Community Pharmacy Patient Safety Group

Resource pack for pharmacy students

An Introduction from our Chair: Victoria Steele

Victoria is the Superintendent Pharmacist of LloydsPharmacy. She is a founding member of the Community Pharmacy Patient Safety Group, and recently took over from Janice Perkins as chair of the group.

The Community Pharmacy Patient Safety Group is guided by the principles of sharing and learning to drive improvements in patient safety. As a group we work together to make community pharmacy as safe as it can be. We believe an open and honest environment which enables colleagues to report when things go wrong is essential in supporting this.

As Chair of the Group, I am delighted to be able to share this resource pack with you. There is no better to time to embed the key patient safety principles which underpin all aspects of community pharmacy, than during your study to become a pharmacist; and we hope you find this pack useful.

Who we are?

We are made up of the Medication Safety Officers (MSOs) from community pharmacies. Our members represent almost all community pharmacies in the country.

Our history

We formed in 2015 following a Stage 3 Patient Safety Alert which directed all large community pharmacy organisations to identify a named Medication Safety Officer (MSO) to review medication incidents and oversee safety improvements. We chose to go further than this, we now meet on a monthly basis to share and learn from each other.

What we do

We bring together MSOs to discuss patient safety incidents and drive improvements in patient care. We facilitate discussions between colleagues and produce resources to support teams in promoting patient safety . We also work with policy makers like NHS England/Improvement, NHS Digital and the MHRA to influence the development of national safety mechanisms and systems.

Our principles

We are guided by the principles of the WHO's Global Patient Safety Challenge - to reduce avoidable harm caused by medication. To do this we believe an open and honest safety culture is absolutely vital. It requires everyone to feel confident in sharing when things go wrong. Without this, pharmacy teams are unable to learn from mistakes and prevent them occurring again.

Our priorities

As well as discussing incidents, we monitor, investigate and respond to incidents which affect patient safety. Our current priorities are:

- COVID-19 pandemic
- Medication errors and medication safety in pregnancy
- Resilience & wellbeing
- LASA medicines
- Controlled drugs and opioid stewardship
- Safeguarding

We work to ensure the principle of sharing and learning are embedded at all levels from education to employment, Continued Professional Development and training to service design and delivery. An infographic of our priorities can be viewed here.

What does this pack include?

This pack provides an introduction to the work of the Community Pharmacy Patient Safety Group. As well as information about who we are and what we do, it includes:

- Information about the principles of reporting and learning from incidents
- Real world examples of Sharing and Learning
- Look-alike-sound-alike medicine posters
- Tips on managing your wellbeing in the pharmacy

We have many more resources on website here.

Reporting incidents and sharing and learning

We all make mistakes, it is part of being human. But it is extremely important how we deal with errors and what we learn from them.

Pharmacy colleagues must be open and honest when things go wrong. This is not about blame but about understanding “what happened and what can we learn”.

As well as reporting errors internally, pharmacists must also report patient safety incidents to the appropriate national or local reporting tool. The Patient Safety Group has produced a diagram to show what happens when a incident is reported. It can be viewed here.

Action should also be taken to investigate and learn from incidents and share these learnings to prevent them happening again.

The Patent Safety Group is guided by the principles of sharing and learning. To support this we have developed a core set of principles about incident reporting which we believe can and should be embedded in all health care settings.

In the following pages we have shared examples of real world incidents and how the Report, Share, Learn, Act, Review or RSLAR principles can be applied.

When you experience an incident we encourage you to use the RSLAR template, to reflect on your own learnings. It can be accessed here.

Safe delivery of medicine: monitored dosage systems

The Patient Safety Group has developed guidance on the safe delivery of medication in a variety of situations. It is available here.

REPORT

- An incident was raised in which a Monitored Dosage System (MDS) was dispensed by a community pharmacy. It was delivered to the home of a vulnerable patient and posted through their letterbox.
- The pharmacy had previously been advised that all medication should be handed directly to the patient's husband.
- The vulnerable patient subsequently took all the medication in the MDS and required treatment in A&E.

