CURRENT THINKING ON... PATIENT SAFETY IN COMMUNITY PHARMACY

Welcome to our CPD module series for community pharmacy technicians. Written in conjunction with the ***Pharmacy Magazine*** CPD series, it will mirror the magazine's programme throughout the year. The series has been designed for you to use as part of your continuing professional development. Reflective exercises have been included to help start you off in the CPD learning cycle.

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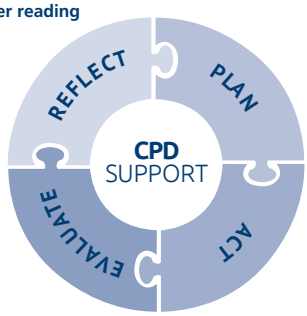
MODULE NUMBER: 80

AIM: To provide principles that community pharmacy teams can embed into their practice and use when reporting and learning from patient safety incidents.

OBJECTIVES: After reading this module, pharmacy technicians will:

- **Appreciate the importance of reporting patient safety incidents**
- **Understand how sharing insights after something goes wrong can create learning opportunities for other pharmacy teams**
- **Champion the important role that community pharmacy team members play in continuous improvement of the services they offer.**



A patient safety incident can be defined as any unintended or unexpected incident that could or did lead to harm for one or more patients. In a community pharmacy, this includes both dispensing errors and other incidents, such as incorrect advice being provided for an OTC product. While things run seamlessly most of the time, it is important to learn lessons when something does go wrong.

In England and Wales, the National Reporting and Learning System (NRLS) enables patient safety incident reports to be submitted to a single database which covers the whole healthcare system. NHS Improvement manages this system on behalf of the NHS.

Since 2005, all pharmacy contractors in England and Wales have been required to report patient safety incidents to the NRLS. In Scotland and Northern Ireland, local anonymous reporting systems are used, supported by the Healthcare Improvement Scotland Adverse Events National Framework and the Health and Social Care Framework for adverse events in Northern Ireland.

In 2014, NHS England issued a directive recommending that all community pharmacies identify a named medication safety officer (MSO) to review medication incidents and oversee safety improvement within their organisation. Many MSOs are superintendent pharmacists or work in their teams.

Community pharmacies upload patient safety incident data to the NRLS in different ways. Some will upload data directly to the NRLS as each incident occurs. Others report the incident to their MSO, who will then work with a central office team to collate incident data centrally and conduct internal trend analysis. These teams will then upload all their reports to the NRLS in batches, usually every few months. Unfortunately, because of the way in which the NRLS is set up, this can sometimes result in data going missing or batches being rejected, which skews the overall national picture of reporting.

Barriers and enablers

In January 2016, the MSOs ran an anonymous survey on safety culture and incident reporting. Respondents to the survey felt their company procedures for reporting incidents were generally clear, but said there were still a number of barriers that prevented them from reporting patient safety incidents.

The two most significant barriers highlighted were time constraints and fear of criminal prosecution. Around half of the respondents said simpler reporting tools and systems would encourage them to report more patient safety incidents, and 42 per cent felt a more open culture would help.

Based on the findings of their survey, the MSOs have

Key facts

- Community pharmacies should have robust but simple systems in place for staff to use when an incident occurs
- Details of every incident should be recorded and reported as soon as possible after it takes place
- Reports should be factual and include enough detail for someone who was not present to understand what happened
- There is no 'correct' or 'safe' number of patient safety incidents
- Incident reporting rates in community pharmacy range from zero to 1.90 incidents per 10,000 items dispensed
- The 'Report, Learn, Share, Act, Review' wheel provides a simple framework for identifying and reporting patient safety incidents
- The value of reporting patient safety incidents is not always seen immediately, but this does not mean that these reports are not used at local and national levels to improve practice.

developed a set of patient safety incident reporting principles, which are presented in the 'Report, Learn, Share, Act, Review' (RLSAR) wheel (see Figure 1). This provides a simple framework that pharmacy teams can use to structure their actions when identifying and reporting patient safety incidents.

