General Pharmaceutical Council

Pharmacy team toolkit: learning from incidents

Examples of notable practice from our Pharmacy Inspections Knowledge Hub

Background

- Pharmacists and pharmacy technicians across different settings work hard to provide person-centred, safe and effective care to patients. But, in reality sometimes things go wrong. The way that professionals respond to these situations is key to supporting the people affected and improving patient safety for the future.
- **All healthcare professionals have a duty of candour** – this is a professional responsibility to be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.
- The responsibility to be open and honest applies even in difficult or challenging times.
- It's vital that professionals do the right thing for patients, their families, and carers.

About this toolkit

- Read some real case studies and examples of notable practice about how pharmacy teams have learned from incidents, to improve patient safety outcomes and minimise the risk of these happening again.
- Use the slides as prompts for reflection and learning.
- Share and discuss the case studies in your pharmacy team meetings or other discussions.
- Think about what other action you could take individually or collectively, to improve patient safety and encourage a culture of openness and learning.
- Whilst the toolkit examples are drawn from our inspections of community pharmacies, the professional duty to be candid applies in all sectors of pharmacy practice.

Pharmacy Inspections Knowledge Hub: examples of notable practice

A culture of learning from incidents

- Dispensing incidents were investigated and documented so that remedial action could be taken to avoid the same incident happening in the future.
- This pharmacy put in place a dispensing signature audit trail and staff signed ‘dispensed by’ and ‘checked by’ boxes on medicine labels to confirm they had completed the activity.
- This audit trail was used to identify staff when dispensing errors were detected, so that **individuals could reflect and avoid the same errors happening in the future**.
- This pharmacy took action due to a few prescription ‘hand-out’ errors with staff now ticking the name and address at the time of supply.
- Staff followed the new ‘hand-out’ SOP, which included additional steps to avoid errors, such as checking the name and address at the time the prescription was requested and again at the time of hand-out.

Read more **here**

Staff were proactive at managing selection errors and a local ‘top 6’ had been developed. This was displayed in a prominent area on the dispensing bench, so that staff were reminded. Staff had agreed to record the ‘top 6’ products on the pharmacy information form (PIF), for example Quinine/Quetiapine, so that all staff took extra care including the checking pharmacist. The ‘top 6’ list was then updated every few months.

Using newsletters to share learning, promote feedback and engage team members in identifying ‘look-alike and sound-alike’ (LASA) medicines

- The pharmacy owner regularly **reminded team members to be open and honest** when reporting mistakes.
- The pharmacy owner carried out regular safety reviews of error reporting across its pharmacies.
- The pharmacy used the information from these reviews to share learning through engaging newsletters. These helped to **maintain a clear safety culture**. There was support for team members in identifying improvements to patient safety.
- Pharmacy teams recorded and submitted safety information to the superintendent pharmacist’s (SI’s) office. They had the option of using an electronic system or a paper-based system, depending on what worked best in each pharmacy.
- The SI carried out regular safety reviews and produced a report of the findings. The report included the **lessons that had been learnt to help reduce risks**. Mistakes were categorised to support learning, such as labelling, strength and formulation mistakes. The reports were published in the company’s regular newsletter.

Read more **here**

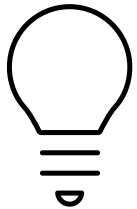
The newsletters were engaging and prompted reflection on both a personal and a team level. In the most recent newsletter, a prize was offered to the pharmacy team that successfully completed a ‘look-alike and sound-alike’ (LASA) based wordsearch quiz. Nine drug names were hidden in the wordsearch and the clue was ‘common medicines that were often mixed up at the time of dispensing’. This approach helped team members to identify the LASA medicines and to think about the steps their own pharmacy took to reduce the risk of the medicines being involved in a patient safety incident.

Effective use of monitoring and review mechanisms

- This pharmacy used proactive review mechanisms of adverse events as **opportunities to learn from and improve services**, and there was a **culture of learning** from incidents.
- Dispensing errors were recorded electronically and reported to head office. Records included possible contributing factors and next steps to prevent recurrence.
- **Errors were discussed amongst the team to minimise the risk of recurrence** and there was a procedure for dealing with errors. **Learning from incidents reported was shared across the company**. Staff referred to a list of common picking errors and adopted a triple check process with these to minimise the risk of errors reaching patients.
- Near misses were brought to the attention of the dispenser who was asked to rectify their own mistakes where possible; such events were recorded and discussed with the individual. There was consideration of possible contributing factors.
- Near miss records were recorded regularly and routinely reviewed for patterns or trends each month; staff were subsequently briefed on the outcomes. Reviews had **identified individual coaching needs** for members of the team and were based on a scoring system for the significance of the near misses.

Read more **here**

To combat a specific concern about selecting Lustral instead of Losartan, extra steps were taken, such as asking a colleague to check the selection before progressing and a shelf edge note was attached to the storage location for these items.

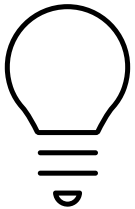


Application of safety and quality monitoring processes to support shared learning

- Pharmacy team members **acted openly and honestly** by sharing information when mistakes happen. They engaged fully in shared learning processes to help reduce identified risks.
- The team took **ownership of their mistakes by engaging in feedback** at the time they occurred and completing near-miss records.
- Entries in the near-miss record included identification of contributory factors and actions taken to reduce risk. Reporting rates were consistent, they rose when pharmacy students and pre-registration pharmacists commenced placements at the pharmacy, as expected.
- Pharmacy team members **discussed how self-reporting and correction of their mistakes assisted their learning**. The SI reviewed near misses monthly and provided the team with safety reports. The reports included trend analysis of the types of mistakes taking place.
- The pharmacy had an incident reporting procedure in place. Reports included a **reflection of the error**, a root cause analysis, learning points and actions. The pharmacy implemented actions following reported errors. For example, it had established additional checks when a person started on methadone. And it shared learning and improvement actions with the substance misuse provider following an incident.

Read more **here**

The pharmacy team engaged in reviews and contributed ideas to manage identified risks. For example, the team had separated gabapentin 300mg capsules from other strengths of gabapentin to reduce the risk of picking error. And pharmacy team members ticked information on the medicine box prior to taking ownership of their work and passing it on for the final accuracy check.



Other useful resources

- Our **standards for pharmacy professionals** and **standards for registered pharmacies**.
- Our guidance on **raising concerns,** which supports Standard 8 of our standards for pharmacy professionals.
- The **Knowledge Hub** on our pharmacy inspections website gives examples of notable practice.
- Focus on responding and learning when things go wrong, **an article** in the December 2017 edition of our online bulletin Regulate, features a case study on good practice in risk management and learning from mistakes
- In February 2018, we **reminded** pharmacy professionals of their duty of honesty and openness when things go wrong and about learning from errors.
- The Professional Standards Authority have produced a **selection of resources** about the professional duty of candour, including blogs, case studies and other materials.