How to meet the patient safety report criteria for the quality payments scheme
November review point

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Webinar: 18 October 2017
The NPA’s Medication Safety Officer (MSO) role

- MSO for all independent community pharmacies in England with fewer than 50 branches

How NPA enhances the role
- Patient safety news story
- Superintendent updates
- MSO Quarterly updates
November review point

• Second review point for the quality payments scheme is fast approaching

• **Deadline:** Friday 24 November 2017

• **NPA:** supporting you in producing the annual patient safety report to meet the required criteria
Patient safety report

- Annual patient safety report **must** be specific to the pharmacy claiming the quality payment
- Summary to reflect events taking place in the pharmacy
- Criterion aims to foster a culture of learning + continuous improvement
- Principles of patient safety report based on, and complementary to, the principles of incident reporting developed in collaboration with community pharmacy Medication Safety Officers (MSOs)
FAQ: Do I need to submit the patient safety report?

• No
• The patient safety report must be completed and kept on the pharmacy premises
• It should be available for inspection at the review point at which it was claimed
Annual patient safety report

• Report should cover:
  – Administration errors
  – Alerts and resulting action taken
  – Communication issues with GPs or hospitals
  – Near misses
  – Controlled Drug incidents
  – Delivery incidents
  – Prescribing errors
Error occurrence

• Errors occur when a complicated set of circumstances converge
• Important to understand relationships between circumstances

Gather information  Analyse  Reflect
Patient safety culture

• Create a culture of learning and continuous improvement that is present in every pharmacy with regards to patient safety

Just culture  Increased reporting  Increased learning  Improved patient safety
Patient safety report criterion

• Community pharmacies are already required to keep and maintain an ongoing log of patient safety incidents

• As part of the quality payments scheme, a “written safety report at premises level available for inspection at review point, covering analysis of incidents and incident patterns (taken from an ongoing log), evidence of sharing learning locally and nationally, and actions taken in response to national patient safety alerts” is required

• Worth 20 quality points which can be claimed only once

• Worth at least £1,280
Breaking down the criterion

- Contractors are required to demonstrate that they have:
  - **Collated incidents and near misses from an ongoing log**
  - **Analysed these and looked for patterns**
  - **Reflected on learning from incidents**
  - **Recorded actions taken to minimise future risk from repeated errors**
  - **Shared learning locally and *nationally***
  - **Evidenced specific actions taken by the pharmacy in response to local errors and national patient safety alerts issued by the Central Alerting System**

Your NPA represents, supports, protects

NPA National Pharmacy Association
1. Patient safety incident occurs (e.g. near miss, dispensing error, prescribing error)

2. Investigate incident, cause of error, learning from it, actions taken to prevent error recurring

3. Act to make changes in practice as identified through investigation

4. Share learning with the pharmacy team, agree changes in practice as required and implement

5. Share learning with other local pharmacies, local GPs, LPC members and other, as relevant

6. Learn from both in-house incidents and those shared by other pharmacies/LPC/GPs locally

7. Monitor and review changed practices for effectiveness

Sharing learning locally
1. Patient safety incident occurs:
Near miss, dispensing error, prescribing error

- Ensure logs (including near miss) and SOPs are in place
- Follow SOPs for reporting incidents
- Ensure intervention book is available
- Bookmark NPA patient safety incident report form
2. Investigate incident: cause of error, learning from it, actions taken to prevent error recurring

- Is a root cause analysis necessary to identify the cause of the incident and prevent reoccurrence?
- Identify specific factors that can be changed to prevent reoccurrence
3. **Act** to make changes in practice as identified through investigation

- For example:
  - Making changes to dispensary layout to separate lookalike and sound-alike drugs
  - PMR alerts added to patients with similar sounding names
4. **Share learning** with the pharmacy team, agree changes in practice as required and implement

- Arrange regular team huddles – ensure team is aware of the errors that occurred, the causes and contributing factors (if identified)
  - In doing so, pharmacy teams can reduce error reoccurrence

- Take suggestions from team on what can be done to prevent incidents and practical solutions based on day-to-day experiences and the way the team works (for example current procedures)
5. **Share** learning with other local pharmacies, local GPs, LPC members and others, as relevant

