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Developing a Safety Management System for Primary Care Medicines Management

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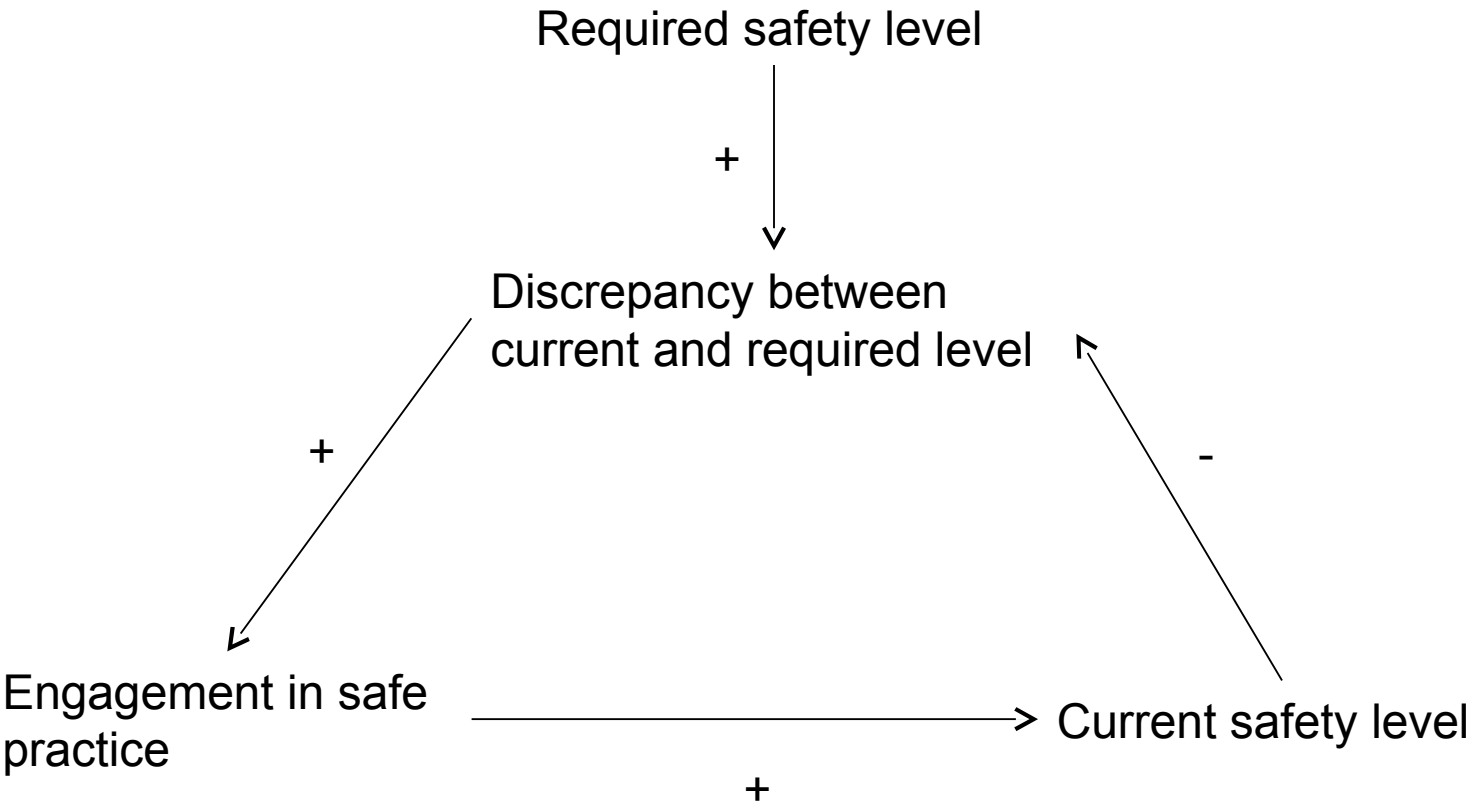
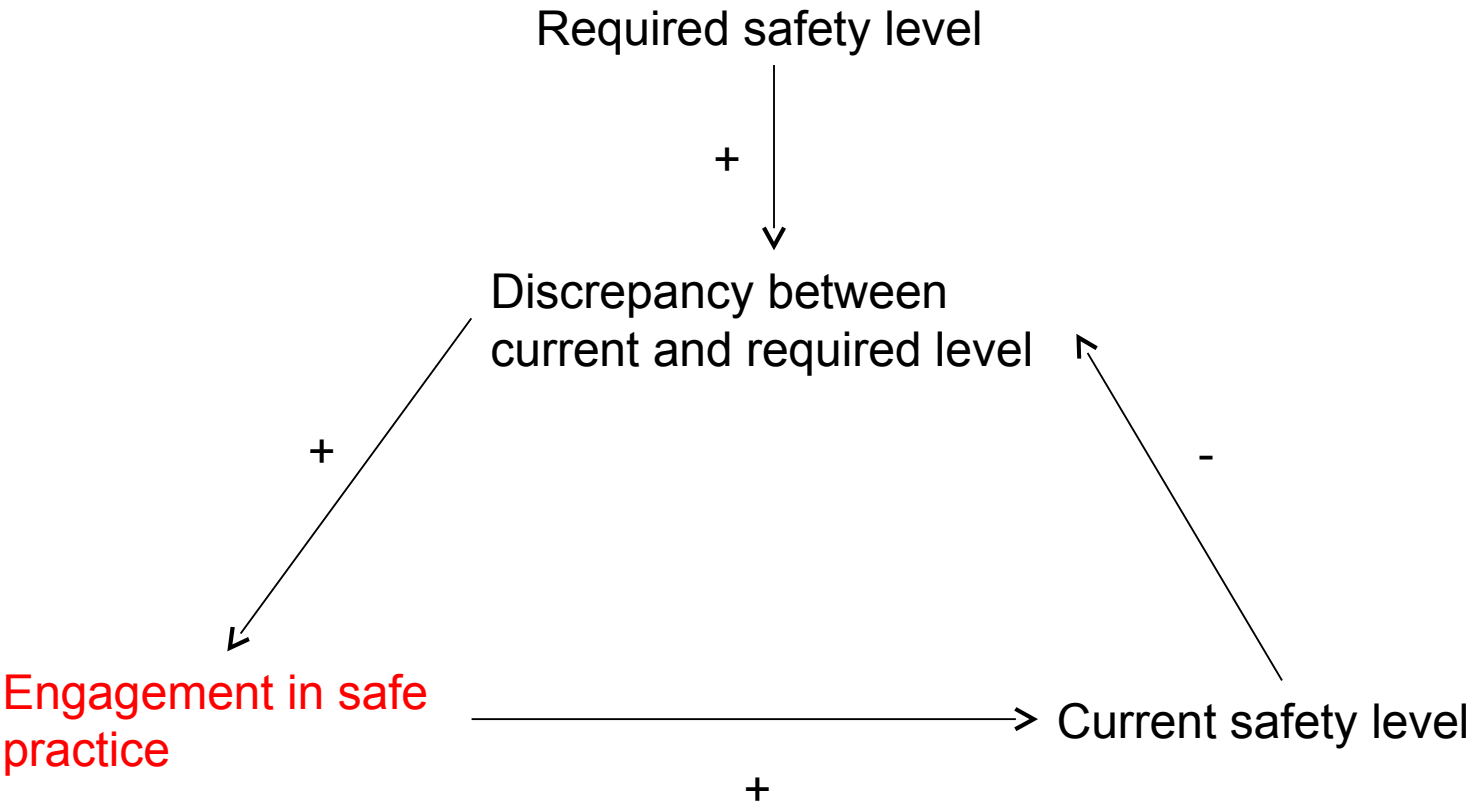
A primary concern?

