Patient safety culture survey

Results

December 2019

Community Pharmacy Patient Safety Group

Context & background

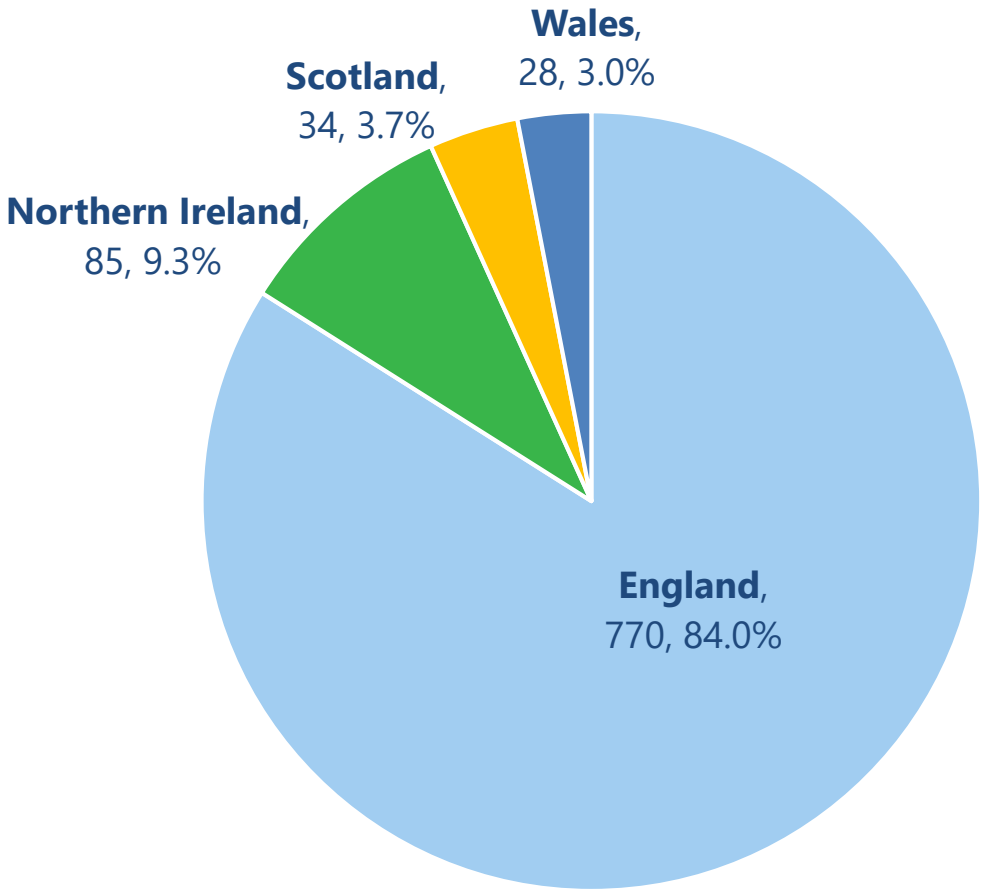
- Anonymous survey available to all community pharmacy staff
- Sought to understand what patient safety culture and practice looks like across the community pharmacy sector from the perspective of frontline teams
- Sought to gather views on current patient safety incident reporting and learning processes and some of the barriers that prevent reporting of incidents
- A similar survey was carried out by Pharmacy Voice in 2016, so the two data sets were compared to ascertain whether there has been any shift in the attitude and behaviour of pharmacy teams around patient safety reporting and learning

Summary findings

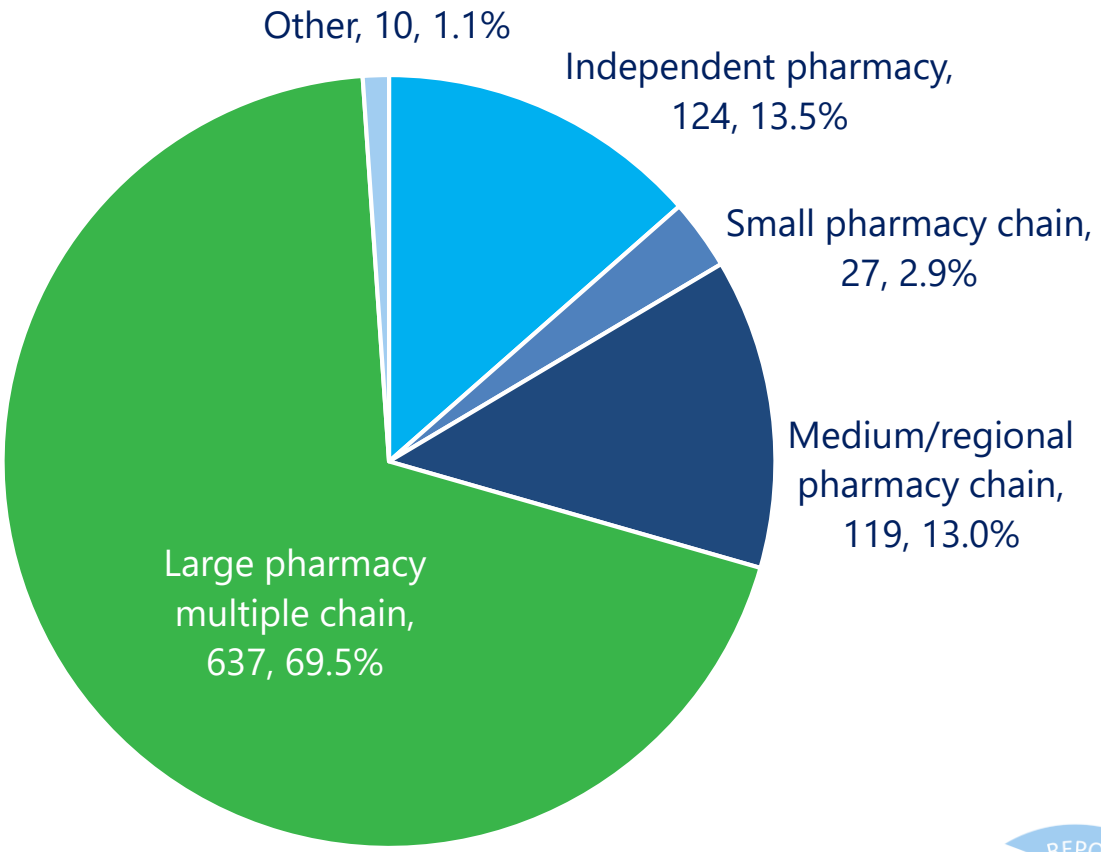
- Survey ran for five weeks in April and May 2019
- **917 responses** from pharmacy professionals across the UK, with the majority of respondents working in large pharmacy chains
- There was a **32% increase** in the number of participants compared to 2016
- 60% of respondents thought that the whole pharmacy team are responsible for reporting patient safety incidents
- 94% of respondents said that the procedure for reporting patient safety incidents was either **very clear** or **clear** (56% and 38% respectively)
- 55% of respondents said that **simpler reporting tools** and systems would encourage them to report more patient safety incidents
- Most respondents chose to give additional feedback about their **honest opinions** and experiences of reporting patient safety incidents

