

## Freedom of Information Request: Our Reference CTMUHB\_490\_21

### You asked:

I write regarding a Freedom of Information request on never events, near miss, patient harm and serious incidents and would be grateful if you could provide me with the following information:

- 1. The number of never events, near miss, patient harm and serious incidents in your Local Health Board area in the financial years 2019-20 and 2020-21, along with monthly figures up to 24 November 2021;**

We can confirm that between the 01.04.19 and 30.11.21 a total of 54,304 patient safety incidents were reported by Cwm Taf Morgannwg University Health Board.

- 2. The number of inadvertent wrong-sided nerve blocks during regional anaesthesia by hospital and month in your Local Health Board area in the financial years 2019-20 and 2020-21 along with monthly figures up to 24 November 2021;**

We do not have a specific category for wrong sided nerve blocks during regional anaesthesia. However, we have carried out a wild card search that returned zero incidents.

- 3. A breakdown by category of these "never events, near miss, patient harm and serious incidents" in each year by listing the root causes;**

Please see provided below a breakdown of the category of incidents, by financial year:

	19/20	20/21	21/22*	Total
Pressure Damage	3689	4650	3620	11959
Slip, Trip or Fall	3379	3242	2004	8625
Delays	1674	2178	1525	5377
Moisture Lesion	887	1137	1124	3148
Medication	1153	936	722	2811
Admission / Transfer / Discharge	849	1123	798	2770
Organisational	832	528	476	1836
Communication	783	644	400	1827
Maternal Event	532	617	455	1604
Infection	369	818	293	1480
Neo-Natal Event	540	531	299	1370
Patient injury	405	429	280	1114
Personal Incident	359	433	315	1107
Self Harm	450	358	241	1049
Laboratory / Pathology Investigations	381	403	245	1029
Consent for Treatment	92	320	469	881
Health Records / Documentation	469	210	154	833
Violence & Aggression	400	234	171	805
Absconding (including actual and attempted)	303	244	256	803

Equipment	322	254	218	794
Unexpected Complications	286	166	177	629
Unexpected or Trauma Related Death	107	274	104	485
Treatment Error	196	159	117	472
Breach of Confidentiality / Information Security	157	183	77	417
Radiological Investigations	125	78	81	284
Security	95	85	44	224
Blood Transfusion	66	58	40	164
Patient Handling	37	42	31	110
Premises & Grounds Specific	31	26	10	67
Patient Transport	27	17	22	66
Information Security & Technology	23	22	13	58
Food Safety	29	16	10	55
Incorrect Surgical Procedure	10	5	16	31
BBV / Needlestick/sharps incident	8	5	7	20
<b>Total</b>	<b>19065</b>	<b>20425</b>	<b>14814</b>	<b>54304</b>

\*01.04.21 to 30.11.21

#### **4. The escalation process should never events, near miss, patient harm and serious incidents be incorrectly classified**

There are a vast number of fields within the Datix system for incident reporting – i.e. type, category, severity. All incidents would be reviewed by the responsible manager who would check the completion of the fields. Feedback is provided to the reporter for all incidents on conclusion.

This is a subjective process and the important thing is that people are reporting and that we are learning from incidents. The position can also change over the course of a review / investigation. Based on the facts available at the time of the reporting the classification may have been correct however, as the investigation processes and more information becomes available, the classification may change. Incorrect classification can have different impacts depending on what may be perceived as incorrect.