- Primary care has been seen as a relatively low-risk environment compared to secondary care – however…
  - Estimated 25% of patients experience adverse events – 11% of which are preventable
  - Estimated 7% of hospital admissions are due to drug-related problems – 59% of which are preventable
- In England alone – c. 900,000,000 prescription items processed each year in primary care
- Dealing with medication safety issues in this sector will lead to benefits for the entire healthcare system

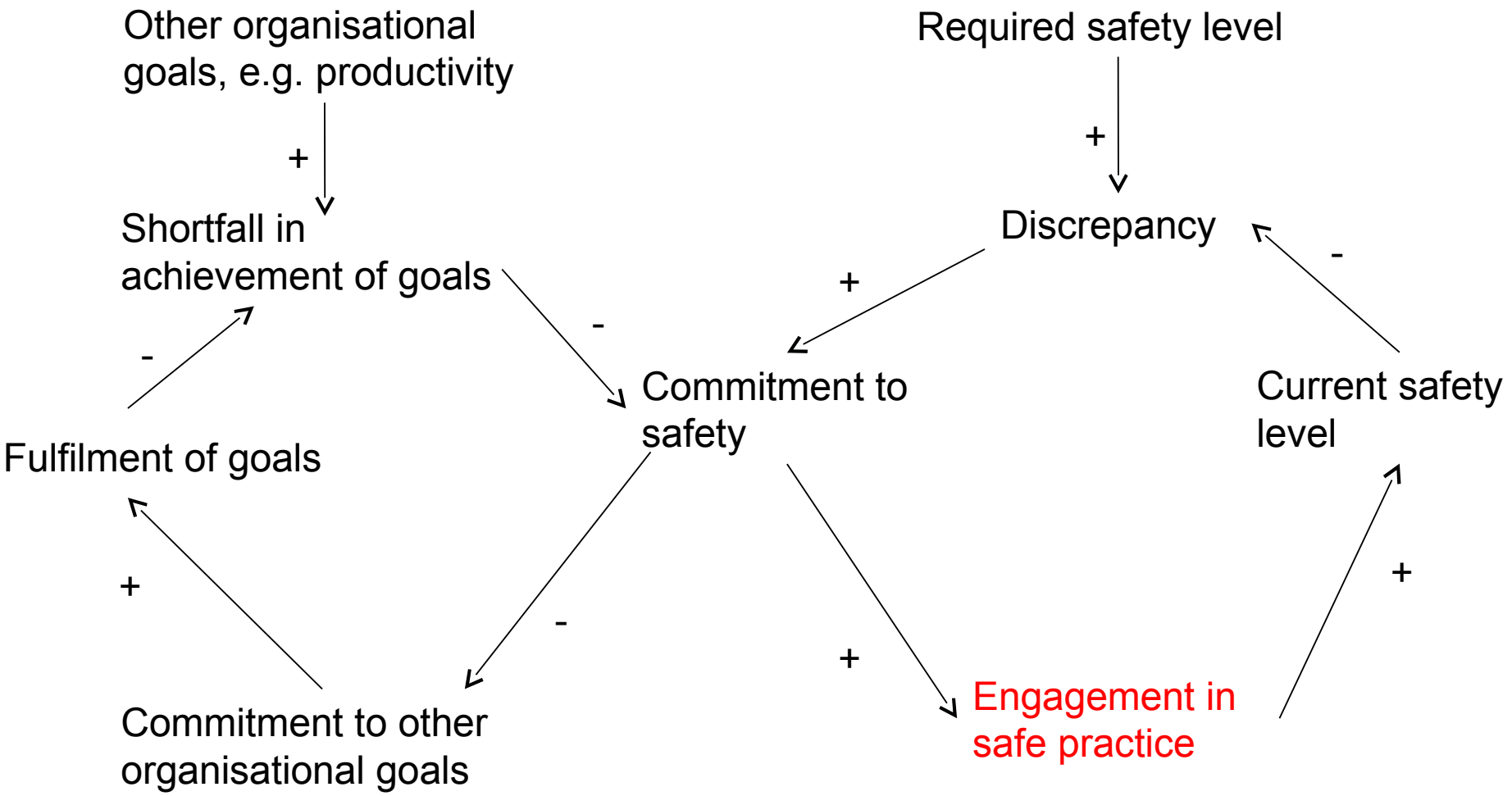
An “open system” view (1)