LEARN

- Although discussion amongst Medication Safety Officers showed many community pharmacy organisations have policies in place which do not allow deliveries to be posted through letterboxes, this incident shows this is not always the case or the instruction is not always followed. If this is allowed it should be documented in the SOP, consent must be sought from the patient, a risk assessment completed and the indemnity provider notified.
- This incident raises concerns about the safe delivery of medication, which are particularly pertinent as drivers adhere to social distancing guidance and "doorstep" deliveries.
- It also highlights the importance of effective communication between prescribers, pharmacists and patients/carers. Any risk should be taken into account when agreeing the suitability of providing an MDS and delivery arrangements. These should be documented.
- The Responsible Pharmacist (RP) must consider how this information is subsequently communicated with the delivery driver. The RP should be aware that any safety interventions which rely on human intervention (e.g. remembering to phone a patient representative) comes with inherent risk.

SHARE

- Details were shared with Medication Safety Officers at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were published on the Pharmacy Safety website, and shared with stakeholders.
- A resource was made available and shared back to the locality who raised the issue.

ACT

- Pharmacies should have robust processes and guidance in place for the home delivery of all medications, including for those in an MDS.
- Where a patient cannot take receipt of their medication, a solution should be determined between the community pharmacist, the GP and the patient representative.
- When coronavirus guidance changes, this may include the use of a key safe access system (with correct consent, SOPs and support for delivery drivers.)
- Pharmacy teams may wish to consider technical solutions to support delivery drivers, this may include:
  - Addition of instructions to bag label (this could be set up via the PMR), which are highlighted to the delivery driver when handed over for delivery.
  - Utilisation of technology (e.g. handheld terminals or software) which allow for personalisation of delivery details / text reminders to patient or patient representative.

REVIEW

- The Patient Safety Group will review whether there have been any similar incidents within their organisations.

Published May 2021

Safeguarding: transfer of medicines

REPORT

- The incident related to a young family of four who were well known to the pharmacy. The mother and two children had been moved to a safe house following a domestic violence situation. This was unknown to the pharmacy team.
- The father came into the pharmacy to collect his prescription. Seeing outstanding prescriptions for the children, the staff member, who had recently returned from maternity leave, inadvertently revealed the children's new address.
- The staff member realised her mistake and reported it to the pharmacist and the branch team reported the incident via the incident management system at the end of the day. The incident was followed up the next morning by the Superintendent's team.
- Concurrently the incident was reported overnight by a family member via the organisations internal complaint procedures, resulting in a duplicate investigation.

LEARN

- Even when patients are well known to the pharmacy team, they should be mindful that family circumstances can change very quickly. Pharmacy teams should ensure they always follow **"**transfer of medicines**"** Standard Operating Procedures (SOPs)
- Pharmacies should have robust processes in place to reintroduce staff after maternity leave.
- Significant serious complaints can come in overnight. A process to triage and address serious complaints may be useful. This should include ensuring other business stakeholders are aware of internal processes.
- Despite increased working from home as a result of COVID-19, it is important that members of staff work together closely to address complex situations.

SHARE

- Details of the incident were shared internally, and a full review took place.
- Details were shared with Community Pharmacy Medication Safety Officers (MSOs) at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were also published on the Patient Safety website and shared with key stakeholders.

ACT

- MSOs have shared the incident with pharmacy teams and reminded them to always follow their company SOPs when transferring medicines.
- Members to consider their processes following the reintroduction of staff after maternity leave.

REVIEW

- Community Pharmacy Patient Safety Group will continue to monitor safeguarding and potential safeguarding concerns.

Published August 2020

Clozapine side effects

REPORT

- Clozapine is an antipsychotic medicine and a third line treatment for schizophrenia.
- In the majority of cases clozapine will be prescribed by a psychiatrist and dispensed by a hospital pharmacy. It can also be supplied by community pharmacists if they have registered as a provider and completed the required training course.
- A lack of understanding about the side effects of clozapine as well the impact of missing clozapine doses, and how this can manifest in secondary care has been raised as a serious safety concern.

LEARN

- Pharmacists registered to provide a clozapine service are aware of the need for mandatory regular blood monitoring. However, mortality associated with gastro-intestinal side effects (specifically constipation) is greater than the mortality rate due to blood disorders. If a patient is admitted into hospital experiencing side effects of clozapine, they should inform their doctor that they are taking clozapine.
- There are also other risks associated with clozapine and hospital admissions. If a patient taking clozapine is admitted to hospital for **any reason** they should inform their doctor that they are taking clozapine for the following reasons:
  - Doses are sometimes omitted when a patient is first admitted. Sudden discontinuation of clozapine may result in an a severe relapse of psychotic symptoms.
  - Omission of clozapine for more than 48 hours necessitates re-titration of the dose. Starting a patient back on the same dose can lead to harm.
  - Patients admitted to hospital will often have an enforced break from smoking. Smoking induces clozapine metabolism. As such, smokers who are admitted to hospital whilst taking clozapine must have their doses reduced to prevent toxicity if they stop smoking.

