

Patient safety report

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

1. Summary of patient safety incidents and activity in the pharmacy (enter monthly totals in the table below)

Month and year	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 your previous patient safety report been acted upon?

3. Outline your learnings and actions in relation to LASA medicines (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?	What actions have been implemented to minimise LASA incidents and near misses since your last annual 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 and near misses, why is this the case and what additional actions will you now take?

4. Outline key patient safety improvements that have occurred within your pharmacy during this review period 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 your patient safety incidents, what were the key learning points and how were they 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 columns F and G in the monthly summary table above).

Reviewing your patient safety alerts, what were the key learning points and how were they 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 sections 3, 4.1 and 4.2) both within your team and externally?

6. What will be the team’s patient safety priorities for the next year?

Priority 1:

Priority 2:

Priority 3: