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Patient Safety in Community Pharmacy

Safety Culture Survey Findings

Overview

- Anonymous survey available to all community pharmacy staff
- Launched following Pharmacy Voice Patient Safety Forum in 2015
- Sought to understand what patient safety culture and practice looks like across the community pharmacy sector from the perspective of frontline teams
- Sought to gather views on current patient safety incident report and learning processes

Summary Findings

- Survey ran from January – April 2016
- Responses submitted from large, medium and small chains and independents
- Approximately 4 in 5 respondents were pharmacists
- Around 3 in 5 respondents felt the whole pharmacy team were responsible for reporting patient safety incidents
- 96.95% of respondents felt that their patient safety incident reporting processes were clear or very clear
- 9 in 10 respondents report patient safety incidents to improve practice in their pharmacy
- Around 65% of respondents undertake root cause analysis for every patient safety incident that occurs in the pharmacy

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Summary Findings (continued)

- 1 in 3 respondents submits incident reports for prescribing errors
- Around 65% of respondents undertake root cause analysis for every patient safety incident that occurs in their pharmacy
- At least 9 in 10 pharmacies record near misses and discuss these as a team
- Time constraints were highlighted as the most significant barrier to reporting incidents, closely followed by a fear of criminal prosecution

- Worryingly, nearly 3 in 10 respondents said they received no feedback and learning from reporting patient safety incidents
- Nearly half of all respondents felt that simpler reporting tools / systems would encourage more reporting

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Responses by Question

What size of community pharmacy do you work in?

Of those who selected 'Other'

- **12** were locum pharmacists
- **1** was a distance-selling pharmacy

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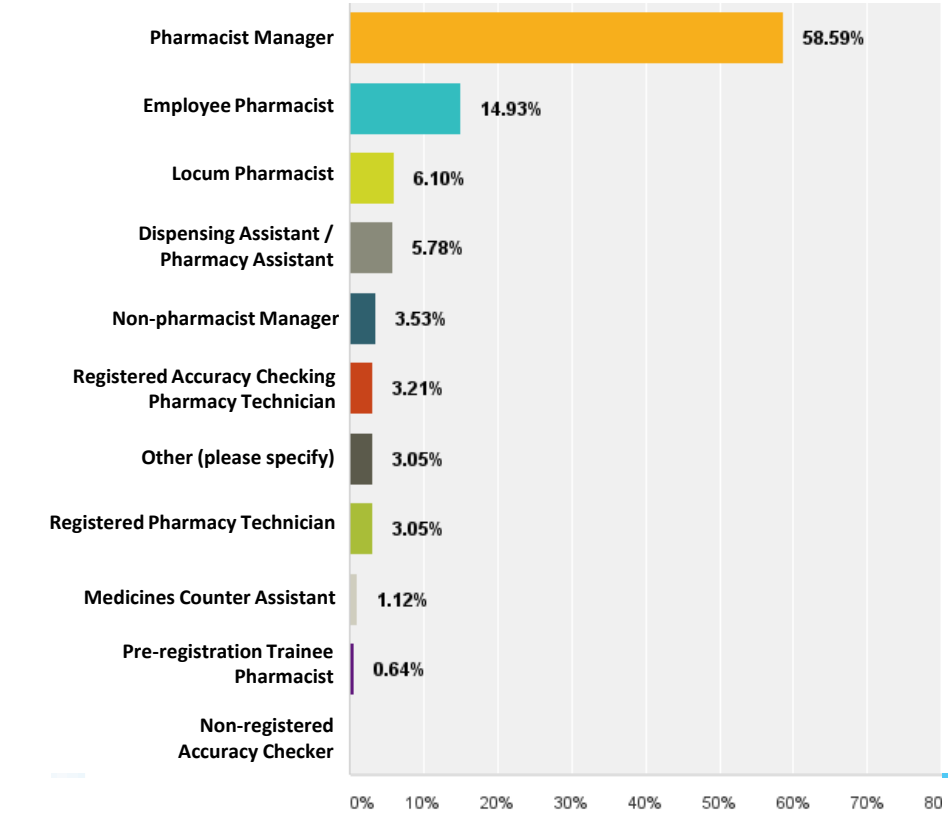
What is your role in the pharmacy team?



Of those who selected 'Other'

- 9 were Pharmacy Superintendents or worked in the Superintendents' team
- 7 were area/regional managers,
- 2 were pharmacy owners
- 1 was a student

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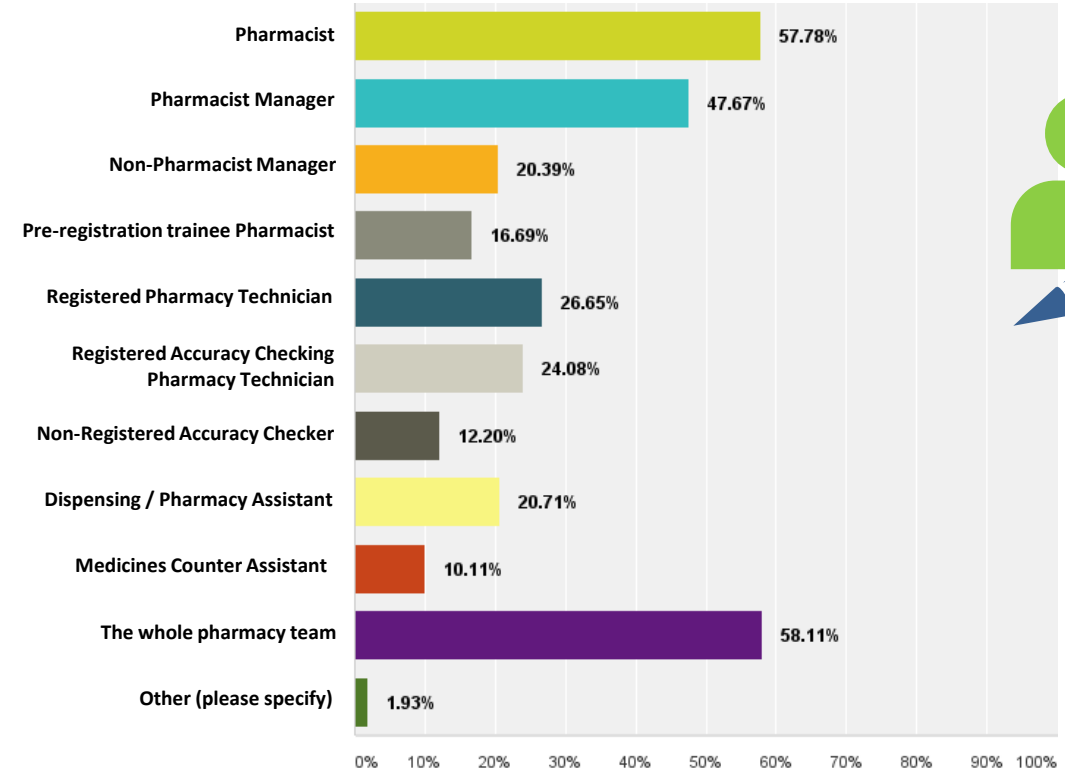
Who do you think is responsible for reporting patient safety incidents that occur in your pharmacy? (please select all that apply)



Of those who selected 'Other' Comments were raised on responsibility for 'internal' versus 'external' reporting

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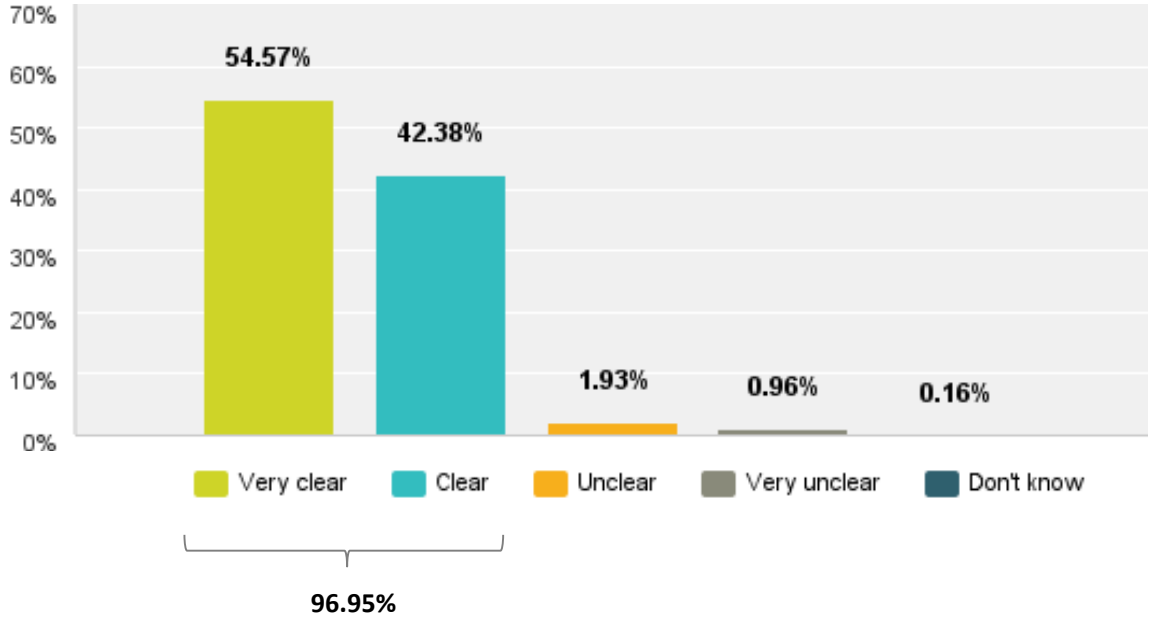
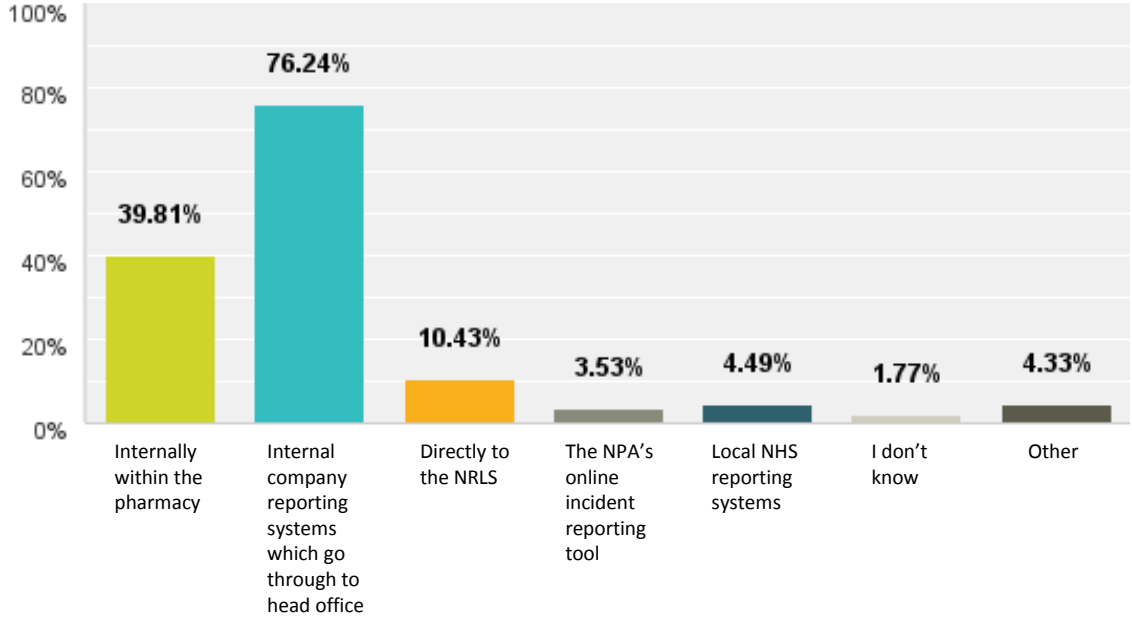
How clear is the procedure for reporting patient safety incidents in your pharmacy?