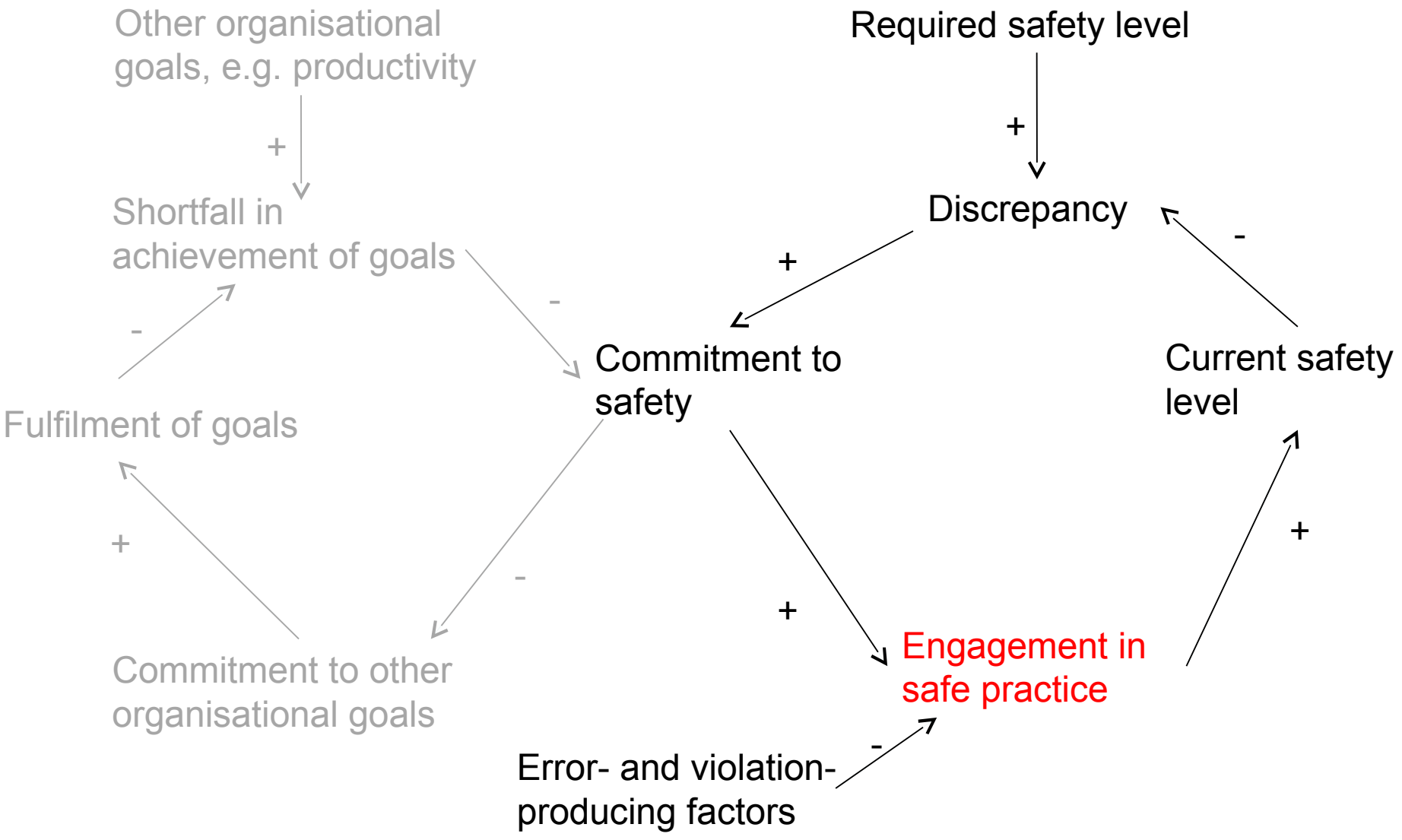
An “open system” view (1)



An “open system” view (2)



An “open system” view (3)



System factors in pharmacy

- Relationships involving the pharmacist

  "I had a boss who I could have killed because he did make mistakes but he refused to admit it"

- Demands on the pharmacist

  "When you're working fast you're just leaping around, grabbing things off the shelf, and unless things have been put in the correct place it's so easy [to make a mistake]"

- Management and governance

  "There's no point in being proactive [with] a management […] which is […] reactive and disciplinary, because that defeats the point of you being proactive in the first place"

Pharmacy types

- The “disenfranchising” pharmacy: staff have little control

  “Having told the manager that it was dangerous working in the pharmacy at the staff levels we had, I was told ‘yes, dangerous for our bonuses’”

- The “challenging” pharmacy: high demand on staff

  “Patient safety always has to be at the forefront and with increasing workload […] I think [it] can be compromised.”

- The “perilous” pharmacy: makes errors and fails to learn

  “Staffing [has] been reduced to unacceptable [levels]. […] [Incident] reporting is scant simply because the workload does not allow for it.”

- The “safety-focused” pharmacy: maintains conditions for safe working

  “[In my new pharmacy I] do a much larger volume of prescriptions but the difference is [having more] support.”

The SMS concept

- "Safety management system": A systematic approach to the control of safety risks throughout an organisation *(NB – not a complex adaptive system)*
- Some key elements
  - Setting and reviewing safety standards
  - Identifying potential hazards
  - Promoting safe working
  - Monitoring safety performance
  - Ensuring continual improvement
- Could this concept be applied to primary care medicines management?

The SMS concept

- Systems theory
  - System: a collection of people and artefacts with a common purpose (e.g. an organisation)
  - Properties of the system emerge from the interactions within it
  - Safety is one such property
- SMS controls the interactions within a system with respect to safety outcomes