- Communicate all prescribing errors with relevant GPs for audit purposes and to prevent reoccurrence
- Report all incidents to GPs to ensure necessary follow up and not compromise patient care
- Consider using LPCs monthly news letters, where available, to highlight key learning points on a local level rather than solely internally, reaching out to a wider audience
6. **Learn** from both in-house incidents and those shared by other pharmacies/LPC/GPs locally

- Share learning with other healthcare professionals
- Actively seek learning points and practical solutions from other healthcare professionals
- Regularly communicate with all healthcare professionals
7. Monitor and review changed practices for effectiveness

- Regular audits ensure practical changes have had the desired effect and positive outcomes on patient safety
  - Have similar incidents reduced?
  - Has the pharmacy team noticed a difference?
  - Have any further leanings emerged as a result of these changes?
1. Community pharmacy - Patient safety incident occurs (e.g. near miss, dispensing error, prescribing error)

2. Community pharmacy - Investigate incident, cause of error, learning from it, actions taken to prevent error recurring

3. Community pharmacy - report the patient safety incident using the NPA patient safety reporting form online

4. NPA - Reports collated and analysed. Incidents reported are anonymised

5. NPA - Quarterly MSO report of trends and learnings gained from analysing the reports produced

6. NPA - Quarterly MSO report cascaded back to independent community pharmacies + shared with NHS Improvement + CPPSG of MSOs

7. Community Pharmacy - share learnings with the pharmacy team with the pharmacy team, local GPs, LPC, other local pharmacies

Sharing learning nationally
NPA MSO quarterly reports

- Quarterly trend analysis of reported incidents
- Identify common errors and themes
- Includes top tips and practical supporting guidance
- Communicate patterns and trends to community pharmacies whilst providing practical solutions
- Examples of NPA resources produced as a result of analysing reported incidents include:
  - Inhaler and insulin identification checkers
  - Dispensing process best practice
- Report shared nationally with community pharmacies, NHS Improvement and the Community Pharmacy Patient Safety Group of MSOs
- Also available on the NPA website (open access)

Next MSO report is due tomorrow via superintendent update to all superintendents and via NPA email on Friday
Annual patient safety report

WORKED EXAMPLE
LEYLA’S PHARMACY
Community Pharmacy Quality Payment Scheme

Annual Patient Safety Report template: guidance and examples

<table>
<thead>
<tr>
<th>Pharmacy name (&amp; branch number if applicable)</th>
<th>Leyla’s Pharmacy</th>
<th>ODS (F code)</th>
<th>FDS1</th>
<th>Date of report</th>
<th>Date of report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report completed by</td>
<td>LH</td>
<td>Period covered by the report</td>
<td>01/04/16</td>
<td>to</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Pharmacy team members who participated in preparing this report (initials)</td>
<td>JP, NP, HR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
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<tr>
<td>2016-2017</td>
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<td>1</td>
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<td>2</td>
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<td>2</td>
<td>1</td>
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<td>Prescribing incidents</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Near Misses</td>
<td>12</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Dispensing incidents</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other patient safety activity*</td>
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<td>0</td>
<td>0</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*(e.g. response to medicines recalls, national patient safety alerts)

1) Describe the key learnings that have made the most significant improvements to your team’s professional practice.

Guidance

- Consider each incident from the previous 12 months and identify the most important things that have been learnt as a result.
- These are incidents that have had made an impact in the way the pharmacy team works, and have led to an improvement in patient safety.
- This will be specific to individual pharmacies. By looking at the previous 12 months, a pattern may appear in the types of errors being made, the specific drugs involved, or particular stages of the dispensing process where the errors are occurring allowing for trend analysis.
Example
- The most common ‘wrong drug/medicine’ name errors were bendroflumethiazide/bisoprolol and pregabalin/gabapentin, each occurring over seven times within the 12 month period.
- On three separate occasions there were dispensing errors involving medication for children – one child in particular was dispensed ciprofloxacin oral suspension 250mg/5ml, incorrectly labelled as 5 x 5ml spoonfuls BD, rather than 1 x 5ml spoonful BD – the child was administered this dose for 3 days.
- There were ten incidents where full patient identification checks were not undertaken when handing out medication.

