# The power of words: respond to improve

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infant PATIENT SAFETY Working together

Asking frontline clinical staff what happens when they complete a patient safety incident[1] report brings a range of interesting responses. Their main expectation will be that appropriate action is taken by their organisation, and while some will describe an impressive chain of events that clearly demonstrates good local governance processes, others will be less convinced that anything happens at all and will share their scepticism about what can possibly be achieved by allocating valuable time to undertake what they perceive to be a bureaucratic exercise. What is almost certain to be true is they will not appreciate how their reports support and influence the patient safety agenda at a national level.

The National Reporting and Learning System (NRLS) set up in 2003 now holds more than 12 million incident reports,[2] the majority collected via upload from local risk management systems. A wealth of information is contained within the NRLS, but knowing where to look and how to respond to what is found is key to supporting the NHS to learn when things go wrong. Large collections of incidents retain a unique capacity to identify and understand infrequently occurring patient safety risks which are unlikely to be characterised at a hospital or local level, including early warnings of the inevitable yet unforeseen new risks associated with changes in health care practices and the introduction of new technologies.[3]

The patient safety team at NHS Improvement has a multidisciplinary function, comprising clinicians and subject experts that advise and manage the risk surveillance, review and response process. 'Reading the words' not merely 'counting the numbers' gives invaluable information on the nature and scale of harm reported by those delivering health care. Remaining vigilant and responding to what staff have to say about error (or prevented errors, sometimes termed locally as 'near misses') is the cornerstone of this function (**FIGURE 1**).

1. Surveillance/vigilance: incident reports graded by reporting organisations as 'severe harm' or 'death' are reviewed weekly by the NHS Improvement patient safety team.
2. Incident categorisation: incidents are grouped by type (themed).
3. Issue identification: an incident is identified as a 'trigger' for potential national response.
4. NRLS scoping: multispecialty discussion and agreement for deep dive into NRLS pool (this will include looking at reports graded at lower levels of reported harm/no harm reports).
5. Review of findings: multispecialty review and discussion.
6. Response: level and nature of response agreed in consultation with other stakeholders, including patient representatives.

**FIGURE 1** The stages of review and response.

'Clinical review' is a mechanism to support this vigilance and response process. It allows us to identify and respond to patient safety risks reported by those at the frontline of care delivery. The functions of clinical review are to identify new or under-recognised issues for national learning and to ensure understanding of the broader types of harm reported from across the NHS. The process also extends, where necessary, to rapid escalation of any patient safety concern (PSC) relating to individual organisations, departments or practitioners as determined by a guiding set of principles (**FIGURE 2**).

To trigger potential national action, incident reports do not need to contain a full and complete local analysis of what happened and why, but what is vital is a clear frontline account that states clearly what happened and what concerned the staff reporting the incident.

## Reviewing major patient safety themes

Clinical review relies on clinical judgement and interpretation of information within the free text of the incident report. Guidelines or 'rules' are available to reviewers to increase inter-rater reliability when theming incidents. Peer review is undertaken to check consistency and rules are revised periodically to reduce variation and reflect changes in clinical practice. The majority of death and severe harm incidents are not new or under-recognised patient safety issues, but fall within themes that are known to be challenging and require complex and cross-system improvement work, such as delays in diagnosis, medication error, suicide prevention, prevention of inpatient falls and pressure ulcers. This aspect of clinical review is used for priority setting (for example, for Patient Safety Collaboratives[4] as a basis for more detailed analyses, and to help ensure national patient safety programmes keep a balance between the challenging areas requiring long-term work and the new and under-recognised patient safety issues.

## Outputs from clinical review

The clinical review process has enabled learning from incident reports to be shared across the NHS. The mechanism by which this learning is shared will depend on the safety issue itself. While some issues lend themselves to the development and dissemination of a National Patient Safety Alert (NaPSA), other

issues can be addressed through other routes. Therefore, it is important to retain and optimise levels of interest and engagement from other networks and organisations that may be better placed to take specific issues of patient safety forward.

The full range of issues that have progressed to alerts issued by NHS Improvement and NHS England can be found online.[5] Examples of alerts with direct relevance to newborn infants include highlighting the risk of inadvertent cutting of in-line or closed suction catheters,[6] and considering Legionella in heated birthing pools filled in advance of labour in home settings.[7]

Issues progressed via other routes include cases of chemical site burns with Hibitane-soaked packs (chlorhexidine 1%) for gynaecological procedures, disseminated via the Royal College of Obstetricians and Gynaecologists; and access to neonatal resuscitation equipment in emergency departments, shared via a Royal College of Emergency Medicine newsflash.

Incident reporting relies on healthcare staff recognising an incident and reporting it. This can never be fully representative of the harm that occurs in health care (for example, a diagnostic error can only be recognised at the point a correct diagnosis is made). The clinical review process recognises this and will draw from other data sources to identify potential need for national action. These sources include:

- Patients and the public
- HM Coroner
- NHS staff who make direct contact
- Serious Incident reports (via the Strategic Executive Information System, STEIS)
- Other professional/national organisations.

The NRLS is not perfect, and work on building an improved successor system is in progress,[8] however, in the meantime it remains a rich and diverse source of information, and the information that reporters provide is essential in supporting the continued efforts to improve the safety of patients.

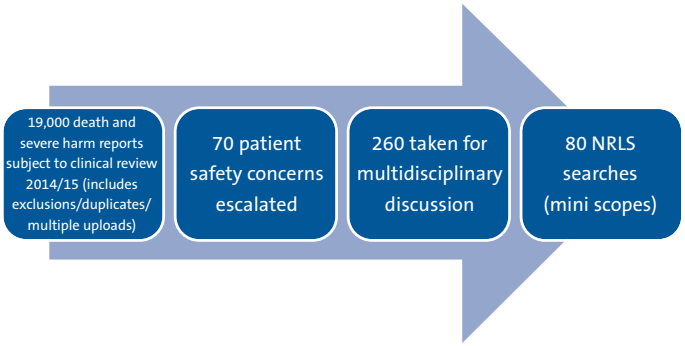


**FIGURE 2** National Reporting and Learning System (NRLS) incidents subject to the clinical review process in a typical year.

## References


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