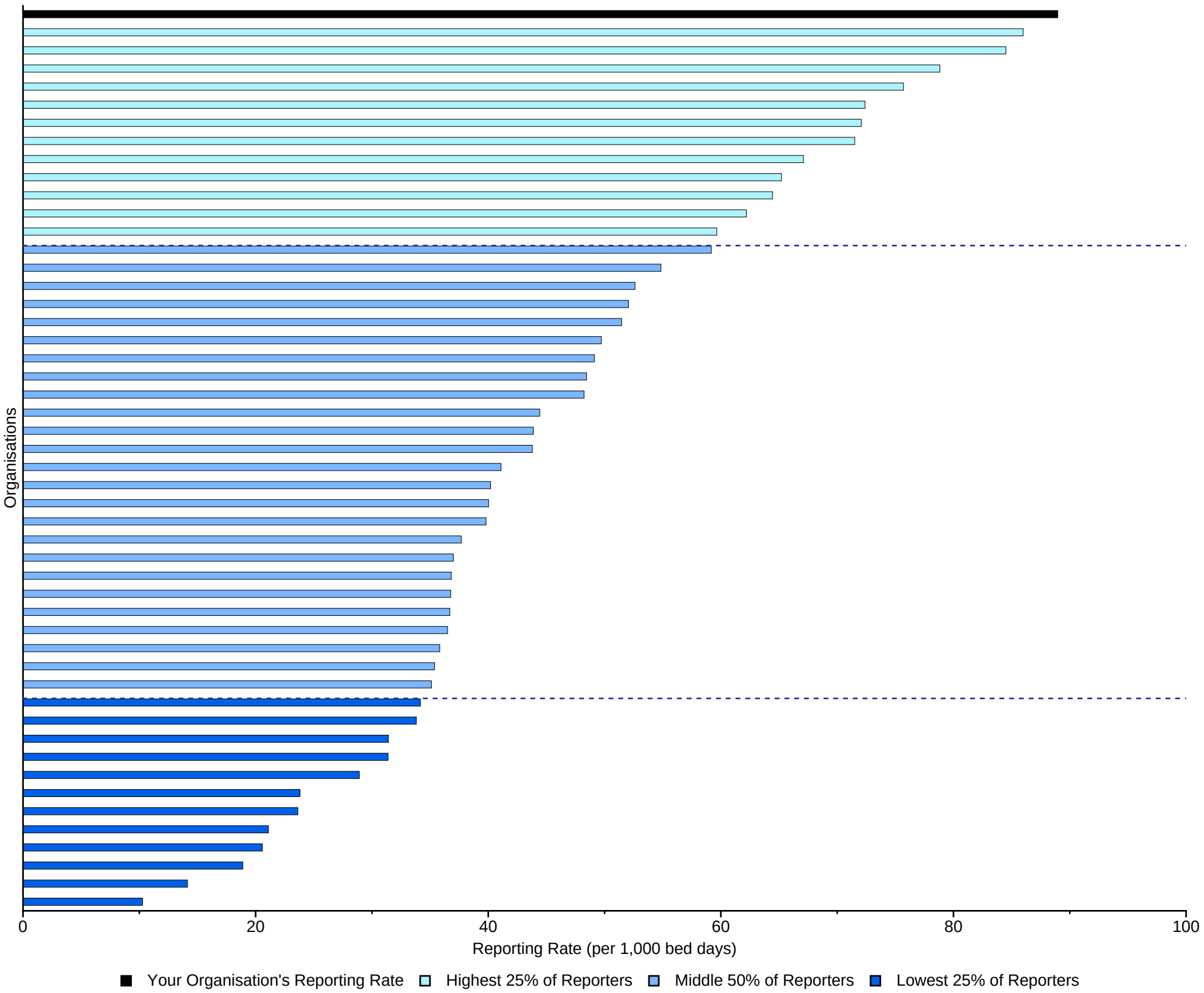
Reported incidents between 01 April 2016 to 30 September 2016

DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST
Organisation type: Mental health organisation

Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 April 2016 to 30 September 2016. Your organisation reported 3,427 incidents (rate of 88.97) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 55 Mental health organisations.



