Monthly patient safety report

Pharmacy name (and branch number, if applicable)		**Month and year**	
Record completed by (name)		**Date of report**	
Pharmacy team members who participated in preparing this report (initials)			

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

Month	A. Prescribing interventions	B. Near misses	C. Near misses involving high-risk LASA* (if known)	D. Dispensing incidents	E. Dispensing incidents involving high-risk LASA* (if known)	F. National safety alerts	G. Other patient safety activity†

* 'Look-Alike, Sound-Alike' (LASA), [sometimes also referred to as Sound Alike Look Alike Drugs (SALAD).

† Including drug recalls.

2. How have the patient safety priorities that were agreed in the last month's patient safety report been acted upon?

3. Outline your learnings and actions, if you have had a LASA medicines incident or near miss in the last month (refer to columns C and E in the monthly summary table above).

What were the key learning points for the pharmacy team following the completion of the CPPE reducing look-alike, sound, alike errors e-learning and e-assessment? (Fill in this box in the month you complete the CPPE training and for the following month)	What actions have been implemented to minimise LASA incidents and near misses from your last monthly Patient Safety Report?
How have these learnings and actions helped to reduce the number of LASA incidents occurring in your pharmacy? Quantify where possible.	**If these learnings have not helped to reduce the number of LASA incidents, why is this the case and what additional actions will you now take?**

4. **<u>Outline key patient safety improvements</u> that have occurred within your pharmacy during the month in relation to:**

   4.1. Improvement 1: Pharmacy safety – patient safety incidents (refer to columns A, B and D in the monthly summary table above).

Reviewing patient safety incidents, what was the key learning point and how was it identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?

   4.2. Improvement 2: National patient safety alerts (refer to column F in the monthly summary table above).

Reviewing patient safety alerts, what was the key learning point and how was it identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?

5. **How have you shared what you have learned above (in relation to section 3, 4.1 and 4.2) both with your team and externally?**

6. **What will be the team's patient safety priorities for the next month?**

Priority 1: **Priority 2:** **Priority 3:**