Pharmacy Quality Scheme (PQS): Completing the Patient Safety Report

Content of the report

The purpose of the report is to improve patient safety by encouraging pharmacy staff to share learning from incidents that occur within the pharmacy, with the focus being what has been learnt from the incident, and the actions taken as a result to improve patient safety. The report itself should cover the whole patient safety realm; it is not limited to dispensing errors. Patient safety issues that can be included in the report include, but are not limited to:

- Administration errors
- Alerts and resulting action taken
- Communication issues with GPs or hospitals
- Near misses
- Controlled Drug incidents
- Delivery incidents
- Prescribing errors
- Issues with transfer of care; for example, from hospital to community
- Actions taken by the pharmacy in response to local errors and national patient safety alerts issued by the Central Alerting System

By including a range of patient safety issues, a pharmacy can demonstrate that it is considering patient safety in everything it does, and not just reacting to patient complaints.

Collating the evidence for the report

It is important to note that the annual report is not a substitute for individual incident reports but is intended to be produced in addition to them. All pharmacies should continue to follow their Standard Operating Procedures (SOPs) covering incident reporting. These reported incidents will need to be considered when compiling the written reports, so it is important to keep electronic or paper copies of each event. The newly designed Monthly Patient Safety Report (Annex 4 of the NHS England and NHS Improvement (NHSE&I) PQS guidance) has been created to enable pharmacies to collect the data required to complete the Annual Patient Safety Report (Annex 5 of the NHSE&I PQS guidance). This document includes worked examples of these reports.

Therefore, it is advisable to use the monthly template form to carry out a monthly analysis of incidents and issues. The content of these reports can then be discussed with the pharmacy team, to aid sharing and learning from incidents. When analysing incidents and issues, it is helpful to remember the core reporting principles:

Figure 1: core reporting principles

- **Report:** report all errors and near misses and involve the whole team
- **Learn:** identify and investigate causes of errors and use them as learning opportunities
- **Share:** discuss with others and promote learning
- **Act:** make changes to practice
- **Review:** review changes to practice

Ensuring that these principles are implemented within the pharmacy for each incident will allow for efficient reporting, maximised learning and a potential prevention in reoccurrence. There is currently no requirement for the annual patient safety report to be sent to NHSE&I; however, it will need to be kept as evidence of meeting the criteria and for 2 NHS years (i.e. April to March) after submission for post payment verification purposes. The report can also be used for Continuing Professional Development (CPD) purposes and to help the pharmacy team to focus on common incidents to reduce the potential for reoccurrence. This report also helps the pharmacy to demonstrate that they are meeting principle 1 of the General Pharmaceutical Council registered pharmacy standards.

Changes to the patient safety report templates

The patient safety report templates have been adapted part way through the year in response to the release of the new PQS. As these templates have changed part way through the year the pharmacy team may not have collected the data required by the new monthly template in the months prior to its release. The pharmacy team should use the data collected in the old format to complete the annual patient safety report to the best of their ability.

October 2019. Produced by the Community Pharmacy Patient Safety Group (CP PSG). For more information about the CP PSG visit https://pharmacysafety.org/.

Monthly Patient Safety Report worked example

Pharmacy Quality Scheme (PSQ)
Monthly Patient Safety Report

Pharmacy name (and branch number, if applicable)	*Anytown Pharmacy Branch Number 0123*	**Month and year**	*September 2019*
Report completed by (name)	*Mrs A Example, Pharmacy Manager*	**Date of report**	*02/10/2019*
Pharmacy team members who participated in preparing this report (initials)	*AB, CD, EF, XY*		

1. **Monthly summary of patient safety incidents and activity in the pharmacy** (enter monthly total in the table below)

Month	A. Prescribing interventions	B. Near misses	C. Near misses involving high-risk LASA* (if known)	D. Dispensing incidents	E. Dispensing incidents involving high-risk LASA* (if known)	F. National Safety alerts	G Other patient safety activity†
September	*9*	*62*	*3*	*2*	*1*	*2*	*3*

* 'Look-Alike, Sound-Alike' (LASA), [sometimes also referred to as Sound Alike Look Alike Drugs (SALAD)] medicines classified as high-risk are: propranolol & prednisolone, amlodipine & amitriptyline, carbamazepine & carbimazole, atenolol & allopurinol and rivaroxaban & rosuvastatin
† Including drug recalls

2. **How have the patient safety priorities that were agreed in the last month's patient safety report been acted upon?**

Last month we highlighted that not all members of staff were reporting near misses in the near miss log. Training was undertaken this month for all the staff working in the dispensary (AB, XY and ZZ). This has resulted in an increase in reporting of near misses this month (only 42 near misses were reported last month in comparison to 62 this month).