The median reporting rate for this cluster is 42.45 incidents per 1,000 bed days.

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

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between 01 April 2016 to 30 September 2016.

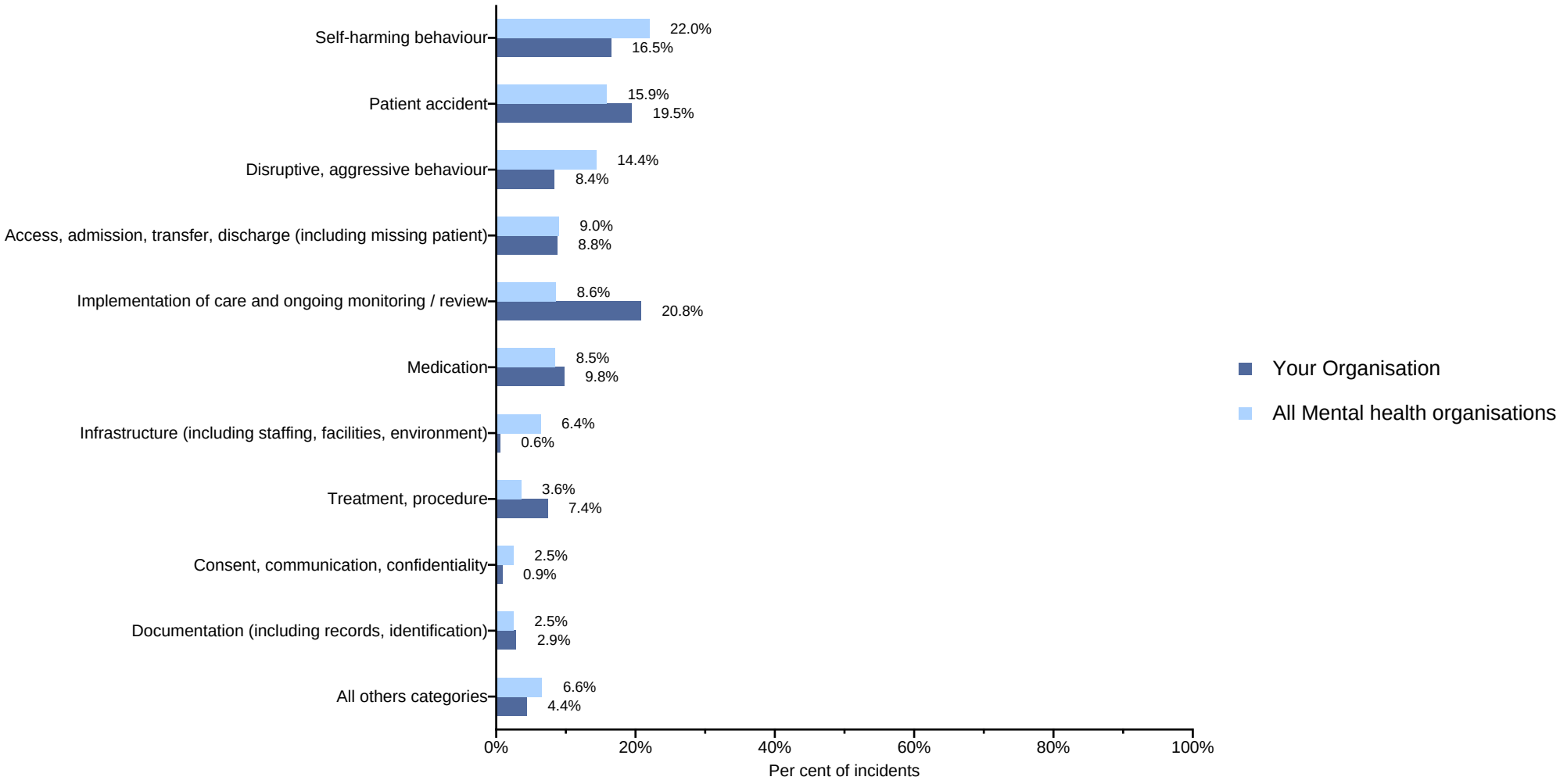
Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 26 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 8 days after the incident occurred.