Who took part?

What country do you work in?



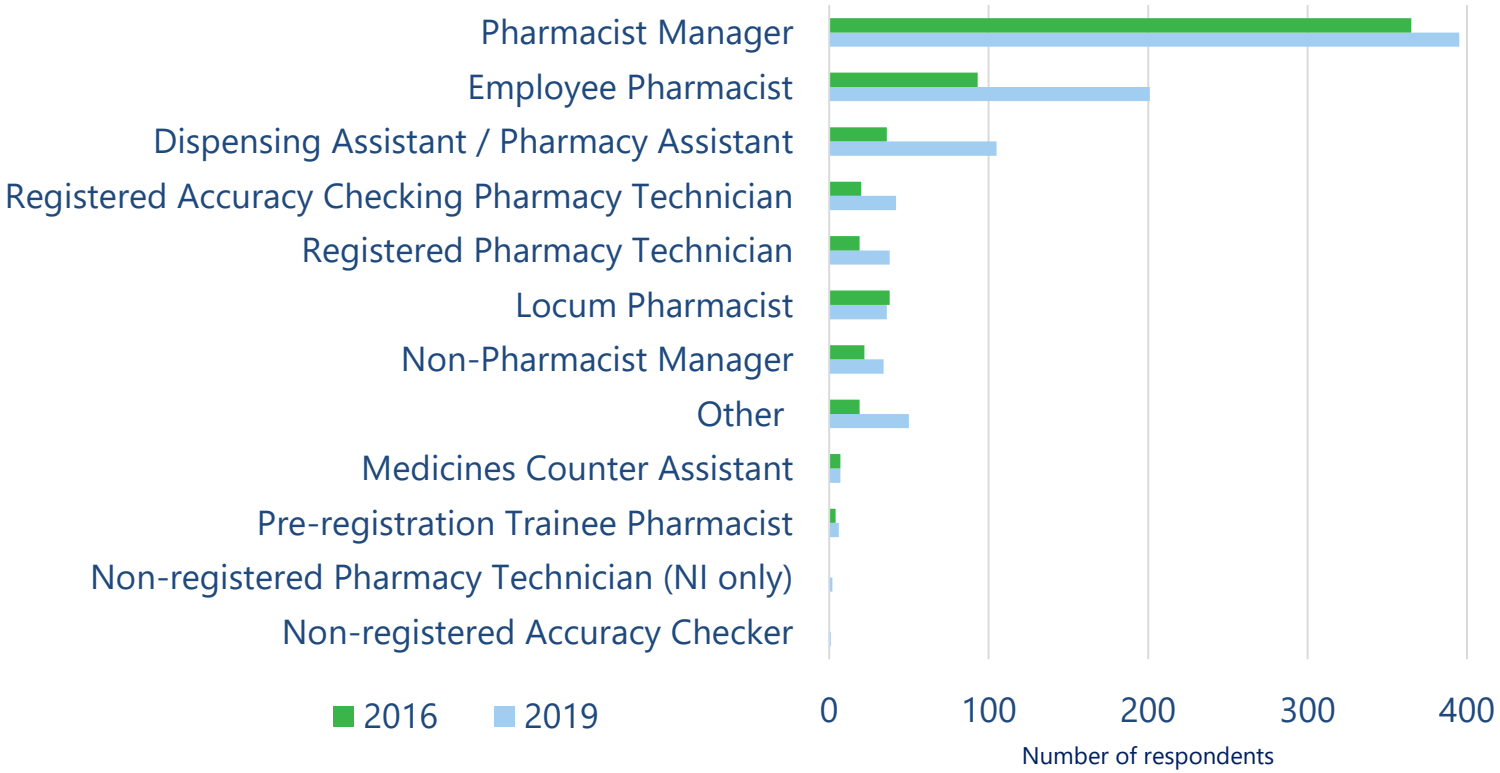
What size of community pharmacy do you work in?