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The SMS concept

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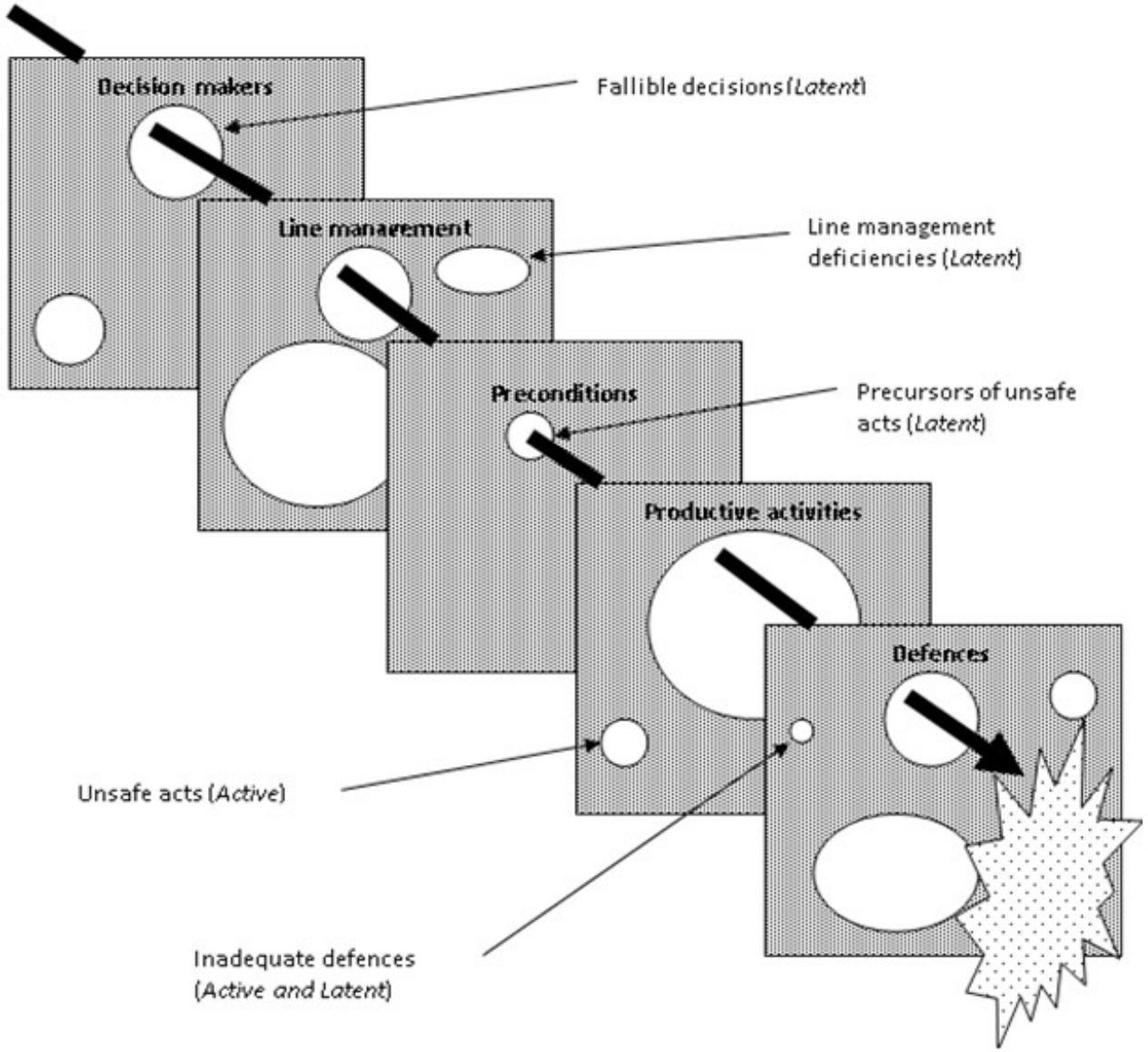

The SMS concept

- Key questions/challenges to be addressed:
  - Which approaches and methods should form part of a SMS intervention;
  - How to build commitment towards the intervention within primary healthcare organisations;
  - How to assess the organisations' readiness for the intervention;
  - How to evaluate the effects of the intervention

Bibliography

- Phipps, D.L., et al. (2009). Medication safety in community pharmacy: a qualitative study of the sociotechnical context. *BMC Health Services Research, 9,* 158
- Phipps, D.L., & Ashcroft, D.M. (2012). An investigation of occupational subgroups with respect to patient safety culture. *Safety Science, 50*(5), 1290-1298
- Phipps, D.L., & Ashcroft, D.M. (in preparation). Looking behind patient safety culture: organisational dynamics, job characteristics and the work domain. To appear in P. Waterson (ed.), *Patient Safety Culture: Theory, methods and application.* Farnham: Ashgate
- Royal, S., et al. (2006). Interventions in primary care to reduce medication related adverse events and hospital admissions: systematic review and meta-analysis. *Quality and Safety in Health Care, 15*, 23-31

Thanks for your attention.

Questions/comments?

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