Pharmacy Quality Scheme 2019/20

Agenda

- Overview of PQS
- PQS payments
- Gateway criteria
- Quality domains
- Action planning

Overview of the Pharmacy Quality Scheme

- Quality Payment Scheme to Pharmacy Quality Scheme
- £75m per year for next five years
- Gateway criteria
- Quality domains with multiple criteria

PQS payments

- £75m per year for next five years
- Each point will have a min. value of £64 and a max. of £128
- Funding will be divided between qualifying pharmacies based on the number of points achieved
- No review point – contractors can choose a day to make their PQS declaration (between 3rd February - 28th February 2020)
- No reconciliation payment – payments will be calculated to distribute the full £75 million funding

Process of claiming

- Declaration period 3rd February - 28th February
- MYS declaration
  - Meet all gateway criteria
  - Meet some or all quality criteria in quality domains
- Payment 1st April 2020

Gateway criteria

- Meeting the gateway criteria does not attract a payment
- Payments for quality points will not be made unless all gateway criteria are met
- Criteria
  - Advanced NHS Services – NMS or FLU – with evidence of claims in run up to declaration plus entry on NHS website
  - NHSmail shared – in use with two active NHS accounts linked
  - *NHS website updated during October / November 2019 – all 3 sections (opening, bank holidays, services)*
  - 80% GPhC registered staff must have completed Safeguarding level 2 training within last 2 years
- Validated as part of PQS declaration

Domains

- Quality points awards only for domains where all criteria are completed

Risk	30
Medicines safety	25
Prevention	25
PCN	12.5 (22.5)
Asthma	5
Digital	2.5

The Risk Domain (30 pts)

- 80% of registered pharmacy professionals have completed the CPPE risk management training and assessment
- 80% of registered pharmacy professionals have completed the CPPE online sepsis training and assessment
- An update of the previous risk review (part of 2018/19 QPS)
- 80% of registered pharmacy professionals have completed the CPPE LASA e-learning and assessment
- A written safety report

Understanding risk

- Hazard – a source of harm
  - Physical
  - Chemical
  - Biological
  - Ergonomic / psychosocial
- Risk

Risk = probability x severity

Quantifying risk

Severity	1	2	3	4	5
Descriptor	**Negligible / no harm**	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Definition	Any unexpected or unintended incident that causes or could cause no or negligible harm	Any unexpected or unintended incident that causes or could cause minimal harm to one or more persons	Any unexpected or unintended incident that causes or could cause short term harm to one or more persons	Any unexpected or unintended incident that causes or could cause permanent or long-term damage to one or more persons	Any unintended or unexpected incident that causes or could cause the death of one or more persons

Probability	1	2	3
Descriptor	**Possible**	**Probable**	**Likely**
Definition	Unlikely to occur (e.g. once per year) and/or has occurred once previously	Reasonable chance of occurring (e.g. occurring a few times per year)	More likely to occur than not (e.g. once per month to once per week)

↑ probability

3	**6**	**9**	**12**	**15**
2	**4**	**6**	**8**	**10**
1	**2**	**3**	**4**	**5**

↑ severity

10-15	**High risk**	Agree immediate actions; escalate risk within organisation (e.g. to Superintendent Pharmacist) if appropriate
5-9	**Medium risk**	Make improvements and complete actions within agreed timescale
1-4	**Low risk**	Continue to review and manage risk by routine procedure

Risk review - sepsis

Date risk identified	Description of Risk	Impact (Severity) Scale 1-5*	Likelihood (Probability) Scale 1-3*	Risk Rating†	Actions required	Person resp. (initials)	Date actions to be completed by	Date of next review
22/01/20	Miss identifying symptoms of sepsis	5	2	10 (High)	• All pharmacists to complete sepsis training • Put sepsis training into booking process for locums • All pharmacy staff to be trained on sepsis symptoms • Sepsis symptom reminder cards at all till points	LS	End Jan '20 End Jan '20 End Jan '20 End Jan '20	End Mar 20

Reflection on previous risk review

What actions did you take to minimise the risk?	ACT going on maternity leave • Train another technician to become ACT • Train dispenser to become technician • Train all HCAs to put away dispensary stock LASA dispensing errors • Brief staff • Reminder card in checking area • Red warning labels on shelf edges for appropriate products
How did these actions affect the risk?	ACT going on maternity leave • ACT did go on maternity leave • Risk mitigated as another ACT available to take on role LASA dispensing errors • No LASA dispensing errors in the past 12 months
Describe any further actions you need to take at premises level to minimise risk going forward.	ACT going on maternity leave • Low risk of second ACT leaving but review salary and responsibilities LASA dispensing errors • Review drugs and quality of reminder card and shelf labels

Annual Patient Safety Report

Summary of patient safety incidents and activity in the pharmacy

Month	A. Prescribing interventions	B. Near misses	C. Near misses involving high-risk LASA* (if known)	D. Dispensing incidents	E. Dispensing incidents involving high-risk LASA* (if known)	F. National safety alerts	G Other patient safety activity †
February 2019							
March 2019							
April 2019							
May 2019							
June 2019							
July 2019							
August 2019							
September 2019							
October 2019							
November 2019							
December 2019							
January 2020							
TOTAL							

Annual Patient Safety Report

How have the patient safety priorities that were agreed in last year's patient safety report been acted upon?

Outline your learnings and actions in relation to LASA medicines (refer to columns C + E in the table)

What were the key learning points for the pharmacy team following the completion of the CPPE reducing look-alike, sound-alike errors e-learning and e-assessment?	What actions have been implemented to minimise LASA incidents and near misses since your last annual Patient Safety Report?
Tactics to reduce LASA errors Tall man lettering	Brief staff Reminder card in checking area Red warning labels on shelf edges for appropriate products
How have these learnings and actions helped to reduce the number of LASA incidents occurring in your pharmacy? Quantify where possible.	If these learnings have not helped to reduce the number of LASA incidents and near misses, why is this the case and what additional actions will you now take?
No LASA errors in the last 12 months	Review drugs and quality of reminder card and shelf labels

Annual Patient Safety Report

Outline key patient safety improvements that have occurred within your pharmacy during this review period in relation to:

4.1 Improvement 1: pharmacy safety - patient safety incidents (refer to columns A, B + D in the table)

Reviewing your patient safety incidents, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?
High proportion of errors occurring during lunch period	Reorganise staff work patterns to improve numbers and skills of staff at lunchtime	Lunchtime errors reduced and now not more common than errors at other times of day

4.2 Improvement 2: national patient safety alerts (refer to columns F + G in the table)

Reviewing national patient safety alerts, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?

Annual Patient Safety Report

How have you shared what you have learned above (in relation to boxes 3 and 4.1 and 4.2) both within your team and externally?

Monthly safety briefing to all staff based on monthly safety report
LASA briefing for all staff involved in dispensing or putting away dispensary stock
Notice board in dispensary

What will be the team's patient safety priorities for the next NHS year (April 2020 – March 2021)

Priority 1:	LASA
Priority 2:	Sepsis
Priority 3:	Errors at the start or end of shifts

The Medicines Safety Domain (25 pts)

- *Lithium audit (or methotrexate, amiodarone or phenobarbital)*
- *Sodium valproate audit*
- Implement findings form previous NSAID audit and repeat audit

Recommendations from NSAIDs audit

- Be aware of the benefits of gastro-protection in patients taking NSAIDs and prioritise high risk patients for referral, making efforts to communicate with patients who don't attend the pharmacy
- Procedures to embed practice to avoid patients being missed
- Pharmacy teams to be clear about their responsibilities
- Maximise the opportunities to work with multidisciplinary teams

NSAID actions

What	By When	Who	Date complete
Identify all patients who have prescriptions collected for NSAIDs and refer them to pharmacist	From 1st Jan	All Dispensary team	Ongoing Review in April
Put warning for all NSAIDs in PMR to check for gastro-protection	31 Jan	Pharm Tech	
Briefing for all staff on process for dispensing NSAIDS	31 Jan	Pharmacist	
Write to all local GPs/GP clinical pharmacists to get their input about referral criteria	31 Jan	Pharmacist	

The Prevention Domain (25 pts)

- The pharmacy is a HLP
- All patient facing staff are Dementia Friends
- Completed the dementia friendly environment checklist
- Check whether all patients with diabetes presenting between 1st October and 31st January have had foot and eye checks
- Sugar sweetened beverages are less than 10% (by volume) of all beverage sales

