Community Pharmacy Quality Payments Scheme

Monthly Patient Safety Report template

Pharmacy name (& branch number, if applicable)	Anytown Chemist (Independent)	Month and Year	March 2017	Date of report	05/04/2017
Pharmacy team members who participated in preparing this report (initials)	AS, AB, CD, EF, GH	Report completed by		Mr A Sample	

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

Prescribing incidents	4	Near Misses	15	Dispensing incidents	1	Other patient safety activity*	0

*(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.

1. There is a risk that pharmacy team members fail to conduct the necessary checks when handing out dispensed medication to patients who are well known to the staff because they feel uncomfortable about asking patients to confirm their address and date of birth details repeatedly or,
2. This risk occurs because the pharmacy team members believe that they know the person to whom they are giving the dispensed medication

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

1. All pharmacy team members now ask every patient/representative for three identifying details - patient's name, patient's address and postcode or date of birth at the point of hand out.
2. When the person collecting the dispensed medication is asked for this information, the pharmacy team members are checking the information that has been provided verbally against that stated on the associated prescription(s) and the bag label(s) to provide a 3-way check.
3. I have updated my pharmacy's standard operating procedure (SOP) for hand out of dispensed medication to highlight the importance of the 3-way check.
4. I have instigated a new system for the application of name and address labels to bagged dispensed medication so that these labels are easily visible in their storage location without the staff having to move the bags. However, the dispensed medication is still stored so that there is no breach of Data Protection legislation.
5. I have set up a system for the regular removal of uncollected medication from the retrieval system so as to minimise the number of bags of dispensed medication being stored within it.

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

Following a hand out error in the month, I have briefed all my staff by having a 1:1 conversation to discuss best practice at hand out. I have also filled in a dispensing incident report form 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)?

There have been no further reported errors or 'near miss' incidents at the hand out stage of the dispensing process. My staff have said that they feel more confident when asking for confirmatory details from patients, as we have explored various ways in which to have the right conversation with patients during our 1:1 discussions.

5) What has the team done in response to any relevant national patient safety alerts and drug recalls this month?

There has been one Drug Recall in the month of March 2017 - involving Trimethoprim 200mg tablets manufactured by SurreyPharm, where there have been reports of a number of packs of 14 tablets not containing a Patient Information Leaflet. I have checked my stock-holding and ascertained that I do not stock any Trimethoprim 200mg tablets produced by that company. Therefore, I have not needed to take any further action beyond initialling and dating the recall notice and filing it securely with previous drug recall notices.

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

This month, the pharmacy staff 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.

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