Supporting a culture of near miss medication incident reporting within community pharmacy

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Incident reporting is an integral component of an organisation's safety culture. Pharmacy staff who don't report near misses (i.e. those detected before leaving the premises) may not learn from them. When near miss incidents are not reported, their causes usually go uncorrected. That means they may happen again, perhaps producing tomorrow's serious incident.

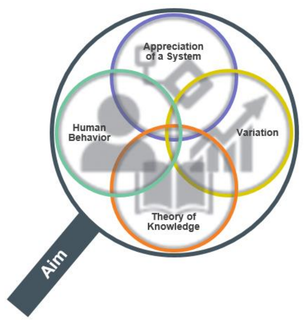
Aim To achieve weekly reporting of a minimum of one 'near miss' medication incident by 80% (8 out of 10) of pharmacy staff in one anonymous community pharmacy by 30th June 2019

Method

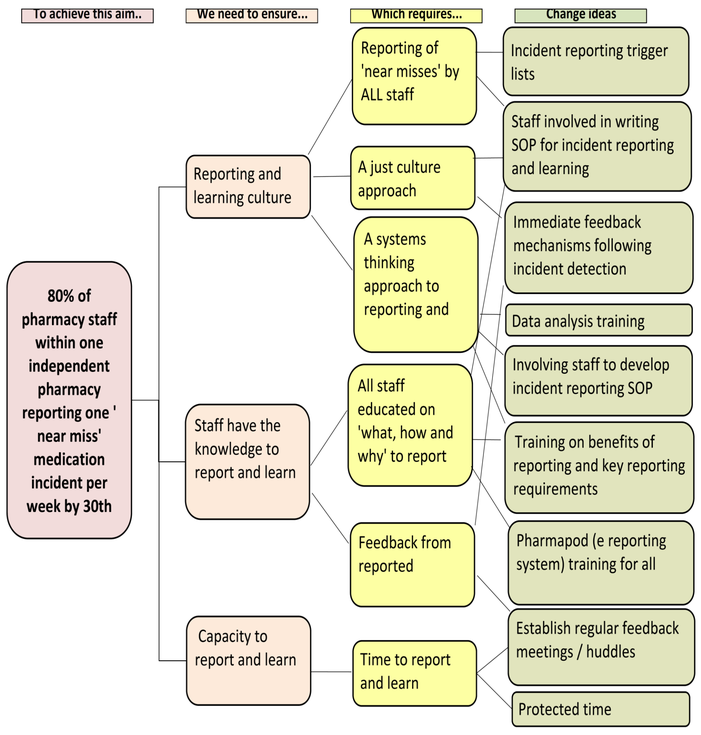
Understanding the system

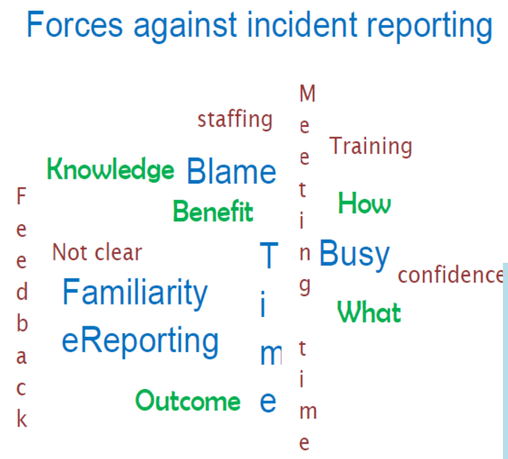
Tools applied to obtain knowledge of the reporting culture within the pharmacy team and ideas to create the vision for change:

- Cultural survey
- 'What's working well? Even better if?
- Force field analysis
- Benchmarking (site visit to another pharmacy)