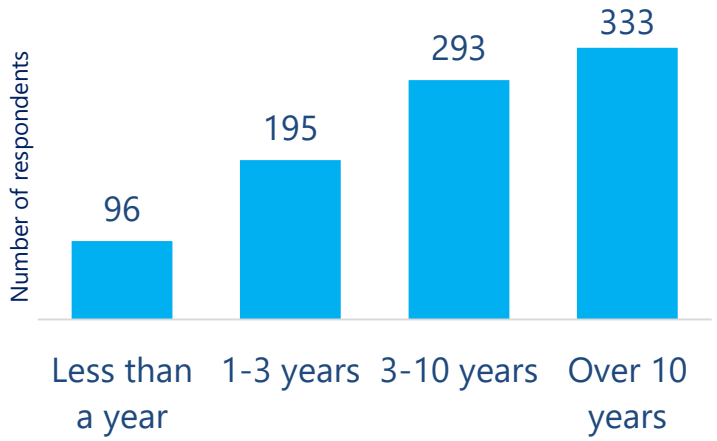
Compared to 2016, there were slightly more responses from employees in large pharmacy chains

Who took part?

What is your role in the pharmacy team?



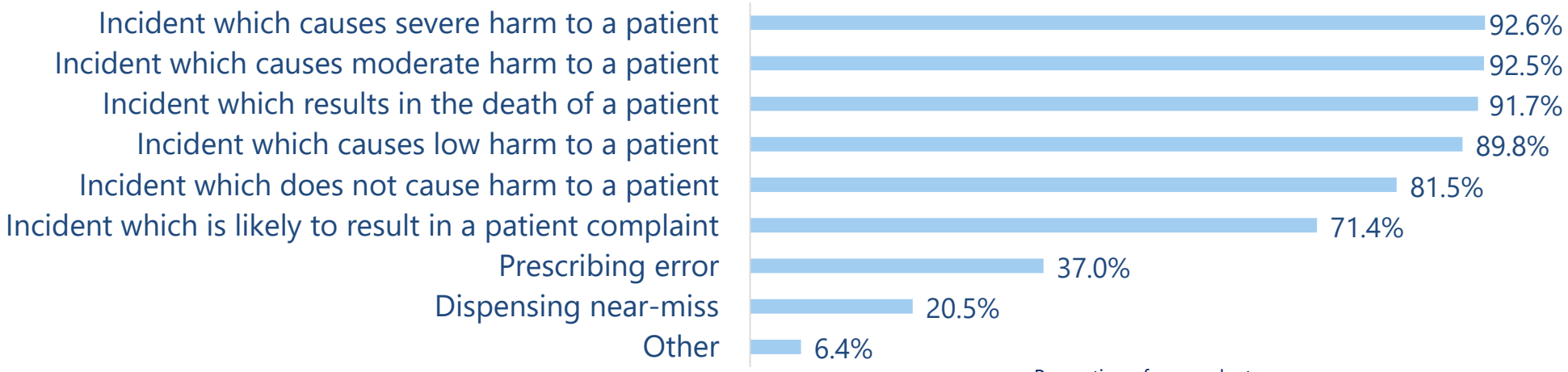
How long have you been in your current role?



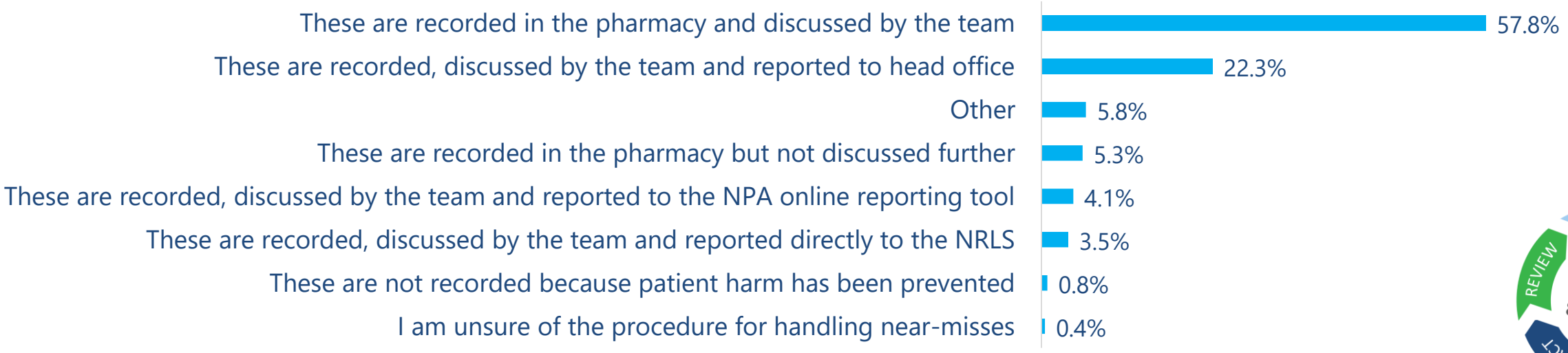
Of those who selected 'other', most respondents were superintendent pharmacists, area/regional managers or trainee pharmacy technicians.

