Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

24 August 2016

[redacted]

By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **18 July 2016** in which you requested information under the FOI Act from NHS Improvement.

Please accept our apologies for the delay in getting back to you in response to this request.

Your request

You made the following request:

"I would like to request some information on medication related incidents in Wales between April 1 2015 and September 30 2015. Please can you tell me how many (number and percentage of total incidents) had poor or illegible writing as a contributory factor in the incident?"

Decision

NHS Improvement holds the information that you have requested.

The information we hold is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations in England to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other

industries has shown that as an organisation's reporting culture matures, staff become more likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

A recent search of the NRLS was carried out of all medication incidents reported as occurring between the dates 1st April 2015 and 30th September 2015 in organisations in Wales if these had been uploaded to the NRLS by 18th July 2016. The following key words, including correct and incorrect spelling variations, were searched for in the free text: Illegible, miss read, couldn't read, unreadable, difficult to read, could not read, handwritting, unclear writing, poor hand writing, poor or unclear writting, poor or badly written, writing poor or unclear or difficult, writing was poor or unclear or difficult. Whilst we have chosen key word searches in good faith as most likely to identify requested incidents we cannot guarantee that there are not additional relevant incidents that an alternative keyword search strategy might have found. It should also be noted that incident reports are often made at the point an error has been identified and are not always updated after investigation has taken place, therefore later findings (that could include examination of how clearly any handwritten prescription had been made) would not necessarily be included within the incident report.

As a result of this keyword search 38 incidents were identified and these were clinically reviewed for relevance. Following review a total of 22 of the 38 incidents described circumstances where poor or illegible writing appeared to have contributed to the incident.

As stated in the Quarterly Data Summary which can be found at the following link: http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135609, there were a total of 2,253 Medication incidents reported for the time period 1 April 2015 to 30th September 2015 from organisations in Wales. These 22 incidents therefore represent 1% (0.98%) of reported incidents categorised as medication incidents from organisations in Wales.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

Dr Frances Healey
Senior Head of Patient Safety - Intelligence