The wheel is now used in the professional standards for pharmacists, pharmacy technicians and the wider pharmacy team, as well as in NHS England's recommended templates for monthly and annual patient safety incident logs, in line with quality payment criteria.

How reporting contributes to incident management

Reporting incidents as soon as they are identified may be critical to the immediate safety of the patient concerned. It also allows for a full investigation to start in an appropriate time frame, ensuring that details are available and lessons are learned as soon as possible. Each pharmacy will have its own incident management standard operating procedure (SOP) and should conduct an internal review to understand the underlying causes or events that led to the incident, as well as any other contributory factors.

In addition to managing the incident at a local level, reporting what happened and what action was taken in the pharmacy to prevent a similar incident happening again raises awareness of potential risks and allows other pharmacy teams to learn from something that has gone wrong. Teams can then reflect on their own practice to consider whether any changes should be made to minimise risks to patients.

What does 'good' reporting look like?

Data gathered by the MSOs in January 2017 found that the number of reported patient safety incidents per 10,000 items dispensed in community pharmacy in 2016 ranged from zero to 1.90, which gives an average of 1.05 per 10,000 items.

There is no 'correct' or 'safe' number of patient safety incidents. A 'low' reporting rate should not be interpreted to mean that a pharmacy is safe, as it may actually represent under-reporting. Similarly, a 'high' reporting rate should not be interpreted to mean a pharmacy is unsafe, but may actually indicate a culture of greater openness and a commitment to patient safety improvement.

Pharmacy teams should always follow their company SOPs for reporting incidents, but the MSOs have developed some general best practice recommendations, including:

- All patient safety incidents should initially be handled at pharmacy level, including discussing the incident with the individuals involved and the immediate pharmacy team
- Details of the incident should be recorded and reported as soon as possible after it takes place
- Reports should be factual and include enough detail for someone who was not present to understand what happened and what impact it had on the patient
- Each report should identify contributing factors and actions planned to prevent the incident from happening again
- Each report should categorise the actual degree of harm caused to the patient as a direct result of the patient safety incident.

The MSOs have also worked with NHS Improvement, NHS England and PSNC to create templates for recording the learning and improvement actions that have been taken. These reports are designed to support community pharmacies achieve the quality criteria set out in the 2017/18 Community Pharmacy Contractual Framework. Further information is available in NHS England's Quality Criteria Guidance and on the PSNC website, at: psnc.org.uk/services-commissioning/essential-services/quality-payments.

Figure 1: Report, Learn, Share, Act, Review principles wheel

> "Reporting incidents as soon as they are identified may be critical to the immediate safety of the patient concerned"

What happens to incident reports?

Incident reports are used in a variety of ways to help identify and address safety risks. Although you may not always receive formal feedback on an individual incident you report, you can be assured that by feeding into the national system you are making a difference to the bigger picture of patient safety.

The MSOs meet every other month to share their learning and recommended practice changes from serious or regular patient safety incidents. Details of serious incidents and actions taken within community pharmacy are also shared with a national network of MSOs from across the health system through regular webinars.

Incident reports are also used by the NHS national patient safety alert response panel, which determines when an NHS-wide alert should be issued relating to a safety risk. The panel recently issued alerts as a result of serious incidents relating to the risks of extracting insulin from pen devices and the risks of valproate medicines for girls and women of childbearing age.

The MSOs also share incident trends and aggregated data with the Medicines and Healthcare products Regulatory Agency (MHRA) at regular meetings. This can be particularly valuable should any packaging changes be recommended to mitigate the risk of selection errors. A recent change was made to the packaging for chloramphenicol ear drops to reduce the likelihood of them being selected instead of chloramphenicol eye drops.

reflective exercise

Think about a patient safety incident that recently occurred in your pharmacy:

- **Was it reported?**
- **Are your procedures for reporting incidents clear?**
- **Was adequate time taken to reflect on what the contributory factors were?**
- **What actions were taken to mitigate the risk of the same (or a similar) incident occurring again?**

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Next month: We focus on palliative care.