Community Pharmacy Incidents Annual Report 2024/25

Executive Summary

Introduction

This Community Pharmacy Incidents Annual Report 2024/25 provides analysis of the medication-related incidents involving Northern Ireland's community pharmacies reported to the Strategic Planning and Performance Group (SPPG) within the financial year.

Publication of this annual report is valuable to reinforce the necessity for continuous improvement and highlight areas requiring additional focus. There are actions for SPPG and community pharmacy to improve the overall safety of medications.

The ongoing trend of reduced numbers of incidents being reported to SPPG remains a concern. Further engagement with community pharmacy professionals to encourage reporting and to develop an appreciation of the prohibitive factors is necessary. The Community Pharmacy Assurance Framework has been utilised as a means of promoting the **Community Pharmacy Anonymous Incident Reporting website** in an attempt to improve the reporting of anonymous incidents.

The HSC Regional Impact Table (Appendix 1) describes the impact levels used to assess both actual and potential harm as a result of an incident. Most reported incidents resulted in no or low harm. A small number resulted in moderate harm. Incidents involving a Monitored Dosage System (MDS) are often associated with a higher risk particularly when the MDS is provided to the incorrect patient. Six (27%) handout errors involved an MDS, of which three (50%) resulted in hospital admission. Due to this additional risk, a thematic review of all medication handout incidents is underway with outputs to be published in 2026/27.

In addition to structured learning through **Medicines Management Newsletters**, SPPG provided other forms of learning in 2024/25 around adverse incidents such as a themed Project ECHO sessions with the Transforming Medication Safety in Northern Ireland (TMSNI) team on Look-alike, Sound-alike (LASA) medications and on medication shortages.

SPPG staff submitted six **Yellow Card Reports** to the Medicines and Healthcare products Regulatory Agency (MHRA) to highlight adverse effects linked to medication incidents, this is another area where a need for education and promotion is evident.

Additional efforts to raise the quality of the information inputted into Datix; a web-based patient safety and risk management solution, is underway in conjunction with Datix colleagues and training of SPPG Directorate of Primary Care (DoPC) teams to take place in 2025/26.

The full report can be viewed on the Primary Care Intranet.

Key Findings

- SPPG received 253 incidents between April 2024 - March 2025, compared with 265 reported last year. Twenty-nine of these were reported anonymously, a 54% decrease from 2023/24

- SPPG DoPC staff reviewed and closed 227 of these incidents in year (198 known and 29 anonymous), with 26 remaining under review

- Based on the potential harm and likelihood of recurrence, Datix automatically assigns a risk grade (Appendix 2) with 53 incidents graded as medium or high risk

- The most common error reported was supply of incorrect medication/product followed by incorrect dose and incorrect strength. Examples of incidents graded as high risk included:

    - propranolol dispensed instead of omeprazole
    - incorrect strength of tacrolimus provided

- Thirteen of the incorrect medication incidents were graded as medium risk and all involved a Look-Alike, Sound-Alike (LASA) medication (medicines that have similar-looking (orthographic) or similar-sounding (phonetic) names, and/or shared features of products or packaging are called LASAs and are a well-recognised cause of medication errors)

- Medication was supplied to the incorrect patient in 22 (9%) incidents as a result of bagging errors, labelling errors, delivery or handout errors including Monitored Dosage Systems (MDS)

- Actual harm occurred in 47 (19%) cases with seven (3%) of these deemed to have caused moderate harm to the patient (requiring hospital admission for 5-14 days or psychological harm beyond a few days or weeks). Examples of these incidents are shown in Figure 1

