

## Guidance and process for General Practice reporting medicines-related incidents

### Background

Improving learning from medicines-related patient safety incidents is important to guide practice and minimise patient harm. Medicines-related patient safety incidents are unintended or unexpected incidents that are specifically related to medicines use, which could have or did lead to patient harm. These include potentially avoidable medicines-related hospital admissions and re-admissions, medication errors, near misses and potentially avoidable adverse events.

[NICE Guidance NG5](#) recommends that

- Organisations should support a person-centred, ['fair blame' culture](#) that encourages reporting and learning from medicines-related patient safety incidents.
- Organisations should ensure that robust and transparent processes are in place to identify, report, prioritise, investigate, and learn from medicines-related patient safety incidents, in line with national patient safety reporting systems
- Health and social care practitioners should report all identified medicines-related patient safety incidents consistently and in a timely manner, in line with local and national patient safety reporting systems, to ensure that patient safety is not compromised.
- Health and social care organisations and practitioners should
  - ensure that action is taken to reduce further risk when medicines-related patient safety incidents are identified
  - apply and share learning in the organisation and across the local health economy, including feedback on trends or significant incidents to support continuing professional development

Recording safety events, whether they result in harm or not, provides vital insight into what can go wrong in healthcare and the reasons why. At a national level, this allows for new or under-recognised safety issues to be quickly identified and acted upon on an NHS-wide scale. It also provides a wealth of data offering essential insight to support ongoing national patient safety improvement programmes, as well as improvement work at a more local or speciality-specific level.

### Examples of medicines-related incidents

Errors can occur at different stages of the medication use process.

- prescribing
- preparing
- dispensing
- administering

- monitoring
- providing advice on medicines.

Medicines-related incidents are not the same as adverse drug reactions. Adverse drug reactions or side effects should be reported to the [MHRA Yellow Card](#)

### **Controlled drugs**

Incidents or concerns related to controlled drugs (including loss or theft) should be reported to the NHS Area CD Accountable Officer via the online Controlled Drug reporting website – [www.cdreporting.co.uk](http://www.cdreporting.co.uk). You should also report incidents to the police (if necessary).

## **New NHS England system for recording patient safety events and incidents (including medicines-related incidents)**

### **Learn from patient safety events (LFPSE) reporting system**

A new national NHS [Learn from patient safety events \(LPSE\)](#) service for the recording and analysis of patient safety events that occur in healthcare is currently being rolled out to health and care sectors.

LFPSE is replacing the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), to offer better support for staff from all health and care sectors.

LFPSE will initially provide two main services:

**Record a patient safety event** – organisations and staff will be able to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement. Primary Care organisations, such as general practice, independent dental surgeries, community pharmacies and opticians, can record patient safety events directly via the [online recording service](#).

**Access data about recorded patient safety events** – Providers and ICBs will be able to access data that has been submitted by their staff and organisations, to better understand their local reporting practices and culture, and to support local safety improvement work.

## Guidance from CQC

CQC encourages Primary Care staff to use the new LFPSE system to record patient safety events including medicines-related incidents. Events recorded in LFPSE can be used for significant event analysis and for continuing professional development and reflective practice.

[GP mythbuster 24: Recording patient safety events with the Learn from patient safety events \(LFPSE\) service](#)

[GP mythbuster 3: Significant event analysis \(SEA\)](#)

As part of their inspections, they will look at how practices,

- identify and assess risks and safety issues
- record patient safety events and concerns
- report, respond, learn, communicate, review, and analyse these internally and externally (e.g to the ICB or other Providers where appropriate)

To improve medicines safety and ultimately patient safety across Frimley ICS, the ICB Medicines Optimisation Team and Quality Team encourage practice staff to [register for a LFPSE account](#) via the web-based service and report medicines-related incidents.

