

A NEW STANDARD CODING SYSTEM FOR REPORTING PATIENT SAFETY INCIDENTS

Over the next year the National Patient Safety Agency will be rolling out the new National Reporting and Learning System for NHS-funded health care in England and Wales. In this article, David Cousins, head of safe medication practice at the NPSA, highlights some important features of the system and how to use the codes for patient safety incidents involving medicines

In the first article in this series, the National Reporting and Learning System (NRLS) was introduced (*PJ*, 22 November, p719). The NRLS has been designed to build on local reporting activity and the system has been developed to interface with all the major commercial local risk management systems used in most NHS organisations. This means that incident information that was previously only collected locally can be gathered to track national trends in a seamless way.

The system uses a standard dataset to code incident reports to enable data pooling, analysis and learning across the NHS. During 2004 the NHS will be requested to adopt this new dataset for use in incident report forms and risk management software. Full details of the NRLS dataset are available on the NPSA website at www.npsa.nhs.uk.

Patient safety incidents involving medicines are defined as any unintended or unexpected event that could — or did — lead to patient harm while the medicine was in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labelling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. This definition has been adopted from the National Co-ordinating Committee for Medication Error Reporting Programmes in the United States.

There are four specific sections in the NRLS relating to medicines (see Panel).

The medicine product data fields (section 4) will initially be free text, but it is planned that the NRLS will use the United Kingdom Clinical Products Reference Source (UKCPRS) which is being developed by the Prescription Pricing Authority and the NHS Information Authority. This medical products database will be continuously maintained and updated and will contain the primary care and secondary care medicine products databases as well as a medical devices database. The use of UKCPRS in the NRLS will enable more accurate coding of the medicine products involved in the incident from pull down tables when entries are being made in the reporting software.

In addition to these four sections there are data fields that identify the type of health care setting, clinical specialty, staff type and grade involved, patient type, age and sex, and clinical condition being treated. There are also data fields for the date and time the incident took place. Free text fields are pro-

vided for descriptions of the incident, measures that prevented or minimised patient harm, and actions taken following the incident to prevent recurrence. Optional data fields are available to describe what were the underlying causes or events which, if rectified, may prevent another patient safety incident.

A data field is provided to grade any actual harm to the patient using the following scale: low (minimal harm — patient(s) required extra observation or minor treatment); moderate (short-term harm — patient(s) required further treatment, or procedure); severe (permanent or long-term harm); and death (caused by the incident).

Having described the medicine section codes of the NRLS, it will be apparent that analysis of this data will provide useful information at local and national level concerning the types of medicine-related patient safety incidents that are occurring.

However, the benefits and learning from this analysis will be reduced if incident reports submitted to the NPSA are inaccurately coded or incomplete. When the system is rolled out throughout 2004, and as their organisation begins participating in national reporting, pharmacists are asked to ensure that the incidents that they report using the codes are completed as required. It would also be helpful if pharmacists offer to assist risk managers and clinical governance leads in trusts regularly to review incident reports involving medicines and ensure that the coding system is used as intended. This is particularly so concerning the details of the medicine products involved in the incidents. Pharmacists can quality assure and, where necessary, supplement the medicines information in the incident report. This will ensure that the maximum learning and systems improvement actions occur as a result of analysis of NRLS data at local and national level.

Panel: NRLS sections relating to medicines

1. At what stage in the medication process did an actual or potential error occur?

- prescribing
- preparation of medicines in all locations or dispensing in a pharmacy
- administration or supply of a medicine from a clinical area
- monitoring or follow-up of medicine use
- advice concerning any aspect of medicines use
- supply of an over-the-counter medicine
- other

2. In-process description of the error

- adverse drug reaction (when used as intended)
- contraindication to the use of the medicine in relation to drugs or condition
- mismatching between patient and medicine
- omitted medicine or ingredient
- patient allergic to treatment
- wrong, omitted or passed expiry date
- wrong or omitted patient information leaflet
- wrong or omitted verbal directions to the patient
- wrong, transposed or omitted medicine label
- wrong or unclear dose or strength
- wrong drug or medicine
- wrong formulation
- wrong frequency
- wrong method of preparation or supply, or administration
- wrong quantity
- wrong route
- wrong storage
- other

3. Other important factors

- failure to refer to hospital follow-up
- failure to monitor or assess medicines therapy

- failure of adequate medicines security (eg, missing Controlled Drug)
- failure of clinical assessment equipment
- failure of compliance aid or monitored dosage system
- failure to order laboratory test
- handwritten prescription or chart difficult to read
- health care practitioner undertaking supplementary prescribing
- involving a medicine supplied under a patient group direction
- involving an over-the-counter medicine
- issues associated with an infusion pump or syringe driver
- medicines with similar looking or sounding names
- omitted signature of health care practitioner
- patient or carer failure to follow instructions
- poor communication between care providers (verbal or written)
- poor labelling and packaging from a commercial manufacturer
- substance misuse (including alcohol)
- use of abbreviation(s)
- variance to guidelines for sound clinical reasons

4. Details of the product(s) involved

- approved name
- proprietary name
- form and strength
- route
- BNF classification (1–15)
- manufacturer
- batch number
- is the medicine an unlicensed special?
- is the medicine a parallel import?
- is the medicine clinical trial material?