Community Pharmacy Quality Payments Scheme
Annual Patient Safety Report template

WORKED EXAMPLE

Pharmacy name (and branch number, if applicable)	*Anytown Pharmacy*	**ODS (F code)**	*F0123*
Report completed by (name)	*Mrs A Example, Pharmacy Manager*	**Date of report**	*01/02/2019*
Dates covered by the report	*01/02/2018* to *31/01/2019*		
Pharmacy team members who participated in preparing this report (initials)	*AB, CD, EF, GH*		

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

Month	Prescribing interventions	Near misses	Near misses involving high-risk LASA* (if known)	Dispensing incidents	Dispensing incidents involving high-risk LASA* (if known)	Drug recalls	Other patient safety activity†
February 2018	*1*	*6*	*1*	*2*	*1*	*2*	*1*
March 2018	*2*	*8*	*0*	*1*	*0*	*2*	*0*
April 2018	*0*	*6*	*2*	*0*	*0*	*1*	*2*
May 2018	*1*	*9*	*0*	*1*	*0*	*2*	*5*
June 2018	*1*	*7*	*1*	*0*	*0*	*0*	*3*
July 2018	*1*	*9*	*0*	*0*	*0*	*0*	*6*
August 2018	*3*	*8*	*0*	*0*	*0*	*0*	*2*
September 2018	*1*	*13*	*1*	*1*	*1*	*1*	*1*
October 2018	*2*	*7*	*0*	*0*	*0*	*0*	*1*
November 2018	*1*	*9*	*2*	*0*	*0*	*2*	*3*
December 2018	*3*	*10*	*0*	*0*	*0*	*1*	*4*
January 2019	*2*	*11*	*0*	*2*	*0*	*0*	*2*
TOTAL	*18*	*103*	*7*	*7*	*2*	*11*	*30*

* *'Look-Alike, Sound-Alike' (LASA) medicines classified as high-risk are: propranolol & prednisolone, amlodipine & amitriptyline, carbamazepine &* carbimazole, azathioprine & azithromycin, atenolol & allopurinol.

† Including national patient safety alerts actioned

Provide 3 examples of key patient safety improvements that have occurred within your pharmacy during the period specified

Example 1

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?
Key learning point: *The importance of understanding the risks associated with dispensing errors involving LASA medicines.* How it was identified: *A near miss involving selecting carbamazepine instead of carbimazole.*	Actions taken: 1. *Dispensary now contains shelf labels and PMR prompts to remind the pharmacy team about the risks of LASA dispensing errors.* 2. *Physical separation of carbamazepine and carbimazole in the dispensary to reduce the risk of selection errors.*	Safety improvements: *Due to the increased knowledge amongst the team as well as the changes in the dispensary to prompt the team, the potential risk of a dispensing error occurring due to LASA medicines has been reduced.*

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Example 2

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?
Key learning point: *Full patient identification checks must be carried out to ensure that medicines are given to the correct patient and to avoid the pharmacy team incorrectly assuming that they know the patient.* How it was identified: *Hand-out error occurred in the pharmacy.*	Actions taken: *A safety huddle was held and the pharmacy team agreed that every time, when handing over medicines, the patient must be asked for three pieces of information to confirm their identity (DOB, name and address) even if the patient is well-known to the pharmacy team.*	Safety improvements: *Asking for three pieces of confirmatory identification from every patient has now become routine to the team when they hand over medicines and this reduces the risks of hand-out errors occurring in our pharmacy.*

Example 3

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?
Key learning point: *Enhanced checking must be carried out to ensure that medicines are dispensed at the correct dose, as indicated on the prescription.* How it was identified: *A near miss involving 500mg flucloxacillin being selected instead of 250mg as indicated on the prescription for a young child.*	Actions taken: 1. *We always check the date of birth on the prescription and use an age sticker during the prescription assembly process to highlight to other colleagues when a prescription is for a child.* 2. *We also carry out enhanced three-point checking to ensure that the correct dose is dispensed, especially where packaging looks similar for different doses.*	Safety improvements: 1. *The risk of dispensing an inappropriate medicine to a child or baby has reduced since using age stickers as the pharmacy team is constantly reminded of the person behind the prescription and increased dangers of errors involving children.* 2. *Enhanced checking has also improved patient safety and reduced the chances of an incorrect dose being dispensed.*

How have you shared what you have learned both within your team and externally?

- *All the patient safety incidents and key learning points have been discussed at our weekly safety huddles*
- *When we are working with a locum pharmacist, we share details of the patient safety incidents that have occurred*
- *I completed an incident report form for each incident and submitted via NRLS (National Reporting and Learning System); when this was for an incident involving a LASA medicine, I also included the text 'LASA' in the description of what happened on the NRLS report as a unique identifier to facilitate future national learning*

What actions have been taken at the pharmacy to minimise the risks associated with high-risk LASA* medicines?

E.g. Physical separation, shelving labels, enhanced checking, PMR prompts etc.

- *Azathioprine and azithromycin, have been separated so that azithromycin is now positioned at Z in the dispensary*
- *Tallman shelf labels for 'aTENolol' and 'alloPURinol' act as prompts when selecting these medicines*
- *We now have PMR prompts which encourage us to take extra care when dispensing high-risk LASA medicines*

What actions have been taken at the pharmacy regarding relevant national patient safety alerts and drug recalls?

Two MHRA drug alerts were relevant to this pharmacy:

- *Imatinib 400mg capsules (3x10) (Cipla EU) – When dispensing these capsules to 2 patients, the pharmacy team removed the defective Patient Information Leaflet (PIL) and provided a corrected copy*
- *Denzapine 50mg/ml oral suspension (Britannia Pharmaceuticals Ltd) – 5 packs found on shelf and returned to wholesaler*

How have the patient safety priorities that were agreed in last year's annual patient safety report been acted upon?

- *There is an increased awareness of the risks associated with dispensing errors involving high-risk LASA medicines and there have been changes in the dispensary (labels and posters) to keep the pharmacy team informed*
- *The team have improved their sharing and discussions about patient safety incidents by initiating safety huddles and sharing at monthly team meetings. There have also been improvements in how information is shared with locums.*

What will be the team's patient safety priorities for the next 12 months?

Priority 1: *Appoint a valproate champion in our team and when dispensing valproate, ensure that women and girls always receive the patient card, patient information leaflet and patient guide and are made aware of the associated risks, regardless of if they have been given this information previously.*

Priority 2: *Improve the communications between our pharmacy and the local GP and hospital to ensure that discharged patients receive the right medicines at the right time and ensure that MURs/NMS are conducted when appropriate.*

Priority 3: *Given the patient safety risks associated with hand-out errors, we will continue to focus on the correct hand out procedure and will encourage other members of the team to ensure that we are all meeting the hand-out SOP and improving.*

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