## Our Vision

To become the preferred local pharmacy in the heart of the communities we serve.

## Our Mission

To go above and beyond to deliver personalised health and wellbeing services and valued products in a friendly and compassionate way so that every customer can make the most of their health.

**Pharmacy Superintendent's Team:**
Contact us at Well Support
0333 010 0111 option 4

- **Patient Safety**
- SOPs
- Responsible Pharmacist
- Information Governance
- NHS Contract
- Business Continuity
- Superintendent's Message

Pharmacy
Superintendent's Team

safe and well

January 2016

Your Essential Guide to

# Patient Safety


Pharmacy
Superintendent's Team

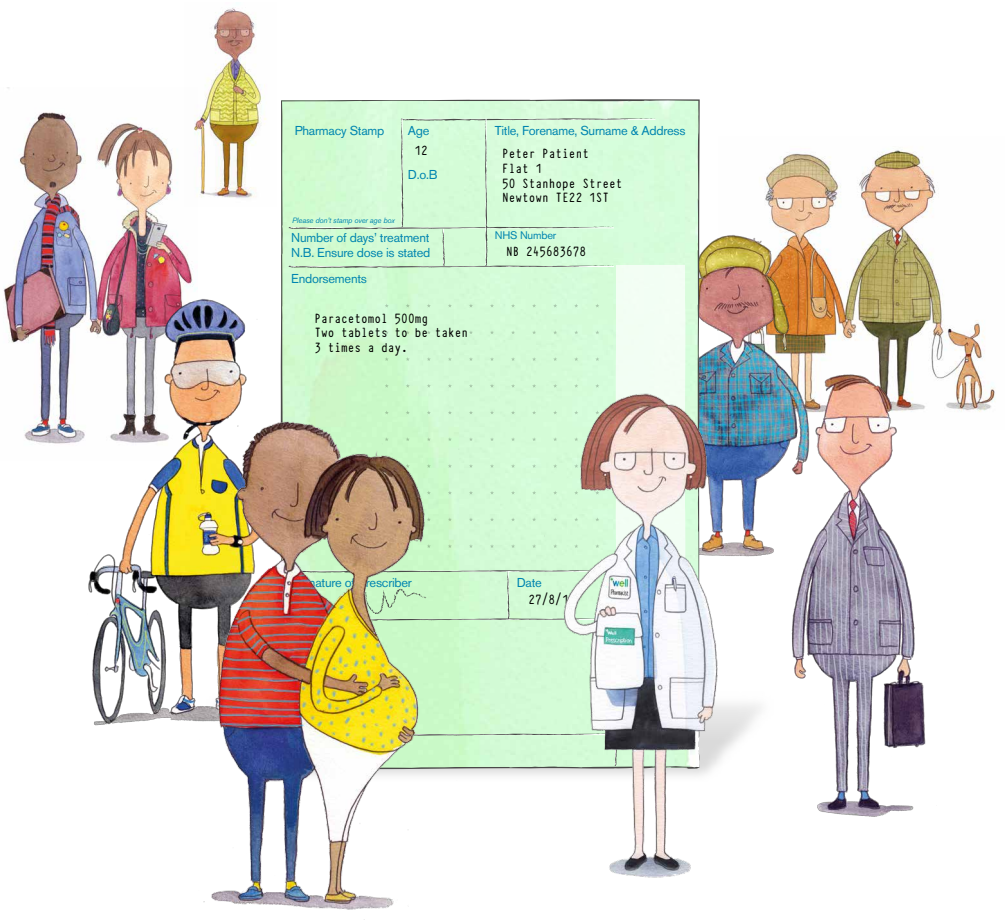
safe and well

well

## Contents

# safe and well

Our patient safety culture



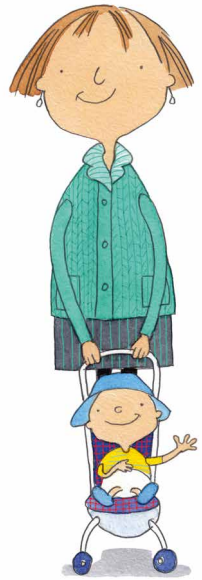

Safe and Well is thinking about the person behind every prescription.

# What is Safe and Well?

Safe and Well is not a campaign, or a service, it's the phrase we use when we are talking about our patient safety culture at Well. It is so important that every colleague understands the part they have to play in patient safety.

As the third largest pharmacy in the UK we serve and advise around 1.3 million customers each week. That is a lot of people who have trusted us with their most precious thing – their health and wellbeing.

Patient safety is about putting our patients first. Identifying where things could go wrong and dealing with them properly when they do. Whether it's getting the right medicine to the right person, or supporting the colleagues that do, we're all responsible for building an open and honest culture around patient safety.



"A key business priority is to embed a culture of patient safety and ensure all colleagues understand the factors that can impact our patients and customers"

Janice Perkins, Pharmacy Superintendent

safe and well

# Patient Safety Culture

# An introduction to Safe and Well

Expert

**We are expert. That means we can be relied on to dispense expert advice as well as medicines, and deliver this with dedication, focus and enthusiasm. But that doesn't mean we don't make mistakes.**

Nobody sets out to get it wrong. But making sure we acknowledge, share and learn from any of the mistakes we've made is really important. It's one of our priorities as a professional healthcare business. By doing this it'll make sure we don't make the same mistake twice, something our patients will not forget or easily forgive.

**The Superintendent's Team** are here to help, they want you to know you are not alone in putting things right and will help you get back on track, giving you the right guidance and support when you need it most.

But safety is everybody's responsibility. If you see something that could be improved...

"speak up!"

Working in a Safe and Well environment is led by teamwork and effective communication and by working together we can find ways of making the patient experience better and safer.

You will have heard about how the NHS is changing through **Building Our Future** and it is really exciting to see the role of the community pharmacy developing and growing, helping make sure we are the first port of call for people's primary healthcare.

But we need to make sure that with these changes we are protecting our patients.

So thinking about the person behind every prescription cannot be under-estimated, whether you're giving advice to Peter, delivering a prescription to Mohammed, or helping Susan to stop smoking, think about what we can do to look after their health and wellbeing.


Human

**Patient Safety shows that we are human and we care and that we can be trusted to face up to challenges, sharing knowledge along the way so everyone can do their job Safe and Well.**

Patient safety underpins all interactions that you have with your patients, when providing dispensing and other services.

The NHS focus on patient safety has changed since the report of the Francis Inquiry into the failings in care at Mid Staffordshire Hospitals. Much work has been done across both hospital and community settings to create an open and honest culture in relation to patient safety, reporting when things go wrong so that learning can be shared for the future protection of patients.

**Safe and Well is personal to Well and sits alongside the work completed in the NHS improving patient safety. We need your involvement, as we develop a culture and focus of working on patient safety together.**

We want to convey an openness and drive on reporting all incidents in branch, it should feel the right thing to do and there should be no reservation. As experts, all our colleagues should be confident in using DATIX, our reporting tool and feel empowered to complete the report, taking ownership to learn from what has happened.

We want to break down any internal barriers to reporting incidents. The focus is on report, share and learn not on blame. The PS Team are here to support you.

# Our Values

There are 3 main ingredients to being Safe and Well:


We always see the person first, not the process. Working to processes and SOPs reduce the risk of error and are important, but thinking of the person first not the process makes sure that we see the **person behind every prescription** and provide a personalised service and protect our patients' safety even more.

We are compassionate and always act with integrity even when something goes wrong.


We work as a team respecting each other and our patients. We take individual and collective responsibility for our actions, discussing ways of working to **protect our patients**.


We are **professional, proud and passionate** and we work to these values to protect the safety of our patients. We share knowledge and information openly if something does go wrong, learning what happened and why, can protect our patients in the future.

# Implementing Our Values

We need every individual working for Well, in branches, in the field, Central Support, the HSC and Wardles to embed **Safe and Well** in their routine and daily workings – it has to be important to everyone.

We hope that you will find that within the PS Team and the company, there is a culture of support when something goes wrong, not judgement. It's about finding out what happened and why, not whose fault, so that by finding out the root cause and contributory factors, the same mistake doesn't happen again.

It is important that individuals know their part in what happened, so they can reflect personally as to what they will do differently in the future.

**Safe and Well** is our company patient safety platform and underpins all business activity. When you hear or see **Safe and Well**, relate back to your patients and their Safety – a consistent reminder of what is important to our patients – 'their health'.

Datix
report, share and learn

**Datix** is our incident reporting system. Using the information submitted by you, through Datix, the PS Team can share any trends identified, to help stop the same thing happening to another patient in another branch.

The PS Team will do our part in sharing if you do yours in reporting.

Think of your family and friends and focus as if you were doing this for them.

# Patient Safety in the NHS

To understand the background thinking and importance of Safe and Well, it is important to have an overview relating to the wider NHS.

Published in February 2013 the report of the **Francis Inquiry** has had far reaching implications for the whole of the NHS. The implications for pharmacy have been discussed across the profession and the key areas of focus are:


**The rebalancing medicines legislation workstream** is looking at the decriminalisation of dispensing errors. The requirement for implementing a duty of candour across the profession and the NHS starts with a culture change of openness and transparency.

The creation of the Medication Safety Officer (MSO) role within community pharmacy has enabled the sharing of safety best practice and learning. This new role exists in the 18 largest multiples and the NPA undertake the role for the independent sector. It's a great example of competitors working together to improve patient safety. This is shared with you through guidance, SOPs and shared learning forums.

Pharmacy Voice joined the NHS England's Sign up to Safety campaign and launched a Patient Safety Group for community pharmacy MSOs. Our superintendent Janice Perkins leads this group. The key priorities of the group are to understand the culture that underpins safe practice and in particular the human factors that impact the dispensing process. It is also about developing patient safety best practice.

Safe and Well is our way of supporting the wider NHS agenda.

# Duty of Candour

It is expected that a healthcare professional will act in open and honest manner when something goes wrong and in a patient's best interest. This is referred to in the NHS as **Duty of Candour.**

This means that when something goes wrong that affects a patient's health or causes distress you should:

- Speak to the patient or those close to them as soon as possible when something goes wrong
- Apologise to the patient or those close to them
- Offer to resolve matters with the patient and explain what will be done to prevent this happening again
- Explain fully to the patient or those close to them the short and any long term effects of what has happened. This may require discussing with the prescriber or referring the patient into medical care.

Our values also support this.

Human

**We are compassionate and always act with integrity**

Effective

**We take individual and collective responsibility for our actions**

Expert

**We share knowledge and information openly**

**The PS Team can support you with this requirement, advising you or speaking to patients or their relatives, so telephone us if it's urgent and remember always report the incident.**

This culture extends to you being open and honest with your colleagues and employers and also encouraging and supporting others to do the same.

Do not try to prevent colleagues from raising concerns about patient safety. Anyone raising concerns is protected from unfair criticism, detriment or dismissal.

Pharmacy Home Page > Raising Concerns for further information



## What Duty of Candour means in practice:


...all errors at an early stage so that lessons can be learned quickly, and patients are protected from harm in the future.


...the importance of patient safety and reporting errors with all colleagues in the branch. We want all colleagues to feel empowered. Patient Safety is not just the responsibility of the pharmacist.


...from near miss recording or any errors that have happened. Have a dedicated monthly Safe and Well huddle.

...from reviewing your ways of working and branch processes against the SOPs. Remember a small change could potentially prevent harm to one of your patients.

...to identify any risks to patient safety and discuss options together.

...to plan ahead during periods of colleague holidays or public bank holidays to protect patients at the most busiest times.

# Raising Concerns

The pharmacy is a constantly changing environment with changes in the prescription and OTC business, new services being implemented and colleague and pharmacist personnel changes, all in a days work. Refits and challenges with equipment failure (PMR) can increase the pressure in the working day.

This can lead to changes in the patient safety risk profile in the pharmacy. One day may be running smoothly with all work completed and patients served as soon as they walk through the door, but this is not every day. Think about how your branch runs:

- Before a public bank holiday
- When colleagues are on holiday or sick
- During driver absence and how this affects the delivery service

In addition over the last few years we have seen the rollout of EPS in England with NMS and DMS services in England and Wales complementing the MUR service, and the introduction of Flu vaccination services. Until effective ways of working and best practice are established this can lead to increased risk to our patients.

Registered professionals have a responsibility under GPhC Standards to raise concerns to protect the health and wellbeing of patients. If something goes wrong and concerns are not escalated resulting in harm to patients, they will be asked to give an account of their actions and decisions.

"speak up!"

If a colleague in any of our branches feels that there is a real risk to the safety of our patients it is important to raise concerns. Firstly with your own team and manager.
Plan the work differently to protect your patients' safety.

Talk to your colleagues in neighbouring branches. Patient safety is everyone's concern and working together as a wider team makes sure we support each other and all our patients.

If you need further advice and support with what to do, then escalate your concerns to the Regional Development Manager (RDM). The Pharmacy Superintendent's Team and Divisional Professional Standards Managers (DPSMs) are also there to talk to and for support.


Pharmacy Home Page / Raising Concerns & Whistle blowing

# GPhC Standards for Registered Premises

**How does the GPhC standards and Inspection Framework relate to Patient safety and our values?**

Putting the patient at the heart of care is a key NHS goal but also a regulatory priority and therefore all 5 principles in the Standards relate back to**… "safeguard the health, safety and wellbeing of patients and the public"**

## The 5 principles:

### 1 The governance arrangements…

Meeting the standards through company SOPs, completing near miss recording and analysis, and reporting and learning from patient safety incidents.
We safeguard children and vulnerable adults.

We create a trusted environment to help those who need it.

Human

### 2 Staff are empowered and competent…

The Responsible Pharmacist SOPs (colleague matrix and colleague rota) help organise the team workload. Completing qualification training and continued learning through company communications, the intranet and our electronic learning platform E Expert, mean our colleagues have the appropriate skills, qualifications and competency for their roles and tasks.

We work as a team, respecting each other and our customers.

Effective


### 3 The environment and condition of the premises from which pharmacy services are provided, and any associated premises…

We are dedicated to make sure the working environment is appropriate for the provision of healthcare through refits, relocation and maintenance.

We are committed to fixing business issues which impact on our people being effective in their jobs.

Effective

### 4 The way in which pharmacy services, including the management of medicines and medical devices, are delivered…

Our services are accessible and offered to our patients and then delivered safely and effectively. Recalls are actioned and in a timely manner.

We can be relied upon to dispense expert advice as well as medicines, services and products and deliver this with dedication, focus and enthusiasm.

Expert

### 5 The equipment and facilities used in the provision of pharmacy services…

Equipment that is needed for services is readily available and facilities protect the privacy and dignity of patients.

We anticipate the needs of our customers and our people; we work proactively to meet them.

Expert

Colleagues are expected to show how they are meeting the standards during an inspection. Any aspect of the inspection rated poor not only means the standards are not being met, but shows there is a significant risk to the health, safety and wellbeing of patients and the public. So the principles of Safe and Well relate closely to the regulatory standards.

# GPhC Standards of Conduct, Ethics and Performance

## General Pharmaceutical Council

The GPhC standards of conduct, ethics and performance fit closely with our values at Well and whilst registered pharmacy professionals embed the GPhC standards in their work ethic and their personal values there is an expectation that all our colleagues will work in a human, effective and expert way.

The GPhC will judge the registered pharmacy professional (pharmacist and technician) against their standards.


### GPhc Standards, as a pharmacy professional, you must:

1. Make patients your first concern
2. Use your professional judgement in the interests of patients and the public
3. Show respect for others
4. Encourage patients and the public to participate in decisions about their care
5. Develop your professional knowledge and competence
6. Be honest and trustworthy
7. Take responsibility for your working practices.

## Pharmaceutical Society of Northern Ireland

As a registered pharmacist in Northern Ireland the governing body is different but the underlying message is the same and you are required to abide by the Code of Ethics.

To fully understand how these standards and values relate to patient safety discuss with your peers and re-read the PSNI mandatory principles & obligations looking at your personal working practices.

Pharmacy Superintendent's Team, Safe and Well GPhC
Pharmacy Home Page / Raising Concerns & Whistle blowing

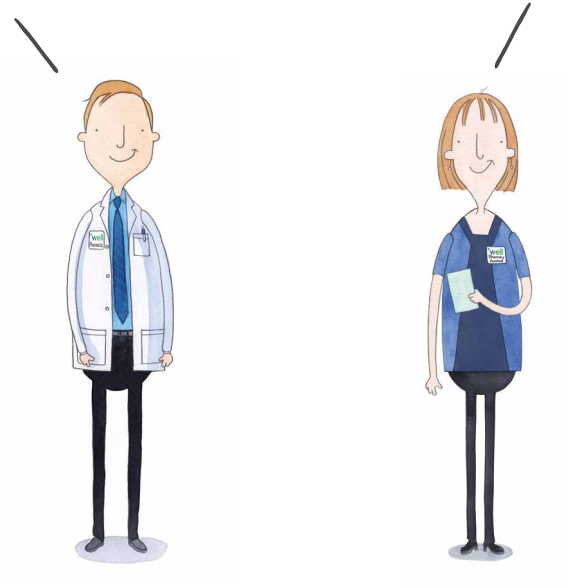
# The Registered Pharmacy Professional

The NHS and healthcare services are changing and the registered pharmacy professional's role is developing with an increased contribution to public health.

