Chronological list of Signals | Emerging issues from national review of serious patient safety incidents

Key risks emerging from review of serious incidents reported by the NHS to its National Reporting and Learning System (NRLS) are shared in the form of Signals.

The NRLS held over six million patient safety incidents, which are reported from across the NHS in England and Wales. NPSA staff reviewed each reported incident of patient death or severe harm - around 350 every week.

From the reviews, around 10 alerts a year are produced. These require actions by NHS organisations to reduce risks to patients. However, there is much rich learning in addition to alerts and this is shared as Signals. The latest set of Signals was issued 28 February 2012.

28 February 2012
Prevention of harm with Buccal Midazolam
Risk of Skin-prep related fire in operating theatres

29 September 2011
Risk of harm from ingestion of Vernagel
Prevention of harm with alfacalcidol preparations

25 March 2011
Intravenous Morphine administration on neonatal units
Multiple Use of Single Use Injectable Medicines

14 February 2011
The risk of harm when using Intravenous Connectors in children and babies
Over Sedation for Emergency Procedures in isolated locations

29 October 2010
Overdose of intravenous paracetamol in Infants and children
Paracetamol Overdose
Anticoagulated patients and head injury

26 February 2010
Injectable Medicines in Theatres
Neonatal Resuscitation
Extravasation of neonates revisited
Wrong strength Phenol
27 November 2009
Residual anaesthetic drugs in cannulae
Pain relief in terminally ill in the community

24 September 2009
Extravasation injury in Neonates
Total intravenous anaesthesia
Vaccine storage