EM		A
REVI	BE OPEN	E
	& HONEST	2

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 report (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							

<sup>\* &#</sup>x27;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.	How have the patient safety priorities that were agreed in last year's patient safety report been acted upon?

Outline your learnings and action the table)	line your learnings and actions in relation to LASA medicines (refer to columns C + E in 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 action reduce the number of LASA incidents your pharmacy? Quantify where poss	occurring in	If these learnings have not helped to reduce the num LASA incidents and near misses, why is this the case what additional actions will you now take?				
Outline key patient safety improve this review period in relation to:						
5.1 Improvement 1: pharmacy sa the table)  Reviewing your patient safety incidents, what were the key learning points and how were they identified?		nave been taken at the	er to columns A, B + D in  How has patient safety improved as result?			
5.2 Improvement 2: national pation Reviewing national patient safety alerts, what were the key learning points and how were they		have been taken at the	•			
identified?  6. How have you shared what you	u have learned	l above (in relation to	boxes 3 and 4.1 and 4.2)			
both within your team and ext	ernally?					
7. What will be the team's patien March 2021) Priority 1:	nt safety prior	ities for the next NH	S year (April 2020 –			
Priority 2:						
Priority 3:						