NHS
West Hampshire
Clinical Commissioning Group

Reporting Medication Incidents

What to Report		How to Report
Adverse Drug Reactions	• Reactions that are serious, medically significant or result in harm* • Caused by medication errors • Caused by NEW medicines & vaccines (identified by black triangle) • Caused by herbal or homeopathic remedies	**YELLOW CARD** TO MRHA https://yellowcard.mhra.gov.uk/yellowcards/reportmediator/
Defective Medicines	• Medicines that are not of an acceptable quality • Medicines not working as expected	
Prescribing, dispensing and administration errors	• All incidents that result in patient harm* • Any error where no harm* has occurred, even when the patient has taken (or been given) the medication.	**NRLS** via e-form (from 26th February) https://report.nrls.nhs.uk/GP_eForm **Tick "Share with CCG" in Question 1**
Prescribing problems related to	• Inadequate safety monitoring eg warfarin • Problems at transfer of care • Updating repeat medicines following hospital admission • Contra-indications or documentation of allergy information • High risk medicines e.g. anticoagulants, opiates, methotrexate, NSAIDS, insulin, amiodarone	

***Refer to following table for definitions and examples of levels of harm**

Level of Harm	Definition	Example
No harm	**Any medication incident that did not result in harm or injury or that had the potential to cause harm but was prevented, resulting in no harm (near miss).**	A GP prescribes the twice the recommended dose of a new drug, which the local community pharmacist picks up when dispensing the prescription.
Low harm	**Any medication incident that required extra observation or minor treatment**	A patient's home visit is missed; the patient has cellulitis of the right leg; this was picked up the following day resulting in the GP deciding to prescribe I.V. rather than oral antibiotics which need to be delivered by community frailty team
Moderate harm	**Any medication incident that resulted in a moderate increase in treatment (eg hospitalisation or prolonged hospital stay) and which caused significant but not permanent harm**	Continuing treatment with warfarin without monitoring INR for 6 weeks. The patient had an upper GI bleed and was admitted to hospital for 5 days for monitoring and follow-up. It was noted on admission that the INR was 7.
Severe harm	**Any medication incident that caused life-threatening, disabling or incapacitating effects or appears to have resulted in permanent or long term harm (including congenital abnormality)**	GP noticed the lithium level in an elderly patient being treated for depression had gone up to 0.97mmol/L but as it was within the local lab range of 0.6-1.2 mmol/L, took no further action. The patient subsequently developed life threatening toxicity and renal failure.
Death	**Any medication incident that directly resulted in death**	A patient is on a repeat prescription for morphine sulphate 10mg twice a day for chronic pain. The patient requests a prescription and, in error, a prescription is issued for morphine sulphate 100mg twice a day. The medication is dispensed and the patient's wife, who looks after his medicines, gives her husband 100mg tablets of morphine sulphate. He takes 2 doses over the next day and then his wife is unable to rouse him in the morning. He is admitted to hospital where he has a cardiac arrest and dies

Julia Wright, Medication Safety Officer, West Hampshire CCG Julia.wright2@nhs.net