How patient safety is being improved

While pharmacists wait for guidelines that could offer greater protection against criminal prosecution of single dispensing errors, it is clear that pharmacies are not prepared to stand still on the issue of patient safety, reports Ailsa Colquhoun

Across community pharmacy networks, tangible initiatives are under way, designed to improve not just daily dispensing practice, but also overall organisational efficiency and inter-pharmacy learning — all of which are seen to contribute to dispensing accuracy.

As Penny Beck, superintendent pharmacist at Tesco, comments: “Patient safety has to receive our constant attention. Nobody makes mistakes on purpose but we do have to ensure that the environment and our work practices are as safe as possible.”

Third check for Tesco

Among the key patient safety initiatives now in place at Tesco is a third check, which takes place just before the medicine is supplied to the customer. Although the company accepts that this has workload implications for its branches, it maintains that the practice has boosted patient safety and that the workload implications for the pharmacist have been acknowledged in a standard operating procedure (SOP) that allows delegation of the third check to trained support staff. In turn, SOPs are constantly reviewed in order to ensure optimum relevance.

Tesco has also evaluated the layout and work flow of its pharmacies, in order to achieve the most ergonomic approach in what Ms Beck admits “can be limited spaces”.

In 2007, the National Patient Safety Agency (NPSA) published guidance on dispensary design after finding that, in community pharmacies, over 80 per cent of dispensing errors are picking errors (ie, the selection of the wrong strength or formulation of the correct medicine, or the wrong medicine completely). Its “Design for patient safety” report highlighted the role of designated areas for prescription receipt and collection, and for prescription checking and preparation.

At Tesco, wherever possible, its pharmacies are designed to avoid “cross over of [prescription] ins and outs” and there are designated, separate areas for prescription preparation and checking, according to Ms Beck. And, noting NPSA statistics highlighting the low error reporting rates from community pharmacies, Tesco prioritises its NPSA error reporting and ensures that lessons are communicated to branches via monthly bulletins, she adds. (The NPSA report “Safety in doses: improving the use of medicines in the NHS” finds that medication incidents make up the third largest group of all incidents reported, but that just 5 per cent of reports relating to medication incidents come from community pharmacy.)

Improvement at Boots

Similar initiatives are also under way at Boots The Chemists, which, according to a spokesman, “works on a continuous improvement programme to systematically improve the operation of our pharmacies”. The company’s patient-safety programme includes a number of initiatives designed to “challenge the tidiness and organisation of [its] dispensaries, reduce interruptions to workflow by better queue management and improved handout processes, and improve the management of repeat prescription deadlines which enables better workload planning.”

Angela Chalmers, pharmacist in charge at Boots’s Holloway Road store in London, says that training in stock and prescription handling, in particular, has made a massive difference to her pharmacy’s efficiency. In her branch, stock is now put straight onto shelves, and sorted alphabetically in situ, rather than initially being sorted on the bench. Assembled prescriptions are also alphabetically sorted, and then subdivided into small trays. Ms Chalmers believes both initiatives save a considerable amount of time during the working day, taking pressure off the dispensary team.

She also commends her pharmacy’s dispensing incident management review process, which takes place after every six near misses. Near misses are categorised by type or medicine and in the review the team is invited to provide solutions to the problem. She
says team members are the best people to ask about this. “They are pleased to take on a little bit of extra responsibility and it gives them ownership of the dispensary.”

In addition, Boots also considers SOPs an essential building block in delivering patient safety. It has over 80 SOPs covering core dispensing processes, Controlled Drug procedures, care home services procedures, pharmacy services and, more recently, responsible pharmacist requirements. The company says: “We take opportunities to update SOPs on an ongoing basis where this is necessary to enhance patient safety or in response to a perceived risk.” In the past four months, for example, Boots has updated SOPs on delivering medicines safely and effectively, handing out medicines to patients and dispensing methotrexate.

**Structured communications at Co-op**

Now comprising nearly 800 branches, the Co-operative Pharmacy has become a major player in UK pharmacy multiples, with many of its branches operated by sole pharmacists. Superintendent pharmacist Janice Perkins is clear where the patient safety priority is for the company: shared learning. This year, the company is ramping up its branch communications strategy, with a risk management initiative designed to boost patient safety.

