An introduction to the Community Pharmacy Patient Safety Group

Who we are?

- The Community Pharmacy Patient Safety Group (CP PSG) is a cross sector forum whose members works together to promote patient safety across community pharmacy.

- The group was formed following the 2014 NHS Stage 3 alert recommending all large community pharmacy organisations identify a named Medication Safety Officer (MSO) as a point of contact.

- Its members include MSOs from the largest community pharmacy businesses, as well as the NPA, Numark and AIM to represent independent and small multiple pharmacies.

Guiding principles

REPORT Report all errors and near misses
Involve the whole team

LEARN Identify and investigate causes of errors
Use them as learning opportunities

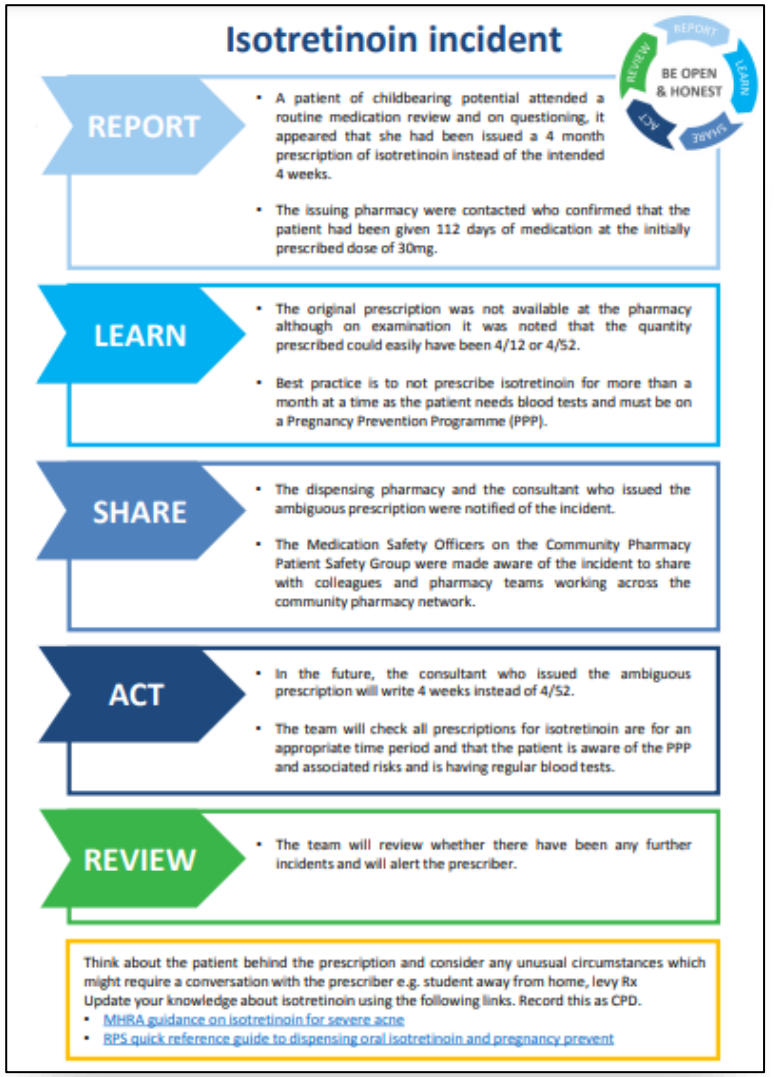
SHARE Discuss with others and promote learning

ACT Make changes to practice

REVIEW Review changes to practice

Collaborative working

- Contacted about an incident where a prescription for Isotretinoin was ambiguous and could have been 4/52 or 4/12.
- The community pharmacy dispensed 4 months instead of 4 weeks.
- The pharmacy involved was notified. Incident was discussed with consultant who agreed to write “4 weeks” on prescriptions.
- The Patient Safety Group developed a resource based on the Report, Share, Learn, Act and Review principles, which was disseminated via membership of the CPPSG and the Trust to raise awareness.
- The resource template was shared with the Trust for use in future incidents.



Community Pharmacy Patient Safety Group: 2020 in Review

A message from our Chair: Janice Perkins

2020 has been a challenging year for everyone - but there is no doubt that community pharmacy has risen to the challenge. It has adapted at every stage to ensure patients continued to receive safe and timely care throughout the pandemic.