Dementia friendly environment checklist

- Do you have a quiet space for someone who might be feeling anxious or confused?
- Are your signs, clear, in bold face, contrasted well between the text and background, for the exit and the toilet (if applicable) clear?
- Are your signs fixed to the doors they refer to?
- Are your signs at eye level and well-lit?
- Have you ensured signs are not highly stylized or using abstract images or icons as representations?
- Have you ensured signs are placed at key decision points (e.g. where there is a choice to turn left or right) for someone who is trying to navigate your premises for the first time?
- Are your glass doors clearly marked?
- Are your entrances well lit?
- Have you taken measures to avoid any pools of bright light or deep shadows?
- Have you avoided having any floor surfaces that are highly reflective or slippery?
- Have you avoided bold patterned carpets?
- Have you ensured changes in floor finish are flush rather than stepped?
- Do the floors in your pharmacy have plain finishes?

Dementia friendly environment checklist (II)

- If your pharmacy does NOT have space for a toilet/other facilities, can you provide information about the nearest toilet/changing facility locally?
- If your pharmacy does have a toilet/other facilities available for patients, does it allow someone to have assistance without causing them or other's embarrassment?
- If your pharmacy does have a toilet available for patients, have you ensured that the toilet seats are of a contrasting colour to the walls and rest of the toilet?
- If space allows, does your pharmacy provide a seating area, especially in areas where people are waiting?
- Have you ensured that any seating looks like seating?
- Does your pharmacy have any 'landmarks' present to help with navigation of the environment?
- Do you have information such as leaflets and posters about local support groups for patients and carers available?

The PCN Domain (12.5/22.5 pts)

- All pharmacies (12.5 pts)
  - Provide name of appointed Pharmacy PCN Lead
  - Provide ODS for the pharmacy they are associated with
- PCN Lead (extra 10 pts)
  - Inform the LPC
  - Evidence they have started the engagement process with the PCN
  - Declare
    - that they are the appointed Pharmacy Lead
    - the name of the PCN
    - that they have notified this to the LPC in which the PCN lies; and
    - that they have evidence of having started the engagement process with the PCN

The Asthma Domain (5 pts)

- evidence that patients with asthma, for whom more than 6 short-acting bronchodilator inhalers were dispensed without any corticosteroid inhaler within a 6 month period have, since the last QPS review point (i.e. 15th February 2019), been referred to an appropriate healthcare professional for an asthma review
- evidence that they have ensured that all children aged 5-15 years old prescribed an inhaled corticosteroid for asthma have a spacer device where appropriate and a personalised asthma action plan.

The Digital Domain (2.5 pts)

- Updated the NHS 111 DoS profile including opening hours for public and bank holidays
- Access to the SCR between 1st October and day of declaration

PQS 2020/21

- Suicide prevention training by pharmacy staff
- Inhaler technique audit
- Anticoagulant audit

Action planning

Training matrix

- Safeguarding
- Risk management
- Sepsis
- LASA
- Dementia Friends
- NSAID
- Health Champion
- HLP leadership

- Give yourself a deadline for declaration
- Update risk reviews and safety reports
- Allocate tasks and responsibilities to different team members
- Access resources from PSNC/CPPE

Links to useful resources

- PSNC resources - https://psnc.org.uk/wp-content/uploads/2019/12/PSNC-Briefing-059.19-Pharmacy-Quality-Scheme-PSNC-resources-1.pdf
- CPPE - https://www.cppe.ac.uk/services/pharmacy-quality-scheme
- NHSE - https://www.england.nhs.uk/publication/pharmacy-quality-scheme-guidance-2019-20/

Action plan

Do what	What support do I need?	What could be a barrier?	By when

Do what	What support do I need?	What could be a barrier?	By when

Pharmacy Quality Scheme (PQS)

2019/2020 Patient Safety Report

Pharmacy name (and branch number, if applicable)		**ODS (F code)**	
Report completed by (name)		**Date of report**	
Dates covered by the report	**February 2019 to January 2020**		
Pharmacy team members who participated in preparing this re (initials)			

1. **Summary of patient safety incidents and activity in the pharmacy** (enter monthly totals in the table below)

