

Community Pharmacy Quality Payments Scheme

Annual Patient Safety Report template



Pharmacy name (& branch number, if applicable)	Anytown Chemist (Independent)	ODS (F code)	F654321	Date of report	16/04/2017
Report completed by	Mr A Sample, Pharmacist Owner	Period covered by the report	01/04/2016	to	31/03/2017
Pharmacy team members who participated in preparing this report (initials)	AS, AB, CD, EF, GH				

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

Year	2016									2017			Total
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Prescribing incidents	1	1	2	3	2	1	2	3	2	1	2	4	24
Near misses	12	10	8	10	13	9	8	9	13	12	11	15	130
Dispensing incidents	0	0	1	1	2	0	1	0	1	1	0	1	8
Other patient safety activity*	1	0	0	0	0	1	0	2	0	0	0	0	4

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

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

- Full patient identification checks must be undertaken whenever dispensed medication is handed out, to avoid the risk of colleagues incorrectly assuming that they know the person who is asking to collect it.
- The risks associated with the pharmacy's provision of a medication delivery service are not obvious to new delivery drivers and a clearly documented process is vital to protect patient safety. (This need was identified from delivery incidents that occurred during our regular driver's sudden long-term sickness absence in the peak holiday season, when it was difficult to find cover at short notice).
- Responding appropriately to Patient Medication Record (PMR) anomalies can have a positive impact on patient safety and help to inspire GP colleagues' confidence in the pharmacy.

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

- The whole pharmacy team has agreed to check three pieces of confirmatory identification (name, address, postcode or date of birth) at the point of every medication hand out, even if the person collecting the item(s) is well-known to the colleague, explaining to patients/representatives the reason for these checks in the event of query.
- Using the current GPhC guidance, I have refined the pharmacy's SOP for the delivery of dispensed medication to prohibit:
 - The handing over of dispensed medication to persons aged under 18 years without the express written consent of the child's parent or legal guardian (after an incident when medication was given to a 13 year old child in her parents' absence, which generated a complaint)
 - The leaving of dispensed medication unsecured at the patient's premises or its posting through the letterbox at the patient's address (following an incident where dispensed medication was accessed and eaten by a dog)
 - Leaving the delivery van unsecured in the driver's absence (after an incident when three bags of dispensed medication could not be accounted for)Additionally, all staff who are (and could be) involved with deliveries have now been trained on this new SOP and they are signed off as competent to follow it. The new delivery driver has also attended the National Pharmacy Association's training course on delivering medicines safely and effectively. He has been provided with a mobile phone and my out-of-hours contact details for use in the event of queries.
- From our monthly meetings on patient safety, the team has identified a number of occasions when drug initiation doses have been inadvertently repeated on prescriptions and specific medication 'stop by' dates have been overlooked and further repeat prescriptions generated. The team agreed to place a 'flashing' message on the PMR for drugs prescribed with specific stop dates and/or initiation doses that are not for repetition - to serve as a warning for the team to check any repeat prescriptions during their labelling.

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

- The key learning points from all our patient safety incidents and activities have been discussed with my regular staff at our monthly team meetings.
- I have shared the details of any relevant patient safety incidents with my two regular locum pharmacists.
- I have completed an incident report form for each patient safety incident and submitted this via the NRLS.

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

- Following a hand out error in March 2017 that resulted in the short-term hospitalisation of an elderly male patient, staff morale and confidence have now improved with a strengthening of our pharmacy's SOP for the hand out of dispensed medication. The staff have engaged well with the new process and fully understand the need for increased vigilance in this area. Although it is still very early days, no further hand out errors have occurred.
- Since the inception of the new delivery SOP and the training of relevant staff, there has been no repetition of the type of delivery incidents listed in (2) above.

- Since the new focus on PMR data, the team has identified (and rectified with the prescriber):
 - Two instances of amiodarone initiation therapy being inadvertently re-prescribed
 - One case of a Vagifem initiation dose being inadvertently re-prescribed
 - A repeat prescription for rivaroxaban being issued for a patient who we knew had already received the expected five week course following his total hip replacement
 - Two instances of drugs from the same therapeutic class being inadvertently co-prescribed (atorvastatin and simvastatin; furosemide and bumetanide)

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

- ** MHRA drug alerts - 22 alerts have been received in the above period; a hard copy of each one has been signed and dated after actioning and retained for reference. Three of these were relevant to this pharmacy:
 - EL (16)A/03 Class 4 - Crestor 5mg PI - two boxes of the relevant batch were found and returned to the wholesaler for credit
 - EL (16)A/12 Class 2 - GlucaGen 1mg HypoKit - one patient was asked to return to the pharmacy with his kit for its replacement
 - EL (16)A/16 Class 2 - Evacal D3 1500mg/400iu Chewable Tablets - two boxes of pack size 56 were found on the shelf and returned to the wholesaler for credit
- ** NHS Improvement alert (NHS/PSA/W/2016/011) - Patient Safety Alert on insulin pen devices - one patient was affected

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

- Given the potential patient safety risks from hand out errors, we will continue to focus on the correct hand out procedures and work together to make the process seem more 'natural' for patients and their representatives. The team will make a conscious effort to observe each other's levels of compliance with the requirements of the hand out SOP and 'call out' any shortfalls in a constructive manner to facilitate improvements within the team.
- We will produce a user-friendly information sheet for patients requesting deliveries, so that they receive advance notice that we will not leave dispensed medication unsecured at their premises or posted through the letterbox. Delivered medication will only be handed to the patient or his/her nominated signatory (which must be agreed in advance). We will further review the suitability of patients for the delivery service, so that it is provided to those where there is a defined health-related need.
- Over the past 12 months, the team has fostered improved working relationships with our two nearest GP practices and we have accepted offers from each surgery to attend their monthly practice meetings from April 2017.

This report may contain confidential information - retain this report within the pharmacy.