2) List the actions the team has taken because of the key learning points (listed in 1).

Guidance
- List the actions that have been taken, in the previous 12 months, as a result of the incidents identified.

Example
- The reasons behind why these mix ups happened have been identified, for example, similar packaging and stored next to each other in the dispensary.
- Additionally, flash up warnings on the PMR appear for the most common medicines involved in ‘wrong drug/medicine’ errors/incidents.
- Additional checks have been implemented when dispensing any medication for patients under 18 years of age – this includes additional dose/clinical checks and also accuracy checks for the products and labels dispensed.
- All members of the pharmacy team have been re-trained to undertake full identification checks, rather than making assumptions.
- All relevant SOPs have been updated too and re-read and signed by all relevant members of the pharmacy team.
- Each member of the pharmacy team then periodically undertakes a small quiz to test their knowledge of the SOP.
3) Describe how you have shared the key learnings (listed in 1).

**Guidance**
- Explain how learnings have been shared within the pharmacy team, or within the wider pharmacy organisation.

**Example**
- Key learning points from any patient safety incidents have been shared with the whole pharmacy team at regular patient safety meetings/huddles, and relevant safety incidents have been communicated to locum pharmacists/staff.
- Key learning points from patient safety incidents have also been shared locally with other pharmacies in the local area to raise awareness.
- Meeting with the local practices every two months to discuss reoccurring prescribing incidents.
- Patient safety incidents have been submitted to the NPA via the online report form. The NPA analyses the reported incidents and identifies common errors and trends, and produces a quarterly report which also includes this information along with suggestions on how to prevent the same errors repeating themselves. The report is cascaded to community pharmacies and also sent to NHS Improvement, as well as shared with the Community Pharmacy Patient Safety Group of MSO to share the learnings nationally.

4) What patient safety improvements have occurred in the pharmacy because of the actions the team has taken (listed in 2)?

**Guidance**
- This should set out how the measures put in place to minimise errors have helped and what evidence there is to account for this.

**Example**
- Near miss audit conducted on: 01 October 2016 and repeated on: 01 March 2017.
- Dispensing errors have reduced by 5% overall between the two audit periods.
- Identified time of the day most dispensing errors occurred – between 2-3pm and 5-6pm – therefore ensured breaks are taken before these periods and staff rota amended to accommodate for these periods.
- Ensure up-to-date resources, such as BNFC, are available to undertake clinical checks of children’s prescriptions and bookmarked EMC website to confirm licensed doses.
5) What has the team done in response to any relevant National Patient Safety Alerts and Drug Recalls within the last 12 months?

Guidance
- This field would include the actions put in place as a result of various alerts that are issued throughout the year by NHS England/NHS Improvement/MHRA/Department of Health
- This will depend on the nature of the alerts issued, but may include:
  - Changes to SOPs
  - Additional warning cards being given out to patients
  - Additional counselling at the point of supply
  - Speaking to patients that may have been dispensed medication that are included drug recalls
  - Following directions regarding drug recalls for example returning recalled batches of medication to the wholesaler

Example
- A total of 34 alerts were received over the year
- 23 of which from the MHRA and 11 from NHS Improvement
- Six of these were relevant to our pharmacy:
  - **EL (16)A/03 Class 4 - Crestor 5mg Pl**: one box of the relevant batch was found and returned to the wholesaler
  - **EL (16)A/06 Class 2 - Epistatus 10mg in 1ml Oromucosal Solution**: one patient was contacted to return the product for checking
  - **EL (16)A/12 Class 2 - GlucaGen 1mg HypoKit**: two patients were asked to return their kits to the pharmacy for replacement
  - **EL (16)A/17 Class 4 - Amoxicillin Sugar Free Suspension 250mg/5ml and 125mg/5ml**: two bottles of the affected batches could not be opened using the handling instructions provided by the company; these were returned to the supplier
  - **EL (16)A/16 Class 2 - Evocal D3 1500mg/400iu Chewable Tablets**: two boxes of pack size 56 were found on the shelf and returned to the wholesaler for credit
  - **MHRA: Drug Safety Update**: Valproate and risk of abnormal pregnancy outcomes: new communication materials
    - Communication materials printed and pharmacy staff are using it to support discussion of the risks of use with women of childbearing potential
    - SOPs amended accordingly
6) Reflecting on this report, what will be the team’s patient safety priorities for the next 12 months?

