Patient safety culture survey

2021 Results

Community Pharmacy Patient Safety Group

Background and introduction

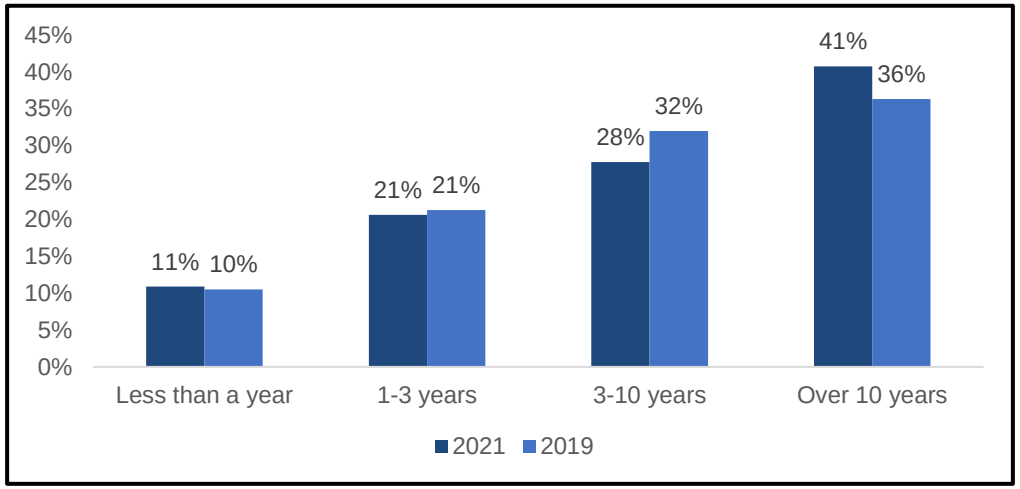
- The Community Pharmacy Patient Safety Group conducted an anonymous survey of community pharmacy staff.
- The survey, which was open to all pharmacy colleagues ran between August 11 and October 15.
- The survey sought to understand what patient safety culture and practice looks like across the community pharmacy sector from the perspective of frontline teams and gather views on processes and barriers and enablers to reporting incidents.
- Similar surveys were carried out by Pharmacy Voice in 2016 and by the Community Pharmacy Patient Safety Group in 2019.
- As such it is possible to ascertain changes in attitudes and behaviour of pharmacy teams.

Key findings

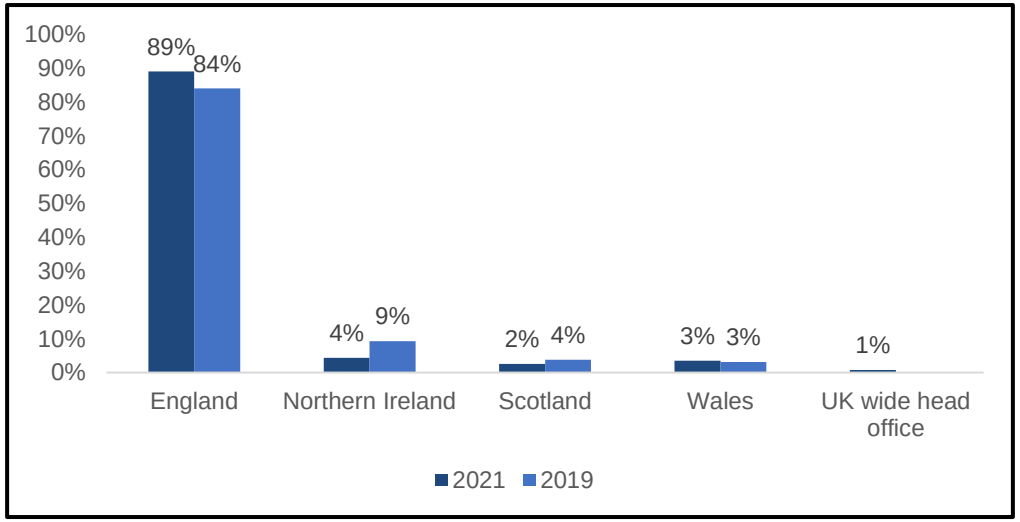
- An increased proportion of respondents said that they report errors to share learnings and improve practice.
- A reduced proportion of respondents said they only report because they are contractually obliged to or because they are instructed to do so by their manager.
- The vast majority of respondents (91%) reported that the reporting procedure in their pharmacy is clear or very clear.
- Around 50% of respondents reported that they were either unfamiliar with the terminology “Just Culture” or didn’t know if their organisation followed the principles of it.
- The biggest enablers for reporting were cited as simpler reporting tools (59%), more time/improved staffing levels (56%) and training (33%).
- The most commonly reported barrier to reporting internally was time (43%) – this was consistent with previous years.
- The proportion of respondents who cited fear or concern of prosecution as a barrier to reporting internally dropped from 22% in 2019 to 18% in 2021.
- The majority (65%) of respondents reported that they were aware of legal changes introduced in 2018 which provide a defence to reporting errors (this is often referred to as decriminalisation and was called decriminalisation within the survey). Of those who were aware of the new legal defence, 29% said it made them more likely to report errors.

Who took part?

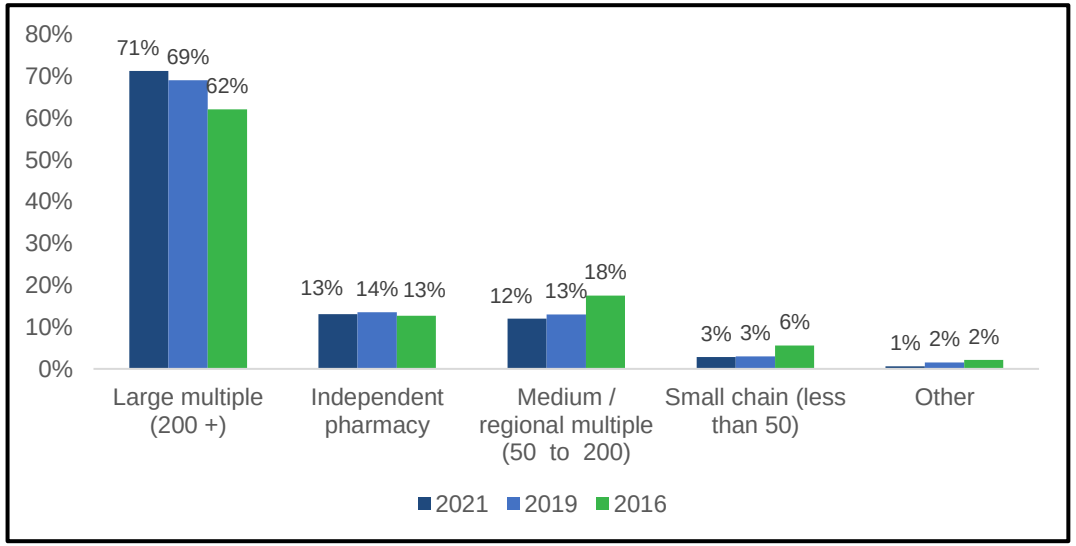
How long have you been in your current role?



What country do you practice in?



What size community pharmacy do you work for?

