Community Pharmacy Safety Culture Assessment Tool

Practical tool building on the MaPSaF

Purpose of this Tool

Pharmacy Voice's Patient Safety Group has worked closely with the primary care team from the Greater Manchester Patient Safety Translational Research Centre (GM PSTRC) to further develop their Manchester Patient Safety Framework (MaPSaF)[1], which was produced to help healthcare teams reflect on their progress in developing a patient safety culture and managing risks to patient safety.

This tool is designed to help community pharmacy teams understand their stage of development with regards to the importance they place on patient safety. The MaPSaF is used regularly in other primary care settings, such as general practice, and Pharmacy Voice's Patient Safety Group has worked with the GM PSTRC team to help make it a more user-friendly and accessible tool for community pharmacy teams and organisations.

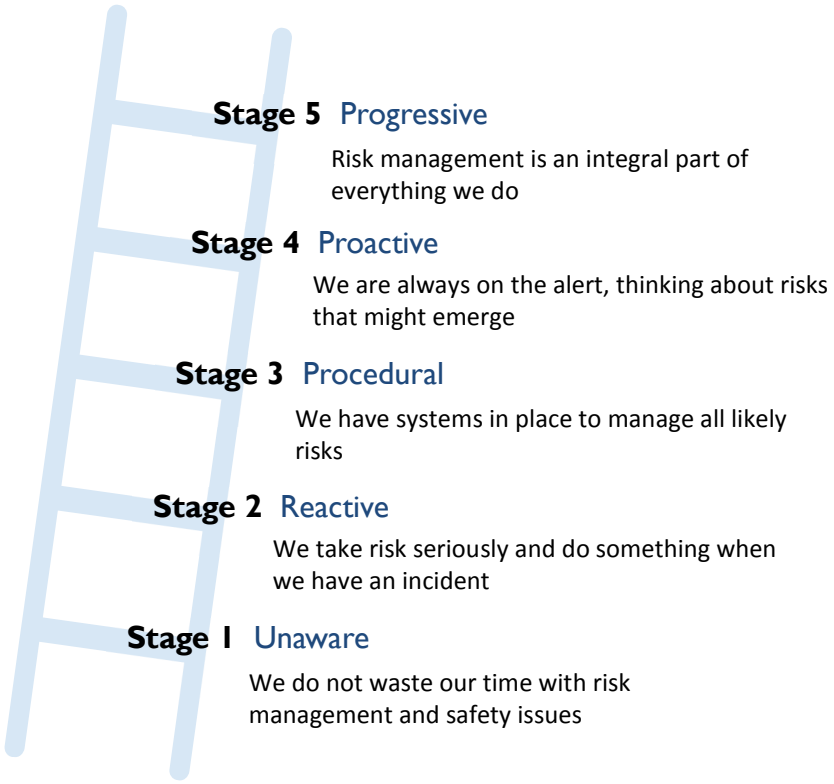
Background and definitions

According to research carried out by the GM PSTRC, the safety of both patients and staff in a community pharmacy is influenced by the extent to which safety is perceived to be important across the pharmacy team and, if applicable, the organisation as a whole.

The NHS National Patient Safety Agency defines a **safety culture** as 'a culture where staff have a constant and active awareness of the potential for things to go wrong. A safety culture is open and fair, and encourages people to speak up about mistakes.' In order to help teams and organisations reflect on and understand their development with respect to the value that they place on patient safety and their progress towards developing a safety culture, the GM PSTRC developed the MaPSaF. The development of the MaPSaF is part of an ongoing programme to create a patient safety toolkit for healthcare professionals.

One way to think about safety culture is in terms of an evolutionary ladder. Each level has distinct characteristics and is a progression on the one before.

Stages of patient safety culture (as defined in MaPSaF)



[1] The community pharmacy MaPSaF was developed by Darren Ashcroft, Charles Morecroft, Dianne Parker and Peter Noyce at the University of Manchester as part of a project that was funded by the Community Pharmacy Research Consortium. The original framework was developed by Dianne Parker, Tanya Claridge, Sue Kirk, Aneez Esmail and Martin Marshall supported by the National Primary Care Research and Development Centre, University of Manchester.

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How to use the tool

The tool should be used to help community pharmacy teams recognise that the process of making changes to improve patient safety culture is developmental and on-going, with a number of different stages. The tool will be useful to help stimulate discussions within pharmacies, highlight any differences in perception between staff and help staff understand how a community pharmacy with a more established safety culture might look. The tool is best used as a team-based self-reflection or education exercise and is **not** designed to be used for performance management or appraisal processes.

Community pharmacy teams should use the tool in line with any existing employer procedures for assessing patient safety culture and risk management. In total the exercise should take no more than an hour to complete. To complete the exercise:

- For each of the eight aspects (A-H) of patient safety culture outlined in the table, each team member should select the 'stage' which they believe best describes the practice in their pharmacy. This should be done individually and privately, without discussion.
- The number of this 'stage' should be marked in the first column.
- Pharmacy teams should then discuss these selections as a group. There may be differences in opinion between different team members. If this happens, discuss the possible reasons for this and address each aspect (A-H) in turn to see if a consensus can be reached.
- The pharmacy team should then consider the overall picture of the pharmacy. There will be areas where the pharmacy is at a mature stage and areas where the pharmacy still is in an early stage of safety culture maturity. The team should discuss how to take steps towards these later stages.

