PHARMACY TECHNICIAN JOURNAL 11 | 2020

PTJ

Journal of the Association of Pharmacy Technicians United Kingdom

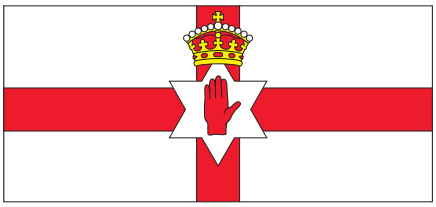
What does safety mean to you?

- Safety Tools and Techniques
- Different Approaches to Understanding Errors
- How You Can Make An Impact

ASSOCIATION OF PHARMACY TECHNICIANS U.K. FOUNDED 1952

Features

APTUK



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Near Miss or Good Catch?

Welcome to the last PTJ of 2020, as usual it's a jam packed edition, although content is a little different to recent editions as there is a theme to this edition; safety. We would welcome your thoughts on having a theme to some editions and whether you think this format works.

I'm very grateful to all the authors who freely submitted information around the safety theme. They have contributed a wide variety of articles and information, hopefully new and interesting to you. Had you heard of a safety bus? Is this an idea you can adapt to your area of practice? Read more on page 17. Community pharmacies deliver incredibly safe care and continue to do throughout the current pandemic. The Community Pharmacy Patient Safety Group is a cross-sector forum who openly share and learn from each other when things go wrong, their article gives a bit of background and information about how you can get involved. And safety is absolutely sector wide and also worldwide, evidenced by the Cleveland Clinic team who used a performance improvement initiative to introduce a safe system of work in Abu Dhabi.

At this time when things are changing around us at a great pace it is vital to ensure our work practices are safe and effective. Kelly's article on page 10 provides a wide range of ideas on how to minimise risks, whereas on page 16 read about Nicola's experience of implementing guidelines. From these articles you will see safety is everyone's responsibility but there are some roles that are specific to safety, on page 20 Sian tells us what a day in the life of a deputy medication safety officer may look like. The safety themed articles were initially submitted BC- before Covid, but all had an opportunity to refresh and renew content in light of our refreshed and renewed work practices.

APTUK work tirelessly to promote pharmacy technicians, their roles and ensure the safety of medicines. During October World Pharmacy Technician Day gave the opportunity to honour pharmacy technicians on the frontline.

A few pharmacy technicians have also been honoured and included in portrait projects. Being a portrait model its maybe not a traditional role for pharmacy technicians but the opportunity to recognise the dedication and hard work is greatly appreciated.

I have to say a huge thanks to all the national officers and authors for their contributions and especially Kelly Wood who helped grow the concept of a safety themed edition and worked with us to gather ideas and ensure an interesting range of relevant safety related articles were submitted. A key message for me comes from Sian who mentions 'good catches' in her article rather than near misses. I think this will be my take away point from the safety topic, read on to find what yours will be.

LIZ FIDLER FAPharmT
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President's Column

Dear Members,

Last edition of the PTJ was a truly special one, celebrating the roles that pharmacy technicians supported as part of a global pandemic response. If you are thinking that this edition is not going to be up to the same mark – you could not be more wrong! Patient safety is our bread and butter and whatever sector you work in patients are always at the heart of what we do.

Since the last PTJ, I reflect on the work undertaken by your professional leadership body on your behalf. I have been honoured to represent the profession at key meetings, discussing roles and the much-needed legislation changes required to enable us to do our jobs to the best of our abilities. I am truly optimistic that work will progress in these areas which will support us with much needed work on career pathways across sectors.

One thing is for certain in these challenging times, the value of pharmacy technicians is acknowledged. I hope that you were able to enjoy pharmacy technician day on 20th October 2020. Check out the centre pages for some of the photos! It was an amazing experience to see the recognition for the profession. I do hope you had the chance to read Dr. Ridge's open letter to the profession, you can find it further on in the journal with my response.

I just want to take this opportunity to thank those that have volunteered to support APTUK at this time. Our services have never been in more demand at a time when we are all balancing our work and family commitments. Without the commitment and dedication of a few individuals, we would not have a professional leadership body.

I refer you back to our outcomes during a pandemic- check out the website again! something to be incredibly proud of. Launching the UK wide National Competency Framework for Primary Care Pharmacy Technicians with our partners Primary Care Pharmacy Association (PCPA) and the Royal College of General Practioners (RCGP) is a key enabler for the profession. In addition, we have lobbied for inclusion on the list of healthcare professionals able to supply and administer medicines via a patient group direction (if that is something you would choose to do). We continue to work with system leaders to ensure that pharmacy technicians can support future vaccination programmes and are delighted that pharmacy technicians are included in the national protocol. More news and support may have been already issued ahead of PTJ publication and if it has not it will be! The Lord Carter review into technical services is out and we have begun discussions around registration for our colleagues in Northern Ireland building on Cathy Harrison's pledge at our APTUK conference in 2019.

In addition, we attended each home countries roundtable events sharing lessons learnt and our key priorities. A valued seat

at tables where strategy and policy are being agreed, providing a voice! Working collaboratively on key areas such as future pre-registration trainee pharmacy technicians.

I hope you have managed to attend one of our national webinars, one of the most informative for me was the 'Silence is not an option' facilitated by Stuart Lawrence. APTUK have been co-chairing a group on health inequalities with NHS England and the Royal Pharmaceutical Society as part of our commitment. I am delighted that Stuart will continue to work with the Board to provide support and expertise whilst we hold a mirror up to ourselves and strive to make things better. We will host more webinars as work progresses.

However, I would be amiss in not mentioning how valuable membership is to us, thank you to those of you that continue to be members – we truly value it, BUT we must strive to increase it. Bringing in more income will enable us to deliver more and look to a future model of paid posts.

As President I have been working with the Board of Directors on sustainability plans – not easy at any time, let alone during a pandemic and I am looking forward to sharing these with you late November. Plans we had before the pandemic had to halt and change dramatically which was disappointing, but reflective of where we all are right now!

We are at a critical point for the Association as we have built our credibility and delivered, but the current model is not sustainable and we need our members to work with us to ensure we are here to champion the profession in future years.

So do encourage your peers who are not members to consider joining and I am looking forward to meeting with you albeit virtually to share and discuss our future.

The future is hugely positive, lets continue to work together to ensure the professional leadership body continues to build on the amazing successes we have had this year!

Liz Fidler - November 2020

Meet the Committee

Name: Amy Laflin
Current APTUK role: National Officer for Foundation Practice
APTUK contact email: foundationpractice@aptuk.org

Describe your APTUK role, what you bring to APTUK & the benefits to you as an individual:

As a national officer I support the professional development workstream. I bring experience of working in academia, specifically for pharmacy support staff and pharmacy technicians of varying experiences whom are in varying stages of their careers. I have gained knowledge and skills from my time as a national officer as well as experienced great networking opportunities with other pharmacy technicians and those within the pharmacy profession. It is an absolute privilege to be a professional committee member and to work to support the profession and the APTUK team.

Current work role:

Amy began her pharmacy career in 2005 working in community pharmacy, where she trained as a medicines counter assistant and a dispenser. She moved into hospital pharmacy in 2009 and qualified as a pharmacy technician in 2012, where she specialised in technical services with Addenbrookes Hospital before returning to work as a rotational pharmacy technician at Ipswich Hospital where she gained her NVQ assessor award. Amy now works within academia and is programme lead for pharmacy education at West Suffolk College. Amy holds her Level 4 Certificate in Internal Quality Assurance, Level 4 Certificate in Education and Training and Level 5 ILM Award in Leadership and Management.

Amy also works as a local CPPE tutor, where she facilitates continued professional development events to pharmacists and pharmacy technicians. Amy also supports the CPPE ACPT programme where she facilitates professional discussions with pharmacy technicians whom are completing their ACPT course.

AMY LAFLIN MAPharmT
National Officer for Foundation Practice
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Name: Warren Francis
Current APTUK role: National Officer Devolved Countries Northern Ireland
APTUK contact email: NI@aptuk.org

Describe your APTUK role, what you bring to APTUK & the benefits to you as an individual:

As National Officer for Northern Ireland Warren is excited to represent APTUK in Northern Ireland.

Current work role:

Warren began his career in pharmacy in 1998 working for Boots the Chemists. In 2005 he moved to work in a busy independent pharmacy in Belfast. After gaining valuable experience, working in community pharmacy Warren moved into hospital pharmacy in 2010 working as a rotational pharmacy technician in the Northern Health and Social Care Trust. Alongside gaining experience in various areas of hospital pharmacy, and in particular Pharmacy Information and Communication Technology (ICT), Warren completed his ACPT accreditation.

After acting as Lead Technician for Community Services responsible for vaccine supplies to GP surgeries and schools in 2016 Warren decided to specialise in Pharmacy ICT and Robotics, taking up his current post as Lead Technician for ICT and Robotics in the Belfast Health and Social Care Trust (BHSCT). Warren has developed streamlined IT solutions for pharmacy which have been introduced across all Trusts in Northern Ireland.

Recently due to the COVID-19 pandemic, Warren was redeployed to the Victoria Pharmaceuticals manufacturing unit in BHSCT where he was involved in the production of medicines for the Northern Ireland COVID-19 centres.

In the next few months, Warren hopes to move to the Northern Ireland Encompass project which is a Health and Social Care wide initiative that will introduce a digital integrated care record to Northern Ireland.

WARREN FRANCIS MAPharmT
National Officer Northern Ireland
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APTUK Branches

Local branches are set up and run by volunteer members of APTUK, located in specific areas all over the UK. Branches carry out their activities and actions in the name of the Association of Pharmacy Technicians UK and deliver the aims, objectives and values of the Association and promote the sharing of best practice. Branches also support educational training and gaining revalidation evidence. They are a great opportunity for APTUK members to network across all pharmacy sectors, which was identified as a key benefit for members in the 2019 Voice of the Member research.

The restrictions, enforced as part of the response to the global pandemic means that branches were paused, along with other APTUK business. During this pause on business as usual for the Association work began on evaluating and then investing in technology to provide our members with a virtual experience.

A meeting with branch committee members and members of the Board of APTUK, held on the 6th October 2020, planned the branch offer to members during the Covid-19 restrictions. Differences in location restrictions, and no ability to be able to predict when the global pandemic will end enabling face-to-face events to return, the meeting focused on providing a virtual experience for our members. A standard agenda was agreed at the meeting and will include updates from the Board and the latest news from APTUK, discussions on any open consultations to gain branch member views, an educational session and local branch updates.

Wednesday 18th November 2020, see the first virtual, national branch meeting for members, with a limited number of tickets allocated for non-members. Zoom webinar will be used as the virtual platform and the London APTUK branch will be the hosts for the meeting. A rotating branch chair will be used to host each virtual, national meeting.

There will be a seasonal meeting held on Tuesday 8th December 2020 where branch updates will be followed by a Christmas quiz and a virtual fuddle! Attendees will be encouraged to wear Christmas attire (reindeer antlers/tinsel etc!) with a prize for the best dressed, have a drink and some Christmas food (mince pies etc!) ready to accompany the quiz. This meeting will be hosted by Yorkshire and the Humber branch and hopes to be a light-hearted, fun event to end what has been a challenging year for us all both personally and professionally.

Members should check out the Branch section of the website for upcoming branch virtual branch meetings and booking information.

Branches – we need to hear from you!

APTUK are contacting all branch committees to update, and improve their communication with branches. Those that attended the 6th October 2020 meeting were given access to a survey to complete to gather information on their branch. Those branches were; Aberdeen, Devon, Kent, London, Swindon, Virtual Technical Services and Yorkshire and the Humber. If you are part of a branch committee that did not attend the meeting, we need to hear from you! Whether you are active or considering closing we need to hear from you now!

Please contact **secretary@aptuk.org** so we can work to support you.

GAIL HALL
FAPharmT
Director APTUK
secretary@aptuk.org

Devolved Countries Update – Northern Ireland

The pandemic has slowed progress of various work streams; however, after much anticipation the Pharmacy Futures NI campaign was launched on 9th November 2020 and runs until January 2021. www.pharmacyfuturesni.com

Pharmacy Futures NI is a landmark campaign designed to significantly bolster the profession in Northern Ireland (NI) by attracting pharmacy staff to come and work here. The campaign is led by Pharmacy Forum NI in partnership with the Department of Health (DoH).

Specifically, Pharmacy Futures NI aims to:

- address the significant gap in the availability of qualified pharmacy professionals in NI
- fill 1,100+ additional roles in the pharmacy sector in NI over the next five years

The appointments will see current vacancies filled and new roles created – up to 560 pharmacists and 600+ pharmacy technicians (PT).

The requirement for the roles has been identified in the DoH 'Pharmacy Workforce Review', published in tandem with the Pharmacy Futures NI campaign and designed to inform Health and Social Care (HSC) workforce development needs in the pharmacy sector over the next 10 years.

The report reviewed the NI pharmacy workforce, to inform HSC workforce development needs for 2019-2029, focusing on the three main employed sectors; community, hospital and general practice pharmacy.

PTs in Northern Ireland (NI) are not regulated healthcare professionals. One consequence of this is that pharmacists in NI are still professionally accountable for all regulated activity in the pharmacy. Therefore, they tend to be reluctant to delegate some of their dispensing and management responsibilities in the absence of another registered professional, which limits the potential for service development. Full benefit of any alternative regulatory model designed to support maximum utilisation of skill mix may only be realised with registration of PTs, ensuring the full capability of the workforce is optimally utilised, whilst maintaining patient safety and public confidence.

For NI PTs the recommendations from the report suggest that:

- PTs should be encouraged to practice at the top of their skillset through appropriate pre- and post-registration training.
- a career as a PT should be promoted, particularly to school leavers. The HSC careers services should be utilised as a means of promoting the PT role.
- to maximise the benefit of skill-mix, work should be urgently progressed to enable the registration and regulation of the PT workforce in NI.

A recent meeting with Cathy Harrison, Chief Pharmaceutical Officer (CPO) for NI related to the recent developments surrounding the changing of legislation to allow registered PTs to administer vaccines under a Patient Group Direction (PGD). Due to NI PTs being unregistered there was concern this could cause a problem, therefore, we are seeking the CPO's support that legislation stipulates that PTs need to be registered to administer vaccines. We hope that this will act as an enabler for NI when PT registration does go through without causing a barrier to the rest of the UK at this stage. We also hope that is will aid in driving the PT registration issue in NI.

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CONSIDER IT DONE

Portraits articles

During the pandemic portraits of pharmacy technicians have been included in 2 projects, Healthcare Heros and Hold Still Project

Healthcare Heros

Michael says "We need the NHS and it was an honour to paint a portrait of my good friend Andrea Ashton who works in pharmacy this was included in an online Healthcare Heros exhibition
https://t.co/MgFQOBKXLi?amp=1.
https://artsandculture.google.com/project/healthcare-heroes

Hold Still Project National Portrait Gallery

My name is Joyce Duah, I'm a specialist oncology pharmacist at St Bartholomew's hospital
My portrait 'All in this together' of two pharmacy technicians, Amelia and Dipal donning PPE, was selected to be part of the Hold Still collection spearheaded by the Dutchess of Cambridge. It is a unique collective portrait launched to capture the UK during the coronavirus lockdown and is now being exhibited by the National Portrait Gallery virtually. They have been working hard as pharmacy technicians, delivering vital medication multiple times a day to ITU. I've watched Amelia and Dipal with such admiration for what they are doing and more importantly their positive attitudes. They spend their precious lunch breaks encouraging each other with humour and I think they are so brave. I decided I wanted to use my photography skills to document some of their journey. I asked Amelia if she would mind if I took some pictures of them donning their PPE and she happily accepted. I'm so proud of the team and all they do and it's been a privilege to capture their journey during this historic time. One of their practices is to write their names on their gowns so that colleagues are able to recognise each other under their PPE and to help the patients who are conscious to feel closer to their carers.

Since its release, I've had an overwhelming response by the pharmacy community and more specifically the pharmacy technician community for raising the profile of the profession and the contributions our sector has made during the pandemic.

For more information, please see **www.npg.org.uk/hold-still/** my image is number 57 - **www.npg.org.uk/hold-still/images/all-in-this-together/**

The Duchess of Cambridge and the National Portrait Gallery unveiled the Hold Still digital exhibition, featuring one hundred portraits selected from 31,598 submissions during the project's six-week entry period. Focussed on three core themes – Helpers and Heroes, Your New Normal and Acts of Kindness – the images present a unique record of our shared and individual experiences during this extraordinary period of history, conveying humour and grief, creativity and kindness, tragedy and hope. A selection of the photographs featured in the digital exhibition will also be shown in towns and cities across the UK later in the year.

www.npg.org.uk/holdstill
#HoldStill2020

This Country Needs you by MJ Ashcroft

Instagram: **@mj_ashcroft**
Twitter: **@MJAshcroft**
Web: **www.michaeljohnashcroft.com**

All in this Together by Joyce Duah

In My View... The Future for Community Pharmacy Technicians?

As a Store Manager who is also a pre-registration pharmacy technician working in community pharmacy, I am keen to know how the role I will be stepping into will evolve and figuring out how my career is going to progress in the future.

Pharmacy technicians are the backbone of community pharmacy. They often manage the day to day running of very busy dispensaries, dispense prescriptions, accuracy check prescriptions and sell medicines over the counter (OTC); the list is endless, however, there is scope for change.

I have noticed the increase in respect that pharmacists receive from patients and other healthcare professionals. However, I feel pharmacy technicians are not always receiving the same level of attention. I visualise, the relationship between pharmacists and pharmacy technicians to that of doctors and nurses. We have seen in recent years, doctors and patients relying so much heavier on the skills that nurses have. Advanced nurse practitioners in many practices are seeing patients with minor conditions and also help to manage long term conditions. The role of nurses has evolved, and many people now happily see a nurse instead of a doctor, so why would you not speak to a pharmacy technician rather than a pharmacist?

Pharmacy technicians are registered professionals who learn about clinical conditions as part of pharmacy technician training and are able to provide support to patients. I love the clinical aspect of my training and being able to learn about the conditions that I see prescriptions for on a daily basis. This training has broadened my knowledge and is providing me with a basic clinical understanding of the conditions which is enabling me to have conversations with patients about their medication. However, I wonder if patients are aware of the advice that pharmacy technicians could give. I feel my patients do not always trust what I or my pharmacy technician colleagues say, which can lead to the pharmacist repeating the exact same information seconds later, or even a strong dismissal when I say "I am a pre-registration pharmacy technician, I might be able to help?" Is it a lack of understanding of pharmacy technician's roles that they want to speak to the 'chemist' about the cold symptoms that they have? I suppose what I am trying to say is, are patients being made aware of the role of pharmacy technicians and being encouraged to come and speak to other pharmacy professionals?

Don't get me wrong, there are a lot of people who do listen to advice I give and are truly grateful, yet there are still those that do not seem to have the confidence in the roles that pharmacy technicians and pharmacy support staff do. I respect the role of the pharmacist and I am not suggesting that everyone should always seek advice from pharmacy technicians instead of pharmacists. More training for pharmacy technicians on common clinical conditions would enable us to provide more complete care for patients.