Where are patient safety incidents that occur in your pharmacy reported?
(please select all that apply)



Of those who selected 'Other'

- 11 reported to Datix, 4 reported to Pharmapod and others reported to other colleagues / organisations including the CQC, Area Teams, GPs and hospital trusts

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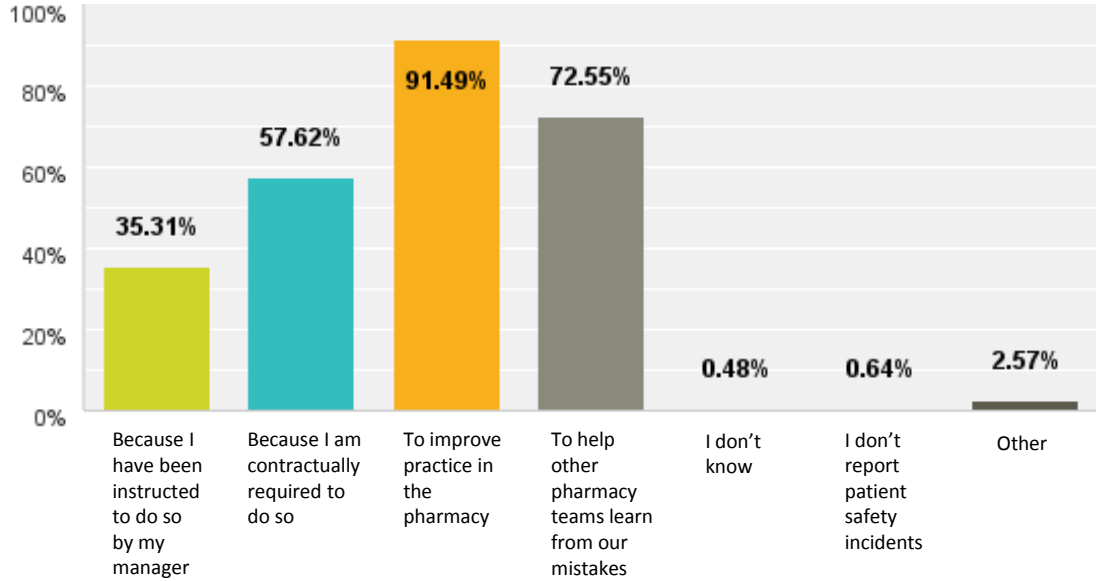
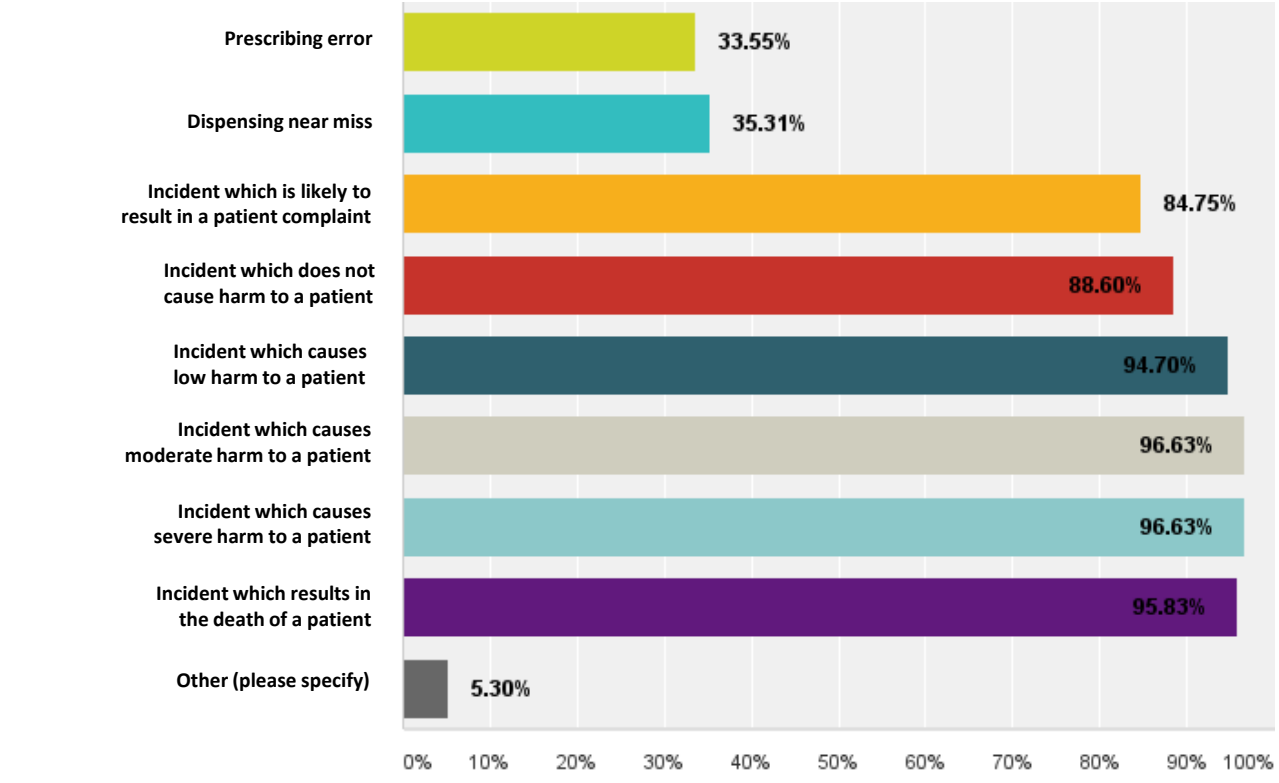
Why do you report patient safety incidents in your pharmacy?
(please select all that apply)