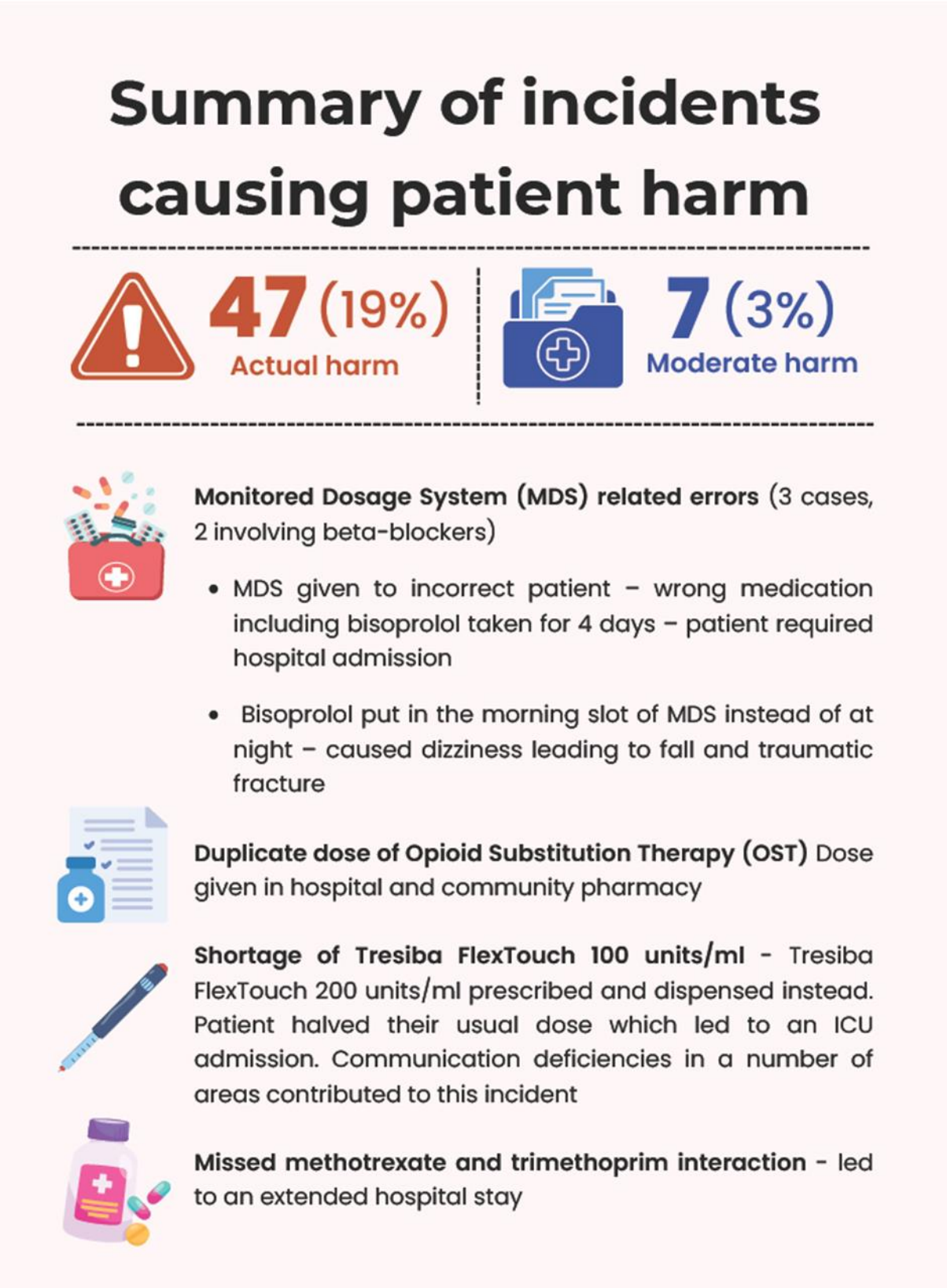
- Twelve incidents had the **potential** to lead to major or catastrophic harm. Two involved anticoagulants i.e.:

    - apixaban and edoxaban both dispensed in MDS
    - patient was changed from apixaban to edoxaban but prescriptions for both were issued on the same day

- As with previous years, anticoagulants, beta-blockers and tacrolimus continue to feature in similar incidents.

Figure 1: Examples of Adverse Incidents causing actual patient harm

Further information on the incidents below are provided in the full version of the Community Pharmacy Incidents Annual Report 2024/25.



Appendix 1: HSC Regional Impact Table – with effect from April 2013 (updated June 2016

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity,* *enquiries from public representatives/media* *Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (e.g., Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.

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	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste* *management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

Appendix 2: HSC Regional Risk Matrix – with effect from April 2013 (updated June 2016 & August 2018)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**