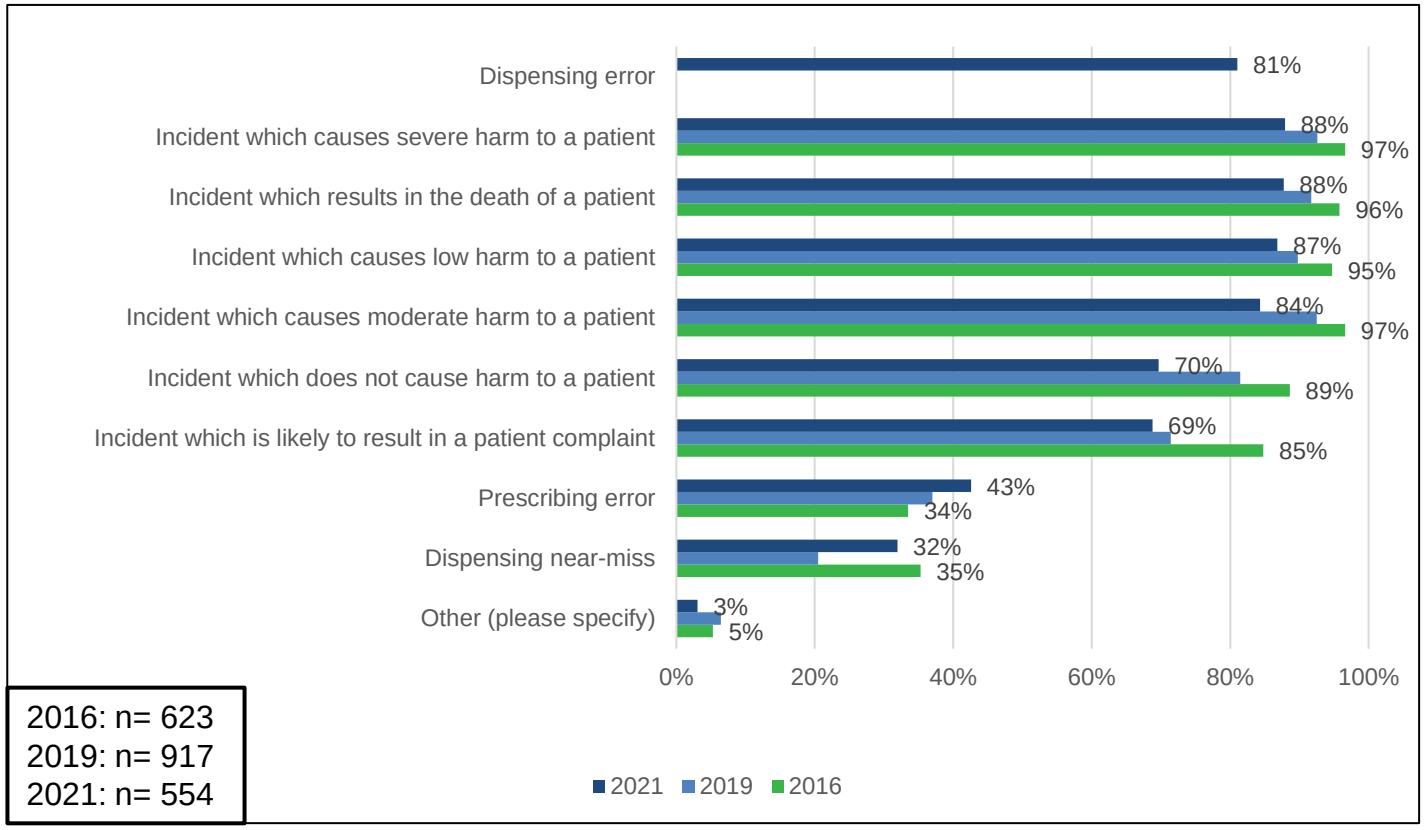


Who took part?

What is your current role?	2016	2019	2021
Pharmacist Manager	59%	43%	34%
Dispensing Assistant / Pharmacy Assistant	6%	11%	14%
Employee Pharmacist	15%	22%	11%
Superintendent pharmacist			8%
Non-Pharmacist Manager	4%	4%	7%
Locum Pharmacist	6%	4%	6%
Registered ACT Pharmacy Technician	3%	5%	6%
Registered Pharmacy Technician	3%	4%	5%
Other (please specify)	3%	6%	4%
Pharmacy owner			2%
Medicines Counter Assistant	1.1%	0.8%	2%
Pre-registration Trainee Pharmacist	0.6%	0.7%	1.6%
Provisionally registered pharmacist			0.5%
Number	**623**	**917**	**809**

Incident reporting

When do you report incidents*



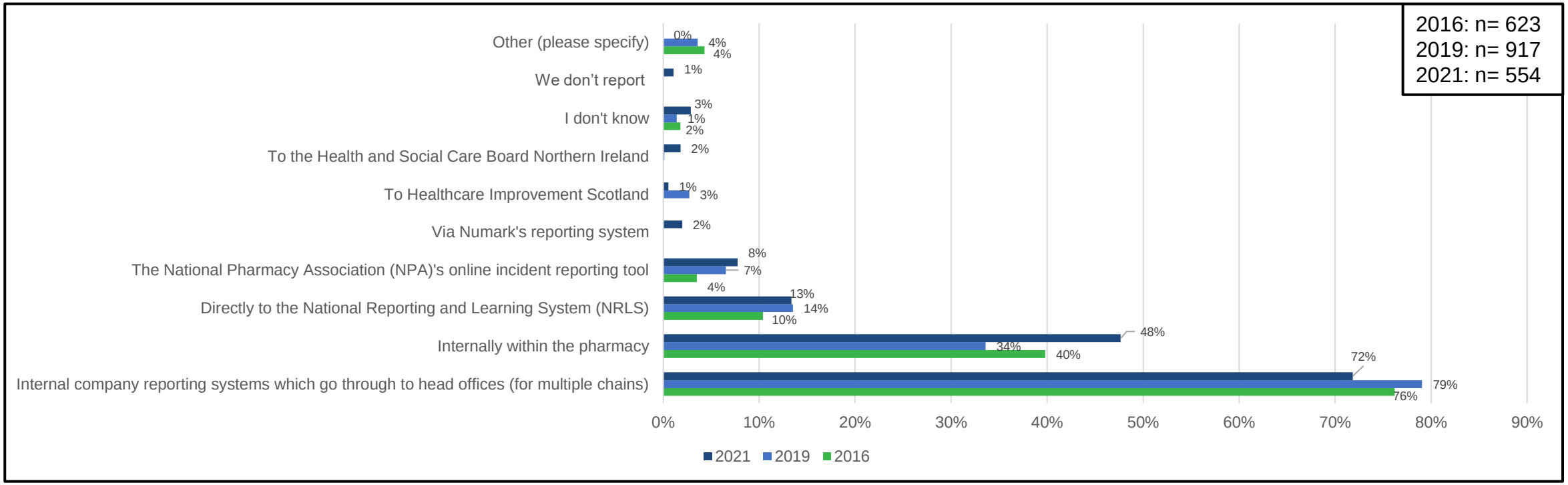
2016: n= 623
2019: n= 917
2021: n= 554

- In 2021 a lower proportion of respondents stated that the reason they report is because a complaint is likely (67% in 2021 compared with 86% in 2016).
- Only 0.7% (n=4) reported only reporting when a complaint was likely.
- In comparison to 2019 and 2016 a lower proportion reported that they would report when any level of harm was caused. In 2021 the option “dispensing error” was added, it is likely that some respondents selected this option rather the stipulating the specific level of harm they report for. When the option for “dispensing error” and the different levels of harm are combined the results between 2016, 2019 and 2021 are equivalent.

