

Guidance on completing the  
Community Pharmacy Patient Safety Incident Report Form

**Instructions for completing & submitting an incident report:**

Complete all sections as fully as possible. All questions marked with # must be completed to allow reporting to the NPSA.

Do **NOT** send this paper form to the NPSA. To report directly to the NPSA use the 'Service eForm' which can be found at the following web address: <https://www.npsa.nhs.uk/eform>

Local procedures should be followed for the verbal reporting of incidents resulting in severe harm or death.

**Definitions for 'degree of actual harm (severity)':**

Near Miss	The incident was identified and prevented from reaching the patient, e.g. final check discovers that another patient's medicines have been included in the bag.
No harm	The incident reached the patient but caused no harm, e.g. the patient returned to the pharmacy to say they had been given a higher dose of their anti-hypertensive drugs; they had taken one before realising, but had suffered no adverse effects.
Low	Minimal harm, minor treatment required, e.g. wrong dose of anti-hypertensive drug dispensed, the GP identified the error when the patient presented with low blood pressure and dizziness. The dose was corrected and the patient recovered with no further ill effects.
Moderate	Short term harm, further treatment required, e.g. wrong dose of warfarin dispensed, patient suffered a minor stroke but made a full recovery and was discharged from hospital after three days.
Severe	Permanent or long term harm, e.g. wrong dose of warfarin dispensed, patient suffered a major stroke resulting in permanent weakness and speech impediment.
Death	As a consequence of the incident, e.g. Penicillamine dispensed instead of Penicillin to a child who subsequently died from the effects of the medicine.

**Medication Incident Codes:**

A	Adverse drug reaction (when used as intended)	J	Wrong/unclear dose or strength
B	Contra-indication to the use of the medicine in relation to drugs or conditions	K	Wrong drug/medicine
C	Mismatching between patient and medicine	L	Wrong formulation
D	Omitted medicine/ingredient	M	Wrong frequency
E	Patient allergic to treatment	N	Wrong method of preparation/supply
F	Wrong/omitted/passed expiry date	O	Wrong quantity
G	Wrong/omitted patient information leaflet	P	Wrong route
H	Wrong/omitted verbal patient instructions	Q	Wrong storage
I	Wrong/transposed/omitted medicine label	Z	Other

**Examples of contributing factors:**

Poor transfer / transcription of information between paper and/or electronic forms
Poor communication between care providers (verbal or written)
Use of abbreviations of drug name / strength / dose / directions (e.g. MTX, .1 mg, 1 po)
Handwritten prescription / chart difficult to read
Omitted signature of healthcare practitioner
Patient / carer failure to follow instructions
Failure of compliance aid / monitored dosage system (MDS)
Failure of adequate medicines security
Substance misuse (including alcohol)
Medicines with similar looking or sounding names
Poor labelling and packaging from a commercial manufacturer
Healthcare practitioner undertaking supplementary prescribing
Variance to guidelines for sound clinical reasons
Involving a medicine supplied under a Patient Group Direction
Involving an over-the-counter (OTC) medicine
Failure in monitoring / assessing medicines therapy
Failure of clinical assessment equipment