According to Ms Perkins, this is likely to take the form of a four-page document, to be distributed to all branches in printed form and via the intranet, with content based on real-life incidents and solutions from the branches, as well as from head office. Provisionally entitled “Focus on…”, the document will cover specific areas of practice, such as CDs, in an easily accessible, bite-sized format.

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- The importance of recording errors and near misses
- The need to review and revise SOPs
- The need for staff training on errors
- That more care is required when dispensing
- The importance and role of accredited checking technicians

**Virtual chains**

According to Numark, over 700 of its members have recently attended a series of free training workshops designed to help pharmacies tackle the challenge of dispensing prescriptions accurately and timely, and in a manner that the patient is used to.

“All of us in pharmacy were shaken recently by the criminal charges brought for a simple error. It has made many of us think how we tackle the unfortunate reality of dispensing errors in pharmacy and manage the associated risks,” says Mimi Lau, Numark’s director of professional and training services.

Run in association with training provider Buttercups, the workshops look at how and why errors occur and what steps can be taken to reduce their incidence. Delegates are encouraged to take actions to maximise patient safety. The main points to arise from the events include:
- Butcher’s local patient safety award
- The importance of recording errors and near misses
- The need to review and revise SOPs
- The need for staff training on errors
- That more care is required when dispensing
- The importance and role of accredited checking technicians

Ray Mackie, a Numark member from Falkirk attended a workshop run in Glasgow. He says: “We found that whether it’s a small rural village pharmacy, or a pharmacy dispensing 20,000 items, there are common themes and problems. It highlighted to me how concerned technicians and dispensers are about getting a criminal record and there isn’t much we can do to reassure them at the moment until the legislation is changed.”

In light of the training, which also highlighted the NPSA research on dispensary design, Mr Mackie has incorporated a more logical dispensary workflow into his planned pharmacy refit. He says the training has also encouraged him and his team to discuss when mistakes happen and how they occur in order to prevent a recurrence.

The workshops are a rolling initiative for Numark members, taking place in two rounds across the UK each year. Members and why errors occur and what steps can be taken to reduce their incidence. Delegates are encouraged to take actions to maximise patient safety. The main points to arise from the events include:
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**A near-miss reporting system**

**Error reporting mechanisms, monthly feedback (via a newsletter) and advisory visits on highlighted areas of risk**

**A focus on CDs, in particular patient counselling and condition prescribing or dispensing dosage errors**

**SOPs covering legal, professional, clinical and technical checking of prescriptions, as well as patient safety (eg, near miss and error reporting)**

**A range of patient safety cards, including a methotrexate warning card, contraceptive pill antibiotic warning and advice card, and a St John’s wort pre-purchase advice card**

**An annual in-house patient safety award that recognises pharmacists, staff and branch teams who commit to improving patient safety through, for example, regular near miss reporting and advice on patient safety themes and problems. It highlighted to me how concerned technicians and dispensers are about getting a criminal record and there isn’t much we can do to reassure them at the moment until the legislation is changed.”**

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**Safety in the independent sector**

Since winning the first Alnus Patient Safety Award in 2005 for a traffic light system of incident reporting put in place, Right Medicine Pharmacy in Scotland, superintendent pharmacist Jonathan Burton has developed his patient-safety offering to suit the needs of a business, the Right Medicine Pharmacy group, now comprising 11 branches based across central Scotland. Mr Burton says the overall aim of his patient safety initiatives is to encourage reporting. He says: “The first part of [the] battle is getting staff to report errors and near-misses. Until recently, errors have been something of a taboo subject but they will happen, so we start from that premise and work back.”

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**Vanessa Kingsbury, managing director at Buttercups, says that Numark is not the only organisation to be placing renewed emphasis on training, particularly in the area of patient safety. She reports that demand for her company’s pharmacy technician checking courses — both from sole proprietors and multiples — has increased three fold over the past year. She attributes the increase to the evolving pharmacy team “who have to redefine their individual roles or find themselves spread too thinly and/or unable to reach organisational targets for additional services.” She adds that there has been a pleasantly surprising shift in attitudes from community technicians, who, she says, “are not only willing, but are enthusiastic about taking on new responsibilities such as checking.”**