***** Respondents could select more than one answer.

Incident reporting

Where do you report patient safety incidents in your pharmacy?*



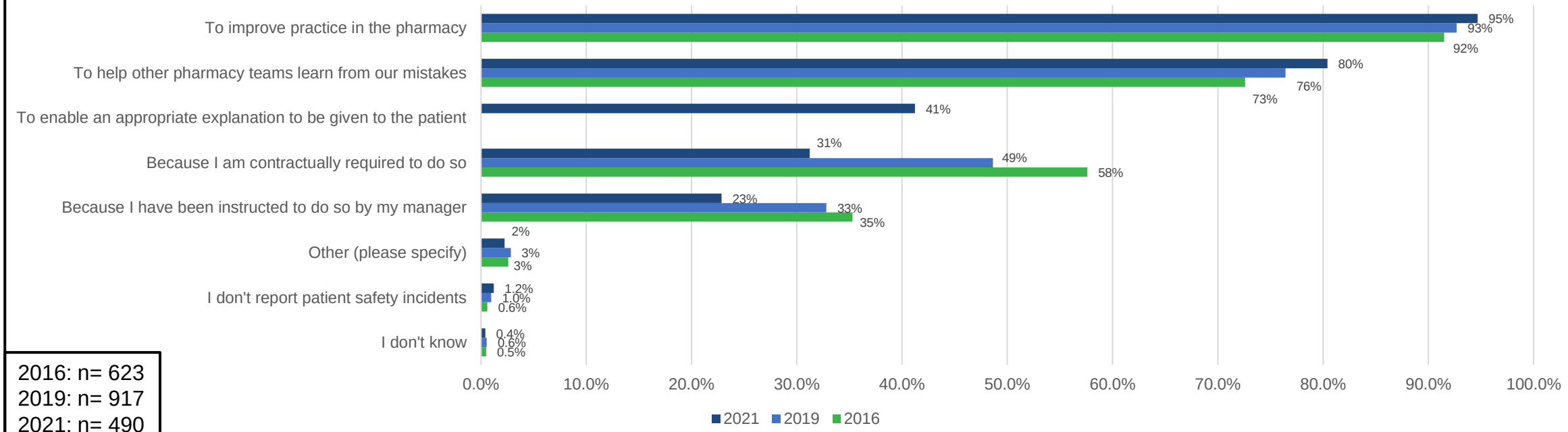
The majority of respondents said they report using internal company systems and/or withing the pharmacy. 13% said they report directly to NRLS.

- In 2021 the option "we don't report" was added. This was selected by 0.9% of respondents (n=5), however of these 5, 3 also said they report errors "internally within the pharmacy". The following reasons for not reporting were cited:
  - *"We are not allowed to report to NRLS"*
  - *"Our company does not report to the NRLS why I don't know"*
  - *"No idea where to report them"*
  - *"Not enough staff and not enough time"*

***** Respondents could select more than one answer.

Incident reporting

Why do you report patient safety incidents in your pharmacy?*



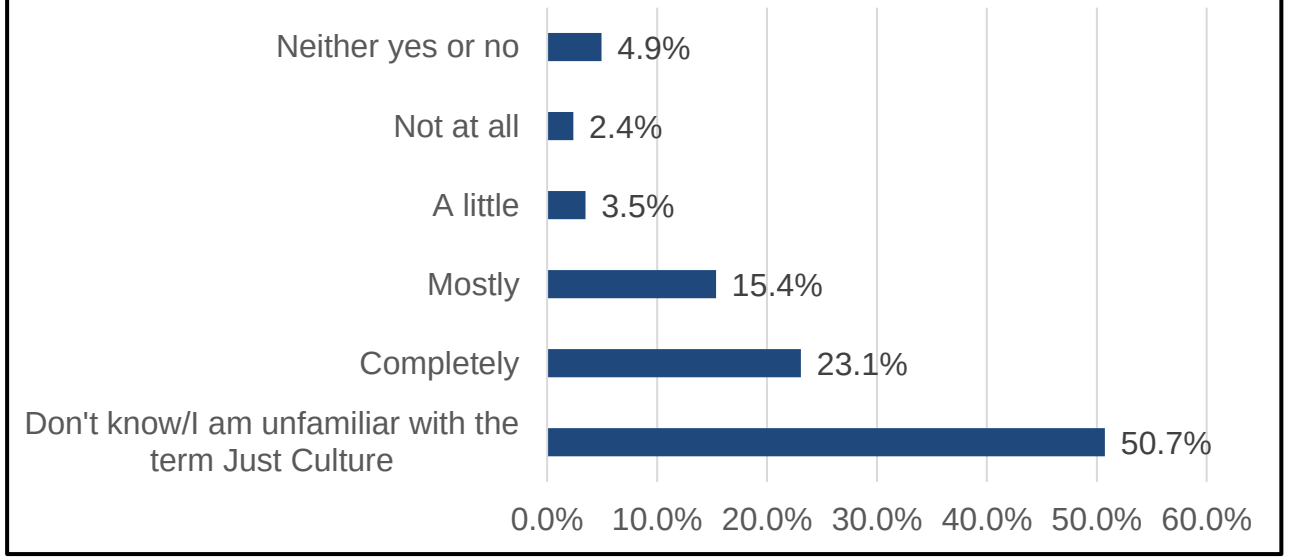
2016: n= 623
2019: n= 917
2021: n= 490

- In 2021 95% of respondent said they reported to improve practice and 80% said they reported to help others learn from mistakes. Both represent an increase from 2016 and 2019.
- Fewer respondents said they report because they are obliged to either by their manager or the contract. In 2021 only 0.6% of respondents (n=3) cited “because I am contractually required to do so” as the only reason they report errors.
- The same proportion cited “because I have been instructed to do my manager” as the only reason they report.
- The following reflect “Other” reasons cited for report.
  - *To improve the safety within the pharmacy setting*
  - *Part of the job to improve safety and reduce harm*
  - *To ensure patient safety is maintained*
  - *To help collate data for NRLS so we can all benefit*

*****Respondents could select more than one answer.

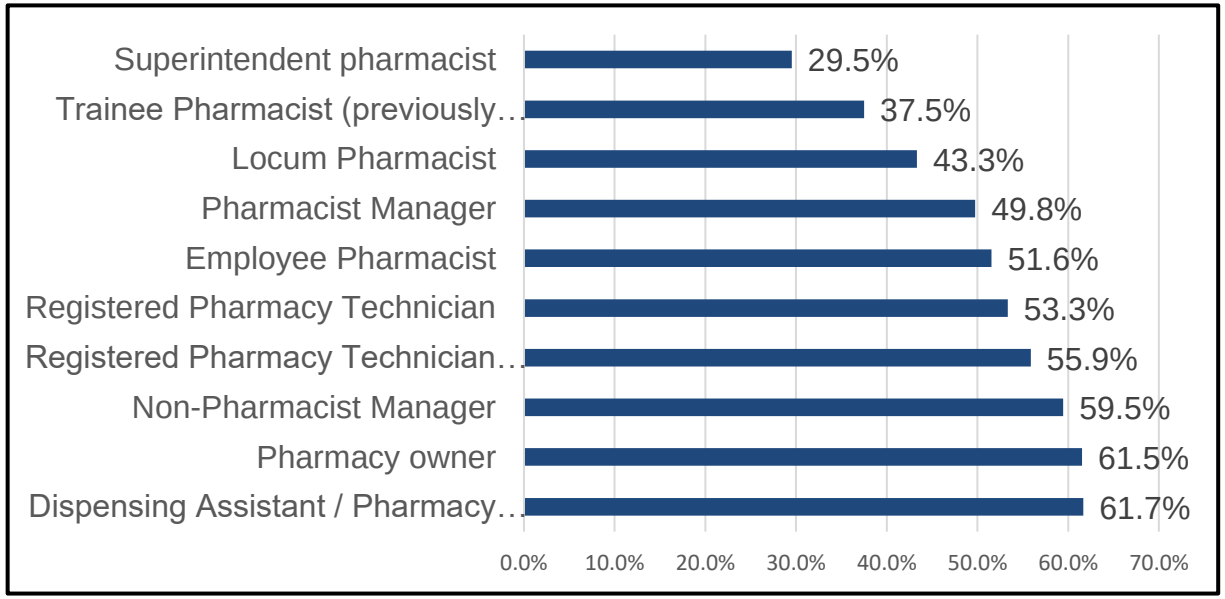
Just culture

Does your organisation follow the principles of Just Culture? (n=446)



