

Mr W Tang  
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Dear Mr Tang

**Professional Error Reporting Standard for Pharmacy – A response from the General Pharmaceutical Council**

The General Pharmaceutical Council (GPhC) is the regulator for pharmacists, pharmacy technicians and registered pharmacy premises in Great Britain. Our role is to protect, promote and maintain the health, safety and wellbeing of patients and the public who use pharmaceutical services in England, Scotland and Wales.

We welcome the opportunity to respond to the Royal Pharmaceutical Society's (RPS) consultation on their draft professional error reporting standard for pharmacy.

We believe that a culture of openness in pharmacy, and across healthcare in general, is critical to improving safety and ensuring there is less emphasis on blame and more focus on transparency, speaking up and learning from mistakes when things go wrong. We know that health professionals being open and honest when things go wrong is one of the best ways to protect patients.

Previously, within pharmacy, the conversation about dispensing errors has focussed on fear, blame and strict liability. A fear of prosecution and a fear that the regulator will seek to 'blame' a pharmacy professional. The focus needs to shift to what positive contributions pharmacy can make to patient outcomes and what needs to be done differently to make a greater contribution. For that focus to change it is fundamental that professionals are being open when things go wrong so that trust can be maintained.

An overall patient safety culture should be supported and encouraged. It is therefore worth considering whether this draft standard for pharmacy is clear enough in saying that it will apply beyond just dispensing errors and mistakes and near misses, to encompass other types of patient safety incidents that arise also.

Patients and service users need honesty when things go wrong, an apology and an assurance that there is real reflection on what went wrong, what lessons will be learnt and how improvements will be made. These patient safety incidents are not limited to dispensing errors or near misses.

It is also important that we, as the regulator, are clear about how we manage concerns that are raised with us, in particular concerns that relate to dispensing errors, so that the fear of prosecution is not replaced by fear of the regulator.

All concerns raised with the GPhC about a registrant in relation to a dispensing error are investigated using policies and procedures which are used to guide the way in which we investigate concerns raised about the fitness to practise of registrants. Single dispensing errors would not in our view constitute a fitness to practise concern, if there was not a wider pattern of errors or significant aggravating factors.

All single dispensing errors which are reported to us are however considered by the GPhC. This is what patients and users of pharmacy services would expect and it is right that we continue to do this.

We make clear in our standards the importance of honesty, candour and learning. These requirements on the registered professional are complemented by our [standards for registered pharmacies](#) which all pharmacies registered with the GPhC must meet and which our inspection team monitor and enforce.

Our inspection decision-making framework identifies the importance of recording, reporting and learning from errors and near misses. And whilst you mention this framework in your table summarising the existing regulatory framework related to error reporting and candour, you have omitted the [standards for registered pharmacies](#) themselves which are a fundamental part of the regulatory framework for registered pharmacies (and which the decision-making framework document is designed to support).

We believe that no one organisation or individual can drive cultural change. It will take a joint effort from all involved; professionals and their leadership bodies, employers, education providers, regulators and governments; to embed the culture of openness and make it the everyday norm. We welcome the work that has been done by the leadership bodies and trade sector organisations collaboratively to promote a culture of openness, including reporting and learning from medication incidents.

If you would like to discuss the points raised in this response, or any other aspects of the GPhC's work, please do not hesitate to contact me.

Yours sincerely,

Hugh Simpson



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