Of those who selected 'Other'

- Responses included to protect themselves and their team in the event of legal action, to recognise patterns, to contribute to a national picture on errors, to provide a clear record of events, to prevent reoccurrences, to record what follow-up action has been taken and to maintain confidence of associated healthcare professionals

According to the procedure in your pharmacy, **which of the following** would you submit an incident report for? (please select all that apply)



Of those who selected 'Other'

- Responses included 'all of the above', any error that leaves the pharmacy / reaches the patient, any error that someone else may be able to learn from

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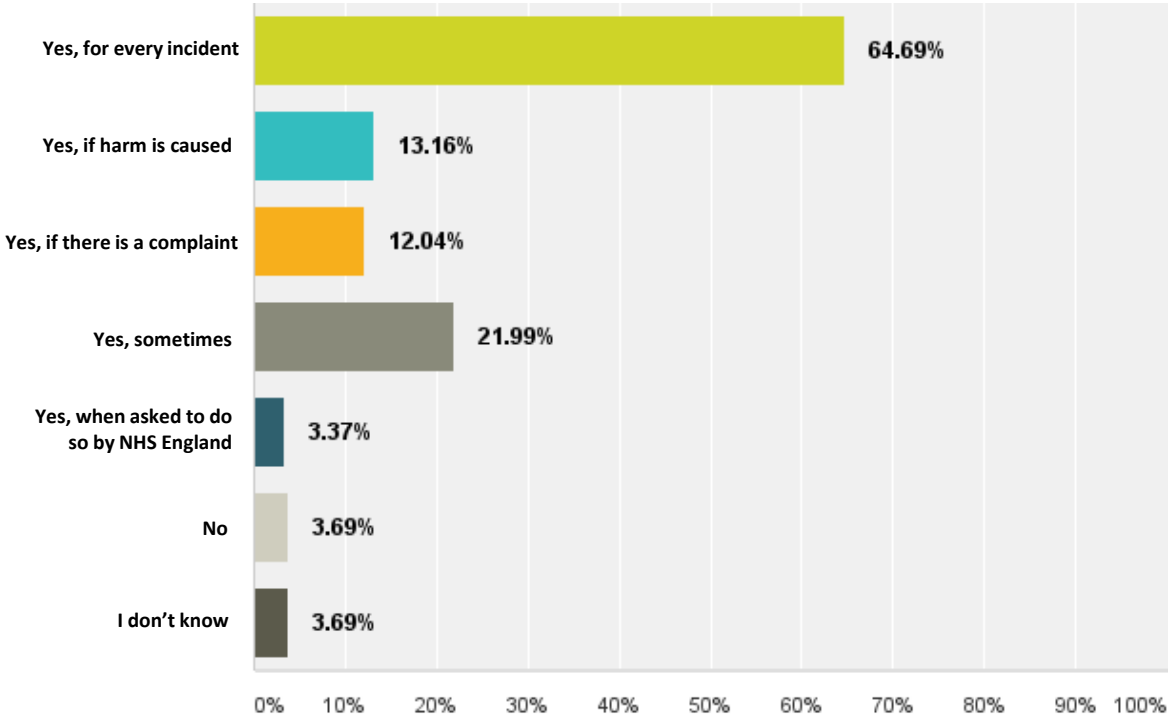
Does your pharmacy team **undertake root cause analysis** to identify the contributing factors for an incident?