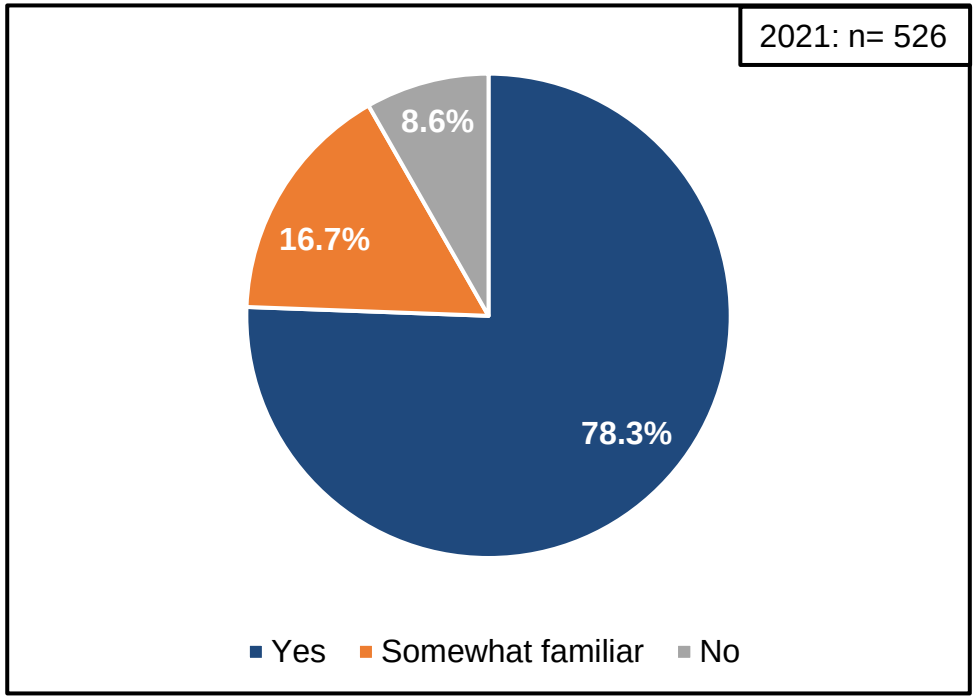
- Over half of respondents said that they were either unfamiliar with the terminology “Just Culture” or didn’t know if their organisation followed the principles of it.
- This was also high among registrants. Around 30% of superintendents, and over half of pharmacists and pharmacy technicians reported “don’t know or unfamiliar” to this question.

Roles of those who reported “unfamiliar or don’t know?” (n=277)

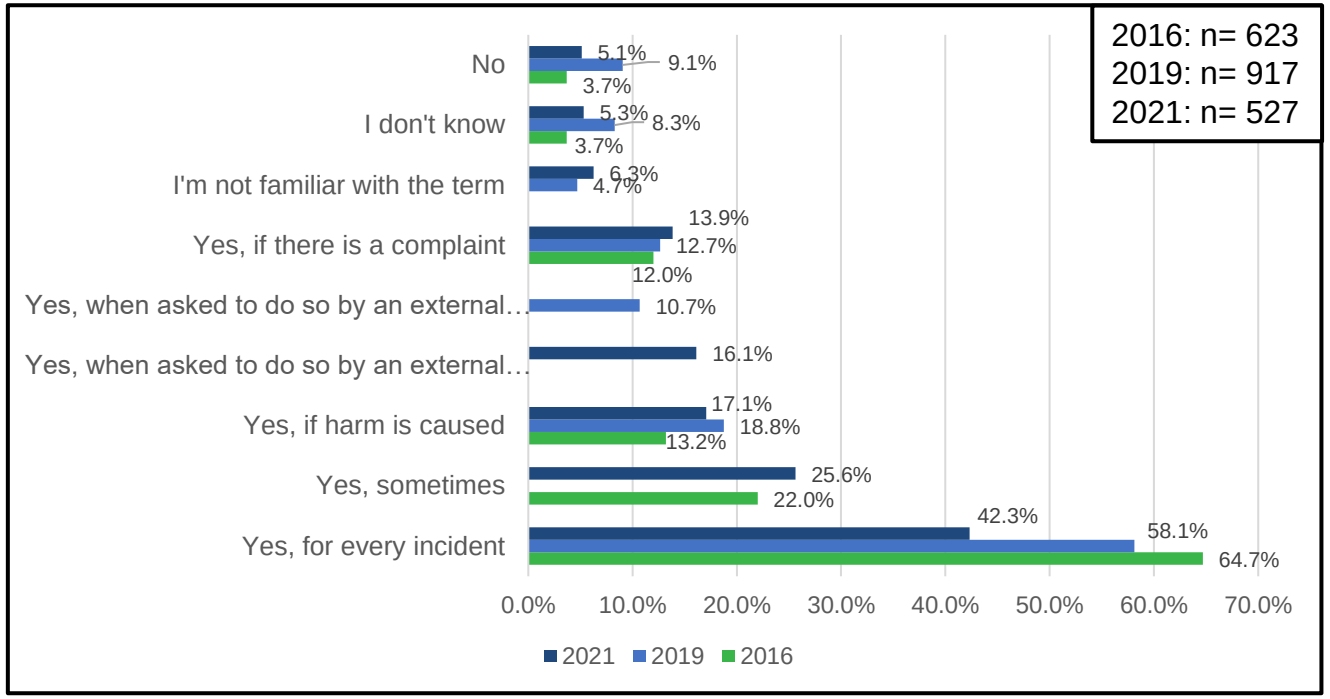


Root Cause Analysis

Are you familiar with the term Root Cause Analysis (2021)?



Does your pharmacy team undertake root cause analysis to identify the contributing factors for an incident?*



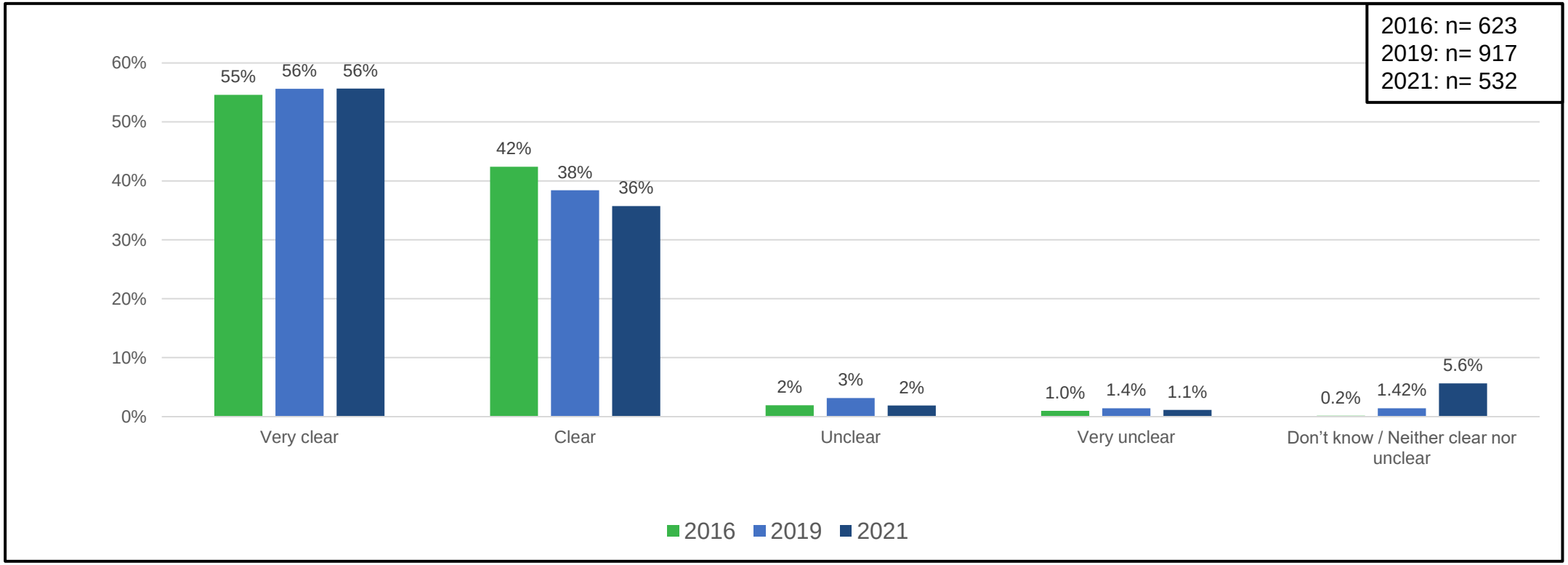
In 2016 almost 65% of respondents said that their pharmacy undertakes a root cause for every incident. In 2021 this figure had dropped to 42.3%.

