Completion of the Patient Safety Report Quality Criterion

Introduction

Patient Safety is a priority for everyone working within Community Pharmacy. NHS England recognise that contractors have invested a significant amount of time and effort in developing a patient safety culture, increasing the levels of incident and near miss reporting as well as sharing learning and top tips across the sector.

The Quality Payments Scheme contains 2 elements related to Patient Safety:

1. On the day of the review 80% of registered pharmacy professionals working at the pharmacy have achieved Level 2 Safeguarding status for children and vulnerable adults in the last two years – http://psnc.org.uk/safeguarding

2. Written safety report at premises level available for inspection at review point, covering analysis of incidents and incident patterns (taken from an ongoing log), evidence of sharing learning locally and nationally, and actions taken in response to national patient safety alerts – http://psnc.org.uk/safetyreport

To claim the quality payment for a written patient safety report, worth £1280 per pharmacy, you will need to write a reflective report regarding your patient safety activity. While NHS England has not defined a time period, the written safety report should cover the previous 12 months if possible. The report should contain details of learning identified within your pharmacy as well as any learning identified and shared within your pharmacy or organisation, via newsletters and other sources.

The pharmacy team should write the report collaboratively, so it will help to agree the actions together before writing it.

The report should consider all aspects of patient safety within the pharmacy not just dispensing errors. Examples could include:

- Incidents that have occurred due to communication issues between doctors, nursing homes, hospitals or community drugs teams
- Delivery incidents
- Near misses
- Handing out incidents
- Prescribing errors
- Controlled drug incidents or discrepancies
- Drug interactions
- Adverse drug reactions that you've reported via the yellow card system
- Actions taken in response to local errors and national patient safety alerts issued by the Central Alerting System

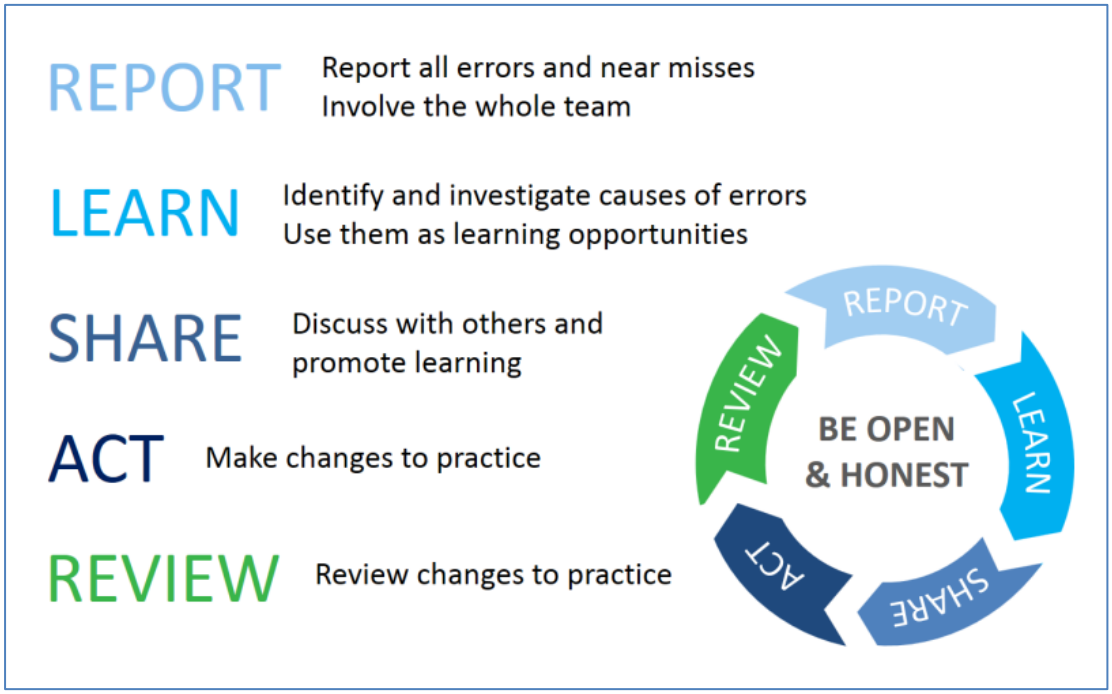
There is no right or wrong answer and the most important thing is that pharmacy teams discuss the reflection, learning and action they have taken in response to patient safety incidents. There is not a model answer, as every report summary will be different and pertinent to the people who were involved in its production.

