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England Team

18th March 2014-03-18

Dear Mr Coverdale,

Response of the Royal Pharmaceutical Society to the Regulation 28 report of senior coroner William Donald Forbes Coverdale regarding the conclusion of the inquest into the death of Judith Lesley Marshall.

Thank you for contacting the Royal Pharmaceutical Society (RPS) and other pharmacy bodies regarding the conclusion of the inquest into the sad death of Judith Lesley Marshall.

As you will know the Royal Pharmaceutical Society is the professional body for pharmacists and pharmacy in Great Britain, representing all sectors of pharmacy. Our role is to lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy.

We are aware that your report has simultaneously been sent to the General Pharmaceutical Council who are the regulator of pharmacists and pharmacies, NHS England and the Secretary of State for Health.

We understand the matters of concern which you have raised, and whilst we do not have regulatory powers, we are keen to assist through observation where this is helpful. Our observations on the concerns you have raised are as follows.

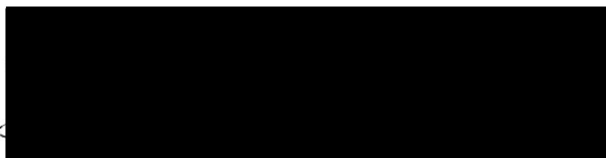
- It is positive that an error log has been maintained and we would expect that this is used by the pharmacy as a prompt for local reflection and improvement within the pharmacy or pharmacy chain. We believe the use of the error log other than as part of an improvement system could inadvertently discourage pharmacy teams from recording errors.
- It is terribly sad when human error contributes to a mistake in dispensing where the consequences are a fatality. The adoption of a 'Human Factors' approach in healthcare is important and there is much work in this area through the Patient Safety First campaign which was setup by the Department of Health. RPS supports this work and other initiatives to improve safety and learning culture within pharmacy. Further details are available on their website. http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/humanfactors/.
- The software you have described to reduce error sounds interesting and welcome. We believe that software with similar function is already being developed as part of the pharmacy IT strategies in England, Scotland and Wales. Further details on the developing system in England are available on the website of the Pharmacy Services Negotiations Committee (PSNC) http://psnc.org.uk/dispensing-supply/eps/
- "Read-back" sounds like useful method in a range of methods to reduce the occurrence of dispensing errors and we could raise awareness and encourage use of "read-back" as one technique amongst others to reduce errors in the guidance that we produce.
- The option of an additional check also sounds interesting and we understand that there are some pharmacies who do indeed use an additional check prior to supplying to the patient. We can raise awareness of this method within future guidance that we produce.

Patron: Her Majesty The Queen   Chief Executive: Helen Gordon

- Regarding a central database of prescription errors, we are pleased to report that this does exist. The national learning and reporting system sits with NHS England and we expect they will be providing details of this within their response to you.
  http://www.nrls.npsa.nhs.uk/

Hopefully this is useful to you.

Yours sincerely,



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