## Why did you join the profession as a pharmacist or technician?

To help patients and the public

To improve patients health and wellbeing




It is important during busy and challenging periods to remember why and what this means.

Take responsibility to lead your team to protect the safety of our patients by following the GPhC personal standards of conduct, ethics and performance / PSNI code of ethics and remember why you joined the register.

Increasingly as a registered pharmacy professional working for Well we will relate your role and responsibilities together with our values to protect patient safety through Safe and Well. You should be clear of the expectations we have for you, as our professional leaders.

# Patient Centred Professionalism

"Someone who is professional, is competent in their discipline, takes pride in their work and keeps up to date with what they need to know. Someone who is patient centred, always puts the interests of their patients and especially their safety first; listens to their patients; and is responsive to their needs and preferences."

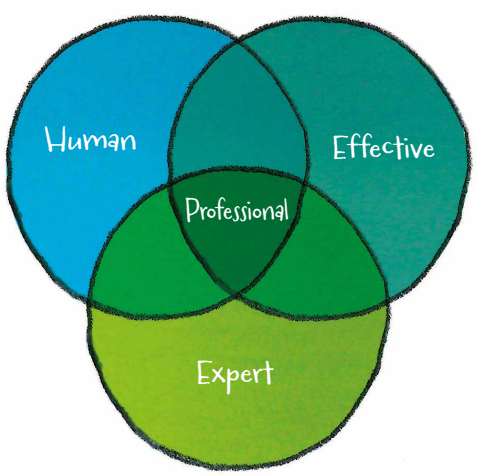
Peter Walsh, Chief Executive, Action Against Medical Accidents

At Well this is what we want from all our colleagues and managers, in branch and Central Support, at the HSC and Wardles.

We want this from colleagues of all roles from health care assistants, drivers, pharmacy assistants as well as our registered pharmacy professionals.

Professionalism; Our patients trust us because we act with honesty and integrity and we have the expert knowledge and competency to provide a high quality service – we care.

Working to our values with an equal emphasis on all leads to overall professionalism – does this describe you and your team?




# Reducing risk and protecting our patients

# Near miss completion and learning

## Why is it important to monitor near misses?

We aim within the culture of Safe and Well to achieve a genuine personal desire for all colleagues to record near misses knowing that the information collated will help, when shared, to reduce the risk of harm to our patients.

Completion of a near miss record is also a clinical governance requirement, a contractual requirement and shows we are meeting the GPhC Standards for Registered Pharmacies (you can use it as evidence in an inspection). The inspector will ask if you record near misses and will expect every colleague from the dispensing team to explain why they are recorded and what is done with the information.

Near misses are now recorded on Datix which can generate a report that can be analysed and discussed at your Safe and Well huddle.

Pharmacy Superintendent's Team / Safe and Well / Patient Safety Resource Pack


# Risk Assessment, Review and Audit.

GPhC Inspectors expect colleagues to not only be aware of the GPhC Standards for Registered Pharmacies but also the more recent guidance relating to providing services at a distance. You may think that this does not apply to the dispensing and services that you provide but it does! It applies to FRPS, EPS, deliveries and more. The importance of risk assessment, review and audit is detailed in the guidance.

Pharmacy Superintendent's Team / Safe and Well / GPhC

Risk Assessments are completed centrally as part of the scope for any new projects and procedures. We also review the risks when we change processes centrally. Often a pilot or trial is run prior to the launch across all branches and the results analysed to make sure that we get it right and protect our patients' health.

The review process for Standard Operating Procedures is completed at least every 2 years to incorporate the learnings and feedback from branch teams to protect our patients' health across all branches.