In Scotland, pharmacist's work under patient group directions (PGDs) which allow them to prescribe in certain circumstances prescription only medicines for certain conditions. The framework is often quite strict; however, they have been able to help a lot of patients. As the future for pharmacist training is evolving to potentially become prescribers at initial registration and with many working towards becoming independent prescribers, in my opinion, it will result in community pharmacy becoming more of a drop in clinic for common conditions, but also for managing long term conditions such as diabetes and hypertension, where pharmacist prescribers will be able to change a patients care plan where appropriate to the benefit of the patient. With independent prescribing pharmacists busy with patients, what is going to happen in the dispensary when patients are needing advice or medication under the Minor Ailments Scheme for example? My answer would be having pharmacy technicians prescribing under a PGD. There would be a formulary that has to be adhered to and inclusion and exclusion criteria for pharmacy technician prescribing. For years, nurses have been supplementary prescribers who prescribe from a formulary and within their clinical competence for patients. Pharmacy technicians, with enhanced clinical training in common clinical conditions, in my opinion, would be able to carry out a role similar to a supplementary prescriber. Pharmacy technicians are regulated pharmacy professionals, who are able to support patients daily. This idea would not only benefit patients but the NHS. As doctors are feeling the pressure, pharmacists are being provided with more powers and responsibility in the community, who is going to help with the jobs that pharmacists have been doing, but now no longer have the time to? Pharmacy technicians.

Over the past few months, community pharmacy has been at the forefront of the global pandemic and fight against Coronavirus. Community pharmacies across the nation have kept their doors open supporting patients when many other healthcare providers closed their doors. Throughout these uncertain times, the role of pharmacy technicians has been looked at to see how as a profession we could support in the fight against Coronavirus such as with administering vaccines. In my opinion, pharmacy technicians are a valuable resource in community pharmacy and in healthcare in general. This pandemic has shown that we have all stepped up and provided care and support to our most vulnerable patients and that we are capable of doing much more. I believe with more support and backing from Government, as a profession, pharmacy technicians could be given so many more opportunities in community pharmacy, providing support and help to patients and complementing the work of pharmacists.

I know this may cause a lot of questions and debate, much like the supervision debate, however, I think all of us that work in community pharmacy need to be open to the changes in our sector. As the role of pharmacists in community evolve, the role of pharmacy technicians must do too in order to provide the best service to patients and help the great burden on NHS resources.

CONOR DOYLE
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Different Approaches To Understanding Errors In The Workplace

Background

In July 2019 The Patient Safety Strategy[1] was published by NHS England and NHS Improvement. It reminds us that patient safety is about maximising the things that go right and minimising the things that go wrong.

Errors are often the consequence of poor systems and how we interact with these. To reduce errors we must understand the actions of the person involved and then identify what change or improvement is needed. Human error is inevitable when working in a busy environment and carrying out highly repetitive tasks. The Patient Safety Strategy acknowledges it is human to make mistakes; there is a continuous drive in the NHS to reduce the potential for error by learning from and implementing change when things go wrong.

In my experience, many people reflecting on errors they have been involved in are likely to be familiar with phrases like `I can't believe I did that' and others detailed in figure 1.

Figure 1: Common responses following an error

This article details two different approaches that can be taken when investigating errors in the work place; the Safety-I/Safety-II and the Yorkshire Contributory Factors Framework.

I use both of these in my role as Medicines Safety Pharmacy Technician and they help me to focus on how the error occurred rather than solely on what the error is.

The safety shift

The dictionary definition of safety is 'the state of being safe and protected from danger or harm'[2]. Across the NHS there is a focus on identifying when a situation is deemed unsafe and then working hard to make it safe. But how often do we stop and look at what is working well and consider what we can learn from it?

I recently tweeted a question asking what the word safety means to people. The general response was about understanding that errors will occur with a focus on minimising risk in a no blame culture. This approach to safety is known as Safety-I, which is defined as "a state where few things as possible go wrong".[3(p3)] When we investigate errors with a Safety-I approach we look for root causes/contributory factors and then identify actions required in attempt to prevent the error happening again.

In line with the Patient Safety Strategy we should be focusing on what goes right and what we can learn from this. This is known as Safety-II and its approach assumes that everyday performance is variable and that we naturally adapt to varying conditions to ensure things go right.[3(p4)] This is explained further in table 1.

	Safety-I	Safety-II
Definition of safety	That as few things as possible go wrong.	That as many things as possible go right.
Safety management principle	Reactive, respond when something happens or is categorised as an unacceptable risk.	Proactive, continuously trying to anticipate developments and events.
View of the human factor in safety management	Humans are predominantly seen as a liability or hazard. They are a problem to be fixed.	Humans are seen as a resource necessary for system flexibility and resilience. They provide flexible solutions to many potential problems.
Accident investigation	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify the causes.	Things basically happen in the same way, regardless of the outcome. The purpose of an investigation is to understand how things usually go right as a basis for explaining how things occasionally go wrong.
Risk assessment	Accidents are caused by failures and malfunctions. The purpose of an investigation is to identify causes and contributory factors.	To understand the conditions where performance variability can become difficult or impossible to monitor and control

Table 1: Overview of Safety-I and Safety-II[3(p26)]

In order for us to learn from what works well we need to understand how some people are able to adjust to different working conditions. In our Trust we have a reporting system called Favourable Event Reporting Form (FERF); similar to many other excellence reporting systems in place across the NHS e.g. SOX (Sharing Outstanding Excellence), TREx (The Thames Valley Reporting Excellence). These reporting systems provide us with the opportunity to highlight what is working well and what we can learn from this. If excellence reporting is new to you or you'd like to know more about it, there are lots of resources available on the Learning From Excellence website **https://learningfromexcellence.com/**

We need to incorporate a balance of both Safety- I and Safety-II into our daily practice and consider reframing safety from 'avoiding that something goes wrong' to 'ensuring that everything goes right'[3].

Reflecting on an error

When supporting colleagues who are reflecting on an error, to help them fully identify how it occurred and what they can learn from it, I use the Yorkshire Contributory Factors Framework shown in figure 2. It can also be helpful to staff involved in the Root Cause Analysis process following an error. This framework is not new and may well be used by other medicine safety teams across the NHS. I wanted to include it in this safety edition of the journal to share with those who have never seen it before.

For those of you reading this who would like further evidence of its practical use, this framework has been used for similar investigations in healthcare. For example, GP perspectives of patient safety incidents were identified using an interview technique based on the framework (Curran et al, 2019)[5].

Similarly, it was used to thematically analyse interviews conducted with palliative care clinicians about their perceptions of opioid errors (Heneka et al 2019)[6].

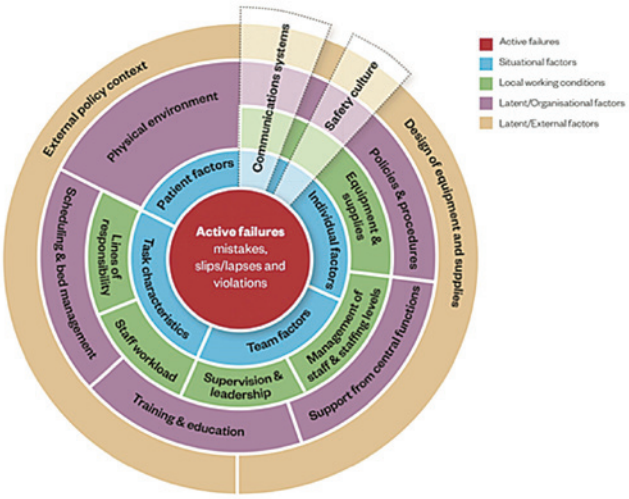

Figure 2: The Yorkshire Contributory Factors Framework[4]

The framework details a number of factors which have potential to contribute to an error. These have been classified into four groups with communication systems and safety culture cutting across them. Active failures (shown centrally in red) include two error types: slips/lapses, where the actions do not go according to plan, and mistakes, where the plan itself is inadequate to achieve its objectives. The rings of the diagram represent different contributory factor categories which the reader can consider when reflecting on the error. These contributory factors are; situational factors, local working conditions, latent/organisational factors and latent/external factors.

Contributory Factor	Considerations
Individual factors	Were there any personal factors affecting how you were working e.g. feeling unwell, tired, fretting over argument with child, family bereavement, excited about an upcoming holiday, flustered from a stressful commute to work?
Team factors	Who were you working with at the time? Are they friendly, helpful, chatty, loud, rude, angry, lazy, have preferred roles, a poor communicator, difficult to approach?
Task characteristics	Was it a task you are familiar with as you do it daily or a task you don't do often? Consider what implications these introduce?
Staff workload	How was your workload affecting you, how will you manage this next time?
Supervision & leadership	Is this adequate? Does it motivate you? Do you feel supported?
Physical environment	Temperature of environment, noise, smell, lighting, layout of equipment, size of work space?
Training & education	Have you learnt something new from this error that you didn't know before? Could this error be made by your colleagues? What can be done to address this?

Table 2: Contributory factors for consideration in error reflection

Our local practice when reflecting on an error is not to assign blame, but to support the individual in recognising how the error occurred and how they, and others, can prevent it happening in the future. Across the NHS, it is important to remember that in our daily practice staff have the best intentions to do the right thing for each patient. Therefore, following an error, it is important to reflect and identify any factors that were influencing how staff were working when the error occurred.

Table 2 provides more detail on a selection of these factors to help you when reflecting on an error in the future.

