
Research Article**Pharmacy Patient Safety: 1. Evaluation of Pharmacy Patient Safety Culture in a tertiary hospital in Bayelsa State, Nigeria.****Owonaro PA, Eneyi KE, Eniojukan JF***

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Abstract: Patient safety, which is the prevention of patient harm resulting from the processes of health care delivery, is a critical component of health care quality. This study sought to evaluate the culture of pharmacy patient safety in a tertiary hospital in Nigeria. The Agency for Healthcare Research and Quality Questionnaire on Pharmacy Safety was adapted and used for this study. The questionnaire was administered randomly to 25 staff working in the pharmacy area where prescriptions were dropped off, filled, dispensed, and picked up or prepared for delivery. A purposive sampling technique was utilized whereby only staffs that had direct professional interactions with patients were randomly selected. Data was analyzed with SPSS V. 20. Over 80% of respondents were professionals (pharmacists /Internees) who were directly involved in providing pharmaceutical services in the department; 57% of respondents had worked in the pharmacy department from 6 months to 6 years and 92% worked at least 32 hours per week. Overall positive responses were highly significant for Teamwork (92%), Overall Perception of Patient Safety (91%), Patient Counselling (81%), but poor for Documenting Mistakes (52%) Response to Mistakes (46%) and Staffing, Work Pressure and Pace (30%). Patient Safety in this Pharmacy received an overall rating of 86.3%. Management of the hospital need re-evaluate current safety culture composites; amend systems where necessary in order to reduce risks and to improve Pharmacy Patient Safety.

Keywords: Culture, Hospital, Patient, Pharmacy, Practices, Safety.

INTRODUCTION

Safety, regarded as the first domain of quality, refers to freedom from accidental injury. This definition is stated from the patient's perspective [1]. Patient safety is freedom from accidental injuries during the course of medical care; activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care [1, 2]. A comprehensive approach to patient safety has advocated six major areas: Structure, Environment, Equipment/technology; Processes; People, and Leadership systems/culture [3, 4, 5].

Thus, a culture of safety is an integrated pattern of individual and organizational behaviour, based upon shared beliefs and values that continuously seek to minimize patient harm which may result from the processes of care delivery. [6]. Patient safety culture has also been defined as the set of values, beliefs, and norms about what is important, how to behave, and what attitudes are appropriate when it comes to patient safety in a workgroup or organization. [7]. There isn't a universally accepted definition of a safety culture in healthcare but it is essentially a culture where staffs have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open

and fair and one that encourages people to speak up about mistakes. In organisations with a safety culture, people are able to learn about what is going wrong and then put things right [8]. A safety culture is essentially a culture where everyone has a constant and active awareness of her/his role and contribution to the organization [9]. Thus, a system-based approach is considered as the proven way to improve patient safety. The systems-based approach takes into account many components recognized as contributing to an incident or to the events leading up to it. This moves the investigator away from focusing blame on individuals and looks at what was wrong with the system in which the individuals were working. [9]

The overall goal of this study was to evaluate the culture of pharmacy patient safety in a tertiary hospital in the Niger delta area of Nigeria. Specifically, the study assessed the current status of patient safety culture, and identified strengths and areas for patient safety culture improvement.

METHOD**Study site**

The study was carried out at the Federal Medical Centre, a tertiary (teaching) hospital facility

located in Yenagoa, the capital of Bayelsa State, Nigeria. FMC, Yenagoa is a federal government-owned health care institution with about 350 functional beds located in the urbanized part of the state and provides specialized healthcare services for the people of Bayelsa State and environ. There were 15 major units/departments catering for the medico-surgical needs of clients. The Pharmacy department had an estimated number of 20 Pharmacists, 12 Pharmacy Technicians, 21 Internees, and 10 other categories of staff. The staffs operate call duties to provide 24-hr pharmaceutical services. The Pharmacy department is decentralized with satellites in Surgical Out-patient, In-patient, Accident & Emergency departments, Obstetrics & Gynaecology, and Paediatric wards. There is also a Unit that caters for HIV/AIDS patients.

Data collection

The Agency for Healthcare Research and Quality (AHRQ) Questionnaire on Pharmacy Safety was adapted and used for this study.