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Practical tool building on the MaPSaF[2]

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	Stage 1 - Unaware	Stage 2 - Reactive	Stage 3 - Procedural	Stage 4 - Proactive	Stage 5 - Progressive
A. Commitment to patient safety **OUR STAGE (1-5)** **= _____**	• The pharmacy team has a poor understanding of patient safety risk. • If an incident happens, the team assumes that the Superintendent will sort it out.	• The pharmacy team has a limited understanding of patient safety risk. • If an incident happens, the pharmacy manager reacts to resolve it but does not consider wider learnings.	• The pharmacy team has processes in place to manage patient safety risk. • Responsibility for managing such risk is given to one person, who does not share learnings with other team members.	• The pharmacy team has a proactive approach to patient safety risk. • If an incident happens it is taken seriously by the whole team, which works together to apply wider learnings to protect patients from further incidents.	• Patient safety is at the heart of all the pharmacy team's activities. • All team members are constantly assessing risk and looking for ways to improve their practice.
B. Perceptions of the causes of incidents and their reporting **OUR STAGE (1-5)** **= _____**	• Incidents are seen as 'bad luck' and outside the control of pharmacy staff. • Incidents and complaints are 'swept under the carpet' if possible • There is a blame culture which deters the staff from reporting	• Incidents are seen as the fault of the staff • There is a reporting system in place which the staff are reluctant to use as it will result in disciplinary action. • When an incident comes to light, there is no support available for the staff and patients involved.	• There is a recognition that systems contribute to incidents and not just individuals. • An anonymous reporting system is in place with a lot of emphasis on form completion. • Staff are encouraged to report incidents but do not feel comfortable in doing this as they do not perceive there is a no blame culture	• It is accepted that incidents occur due to individual and system shortfalls. • Accessible, 'staff friendly' reporting methods are used, with which the staff feel comfortable. • There is a supportive, learning culture rather than allocation of blame.	• All staff fully understand that incidents occur due to individual and system shortfalls and they are aware of their own accountabilities. • Incidents are reported as a matter of course because staff and patients are actively. supported as soon as an incident comes to light. • Staff have confidence in the investigation process and believe in the value of reporting.
C. Investigating incidents **OUR STAGE (1-5)** **= _____**	• Incidents which are resolved quickly with the customer at the time receive no investigation. • Minimal action is taken following other incidents and this is likely to involve blaming the team members involved.	• Incidents are investigated but the focus is on blaming the individuals rather than looking at the systems in the pharmacy. • Quick fix solutions are proposed that deal with the specific incident but may not be carried out once the 'heat is off'.	• Incidents are investigated for the sake of form-filling. • Changes may be made to procedures but these are not necessarily shared with the wider pharmacy team.	• Incidents are investigated with the pharmacy team members involved, with a focus on identifying learnings rather than allocating blame. • These learnings are shared with the whole team to enable continual improvement.	• The pharmacy is open to inquiry and welcomes any outside involvement in investigations. • The team has a deep understanding of the root causes of incidents and how to use trend data to improve training and minimise future risks. • Fewer incidents are occurring as a result of these activities.

[2] Manchester Patient Safety Assessment Framework (MaPSAF) tool adapted for community pharmacy teams by Pharmacy Voice in collaboration with the Greater Manchester Primary Care Patient Safety Translational Research Centre (GM PSTRC). The original MaPSaF was developed by Dianne Parker, Sue Kirk, Tanya Claridge, Aneez Esmail and Martin Marshall in a project supported by the National Primary Care Research and Development Centre, University of Manchester.

	Stage 1 - Unaware	Stage 2 - Reactive	Stage 3 - Procedural	Stage 4 - Proactive	Stage 5 - Progressive
D. **Learning following an incident** **OUR STAGE (1-5)** **= _____**	• No attempt is made to learn from incidents. • No changes are made to the running of the pharmacy after an incident. • The pharmacy considers that it has been successful when its management or an inspector do not become aware of an incident.	• Little, if any, learning occurs after an incident. • Any learning that does occur is only related to the specific incident. • Any changes from the Superintendent are 'knee jerk' reactions and not maintained. • Consequently, similar incidents tend to reoccur.	• Some systems are in place to enable learning from incidents but these are not communicated to the whole pharmacy team. • Management or head office decides on any changes that need to be introduced. • The lack of staff involvement in the changes required leads to them not being integrated into working patterns.	• The pharmacy has a history of learning from incidents • Members of staff are actively involved in deciding what changes are needed and committed to their maintenance. • The pharmacy team looks for learning opportunities and is keen to share insights with others.	• The pharmacy team is committed to learning from incidents and sharing its insights across the organisation. • Incidents are discussed openly and all staff contribute. • Incidents are recognised as providing an opportunity to learn and develop. • Improvements in practice do not have to be triggered by the occurrence of an incident, as the culture is one of continual improvement.
E. **Communication** **OUR STAGE (1-5)** **= _____**	• Incidents are not talked about within the pharmacy team. • Any such communication comes from the manager or head office and is focused on blame. • There is no process for the pharmacy team to speak to their manager or head office about risk.	• Communication about risk from staff to the management occurs only after an incident. • The response from the manager (or head office) involves the issuing of instructions. • The pharmacy team feel that they have been 'told off'.	• There is a process for communication in the pharmacy but it is not linked to risk management and no one checks whether it is working. • SOPs for dealing with risk and incidents are in place. • Lots of records are kept but little is actually done with them.	• Pharmacy team members communicate well and share information on safety issues. • Discussions on managing risk occur regularly and team members are encouraged to set the agenda. • The pharmacy team keeps a record of these discussions and the outputs are audited. • The level of communication between the pharmacy team and head office helps to identify and reduce risk.	• Mechanisms for communication are well established within the pharmacy. • All staff are involved in communication about safety issues and are expected to learn from each other. • Management embraces the opportunity to learn from its staff and novel ideas are encouraged. • This is a 'praising' pharmacy.
F. **Staff management and safety issues** **OUR STAGE (1-5)** **= _____**	• Recruitment of staff is ad hoc and they are seen as 'bodies to fill posts'. • There is no structured staff development programme. • Staff feel unsupported and their opinions on safety are not valued. • Management criticises staff unfairly and do not link staff absence with potential issues of safety and risk.	• Changes to staffing levels are considered only in response to areas previously identified as vulnerable. • Job descriptions and staff roles change only in response to problems. • Development of team members is undertaken only in response to incidents.	• Procedures for the recruitment and retention of staff are in place but these are not linked to risk management issues. • Procedures for appraisal, incident investigation and staff development exist but they are not applied consistently and so do not always achieve their aims. • These procedures are seen as tools for the manager or head office to use in the control of staff.	• Staffing levels are reviewed regularly as the business evolves. • Recruitment involves careful assessment to ensure that all staff are suited to their roles. • Effort is made to understand why incidents occur and to 'nip problems in the bud'. • There are good systems for appraisal, monitoring and review of staff. Management show genuine concern for staff wellbeing and offer support services as required.	• The effective management of staff is an integral part of the organisation. • Pharmacy team members are committed to each other's success and everyone has confidence in the management structure. • Safety and risk issues are reviewed proactively and the insights are reflected in a culture of continual improvement.

	Stage 1 - Unaware	Stage 2 - Reactive	Stage 3 - Procedural	Stage 4 - Proactive	Stage 5 - Progressive
G. **Staff training about risk management** **OUR STAGE (1-5)** **= _____**	• Team members and management have not considered any need for training beyond the basics for their roles. • Therefore, no checks are made on the quality or relevance of any previous training regarding patient safety and risk.	• Training tends to focus on topics that will maximise income for the pharmacy. • Specific training on risk management is regarded as irritating, time consuming and costly. • Such training occurs only if there have been specific problems, when it relates to high-risk areas and focuses on 'keeping the owner out of trouble'.	• Staff receive information on risk management when they join the pharmacy but it is the responsibility of each individual to read and act upon this. • All team members are issued with personal development plans but the completion and return of these is not always given priority. • Training on safety issues is seen as the way to prevent mistakes.	• Effort is made to identify the training needs of each individual pharmacy team member. • Training is seen as integral to each individual's personal and professional development and it includes a specific focus on patient safety and risk issues. • Such training is well planned, well-resourced and regularly updated.	• Individuals are motivated to undertake self-directed learning and identify training needs. • The approach to risk management training is flexible and encouraged by management as a means by which staff can fulfil their potential. • Training on patient safety issues is integral to the organisation's culture of continual improvement.
H. **Team working** **OUR STAGE (1-5)** **= _____**	• Individuals work on their own tasks without considering how their outputs affect other people in the pharmacy or patient safety. • There is a hierarchy of roles within the pharmacy and no evidence of cross-functional working.	• Individuals do not feel as though they belong to a team although they pay 'lip service' to its existence. • Staff only work together when they are told to do so and in response to an incident. • The pharmacist and/or the management seem to focus on some individuals more than others.	• Processes are in place which set out how the team will work together to deliver specific tasks but no-one checks whether these procedures are effective. • Individuals do not feel that their ideas are listened to unless the pharmacist and/or the management makes a specific request for information. • The pharmacy team seldom shares information or ideas about safety and risk.	• Team members work together willingly within a flexible team structure; they are adaptable and collaborative in their approach to tasks. • Team members feel free to contribute to the pharmacy's risk management agenda. • The team often reviews how well it is working and changes are made if needed.	• All individuals are valued equally within the team and all contribute actively to risk management. • The team welcomes insights from other people who do not usually work in the pharmacy, such as locums, area managers and head office colleagues. • Patient safety is seen as a shared responsibility and there is a shared commitment to continual improvement within the pharmacy