NABP
National Association of Boards of Pharmacy

*Report of the Task Force on*

# WORKPLACE SAFETY AND WELL-BEING

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# Report of the Task Force on Workplace Safety and Well-Being

## Members Present

John Kirtley, (AR), *chair*; Ashley Duggins (NC); Diane Halvorson (ND); Marty Hendrick (OK); Kevin Morgan (MD); Carrie Phillips (VT); Kristopher "Kris" Ratliff (VA); Kari Shanard-Koenders (SD); Ellen Shinaberry (VA); Jeffrey "Jeff" Sinko (NJ); Joanne Trifone (MA); Tim Tucker (TX); Keith Vance (NC); Barbara Ellen Vick (NC).

## Others Present

Shane Wendel, *Executive Committee liaison;* Mitch Rothholz, American Pharmacists Association, *Guest;* Lemrey "Al" Carter; William "Bill" Cover, Melissa Madigan; Eileen Lewalski; Maureen Schanck; Cameron Orr; and Andrea Busch, *NABP staff*.

## Introduction

The task force met on November 18-19, 2021, at NABP Headquarters in Mount Prospect, IL. This task force was established pursuant to Resolution 117-4-21, Task Force on Workplace Safety and Well-Being, which was approved by the NABP membership during the Association's 117th Annual Meeting that was held virtually in May 2021.

## Review of the Task Force Charge

Task force members reviewed their charge and accepted it as follows:

1. Examine the topics of pharmacy workplace safety and pharmacist well-being and their effects on patient safety.
2. Review existing guidelines and objective tools that address these issues and make recommendations regarding their use.
3. Amend, if necessary, the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* to reflect the work of this task force.

## Background and Discussion

The meeting began with the guest from the American Pharmacists Association (APhA) describing APhA's collaboration with the National Alliance of State Pharmacy Associations (NASPA) to develop the *Pharmacist's Fundamental Responsibilities and Rights,* which focusses on pharmacists' responsibilities and the workplace expectation needed to fulfil those responsibilities. Members reviewed the document's principles that "were established as a guide for pharmacists, pharmacy personnel, employers, patients, health professionals, and those that govern pharmacy practice and healthcare delivery and to facilitate meaningful discussions." The guest stressed that workplace demands have significantly increased, caused in large part by the coronavirus disease 2019 (COVID-19) with an unprecedented demand to test and vaccinate, compounded by the stress

caused by patient demands to dispense medication against the pharmacist's professional judgment. These issues are further worsened by staffing shortages and require additional management and technology support to maintain patient safety standards and safe working conditions while continuing to provide quality care. Ultimately, the task force agreed that NABP should endorse the APhA/NASPA principles acknowledging, however, that certain provisions pertaining to specific business models may fall outside of the regulatory purview of the boards of pharmacy.

The task force discussed medication errors and continuous quality improvement (CQI) programs at great length. In discussing medication errors, members referenced various workplace safety issues that may play a role in causing them. The task force voiced concern regarding vital staffing issues, particularly in light of the fact that COVID-19 has increased workload demands; however, staffing levels have either stagnated or, worse-case scenario, decreased. Several members shared that some pharmacies have had to significantly reduce services and have, on some occasions, been unable to accept new prescriptions over the phone or have had to leave prescriptions on hold because of insufficient time to contact the prescriber for clarification. Pharmacies have also cut business hours due to staffing shortages, thereby impacting patient access for those who depend on their pharmacy being open nights and weekends. Members also discussed the safety concerns of working understaffed or with unqualified personnel as another contributing factor to medication errors. It was noted that in many instances pharmacy technicians can earn substantially more from other potential employers, such as fast-food restaurants and grocery stores, and that, in addition to pharmacy technician education and training requirements, makes it especially difficult to recruit and retain qualified individuals to work in pharmacies. Members lauded the efforts of the Oklahoma State Board of Pharmacy, which developed the Inadequate Staffing Report to investigate pharmacy understaffing that may compromise public safety. The task force encouraged such reporting to the boards of pharmacy to help facilitate communication between the pharmacy permit holder and licensees to resolve staffing issues and improve working conditions. Overall, members voiced their concern that the current model for community pharmacy practice needs to be changed, not only for the mental well-being of pharmacy staff, but for overall public protection.

Although several states have established mandatory CQI provisions for pharmacies to address and prevent medication errors, often times medication errors are reported to patient safety organizations, which makes it impossible for boards of pharmacy to access any of the reported information. Members agreed that this lack of access to error reports and any aggregate data hampers the ability of a board of pharmacy to conduct a full analysis to detect trends and subsequently, could negate implementing meaningful change. The task force also pondered if pharmacy staff have adequate time to report significant occurrences to CQI programs to assist with error prevention. Members agreed nevertheless that CQI programs can be instrumental in changing the status quo by illuminating problematic workplace safety issues that affect patient safety; therefore, they recommended that NABP collaborate with various stakeholders, such as the Agency for Healthcare Research and Quality (AHRQ), the Pharmacy Quality Alliance (PQA), and the Institute for Safe Medication Practices (ISMP) to develop a standardized CQI program. Such

program should include training for boards of pharmacy staff on developing and implementing the program for the boards to recommend to their licensees. Being cognizant that developing and implementing a standardized CQI program will not automatically guarantee its success, the task force also recommended that the program must include ongoing annual monitoring to ensure that it is being used effectively. Along those lines, the task force also recommended that NABP collaborate with AHRQ to provide a platform to obtain de-identified aggregate data on medication errors that can be shared with boards of pharmacy, pharmacies or pharmacy chains, and other industry specialists so the data can be further analyzed to ascertain actual error rates in various settings and their attributing factors, such as staffing levels and prescription volume.

Several of the task force members conveyed that board of pharmacy inspectors, when investigating a medication error complaint, attempt to gather as much objective evidence as possible to ascertain whether workplace issues played a role in the error. Members discussed the fact that not all pharmacy inspectors are adequately trained in this regard, which can play a role in affecting positive change and ultimately increasing safety. NABP staff shared that the recent Task Force on Safety Sensitive Measures to Review Medication Errors recommended that NABP explore the development of a medication safety training academy that would train board members and compliance officers, as well as NABP accreditation surveyors, in applying just culture approaches to medication errors, including root cause analyses. Members unanimously agreed that developing a safety training academy could be extremely beneficial for increasing patient safety by shifting away from the current model and decided to endorse that recommendation.

After discussing workplace safety conditions that may be a factor in medication errors, the task force members focused on environmental issues that affect the well-being of pharmacists and pharmacy staff. Members noted that the current model has increased customer expectations, but drive-throughs and patients' expectations for short prescription wait times have created unattainable goals, especially combined with responsibilities for providing immunizations and additional clinical services that constantly interrupt workflow and increase stress levels. Members deemed that reaffirming pharmacists' access to care for mental health that is non-retaliatory was vitally important and noted that mental health and burnout has been a recent topic that has been addressed during various meetings and in publications. The task force agreed that NABP should collaborate with organizations, particularly those treating impaired pharmacists, to emphasize the importance of mental well-being and care, specifically for mental health. Additionally, it was recommended that NABP develop webinars that focus on burnout, well-being, and stress management. The APhA guest shared that his association has been surveying its members to determine well-being indices on a state-by-state basis and that there appears to be a correlation with a poor well-being index and an increased number of medication errors. The members recommended that NABP disseminate this information to further increase awareness of the problems associated with on-the-job stress.

Lastly, several regulatory issues arose during the task force's discussion that could be addressed by amendments to the *Model Act*. Members concurred that the definitions pertaining to errors, adverse events, and missed errors should be reviewed to mirror those used by the Centers for

Medicaid and Medicare Services and be added and/or amended accordingly. Staffing levels was one reoccurring issue that the task force discussed throughout the meeting. While several members mentioned pharmacy technician-to-pharmacist ratios and several states' efforts to address them, the task force made no formal recommendation for NABP to act regarding the issue. It should be noted that NABP policy has consistently been silent on the issue of ratios. After discussing various state- and corporate-based mandatory break provisions, members agreed that, although in some instances taking breaks may cause workflow backlogs, a provision for mandated breaks should be added to help alleviate physical and mental stressors. Additionally, members decided that an anti-retaliatory or whistleblower provision should be added to encourage pharmacy personnel to report unsafe working conditions to boards of pharmacy without concern for retaliatory action. Specific language regarding the above recommendations will be provided to the Committee on Law Enforcement/Legislation and ultimately the NABP Executive Committee for consideration.

After careful review and consideration, the task force recommended that:

1. NABP collaborate with relevant stakeholders, including AHRQ, PQA, ISMP, and others, to develop a standardized CQI program that boards of pharmacy can recommend to their licensees and includes:
    a. training on developing and implementing the program; and
    b. monitoring on an annual basis to ensure it is effectively being used.
2. NABP collaborate with AHRQ to provide a platform to obtain de-identified aggregate medication error data that can be shared with boards of pharmacy, pharmacies or pharmacy chains, and other industry specialists.
3. NABP endorse the recommendation of the Task Force on Safety Sensitive Measures to Review Medication Errors to explore the development of a medication safety training academy.
4. NABP endorse the APhA/NASPA *Pharmacist's Fundamental Responsibilities and Rights* while acknowledging that certain provisions pertaining specifically to business models may fall outside the boards of pharmacy's regulatory purview.
5. NABP collaborate with other organizations, such as impaired pharmacist programs, to emphasize the importance of mental well-being and care for mental health through the development of webinars for burnout, well-being, and stress management and the dissemination of information regarding the correlation between a poor well-being index and increased medication errors.
6. NABP review the *Model Act* and, if necessary, consider the following:
    a. adding or further amending the definitions pertaining to errors, adverse events, and missed errors that mirror those used by the Centers for Medicaid and Medicare Services;
    b. adding a provision for mandated break periods; and
    c. adding a provision for anti-retaliatory (whistleblower) protections.