The survey tool included 36 items measuring 11 composites. The survey used either 5-point agreement scales (“Strongly disagree” to “Strongly agree”) or frequency scales (“Never” to “Always”). In addition to the composites, the pharmacy survey included three items about the frequency of documenting different types of mistakes, three items about respondents’ background characteristics, and an overall rating question. The survey tool had a total of 42 items.

Sample

The questionnaire was administered randomly to 25 staff working in the pharmacy area where prescriptions were dropped off, filled, dispensed, and picked up or prepared for delivery. A purposive sampling technique was utilized whereby only staff who had direct professional interactions with patients were randomly selected (Staff Pharmacists, Pharmacy Interns, and Pharmacy Technicians).

Data analysis

All sorted questionnaires were coded and entered into SPSS V. 20 spreadsheet for descriptive analysis. Negatively worded items were given due considerations during analysis in order to maintain consistency. Cronbach’s alpha was run on all items pertaining to composites to check for internal consistency. All responses were grouped into positive (>3), neutral (3) and negative (<3) to items on the Likert scale of 1 to 5.

RESULTS AND DISCUSSION

Response rate

The response rate was 100%

Characteristics of Respondents

Table 1 displays the distributions of the 25 respondents by Staff position, Tenure in the pharmacy

and Hours worked per week in the pharmacy. Staff Pharmacists and Pharmacy Interns each constituted 43.5% of respondents and 13% were Pharmacy Technicians. All respondents, therefore, had contacts with Patients. Sixty-five percent of respondents had worked in their pharmacy units from less than 6 months up to 1 year; 31% between 1 year up to 6 years; 26% at least 3 years. Ninety-two percent of respondents worked in their pharmacy at least 32 hours per week.

Evaluation of Safety Practices

Tables 2 and 3 display the average percent positive responses on the patient safety survey items and culture composites.

Physical Space & Environment

A majority of respondents (70%) had a positive opinion about this safety culture composite. Where there was greater need for improvement was the survey item addressing connection between physical layout of the pharmacy and good work flow for which an average positive opinion of 54.2% was expressed. A well laid out pharmacy will remove clutters, support good work flow and enhance patient safety. Factors in the environment that must be considered relative to patient safety from both the patient’s perspective, as well as the practitioner include: Lighting, surface types, temperature, noise levels, design, and functionality. Noise levels can also distract attention [10]

Staffing, Work Pressure and Pace

The sore points in this safety culture composite were Staff strength to handle workload (16%), Distractions that make it difficult for staff to work accurately (20%) and taking of adequate breaks by staff during their shifts (37.5%). Respondents actually scored this composite a mere 30% overall. The idea of “feeling rushed” while processing prescriptions creates room for errors to occur. Work overload subjects staff to intense pressure and stress which promote error-making. Understaffing is said to impact patient safety through a structure-process-outcomes framework [10]. Understaffing produces conditions of work that open the door to active errors. Understaffing is a *part* of the working environment component; therefore, Understaffing is not only a latent failure; it can also be the result of other latent failures, including that of Understaffing itself [11-13]. The evidence is strong that adequate staffing is necessary for patient safety [10].

Further, when staff are continually distracted whilst dispensing and counselling, they lose essential concentrations needed for accurate performance of these activities. An adequate break-time (Tea-time etc) is important to invigorate staff both physically and mentally and this should enhance performance. Humans have a limited attention span, can only attend carefully to a few things at once, and are subject to distractions and interruptions [14].

This facility was rated very poorly on the safety culture and it is recommended that more staff be employed to reduce workload (which adds to the feeling of being rushed), interruptions and distractions should be minimized and adequate break periods should be provided for staff during their shifts. An adequate level of resources, an appropriate number of well-trained staff; the creation of suitable working conditions and atmosphere through: correct work organization, the reduction of stress and tension; the provision of good, safe, social and health conditions for health-service workers; and increased motivation reduces the role of the “human-factor” issues in patient safety incidents [9]. Fatigue has been posited to have an impact on performance by reducing alertness and reaction time [15] which impact patient safety negatively. Errors of performance or execution are also said to be the result of many factors such as distractions, interruptions of routines, breakdowns in communication, stress, or forgetfulness [5].

