Completing the NPA online Patient Safety Incident Report form: 2016

The National Pharmacy Association (NPA) Patient Safety Incident report form can be used within the community pharmacy to log patient safety incidents. The online form should not include any patient-identifiable data; this can be added by hand after printing the form.

Emailing and printing the form

The form can be emailed to you, if you complete your email address in the relevant section. If you choose this option, there is no need to print the first section of the form. However, you may wish to print the second section in order to record the patient details by hand; alternatively, you can add these details to the email after receipt. If you do not opt to have the form emailed to you, you will need to print the form before submitting it. This can be done by right clicking on your mouse and selecting 'print' from the menu. To print using an Apple Mac computer without the use of a mouse, you can press Command + P to print. Please note that, to print the whole form, you need to print each page separately.

Completion of the form – section 1: essential information

- **Pharmacy/ Branch Name**
  If the pharmacy is part of a small chain, the branch number should be included here.
- **NPA membership number**
  The NPA membership number should be included here if applicable.
- **Date report completed**
  This is the date the report is filled out, not the date of the incident.
- **Date of incident**
  Record when the incident occurred.
- **Description of medication incident**
  Choose the most appropriate from:
  - Adverse drug reaction (when used as intended)
  - Contra-indication to the use of the medicine in relation to drugs or conditions
  - Mismatching between patient and medicine
  - Omitted medicine/ ingredient
  - Patient allergic to treatment
  - Wrong/omitted/passed expiry date
  - Wrong/omitted patient information leaflet
  - Wrong/omitted verbal patient directions
  - Wrong/transposed/omitted medicine label
  - Wrong/unclear dose or strength
  - Wrong drug/medicine
  - Wrong formulation
  - Wrong frequency
  - Wrong method of preparation/supply
  - Wrong quantity
  - Wrong route
  - Wrong storage
  - Other
  - Unknown

Direct Dial: 01727 891 800 **Email:** pharmacyservices@npa.co.uk **Online:** www.npa.co.uk

Completing the NPA online Patient Safety Incident Report form: 2016

- **Describe what happened (give as much detail as necessary to enable others to understand the circumstances and be able to learn from the event. State facts only, not opinions.)**
  Patient details should not be included in this section for reasons of confidentiality; code names can be used for patients, for example, 'Patient A' or 'Mrs B'. Try and include as much information as possible. For example:
  Example A

Patient given wrong medicine.

  The above does not provide a great amount of detail about the incident. Compare it to the following:

  Example B

Patient given wrong medicine. Patient A's simvastatin tablets10mg fell into Patient B's dispensing basket during the dispensing process. This was not noticed at the checking stage and Patient B was supplied with simvastatin 10mg tablets. Patient B took 10mg simvastatin daily for one week. Patient B was already taking 20mg of simvastatin daily, which is the maximum recommended dose when taken in conjunction with amlodipine, which Patient B was taking. Patient B reported muscle pain after one week and error was identified by hospital pharmacist on admission to hospital.

  This example provides a lot more information about what actually occurred in the incident.

- **Were there other important factors?**
  Choose one or more of:
  - Poor transfer/transcription of information between paper and/or electronic forms
  - Poor communication between care providers (verbal or written)
  - Use of abbreviation(s) of drug name/strength/dose/directions (e.g. MTX, 1mg, 1 po)
  - Handwritten prescription/chart difficult to read
  - Patient/carer failure to follow instructions
  - Failure of compliance aid/monitored dosage system (MDS)
  - Failure of adequate medicines security (e.g. missing controlled drug [CD])
  - Substance misuse (including alcohol)
  - Medicines with similar looking or sounding name
  - Poor labelling and packaging from a commercial manufacturer
  - Involving a medicine supplied under a Patient Group Direction (PGD)
  - Involving an OTC medicine
  - Failure in monitoring/assessing medicines therapy
  - Other or Unknown – please specify

- **Contributing factors: what were the apparent contributing factors?**
  More than one can be selected

Direct Dial: 01727 891 800 **Email:** pharmacyservices@npa.co.uk **Online:** www.npa.co.uk

Table 2: examples of contributing factors

Contributing factors	Example
Communication factors (includes verbal, written and non-verbal between individuals, teams and/or organisations)	Patient was not correctly counselled on the use of the medicine
Education and training factors (e.g. availability of training)	A new medicines counter assistant was not appropriately trained to make a sale over the counter
Equipment and resources factors (e.g. clear machine displays, poor working order, size, placement, ease of use)	Weighing scales had not been appropriately calibrated
Medication factors (where one or more drugs directly contributed to the incident)	Patient did not disclose prescribed medicine use when buying an over-the-counter product
Organisation and strategic factors (e.g. organisational structure, contractor/agency use, culture)	Not enough trained staff present in the dispensary
Patient factors (e.g. clinical condition, social/physical/psychological factors, relationships)	Patient is known to only take white tablets, which the prescription requested, red tablets were unintentionally supplied; the patient did not take the medicine because of this
Task factors (includes work guidelines/procedures/policies, availability of decision-making aids)	Standard operating procedures were not appropriately followed
Team and social factors (includes role definitions, leadership, support and cultural factors)	The pharmacy manager pressurised the pharmacist dispense more prescriptions per hour and as a result an error occurred
Work and environment factors (e.g. poor/excess administration, physical environment, work load and hours of work, time pressures)	Untidy dispensary