This is not an exercise in testing the report writing skills of pharmacy teams and you are not being judged on your grammar or literacy skills, so there is no need to overthink the content.

The small, everyday changes that teams agree themselves can have the biggest impact on patient safety, so make sure you capture them so they are not lost.

Your annual report should tell a story of what has happened in your pharmacy during the year.

Summarise what happened, what you learnt, how you discussed and shared it as a team, what you did and how you know it made a difference. The Report, Share, Learn, Act, Review (RLSAR) wheel will help you with this.



Completing the annual report

The Pharmacy Voice Patient Safety Group (now known as the Community Pharmacy Patient Safety Group), PSNC and NHS Improvement have created monthly and annual report templates, which contractors may choose to use to create their report to meet the quality criterion. The template documents are available at psnc.org.uk/safetyreport.

The steps below relate to completing the annual report using the templates highlighted above.

Pharmacy name (& branch number, if applicable)		ODS (F code)		Date of report	
Report completed by		Period covered by the report		to	
Pharmacy team members who participated in preparing this report (initials)					

Complete the top of the report in full, the report should cover a period over the past 12 months if possible. The ODS or F code is your NHS account number that you use to submit prescriptions at the end of the month.

Summary of patient safety incidents and activity at this pharmacy (enter numbers in the table below)

Year													
Month	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Prescribing incidents													
Near misses													
Dispensing incidents													
Other patient safety activity*													

*(e.g. response to medicines recalls, national patient safety alerts)

Complete the table above (if you have used the monthly template each month, you can refer to these documents to help you collate this information).

Question 1 relates to the learning your team has identified from logging near misses and reporting dispensing errors. The answers to this question need to contain your team's reflection of what has been learnt.

1) Describe the key learning points that have made the most significant improvements to your team's professional practice.

-
-
-

The pharmacy team could consider the following questions:

- Have any specific medicines been identified as contributing to errors, e.g. 'look alike sound alike' (LASA) medicines such as atenolol and allopurinol?
- Has the storage location of any medicines contributed to an error, e.g. chloramphenicol eye and ear drops?
- Has your review of prescribing errors highlighted any trends you can share with the local surgery?
- What learning points have you identified from NHS communications, local newsletters etc.?
- Are there more incidents on certain days and at certain times?
- Have incidents reoccurred because not all team members are aware of previous incidents, e.g. part-time team members, locums?
- Have you identified problems with your workspace or workflow and the organisation of the dispensing process?
- Have you identified specific training requirements for the team to help them follow your Standard Operating Procedures?
- Do errors occur more frequently when you have changes in personnel, e.g. a different pharmacist or new members of the team?
- Has medication packaging caused any issues?
- Have you had any reoccurring near misses or dispensing errors?

Question 2 asks what changes you have made as a team as a result of the learning points identified in Question 1. You should detail what actions you've implemented to prevent a reoccurrence of these incidents.

2) List the actions the team has taken because of the key learning points (listed in 1).

-
-
-

Examples could include:

- Moving stock within the dispensary to ensure it is physically separated and/or applying warning signs to specific areas
- The team reviewing a specific Standard Operating Procedure
- Changing how the team works or what they focus on at particular times of day
- Adding notes to a patient's PMR or drug records to alert the team to a previous issue
- Identifying specific medicines that will receive an additional check e.g. insulin or controlled drugs
- Providing additional training or CPD opportunities
- Working differently with local surgeries or community health teams
- Implementing new processes to assist patients when discharged from hospital or other care settings
- Reviewing how stock is managed to prevent patients being without medication
- Reviewing and amending your staff profile and/or rota
- Discussing no-blame culture and the RLSAR principles wheel
- Reviewing how incidents are investigated and contributing factors and the root cause identified
- Changing how deliveries are organised

Question 3 focuses on how the learning points have been shared with your team and with external organisations/other healthcare professionals.

3) Describe how you have shared the key learning points (listed in 1).

