A workbook-style resource has been developed to help pharmacy teams build skills and knowledge around medication safety. What can be learnt from such an approach?

Ways to embed medication safety in pharmacy practice

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It is well recognised that medication incidents account for a substantial proportion of patient safety incidents1,2 and that pharmacists in all sectors of healthcare are central to delivering safer medication practice.3,4

Pharmacy staff at all levels of practice need to embed medication safety into their day-to-day work, and the training and development they receive must support them in this aim.

The medicines use and safety team at East and South East England Specialist Pharmacy Services have an established role in providing learning events and written resources around medication safety. We decided to build on these well evaluated resources and, to do so, explored the medication safety training that was being delivered in the NHS organisations within our catchment area. Here we set out:

- What we learnt about the medication safety training that is currently used by pharmacy staff
- How an NHS resource could be used by individuals and small groups to develop their medication safety practice
- What extra resources we are developing to complement such training and development

Developing resources

We started by preparing a workbook-style resource, with sections that refocused the seven steps of patient safety (developed by the National Patient Safety Agency) more specifically around medication safety.3,5 For example, the section on “leading and supporting staff” was adapted to cover: the expectations of pharmacy as a profession; instilling safe medication practice in others; assuring pharmacy services are safe; and developing the pharmacy team in medication safety.

All grades of pharmacists and senior pharmacy technicians can use the workbook to support their personal CPD, to help with formal post-qualification development and to encourage peer-group discussions and pharmacy team development in the workplace. Each section of the workbook contains learning outcomes, top tips, case studies and ideas for CPD. Different fonts and text colours are used to distinguish material aimed at all pharmacy staff from information designed for lead medication safety pharmacists.

Launch

We launched the workbook resource at face-to-face group sessions for pharmacist and pharmacy technician leaders, including those with lead roles in medication safety, to demonstrate how it might be used. The sessions were attended by 160 participants (63 pharmacists and 97 pharmacy technicians) from 70 primary- and secondary-care NHS organisations across London and the east and south east of England.

We used two sections of the resource to illustrate its use; we covered risk assessment and the reporting of medication errors in sessions that were a mixture of formal presentations and interactive contributions from participants. During the sessions we also explored the following with the participants through discussions and an evaluation questionnaire:

- What training they received in the workplace relating to medication safety
- How they might use the workbook in their workplace
- What support they needed to achieve their aims

Feedback

We collated the contributions from the sessions and we were able to identify key themes from the feedback and evaluation.

Currently available training

According to information gathered in the face-to-face sessions, medication safety training tends to be embedded within other training rather than delivered as a stand-alone topic. Responses around medication safety training are summarised in the Box on p151.

Uptake of the workbook

From the questionnaires completed at the end of the sessions, a total of 47 different intentions were declared by 138 participants which, when grouped, showed that:

- 37 (27%) planned to use the resource for their own development
- 24 (17%) planned to deliver training on medication safety
- 28 (20%) planned to review their processes to improve reporting and feedback on medication incidents

Specific examples included using the workbook for a review of current medication safety policies, for...
improving operational and clinical pharmacy procedures (to include a reporting aspect within them) and for training small or large groups of other healthcare professionals of all grades.

**Longer-term follow-up**
All participants were sent a post-session questionnaire in November 2011, which was six months after we delivered the last launch session. We wanted to find out whether the participants had used the workbook and, if so, how they had used it, the barriers they had encountered and what further support or resources we could provide to overcome these barriers.

The follow-up survey was returned by 25 of the 160 participants (16%) representing 25 of the 70 original organisations (36%). Just under half of respondents used the resource for personal CPD, with reporting and implementing solutions to reducing harm being the most popular sections used. In addition, 32% of respondents used the resource with others in the workplace, with all seven sections used; the most popular topic was investigating adverse events.

**Barriers identified**
The main barrier to use of the resource was a lack of time to develop and deliver specific sessions; other barriers included staff shortages and difficulty presenting the more complex aspects in short session formats.

The additional support they required to facilitate local dissemination and embracing medication safety operationally could be grouped into three main themes:

- Networking and sharing of issues and resources relating to medication safety
- Development of web-based or smaller training resources such as online sessions, further case examples or short session packs that could be delivered locally
- Time to prepare for and deliver local sessions

**Solutions**
As a result of the evaluation and feedback from the sessions, we have delivered further sessions around reporting medication errors and risk assessment, applying this to medicines reconciliation in particular.

We have also produced the first of a planned series of one-hour training packages, starting with identifying and reporting medication-related adverse events (based on our seven steps resource). This includes a comprehensive lesson plan, slides and adaptable case examples; the package is designed for easy delivery at a local level. These additional resources should help solve the time commitment required for in-house development of such delivery tools.

We also have a medication safety network for pharmacists and pharmacy technicians to share issues and queries.

**Next steps**
It is clear from our findings that there is a demand for formal local training and communication mechanisms to encourage consistent reporting and feedback that will embed medication safety into everyday practice.

Such initiatives need to reach all pharmacy staff so that medication safety is at the forefront of their daily work routines. This is becoming increasingly important in light of changes within the NHS; it is also worth noting that medication error reporting has been highlighted in the NHS Outcomes Framework.

The medication use and safety team will continue to develop tools that aim to make this achievable. All the resources mentioned in this article are available at www.medicines.nhs.uk/en/Communities/NHS/SPS-E-and-SE-England/Meds-use-and-safety.

**References**