SHARE

- These issues was raised at the Northern Ireland Medicine Safety Conference.
- Details were shared with Medication Safety Officers (MSOs) at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were published on the Pharmacy Safety website, and shared with key stakeholders, including LPCs.

ACT

- Pharmacists providing a clozapine service should discuss smoking status with these patients and highlight the risk.
- Pharmacy teams have been reminded to advise patients and their carers to inform clinicians that they are taking clozapine if they are admitted to hospital.
- Health Care Professionals should note smoking status if reporting an incident or ADR involving clozapine to aid future learning & improve care.
- For patients who have been admitted to hospital, the secondary care facility should contact the pharmacy that supplies their clozapine, to ensure they are aware of the admission.

REVIEW

- The Patient Safety Group will work with secondary care colleagues to monitor the issue.

Published February 2020

Methadone handout errors

REPORT

- Concerns have been raised about a number of handout errors, in which methadone has been supplied to the wrong patient. Such errors have the potential to cause significant harm.
- Medication Safety Officers (MSO) have highlighted increased risk on weekends when locums may need to rely on the team to help confirm the identity of a patient.

LEARN

- The root cause of hand-out errors is often over familiarity. In such cases pharmacy colleagues may not perform the necessary checks because they believe they know and recognise the patient in question.
- Checks should always include
  - Name
  - Address (where available)
  - Date of birth
- Where photo ID is not available, pharmacists should check how local clinics identify patients.
- When dispensing methadone it is good practice to complete an additional check by asking the patient to confirm the volume or quantity that they are expecting to receive.

SHARE

- The issue of methadone handout errors has been raised in a number of Controlled Drugs newsletters.
- Details were shared with MSOs at the Community Pharmacy Patient Safety Group meeting. MSOs will disseminate learnings via their networks.
- Details were also published on the Pharmacy Safety website, shared with the Controlled Drugs Accountable Officers (CDAOs) for inclusion in monthly newsletters and will be shared with LPCs.

ACT

- Health care professionals and key workers should ensure patients are aware of the required identification checks that will take place prior to them receiving methadone. The acceptance of this as a norm, will support the reduction of errors as patients are prepared to show identification.
- MSOs have raised the issues with pharmacy teams and reminded them to always follow their company Standard Operating Procedures when supplying methadone, to ensure patients are correctly identified.
- The Community Pharmacy Patient Safety Group will explore the opportunity to engage with researchers from the University of Bath, to consider processes to prevent errors.

REVIEW

- The Community Pharmacy Patient Safety Group to continue to monitor the issue and the impact of harm caused.

Published February 2020

Isotretinoin incident

REPORT

- A patient of childbearing potential attended a routine medication review and on questioning, it appeared that she had been issued a 4 month prescription of isotretinoin instead of the intended 4 weeks.
- The issuing pharmacy were contacted who confirmed that the patient had been given 112 days of medication at the initially prescribed dose of 30mg.

LEARN

- The original prescription was not available at the pharmacy. On examination it was noted that the quantity prescribed could easily have been 4/12 or 4/52.
- Best practice is to not prescribe isotretinoin for more than a month at a time as the patient needs blood tests and must be on a Pregnancy Prevention Programme (PPP).

SHARE

- The dispensing pharmacy and the consultant who issued the ambiguous prescription were notified of the incident.
- The Medication Safety Officers on the Community Pharmacy Patient Safety Group were made aware of the incident to share with colleagues and pharmacy teams working across the community pharmacy network.

ACT

- In future, the consultant who issued the ambiguous prescription will write 4 weeks instead of 4/52.
- The team will check all prescriptions for isotretinoin are for an appropriate time period and that the patient is aware of the PPP and associated risks, and is having regular blood tests.

REVIEW

- The team will review whether there have been any further incidents and will alert the prescriber.