Guidance

- This will be unique to the pharmacy, and will depend on what the pharmacy team feel is the most important area to focus on.
- Factors such as whether further improvements need to be made in areas already identified, or whether there are new areas to focus on in addition to recognising what changes have made a difference should be considered.

Example

- The past year has seen an improved patient safety culture within the pharmacy and amongst the pharmacy team.
- Regular staff huddles are planned over the next 12 months.
- Over the past 12 months, the team improved the working relationships with the nearest GP practices and have arranged to attend their monthly practice meetings.
- We aim to reduce patient safety incidents by a further 8%, by implementing the following changes:
  - SOPs reviewed to ensure two members of staff are always involved in the dispensing process.
  - Alerts to be added on PMRs of patients with similar surnames to confirm date of birth when giving out.
  - NPA Patient safety quarterly reports printed and staff briefed in order to prevent potential errors thereby ensuring the pharmacy implements a proactive rather than reactive approach to patient safety.
  - Nominating a member of the team as the patient safety champion – responsibilities include collating and briefing the team in relevant patient safety updates and information on a weekly basis.

This report may contain confidential information – retain this report within the pharmacy.
<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SUGGESTIONS ON HOW TO MEET CRITERIA</th>
</tr>
</thead>
</table>
| ✓ Collated incidents and near misses from an ongoing log | • Near miss log  
• NPA patient safety incident report from – print/email back  
• Intervention book |
| ✓ Analysed these and looked for patterns | • Regular patient safety audits  
• Any commonly occurring incidents  
• Trend analysis |
| ✓ Reflected on learning from incidents | • Root cause analysis  
• Include findings and prevention of reoccurrence |
| ✓ Recorded actions taken to minimise future risk from repeated errors | • A written action plan  
• Keep track of changes being implemented  
• Facilitate auditing |
| ✓ Shared learning locally and nationally | • Team meeting huddles ; can include minutes  
• Keep copies of written correspondence  
• Keep records of verbal correspondence |
| ✓ Evidenced specific actions taken by the pharmacy in response to local errors and national patient safety alerts issued by the Central Alerting System | • Drug and device alerts log  
• NPA Pharmacy team: MHRA and CAS alerts  
• Keep a copy of alerts and a written log with action taken |
Validation process

- NHS England has been working with the NHS BSA to undertake validation checks
- Contractors may be requested to provide further information
- Some validation procedures are still to be undertaken
- Currently validation or quality checking process for patient safety written report is not known
Potential validation processes

• NHS BSA receives all quality payments declarations made by contractors

• A potential validation process may involve:
  – A small number of contractors may be asked to submit copies of their annual patient safety report
  – The sample cohort is likely to be analysed and checked against the QP patient safety report criteria as covered earlier
  – If many sample reports are found to be non-compliant, a larger sample may be called up
  – If the original sample is found to be meeting the criteria, then unlikely that a larger sample would be called for
Top tips

✓ Collate information monthly and combine annually
✓ Involve all pharmacy staff
✓ Ensure annual report does not replace previous provisions for incident reporting
✓ Look at the NPA’s quarterly MSO reports
✓ Think about patient safety on a wider scale
✓ Action all Patient Safety Alerts, and record what you have done
✓ Reflection is key
✓ Keep clear records and make it auditable
NPA support

• Representing independent community pharmacies as part of the Community Pharmacy Patient Safety Group (CPPSG)

• Range of resources
  – MDS suite of resources
  – Delivery resources and guidance documents
  – Best practice dispensing guidance
  – Insulin identification checker
  – Inhaler identification checker

• Essential SOPs pack which has patient safety at its core
Advice and Support

NPA Pharmacy team

📞 01727 891800

9am - 6pm (Mon-Fri)
9am - 1pm (Sat)

✉️ pharmacyservices@npa.co.uk