Team Work

This culture composite had the highest positive rating of 92%. Specifically, staff in this facility worked together as an effective team with a positive score of 95.5%. Patient safety is a complex, multidisciplinary topic that requires a team approach; the collaborative efforts of a team are essential for the patient safety initiative to be successful. Research has shown that the lack of communication among team members is the basis of most medical errors [16]. Teamwork has been associated with increased patient safety [17] and it is increasingly advocated by health care policy makers as a means of assuring quality and safety in the delivery of services [1]. Teamwork can lead to better decisions, products, or services. A team that continues to work together will eventually develop an increased level of bonding. This can help people avoid unnecessary conflicts since they have become well acquainted with each other through team work. Team members’ ratings of their satisfaction with a team is correlated with the level of teamwork processes present [18].

Staff training and Skills

The overall positive score of 80% for this safety composite was impressive, and more impressive was the positive score of 96% for staff having the skills to perform their jobs. But still, respondents felt there was not enough training being provided for staff; meaning, there was room for improvement for this safety culture. Training, we know, impart knowledge and skills; and in a dynamic field like Pharmacy, this is sine qua non to professional practice excellence. Training and education are critical for practitioners to stay abreast of new medications, treatments, tests, equipment, and policies. Without education, or with inadequate education, practitioners may not have all of the information needed when confronted with a new situation or problem [10].

The pharmacist should ensure that the education and training of pharmacy assistants enables them to identify consumers who may benefit from additional counselling by a pharmacist. All health professionals involved in patient counselling should have a good basic and continuing education that covers drug therapies, therapeutic guidelines and communication skills, including human relations. They should be educated to communicate about medicines with patients in an empowering way so as to involve them in their own care as active partners and experts of their disease/symptoms and finally check that patients receive the information they need [9]. Continuous education should contribute towards building a safety culture in health care by changing attitudes, from an illusion of infallibility to acceptance of human error and to the ability to learn from mistakes [9].

Communication Openness

In this pharmacy, staff felt comfortable to ask questions (80%) but staff ideas and suggestions were poorly valued (50.5%). With an overall positive response of 70%, there was still room for improvement in this culture composite. When staff ideas are poorly valued, this can constitute a barrier to error reporting. An organization can improve upon safety only when leaders are visibly committed to change and when they enable staff to openly share safety information. When an organization does not have such a culture, staff members are often unwilling to report adverse events and unsafe conditions because they fear reprisal or believe reporting won’t result in any change [19]. Mutual respect among all the team members allowed for structured information exchange opportunities, such as a quick debriefing following a near miss adverse event [20]. We need to develop a coherent and comprehensive patient safety policy framework which: emphasizes the importance of learning from patient safety incidents, non-punitive and fair in purpose, encourages personnel to report safety incidents [9]. Leaders should develop willingness to be receptive to the communication of others as, one who is open to experience evaluates threats more accurately and tolerates change more graciously and maturely than someone that is more closed to experience. In an open environment, people are more able to explore their own ideas, the group’s perceptions of their ideas, and the ideas of others in the group. It has been found that managers' communication openness was positively and significantly related to subordinates' motivation [21]

Patient Counselling

Overall, the culture of Patient Counselling in this pharmacy was very good with an average positive composite score of 81%.

What is significant here was that there was a particularly good culture of encouraging patients to talk to pharmacists about their medications (92% item level

score) even though this could still be further enhanced. It was a reflection of good communication skill! In patient counselling, communication should be a 2-way process and patients should participate in decisions about their health care. The fundamental principle for planning patient education services to promote medication safety is to include patients as active partners in their care [22, 23]. With a view to involving patients, they should be encouraged to ask questions about the medicines they are receiving [9].

In this pharmacy, there was need to improve the culture of spending enough time talking to patients about their medications.

A rushed counselling may not be effective as it may not cover the essential details, may be un-organized and may be difficult for the patient to follow or understand. This might have been responsible for the low score (80%) for the survey item on Pharmacists telling patients important information about their new prescriptions. In addition to oral information, patients should be provided with up-to-date, useful written information.

With improvements in the first 2 survey items, patients will be further encouraged to discuss many issues with the Pharmacists; patients will readily

volunteer relevant information, build up greater trust in the Pharmacist thereby enhancing the therapeutic relationships between them which is critical to the provision of Pharmaceutical care.