Think about the patient behind the prescription and consider any unusual circumstances which might require a conversation with the prescriber e.g. student away from home, levy Rx.
Update your knowledge about isotretinoin using the following links. Record this as CPD.

- MHRA guidance on isotretinoin for severe acne
- RPS quick reference guide to dispensing oral isotretinoin and pregnancy prevent

Published September 2019

Look-alike-sound-alike (LASA) errors

It deosn't mttaer in waht oredr the ltteers in a wrod are. Tihs is bcuseae the huamn mnid deos not raed ervry lteter by istlef, but the wrod as a wlohe

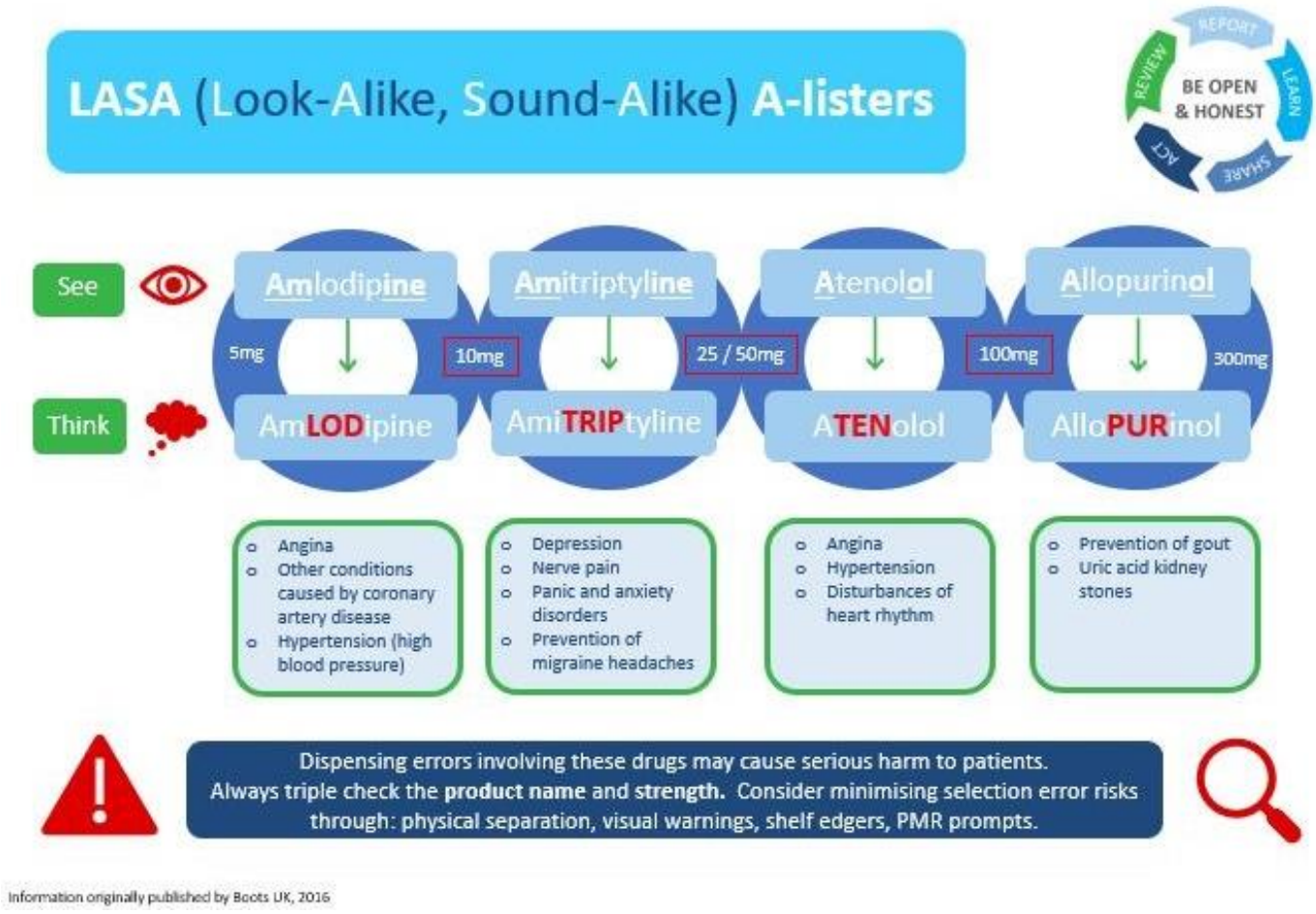
The reduction of errors involving Look-Alike Sound-Alike (LASA) medicine is a key focus of the Community Pharmacy Patient Safety Group's work and LASA errors often feature in the 'Share and Learn' discussions at our meetings.

