Gateway number 17365

INCIDENT REPORTING SYSTEM

The below outlines the requirements to fulfil paragraph 26 (2) (c) (iii) of Schedule 1 to the National Health Service (Pharmaceutical Services) Regulations 2005.

Approved Particulars

1. Pharmacies must have a patient safety incident log for all incidents as below. The log must capture the following information, where known. Some of this information is required by the National Patient Safety Agency (NPSA). Other information will need to be retained at the pharmacy for internal review.
    a) date the form was completed, who it was completed by, their position and GPhC number (if any), date of the incident, time of the incident, who dealt with the incident, where the incident was a dispensing error who it was dispensed by and checked by;
    b) patient's name and address;
    c) patient's details - date of birth, sex, ethnicity any disabilities;
    d) if it concerns a dispensing error, the type (drug, strength, quantity, dose, label or other)
    e) describe the incident;
    f) degree of harm (near miss, no harm, low harm, moderate harm, severe harm, death);
    g) describe any action which prevented incident reaching patient or minimised impact on patient;
    h) describe any apparent contributing factors;
    i) describe any actions taken to prevent reoccurrence;
    j) if a note has been put on the patient's record;
    k) what were the underlying causes and if the new procedures will prevent occurrence;
    l) patient follow-up - describe action taken with patient and patient's reaction/view of the incident.
2. Patient safety incidents must be reported to the National Reporting and Learning Service at the NPSA or its successor organisation.
3. Patient safety incidents must be reported using the NPSA defined levels of harm:
    a) 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 NHS-funded care;

b) No harm – impact not prevented. Any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care;
c) Low. Any patient safety incident that required extra observation or minor treatment;
d) 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 NHS-funded care;
e) Severe. Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care;
f) Death. Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

4. Appropriate staff are required to participate in the analyses of critical incidents and the analyses must only involve relevant staff involved in providing NHS services who would have legitimate input into the analyses of the patient safety incidents.

The effective date for these approved particulars is 1 July 2012.