Month	A. Prescribing interventions	B. Near misses	C. Near misses involving high-risk LASA* (if known)	D. Dispensing incidents	E. Dispensing incidents involving high-risk LASA* (if known)	F. National safety alerts	G Other patient safety activity †
February 2019							
March 2019							
April 2019							
May 2019							
June 2019							
July 2019							
August 2019							
September 2019							
October 2019							
November 2019							
December 2019							
January 2020							
TOTAL							

* 'Look-Alike, Sound-Alike' (LASA), medicines (sometimes referred to as Sound Alike, Look Alike (SALAD) medicines classified as high-risk are: propranolol & prednisolone, amlodipine & amitriptyline, carbamazepine & carbimazole, atenolol & allopurinol and rivaroxaban & rosuvastatin

† Including drug recalls

2. **How have the patient safety priorities that were agreed in last year's patient safety report been acted upon?**

3. **Outline your learnings and actions in relation to LASA medicines (refer to columns C + E in the table)**

What were the key learning points for the pharmacy team following the completion of the CPPE reducing look-alike, sound-alike errors e-learning and e-assessment?	What actions have been implemented to minimise LASA incidents and near misses since your last annual Patient Safety Report?
How have these learnings and actions helped to reduce the number of LASA incidents occurring in your pharmacy? Quantify where possible.	If these learnings have not helped to reduce the number of LASA incidents and near misses, why is this the case and what additional actions will you now take?

4. **Outline key patient safety improvements that have occurred within your pharmacy during this review period in relation to:**

4.1 Improvement 1: pharmacy safety - patient safety incidents (refer to columns A, B + D in the table)

Reviewing your patient safety incidents, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?

4.2 Improvement 2: national patient safety alerts (refer to columns F + G in the table)

Reviewing national patient safety alerts, what were the key learning points and how were they identified?	What actions have been taken at the pharmacy as a result?	How has patient safety improved as a result?

5. How have you shared what you have learned above (in relation to boxes 3 and 4.1 and 4.2) both within your team and externally?

6. What will be the team's patient safety priorities for the next NHS year (April 2020 – March 2021)

Priority 1: Priority 2: Priority 3:

Risk Review

If using this template, <u>all columns</u> must be populated and actions must be completed by agreed dates

Date risk identified	Description of Risk	Impact (Severity) Scale 1-5*	Likelihood (Probability) Scale 1-3*	Risk Rating†	Actions required	Person resp. (initials)	Date actions to be completed by	Date of next review

Reflecting on your previous risk review

What actions did you take to minimise the risk?	
How did these actions affect the risk?	
Describe any further actions you need to take at premises level to minimise risk going forward.	

NSAID audit recommendations and SMART actions

Recommendations

- Be aware of the benefits of gastro-protection in patients taking NSAIDs and prioritise high risk patients for referral, making efforts to communicate with patients who don't attend the pharmacy
- Procedures to embed practice to avoid patients being missed
- Pharmacy teams to be clear about their responsibilities
- Maximise the opportunities to work with multidisciplinary teams

(paraphrased from https://www.england.nhs.uk/wp-content/uploads/2019/11/NSAID-safety-audit-1819.pdf)

SMART Actions

What	By When	Who	Date complete

Community Pharmacy Dementia Friendly Environment Checklist

Contractors must demonstrate that they have reviewed their pharmacy premises based on the elements described in this checklist. Due consideration should be given to what is reasonably achievable, which actions can be acted upon and by when. Some elements of the checklist may need to be considered as part of future development work to the pharmacy.

Pharmacy name:

Pharmacy ODS code:

Date checklist completed:

	Element description	Currently available in your pharmacy (Please circle)	If no, identify if an action can be taken and state when this will be completed by
1.	**Quiet Space**		
	Do you have a quiet space for someone who might be feeling anxious or confused? *A few minutes of talking to a supportive person in a quiet space might be all that's needed to continue the transaction.*	YES/NO	
2.	**Signage**		
	Are your signs: - **clear?** - **in bold face?** - **contrasted well between the text and background?** - **for the exit and the toilet (if applicable) clear?** *For example, using a very dark coloured background and a very light colour for the text of a sign will make it easier to read.* *It is recommended to also ensure there are exit signs inside the toilet cubicle and the inside of the toilet room showing how to get out.*	YES/NO YES/NO YES/NO YES/NO	

NHS England and NHS Improvement would like to acknowledge Dementia Action Alliance and the Alzheimer's Society whose original check list informed the basis of this checklist and action plan.