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.

***Respondents could select more than one answer.**

Clarity of reporting

How clear is the procedure for reporting patient safety incidents in your pharmacy?



- The vast majority (91.4%) of respondents said the reporting procedure was “clear” or “very clear”.
- Whilst the number who recorded the procedure as “vey clear” has remained consistent there has been small drop in the proportion reporting procedures as “clear.”
- The proportion who reported procedure as “unclear” or “very unclear” dropped from 4.6% in 2019 to 3% in 2021.
- In 2021 just over 5% of respondents reported being “neither clear not unclear.” This category choice was added in 2021, and the response “Don’t know” which was included in 2019 and 2016 was removed.

How could clarity be improved?

Easier and simpler reporting systems

"Would like it to be reported on one form only rather than in two places"

"Better and easier IT"

"Less lengthy forms"

"Easier to access"

"Embedded with the pharmacy's PMR, to allow instant reporting."

"Datix is too clunky "

More reliable links to PMRs"

"A way to view reports after submitting"

"Less portals and password securities"

"Very fiddly and annoying"

"Simplify Pharmapod"

"More options to enable us to report a wider variety of incidents that may not fit in to the set choices."

"Less cumbersome"

Improved resource

"Only one computer in the pharmacy"

"Difficult to find opportunities to access computer to report"

Time

"Have more time to complete it and implement actions"

"Less time consuming"

"More time to be proactive"

"Better staffing level so have more time to report"

"Ensuring every one is recorded at the time- not left until later"

Support for locums

"Development of the system to allow access for locum pharmacists to report directly."

Anonymity

"Avoid identifying the person.."

"Remove individual identifying marks."

Sanctions

Use sanctions if reporting is found to be not done."

Stigma

Less stigma or disciplinary action "

Training / guidance

"Train everyone in the team to report promptly"

"Showing each person how to use the system "

"To ensure entire team aware of the procedure, when and how to report"

"train everyone to report promptly"

"By continual training and reminders to repot any errors."

"Continuing education"

Discussion/feedback

"Regular …meetings to review outcome of incidents reported"

"More regular discussion."

"Findings collated and shared so learnings can be made."

"Discuss why the incident(s) occurred."

Everyone's issues

"Some locums will not report when they on duty"

"Everybody's responsibility to record"

"More people involved"

"If the task wasn't left to one member of staff to record"

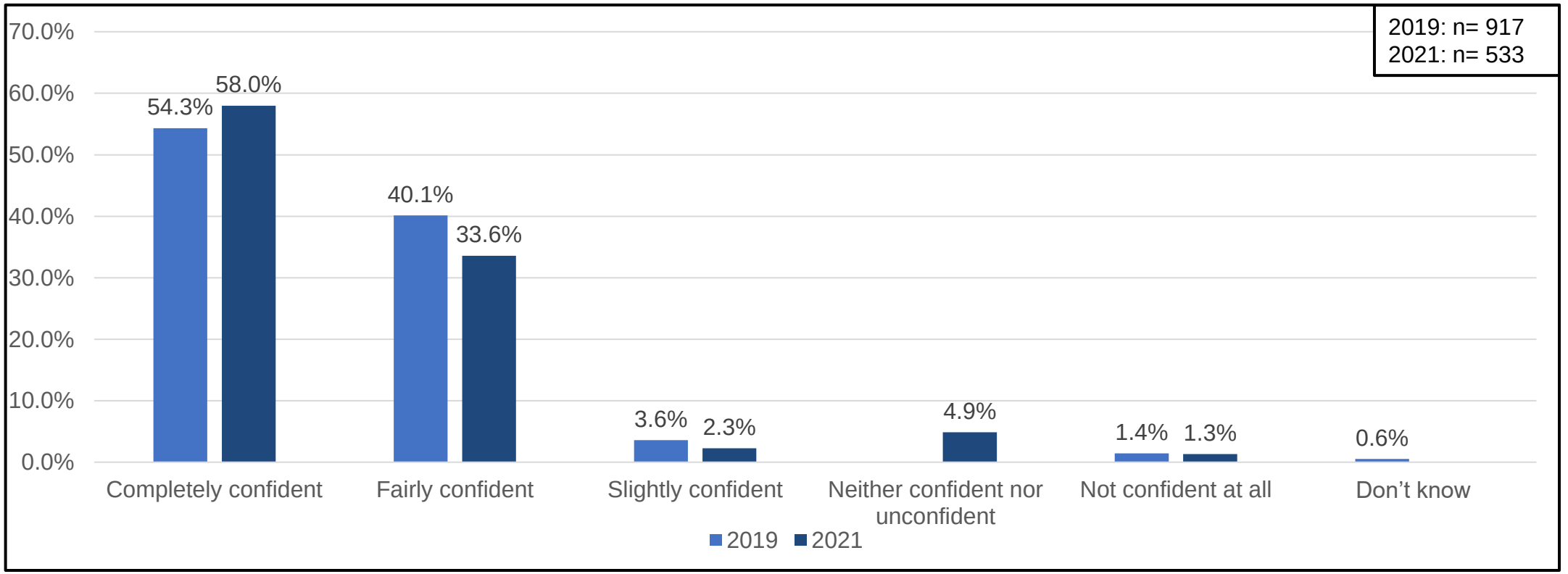
Encourage / remind staff

""Embedding the system as a norm rather than the exception. "

"Reinforce importance"

Confidence in reporting

How confident do you feel that you can follow the incident reporting procedure correctly?



- In 2021 the vast majority (91.6%) of respondents said they felt "fairly confident" or "completely confident" following reporting procedures correctly.
- Whilst the number who were "completely confident" increased from 54% to 58%, the number who said they were "fairly confident" dropped from 40.1% to 33.6%.
- This contributed to an overall drop in confidence from 94.4% in 2019 to 91.56% in 2021.
- In 2021 just under 5% of respondents reported being "neither confident not unconfident." This category choice was added in 2021, and the response "Don't know" which was included in 2019 was removed.

How could your confidence be improved?

Training

"Being told how to do things in the first instance"

"Better communication from HO to make sure, as a relief pharmacist, I stay up to date with any changes in procedures."

"Continual training "

"Emailing a standard best practice as there is lots of conflicting information"

"More examples of how it should be done"

"Getting up to date with requirements"

"Seeing examples of good reporting"

"Thorough discussion"

"More training"

"To do it more often"

"More guidance on how to put together patient safety reports to allow instant reporting."

"Frequent discussions surrounding incidents and the reporting process."

"More practice but I don't really want more practice do I?"

Feedback

"Feedback on report"

"Report back to the team

Decriminalising

"Decriminalisation"

Blame culture

"Simplify and remove the blame culture"

"Really worried about the blame culture surrounding Pharmacy and life in general."

