Identifying the challenges of maintaining a good safety culture in community pharmacy using the Manchester Patient Safety Assessment Framework.


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Background

Safety culture has become firmly established within organisational research and practice as a means for explaining and predicting safety-related behaviour (1). The aim of this study is to gain a deeper understanding of safety culture and how it is maintained in community pharmacy.

Methods

Four community pharmacies, a total of 23 participants were recruited between May and July 2014 in Greater Manchester. Participants were recruited through local contacts and pharmaceutical committees. In each pharmacy, focus groups were held in which participants assessed their pharmacy’s safety culture using the Manchester Patient Safety Assessment Framework (MaPSaF) and then discussed the outcomes of their assessment as a team. MaPSaF is based on the five level model of safety culture developed by Parker and Hudson (2). At the highest level of safety culture, risk management is seen as an integral part of behaviour in the workplace. Researchers visited pharmacies on monthly follow up visits for four months to observe and discuss their progress following the initial focus group. Verbatim transcripts from the focus groups were subjected to template analysis. This involved identifying a priori themes from the literature as well as themes emerging from the data to create a template that was then applied to each transcript. Ethical approval was obtained from the University of Manchester Research Ethics Committee.

Results

Seven common factors were identified as challenges to maintaining safety culture in community pharmacy: firstly, though error reporting was common, knowing how to learn from errors was often perceived as challenging; following rules was identified as integral, however they were sometimes shown to be difficult to follow due to lack of flexibility; latent factors, mainly differences in support offered by area management, led to variation in safety culture. Thirdly, the intense pressure to complete a large amount of tasks simultaneously within limited time made maintaining a good safety culture sometimes challenging.

Communication was noted as a challenge, particularly for pharmacies that had varying shifts, especially when a lack of written communication existed amongst the team. Task management decisions such as delegation and prioritisation were highlighted as needing to be constantly balanced. Finally, keeping the importance of patient safety in mind at all times was seen as fundamental to maintain a good safety culture. Each factor was shown to vary between pharmacies, for example flexibility of rules was not as problematic for the independent pharmacy when compared to the medium sized chain.

Discussion/conclusion

Overall participants felt that being able to discuss the pharmacy’s safety culture as a team to be a valuable experience. Our findings suggest a range of factors that need to be managed within a
community pharmacy setting in order to maintain a good safety culture. We have found MaPSaF to be a helpful discussion tool and a useful framework for assessing safety culture in community pharmacy.

References