Incident reporting

According to the procedure in your pharmacy, which of the following would you submit a patient safety incident report for?*



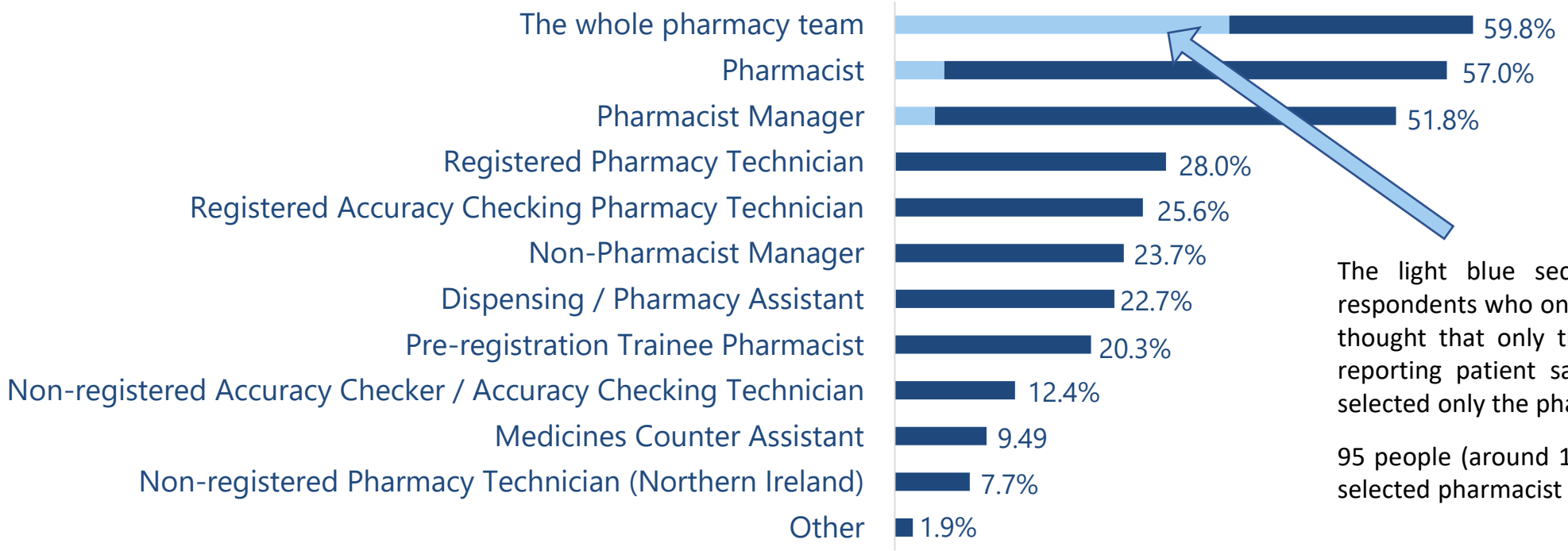
How does your pharmacy handle near-misses?



*This indicates questions for which respondents could choose more than one answer option

Incident reporting

Who do you think is responsible for reporting patient safety incidents that occur in your pharmacy?*



The light blue section of the bar indicates the respondents who only selected one option. 47 people thought that only the pharmacist is responsible for reporting patient safety incidents, while 38 people selected only the pharmacist manager.

95 people (around 10% of all the respondents) only selected pharmacist and pharmacy manager.

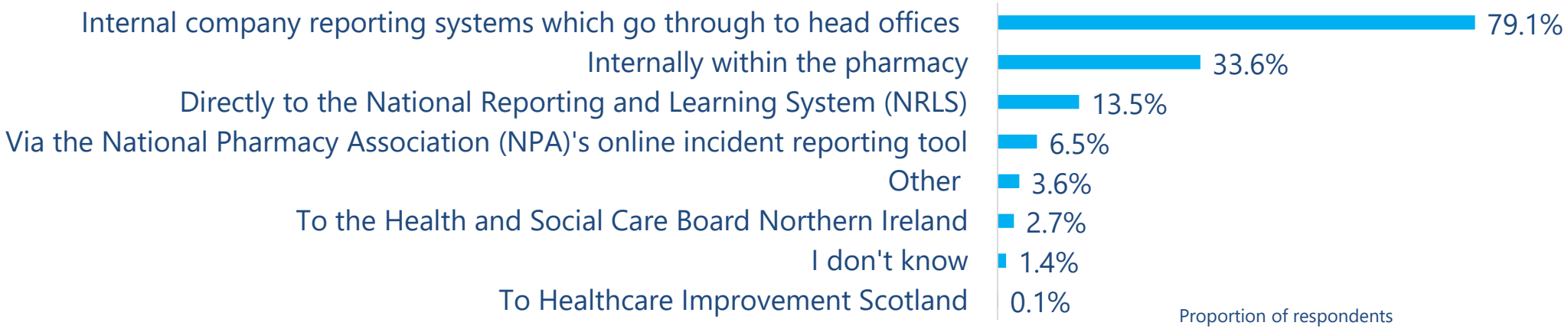
Of those who selected 'other', the superintendent pharmacist was the most common answer.

