PATIENT SAFETY BULLETIN

PharmacyVoice
Speaking up for community pharmacy

JULY 2016

Results of our safety culture survey for community pharmacy teams

Last year Pharmacy Voice held its first Patient Safety Forum, celebrating the achievements of our Patient Safety Group's first year in action and bringing together stakeholders from across healthcare to promote and advance community pharmacy's vital role in keeping people safe. Using insight from discussions at this event, in December we launched a survey for pharmacy teams, seeking their views on current patient safety culture and practice including incident reporting and learning processes. Over 620 pharmacy staff participated, from all different sized pharmacy businesses and we found that

- Around 3 in 5 respondents felt the **whole team are responsible for reporting** incidents
- 97% of respondents felt that their **internal incident reporting processes were clear or very clear**
- **Time constraints** were seen as the **most significant barrier** to reporting, followed by a fear of criminal prosecution
- Around 65% of respondents **undertake root cause analysis** for **every patient safety incident** that occurs
- Worryingly 3 in 10 respondents felt they did not **receive helpful feedback and learning** from reporting incidents

It is noticeable from the **results of the survey** that a fear of criminal prosecution is still seen as a significant barrier to reporting incidents. Our Patient Safety Group will continue its focus on improving feedback for teams from reporting incidents and encouraging culture change across the sector. This work to change culture will run alongside the simultaneous work being carried out as part of the Rebalancing Programme to create a criminal defence for inadvertent dispensing errors. Pharmacy Voice will also feed directly into this process through engagement with the Department of Health's public consultations.

Patient Safety Incident Reporting Principles

Pharmacy Voice is using the contributions from frontline pharmacy teams to our patient safety culture survey to shape our patient safety work programme and future lobbying activities. Having analysed the responses, our Patient Safety Group has agreed a set of **core reporting principles** that we believe all community pharmacy team members will be able to sign up to and embed in their reporting and learning procedures. These principles have been shared and discussed with the Royal Pharmaceutical Society to feed into their development of professional standards for error reporting.

Now available on the Pharmacy Voice website, community pharmacy teams are encouraged to discuss the principles and agree how to ensure these are embedded in their own practices. These principles form one piece of work which the community pharmacy Medication Safety Officers (MSOs) are doing to help fulfil their duty in increasing reporting and improving learning from incidents across their own organisations and for the pharmacies they represent.

The Report, Learn, Share, Act, Review wheel is **available for anyone to download** as an image from the Pharmacy Voice website. The community pharmacy MSOs will be promoting the principles to their pharmacies and including the wheel on their own safety resources and documents as they wish.

Community pharmacy's role in safeguarding vulnerable adults and children

One of the top priorities and key focus areas for the Patient Safety Group this year has been to better understand and clarify community pharmacy's role in safeguarding vulnerable people. Community pharmacy holds a unique position amongst healthcare professionals to support safeguarding due to the immediate accessibility of the local community. In January 2016, the Patient Safety Group's work on this kicked off when all of the community pharmacy Medication Safety Officers, in addition to some of their team members, received Level 3 Safeguarding training from Helen Hipkiss, National Safeguarding Lead for NHS England.

Following this training, the Group have worked together to identify best practice for community pharmacy teams in handling safeguarding issues and have established a set of shared minimum principles. The Group have used these principles to develop a briefing that will soon be published on the Pharmacy Voice website. This briefing sets out a series of recommendations to enable the community pharmacy sector to undertake its obligations set out in the *NHS Accountability and Assurance Framework*. Pharmacies will be able to use the shared principles alongside other resources available to inform and update their own safeguarding policies and procedures.

> The Patient Safety Group recognises the important role the profession has, as part of a wider multi-disciplinary team in safeguarding children and adults at risk. Community pharmacy is a unique care provider in its accessibility to the public and pharmacy teams are potentially an untapped source of intelligence in protecting the more vulnerable members of society.
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> The training that Helen Hipkiss provided to the Group was invaluable in enabling us all to have a clearer understanding of the safeguarding requirements and we see enormous value in the profession agreeing overarching principles and working within a common policy.

Victoria Steele, LloydsPharmacy
Patient Safety Group Safeguarding Lead

What else have the Pharmacy Voice Patient Safety Group been up to so far this year?

January

Pharmacy Voice **response** issued to the RPS, APTUK, PFNI draft standards for error reporting

All community pharmacy MSOs received Level 3 safeguarding training from NHS England

February

Patient Safety Group agreed their work plan for 2016 and learnt from NHS England about the new GP e-Reporting system

Pharmacy Voice met up with the MHRA to discuss the serious risks of valproate and pregnancy, amongst other medication issues

April

Patient Safety Group heard from NHS Improvement about the **DPSIMS project** to develop the national patient safety incident reporting & learning system

May

Patient Safety Group shared best practice and learning to support upcoming work on safer medication transfer services

And what's coming next?

One of the initial reasons the Patient Safety Group was set up last year was to provide an open, accessible forum that allowed all community pharmacy Medication Safety Officers to share best practice on patient safety, learn from each other and then use this learning to make changes within their own organisations or for their member pharmacies.

Over the next few months the Group will be continuing in this spirit and focussing on discussing some 'Top Tips' for how to embed patient safety into every day conversations in pharmacies; how to maximise any learning opportunities from near misses; and how to ensure all risks to patients and pharmacy staff associated with medication delivery services are minimised.

The Group will also be working closely with a number of universities to feed directly into the design and testing of their projects in primary care patient safety research.

If you would like to find out more about our work and get involved, please get in touch using the details below and sign up to our **weekly Pharmacy Voice newsletter**.

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