MSOs have and shared numerous different risk minimisation measures to reduce the likelihood of LASA errors occurring this includes. This includes:

- physical separation
- visual warnings
- robots
- revisiting checking procedures
- moving one of the LASA pair into a 'high risk' medicines area in the dispensary, others move one of the LASA pair down to 'Z'.

In the following few pages we have shared a series of posters on common LASA errors. These were developed to support pharmacy teams in their safety huddle discussions around LASA errors.

They were inspired and informed by the Boots UK 'Drug of the Month' posters.



Information originally published by Boots UK, 2016

LASA

Atenolol + Allopurinol

Amlodipine + Amitriptyline

Carbamazepine is used to treat **epilepsy**, trigeminal neuralgia & bipolar disorder.
Side effects: nausea, vomiting, dizziness & allergic skin reactions.
In adults, carbamazepine is usually started at **100mg/300mg** daily and the **dose is increased** until seizures stop or side effects occur.
In adults, the average daily dose is 800-1200mg, but some people may need daily doses of 2000mg.

Carbimazole is used to treat an overactive thyroid gland (**hyperthyroidism**).

Side effects: headaches, sickness & joint pain.
The initial dose is **15-40mg** for adults and is usually **750mcg/kg** for children under 11 and 30mg for 12-17 year olds.
Once control is achieved, the **dose is reduced**.

Think about the person behind the prescription

Carbamazepine is broken down faster in **children**, so young children may require a larger dose than adults
Carbamazepine can make hormonal methods of birth control less effective, increasing **risk of pregnancy**
Carbamazepine can cause dizziness or blurry vision in **older people**, increasing the risk of falls

Carbamazepine and Carbimazole can cause **harm** to a developing foetus
Carbimazole can **affect other medicines** such as some anticoagulants, steroids, antibiotics & beta-blockers

Take extra care when selecting look-alike, sound-alike (**LASA**) medicines, especially when stored in close proximity

Think carbamaz**EPINE** & carbimaz**OLE**

Check the dose: carbamazepine is prescribed at a **much higher dose** compared to carbimazole.
To control seizures, the dose of carbamazepine is **gradually increased**, whereas carbimazole is taken at a **gradually reduced** dose once the hyperthyroidism is under control.

LASA
Carbamazepine + Carbimazole

proPRANololL

Heart conditions & relief of situational anxiety

prEDNISoloNE

Reduces inflammation in asthma & rheumatism

Dispensing propranolol

- **Contra-indicated** for patients with some conditions (e.g. **asthma**)
- Taken **regularly** and continuously for cardiovascular conditions
- Taken **occasionally** for anxiety & migraine relief

Dispensing prednisolone

- Doses **vary** depending on the condition (between 5mg and 60mg daily)
- Ensure dispensing labels have **clear directions**
- Provide **counselling** & additional material
- Give **'Steroid Card'** for regular treatments

Check for potential drug interactions

Check the strength & formulation

- If **propranolol** tablets are supplied in error, consequences include **bronchospasm** and a **fall in blood pressure** which can cause **fainting, coma** or even **death.**
- Rapid **withdrawal of high dose prednisolone** can be **dangerous.**
- Dispensing **prednisolone** in error can cause many unpleasant side effects.

Information originally published by Boots UK, 2016

LASA

Propranolol + Prednisolone

Rosuvastatin & Rivaroxaban

A build up of cholesterol causes a partial blockage of blood vessels so that blood flow is reduced.

Rosuvastatin is used to **reduce high cholesterol.**

Rosuvastatin helps to reduce the risk of having a heart attack, a stroke, or related health problems.

Blood needs to be at the right viscosity to flow steadily through the body. Blood clots formed too readily may cause blockages. Blockages could occur in the veins of the legs, in the lungs or in the brain, where they might cause a stroke.

Rivaroxaban is an **anticoagulant** used to **prevent blood clots** and doses should not be missed.

Rivaroxaban is used at **various doses** for different conditions and it could cause bleeding if the dose is too high or if too much is taken.