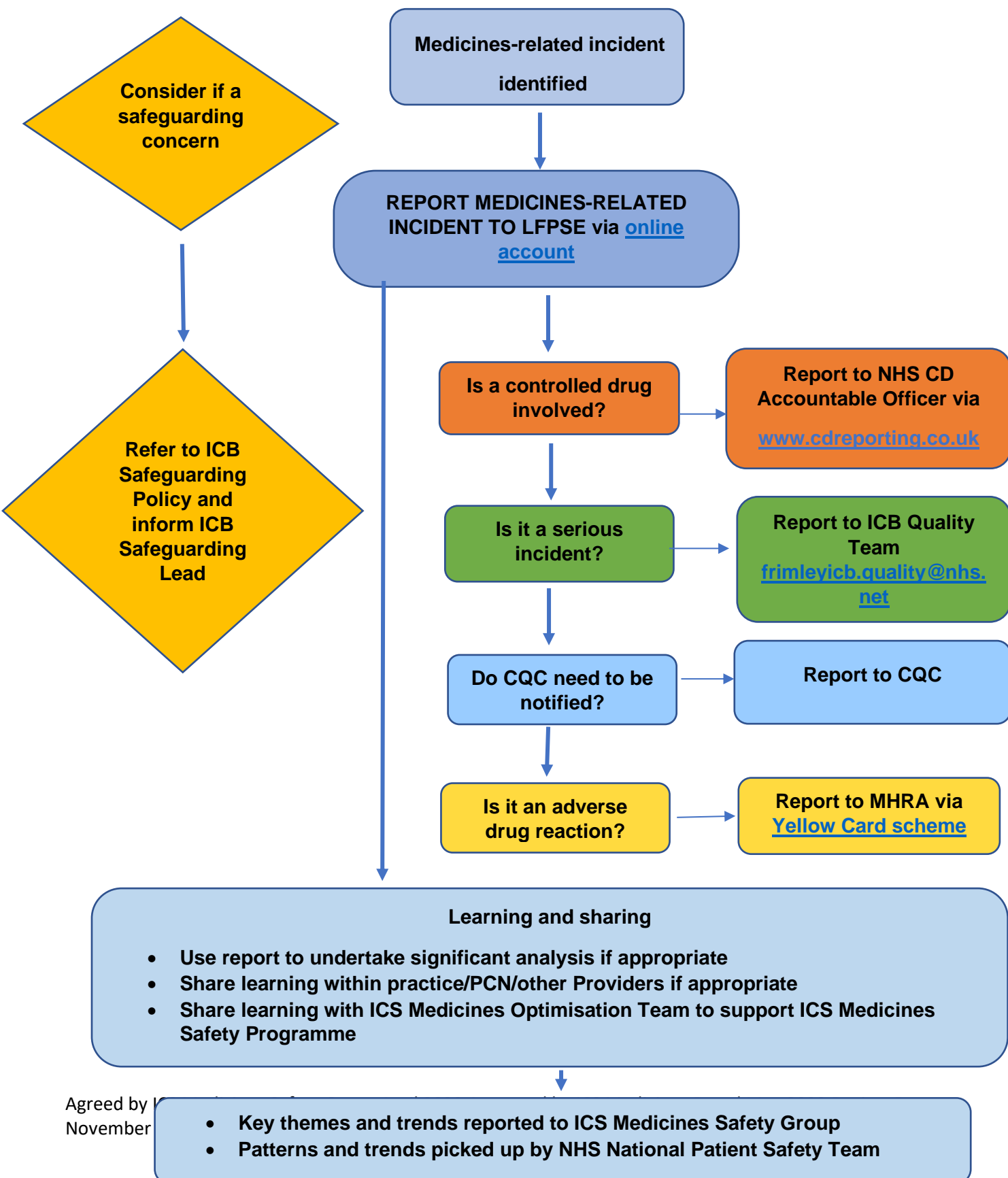
**LFPSE reports can be used for significant event analysis (SEA) reports.**

**Annex 1** shows the process for reporting and learning from medicines-related safety incidents in primary care.

**Annex 2** lists resources on LFPSE from NHS England for Primary Care staff

Annex 1

**Process for reporting and learning from medicines-related incidents reported in Primary Care**



**Annex 2**

**LFPSE resources for Primary Care staff**

**Video – Introducing the Learn From Patient Safety Events Service**

<https://www.youtube.com/watch?v=mIRu-B-XbGM>

**How to use the service -** [LFPSE: Online Record Patient Safety Events Service \(Standard Access\) - User Guidance](#)

**LFPSE poster for Primary Care**



Editable LFPSE  
poster for Primary C: