About this guide to risk management

We have written this guide to support pharmacy professionals who want to learn more about how they can manage the risks that are inherent in their practice. This guide will signpost you to the most appropriate places for your learning and to other key resources. It will also suggest some activities that you could try out to help you implement change into the way you work.

We have included case studies throughout this guide so that you can apply the learning to the NHS Community Pharmacy Contractual Framework and consider how you can identify and manage risk in your regular practice.

We cover four key aspects relating to risk in this guide:

1. What can go wrong in pharmacy practice?
2. How do you learn from things that go wrong?
3. How do you assess risk?
4. How do you manage risk?

There are exercises and case studies throughout for you to complete. The majority do not have suggested answers. They are an opportunity for you to apply what you have learned to a scenario.

Why should you learn about risk?

In pharmacy practice, the key external driver for being aware of risky practices and planning solutions is patient safety. However, you may also have identified financial risks to your business and physical risk to you, your pharmacy team and your customers.

Clinical governance is one of the essential services offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework – risk management is a key element of this. You have a responsibility to be aware of the risks associated with your work, and to do what you can to reduce these.

You can visit the Pharmaceutical Services Negotiating Committee (PSNC) website to look at the current guidance for pharmacy contractors in relation to clinical governance: http://psnc.org.uk/contract-it/essential-service-clinical-governance/

Risk management is often uncertain and it is unlikely that you will find a single solution that fits all circumstances.

Managing risk is about balancing different factors, some of which may be unknown and some of which will vary over time and in response to a range of influences. This is also affected by perception; your viewpoint, experience and circumstances will affect how you assess risks and how you choose to manage them.
Violations
Violations are when someone deliberately deviates from rules, policies or procedures. They may do this because everyone else does too or because they are taking a shortcut to work around an impractical system. An example of a violation would be ignoring all of the interaction alerts on your dispensing system even though the standard operating procedure (SOP) dictates that they should be reviewed.

2.5 The Swiss cheese model of accident causation
Many of the most serious patient safety incidents are identified as having a series of errors and failures contributing to the eventual outcome and safety science proposes models of how these may occur.

One such model is known as the Swiss cheese model of accident causation. This uses the analogy that the slices of Swiss cheese represent different types of safeguard.

The holes in each layer of the cheese represent weaknesses in the safeguard which could be many things, such as an unplanned and uncommunicated change in practice, an IT failure or a design fault.

If multiple slices are lined up in just the right arrangement, there would be a hole all the way from one side to the other, as per the diagram below.

When this occurs and an incident is not prevented, it appears that there were no effective safeguards in place.

For example, there may be many safeguards used to ensure that patients are provided with medicines that are safe and appropriate for their use.

Some of these safeguards will work prior to a person visiting a pharmacy:

- A patient’s conversation with a GP and a warning that the medicine they are taking is incompatible with other medicines.
- Manufacturers’ efforts to ensure their packaging is clear and that their products with similar names or different doses can be easily distinguished.
- International and national regulations, policies and recommendations. For example controlled drug regulations.

In the pharmacy, there will be several more safeguards ranging from access to patients’ records, SOPs for dispensing and accuracy-checking, and interaction alerts built in to dispensing systems.

All of these could be seen as different layers of the Swiss cheese. However, despite the number of safeguards in place, there is still a probability – a risk – that the holes in the cheese could line up and a patient could be involved in a safety incident.
4. How do you manage risk?

**Background reading**


HSE. *Safe handling of cytotoxic drugs in the workplace.*
[www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm](http://www.hse.gov.uk/healthservices/safe-use-cytotoxic-drugs.htm)

4.1 Risk management strategies

From the previous section, it might seem that for every risk you find, you need to be reducing it in some way. However, it should reassure you that there are four different strategies to managing risk. These are:

- **Mitigate**
- **Avoid**
- **Transfer**
- **Accept**

**Mitigate** is likely the most common risk management strategy that you will consider. This is where you seek to control the risk and bring it to a level that is deemed to be acceptable. This may be by attempting to reduce the probability of occurrence or the severity of the outcome and we will be going into more detail on this in this section.

**Avoid** is where you identify that the risk exists and choose actions that are beyond simply mitigating it, and avoid all actions that would give rise to this risk. For example, if you were concerned about the risks associated with a delivery service, you might decide that you do not want to offer a delivery service. If your pharmacy is debating taking on some additional services and you were concerned that the staff would not be able to deliver these safely, you might decide that it is better that you do not offer them at all.

**Transfer** involves insuring against the risk. Pharmacies are required to carry insurance. In some cases, pharmacy owners may want to take out extra insurance to cover specific issues where they feel the risks exist and may not be adequately managed.

**Accept** is where you acknowledge that the risk exists but you do not take any action to either avoid, transfer or mitigate against the risk. For example, there may be a very low probability that all of your pharmacy vehicles will break down on the same day. You are not going to mitigate this by ensuring there is another. You may not be able to avoid this risk and you choose not to insure against it. Therefore, you are accepting this risk.

Deciding which you should do is often decided by the policy on risk management in your organisation. For example, if you consider the risk matrix introduced in the previous section, organisations may categorise low, medium and high risk differently.

We can consider how organisations view risk differently by looking at the following risk matrices for two different organisations. Organisation 1, on the left, appears to be more risk-averse. They have few risks (the green section) which they would consider to be low risk. In contrast, Organisation 2, on the right, is less risk-averse and they consider few risks to be high risk.
4.8 Risk minimisation in the real world – a safer culture

Now that you’ve assessed your risks and put strategies in place to minimise the possibility of things going wrong, you still need to have an ongoing awareness of risk.

The strategic systems and good practice that you put in place can protect you and your patients from many risks. However, the Swiss cheese model will still apply and other potential gaps and weaknesses are inevitable in the system. Therefore, you still need to be risk-aware every day, keeping up to date with incident reports from elsewhere, reinforcing the ideals of being open and actively looking for risk potential to reduce it in your own practice. These are all features of a good safety culture.

Sometimes managers are surprised by the perceptions of the people who work for them, not realising that they may not have a clear understanding of the expectations placed upon them, or that there is conflict between several goals. Sometimes staff may feel unwilling to tell their manager that the working conditions make it difficult for them to perform well and that this can lead to errors. Having a good safety culture should make it easier to communicate and help identify and address these misunderstandings before they lead to incidents.

A good safety culture also means sharing information openly and freely, and fair treatment for staff when an incident happens. We are all likely to have an emotional response to when things go wrong. You may recognise some of the stages listed in this diagram.

Adapted from the work of Elizabeth Kubhler Ross (Devine M and Hirsch W. Mergers and acquisitions: getting the people bit right. 1998. Roffey Park Management Institute: Horsham).

While safety culture may sound like a vague concept, there are means of measuring it and working together to improve it. One such method is the Manchester Patient Safety Assessment Framework (MaPSaF) technique, which is used by pharmacy teams to evaluate their own performance and look towards improving it.

This involves assessing a range of features of the environmental culture against levels on a rating scale. These would include local responses relating to incidents or safety issues.

These levels are described as follows:

- Pathological – ‘why do we need to waste our time on safety issues?’
- Reactive – ‘we take patient safety seriously and do something when we have an incident.’
- Bureaucratic – ‘we have systems in place to manage patient safety.’
- Proactive – ‘we are always on the alert/thinking about patient safety issues that might emerge.’
- Generative – ‘managing patient safety is an integral part of everything we do.’