Challenges

It can be a real challenge trying to prevent specific errors. To prevent a recurring dispensing error, in the past I have re-arranged the dispensary shelf, moved the storage, made clearer coloured shelf labels all to highlight the risk of error, yet the error has still occurred. A common action from Root Cause Analysis is to provide staff with additional training. Although training is useful there are many reasons why that isn't enough. Looking at other drugs/areas of pharmacy where specific errors do not occur and the process works well is where the focus needs to be so we can ask ourselves "what is happening here that means it is working well"?

Conclusion

The Patient Safety Strategy reminds us that we should be doing everything possible to prevent errors. However, we are not infallible and errors will invariably still happen. To try and minimise the frequency and severity of errors, following a Safety-II approach and reflecting on what has gone right using frameworks such as the Yorkshire Contributory Factors Framework, enables us to learn from errors whilst avoiding assigning blame onto an individual or team.

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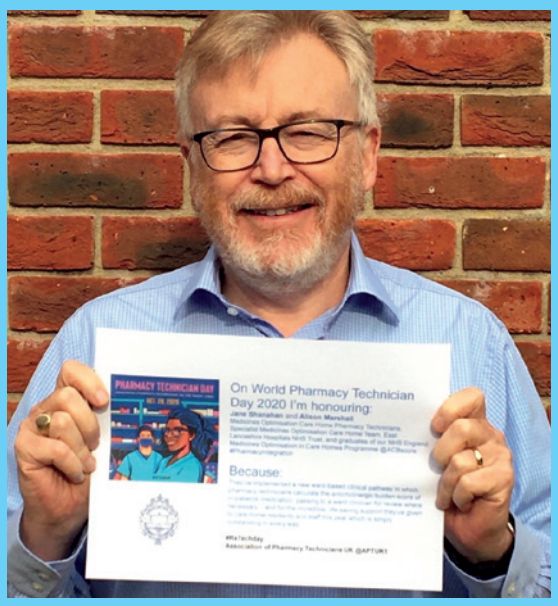
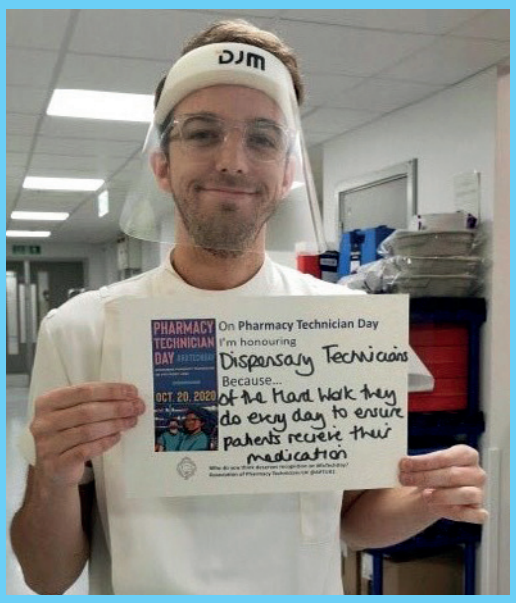

PHARMACY TECHNICIAN DAY
On World Pharmacy Technician Day 2020 I'm honouring:
Because: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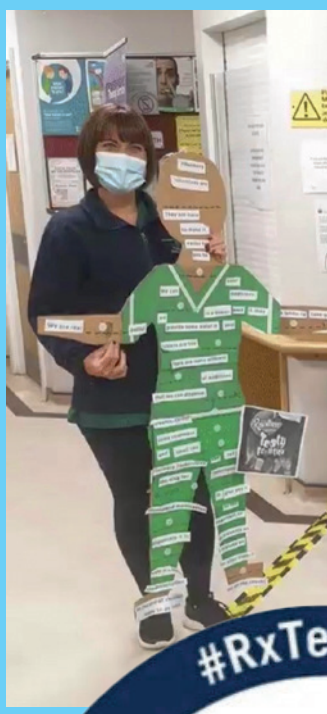
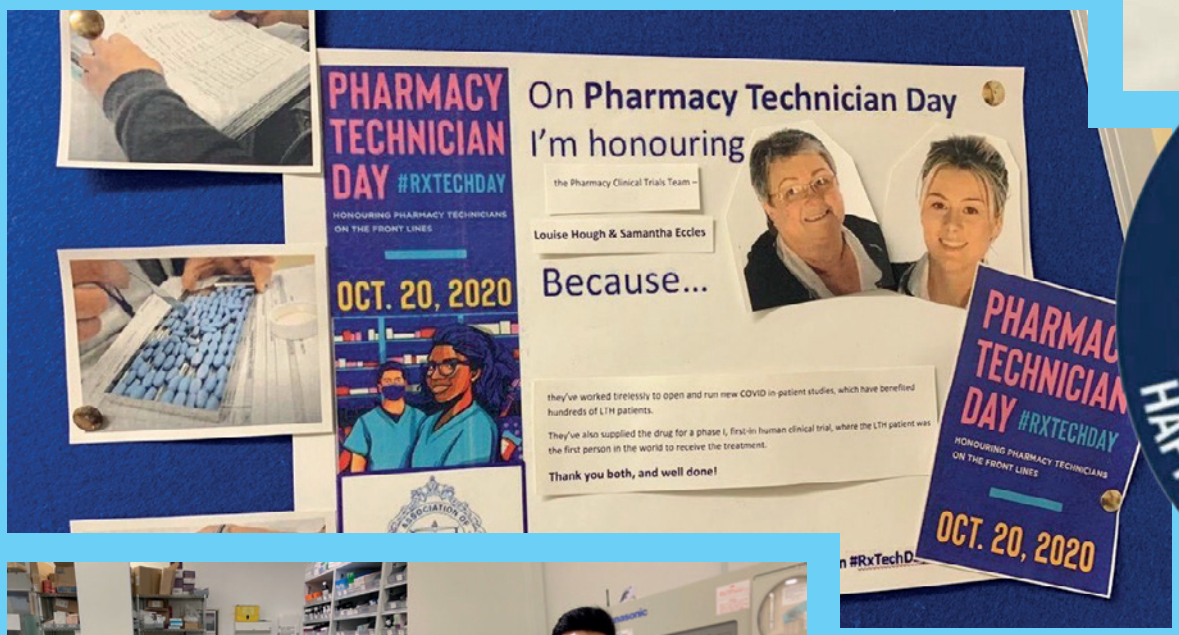
PHARMACY TECHNICIAN DAY #RXTECHDAY
OCT. 20, 2020
On Pharmacy Technician Day
I'm honouring
Dispensary Technicians
Because...
of the Hard Work they do every day to ensure patients receive their medication




PHARMACY TECHNICIAN DAY #RXTECHDAY
HONOURING PHARMACY TECHNICIANS ON THE FRONT LINES
OCT. 20, 2020
On Pharmacy Technician Day
I'm honouring
the Pharmacy Clinical Trials Team –
Louise Hough & Samantha Eccles
Because...
they've worked tirelessly to open and run new COVID in-patient studies, which have benefited hundreds of LTH patients.
They've also supplied the drug for a phase I, first-in human clinical trial, where the LTH patient was the first person in the world to receive the treatment.
Thank you both, and well done!
PHARMACY TECHNICIAN DAY #RXTECHDAY
HONOURING PHARMACY TECHNICIANS ON THE FRONT LINES
OCT. 20, 2020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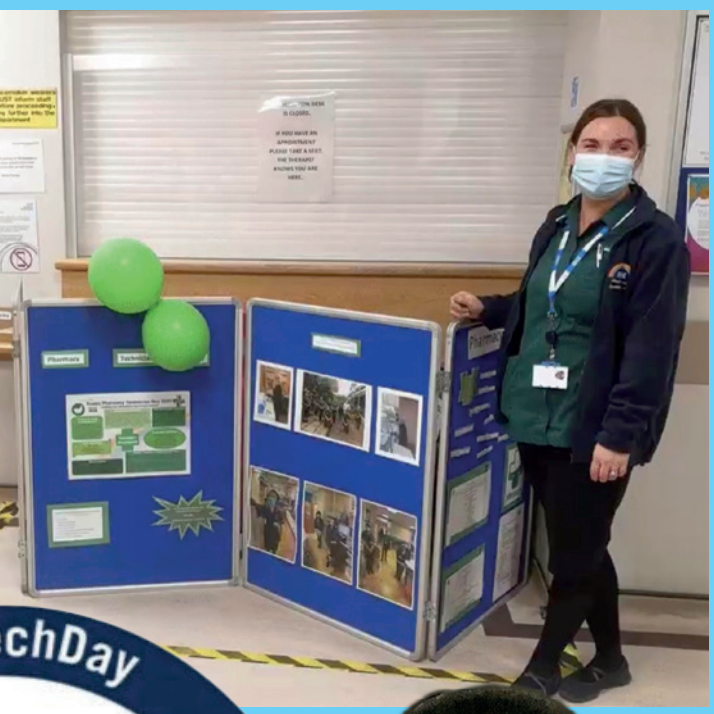

