Community Pharmacy Patient Safety Incident Report Form

This form is for use within the pharmacy. It should **NOT** be sent to the NPSA.
To report the incident to the NPSA use the eForm which can be found at www.npsa.nhs.uk/eform
 # = mandatory fields which must be completed

Reference Number:		Pharmacy/Branch name	
Details of patient affected by incident			
Name			
Address			
Date of birth/Age			
Sex		Ethnicity (if known)	
Doctor/Prescriber details (if applicable)			
Name		Telephone number	
Address			
Incident details			
Date of incident (#)		Time of incident	
What was the location of incident? (#)	Pharmacy ☐ GP Surgery ☐ Hospital ☐ Other (please specify) ☐ ……		
Type of incident? (#)	Medication error ☐ Device/product failure ☐ Wrong device/product ☐ Device/product user error ☐ Lack of device/product ☐ Other (please specify) ☐	Diagnosis wrong/inappropriate ☐ Treatment/prescription inappropriate ☐ Failure to undertake Tests ☐ Test results incorrectly recorded ☐ Breach of confidentiality ☐ ……..	
Please describe what happened (#) (State facts only and **not** opinions) (continue on a separate sheet if necessary)			
Degree of actual harm (severity) (#) (see guidance for definitions)			
Near miss ☐ No harm ☐ Low ☐ Moderate ☐ Severe ☐ Death ☐			

Describe any action which prevented the incident from reaching the patient or minimised the impact on the patient				
If harm occurred, describe the injury (#)				
Describe any apparent contributing factors (see guidance for examples)				
Describe any actions taken to prevent a reoccurrence				
In your view, what were the underlying causes or events which, if rectified, may prevent another incident?				
Has the GP been informed?	Yes ☐ No ☐		Has the PCT/LHB been informed?	Yes ☐ No ☐
Have you contacted your insurers?	Yes ☐ No ☐	If yes, what advice have they given?		

If this is a medication incident, or a medicine contributed to the incident complete the box below

Details of medication involved in the incident			
At what stage of the medication process did the incident occur? (#)	Prescribing ☐	Dispensing ☐	Monitoring therapy ☐
	Advice ☐	Other (please specify) ☐ ……	
Enter the medication incident code (#) (see guidance for codes)			

Medication details	correct/intended	incorrect (if applicable)
Medication name		
Form		
Dose/strength		
Route		
BNF Classification		
Is the medicine a manufactured special?		Yes ☐ No ☐
Is the medicine a parallel import?		Yes ☐ No ☐
Has a copy of the prescription (front & back) been retained?		Yes ☐ No ☐
Has a photocopy of the dispensing label in situ been made or has the patient returned the original container (if so, then retain)		Yes ☐ No ☐

If a medical device/medical product caused an incident or a device/product contributed to the incident, complete the box below

Details of medical device involved in the incident			
Type of device (#) (e.g. dressing, blood testing kit etc.)			
Product name			
Model		Serial number	
Manufacturer		Batch number	
Expiry date		Date manufactured	
Any defective equipment should be retained for inspection			

Details of staff involved (use a separate sheet if necessary)			
Name		*Job title (#)*	
Staff status (#) (e.g. locum, permanent etc.)			
Role in incident (#)	Directly dispensing ☐ Assisting/checker ☐ Informed of incident ☐ Overall responsibility ☐		
Name		*Job title (#)*	
Staff status (#) (e.g. locum, permanent etc.)			
Role in incident (#)	Directly dispensing ☐ Assisting/checker ☐ Informed of incident ☐ Overall responsibility ☐		

Reporter details			
Name		*Job title (#)*	
Staff status (#) (e.g. locum, permanent etc.)			
Role in incident (#)	Directly dispensing ☐ Assisting/checker ☐ Informed of incident ☐ Overall responsibility ☐		
Date reported			

Superintendent/Pharmacist in Charge follow up (investigations, findings and planned actions)

Name		*Job title (#)*	
Staff status (#) (e.g. locum, permanent etc.)		Date	

Patient follow up	
Has feedback about the incident and the investigation been provided to the patient?	Yes ☐ No ☐
Does the patient want to pursue the matter further? (if yes, explain the complaints procedure to the patient)	Yes ☐ No ☐
What outcome does the patient want?	

Number of extra sheets attached	