Patient safety incident reporting in community pharmacy

Purpose

The community pharmacy medication safety officers have developed a schematic tool to help illustrate what happens when a patient safety incident is reported in a community pharmacy.

Background information

Patient safety is a fundamental consideration for all frontline health and care professionals, and their employers. All pharmacists, pharmacy technicians and other pharmacy support staff recognise and value the importance that community pharmacy businesses place on safely dispensing medication and providing advice to their patients and customers. They will also be aware that almost all the time, things run seamlessly; however, it is important to learn from when they do not.

Significant progress has been made over the last decade to detect, report and learn from patient safety incidents, but reporting systems vary greatly and the general picture of community pharmacy reporting and learning is not always well understood at a national level. Due to compatibility issues, significant proportions of the community pharmacy sector's patient safety incident reports have not been actively appearing in the NHS National Reporting and Learning System (NRLS) database to date, resulting in a decrease in the opportunities for pharmacy teams to learn from others, and a misperception that community pharmacies do not report incidents.

In 2014, NHS England (now NHS Improvement) and the Medicines and Healthcare products Regulatory Agency issued a Directive which recommended all community pharmacy organisations (as well as all NHS Trusts, home healthcare companies and independent providers) to identify a named Medication Safety Officer (MSO) to review medication incidents and oversee safety improvement within their organisation, including by increasing incident reporting rates.

In 2015, the newly appointed community pharmacy MSOs established a Patient Safety Group to enable better exchange of information and learning from each other at a national level, and to work with NHS Improvement to improve the mechanisms by which incident data was captured and fed into the NRLS database. The Group used input from frontline pharmacy teams to agree the 'Report, Learn, Share, Act, Review' principles and have now developed a simplified schematic which generically illustrates what happens at both pharmacy level and at 'head office' level when a patient safety incident is reported in a community pharmacy.

Further information and resources

- **Community pharmacy Patient Safety Group work and reporting principles**
  https://www.pharmacysafety.org/principles

- **Professional Standards for the reporting, learning, sharing, taking action and review of incidents** – Royal Pharmaceutical Society, Pharmacy Forum Northern Ireland and Association of Pharmacy Technicians UK
  http://www.rpharms.com/support-pdfs/rslar-standards-nov-2016.pdf

- **Patient Safety Alert – Stage Three Directive: Improving medication error incident reporting and learning** – NHS England and the MHRA
  https://www.england.nhs.uk/wp-content/uploads/2014/03/psa-sup-info-med-error.pdf

Community pharmacy patient safety incident reporting

An Overview

Safety incident brought to attention of pharmacy
patient, carer, hospital, police, area team

Pharmacist and team in pharmacy handle incident

Incident reported directly to NRLS or Yellow Card Scheme

Pharmacy reports incident to local reporting system / MSO
e.g. company Head Office, NPA online tool, regional managers or team

Internal incident review
Harm assessment; contributory factors / root cause analysis;

Reassurance of patient / carer and family using incident management SOP

Contact patient's GP (if applicable)

Discuss with pharmacy team e.g. in safety huddle

Resolution of error e.g. through changes to practice; dispensary re-organisation; contacting manufacturer

Share learning and changes to practice locally e.g. with LPC

Review learning and changes to practice

Incident review / risk & harm assessment
Including contributory factors / root cause analysis;

Provide support for pharmacy team

Report to primary care organisation
(e.g. Controlled Drugs, significant events)

Report to insurance provider
(if applicable)

Report to company Board
(if applicable)

Corporate review of incidents

Incident details shared with relevant or required bodies to act upon and investigate further
(including police, coroner etc.)

Collation and analysis of incidents
Trends and learning opportunities identified; changes to Standard Operating Procedures

Shared learning resources created
Reports, newsletters, Superintendent emails, best practice, Top Tips

Incident details and learning shared with NHS Improvement / MHRA national medication safety network e.g. on global MSO webinar

Incident details and learning shared with other community pharmacy Medication Safety Officers at Patient Safety Group meeting

Learning and changes to practice disseminated across wider healthcare

Learning and changes to practice disseminated across pharmacy network

Review learning and changes to practice