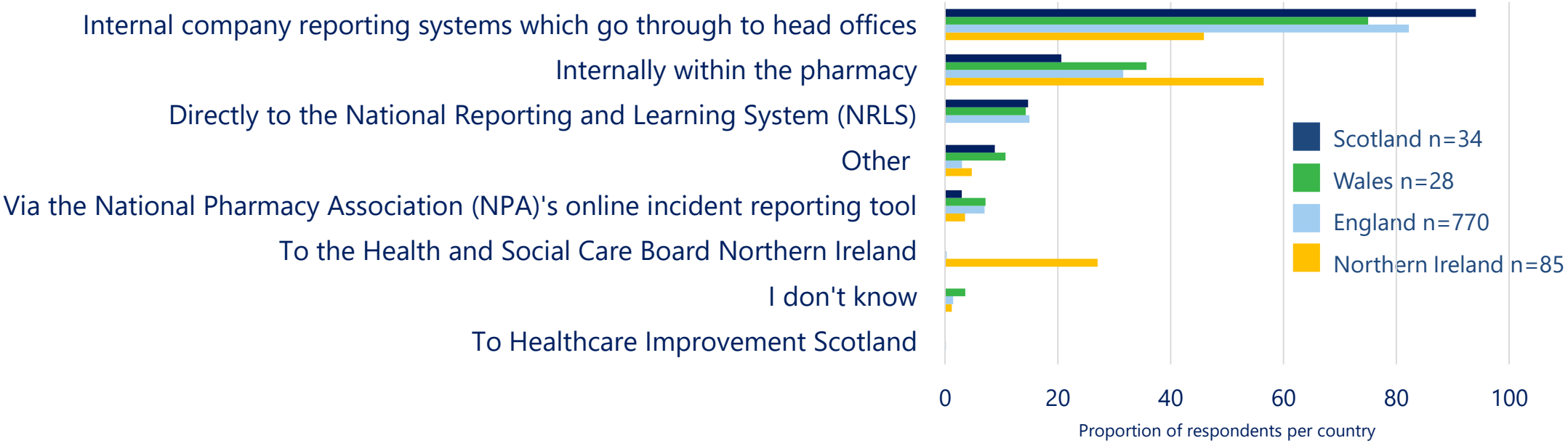
"We try to encourage team members to use every event as a learning tool"

"We need to make it clearer to the whole team and enable everyone to become more involved and to learn from our mistakes without fear of any judgement"

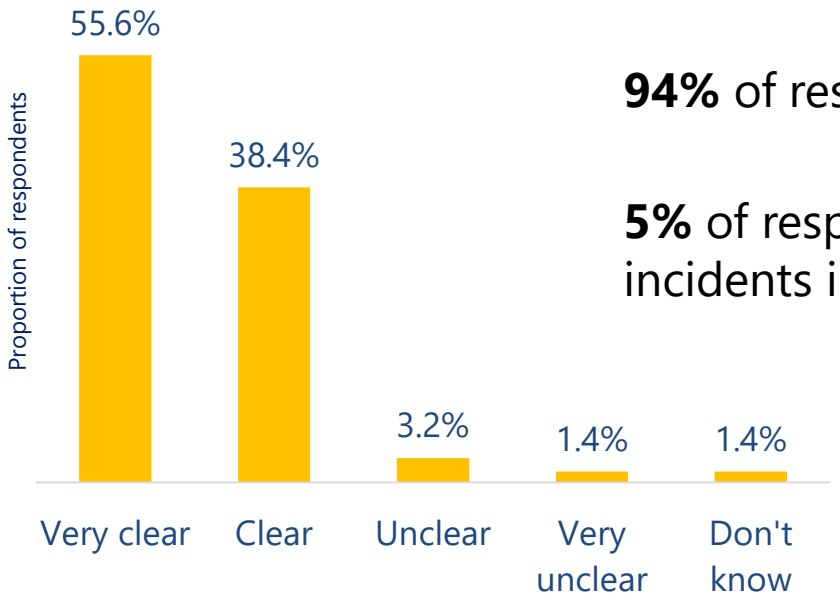
Incident reporting

Where are the patient safety incidents that occur in your pharmacy reported?*





How clear is the procedure for reporting safety incidents?



94% of respondents found their reporting procedure either **very clear** or **clear** (n=862).

5% of respondents indicated that the procedure for reporting patient safety incidents in their pharmacy was either **very unclear** or **unclear** (n=42).

- The best way to improve reporting is to create a simple and efficient reporting system
- We need a simpler process to report issues
- I could only ask that the reporting system was simpler and more efficient
- NRLS is very difficult to follow