"Try not to blame the other people just try to sort out the problem"

Staff time

"Realistic time capacity at branch"

"Enough staff on the ground to allow tasks other than dispensing and supply of meds alone to be un"

"More staff to allow more time to report correctly"

"In a ideal world I will love to see pharmacies given the golden hour or two for reporting"

"Ensuring every one is recorded at the time- not left until later"

Simpler/clearer tools

"Form not always clear - not enough options"

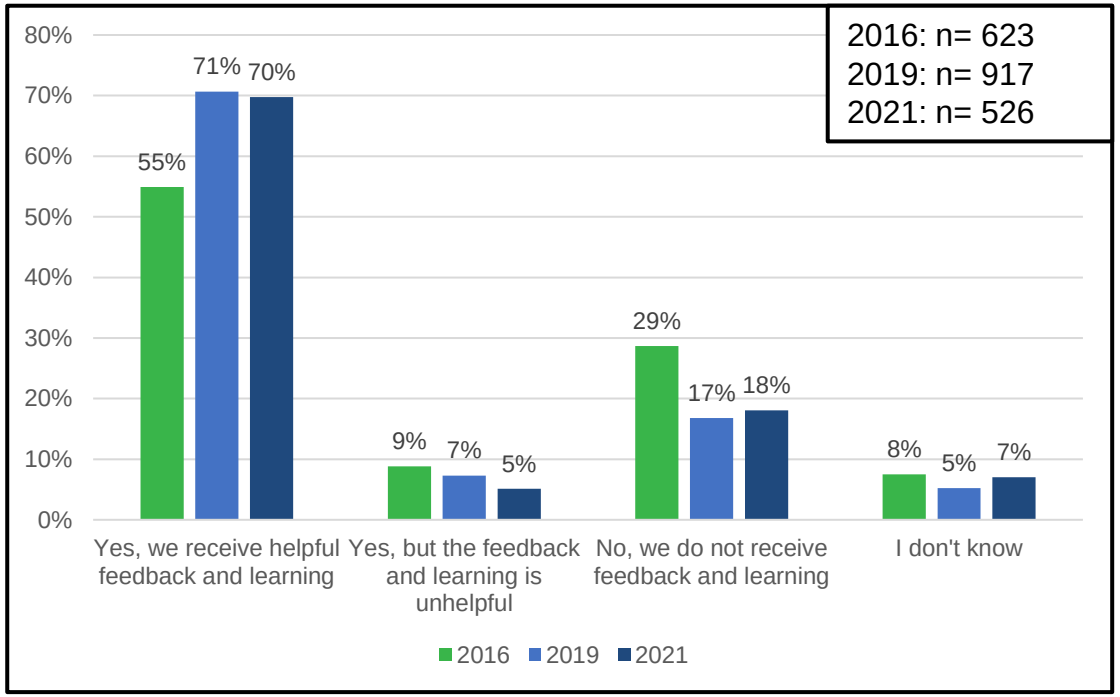
"Making the NRLS reporting data set more in tune with the nature of pharmacy operations."

"Questions need to be clearer."

Feedback

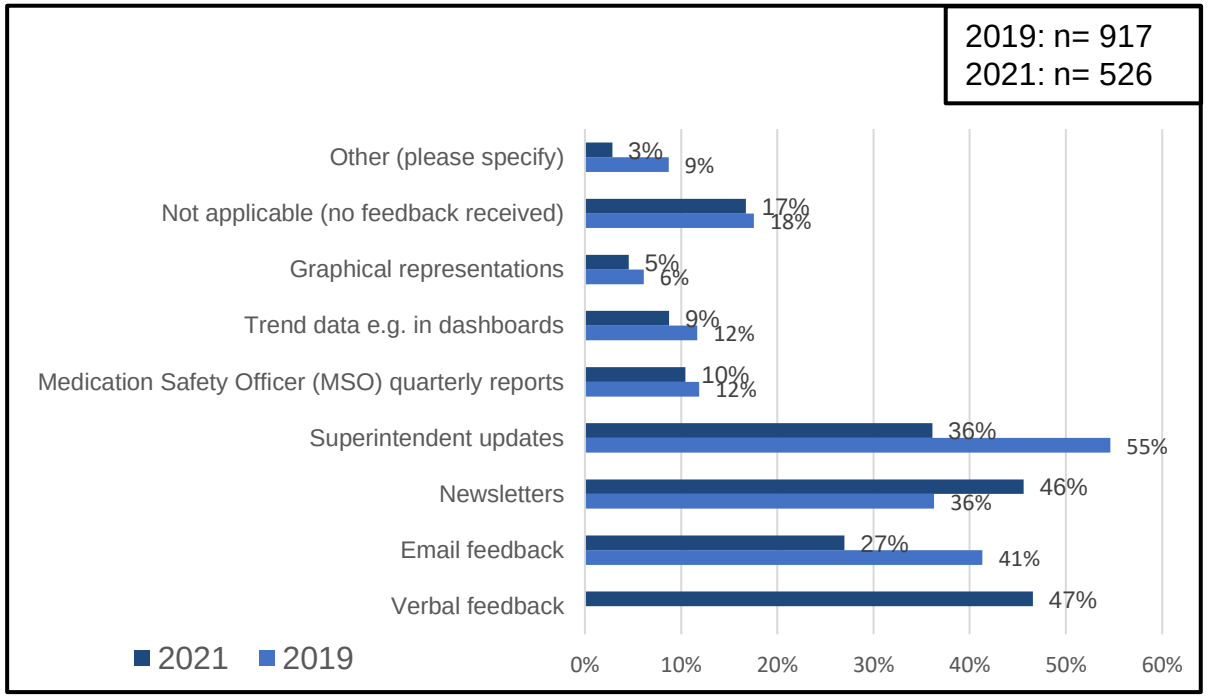
*Respondents could select more than one answer.

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



- Most (70%) respondents said they received helpful feedback as a result of reporting incidents.
- There was a small drop in the number reporting that they receive unhelpful feedback.
- Whilst it has remained static since 2019, almost 1 in 5 report reporting receiving no feedback suggesting there is capacity for improvement.

What type of feedback do you receive?*



- The most common types of feedback received in 2021 was verbal feedback (47%), (which was a new field in 2021), newsletters (48%) and superintendents updates (36%).
- The latter had dropped from 55% in 2019. This may be a result of capacity changes during the pandemic. Anecdotally some superintendents reported reducing the frequency of updates during the pandemic.

Barriers to reporting

What might prevent you from reporting patient safety incidents internally?*

Barriers	2021
Time constraints	42.5%
Fear of disciplinary action by your employer	21.6%
Fear of criminal prosecution	17.5%
Fear of referral to GPhC	17.3%
Fear of reporting on your colleagues / getting someone into trouble	17.3%
Fear of judgement by your colleagues in the pharmacy	15.3%
Lack of an open/supportive pharmacy culture	13.0%
Reporting systems are difficult to use	13.0%
When no harm is caused to patients	11.1%
Lack of experience in using reporting systems	8.9%
Lack of training	8.7%
No feedback is provided when incidents are reported	7.6%
Fear of referral to PSNI	6.2%
Other	2.9%
It isn't my responsibility	1.4%
I don't see the benefit of reporting	1.2%
Nothing would stop me	*41.6%*
Answered question (n)	**485**

- In 2021 the most common barrier to reporting internally was time constraints (42.5%), which was in line with findings from previous years.
- This was followed by fear of disciplinary action (21.6%).
- Over 40% of respondents said that nothing would stop them reporting errors.
- 13% reported that a lack of an open culture was a barrier to reporting.
- In 2021 17.5% reported that concern about criminal prosecution would be a barrier to reporting internally. In 2019 21.7% of respondents reported this as a barrier.