As we all responded to the huge workloads and changes to the way we deliver services, it is clear that the group's principles of shared learning have been more important than ever. To allow Medication Safety Officers (MSOs) to share and learn in real time, the group continued to meet virtually and we were pleased to develop a suite of materials to support contractors as they adapted.

The pandemic, however, has not been our only focus and we continued to provide our expert input across a range of topics.

As the dust settles on 2020, and we take stock of what we have learnt, we know that 2021 will bring fresh challenges and we will continue to work with partners to ensure patient safety is embedded at all levels of community pharmacy.

Who we are

The Patient Safety Group is a cross sector group made up of the 17 largest pharmacy businesses as well as the NPA and Numark to represent independent pharmacies. This year we have been pleased to welcome representatives from Pharmacy2U and AIM as observers. The group works together to promote a culture of patient safety across community pharmacy and embed principles of sharing and learning from incidents.

2020 at a glance

We hosted **13** meetings which were attended by MSOs representing **ALL community pharmacies in England.**

We developed a suite of materials to support contractors during the covid pandemic, on subjects including:

- Patient returns
- Medicines delivery
- Safe use of consultation rooms
- Safeguarding
- Private electronic prescriptions

Stakeholder engagement

We reached our stakeholders via coverage in the pharmacy trade press about safeguarding, opioids, adverse drug reactions and more. We also shared our views at webinars organised by the RPS and the RCGP.

We sat on working groups for emollient safety, valproate, red steroid cards, the Pharmacy Integration Fund, medicine compliance aids and more.

We provided expert feedback to **4** consultations

We provided our input into **3** CPPE modules; the Just Culture, LASA & Patient Safety toolkit programmes.

National mechanisms

We engaged with policy makers to further patient safety at a national level.

- The resources we developed with NHS E/I and PSNC were used by contractors from across the sector to support safety components of the 2020 Pharmacy Quality Scheme.
- We engaged MHRA (and will continue to work with them) to ensure drug safety alerts meet the needs of patients and community pharmacy.
- We worked with NHS Digital and the team developing the Patient Safety Incident Management System to provide feedback and ensure the patient and community pharmacy voice is heard.

Our concerns about the use of Nytol Liquid Caramel Flavour in children were heard.

It is now indicated as a sleep aid for adults only.

After many years working to raise awareness of LASA errors, we were delighted that our LASA resources were published on the WHO Good Practice Repository.

To support pharmacy teams to learn from errors and embed principles of sharing and learning, we discussed numerous incidents.

We added **3** resources relating to the transfer of medicines, methadone hand out errors and clozapine, to our share and learn hub.

Managing patient returned medicines

The acceptance of unwanted, out of date, or waste medicines for disposal from patients and household by community pharmacies is an essential service.

This service has not been suspended during the current coronavirus (COVID-19) pandemic.

Avoiding hand out errors during the COVID-19 pandemic

Pharmacy teams must take action to reduce the spread of coronavirus. This includes:

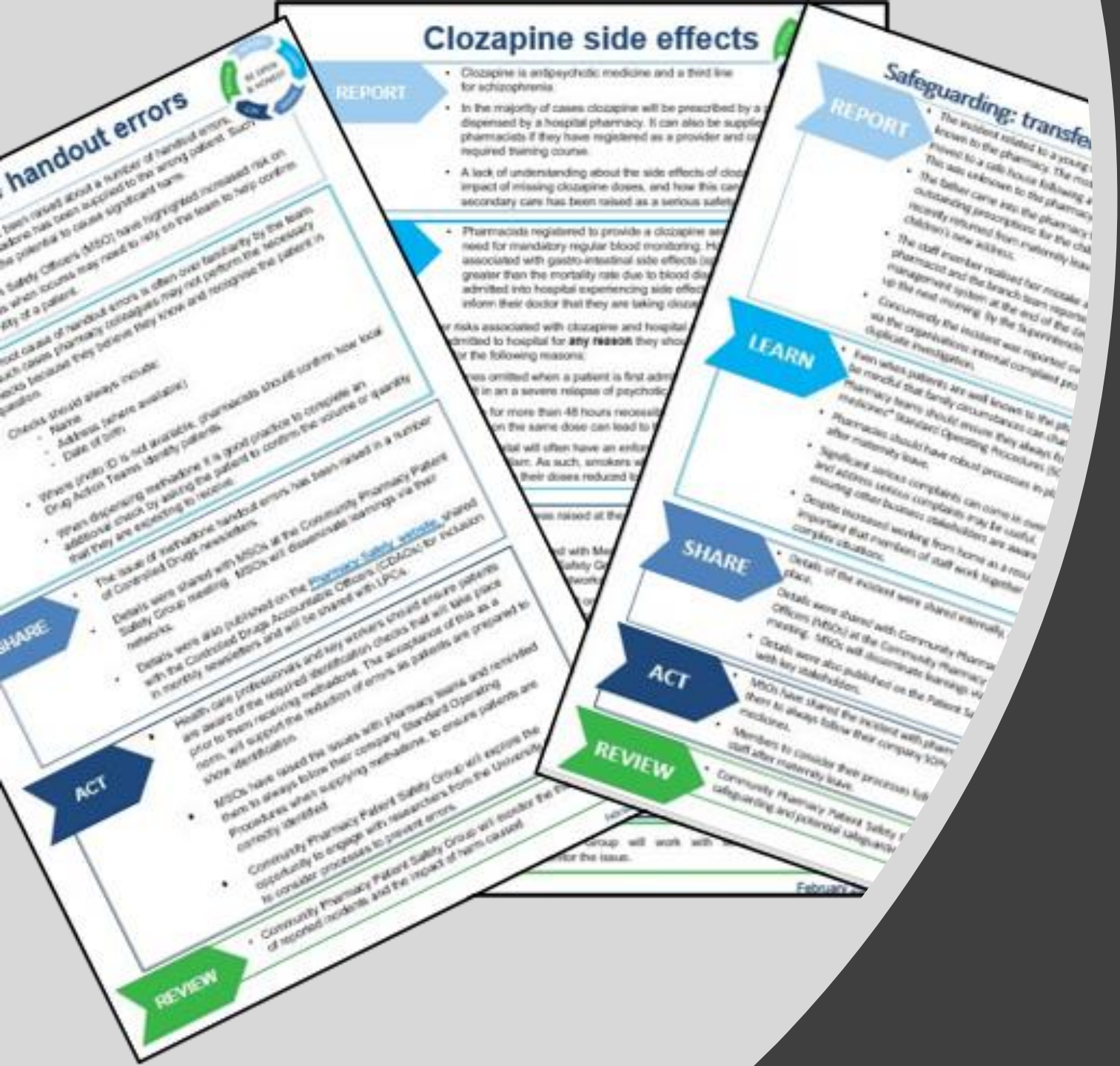
- Maintaining social distancing of two metres, except when providing clinical care and wearing Personal Protective Equipment (PPE).
- Practising good hand and respiratory hygiene.
- Wearing appropriate PPE at all times. Type 11R face masks should be worn to reduce the spread of coronavirus.

Medication delivery and prescription collection: COVID-19

Safeguarding patients: guidance during the COVID-19 pandemic

Safe use of consultation rooms: COVID-19

Covid resources & guidance



Share and learns

Community Pharmacy Patient Safety Group Priorities 2022

Embed

In 2022 we will work to embed patient safety at all levels, including within education, training and service design and delivery

Respond

In 2022 we will respond proactively and reactively as issues arise. Our areas of focus will include resilience, medication errors, medication safety in pregnancy, health inequalities and controlled drugs and opioids.

Influence

We will work with policy makers including NHS England, Welsh Government, NHS Digital and MHRA to inform programmes related to the Pharmacy Quality Scheme, incident reporting and the patient safety strategy.

National Mechanisms

Support	Work with NHS E/I and PSNC to support safety components of the Pharmacy Quality Scheme.
Engage	Engage MHRA to ensure drug safety alerts meet the needs of patients and community pharmacy.
Work	Work with NHS Digital and the team developing the Patient Safety Incident Management System to provide feedback and ensure the patient and community pharmacy voice is heard.

What next ?

- COVID-19 pandemic and Long Covid
- Duty of candour
- Controlled drugs and opioid stewardship
- Medication errors and the impact of technology
- Medication safety in pregnancy
- Resilience & wellbeing
- Safeguarding
- LASA medicines

Get in touch

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https://pharmacysafety.org/