A professional duty to support patient safety culture through reporting, sharing and learning

*All pharmacists, pharmacy technicians and members of the pharmacy team need to uphold a professional duty to support a patient safety culture and a culture of learning and improvement by being open and honest when things go wrong and reporting actual errors and near misses to the appropriate reporting programme**

Introduction

The Royal Pharmaceutical Society, Pharmacy Forum NI, and Association of Pharmacy Technicians UK have supported changes to the law [1] [2] in the interests of improving patient safety and to promote increased error reporting, by removing the fear of criminal sanction for inadvertent dispensing errors.

It is our and the public's expectation that pharmacists, pharmacy technicians, and the teams they lead, report, share and learn from dispensing errors and near misses.

*All pharmacists, pharmacy technicians and members of the pharmacy team need to uphold a professional duty to support a patient safety culture and a culture of learning and improvement by being open and honest when things go wrong and reporting actual errors and near misses to the appropriate reporting programme**

*Derived from (1999) FIP statement of professional standards medication errors associated with prescribed medicines

Patient safety culture

In an organisation with an established patient safety culture the healthcare team will routinely demonstrate behaviour, ethos and values consistent with;

- being able to acknowledge mistakes, report them, share the intelligence, learn from the experience and then to put things right
- being open and transparent
- having respect and compassion for patients and colleagues
- empowerment and shared leadership across the healthcare team
- shared ownership, and the whole team taking part in reporting, sharing and learning
- habitually reporting all errors and near misses, with nothing too small to report

Culture is considered to be of paramount importance. Professor Donald Berwick described it's significance within his report to the NHS in 2013 'A promise to learn, a commitment to act'. He wrote "In the end, culture will trump rules, standards and control strategies every single time."

Why reporting, sharing and learning from errors is fundamental to prevention

The value in error reporting is to gather information and data which can used to identify the root causes of an incident. The information results in learning and the possibility of putting into place changes to minimise re-occurrence across a local or national system [3]. Error reporting is a fundamental part of a patient safety and improvement culture.

Near miss reporting is similarly valuable and benefits from being a pro-active approach to improving patient safety.

Barriers and enablers for error reporting

The table below summarises barriers to reporting and corresponding system enablers which encourage teams and organisations to report errors and share learning [6 7 8]

To promote error reporting as part of a culture of patient safety, it is important that these barriers are eroded and enablers supported by all stakeholders.

Barriers to reporting	System enabler
Fear of blame, reprimand, negative attitudes from colleagues, patients and employers, and involvement of the regulator. Fear that increased rates of error reporting will be perceived to be a sign of failure by patients and other stakeholders. Fear that increased rates of error reporting will be unfairly described out of context.	Create a defence to criminal sanction for inadvertent dispensing errors through the Rebalancing Medicines Legislation and Pharmacy Regulation programme
	Proportionate levels of anonymity for people or organisations reporting errors are built into local or national reporting systems
	Error reporting is actively promoted and supported by employing organisations
	Just culture principles and quality systems are embedded within teams 1. Within employing organisations 2. Within guidance and training programmes 3. Within regulation including through inspection and infringements 4. Within contract monitoring processes
	Campaigns to educate and raise awareness with the public and stakeholders that encouraging error reporting improves patient safety but to also expect that more errors will be reported as a result.
	Implement and/or make use of the leadership roles of patient safety networks across UK including: • "Freedom to Speak Up Guardians" or Care Quality Commission National Guardians • Medicines Safety Officers network [10]. • Scottish Patient Safety programme networks • HSC safety forum

	• Patient Safety Wales network
Burden (e.g. time and effort required to complete a report)	Making error reporting easy is a key behavioural science insight which can increase reporting [8]. Local and national error reporting systems need to be well-designed so reporting is as easy as possible[6 8], time to report is minimised, and doesn't require duplicate reporting for the same incident to multiple parties .
Perception of value of error reporting	The error reporting system needs to be able to provide feedback to pharmacy teams reporting those errors. This reinforces the perception that reporting is worthwhile and valued.
	Encourage error reporting behaviour e.g. local praise for reporting, sharing and learning as positive for patient safety but also to discourage non-reporting as unacceptable and detrimental to patient safety culture.
	For the wider system to incentivise reporting, sharing and learning and resulting patient safety outcomes.
Lack of knowledge of error reporting processes and understanding of positive examples of patient safety culture.	A number of behavioural science insights [8] relate to raising awareness of reporting including through: • highlighting key messages in communications promoting error reporting including positive examples of patient safety culture and value of reporting, sharing and learning • personalising communications e.g. colleague is addressed by name in communications which may be signed by a known respected leader • communications describing positive stories of active error reporting by other teams • communications highlighting the risk and impact if a report had not been made
	Use existing toolkits and support tools to promote reporting, sharing and learning • National Patient Safety Agency tools to help reporting • Scotland Patient Safety Tools • Patient Safety First, Implementing human factors in healthcare resource • Medicines Governance Northern Ireland website

Table summarising the existing regulatory framework related to error reporting and candour

This professional standard sits alongside the existing regulatory framework related to error reporting and candour which is summarised below.