Patient Counselling is an important obligation for pharmacists. As a standard of practice, a pharmacist shall promote the safe and effective use of medication by educating patients about their drug therapy. Patient counselling is a valuable tool for intercepting medication errors, e.g. before patients leave the pharmacy since it takes place after the pharmacist's accuracy check and before the patient leaves the pharmacy [24]. The interactive environment created during the patient encounter is likely to increase concentration and facilitates the detection of previously overlooked prescribing or dispensing error [9]. Thus, the pharmacist has a legal and professional obligation to ensure consumers have sufficient information to enable them to make informed decisions about their medicines. It is envisaged that counselling will be offered to all consumers each time a medicine or therapeutic device is supplied, and that where the need for counselling is identified, the pharmacist will be available in a timely manner. Summarily, the pharmacist ensures that the consumer has sufficient knowledge of their medicines and therapeutic devices to facilitate their safe and effective use [9, 25- 28].

Table 1: Characteristics Of Respondents

Staff Position	Study Respondents	
	Number	Percent
Staff Pharmacists	10	43.5
Pharmacy Technicians	3	13
Pharmacy clerks	0	0
Pharmacy student interns/externs	10	43.5
Other positions	0	0
Total	23	100
Missing	2	
Overall total	25	
Tenure	Study Respondents	
	Number	Percent
Less than 6 months	9	39
6 months to less than 1 year	6	26
1 year to less than 3 years	2	9
3 years to less than 6 years	5	22
6 years to less than 12 years	1	4
12 years or more	0	0
Total	23	100
Missing	2	
Overall total	25	
Hours Worked per Week	Study Respondents	
	Number	Percent
1 to 16 hours per week	1	4
17 to 31 hours per week	1	4
32 to 40 hours per week	13	57
More than 40 hours per week	8	35
Total	23	100
Missing	2	
Overall total	25	

Table 2: Responses on the patient safety survey items and culture composites

Survey items/composites	% Negative Responses	% Neutral Responses	% Positive Responses	% overall Positive Response
Physical Space and Environment <ul style="list-style-type: none"> This pharmacy is well organized This pharmacy is free of clutter The physical layout supports good work flow 	12 20.8 25.0	4 8.3 20.8	84 70.8 54.2	70
Staffing, Work Pressure, and Pace <ul style="list-style-type: none"> Staff take adequate breaks during their shifts. We feel rushed processing prescriptions. We have enough staff to handle workload. Interruptions/distractions make it difficult for staff to work accurately. 	41.7 16 52 52	20.8 32 32 28	37.5 52 16 20	30
Teamwork <ul style="list-style-type: none"> Staff treat each other with respect Staff clearly understand their roles Staff work together as an effective team. 	4.2 0.0 0.0	12.5 4.2 4.2	83.3 95.8 95.8	92
Staff Training and Skills <ul style="list-style-type: none"> Technicians receive training for their jobs Staff have the skills to do their jobs well. New Staff receive adequate orientation Staff get enough training from this pharmacy 	16.7 0.0 0 25	0.0 4 28 8.3	83.3 96 72 66.7	80
Communication Openness <ul style="list-style-type: none"> Staff ideas and suggestions are valued. Staff feel comfortable asking questions. It is easy for staff to speak up to their supervisor on patient safety concerns 	13.6 0 8	31.8 20 16	54.5 80 76	70
Patient counselling <ul style="list-style-type: none"> We encourage patients to talk to pharmacists. Our Pharmacists spend enough time talking to pts Our Pharmacists tell pts important information 	0 16 12	8 12 8	92 72 80	81

Communication about Prescriptions across Shifts

Respondents had an average (56%) positive opinion about this safety culture. Specifically, the status of problematic prescriptions was poorly transmitted across shifts, there were not very clear expectations about exchanging important prescription information across shifts and there were inadequate standard procedures for communicating prescription information across shifts. These communication lapses can have very negative impact on patient safety [9]. Poor information transfer and faulty communication can compromise patient safety [5].

Communication about Mistakes

Although respondents had an average of 70% positive opinion on this composite, there was still greater room for improvement for the survey items "Staff in this pharmacy discuss mistakes" and "Staff discuss patient safety issues as they occur" with 56% and 63% positive responses respectively. If there were no sufficient discussions among staff about mistakes and safety issues as they occurred, then the gains of 92% positive opinion about staff discussing ways of preventing mistakes from happening again would be

lost or, at best, insignificant. In order to enhance the relevance of teamwork, staff must engage in discussion on mistakes and patient safety issues as they occur in order to have a high-level mutual understanding of probable and possible sources of errors and ways of detecting and avoiding them, which will promote patient safety. The greatest effect on safety and quality improvement is generated locally when the institution uses patient safety incident reporting as part of a continuous system of safety and quality improvement [9].