## What are you doing in your branch?

- When you change a way of working do you think if there could be an adverse effect on your patients' health? – Consider any unintentional consequences when changing how you do things in branch.
- When you have a change in personnel or when a new colleague starts do you plan out their training and allocate tasks with patient safety in mind?
- After a change to ways of working do you go back in a month's time to review if the changes have unintentional consequences?
- Are you confident speaking to an inspector about how you risk assess processes in branch to protect the health, safety and wellbeing of patients and the public?

# Colleague training and capability

It is a GPhC requirement and included in the Responsible Pharmacist Regulations, that all colleagues working in a pharmacy have the appropriate qualification for their role and their tasks should match their qualification and expertise.
(RP SOPs)

From healthcare assistants and pharmacy assistants in the dispensary to the Registered Pharmacy Technician and Pharmacist all qualification training is equally important for the roles needed in the pharmacy.

A colleague cannot work outside their competency or qualification without a real and serious risk to patient safety.

The initial training is just the start, to protect patients and give a personal and expert service it is important that all colleagues are competent and confident in the role. Community pharmacy is continually evolving and the required learning evolves alongside. Registered pharmacy professionals have a requirement to complete CPD relevant to their role, but it is as important that all colleagues keep up to date. Remember our company value to be expert.

Well can provide tools to help with your learning, but everyone is individual with different knowledge and experience so every colleague, both in Central Support and in branch, needs to take the responsibility to be an expert in their role. We are a pharmacy business and our patients can expect personalised and expert care.

## Top tips

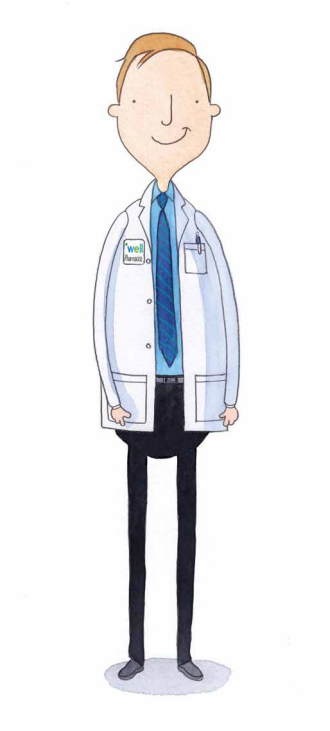
**Use the information on the intranet and associated links to improve your knowledge.**

**During a planogram changeover discuss how any new products in the pharmacy will be sold.**

**Read Branch Talk and other communications and discuss the learnings within the team so you know all the team have understood the message. Complete online E Expert training modules relating to your role.**

# Standard Operating Procedures (SOPs)

**SOPs** may be a GPhC requirement or required for the delivery of a service within the SLA, but the importance of SOPs is to ensure a consistent and safe way of working across the business to protect patients.



SOPs can protect the health of our patients but only if the processes detailed in the SOP are implemented and followed. The periodical review of SOPs incorporates changes to regulations, best practice and learning from previous incidents reported by branch colleagues.

Previously the company SOPs were detailed and the number of SOPs meant they were time consuming to read and implement. Our SOPs have been simplified and now detail the basics of 'what' it is that you need to do, but not 'how' to do it. There is operational guidance that sits alongside the SOPs to help you with 'how'.

## Much time is taken by colleagues reading the SOPs but what is the next step?

Set up a dedicated huddle after you receive a new / updated SOP to discuss how the content differs from practices in your branch. **Are any changes needed to your ways of working?**

We realise that not all pharmacies are the same and so you do have the option of completing a Local Variation (LV). **You should always consider: is a LV really necessary? Will this increase the risk to patient safety?**

## Some of our learning:

Bagging MDS as part of the accuracy check prevents the incorrect name and address label being attached when MDS are being prepared for delivery.

It also means that any MDS in the pharmacy that has not been bagged has not been checked and so also stops unchecked MDS being handed out or delivered to our patients. We know this because it's happened and has resulted in **vulnerable patients being hospitalised.** Think about whether **you are protecting your patients** as well as you could.

The MDS record card and event diary are detailed in the SOP. Our experience says that if these are not used and kept up to date then this increases the risk of incorrect dispensing to our vulnerable patients receiving MDS.