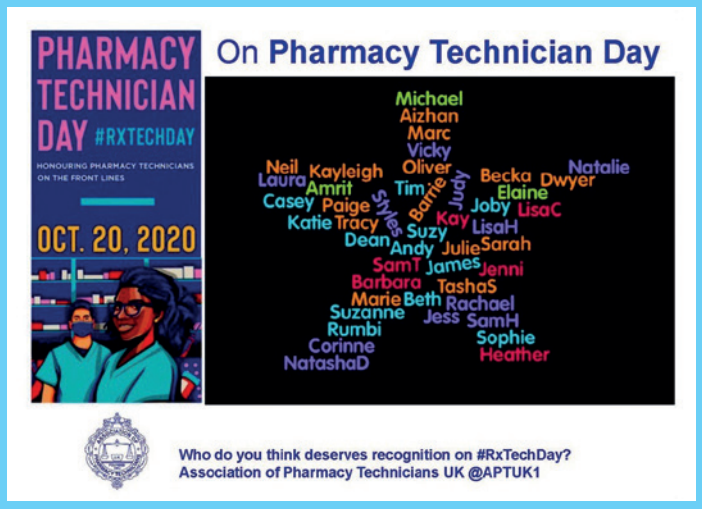
PHARMACY TECHNICIAN DAY #RXTECHDAY
HONOURING PHARMACY TECHNICIANS ON THE FRONT LINES
OCT. 20, 2020
On Pharmacy Technician Day
Michael
Aizhan
Marc
Vicky
Neil
Kayleigh
Oliver
Natalie
Laura
Amrit
Tim
Becka
Dwyer
Barrie
Judy
Elaine
Casey
Paige
Styles
Joby
LisaC
Katie
Tracy
Kay
LisaH
Dean
Suzy
Andy
Julie
Sarah
SamT
James
Jenni
Barbara
TashaS
Marie
Beth
Rachael
Suzanne
Jess
SamH
Rumbi
Sophie
Corinne
Heather
NatashaD
Who do you think deserves recognition on #RxTechDay?
Association of Pharmacy Technicians UK @APTUK1


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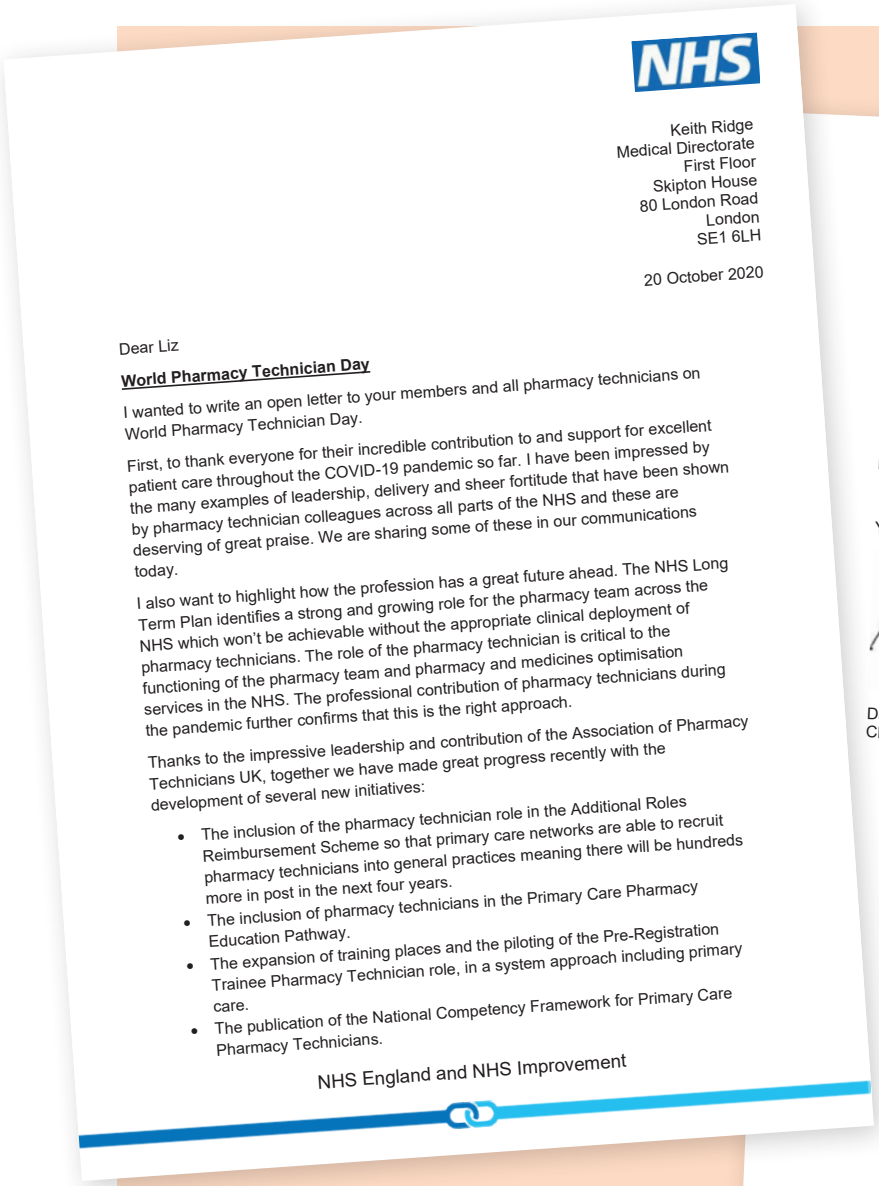
PHARMACY TECHNICIAN DAY
OCT. 20, 2020

PHARMACY TECHNICIAN DAY #RXTECHDAY
OCT. 20, 2020
On Pharmacy Technician Day
I'm honouring
Graeme Johnston
Because...
He has been an inspiration in mentoring, motivating and Undivided Support.
Who do you think deserves recognition on #RxTechDay?
Association of Pharmacy Technicians UK @APTUK1



NHS

Keith Ridge
Medical Directorate
First Floor
Skipton House
80 London Road
London
SE1 6LH

20 October 2020

Dear Liz

World Pharmacy Technician Day

I wanted to write an open letter to your members and all pharmacy technicians on World Pharmacy Technician Day.

First, to thank everyone for their incredible contribution to and support for excellent patient care throughout the COVID-19 pandemic so far. I have been impressed by the many examples of leadership, delivery and sheer fortitude that have been shown by pharmacy technician colleagues across all parts of the NHS and these are deserving of great praise. We are sharing some of these in our communications today.

I also want to highlight how the profession has a great future ahead. The NHS Long Term Plan identifies a strong and growing role for the pharmacy team across the NHS which won't be achievable without the appropriate clinical deployment of pharmacy technicians. The role of the pharmacy technician is critical to the functioning of the pharmacy team and pharmacy and medicines optimisation services in the NHS. The professional contribution of pharmacy technicians during the pandemic further confirms that this is the right approach.

Thanks to the impressive leadership and contribution of the Association of Pharmacy Technicians UK, together we have made great progress recently with the development of several new initiatives:

- The inclusion of the pharmacy technician role in the Additional Roles Reimbursement Scheme so that primary care networks are able to recruit pharmacy technicians into general practices meaning there will be hundreds more in post in the next four years.
- The inclusion of pharmacy technicians in the Primary Care Pharmacy Education Pathway.
- The expansion of training places and the piloting of the Pre-Registration Trainee Pharmacy Technician role, in a system approach including primary care.
- The publication of the National Competency Framework for Primary Care Pharmacy Technicians.
- A national framework procurement process to facilitate access to apprenticeship funding to train pharmacy technicians in all settings.

Now, with the help of APTUK, we need to go further to ensure we really deliver on these challenges. This means working together to increase recruitment, maximise the potential of the clinical role of pharmacy technicians in the NHS, increase the numbers of those seeking professional registration and ensure support for APTUK as the professional body.

To do this I propose we need to strengthen the advice, feedback and opinion from senior pharmacy technicians currently working within the NHS including primary care. This letter invites you and your Committee to work with us to develop a sustainable approach that will be beneficial to pharmacy technicians in terms of career progression and professional development.

I look forward to hearing your thoughts and discussing with you and your colleagues,

Yours sincerely

Dr Keith Ridge CBE
Chief Pharmaceutical Officer

NHS England and NHS Improvement

Response to CPhO letter on Pharmacy Technician Day – 20th October 2020

Receiving this letter on World Pharmacy Technician Day demonstrates the recognition by Dr Ridge of the role pharmacy technicians have in contributing to better patient care health outcomes and pharmacy services.

The offer to work with the professional leadership body, Association of Pharmacy Technicians UK is extremely welcomed and will build on the strengthening relationship that has evolved particularly during the pandemic.

APTUK has worked tirelessly to ensure there has been professional representation and a voice for pharmacy technicians and support staff. Enabling systems and key leaders to recognise the opportunities for the profession but also understand some of the barriers. The outcomes listed within the letter provides an overview of some of the work APTUK has led or supported during the last few months.

This supportive letter which expresses how valued the profession is at this time is extremely welcomed and we look forward to supporting the aspirations in the letter.

APTUK is a membership organisation run by volunteers, we welcome Dr Ridge's encouragement for pharmacy technicians to consider joining us to aid their professional development and secure the future the profession so rightly deserves.

Liz Fidler
President
APTUK

THE ASSOCIATION OF PHARMACY TECHNICIANS UK

23rd October 2020

Dear Keith

On behalf of members of the Association of Pharmacy Technicians UK and the profession, I would like to thank you for recognising the significant role pharmacy technicians have contributed to healthcare systems and most importantly patients in response to the pandemic

I have been incredibly proud of the way that pharmacy technicians have deployed their skills and expertise in innovative ways, putting patients first. The skill mix and teamwork displayed across all pharmacy sectors and healthcare settings where pharmacy technicians work is to be commended.

The pharmacy technician profession is keen to build on the great examples of work undertaken and revisit key priorities, working in partnership with NHS England, NHS Improvement, and other key stakeholders.

APTUK particularly welcomes the offer to ensure that the NHS Long Term Plan aspirations is inclusive of the pharmacy technician agenda.

It is vital that the pharmacy technician profession is sufficiently supported. Enabling growth and investing in education and pipeline are integral to policy and strategy. APTUK is keen to progress this work with you and your teams and looks forward to opportunities to strengthen this.