-
-
-

This could be done by:

- Reporting errors and learning to a central office within your organisation (if applicable)
- Reporting errors and learning direct to the NRLS
- Discussing learning during dispensary meetings or huddles
- Discussing learning with your area manager (if applicable) during their cycle of visits
- Discussing prescribing errors with your local surgeries
- Discussing errors with other pharmacies in your area to share best practice
- Sharing information with your LPC (some LPCs may look to share information locally on behalf of pharmacy teams – contact your LPC to see if this is happening in your area)
- Sharing information via the Local Professional Network (LPN) or at a Local Practice Forum (LPF) event

Question 4 asks you to reflect on whether the learning you identified in Question 1 and the actions taken in Question 2 have made a difference.

4) What patient safety improvements have occurred in the pharmacy because of the actions the team has taken (listed in 2)?

-
-
-

Have you and your team noticed:

- A change in the frequency and type of dispensing incident/near miss?
- An increase/decrease in the number of dispensing incidents/near misses?
- A change in the type of incidents reported?

Question 5 asks you to summarise what action has been taken in response to safety alerts and drug recalls. This section is best written as a short summary.

5) What has the team done in response to any relevant national patient safety alerts and drug recalls within the last 12 months?

PSNC provides a summary of national alerts and recalls which have been highlighted on their website. This is available at psnc.org/patientsafetyinfo.

An example is given below:

Medicines and Healthcare products Regulatory Agency (MHRA) drug alerts

The pharmacy received and actioned "x number of" alerts in the past twelve months. A hard copy of these alerts has been signed off by the team and filed in the patient safety folder. The following requested actions from the pharmacy:

Recall number 0001. Class 2 recall for Atenolol 50mg tablets. Eight boxes of the affected batch were identified in the pharmacy and returned to the wholesaler.

MHRA/NHS Improvement Safety Alerts

1) **Patient Safety Alert for Sodium Valproate:** The alert was discussed with the surgery team. Women of childbearing age were identified on the PMR and issued with warning cards highlighting the risk. We provided advice to "x number of" patients

2) **Safety Alert on Paraffin Emollients:** Following a recent incident we revisited the reminder issued by the MHRA. Patients were counselled on the risk of fire with paraffin based creams and ointments which has soaked into clothing. A leaflet was provided and advice given. This noted on the patient's PMR.

Question 6 asks the team to reflect on the areas they'd like to focus on in the coming year so that your patient safety culture continues to evolve.

6) Reflecting on this report, what will be the team's patient safety priorities for the next 12 months?

This will be individual to each pharmacy; however, you may find it easier to review in 12 months' time if you use certain techniques to set your goals, e.g. by writing them as SMART objectives i.e. **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound.

The Centre for Pharmacy Postgraduate Education (CPPE) offers training programmes which can help pharmacy teams better understand and improve goal and objective setting. You can find out more at: https://www.cppe.ac.uk/programmes/l/goal-g-01/.

Validation of the Patient Safety Report Quality Criterion

The NHS Business Services Authority (NHS BSA) will collect information on behalf of NHS England to validate that contractors have met the patient safety report quality criterion. The Drug Tariff identifies four key areas which pharmacy teams must be able to evidence to meet the criterion:

1. An ongoing log of incidents
2. Incidents are being reviewed and trends identified
3. Learning is shared locally and nationally
4. Safety alerts are implemented and action taken

Before you make your declaration, it is important that you read your annual summary and check that these four areas have been covered to prevent you making an inaccurate declaration.

Frequently Asked Questions

1. **Where should the report be stored once complete?**

   Store the completed report securely within the Pharmacy. NHS England or NHS BSA may request to see this as part of the validation process for the quality criteria as part of the Quality Payments Scheme or as part of contract monitoring in the future. The form can also be used to evidence patient safety and quality improvement activities to your GPhC inspector during their routine inspections.

2. **Does the report need to be sent anywhere?**

   No. The report does not need to be submitted routinely to NHS England; however, a copy may need to be submitted to NHS England or NHS BSA as part of the validation process for the Quality Payments Scheme (the process for validation of the quality criteria has not been confirmed at the time of writing; further information will be published on the PSNC website when available).

3. **Do I have to type the report or can I handwrite it?**

   The report can be handwritten or typed and should be an accurate summary of your reflection and actions as a team.