Patients have received medication that has previously been stopped by their doctor, been given medication at the wrong time of day and had current medication missed out of the MDS as a result of incomplete paperwork. We have a duty of care to these patients to ensure they receive their current medication at the right time and on the right day before they run out. **Are the MDS record card and events diary up to date for all of your patients?**

# Safeguarding – Protection of children and vulnerable adults

**Safe and Well** is about protecting our most vulnerable customers and all our colleagues have a role, including our drivers. Safeguarding in pharmacy is also an NHS contractual requirement and included in the GPhC standards for registered premises, it is an important aspect of patient safety.

## For our drivers

- It isn't just about delivering medication to the right address but recognising when a child, an elderly person or any of the patients you deliver to needs help – it's how you care for your patients.
- You may have concerns about a patient's living conditions or notice that they seem a bit confused.
- Understanding the importance of raising concerns with the pharmacist back in branch could have a huge effect on the patient's health.

Pharmacy Superintendent's Team / Safe and Well / Safeguarding

# Patient Safety Incidents (PSIs)

# Patient Safety Incidents – What to do if things goes wrong

## What is a patient safety near miss?

An error in dispensing, OTC advice or service delivery that is identified before reaching a patient.

## What is a Dispensing Incident (DI)?

An error that occurs at any stage of the dispensing process and is not identified until after the patient has received the medication.

## What is a Patient Safety Incident (PSI)?

This is more wide reaching, it focuses on the patient, their care and their health, so a PSI is any error that has affected a patient's health or has had the potential to affect a patient's health.

- A prescribing incident which was not picked up during the dispensing and checking process and so reached the patient
- A dispensing incident where a patient may have received the incorrect medication, incorrect directions or medication intended for another patient
- A significant interaction between two medicines, either dispensed or bought
- Supply or sale of out of date medication
- Incorrect service provision, including needle stick injuries to patients, incorrect advice or provision of a service outside the Service Level Agreement (SLA) or PGD
- Incorrect counselling of prescribed or OTC medication
- Missed medication – a patient running out of their medication and missing one or more doses. (think about FRPS, missed late deliveries and EPS)

**You should report all Patient Safety Incidents and not just dispensing incidents, as protecting the health of our patients is what is important to us.**



# The Importance of Reporting

**Safe and Well** aims to create an open and honest culture encouraging reporting and reinforcing our Duty of Candour.

**Datix** is our reporting tool that makes reporting easier and allows trends and learning to be shared with branch teams and with the National Reporting and Learning System (NRLS).

NRLS reporting is a requirement, but more importantly it gives the NRLS the opportunity to gather nationwide data and share across the wider NHS, to protect patients on a larger scale.

We understand that things go wrong, but what we cannot understand is choosing not to report an incident. Whether you are a branch colleague, locum or branch manager protect your patients and report.

If there are any barriers to reporting talk to your Regional Development Manager, your Divisional Professional Standards Manager (DPSM) or the Pharmacy Superintendent's Team – we are there to support and advise, not to judge.

# The root cause and contributing factors

## Step 1

Take immediate action to make sure that the patient gets any medical and supportive care they need.

## Step 2

Report the incident.

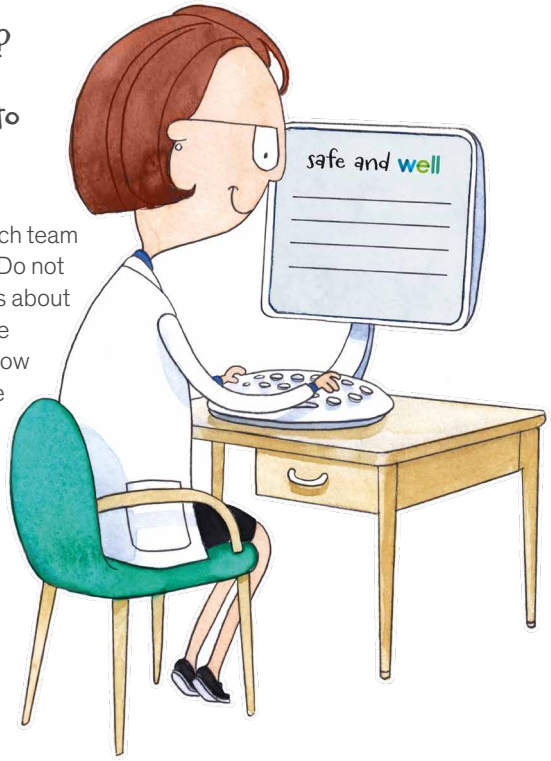
You could stop there but does this really protect your patients?