APTUK is proud to represent the profession and at this time will continue to focus on our priorities:

- Represent the best interests of the profession and patients at key stakeholder events as they begin to restart services and review policy
- Develop a sustainable business model for the Association to present to members in November
- Explore and implement a strategy for enhancing the use of technology to enable a more effective business model and communications strategy
- Lobby for the inclusion of pharmacy technicians on the list of Health Care professionals able to supply and administer medicines and medicinal products under a Patient Group Direction
- Support our future professional registrants (Pre-registration Trainee Pharmacy Technicians) with educational and professional development
- Develop and implement an equality and inclusivity strategy working with key stakeholders

As the Professional Leadership Body for pharmacy technicians we appreciate the signposting you have provided. We are keen to explore ways our organisations can encourage membership growth, to enable us to deliver more for the profession and continue to represent pharmacy technicians effectively.

I look forward to working with you on our mutual aims and celebrating the outcomes on World Pharmacy Technician Day 2021.

Kindest regards

Liz Fidler – FAPharmT
President
On behalf of the Board of Directors
Association of Pharmacy Technicians UK

Labelling And Dispensing Guidelines:
Medication Safety In Dispensary

Background
Each year we have new cohorts of pre-registration staff both pharmacists and pharmacy technicians, who have a lot to learn in a relatively short period of time. Particularly with the recent changes to the pharmacy technician training, time spent in the dispensary will be incredibly significant to now develop final accuracy checking skills as well as dispensing. In addition to cohorts of trainees, there will always be new members of the team needing to be welcomed and trained in our dispensaries too. When I was a pre-registration pharmacy technician and new to the hospital environment, I never thought I would learn all the different ways to label and dispense medication! There were many additional pieces of information to remember, which varied depending on:

- The age of the patient.
- The form of medication i.e. creams/injections/nebules.
- The wards' speciality and their specific requirements.
- The computer 'short codes' which can produce lengthy specific instructions.

Back then, I used my BNF and started writing all the little useful bits of specific extra information next to the drugs so I would remember for next time. Years later during my time at the same Trust, a guide written by the dispensary pharmacist with standard labelling directions was rolled out. It was so useful and instantly replaced my old BNF. I later moved Trusts and I suddenly had different 'short codes' and specific ways of wording directions to learn all over again!

Situation
In Hampshire Hospitals Foundation Trust, I lead the Dispensary service, overseeing two dispensaries on different sites, and medication safety is paramount to us. Our Dispensary service works closely with our Medication Safety team, and we have arranged for interactive teaching sessions for our pharmacy department. Considering the ongoing national COVID-19 pressures on frontline healthcare workers and the usual winter pressures too, we must be aware of Human Factors and that this has the potential to lead to dispensing errors. To support our team we have adapted the labelling and dispensing guidelines kindly shared by our neighbours at the University Hospitals of Southampton Foundation Trust.

Through using labelling and dispensing guidelines, the aim is to continue to focus on patient safety by standardising labelling across our sites and supporting our team. The guidelines are support for our team alongside our Dispensary Standard Operation Procedures (SOPs), and are intended to be used as a guide. It includes key medication safety points within it such as prompts for:

- o Additional information for flammable emollients/gels etc.
- o Steroid cards when supplying for long term steroid use.
- o Methotrexate weekly frequency of dose.
- o Sodium Valproate and additional dispensing requirements for women of child-bearing potential.

Assessment
My deputies, our Lead Medicines Management Pharmacy Technician and I, adapted the guidelines by considering our demographics of patients at each site and our formulary/commonly prescribed items. The guidelines were then were trialled for 6 months to be tested in practice; they were reviewed and used by both existing colleagues and those who had recently joined our team, on both sites, including:

- Pharmacy assistants
- Pharmacy technicians
- Service lead pharmacists and rotational pharmacists

Results
I'm pleased to say feedback was and continues to be positive, with one colleague referring to it as "supportive and reassuring". The labelling and dispensing guidelines have been approved for use following the 6 month trial, and will be reviewed each time with our Dispensing SOP and whenever amendments are required. The labelling and dispensing guidelines are now provided to all new starters, prior to their induction along with meeting the team, and an orientation of the dispensaries.

The key motivation for introducing the guidelines was to ensure that our dispensaries continue to be environments that new and existing members of the team feel they are supported in the work place. The COVID-19 epidemic continues to be a source of stress and anxiety and we must anticipate the potential of Human Factors on our teams and the subsequent impact to patients wherever possible.

Medication safety awareness and other skills developed and practiced in Dispensary settings such as accurate, safe practice and vigilance will be required wherever their future career paths take them, and the patients they will impact along the way.

NICOLA STOCKMANN
MAPharmT
Dispensaries Service Lead
Hampshire Hospitals Foundation Trust
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Medicines Safety Bus

My name is Nicola Wigan, I am the medicines governance and safety pharmacy technician situated at Manchester Foundation Trust (MFT).

My fellow pharmacy technician Michael Brown (lead governance and safety pharmacy technician) and I have both had many years' experience working in various aspects of hospital pharmacy, but now find ourselves in the specialist technician role of medicines governance and safety. Our role within the medicines governance and safety team is predominantly investigating medication incidents across the trust to identify how and why each incident has occurred. We review all incident investigations on a monthly basis and help to develop new processes and systems to minimise the chance of error in the future.

From the review of medication incidents that occur on the wards we were tasked to lead on a project to develop a medicines safety platform to help highlight to all MFT ward staff high-risk areas we as a trust were facing with medicines. We took inspiration from a monthly quality bus that St Marys Hospital (one of the nine hospitals that make up MFT) runs each month; they change themes regularly to educate staff on safe practice. We thought this was the perfect platform to carry our safety messages out to the wards.

The themes were identified from recurring themes from our hospital reported incidents and they are also recognised nationally as high-risk medicines. These were;

- **Controlled Drugs (opiates)**
- **Anticoagulants (including omitted doses)**
- **Insulin**
- **Sound A-like Look A-like Drugs (S.A.L.A.Ds)**

Within our team we run an error workshop on a 6-monthly basis. This is where we directly replicate an incident that has occurred within our team that we feel the pharmacy as a whole could learn from. We place all the components from the incident as close to the original as possible and ask the participants to 'spot the error'. We had a lot of positive feedback from this approach and felt we could take it out on the wards to encourage a more interactive and conversation-based learning.

The Medicines safety bus was born, the bus is simply a trolley that consists of four trays; for this initiative we allocated a theme per tray.

Tray 1: Controlled Drugs (opiates)

For this theme we collected empty boxes of controlled drugs and filled the tray to imitate a controlled drugs cupboard. We created mock prescription charts from recent incidents. The task was to ask, from looking at the prescription what they would administer to the patient or if they would need to clarify anything prior to administration.

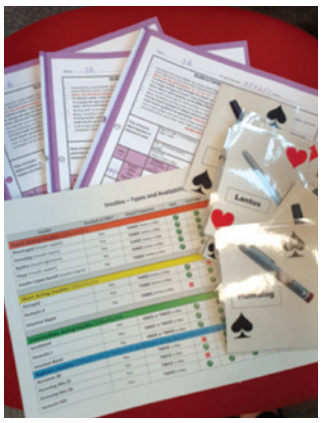
We had 4 prescription charts, showing prescribing and administration confusion around the use of brand names and also the confusion around abbreviations such as, MR, SR, IR. These games were to advise nurses to look at the prescription as a whole before administering any medicines to the patient as there is sometimes a clue to the prescription being incorrect in the frequency (i.e. modified release – twice daily and immediate release – four times daily/ PRN). We also captured many prescribers of all levels on our travels, this game highlighted to them that when prescribing they need to be very clear what they are asking to be given to the patient and when using brand names or using non approved abbreviations they are putting the nursing staff and patients at risk.

Tray 2: Anticoagulants (omitted doses)

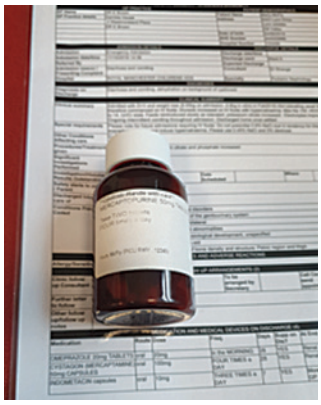
The key messages were not give two anticoagulants together when involving the newer anticoagulants such as apixaban and rivaroxaban. For this our mock chart had both dalteparin and rivaroxaban prescribed, and the participants were asked to spot the error. This was picked as a theme because there is a lack of knowledge with the newer anticoagulants. We found that staff were either unaware that they were anticoagulants or assumed that all DOACs had similar bridging therapy to warfarin. The second half of this tray we focused on the importance of critical medication; we had a case study that showed the catastrophic consequences of omitting critical medication. From the case study we were able to chat to staff about the importance of ensuring all medicines are given and if they are to be withheld for valid reasons to ensure full and accurate documentation.

Tray 3: Insulin

We got engagement for the insulin theme by using an insulin inspired card game. This was developed in conjunction with one of our trust pharmacists. This game involved small mock playing cards with different types of insulin pens on them alongside three prescription charts. The insulin on chart one was



prescribed once daily before food, the second prescribed twice daily with meals and the third was three times daily with meals. The idea was to test your insulin knowledge and to highlight some of the newer insulins that have come onto the market. We had made a hand out to give to staff which contained all the insulins they may come across and the frequency you would expect to see them prescribed, it also contained the devices available and if they were stocked within our trust.



Tray 4: Sound A-like Look A-like Drugs (S.A.L.A.Ds)

This was the fourth and final theme. For game one we had some ambiguous prescribing and a tray of medicines which sound alike and/or look alike e.g. omeprazole and aripiprazole. We again created mock prescriptions and in the tray included both correct and incorrect medicines.

