		PATHOLOGICAL
A	**Commitment to patient safety**	A low priority is given to patient safety. The few risk management systems that are in place are there because they have to be and nothing is actually improved. This pharmacy believes that risks are worth taking and that if an adverse event occurs insurance schemes are there to bail them out.
B	**Perceptions of the causes of incidents and their reporting**	Incidents are seen as 'bad luck' and outside the control of pharmacy staff. Ad hoc reporting systems are in place but the pharmacy is largely in 'blissful ignorance' unless serious adverse events occur or they are visited by a pharmacy inspector. Incidents and complaints are 'swept under the carpet' if possible. There is a blame culture with individuals subjected to disciplinary action.
C	**Investigating incidents**	Incidents are superficially investigated with the aim of 'closing the book' and 'hiding any skeletons in the cupboard'. Information gathering from the investigation is stored but little action is taken apart from disciplinary action ('public executions') and attempts to handle the pharmacy inspector.
D	**Learning following an incident**	This is not a learning organisation, as no attempts are made to learn from incidents unless imposed by the pharmacy inspectors. The aim of the pharmacy after an incident is to 'paper over the cracks' and protect itself. The pharmacy considers that it has been successful when the inspectors do not become aware of an incident. No changes are made after an incident apart from those directed at the individuals concerned.
E	**Communication**	Communication is poor. What communication there is comes directly from the manager/owner, with no mechanism for staff to speak to their manager/owner themselves about risk. Incidents are not talked about. The pharmacy is essentially closed, not open to new ideas. What communication there is, is negative, with a focus upon blame.
F	**Staff management and safety issues**	Members of staff are seen just as bodies to fill posts. There is no structured staff development program and the recruitment of staff is ad hoc. Staff feel unsupported, and there is a clear hierarchy of roles. The management of staff takes on a punitive role following an incident; the language is negative and poor health and attendance records are seen as disciplinary matters.
G	**Staff education and training about risk management**	Training has low priority. It is seen by the manger/owner as irritating, time consuming and costly. There are consequently no checks made on the quality or relevance of any risk management training given. Staff are seen as already trained to do their job, so why would they need more training?
H	**Team working**	Individuals mainly work in isolation but where there is a team they are ineffective in terms of risk management. There are tensions between the team members and a hierarchy within the pharmacy. They are more like a group of people brought together under the direction of a leader.

REACTIVE	CALCULATIVE
Patient safety only becomes a priority once an incident occurs and the rest of the time only lip service is paid to the issue apart from meeting legal requirements. There is little evidence of any implementation of a risk management strategy. Patient safety is only considered by the manager/owner in relation to specific incidents. Any measures that are taken are aimed at self-protection and not patient protection.	Patient safety has a high priority and there are a number of procedures in place to protect it. However these systems are not widely circulated to staff or reviewed. The methods also tend to lack flexibility to respond to unforeseen events and fail to capture the complexity of the issues involved. Responsibility for managing risk is given to a single individual who does not communicate it to the wider pharmacy staff.
Staff in the pharmacy are seen as the cause and the solution is retraining and punitive action. There is a reporting system, although staff are not encouraged to report incidents. Minimum information on the incidents are collected but not analysed. There is a blame culture, so staff are reluctant to report incidents. When incidents occur there is no attempt to support any of those involved, including the patient and their relatives.	There is a recognition that systems contribute to incidents and not just individuals. The pharmacy says that it has a no blame culture but it is not perceived in that way by staff. An anonymous reporting system is in place with a lot of emphasis on form completion. Attempts are made to encourage staff to report incidents and near misses, but they do not feel comfortable doing so.
Investigations aim to limit the damage for the pharmacy and assign blame to individual(s). The investigation focus on a specific event and the actions of an individual. Quick fix solutions are proposed that deal with the specific incident but may not be carried out once the 'heat is off'.	The investigation focuses on the individuals and systems surrounding the incident. There is a detailed procedure for the investigation process, which involves the completion of multiple forms. The investigation is conducted for its own sake rather than examining root causes. There is some desire to review procedures and/or change the way in which procedures are communicated to staff.
Little if any learning occurs and what does take place only relates to the amount of irritation that the manager/owner has experienced. All learning is specific to the particular incident. Any changes made after an incident are not maintained, as they are knee jerk reactions to individual errors and are devised and imposed by the manager/owner. Consequently similar incidents tend to reoccur.	Some systems are in place to enable learning to take place but the lessons learnt are not communicated throughout the pharmacy. This learning results in some enforced local changes that relate directly to the specific incident. The manger/owner decides on the changes that need to be introduced and this lack of staff involvement leads to changes not being integrated into working patterns.
Communication about risk from staff to the manager/owner is possible but only after something has gone wrong. Communication is ad hoc and restricted to those involved in a specific incident. Communication is very directive, with the manager/owner issuing instructions. This is a 'telling-off' pharmacy.	There is a communication strategy though it is not directly linked to the management of risk within the pharmacy. Procedures and ways of dealing with risk and incidents are in place, and lots of records are kept. This leads to information overload in which little is actually done with the information recorded by staff and received by managers. A method to communicate risk issues is in place, but no-one checks whether it is working.
Job descriptions and staffing levels change only in response to problems, so there are good selection and retention policies in areas that have been vulnerable in the past. The recruitment of staff has been developed in response to incidents that have already been experienced.	Recruitment and retention procedures for staff are in place, which are separate from risk management procedures. References are always checked for new staff. Procedures on appraisal, incident investigation and staff development are there but are not rigidly applied and so do not always achieve what they were designed for. These procedures are seen as a tool for the manager/owner to control staff.
