# A close up of a sign Description generated with very high confidence

**Pharmacy Quality Scheme (PSQ)**

## Monthly Patient Safety Report

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| **Pharmacy name**  **(and branch number, if applicable)** |  | **Month and year** |  |
| **Report 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)

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| **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†** |
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\* *‘*Look-Alike, Sound-Alike’ (LASA), [sometimes also referred to as Sound Alike Look Alike Drugs (SALAD)] medicines classified as high-risk are: propranolol & prednisolone, amlodipine & amitriptyline, carbamazepine & carbimazole, atenolol & allopurinol and rivaroxaban & rosuvastatin

**†** Including drug recalls

1. **How have the patient safety priorities that were agreed in the last month’s patient safety report been acted upon?**

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

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| 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? |
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| 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? |
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| 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? |
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1. **Outline key patient safety improvements 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 + D in the table)**

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| 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? |
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* 1. **Improvement 2: national patient safety alerts (refer to column F in the table)**

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

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1. **What will be the team’s patient safety priorities for the next month?**

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| Priority 1:  Priority 2:  Priority 3: |