All pharmacy professionals have now undertaken the CPPE Risk management training. Key learning from this was shared in the weekly group huddles.

The dispensary team has been briefed on the large number of errors involving pregabalin and gabapentin. The team read the pregabalin guidance booklet from the community pharmacy patient safety group website which helped them understand how pregabalin can be abused. We have introduced a policy of second checking the dispensing of these two medicines and LASA stickers were added to the shelves of these medicines.

3. **Outline your learnings and actions, if you have had a LASA medicine incident or near miss in the last month (refer to columns C + E in the table)**

What were the key learning points for the pharmacy team following the completion of the CPPE reducing look-alike, sound-alike errors e-learning and e-assessment? (Fill in this box in the month you complete the CPPE training and for the following month)	What actions have been implemented to minimise LASA incidents and near misses from your last monthly Patient Safety Report?

This training has taught us about the top 5 LASA combinations. The training has also taught us about some key management strategies to help reduce these errors. These include separating out stock of LASA medicines and using LASA stickers on the edge of the dispensary shelves to help highlight LASA medicines. We have also gone through the key examples of LASA incidents which have occurred in our pharmacy over the last year. These measures have helped highlight to the team the seriousness of LASA errors and some of the key measures that can be taken to prevent them from happening. All staff have been advised to dispense from the original prescription and not from labels.	*We reviewed where the top 5 LASA combinations were situated in the dispensary. We have since separated all 5 combinations to different areas of the dispensary and we have labelled all the shelves with our LASA stickers.*
How have these learnings and actions helped to reduce the number of LASA incidents occurring in your pharmacy? Quantify where possible.	If these learnings have not helped to reduce the number of LASA incidents, why is this the case and what additional actions will you now take?
Since this has been undertaken there has been 3 near misses and 1 dispensing incident involving the top 5 LASA errors. *Both of these figures have decreased from last month when we identified 8 near misses and 2 dispensing incidents involving the top 5 LASA errors.*	*We believe that the actions we have taken have reduced the number of LASA errors. We will monitor the number of LASA incidents being reported monthly to check the measures put in place continue to be effective.*

4. <u>Outline key patient safety improvements</u> that have occurred within your pharmacy during the month in relation to:

4.1 Improvement 1: pharmacy safety - patient safety incidents (refer to columns A, B + D in the table). *Only one example has been provided here, all learning points identified should be detailed below to be submitted by contractors.*

Reviewing your patient safety incidents, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?
<u>Key learning point:</u> *The importance of following the 'handing out prescriptions' SOP, including making full patient identification checks to prevent handing out errors.* *The importance of ensuring all staff regularly review SOPs.* *<u>How it was identified:</u>* *Both incidents were identified by the patients involved on receipt of their medicine, the patients then informed the pharmacy.*	*All staff have received refresher training on handing out dispensed medicines. All counter staff have re-read and signed the 'handing out prescriptions' SOP.* *The importance of checking the name and address of the patient has be reiterated to the team.*	*This training and review of SOPs has helped patient safety by preventing patients accidently receiving the wrong prescription.*

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4.2 Improvement 2: national patient safety alerts (refer to column F in the table) *Only one example has been provided here, all key learning points identified should be detailed below to be submitted by contractors.*

Reviewing patient safety alerts, what was the key learning point and how was it identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?
Key learning point: *The use of all types of HRT (except vaginal estrogens) increases the risk of breast cancer and this can persist for more than 10 years after stopping HRT.* *How it was identified:* *This patient safety alert was communicated to us via email from head office.*	*When HRT prescriptions are received, a 'counselling' sticker is placed onto the prescription by the dispenser. This highlights to the pharmacist that counselling should be undertaken to ensure the patient has received the most up to date information on their medicine and is referred to their GP if they have any concerns.*	*Patients receiving HRT on prescription are now being counselled to ensure they are aware of the risk and signs of breast cancer.* *We also counsel patients when handing out HRT products that they should be using the lowest possible dose for the shortest period of time.*

5. How have you shared what you have learned above (in relation to box 3, 4.1 and 4.2) both within your team and externally?

Our weekly team huddles have been used to share learning from training and incidents which have happened in the pharmacy. Where team members have received training, they have been asked to train the rest of the team in these huddles, this has helped the individuals to ground their learning and also helped share learning with the rest of the team.

Near misses and incidents have been reported to the NRLS.

6. What will be the team's patient safety priorities for the next month?

Priority 1: *To ensure that as many eligible patients receive the flu vaccination as possible, all staff are to be trained on flu vaccination eligible groups and how to start conversations about flu vaccination in preparation for the upcoming flu season.*

Priority 2: *Refresher training for anybody delivering prescriptions, as delivery of the wrong bag to the wrong patient continues to be a key theme in errors reported. The members of staff will also review and resign the SOP.*

Priority 3: *Undertake CPPE sepsis training in line with the Pharmacy Quality Scheme quality criteria. Ensure that training about sepsis is provided to all staff to help ensure that appropriate patients are being referred to the pharmacist.*

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Annual Patient Safety Report worked example

Pharmacy Quality Scheme (PQS)
2019/2020 Patient Safety Report

Pharmacy name (and branch number, if applicable)	*Anytown Pharmacy Branch Number 0123*	**ODS (F code)**	F00000000
Report completed by (name)	*Mrs A Example, Pharmacy Manager*	**Date of report**	01/02/2020
Dates covered by the report	**February 2019 to January 2020**		
Pharmacy team members who participated in preparing this report (initials)	*AB, CD, EF, XY*		

1. Summary of patient safety incidents and activity in the pharmacy (enter monthly totals in the table below)

Month	A. Prescribing interventions	B. Near misses	C. Near misses involving high-risk LASA* (if known)	D. Dispensing incidents	E. Dispensing incidents involving high-risk LASA* (if known)	F. National safety alerts	G Other patient safety activity †
February 2019	*5*	*40*	*4*	*1*	*1*	*0*	*5*
March 2019	*8*	*38*	*5*	*3*	*2*	*0*	*1*
April 2019	*6*	*42*	*5*	*2*	*1*	*4*	*0*
May 2019	*9*	*45*	*7*	*2*	*2*	*0*	*2*
June 2019	*7*	*48*	*5*	*4*	*0*	*0*	*2*
July 2019	*10*	*40*	*7*	*3*	*1*	*1*	*2*
August 2019	*9*	*42*	*8*	*2*	*2*	*2*	*1*
September 2019	*9*	*62*	*3*	*2*	*1*	*2*	*3*
October 2019	*10*	*65*	*3*	*4*	*2*	*2*	*3*
November 2019	*9*	*60*	*2*	*3*	*1*	*1*	*0*
December 2019	*7*	*71*	*3*	*4*	*0*	*3*	*1*
January 2020	*6*	*57*	*2*	*3*	*1*	*2*	*2*
TOTAL	*95*	*610*	*54*	*33*	*15*	*17*	*22*

* 'Look-Alike, Sound-Alike' (LASA), medicines (sometimes referred to as Sound Alike, Look Alike (SALAD) medicines classified as high-risk are: propranolol & prednisolone, amlodipine & amitriptyline, carbamazepine & carbimazole, atenolol & allopurinol and rivaroxaban & rosuvastatin

† Including drug recalls

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2. How have the patient safety priorities that were agreed in last year's patient safety report been acted upon?

A valproate champion has been appointed and the MHRA guidance is followed when dispensing valproate. An SOP for dispensing valproate has also been designed and implemented. The PMR has an alert set to flag up at the dispensing process that valproate is a high-risk medicine and additional precautions/counselling is required.

Whilst we continue to have some handing out errors, the total number of these errors has been reduced through focusing on our hand out procedure and ensuring that the hand-out SOP is regularly reviewed by the relevant team members. Any changes to the SOPs are communicated with the team and each team member is asked to sign the SOP to say it has been read and understood.

Increased communication between our four main GP surgeries and the pharmacy has allowed us to help ensure that when patients are discharged from hospital, they receive the correct medication and support, optimising medicines usage.