Take extra care when selecting look-alike, sound-alike (**LASA**) medicines with similar names, especially when stored in close proximity.

Consider minimising selection error risks through:
physical separation, vision warnings, shelf stickers and PMR prompts.

Information originally published by Boots UK, 2018

LASA
Rosuvastatin +
Rivaroxaban

Pregabalin and Gabapentin

Pregabalin and Gabapentin are used to treat epilepsy. They are also often considered first-line treatment for nerve pain. Pregabalin is also licensed to treat generalised anxiety disorder. Both medicines became **Schedule 3 Controlled Drugs in** April 2019.

Dispensing Pregabalin

In adults pregabalin is usually started at 50 mg -150 mg a day, in 2 or 3 doses.

This may be increased to a **maximum of 600 mg a day.**

Dispensing Gabapentin

In adults the usual starting dose of gabapentin is 300 mg once a day on **day 1,** 300 mg twice a day on **day 2** and 300 mg three times a day on **day 3**.

The **maximum dose is 3600 mg a day** although doses of up to 4800 mg a day have been tolerated in long-term studies.

Interactions and side effects

Using pregabalin and gabapentin with some other substances including alcohol may increase certain side effects including drowsiness, dizziness, light-headedness, confusion & depression. Other side effects can include change in mood and confusion.

Dispensing errors involving *pregabalin and gabapentin* can cause serious harm to patients

Always triple check the name, strength and quantity before dispensing

- Doses which are too **low** can result in pain, increased frequency and severity of seizures or unmanaged anxiety.
- Doses which are too **high** can cause many unpleasant side effects. In addition to those highlighted above, this can include loss of consciousness and coma.
- Pregabalin has a higher potency than gabapentin. This means it is more dangerous than gabapentin in higher doses.
- Mistakenly taking pregabalin instead of gabapentin (or vice versa) can increase and exacerbate side effects.

December 2019

LASA
Gabapentin + Pregabalin

Tips for self-managing wellbeing in the pharmacy during the COVID pandemic

Learning what to do if you feel stressed at work is important for your health and wellbeing. This is particularly important as the COVID pandemic wares on. These tips are designed to give you some ideas about what to do if you or a team member is feeling under pressure.

Further wellbeing information and support is available on the Pharmacist Support website including via the Wellbeing Hub and from NHS E/I.

Talk to each other

Talking to colleagues about reasons for your stress may reveal that they are having similar difficulties. This gives you the opportunity to share ideas about how to manage stress.

Talk to your Line Manager

Research shows that your relationship with your Line Manager is the most important relationship you will have at work. If you are finding things stressful, talking to your Line Manager is a good first step. It is often useful to make a written note of your conversation too. If you don't want to speak to your manager speak to another senior colleague.

Take a break

No one does their best work when they're tired or hungry. Pay attention to your wellbeing and make sure you always take a break and encourage team members to take theirs too.

Use your holiday

Having time off from work is essential for your wellbeing. While we know this has been difficult during the pandemic, it is important to use your annual leave to switch off from work and avoid burn out – even if that just means relaxing at home.

Think about working hours

Don't regularly work extra hours that no one knows about. This may hide problems occurring in your pharmacy and won't help solve any underlying issues. While staying in contact with colleagues outside work can be convenient, it is important to respect other people's time away from work.

Work together

Team work is essential for a happy and productive pharmacy. Regular huddles throughout the day can help make sure that everyone is on track and is a helpful way for colleagues to voice any concerns they may have.

Speak kindly to your colleagues

Research shows that civility or politeness at work is crucial, not only for you and your team's wellbeing but also because it reduces patient safety errors. Even if you're feeling stressed, always speak politely to your colleagues and expect the same back from them.

Try not to take things personally

If people make complaints it can be distressing. Make sure you support your colleagues and don't take things personally as this can impact care and safety. Remember many customers and patients may be feeling overwhelmed and stressed too, which may result in more issues being raised. However, it is unacceptable for patients or customers to be abusive or violent. If any incidents do occur make sure you report them in line with your company policy.

One job at a time

Dispensaries can be noisy, busy environments with many distractions. That's why it's important to stay focused on the task in hand. Ensure your team know when it is or is not OK to disturb you.

You're doing great

It's an extremely challenging time for all healthcare professionals. Remember challenges are not a reflection on your own performance but of the circumstances. **Keep going, you're doing a great job!**