- **At what stage during the medication process did an actual or potential error occur?**
  Choose from:
  - Prescribing
  - Preparation of medicines in all locations/dispensing in a pharmacy
  - Administration/supply of a medicine from a clinical area
  - Monitoring/follow-up of medicine use
  - Advice
  - Supply or use of over-the-counter (OTC) medicine
  - Other (please specify)

- **Details of the correct main medication associated with the incident (if applicable)**
  Include information about what medicine should have been prescribed and/or given to the patient. Do not include medical devices in this section; this is covered in a later section.

Completing the NPA online Patient Safety Incident Report form: 2016

- **Details of the incorrect main medication associated with the incident (if applicable)**
  Include information about what was incorrectly prescribed and/or given to the patient. Also include if the product was a parallel import, in the relevant section.

- **Severity of actual harm incurred by patient**
  Choose from:
  - Near miss
  - No harm
  - Low
  - Moderate
  - Severe
  - Death

- **Definitions for 'degree' of actual harm (severity):**
  - *Near miss*
    The incident occurred and was resolved without involving the patient. The potential to cause harm was low, for example, the final check identified the problem.
  - *No harm*
    Impact prevented — any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving healthcare.
    Impact not prevented — any patient safety incident that ran to completion but no harm occurred to people receiving healthcare.
  - *Low*
    Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving healthcare.
  - *Moderate*
    Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving healthcare.
  - *Severe*
    Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving healthcare.
  - *Death*
    Any patient safety incident that directly resulted in death of one or more persons receiving healthcare.

Direct Dial: 01727 891 800 **Email:** pharmacyservices@npa.co.uk **Online:** www.npa.co.uk

Table 1: examples of degree of actual harm

Degree of actual harm	Example
Near miss	Propranolol was dispensed instead of prednisolone. It was detected during the accuracy checking process and rectified before anything was handed to the patient.
No harm	The patient was dispensed 21 days worth of treatment instead of 28 days worth of treatment. The patient realised on day 20 that an error had occurred, contacted the pharmacy and the pharmacy provided the patient with the remaining amount of treatment after identifying the dispensing error.
Low	The medicine was incorrectly labelled as "Take two tablets once daily" instead of "Take one tablet twice daily". The increased amount meant the patient took two tablets on one occasion, which meant that they needed monitoring for 24 hours.
Moderate	A spacer was not dispensed with a steroid inhaler when it was ordered on the prescription. The patient subsequently suffered from oral thrush that was treated with nystatin oral suspension and the patient was later provided with a spacer to enable them to use their steroid inhaler correctly.
Severe	Incorrect labelling of a medicine meant that the patient took suboptimum dosing of medicine that led to a long-term consequence for the patient.
Death	The patient was dispensed an incorrect medicine and as a result the patient died.

- **Details of the correct medical device associated with the incident (if applicable)**
  Include information about what should have been prescribed and/or given to the patient.
- **Details of the incorrect medical device associated with the incident (if applicable)**
  Include information about what was incorrectly prescribed and/or given to the patient.

Completion of the form – section 2: optional questions for pharmacy use only

- **Reference number**
  This should be decided by the pharmacy. For example, 2016/01 could be used for the first incident reported in 2016 and the pattern carried on accordingly.
- **Reporter's details**
  Details of who is filling out the incident report should be added here, not the name of the person who reported the incident to the pharmacy.
- **Staff involved in incident**
  Include the name(s) and employment status of the staff involved in the error.
- **Details of main patient affected by the incident**
  This section must not be filled out electronically for reasons of patient confidentiality; it should be completed by hand after printing.

Direct Dial: 01727 891 800 **Email:** pharmacyservices@npa.co.uk **Online:** www.npa.co.uk

Completing the NPA online Patient Safety Incident Report form: 2016

- **If the patient took/used the medicine/medical device, what symptoms did they experience?**
  Patient details should not be included in this section for reasons of confidentiality; code names can be used for patients, for example, 'Patient A' or 'Mrs B'. Try and include as much information as possible. For example:

  Example A

The patient was in pain.

  The above does not provide a great amount of detail about the incident. Compare it to the following example:

  Example B

Patient complained of muscle pain and weakness in the legs and self-referred to Accident and Emergency.

  This example provides more information about the type of pain the patient suffered.

Direct Dial: 01727 891 800 **Email:** pharmacyservices@npa.co.uk **Online:** www.npa.co.uk