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

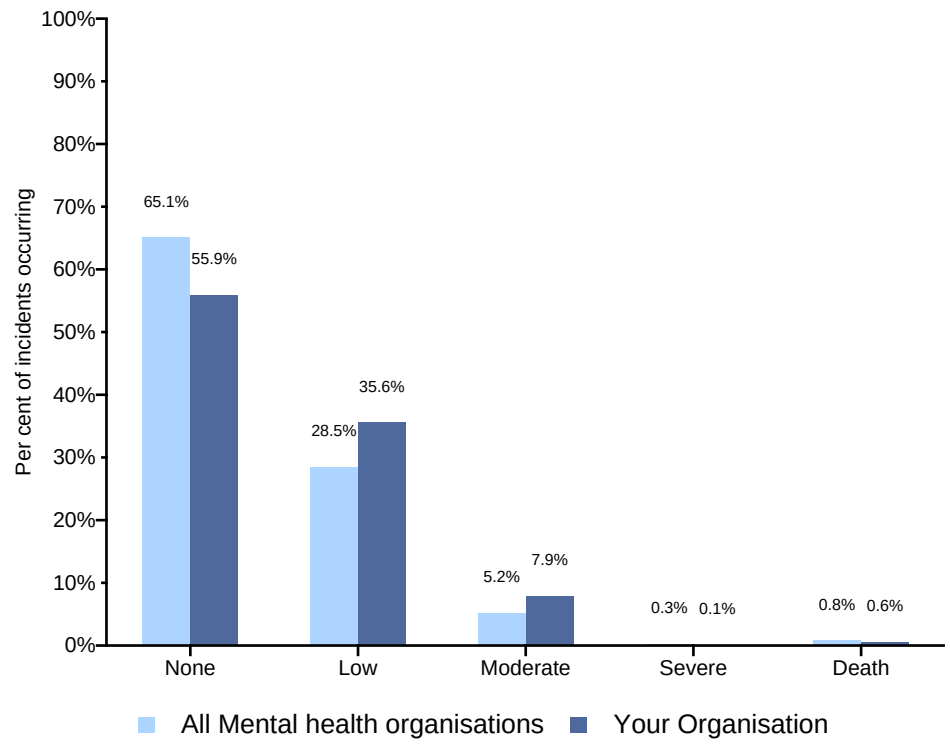
What types of incidents are reported in your organisation?

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 Mental health Organisations



Degree of harm

Your figures:

None	Low	Moderate	Severe	Death
1,915	1,219	271	3	19

Do you understand harm?

Nationally, 73 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

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

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

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.

Learning from your incident reports

We know from international research studies that not all patient safety incidents are recognised and reported, even in the most safety-aware organisations. NHS Improvement are keen that numbers of reported incidents to the NRLS are always framed in terms of reporting patient safety incidents is good, not that high reporting equals an unsafe organisation.

An NHS trust where staff feel encouraged and supported to report should show a higher rate of incident reports, a higher proportion of no harm reports, and staff survey responses about incident reporting behaviour that are above average.

NHS organisations are encouraged to apply their local knowledge and expertise – in addition to considering these other related sources of patient safety information (such as CQC reports, local serious incident information, 'friends and family' patient feedback, and local complaints data) alongside their NRLS data, in order to check that the messages from each data source are consistent and learning is identified and acted upon.

For further information click here.

Further information

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at: https://improvement.nhs.uk/resources/patient-safety-alerts/ and national data can be found at: www.nrls.npsa.nhs.uk/patient-safety-data/.

For further information on the reporting of serious incidents please see NHS Improvement's guidance
http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/