Response to Mistakes

The attitude of respondents to this composite was very poor at 46% positive response.

Two survey items were critical here. First, the issue of looking at staff actions and the way things were done to understand why mistakes happened left much to be desired with a positive response of a mere 26%. Secondly, it was the opinions of 96% of respondents that staffs felt like their mistakes were held against them.

Patient safety incidents should be considered as opportunities to learn which component has failed in a system for preventing worse repeating. All medication errors should be considered as opportunities to learn which element of the medication use system has deficiencies in order to reduce the risk of similar errors recurring [9].

Fear of blame, resulting from a lack of open and fair culture has been identified as a barrier to error reporting. There is a need to establish an environment in which the whole organisation learns from safety incidents and where staff is encouraged to both proactively assess and reactively report risks [29]. Further, health professionals should be given the opportunity to learn how to handle guilt and be supported to avoid becoming “the second victim” of the safety incident [9].

A safety culture creates an environment where it is accepted that people will make mistakes and processes and equipment will fail, where individuals are allowed to make errors, where problems and errors are treated openly and fairly in a non-blame, non-punitive atmosphere at all levels, where problem analysis focuses on organisational performance, where the whole organisation is able to learn from safety incidents and then put things right [30]. A just culture is advocated which provides a fair and productive alternative to the two extremes of punitive or blame-free cultures [6, 31]. A just culture reconciles professional accountability and the need to create a safe environment to report medication errors; seeks to balance the need to learn from mistakes and the need to take disciplinary action [32].

A system-based approach is the proven way to improve patient safety. The systems-based approach takes into account many components recognized as contributing to an incident or to the events leading up to it. This moves the investigator away from focusing blame on individuals and looks at what was wrong with the system in which the individuals were working [9]. A system-based approach presupposes the systematic design of safe structures, procedures and processes, together with corrective reactions in response to safety incidents. It is accepted that errors are a consequence of normal human fallibility and/or deficiencies of the system; these could be prevented by improving the conditions in which humans work. The aim is a system designed with built-in defenses [9].

Organizational Learning Continuous Improvement

There was an appreciably high positive opinion (84%) among staff concerning this safety composite. More so was the fact that 90% positive opinion was ascribed to the culture of learning from mistakes that led to positive changes in the pharmacy. The greatest effect on safety and quality improvement is generated locally when the institution uses patient safety incident reporting as part of a continuous system of safety and quality improvement [9]. Recognising that although error is inherent in all fields of human activity, it is however possible to learn from mistakes and to prevent their reoccurrence and that health care providers and organisations that have achieved a high level of safety have the capacity to acknowledge errors and learn from them [9].

Documenting Mistakes

The culture of documenting mistakes in this pharmacy was found to be average (52%). No matter the scenario, either potential or real mistakes that reached the patient or not, all mistakes ought to be documented and discussed. By so doing, an appropriate database is being created which could be used for internal audits of the processes of service delivery with a view to removing avoidable mistakes. Current emphasis is on promoting the development of a reporting system for patient safety incidents and establishing an environment in which the whole organisation learns from such safety incidents[9].

Overall Ratings

Table 4 details the overall perceptions and ratings of respondents of patient safety in this pharmacy.

In terms of overall perceptions of patient safety, respondents gave an overall positive rating of 91% despite the deficiencies and lapses observed with a number of survey items and composites. It was the opinion of respondents that this pharmacy was good at preventing mistakes (90%) and the way things were done in this pharmacy reflected a strong focus on patient safety (90%).

In terms of the overall rating of Patient Safety, respondents gave an overall positive response of 86.3%. From this final rating, it is obvious there was still room for improvements of the safety culture in this pharmacy.