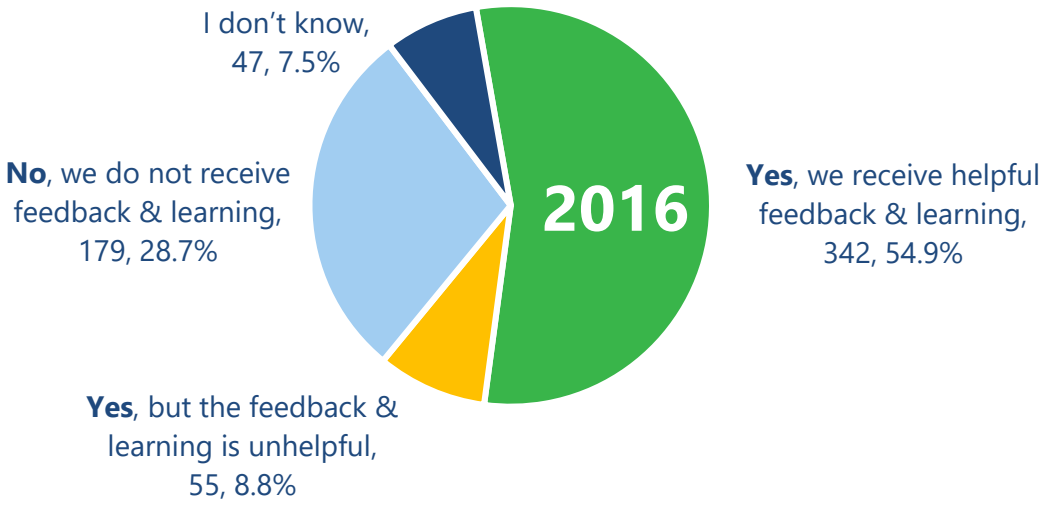
Reasons for incident reporting

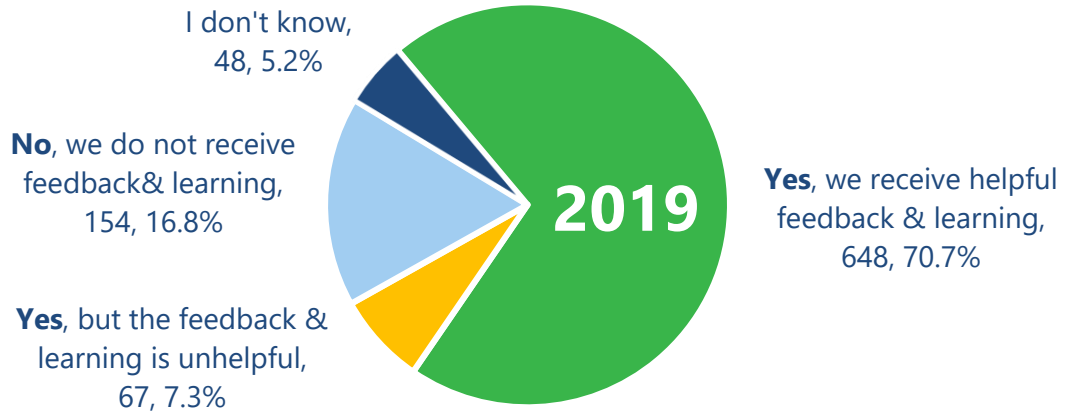
Why do you report patient safety incidents?*

Of the 449 respondents who report incidents because they are contractually required to do so (49.0%), three quarters of them work in a large pharmacy organisation (74.4%) and half of these respondents were pharmacist mangers (50.1%).

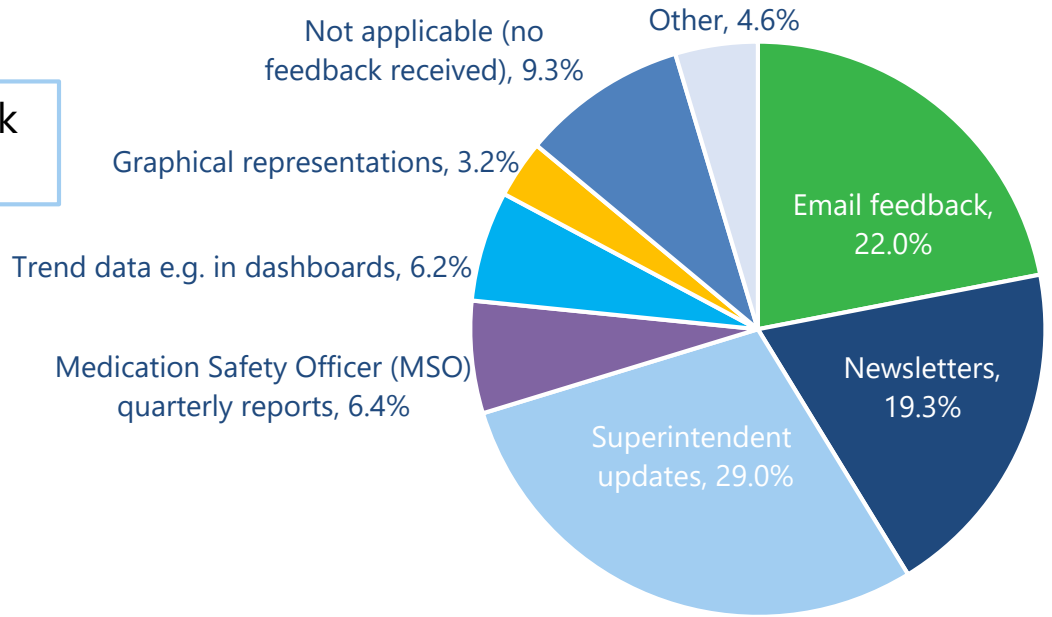
Feedback & learning

Do you receive feedback & learning as a result of reporting incidents?





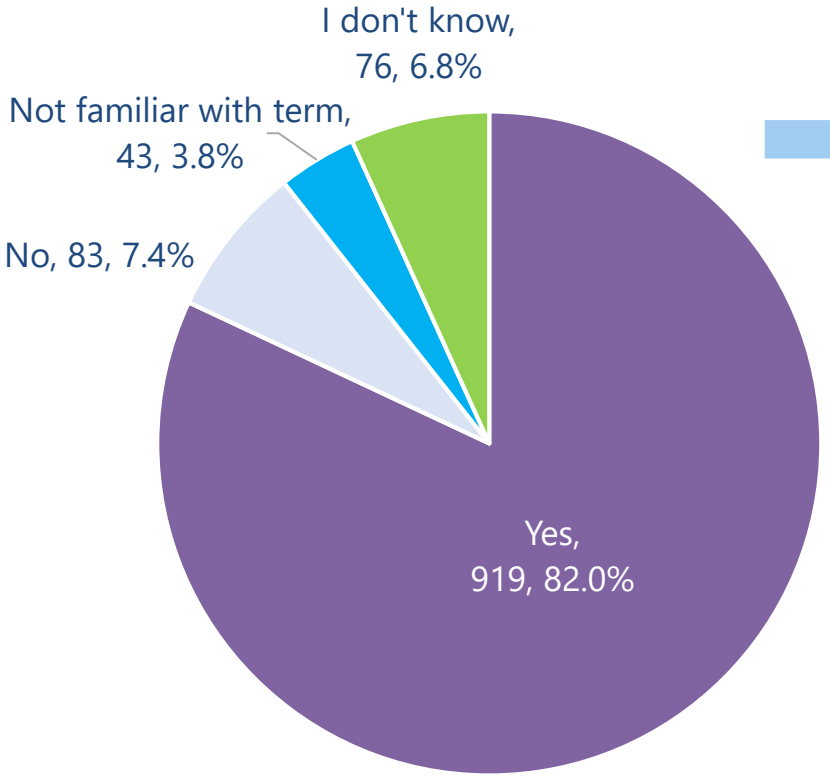
In what format do you receive feedback as a result of reporting incidents?*