**Safe and Well** is that next step, the personal and team responsibility and desire to want to understand the detail and find out why the incident happened.

## What was the Root Cause?

## What factors contributed to the incident?

With most incidents there will be a branch team learning and learning for the individual. Do not only look at one aspect. Safe and Well is about finding the root cause and assessing the contributing factors in branch to learn how the risk could have been minimised. The individual dispenser and checker can spend time reflecting personally and this is also important.




**Don't wait for your Branch Manager, your RDM or the Pharmacy Superintendent's Team to ask, empower yourself and use the tools available:**

## Information Gathering

Look at finding out and documenting what happened, when it happened and environmental factors that could have contributed. From this information you can then identify the Root Cause(s)

## Analysing:

The information gathering tool may be sufficient to understand what went wrong, however many complex incidents include a combination of factors that require further questioning or thinking.

## For complex incidents you might also want to use:

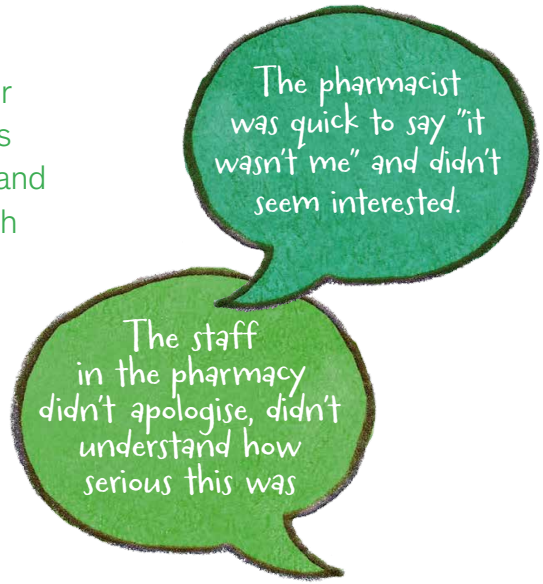
- **A timeline of events**
- **The Swiss Cheese Model**
- **NHS Fishbone Analysis Tool**
- **The 5 Whys**

Pharmacy Superintendent's Team / Safe and Well / Patient Safety Resource Pack

# Escalation and Resolution of PSIs

When our patients suffer harm or there has been a potential for harm, patients and their families feel let down, upset and angry and understandably sometimes wish to escalate their concerns.

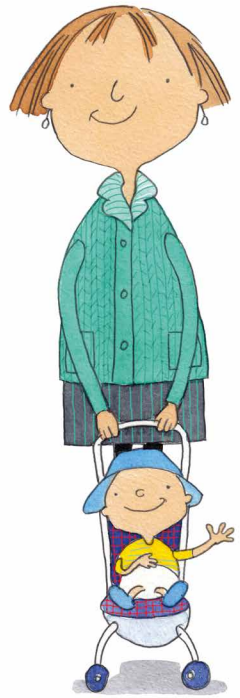
Patients often escalate their concerns due to the way they feel they have been treated in branch.




It is important to apologise and reassure the patient of the next steps – what do they want to happen?

**Remember Duty of Candour.**

Resolution of a PSI may be between the patient and the branch team, but the patient may not be happy with this and want to escalate as a formal complaint to the PS Team, the NHS, the GPhC, the ombudsman or even speak to the media. When it gets complicated let the Pharmacy Superintendent's Team take the lead, this is their role to support you and make sure the matter is resolved quickly and effectively. Speak to us.



## In particular:

- escalate any solicitor letters to us as we need to liaise with our insurers as a matter of urgency
- incidents involving Controlled Drugs require us to report to the Accountable Officer – we do this on your behalf

Pharmacy Superintendent's Team / Patient Safety Resource Pack

# Key Messages

**Reducing the risk and protecting our customers**

- Safe and Well is everyone's responsibility. By thinking differently we can improve patient safety in all of our branches.
- Trying to prevent something going wrong protects patients' health
- No one goes to work to make a mistake yet mistakes happen and sometimes with serious consequences

**Patient safety incidents – when it goes wrong**

- Be Human, Effective and Expert; making sure you acknowledge, apologise, report and learn from any mistakes or near misses.

...and remember the person behind every prescription