Training occurs where there have been specific problems and relates almost entirely to high-risk areas where obvious gaps are filled. Information about risk management is given to new staff in an introductory pack. It is the responsibility of the individual to read and act upon this. Education and training focus on maximising income and covering the pharmacy's back.	The training program reflects the pharmacy's needs and is supported only if it benefits the pharmacy. Basic personal development plans are in place so everyone has their own file. However, these are not very effective as they are not properly returned or given priority. Training about safety issues is seen as the way to prevent mistakes.
There is a team but they have been told to work together, and only pay lip service to team working. People only work as a team following an adverse event. There is a clear hierarchy within the pharmacy. The team does work together, but individuals are not actually committed to the team.	A team is put together to respond to new initiatives but there is no way of measuring how effective they are. Working as a team is seen by lower grades of staff as paying lip service to the idea of empowerment. There is little sharing of ideas or information about safety issues across the team.

PROACTIVE	GENERATIVE
Patient safety is promoted throughout the pharmacy and staff are actively involved in all safety issues and processes. Patients, the public and other community pharmacies are also involved in reviewing risk. Measures taken to reduce risk are aimed at patient protection and not self-protection. Risks to patients are identified and action taken to manage them. There are clear accountability lines and while one individual takes the lead for patient safety in the pharmacy, it is a key role of all staff.	Patient safety is integral to the work of the pharmacy and its staff and is embedded in all activities. Responsibility is seen as being part of everyone's role. Staff are constantly assessing risks and looking for potential improvements. Patient safety is a high profile issue throughout the pharmacy.
It is accepted that incidents occur due to individual and system faults. Reporting incidents is encouraged and they are seen as learning opportunities. Accessible, 'staff friendly' reporting methods are used, allowing trends to be readily examined. Staff feel comfortable reporting near misses. Staff and patients are supported from the moment that an incident is reported.	Failures are noted, although staff are aware of their own accountability in relation to errors. It is second nature for staff to report incidents as they have confidence in the investigation process and understand the value of such reporting. Integrated systems enable incidents and complaints to be analysed together. Staff and patients are actively supported from the time of the incident.
The pharmacy is open to inquiry and welcomes any outside involvement in investigations. The staff involved in an incident are also involved in its investigation, which examines the root causes. The aim of the investigation is to learn from incidents and communicate the findings widely. Information from the investigations is used to analyse trends, identify 'hot spots' and examine training implications.	The pharmacy conducts internal investigations that include the staff involved in incidents. Investigations are seen as learning opportunities and focus upon improvement rather than judgement. The investigation process itself is thoroughly reviewed by all staff. Fewer incidents are occurring as a result of learning from the past. It is a learning pharmacy.
The pharmacy has a learning tradition and systems exist to share learning, such as reflection and audit. Members of staff are actively involved in deciding what changes are needed and there is a real commitment to change throughout the pharmacy. Hence changes are maintained. The pharmacy looks for learning opportunities and is keen to learn from others' experiences. The learning that follows incidents is used in forward planning. It is an open, self-confident pharmacy.	The pharmacy learns and shares information about incidents with staff and other pharmacies. It is committed to sharing this learning both within the pharmacy and with other community pharmacies. Incidents are openly discussed where all staff feel able to contribute. Incidents are seen as a learning opportunity, they are inevitable but learning can occur to reduce their likelihood of occurrence. Learning within the pharmacy is evaluated. Improvements in practice occur without a trigger of an incident, as the culture is one of constant improvement.
The method of communication and record keeping are both fully audited. There is communication between pharmacies which helps to identify and reduce risk. All levels of staff are involved. Information about safety issues is shared; there are regular risk management discussions where members of staff are encouraged to set the agenda.	All staff are involved in communication about safety issues. The manager/owner realises that they can learn a lot from their staff. They expect everyone to know about and learn from each other's experiences as it happens. Novel ideas are encouraged. Mechanisms for communication are well established within the pharmacy. This is a 'praising' pharmacy.
There is some commitment to matching individuals to posts. There are also visible, flexible support systems, tailored to the needs of the individual. There is a review of staffing levels in light of changes in risk management policy; and changes are made when necessary. There are attempts to understand why incidents occur and to 'nip problems in the bud'. There is genuine concern about staff health and good systems of appraisal, monitoring and review.	The pharmacy is committed to its staff, and everyone has confidence in the management structure. The management of staff is not a separate entity but an integral part of the pharmacy. Reflection and review about safety issues (risk) occur continuously and automatically, rather than periodically.
There is an attempt to identify the training needs of the pharmacy and the training needs of individuals about safety issues, and to match them up. Such training is well planned, well resourced and continually updated. Education is seen as integral to individual professional and personal development and is linked directly to other safety systems, like incident reporting.	The approach to risk management training and education is flexible and seen as a way of supporting staff in fulfilling their potential. Individuals are motivated to negotiate their own training program. Education about safety issues is integral to the pharmacy culture. Learning is a daily occurrence.
There is a flexible team structure with people taking up the role most appropriate for them at the time. Teams are collaborative and adaptable and actively contribute to the risk management agenda within the pharmacy. There is evaluation of how effective the team is and changes are made when necessary. Teams may involve people who do not routinely work in the pharmacy.	Membership to the team is flexible, with different people making contributions when appropriate. The team is about shared understanding and vision about safety issues, rather than groups of people. This way of working is just the accepted way in the pharmacy. Everyone is equally valued and feels free to contribute. 'Everybody is part of the risk management team.'