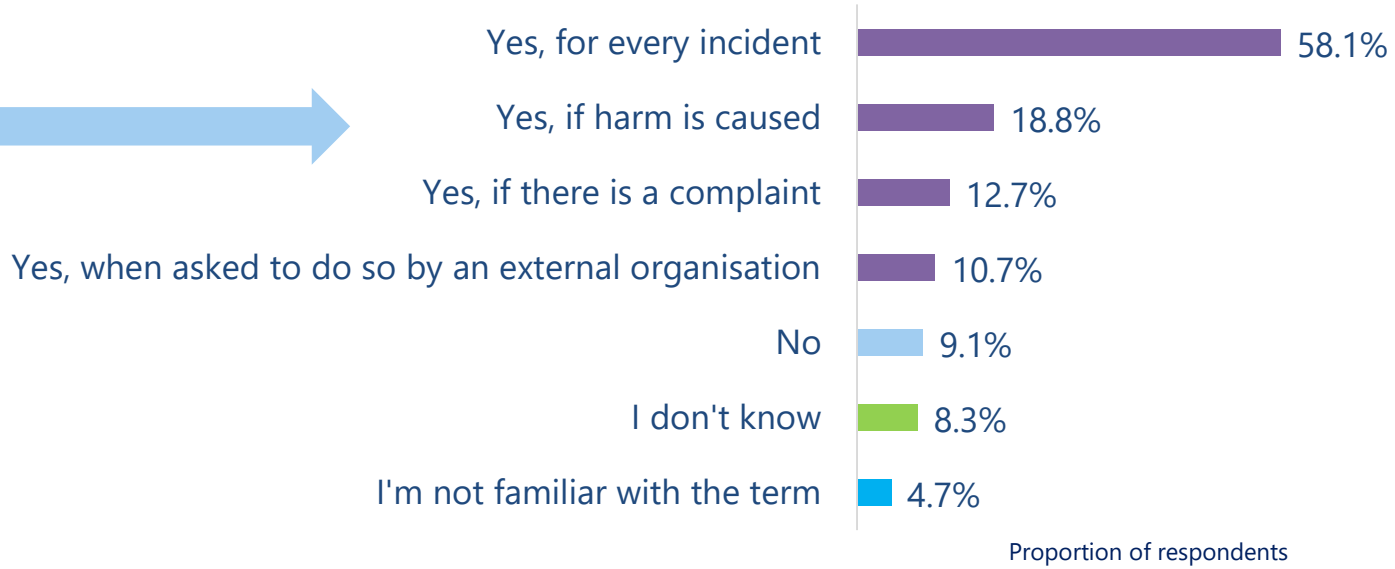


Of those who selected other, common ways of receiving feedback were through regular safety huddles and team discussions or via conference calls and conversations with area managers or the superintendent pharmacist.

Root cause analysis

Does your pharmacy team undertake root cause analysis to identify the factors which contributed to an incident?