	Are your signs fixed to the doors they refer to? *Signs should not be on adjacent surfaces if at all possible. E.g. a toilet sign should be on the door of the toilet (rather than an adjacent wall) as people will know to push the door as it has a sign on it.*	YES/NO	
	Are your signs at eye level and well-lit? *This will make signs easier to see and read.*	YES/NO	
	Have you ensured signs are not: - **highly stylized** - **using abstract images or icons as representations?** *For example, it is preferred to use the words 'Male' and 'Female' on toilet signs rather than Mars (♂) and Venus (♀) symbols for males and females respectively as these are easily understood.*	 YES/NO YES/NO	
	Have you ensured signs are placed at key decision points (e.g. where there is a choice to turn left or right) for someone who is trying to navigate your premises for the first time? *People with dementia may need signs every time they come to your building.*	YES/NO	
	Are your glass doors clearly marked? *Glass doors can sometimes be hard to see which means people may walk into them.*	YES/NO	
3.	**Lighting**		
	Are your entrances well lit? *Try to make as much use of natural light as possible. This can be done by opening blinds and ensuring that windows are not too busy or cluttered where possible to let natural light in.*	YES/NO	

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	Have you taken measures to avoid any pools of bright light or deep shadows? *Pools of darkness or light can affect people's perception and depth and could make them fall over. Checks can be made by ensuring there is sufficient lighting throughout the pharmacy and carrying out regular checks to ensure all bulbs are working.* **Are all light bulbs working?**	YES/NO YES/NO	
4.	**Flooring**		
	Have you avoided having any floor surfaces that are: - **highly reflective** - **slippery?** *Reflections can cause confusion and slippery surfaces are dangerous. Non-black mats or runners could help with this.*	YES/NO YES/NO	
	Have you avoided bold patterned carpets? *Plain or mottled surfaces are easier; patterns can cause problems to people with perceptual problems.* *If the carpet cannot currently be replaced, purchasing uniform colour mats that will obscure the patterned carpet temporarily may be an option.*	YES/NO	
	Have you ensured changes in floor finish are flush rather than stepped? *Changes in floor surfaces can cause some confusion due to perceptual problems. If there is a step at the same time you also introduce a trip hazard.* *If you are unable to change your floor surfaces you may wish to consider signage to alert patients to the presence of steps or uneven flooring.*	YES/NO	
	Do the floors in your pharmacy have plain finishes? *Avoid blue or black floors and avoid putting a black mat at the entrance to the pharmacy as it can look like a hole to someone with dementia. Other less dark primary colours have helped those affected.*	YES/NO	

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5.	**Toilets**		
	If your pharmacy does NOT have space for a toilet/other facilities, can you provide information about the nearest toilet/changing facility locally?	YES/NO	
	If your pharmacy does have a toilet/other facilities available for patients, does it allow someone to have assistance without causing them or other's embarrassment? *A disabled cubicle would be helpful.*	YES/NO	
	If your pharmacy does have a toilet available for patients, have you ensured that the toilet seats are of a contrasting colour to the walls and rest of the toilet? *Using contrasting colours for each part makes it easier to see that it is a toilet.*	YES/NO	
6.	**Seating**		
	If space allows, does your pharmacy provide a seating area, especially in areas where people are waiting?	YES/NO	
	Have you ensured that any seating looks like seating? *People with dementia will find this easier - so for example a wooden bench would be preferable to an abstract metal Z-shaped bench* *If pharmacies cannot currently replace their seating, signage with words such as 'Take a seat' may help this challenge*	YES/NO	
7.	**Navigation**		
	Does your pharmacy have any 'landmarks' present to help with navigation of the environment? *Research shows that people with dementia use "landmarks" to navigate their way around, both inside and outside. The more attractive and interesting the landmark (which could be a painting, or a plant) the easier it is to use it as a landmark. Have you had a good look round and thought about these landmarks?*	YES/NO	
8.	**Information**		
	Do you have information such as leaflets and posters about local support groups for patients and carers available?	YES/NO	

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