Patient Safety Alert

Stage Three: Directive

Improving medication error incident reporting and learning

20 March 2014

Alert reference number: NHS/PSA/D/2014/005 Alert stage: Three - Directive

NHS England and MHRA are working together to simplify and increase reporting, improve data report quality, maximise learning and guide practice to minimise harm from medication errors by:

- sharing incident data between MHRA and NHS England reducing the need for duplicate data entry by frontline staff;
- providing new types of feedback from the National Reporting and Learning System (NRLS) and MHRA to improve learning at local level;
- clarifying medication safety roles and identifying key safety contacts to allow better communication between local and national levels; and,
- setting up a National Medication Safety Network as a new forum for discussing potential and recognised safety issues, identifying trends and actions to improve the safe use of medicines. The network will also work with new Patient Safety Improvement Collaboratives that will be set up during 2014.

The Yellow Card Scheme for reporting suspected adverse drug reactions to the MHRA will continue to operate as normal.

Actions (Target date for completion 19 September 2014)

All *large** healthcare providers including NHS Trusts, community pharmacy multiples, home healthcare companies and those in the independent sector should:

1. identify a board level director (medical or nursing supported by the chief pharmacist) or in community pharmacy and home health care, the superintendent pharmacist, to have the responsibility to oversee medication error incident reporting and learning;
2. identify a Medication Safety Officer (MSO) and email their contact details to the Central Alerting System (CAS) team. This person will be a member of a new National Medication Safety Network, support local medication error reporting and learning and act as the main contact for NHS England and MHRA; and,
3. identify an existing or new multi-professional group to regularly review medication error incident reports, improve reporting and learning and take local action to improve medication safety.

*Small** healthcare providers including general practices, dental practices, community pharmacies and those in the independent sector should:

4. continue to report medication error incidents to the NRLS using the e-form on the NRLS website, or other methods and take action to improve reporting and medication safety locally, supported by medication safety champions in local professional committees, networks, multi-professional groups and commissioners.

Healthcare commissioners including Area Teams, and Clinical Commissioning Groups are invited to:

5. identify a MSO and email their contact details to the CAS team. This person will be a member of the National Medication Safety network, support reporting and learning and take local actions to improve medication safety. The MSO can also use learning to influence policy, planning and commissioning as part of clinical governance in the commissioning organisation; and,
6. regularly review information from the NRLS and the MHRA to support improvements in reporting and learning and to take local action to improve medication safety. This should done by working with medication safety champions in local professional committees and networks, and with a new or existing multi-professional group.

Supporting information

*More detailed information to support the implementation of this guidance is available at:
www.england.nhs.uk/patientsafety/PSA

Contact NHS England: patientsafety.enquiries@nhs.net
Contact MHRA: pharmacovigilanceservice@mhra.gsi.gov.uk

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