Other

"*People panic they will be in trouble for mistakes.*"

"*Good intentions go out the window when short of trained staff.*"

***Respondents could select more than one answer.

Barriers to reporting

What might prevent you from reporting patient safety incidents externally?*

Barrier	2021
My head office does this on my behalf	49.2%
Time constraints	17.2%
Fear of criminal prosecution	14.3%
Fear of referral to GPhC	13.9%
Lack of experience in using reporting systems	9.4%
Fear of reporting on your colleagues / getting someone into trouble	9.2%
Lack of training	7.8%
Lack of an open/supportive pharmacy culture	7.0%
Fear of referral to PSNI	6.4%
Reporting systems are difficult to use	6.4%
No feedback is provided when incidents are reported	4.3%
It isn't my responsibility	3.3%
The NPA does this on my behalf	2.3%
Other	1.8%
I don't see the benefit of reporting	0.8%
Nothing would stop me	*25.6%*
Answered question (n)	**488**

- In 2021 the most common barrier to reporting externally was the fact that the head office does this on behalf of branches.
- A quarter of respondents said nothing would stop them reporting errors.
- Between 2019 and 2021 fear or concern about criminal prosecution remained static (at 14.3%) as a barrier to reporting externally.

Other

"We don't have any training or sop for this"

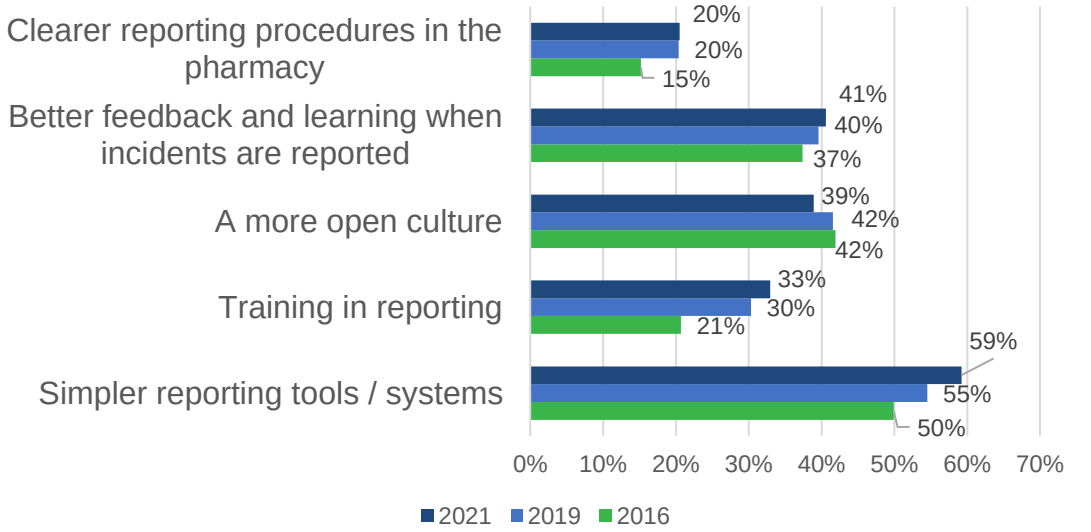
"Employer forbids it"

"We operate a no blame culture - not sure external organisations do"

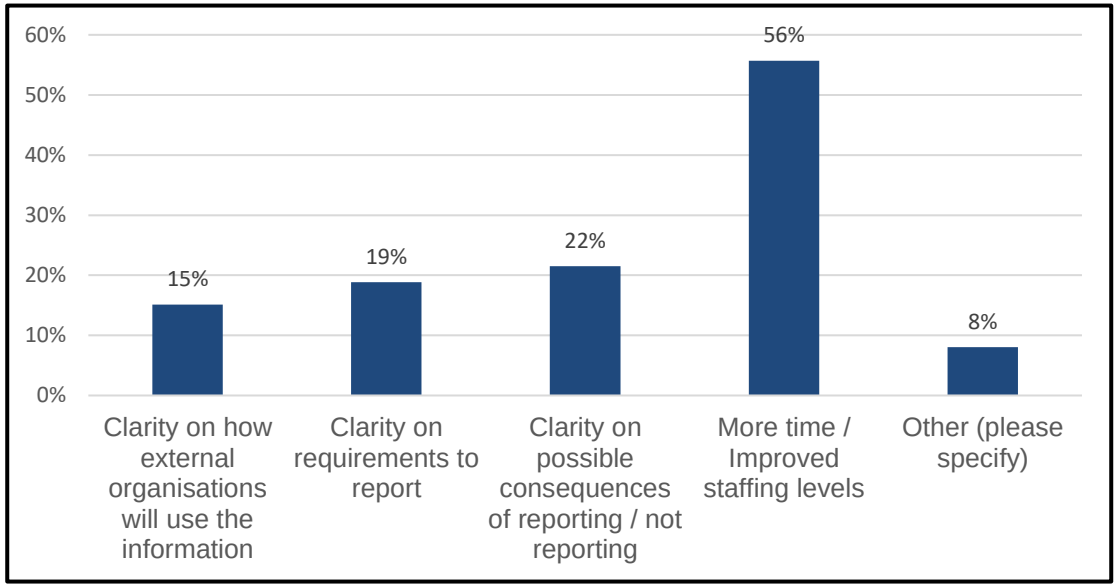
* Respondents could select more than one answer.

Enablers to reporting

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



What might encourage you to report more patient safety incidents?* (Additional parameters in 2021)



- In 2021 the most common enablers to reporting were simpler reporting tools (59%), more time/improved staffing levels (56%) and better feedback (41%).
- A third of respondents said training in reporting would enable more reporting. Since 2016 there was a 60% increase in the number of respondents who reported training in reporting as a factor which might encourage them to report more.

* Respondents could select more than one answer.

Enablers to reporting

Culture

"As in the aviation industry anonymous reporting encourages more reporting and incidents available for all to see

"If we had a no blame culture "

Staff

"They are all reported, however, it is a lengthy process, so extra staffing makes these things easier"

"Improved staffing levels"

Decriminalisation

"Removal of legal prosecution"

"A legal protection from prosecution for reporting incidents."

Understanding of processes

"I can not understand why our company will not allow us to report to NRLS and why they do not report to NRLS."

Feedback

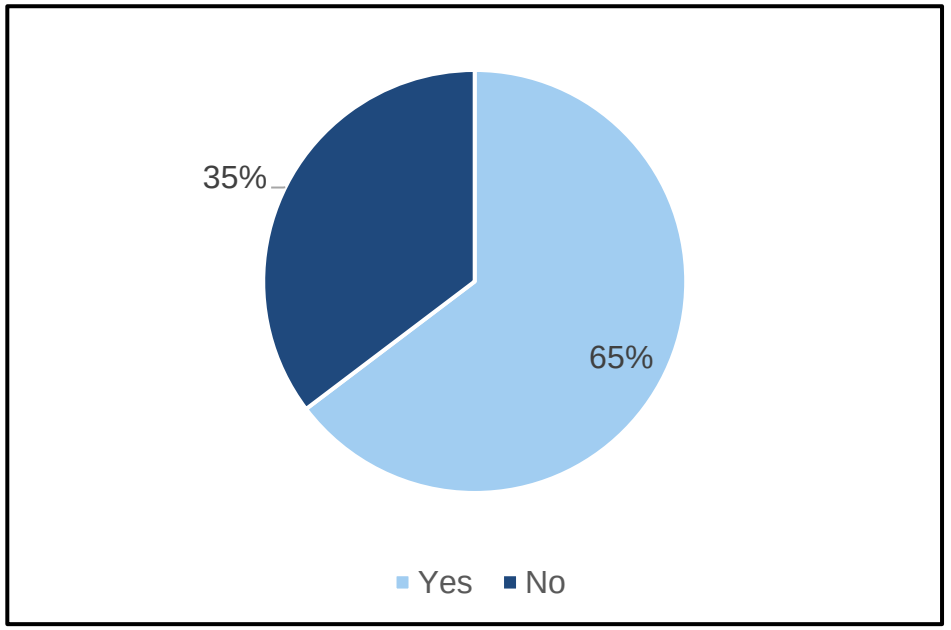
"Gaining feedback from the NHS on incidents reported via the NRLS would be a welcome development."