<table>
<tr><th></th><th>England</th><th>Wales</th><th>Scotland</th><th>Northern Ireland</th></tr>
<tr><td rowspan="2">Individual pharmacists and pharmacy technicians</td><td colspan="3">GPhC standards of conduct ethics and performance (standards 1, 2, 7, 7.11) require registrants to ‘Make patients your first concern’, to ‘Be honest and trustworthy, and to ‘Make the relevant authority aware of any policies, systems, working conditions, or the actions, professional performance or health of others if they may affect patient care or public safety. If something goes wrong or if someone reports a concern to you, make sure that you deal with it appropriately’</td><td>Pharmaceutical Society of Northern Ireland code of ethics (standards 1, 7, 8, 8.13) require registrants to ‘Make the safety and welfare of your patients you prime concern, to ‘Act with honesty and integrity’ and to ‘Make known to relevant persons or bodies any concerns about policies, systems, working conditions, or the actions, professional performance or health of others that are likely to compromise patient care or public safety, or are already doing so</td></tr>
<tr><td colspan="4">The Chief Executive Officers of 8 healthcare regulatory bodies issued a joint statement on the professional duty of candour statement setting out their expectations for their registrants to be open and honest with patients when things go wrong.</td></tr>
<tr><td rowspan="2">Registered pharmacy premises</td><td colspan="3">The GPhC inspection decision-making framework for registered pharmacy premises references learning from error and near miss reporting as descriptors of ‘good’ pharmacies</td><td rowspan="2">The Health and Social Care Board (HSBC) has an anonymous adverse incident reporting system for community pharmacists. Although pharmacists are encouraged to report their adverse incidents to the HSCB, this is currently not a contractual requirement.</td></tr>
<tr><td>It is a requirement of the NHS community pharmacy contractual framework to record and report incidents to the National Reporting and Learning Service (NRLS)</td><td>It is a requirement of the NHS Welsh community pharmacy essential services specifications to record and report incidents to the National Reporting and Learning Service (NRLS)</td><td>The Health improvement Scotland national framework sets out the incident reporting system in Scotland</td></tr>
</table>

Healthcare organisations (e.g. NHS trust and independent sector)	A statutory duty of candour is applicable in England to NHS provider bodies registered with the Care Quality Commission (CQC). Implementation is currently subject to further review. CQC also expects notifications of incidents to be reported to NRLS* and CQC. The NHS constitution sets outs rights to which patients are entitled from the NHS or those providing NHS services.	Health Inspectorate wales have published a standard which requires reporting of incidents to the National Reporting and Learning Service (NRLS*)		Trusts are required to comply with Health and Social Care Board Serious Adverse Incident Procedure October 2013. The Department of Health, Social Services and Public Safety (DHSSPSNI) Controls Assurance Standards for Medicines Management and for Governance respectively also require Trusts and Trust pharmacies to report adverse incidents involving medicines. The Regulation and Quality Improvement Authority(RQIA) expects incidents in registered establishments to be reported to RQIA in line with and DHSSPSNI Minimum Care Standards.

* Not all providers currently have access to NRLS

Appendix 1

Members of the statement working group

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Appendix 2

<Promotional one page infographic/poster with the following key messages>

- Report errors
- Share intelligence
- Learn when things go wrong

…to establish a patient safety culture

All pharmacists, pharmacy technicians and members of the pharmacy team need to uphold a professional duty to support a patient safety culture and a culture of learning and improvement by being open and honest when things go wrong and reporting actual errors and near misses to the appropriate reporting programme

References

1. Royal Pharmaceutical Society consultation response to Department of Health Consultation on *Rebalancing Medicines Legislation and Pharmacy Regulation: draft orders under section 60 of the Health Act 1999*
2. Pharmacy Forum NI consultation response to Department of Health Consultation on *Rebalancing Medicines Legislation and Pharmacy Regulation; draft orders under section 60 of the health Act 1999*
3. General Medical Council & Nursing and Midwifery Council (2015) Openess and honesty when things go wrong: the professional duty of candour
4. Impact assessment: Rebalancing medicines legislation and pharmacy regulation programme: Dispensing errors
5. International Pharmaceutical Federation (1999) FIP statement of professional standards medication errors associated with prescribed medicines
6. NHS quality improvement Scotland (2007) Incident reporting culture extended national summary report
7. Wolf ZR, Hughes RG. Error Reporting and Disclosure. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 35.
8. Cabinet Office Behavioural Insights Team (2012) Applying behavioural insights to reduce fraud, error and debt
9. National Advisory Group on the Safety of Patients in England (2013) A promise to learn a commitment to Act
10. NHS England Patient Safety Alert (2014) Improving medication and error incident reporting and learning