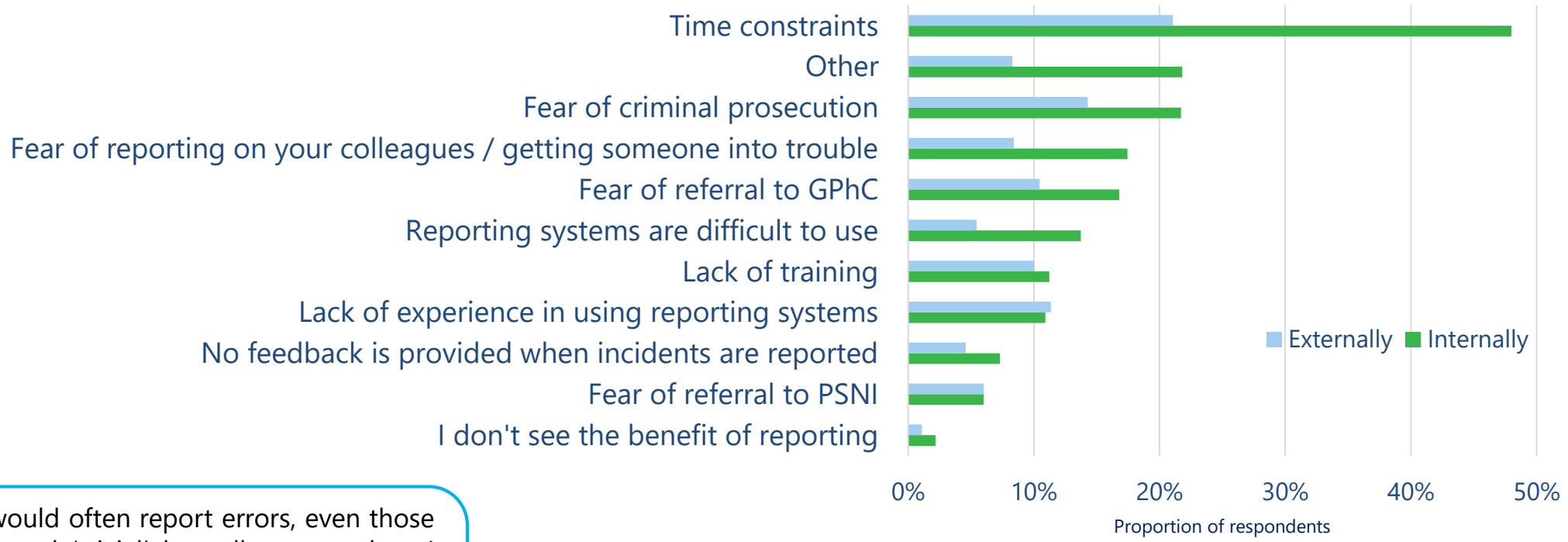




It cannot be assumed that those who did not undertake root cause analysis did not investigate patient safety incidents. Different methods of investigation may have been used which were not accounted for in this question

Barriers to reporting

What might prevent you from reporting patient safety incidents?*



"I would often report errors, even those deemed 'trivial' by colleagues, when I worked in hospital practice. Community pharmacy seems to be so much more pressurised that only the essential tasks can be completed at times"

"Reporting tools are far too time consuming"

"I have no issues reporting but this is the responsibility of the pharmacy manager"

"The company I work for is very safety conscious"

"We have an open culture in the pharmacy but there is still the fear of the GPhC and now with social media that exacerbates the fear"

Barriers to reporting

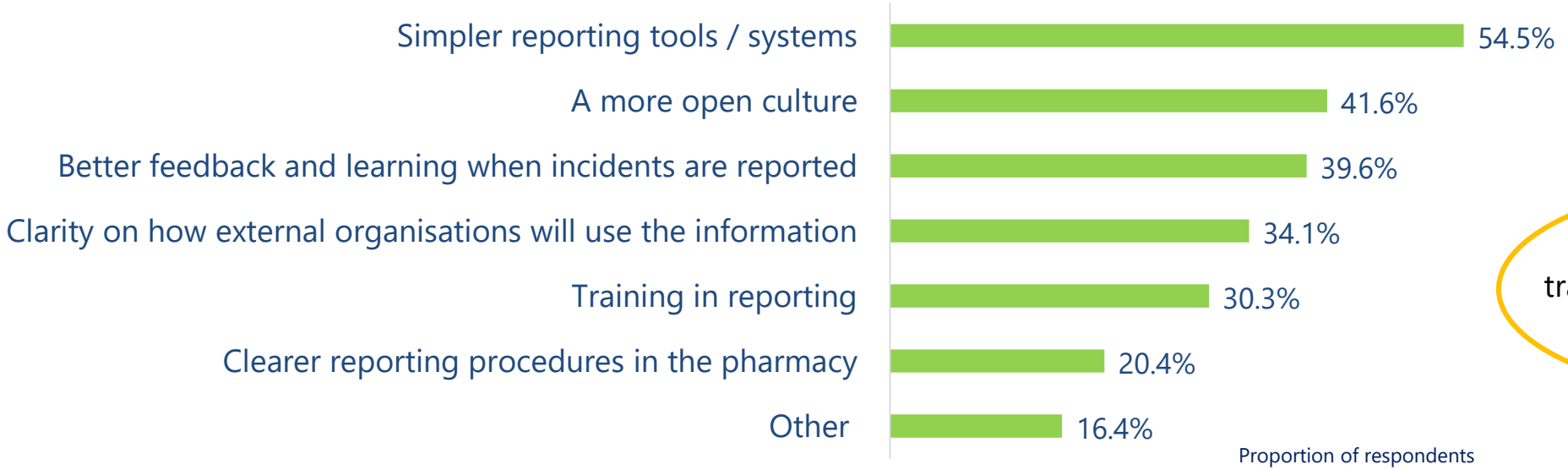
In **2016**, the most commonly cited barrier preventing people from reporting patient safety incidents was **time constraints** (**44.1%**).

In **2016**, **40.0%** of respondents claimed **fear of criminal prosecution** might prevent them from reporting. This was much higher than the **21.7%** and **14.3%** of **2019** respondents who stated that fear of criminal prosecution might prevent them from reporting patient safety incidents internally and externally, respectively.

This **reduction in fear of criminal prosecution** could be attributed to the **new legal defence** for dispensing errors which came into law in April **2018**.

Enabling more reporting

What might encourage you to report more patient safety incidents?*



"Protected learning time is now a must for community pharmacy"

"It would be great to issue some training for pharmacy teams on why it is important to report errors"

When respondents were invited to give further comments on their experiences of patient safety culture, three recurring themes that were raised were:

1. Time constraints
2. Staffing levels and skill mix
3. Complex reporting systems

Of the 150 respondents who selected other, the most common response was that the question was not applicable since they already reported all incidents. Time constraints, funding pressures, staffing difficulties and complex reporting tools were cited as factors preventing reporting.

Conclusions & next steps

The findings demonstrate some significant positive improvements since 2016, such as the increase in the proportion of respondents who receive helpful feedback and learning as a result of reporting incidents.

From the feedback given by survey participants, the following key improvements will help enable the community pharmacy sector to continue improving incident reporting levels and the culture in pharmacies:

- **Simpler reporting** tools
- **Training** for pharmacy staff on incident reporting
- Ensuring that all pharmacy staff receive **feedback** and **learning** they find helpful
- Fostering an **open culture** of sharing and learning