The second game we had a discharge letter and medications and asked staff to go through the bag and spot any errors. There were a couple of minor errors but the main S.A.L.A.D in the bag was the intended drug mercaptamine. The prescription states mercaptamine but the bag of medicines contained mercaptopurine. If staff did not pick up this error, it allowed them to think and reflect in a safe environment about what could happen in reality and the effects that this kind of mistake could have had on the patient and their families.

Conclusion

The medicines safety bus is a novel way to get our key safety messages out to the wards in context, without just blindly circulating information via email or other platforms where there's a choice just to ignore or delete.

The ward-based pharmacy team supported us with this project to get engagement from the ward staff as they were comfortable talking to and listening to their ward pharmacists and pharmacy technicians. We also reached out to the Nurse Clinical Educators to help raise the profile. We have had amazing feedback from all participants and have been invited to bring the bus to the new nurse starter inductions on a regular basis. We now have a fleet of buses which have been deployed on their safety journey around all our inpatient hospitals.

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Medicines Governance and Safety Pharmacy Technician, Manchester University NHS Foundation Trust
Nicola.Wigan@mft.nhs.uk

MICHAEL BROWN
Lead Governance and Safety Pharmacy Technician, Manchester University NHS Foundation Trust

The Patient Safety Group

Pharmacy technicians will be familiar with the importance of reporting patient safety incidents, but you may not know about a national group that meets to share good practice in this important area.

In 2014 NHS England issued a Stage 3 Directive recommending all large community pharmacy organisations identify a named Medication Safety Officer (MSO) to review medication incidents and oversee safety improvement within their organisation. The Community Pharmacy Patient Safety Group, a cross-sector forum for community pharmacy organisations - competitors in a commercial sense – brings together the MSOs to openly share and learn from each other when things go wrong, as well as from other sectors and industries.

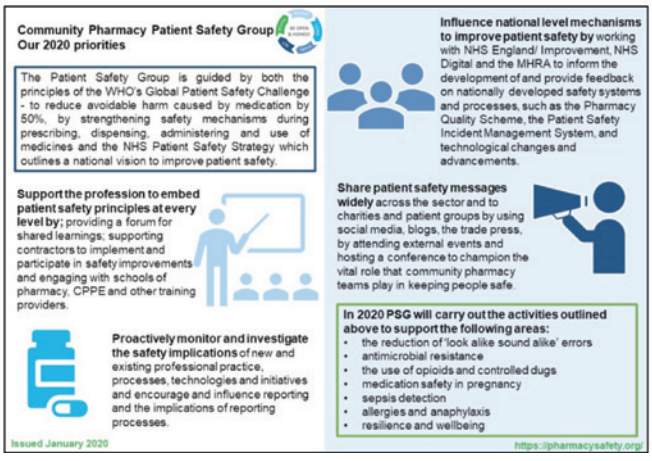
The group is made up of community pharmacy MSOs from the 17 largest community pharmacy chains, as well as the National Pharmacy Association and Numark to represent independent pharmacies. Whilst it operates primarily in England, many of the members own community pharmacies in Scotland, Wales and Northern Ireland – allowing learnings to be shared across the UK.

Our priorities

The Group is committed to improving patient safety. We are guided by the principles of the World Health Organisation's Global Patient Safety Challenge – to reduce avoidable harm caused by medication. We are committed to making all aspects of community pharmacy as safe as they can be. To do this, we believe an open and honest safety culture is absolutely vital.

It requires everyone to feel confident in sharing when things go wrong. Without this pharmacy teams are unable to learn from mistakes and prevent them occurring again.

When incidents do occur, we believe all pharmacy teams should embed the principles of Reporting, Learning, Sharing,



Acting and Reviewing in their everyday procedures. Examples of these resources are available on our website: https://pharmacysafety.org/share-and-learn/

Promoting a safety culture

We facilitate discussions between colleagues and produce resources and materials to support teams promote patient safety as issues arise. We encourage anyone working within a pharmacy team to check out our materials and share them as widely as possible!

Inevitably this has been extremely important throughout the outgoing pandemic and we've developed resources to support teams (in the context of the pandemic) to; manage patient returns, deliver medication; use their consultation rooms and safeguard their patients and customers.

Whilst patient safety relating to COVID-19 remains a big priority we will continue to outline other concerns like those relating to Look-Alike-Sound-Alike medication, valproate safety, and health and wellbeing in the pharmacy. All of our resources are there to support you.

- **https://pharmacysafety.org/managing-patient-returned-medicines/**
- **https://pharmacysafety.org/medication-delivery-and-prescription-collection-covid-19/**
- **https://pharmacysafety.org/safe-use-of-consultation-rooms-covid-19/**
- **https://pharmacysafety.files.wordpress.com/2019/12/lasa-one-pagers-191219.pdf**
- **https://pharmacysafety.org/2018/06/25/valproate-safety/**
- **https://pharmacysafety.org/2019/09/24/wellbeing-in-the-pharmacy/**

We also collect data and carry out surveys to monitor patient safety. Last year we conducted a survey on patient safety culture and invited pharmacy staff from across the UK to participate. This anonymous survey sought to understand patient safety practice from the perspective of frontline pharmacy teams. A similar survey was carried out in 2016.

The results which can be found on the **pharmacysafety.org** webpage: resources hub: safety culture survey topic (**https://pharmacysafety.org/2019/12/18/safety-culture-survey/**) demonstrate that there have been significant positive improvements since 2016. In 2019, 71% of respondents said that they received helpful feedback after reporting incidents, compared with 55% in 2016, and we were particularly pleased to hear that the feedback of MSOs and superintendents was having an impact.

While in 2016, 40% of people said that fear of a criminal prosecution might prevent them from reporting an incident, this figure had fallen to 14% for external reporting in 2019.

This reduction in fear of criminal prosecution, follows

changes to legislation which provide a legal defence for inadvertent dispensing errors which came into effect in April 2018 with the intention of promoting patient safety by encouraging a more open culture of error reporting.

Despite these really welcome improvements, participants highlighted the need for simpler reporting tools, and this is all part of the next challenge for the Patient Safety Group. That's why we are working with NHS Improvement/England to inform the development of a new reporting tool called the Patient Safety Incident Management System. (It is not yet available, but watch this space..!) **https://improvement.nhs.uk/resources/development-patient-safety-incident-management-system-dpsims-project-completes-its-alpha-phase/**

So, what next?

Community pharmacies deliver incredibly safe care. Whilst it will never be possible to eliminate all patient safety incidents in health settings, including in pharmacies, we will work with policy makers, pharmacy colleagues and other sectors to ensure community pharmacy continues to embed patient safety into everything it does.

Collaboration is a key part of this. If there's anything you are particularly interested in, we would love to hear – you can contact us here: **https://pharmacysafety.org/contact/**.

JANICE PERKINS FRPharmS
Chair of the Community Pharmacy Patient Safety Group

PTJ 2021 Timeline

Edition	Copy deadline
Spring	9th April 2021
Summer	9th July 2021
Autumn	8th October 2021

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A Day In The Life Of A Deputy Medication Safety Officer

A bit about me & my place of work:

I'm Sian; I have a keen interest in patient safety, quality improvement and empowering others to work as safely as possible. I work closely with the Medication Safety Officer, Senior Pharmacy Technician for Medicines Information / Safety & Medicines Safety Nurse. I am employed by the University Hospital of North Midlands (UHNM) which is a teaching hospital with 1450 beds and 10,000 staff across two sites.

A typical day:

8:30am: The first thing I do with a hot cup of coffee is check my inbox for new adverse incident reports.

Part of the day involves some form of adverse incident management. As the Medicines Safety Lead for controlled drugs (CDs) I pay particular attention to patient safety incidents & anything of concern e.g. CD discrepancies. Adverse incident management may include:

- Making recommendations on individual incidents or themes. This ensures that there is an equitable approach to incidents & learning across the organisation.
- Quarterly review of all CD incidents to establish themes, identify how to reduce risk and learn as an organisation. Example – implementation of a transdermal patch body map / administration record see figure 1. I led the pilot and implementation with support from pharmacy and nursing colleagues. We received great feedback and will be monitoring how this improves patch safety in our organisation.
- Producing the quarterly Trust CD report for the Local Intelligence Network selecting incidents, risk grading them and detailing learning.

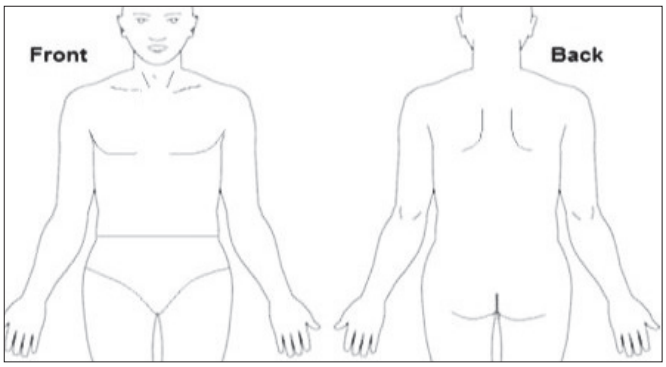

Figure 1

Being CD Lead has given me the opportunity to improve the governance arrangements for CDs:

- Production of a CD Root Cause Analysis (RCA) Tool to support ward managers in the investigation of discrepancies and identify learning.
- Creation of panel where we review CD RCAs with the Accountable Officer and a Quality Matron. This has received positive feedback from the users and we've found it much easier to identify common themes e.g. process deviations, technical issues e.g. bungs not fitting well. This in turn has helped us to identify wider learning and share / provide education.
- Set up a Pharmacy CD Task & Finish Group to streamline CD processes and improve efficiency & safety.