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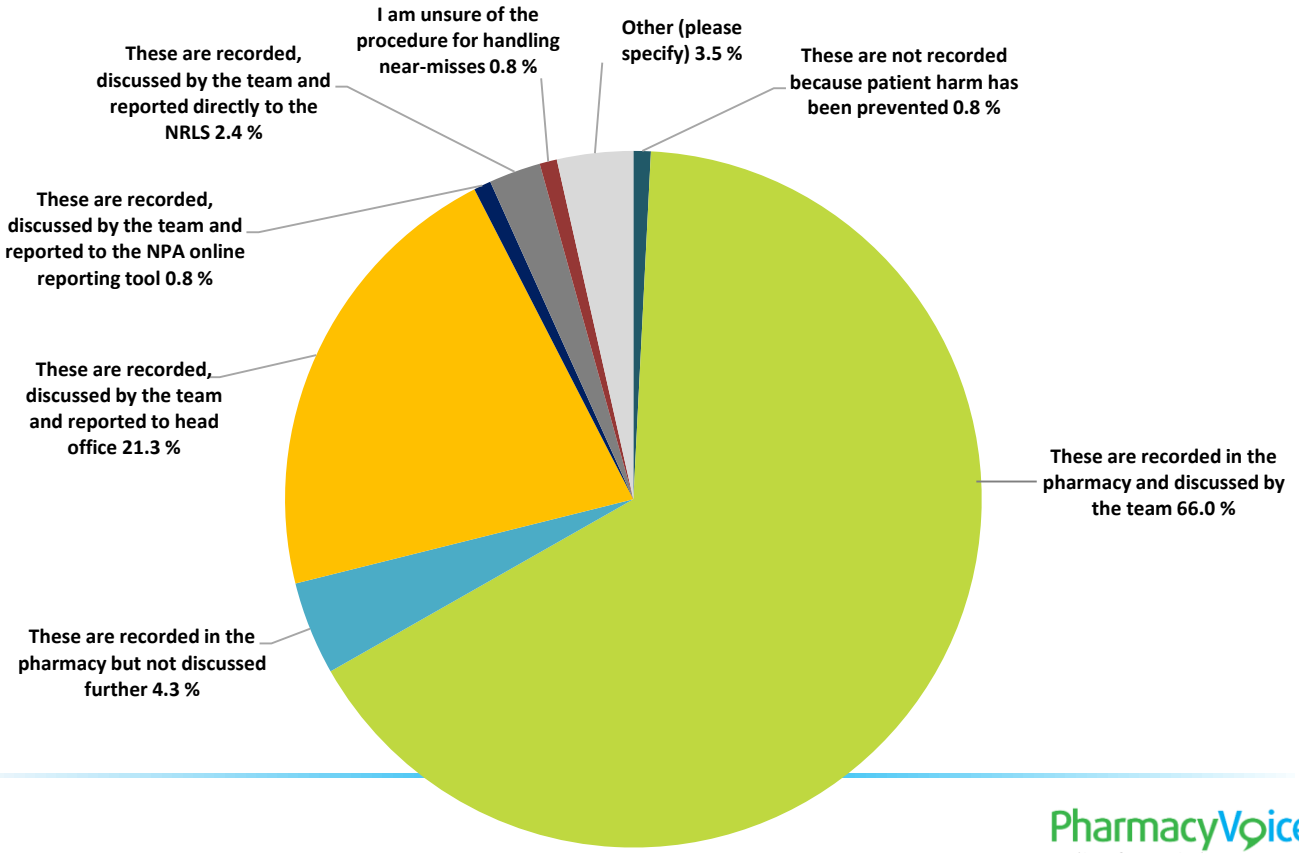
How does your pharmacy handle **near-misses**?



