NHS Frimley

What to include in a Learning From Patient Safety Events (LFPSE) report

Accuracy and completeness

The report should provide accurate and comprehensive details about the patient safety / medication safety event. It should include, where applicable, information such as the medication involved, dosage, route of administration, date, time, individuals involved (e.g. prescriber, pharmacist, nurse) and a clear description of what happened.

Timeliness

Reporting the patient safety / medication event in a timely manner is crucial to ensure that appropriate actions can be taken promptly. The report should be submitted as soon as possible after the event occurs to facilitate quick analysis and response.

Objectivity

The report should maintain objectivity and avoid assigning blame. It should focus on factual information and observations related to the event rather than personal opinions or judgments. This helps in understanding the underlying causes and contributing factors.

Clarity and organisation

The report should be well-structured and easy to understand. Use clear and concise language to describe the event, including any relevant context or factors that may have contributed to the event/error. Organise the report in a logical manner, ensuring that important information is easily accessible.

Description of the Patient Safety / Medication Safety Event:

Provide a detailed description of the event, including how it occurred, the sequence of events, how it was identified, and any relevant factors (e.g., a medication error may have similar drug names, look-alike packaging) that may have contributed to the incident/error. This information helps in analysing the root causes and identifying potential preventive measures that could be shared wider.

Impact on patient

Describe the impact of the patient safety / medication safety event on the patient's health and well-being. Include information about any adverse effects experienced by the patient and the actions taken to address them. This helps in understanding the consequences of the error and the severity of the event.

Learning and improvement:

A good report goes beyond documenting the patient safety / medication safety event. It should include recommendations for improvement, actions that can/have been taken to prevent similar errors in the future and what was the learning? This demonstrates a proactive approach towards patient safety and a commitment to learning from mistakes.

Produced by Frimley Medicines Optimisation Group May 2024
Review date May 2026