MANCHESTER 1824

The University of Manchester

Manchester Patient Safety Assessment Framework

Risk management culture in community pharmacy

Why was the framework developed?

The safety of both patients and staff in a healthcare organisation is influenced by the extent to which safety is perceived to be important across the organisation. This 'safety culture' is a new concept in the health sector and can be difficult to assess and change. This is particularly true for community pharmacy.

We have produced this framework to help make the concept of safety culture more accessible. It was initially designed for use by general practices and PCTs to help these organisations to understand their level of development with respect to the value that they place on patient safety. It uses eight dimensions of patient safety and for each of these describes what a pharmacy would look like at five levels of safety culture maturity. The framework is based on an idea used successfully in non-health sectors. The content is derived from in-depth interviews with a range of primary care health professionals and managers, and focus group discussions with both community pharmacists and support staff.

When to use the framework

We hope that you will find this framework useful and flexible. We think that it can be used in the following ways:

- To help your team recognize that patient safety is a complex multidimensional concept
- To stimulate discussion about the strengths and weaknesses of the patient safety culture in your community pharmacy.
- To show up any differences in perception between staff.
- To help you to understand how a community pharmacy with a more mature safety culture might look
- To help you to evaluate any specific attempt to change the safety culture of your community pharmacy.

Further information

The community pharmacy framework was developed by Darren Ashcroft, Charles Morecroft, Dianne Parker and Peter Noyce at the University of Manchester as part of a project that was funded by the Community Pharmacy Research Consortium. The original framework was developed by Dianne Parker, Tanya Claridge, Sue Kirk, Aneez Esmail and Martin Marshall in a collaborative project supported by the National Primary Care Research and Development Centre, University of Manchester. If you have any questions about the framework or its use, please contact Darren Ashcroft at darren.ashcroft@man.ac.uk

The framework explained

How were the dimensions developed?

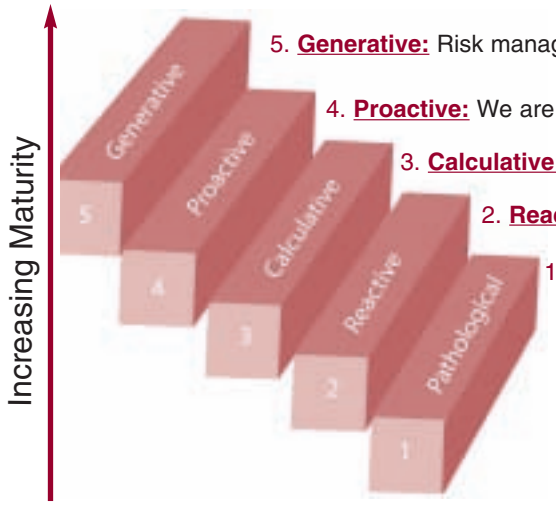
The dimensions are themes that emerged following

- a literature review about patient safety in health care (and specifically in Primary Care)
- feedback from opinion leaders, interviewees and focus group participants
- consideration of the dimensions in terms of their comprehensiveness and appropriateness for community pharmacy.

Dimension label	Defining the Dimensions
Commitment to patient safety	How seriously is the issue of patient safety taken within the community pharmacy? Where does responsibility lie for patient safety issues?
Perceptions of the causes of incidents and their reporting	What sort of reporting systems are there? How are reports of incidents received? How are incidents viewed, an opportunity to blame or improve?
Investigating incidents	Who investigates incidents and how are they investigated? What is the aim of the investigation? Does the pharmacy learn from the event?
Learning following an incident	What happens after an incident? What mechanisms are in place to learn from the incident? How are changes introduced and evaluated?
Communication	What communication systems are in place? What are their features? What is the quality of communication about safety issues like?
Staff management and safety issues	How are safety issues managed in the workplace? How are staff problems managed? What are the recruitment and selection procedures like?
Staff education and training about risk management	How, why and when are education and training programs about risk management developed? What do staff think of them?
Team working	How and why are teams developed? How are teams managed? How much team working is there around patient safety issues?

What about public and patient involvement? It might seem that patient and public involvement in a maturing risk management culture should be included as a ninth dimension. However the development of processes to ensure meaningful participation should be seen as being integral to all eight dimensions identified.

The levels of patient safety culture explained



5. **Generative:** Risk management is an integral part of everything we do.
4. **Proactive:** We are always on the alert, thinking about risks that might emerge.
3. **Calculative:** We have systems in place to manage all likely risks.
2. **Reactive:** We take risk seriously and do something when we have an incident.
1. **Pathological:** Why do we need to waste our time on risk management and safety issues?

How to use the framework

We suggest that the framework should be used in the following way:

1. It should be used by all appropriate members of your pharmacy and will take about an hour to complete.
2. For each of the eight aspects of safety culture, select the description that you think best fits your pharmacy. Do this individually and privately, without discussion.
3. Use a tick in the corresponding box on the score sheet to indicate your choices. If you really cannot decide between two of the descriptions, tick both. This will give you an indication of the current risk management culture profile for your pharmacy.
4. Discuss your profiles with those of the rest of your team. You may notice that there are differences between staff groups. If this happens, discuss possible reasons. Address each dimension in turn and see if you can reach consensus.
5. Consider the overall picture of your pharmacy. You will almost certainly notice that the emerging profile is not uniform - that there will be areas where your pharmacy is doing well and less well. Where things are going less well, consider the descriptions of more mature risk management cultures. Why is your pharmacy not more like that? How can you move forward to a higher level?

EVALUATION SHEET (Sample – please photocopy)

ASPECT OF RISK MANAGEMENT CULTURE	1 Pathological	2 Reactive	3 Calculative	4 Proactive	5 Generative
A Commitment to patient safety					
B Perceptions of the causes of incidents and their reporting					
C Investigating incidents					
D Learning following an incident					
E Communication					
F Staff management and safety issues					
G Staff education and training about risk management					
H Team working					