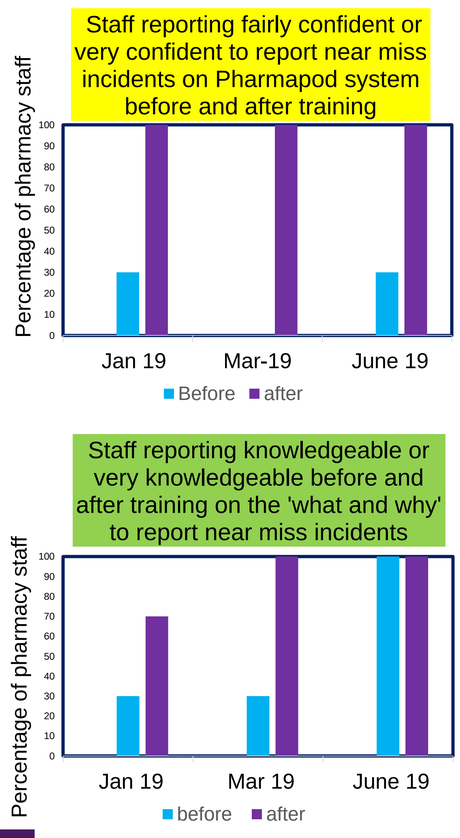
Change Theory



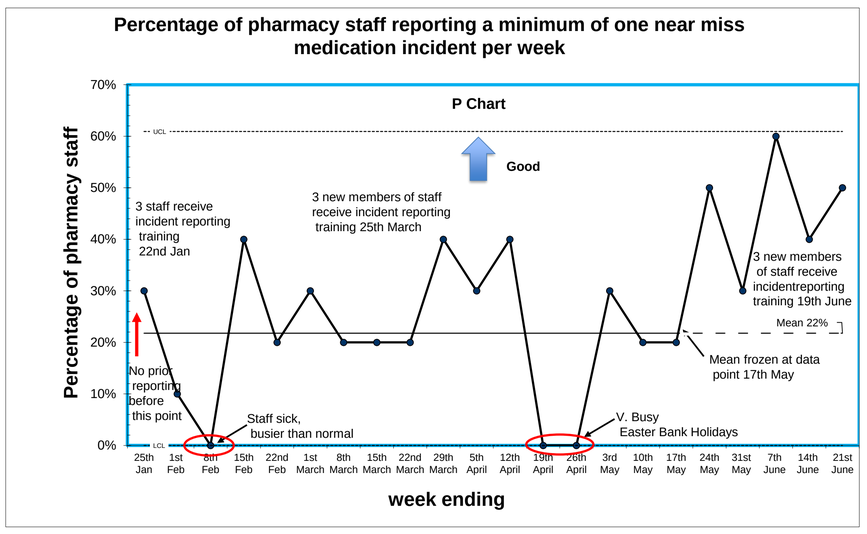


Strongest change ideas from Force Field Analysis

- Training on 'what' and 'why' to report
- Access and training for all staff on the electronic reporting system



Results



Baseline reporting was zero, results demonstrate an improvement. Special cause variation detected when there was no reporting over a bank holiday period.

Conclusions

- Embedding a culture of 'near miss' incident reporting is multi-factorial and must include ALL staff
- Knowledge on 'what', 'why' and 'how' to report leads to improved reporting
- Workload pressures are a barrier to reporting and would benefit from quality improvement approaches

Learning Points

Reflect often on Kotter's 8 stage process for change
A strong project team is the core of a successful project, invest the time
Don't use QI jargon with staff who don't understand the 'lingo'
Don't set 'aim' too high, important that staff celebrate success with early small wins
Improvement methodology must be an integral component to any organisation / business

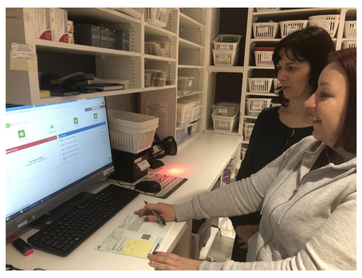
Achievements

- Good understanding of the system and team engagement
- Increased confidence of all pharmacy staff to identify and report 'near misses'
- Staff reporting 'near misses'
- Using data to inform improvement progress
- Development of personal skills to lead improvement and interpreting data charts to identify non random variation

Next steps

Share project learning with Northern Ireland's Health and Social Care Board and professional bodies.

Use improvement skills to lead and develop a regional medication safety quality improvement programme.



Key Reference Materials

Professional standards for the reporting, learning, sharing, taking action and review of incidents. RPS, APT, Pharmacy Forum NI, 2016
The Improvement Journey, Health Foundation May 2019

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