10:00am: Usually my day involves me attending at least one meeting and I'm an active member of:

- Various governance / safe medicine related meetings both in pharmacy and the wider Trust.
- Pharmacy Senior Management Team.
- I attend the regional Medicines Safety Officer meetings where workload allows.

A new development for me has been chairing the Pharmacy Safe Medication Group and am working hard to raise perceptions of 'Medicines Safety' by implementing the Just Culture principles into how we conduct the meeting.

We are now:

- Using 'Greatix' to celebrate brilliant clinical interventions, good catches or when a team member has gone the extra mile for patient safety. The idea is that we celebrate and use the examples to empower others to be medicine safety advocates and speak up.
- Focusing on ways that the group can support staff by eliminating or reducing the risk of error through use of technology, a change of process or education, rather than focus on individuals involved in errors. If there is an error theme it's often an indication that there is an improvement to be made in the system.

11:00: A member of the medicines safety team inspects two wards every week.

Our medicines safety assessment & recommendations feed into a broader inspection led by the Quality Matrons and we've become an integrated part of that process. The ward is awarded a status as a result of the inspection e.g. platinum, gold, silver or bronze. It's a real privilege to work with the experienced nurses and learn from them and a fantastic opportunity to gain support for improvement. When I'm on the inspection I use the opportunity to commend good practice and talk to ward staff about current patient safety points of interest. I check if areas have seen safety alerts or adopted new practice and if there is anything that the ward want to raise whether that be a concern or an idea. We provide a verbal report at a debrief meeting and then a written report.

13:30: Lunch - I do my best to time lunch so that I can sit with work friends and enjoy some down time. It makes me much more productive and ready for the afternoon. In summer I like to sit outside in the garden area and play table tennis when I can find a willing partner!

14:30: My afternoon activities vary. I try and work flexibly so that I can meet leads from other areas to work together on such activities as:

- Investigating serious incidents. This would usually involve me acting as co-investigating officer with a senior nurse. I've learned so much from this experience.
- Collaborating with roles like the Medicines Device Safety Officer.
- Meeting with senior nurses and doctors to plan improvement in a particular area as needed.
- Risk assessing medicines related processes on wards / departments.

What are your favourite things about the job?

I love to talk to people. I find that the best ideas come simply from talking and collaborating with others. The staff on the ground doing the job usually have the best understanding of why things go wrong in their areas and often have brilliant ideas on how to improve if we only ask them.

Sharing learning is my favourite thing to do. Our team are working hard to expand how we do that to try and capture as many people as possible and appealing to different personalities and learning styles, for example:

- Walking the patch and talking to staff as much as possible.
- Newsletters – focus on good practice, learning from adverse incidents, 'how we can help you' or 'how we have listened to you' & topical information from national safety alerts.
- Quizzes
- Posters / guidance
- Presenting at study days
- Producing safety alerts / memos to communicate key safety issues, themes and improvements from audits etc.
- Using social media:
- I've set up a UHNM Medicine Safety Twitter account to regularly communicate key safety principles to our staff. This provides bite sized pieces of information and is used sensitively as this is an open account.
- I use closed social media pages where I can provide more detailed information but of course still exercise caution.

Challenges

One particular challenge for me is time management as my workload is diverse and can be reactive. One small change I made that helped was to dedicate 30 minutes per day to emails and switching off the notification pop ups. Restricting my time on emails has allowed me more time to focus on specific work streams and given me more head space for new ideas.

It can sometimes be a challenge to find a voice when attending new meetings. Meetings are a great opportunity to network and learn from other roles and experiences. For staff new to meetings my two recommendations would be to prepare well and set goals e.g. be prepared to share one useful point to contribute at each meeting or talk to one person you don't know well after the meeting.

How to get involved in medicines safety

I would advise looking for opportunities within your role to improve safety and reduce risk. Share ideas, participate in safety huddles, make safety a topic of conversation and be recognised as a person who is passionate about safety.

Volunteer for opportunities to be involved e.g. are your team looking for someone to implement a new process to improve safety, can you be involved or lead it? Can you be part of a pilot? Can you review the process from a safety perspective thinking of risks, benefits and how to mitigate the risks?

Ask for specific development as part of your appraisal / PDP.

Ask to be involved - e.g. producing safety posters, a new standard operating procedure, participating in or leading an audit. Spend time with your medicines safety team, shadow them if possible, see exactly what they do and visualise yourself in that role and what you would do with it.

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Introduction Of An Infusion Center Satellite Pharmacy To Reduce Patient Waiting Times

Decentralizing the preparation of sterile intravenous medication was initiated by a performance improvement initiative done by the inpatient pharmacy in collaboration with the infusion center management.

The primary objective of the project was to reduce waiting times by ensuring timely preparation and delivery of chemotherapy medication and biologics prepared within the infusion center.

The satellite pharmacy is attended by one pharmacist and one technician who take care of the preparations starting from 9:00am till 14:00pm. Medications are hand-delivered by our delivery agent to the nursing stations; one is adjacent to the pharmacy room and the other to the Oncology Center.

Inpatient pharmacy, technician team

The room, within the satellite pharmacy, is equipped with all the required supplies used for preparation of medications, including Personal Protective Equipment (PPE), materials such as syringes, needles, swabs, connectors and the Intravenous (IV) solution bags.

The team wearing appropriate PPE.

We have one horizontal laminar air flow hood and one biological safety cabinet in our satellite pharmacy. The biological safety cabinet is a vertical flow Class II-B safety cabinet which is used to prepare all the chemotherapy and hazardous sterile medications. The horizontal laminar air flow hood is used for the preparation of non-hazardous medications.

The horizontal laminar air flow hood is placed in a segregated compounding area while the biological safety cabinet is placed in a contained segregated area assigned for preparation of hazardous medications only

The medication used for mixing are stored in an automated dispensing machine (ADS) with restricted access to authorized caregivers only. Refrigerated medications are stored in a specific fridge controlled by the ADS. All the medicines always must be barcoded with our own labels prior to ADS loading to maintain the practice of medication safety. The barcoding system that we use is very important in assuring safety; that the right product of the right medication is used to prepare the right volume and concentration.

A very detailed, thorough and accurate process of preparation and handling of both chemotherapy and biological agents is used, starting from the barcoding until the delivery of the final product.

Process

- Each order is verified by the pharmacist,
- A dispense action will appear on our dispensing queue according to the time that medication is due
- The technician or the pharmacist will print the production label
- Then scan the preparation instructions, the medication vial and the IV solution bag.

Our automated dispensing machine (ADS).

- Once the production label is printed the medication will be destocked from the ADS
- The pharmacy technician must perform the "dispense preparation" step in the computerized provider order entry (CPOE) by scanning both the medication vial and the IV solution bag.
- The system will send an alert if the wrong medication vial or IV solution bag was scanned.
- After successfully scanning the label, medication and diluent the technician will prepare the medication as stated in the production label.
- When the preparation is completed the final product must be checked by the pharmacist in the computerized provider order entry (CPOE) by scanning the barcode on the final product bag label.
- The materials utilized will also be checked manually for accuracy and safety purposes.

In order to maintain the quality and efficacy of the prepared medications, additional auxiliary labels such us "keep at room temperature", "protect from light", "chemotherapy; handle with care", "high alert" are used when required, as these are catchy enough to notify our nurses about the proper handling and storage conditions of these medications when they are handed over to them.

Additional safety processes

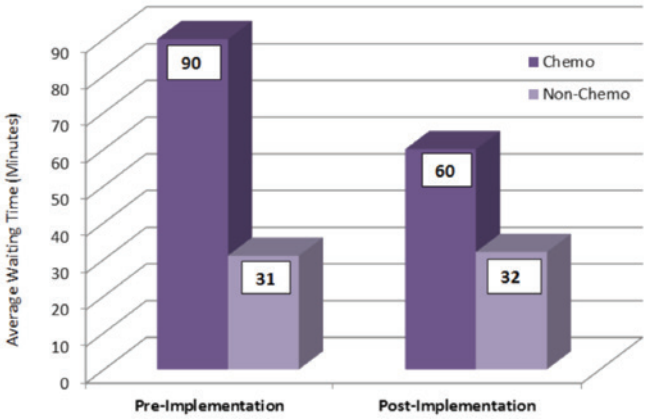
With chemotherapy preparations; our PPE, manner of preparation and checking are different from biologics and non-hazardous medications. The additional PPE required for chemotherapy preparations include an added head cap, N95 mask, goggles (for volatile hazardous medications), chemo gown, extra shoe cover and chemo gloves.

To ensure we are providing the best possible care to our patients, pharmacy management in Cleveland Clinic Abu Dhabi has provided us with specialized training on the use of close system devices. Clinically proven closed-system drug transfer devices are used to prevent hazardous drug interaction exposure, this has given us control and confidence in the safe preparation of chemotherapy medications.

Before preparing chemotherapy medication, two pharmacists must verify the chemotherapy order as mandated by our computerized provider order entry (CPOE).

The production label for chemotherapy medications will be scanned along with the ingredients then 2 labels will be printed (one for the medication IV bag/syringe itself and another one for the outer bag).

The chemo meds will only be handled using the close system devices and the pharmacist will check it as per the production label and scan it. Then we will proceed with the injection of medicines into the IV solution bags. The final product would then be placed in a special chemotherapy transport bag, then delivered to the nurse.



The average patient waiting time before and after implementation of the infusion center satellite pharmacy.

The workflow has been improved time after time depending on the safety recommendation, nurses' feedback and the needs of our patients; it has given us the benefits of sustaining a positive patient experience by reducing the waiting time in the infusion center and an improved pharmacy-nursing communication.

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