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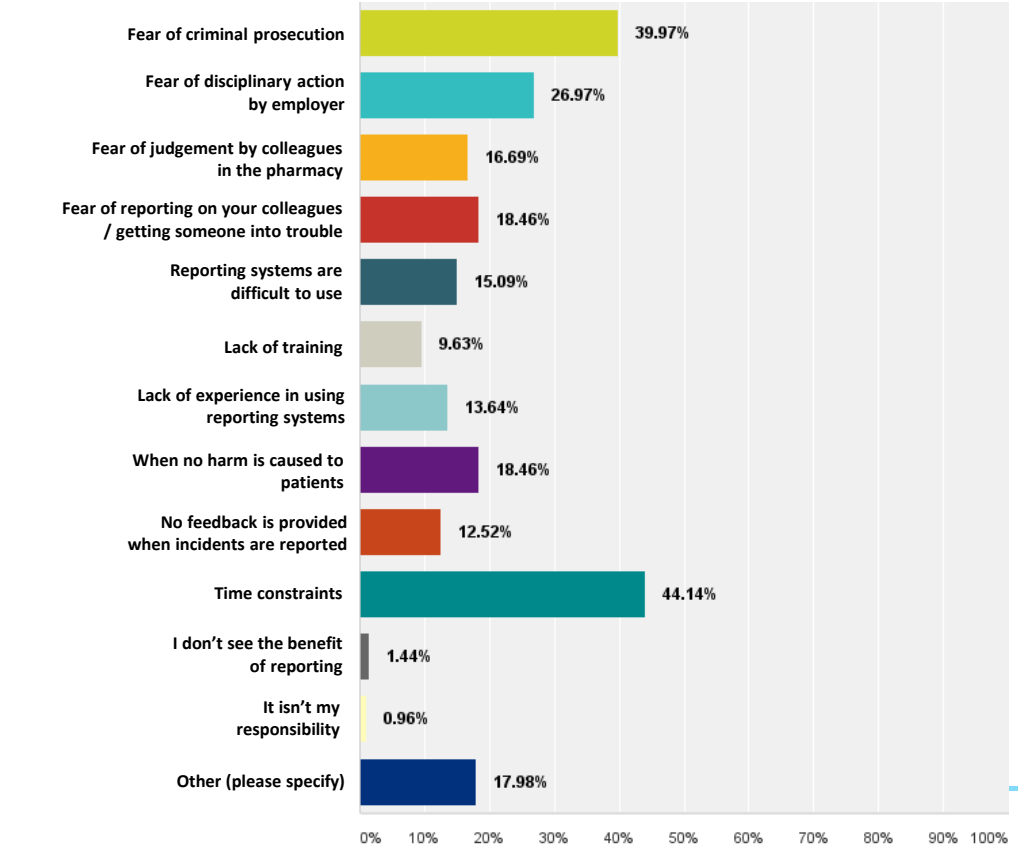
What might **prevent you from reporting** patient safety incidents?

(please select all that apply)



Of those who selected 'Other'

- **95** felt that nothing prevents them from reporting incidents
- **7** felt that reports may be delayed due to the pharmacy being busy or incident details still being determined
- **6** felt that a culture of blame prevents incident reporting

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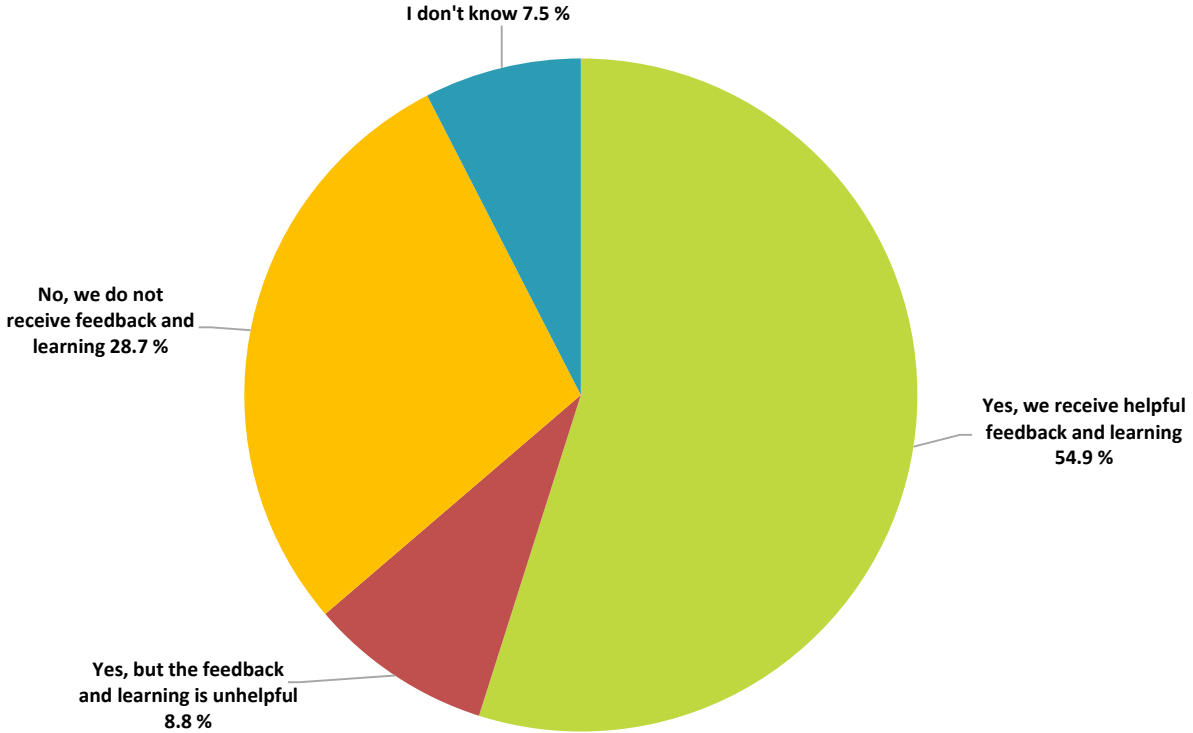
Do you receive **feedback and learning** as a result of reporting incidents?