Table 3: Responses on the patient safety survey items and culture composites

SURVEY ITEMS/COMPOSITES	% Negative Responses	% Neutral Responses	% Positive Responses	% overall Positive Response
Communication About Prescriptions Across Shifts				
• Have clear expectations about exchanging important prescription information across shifts	29	14	57	56
• Have standard procedures to communicate prescription information across shifts.	15	29	56	
• The status of problematic prescriptions is well communicated across shifts.	34	13	53	
Communication About Mistakes				
• Staff in this pharmacy discuss mistakes	4	40	56	70
• Staff discuss patient safety issues as they occur	17	21	63	
• We talk about ways to prevent mistakes from happening again.	4	4	92	
Response to Mistakes				
• Staff are treated fairly when they make mistakes	8	21	71	46
• This pharmacy helps staff learn from their mistakes rather than punishing them.	0	13	87	
• We look at staff actions and the way we do things to understand why mistakes happen in this pharmacy	48	26	26	
• Staff feel like their mistakes are held against them.	0	8	92	
Organizational Learning—Continuous Improvement				
• When a mistake happens, we try to figure out what problems in the work process led to the mistake.	0	17	83	84
• When the same mistake keeps happening, we change the way we do things.	0	21	79	
• Mistakes have led to positive changes in this pharmacy.	0	10	90	
Documenting Mistakes				
• When a mistake reaches the patient and could cause harm but does not, how often is it documented?	38	14	48	52
• When a mistake reaches the patient but has no potential to harm the patient, how often is it documented?	38	24	38	
• When a mistake that could have harmed the patient is corrected before the medication leaves the pharmacy, how often is it documented?	18	13	69	

Table-4: Overall Perceptions and Rating of Patient Safety

SURVEY ITEMS/COMPOSITES	% Negative Responses	% Neutral Responses	% Positive Responses	% overall Positive Responses
Overall Perceptions of Patient Safety				
• This pharmacy places more emphasis on sales than on patient safety.	0	8	92	91
• This pharmacy is good at preventing mistakes	5	5	90	
• The way we do things in this pharmacy reflects a strong focus on patient safety.	0	10	90	
Overall Rating on Patient Safety	Poor / Fair	Good	V. Good / Excellent	% overall Positive Responses
• How do you rate this pharmacy on Patient Safety?	14	54	32	86

CONCLUSIONS

Respondents in this survey were professionals who were directly involved with the provision of

pharmaceutical services to patients. More than half of respondents had worked in the pharmacy department from 6 months to 6 years; over 80% of respondents

were professionals (pharmacists /Internees) who were directly involved in providing pharmaceutical services in the department and who, therefore, interacted with patients and consequently interfaced with the safety practices; and 92% of respondents worked in their pharmacy at least 32 hours per week. Therefore, the respondents were competent to address the safety practices in the department.

Regarding Physical Space & Environment, respondents had a fairly high positive opinion but with a need to improve the physical layout of the pharmacy for good work flow.

Staff in this facility worked together as an effective team with the highest overall positive composite score. However, survey items relating to Staff strength to handle workload, Distractions that make it difficult for staff to work accurately and Taking of adequate breaks by staff during their shifts all received very poor positive ratings by respondents.

Overall, the culture of Patient Counselling in this pharmacy was rated very high. However, there was need to improve the culture of spending enough time talking to patients about their medications.

Regarding Communication Openness, staff felt quite comfortable to ask questions but staff ideas and suggestions were poorly valued.

The culture of learning from mistakes that led to positive changes in the pharmacy received a very high positive rating. However, the culture of responses to mistakes was rather poor; Communication about Mistakes was above average, in particular, the culture of discussion of mistakes was rather poor; Communication about Prescriptions across Shifts was also poor.

In this pharmacy, a large majority of staff were said to have the needed skills to perform their jobs. But still, respondents felt there was not enough training being provided for staff.

The culture of documenting mistakes in this pharmacy was found to be poor.

The overall perceptions of patient safety attracted a very high positive rating from respondents and it was the opinion of a large majority of respondents that this pharmacy was good at preventing mistakes and the way things were done in this pharmacy reflected a strong focus on patient safety.

Finally, respondents gave an overall positive rating of 86.3% for Patient Safety in this pharmacy.

No doubt, this pharmacy had done quite well in a number of safety culture composites, prominent

among which were: Team Work, Organizational learning – continuous improvement, Patient Counselling and Staff Training & Skills.

However, they did not score quite well in some other safety culture composites like Communication amongst staff across shifts, Documentation of Mistakes, Response to Mistakes, and in particular, Staffing, Work Pressure & Pace.

From the final rating, it is obvious there is still room for improvements of the safety culture in this pharmacy.

There is therefore a dire need for management of the hospital to look into the safety culture composites, amend systems where necessary to reduce risks and improve patient safety.

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