"Does anything actually happen as a result of reporting?"

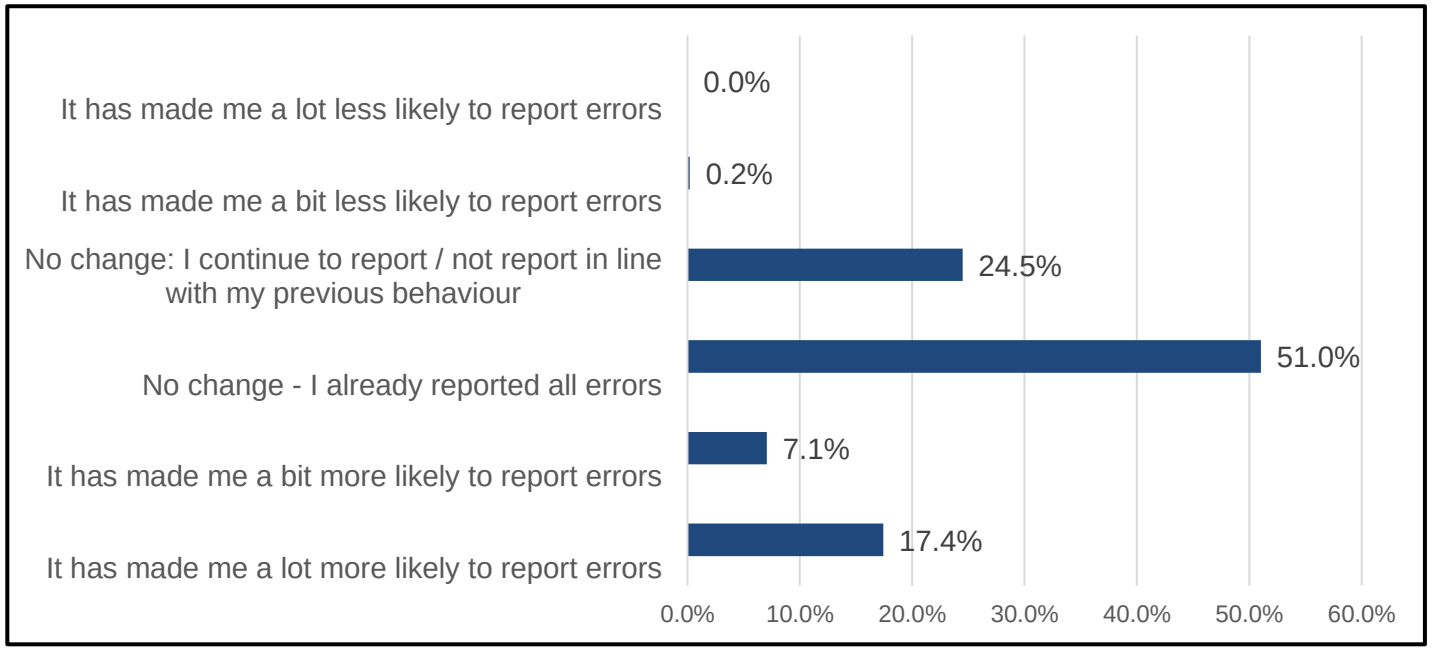
"Better understanding of the statistics: how dispensing errors relate to quantity of near misses and the chances of missing an error. Reporting more may highlight an underlying cause eg lack of trained staff"

Legal defence

Are you aware of the legal changes that 'decriminalised' dispensing errors? (n=490)

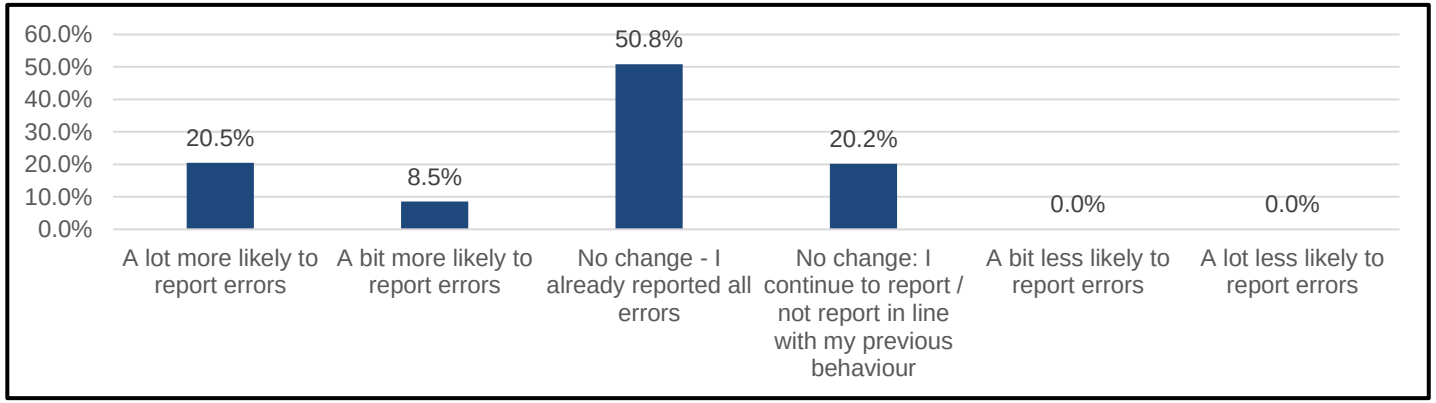


How has it impacted your behaviour, in relation to reporting errors? (n=482)



Impact on behaviour of those who were aware of legal changes (n=317)

Almost 30% of respondents who knew about the change said they are more likely to report errors because of changes.



Conclusion

The findings demonstrate some significant positive improvements since 2016 and 2019 including:

- Increases in the numbers reporting to improve practice and share learnings.
- Drops in the number reporting because they are required to do so.
- Continuing high levels of confidence and clarity in reporting systems.
- A drop in the number reporting fear of criminal prosecution as a barrier to reporting which is around 14% for reporting externally and 17.5% for reporting internally. This compares to 40% In 2016 when the question was not split.
- The legal defence has increased the likelihood of reporting in a quarter of colleagues. However a large proportion (35%) are not aware of changes. To further increase reporting a communication exercise is necessary.

However:

- Time constraints and complex reporting tools were citied as a barrier to reporting.
- A drop in numbers stating that they use Root Cause Analysis in order to investigate errors.
- Over half of respondents were either unfamiliar with the terminology “Just Culture” or didn’t know whether their organisation followed the principles of “Just Culture” .
- 13% reported a lack of an open supportive culture as a barrier to reporting.
- Qualitatively some respondents indicated that their company doesn’t report to NRLS and they are unsure why. Many Head Offices report on behalf of branches. This may need to be made clearer to team members.

Recommendations

Recommendations for national bodies

- The Patient Safety Group is aware of changes to national reporting systems. We recommend national bodies (e.g. NHSE&I) work with community pharmacy groups when developing reporting tools to ensure that they meet the needs of contractors.
- Clear feedback and outputs should be provided by national bodies following the submission of reports to NRLS, Health Improvement Scotland or to the Health and Social Care Board Northern Ireland.

Recommendation for national bodies, contractors and providers

- Improved systems in place to reduce the time required to report incidents.

Recommendations for contractors

- Clear expectations with regards to reporting errors.
- Adoption of a Just Culture.
- Clear training on how to use reporting tools.
- Improved feedback on reporting from contractors.