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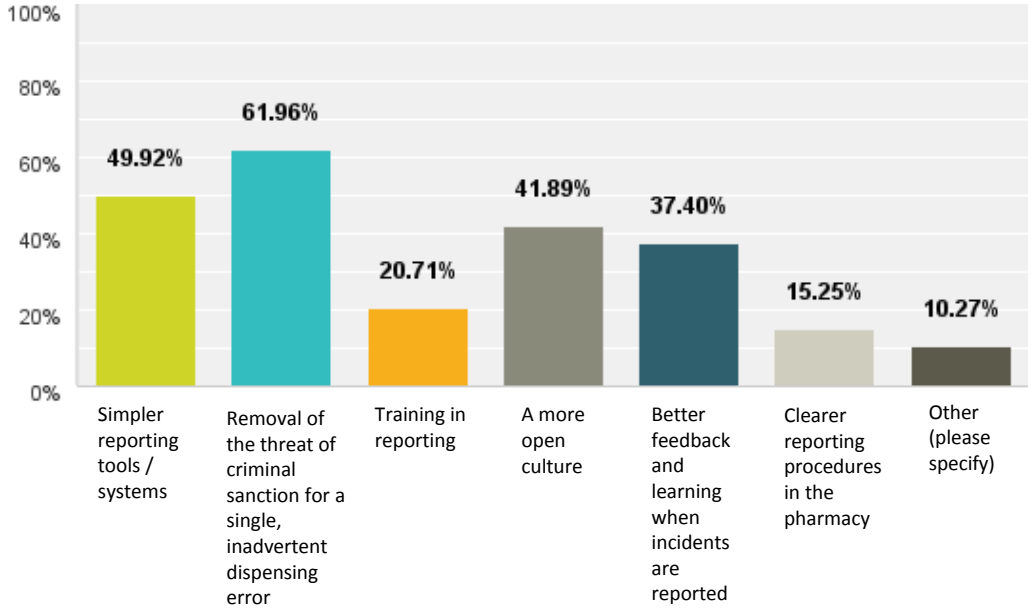
What would **encourage you to report more** patient safety incidents?

(please select all that apply)



Of those who selected 'Other'

- **40** felt that nothing would encourage more reporting and everything is reported, **10** felt that more time was needed for effective reporting, **3** felt that more staff were needed, **4** felt that reporting should be anonymous

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Any other comments? A handful below…

- The reduction in funding for pharmacy will result in increased errors
- Incident reporting is very dependent on the culture within the branch
- I think there are no clear guidelines for patient safety incident reporting
- The biggest factors are criminal sanction, time and ease of reporting – most tools assume you have unlimited desk time and a knowledge of management speak!
- There needs to be more training and openness with the pharmacy team to ensure that reporting incidents and near misses is not seen as a punishment
- Do the GPs have the same incident reporting system?
- There should be a standard form to be used by all pharmacies for reporting patient incidents nationally
- I am convinced that the complexity and time implications in completing the reporting forms is a key factor in under-reporting
- Blame culture exists rather than an open learning culture – at the end of the day we are only human and mistakes do happen