3. Outline your learnings and actions in relation to LASA medicines (refer to columns C + E in the table)

What were the key learning points for the pharmacy team following the completion of the CPPE reducing look-alike, sound-alike errors e-learning and e-assessment?	What actions have been implemented to minimise LASA incidents and near misses since your last annual Patient Safety Report?
This training has taught us about the top 5 LASA combinations. The training has also taught us about some key management strategies to help reduce these errors. These include separating out stock of LASA medicines, using our LASA stickers on the edge of the dispensary shelves to help highlight that this is a LASA medicine. We have also gone through the key examples of LASA incidents which have occurred in our pharmacy over the last year. These measures have helped highlight to the team the seriousness of LASA errors and some of the key measures that can be taken to prevent them from happening. All staff have been advised to dispense from the original prescription and not from labels.	*Shelf labels have been adopted and utilised across the dispensary for the top 5 nationally agreed LASA combinations and additional LASA combinations which we have identified are common in our pharmacy.* *We reviewed where the top 5 LASA combinations were situated in the dispensary.* *We have separated all 5 combinations to different areas of the dispensary, and we have labelled all the shelves with our LASA stickers.* *Learning from the CPPE LASA training was shared in our weekly huddles to ensure the whole pharmacy team are on board with prevention of LASA errors.*
How have these learnings and actions helped to reduce the number of LASA incidents occurring in your pharmacy? Quantify where possible.	If these learnings have not helped to reduce the number of LASA incidents and near misses, why is this the case and what additional actions will you now take?
Yes, there has been a reduction in the number of near misses involving high-risk LASA since the CPPE LASA training was undertaken in August. The average number of near misses involving high-risk LASA per month prior to the training was 5.8, the average number of near misses involving high-risk LASA per month after the training was 2.6.	*We believe that the actions we have taken have reduced the number of LASA errors. We will monitor the number of LASA incidents being reported monthly to check the measures put in place continue to be effective.*

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4. <u>Outline key patient safety improvements</u> that have occurred within your pharmacy during this review period in relation to:

4.1 Improvement 1: pharmacy safety - patient safety incidents (refer to columns A, B + D in the table) *Only one example has been provided here, all key learning points identified should be detailed below to be submitted by contractors.*

Reviewing your patient safety incidents, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?
Key learning point: *When dispensing controlled drugs, a second accuracy check should be undertaken to ensure that the product dispensed is correct to the prescription.* *How it was identified:* *A near miss involving morphine sulphate slow release 10mg tablets being selected instead of 100mg tablets as indicated on the prescription.*	*We always aim to have a second member of staff undertake an accuracy check on dispensed controlled drug items. Where this is not possible the person checking the prescription must take a small mental break before checking the prescription again. The dispensing controlled drugs SOP has been updated to reflect this.*	*The risk of a dispensing incident has been reduced by ensuring a double check on all controlled drug prescriptions.* *Increased awareness surrounding the prevention of controlled drug errors has helped the safety culture in the pharmacy and is believed to have contributed to the decrease in controlled drug errors.*

4.2 Improvement 2: national patient safety alerts (refer to columns F + G in the table) *Only one example has been provided here, all key learning points identified should be detailed below to be submitted by contractors.*

Reviewing national patient safety alerts, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?
<u>Key learning point:</u> *The use of all types of HRT (except vaginal estrogens) increases the risk of breast cancer and this can persist for more than 10 years after stopping HRT.* *<u>How it was identified:</u>* *This patient safety alert was communicated to us via email from head office.*	*When HRT prescriptions are received, a 'counselling' sticker is placed onto the prescription by the dispenser. This then highlights to the pharmacist that counselling should be undertaken to ensure the patient has received the most up to date information on their medicine.*	*Patients getting HRT on prescription are now being counselled to ensure they are aware of the risk of breast cancer and are aware of the signs of breast cancer.* *We also counsel patients when handing out HRT products that they should be using the lowest possible dose for the shortest period of time.*

5. How have you shared what you have learned above (in relation to boxes 3 and 4.1 and 4.2) both within your team and externally?

The entire team has been briefed on patient safety incidents at our team huddles.
Team huddles have also been used to share learning from internal and external training.
Our Pharmacist manager has had a conversation with the MSO for our organisation regarding LASAs which have occurred due to similar packaging in the pharmacy. This has helped us to source medicines which do not look the same as others.
Near misses and incidents have been reported to the NRLS.
One key incident was shared at an LPC event.
Locum pharmacists are also briefed on patient safety incidents that have occurred.

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6. What will be the team's patient safety priorities for the next NHS year (April 2020 – March 2021)

Priority 1: *As dispensed medicines which are FMD compliant continue to increase, we will focus on reviewing national guidance for FMD with particular emphasis placed on the steps to take if error messages are returned when products are scanned.*

Priority 2: *Medicines with similar packaging continue to pose a significant patient safety risk. We will identify items delivered to the pharmacy which have similar packaging and document these in a specially designed log. It is hoped that this will help staff to order in items which do not have similar packaging.*

Priority 3: *As we are now providing a service to a care home, we would like to increase channels of communication with the doctors prescribing for these patients to ensure that patients are assisted to take their medicines in the most appropriate way.*