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ISMP
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Community/Ambulatory Care
ISMP Medication Safety Alert!®
Educating the Healthcare Community About Safe Medication Practices

Implement strategies to support safer community pharmacy workplaces and staff well-being

Problem: Historically, community pharmacists have silently accepted unsatisfactory work conditions. However, the coronavirus disease 2019 (COVID-19) pandemic uncovered system weaknesses in retail pharmacies as work conditions further deteriorated, often times to breaking points. In fact, work conditions became dangerously overwhelming, threatening both patient safety and staff well-being.[1-6] Nothing exemplifies this more than the death of Ashleigh Anderson in 2021. She was the lone pharmacist working at a busy pharmacy when she began to experience symptoms of a heart attack. Feeling pressure to meet performance metrics, especially in the wake of two staff pharmacists and the previous pharmacy manager recently resigning, she did not want to close the pharmacy and get behind on filling prescriptions. So, she delayed seeking treatment while trying to arrange for another pharmacist to cover the remainder of her shift. Unfortunately, before she could leave the pharmacy, she collapsed and died from a heart attack.[7]

Some retail pharmacies are trying to improve some working conditions for pharmacy staff. This includes closing pharmacies for a scheduled 30-minute lunch break. However, the increased workload and continued issue of inadequate staffing causes some pharmacists to feel pressured to skip their lunch (and restroom) breaks to try to catch up on the never-ending tasks and meeting unrealistic metric expectations.[8-10] Pharmacists may also arrive early and/or stay after their shifts "off-the-clock."[10] Instead of a usual 10- to 12-hour shift, retail pharmacists may end up working 13 or more hours per day, all while standing up and completing various tasks in a mentally, physically, and emotionally taxing fast-paced environment.[3,11] And, according to the Mayo Clinic Well-Being Index (WBI), 33% of pharmacy staff were at high risk for distress (as of March 2021), which may increase medication error risk twofold.[8,12]

In the fall of 2023, Walgreens and CVS pharmacists staged "#Pharmageddon," a nationwide 3-day walkout (October 30 through November 1, 2023), to protest pharmacy work conditions.[10,11,13] CVS pharmacy staff across the nation also signed a petition demanding safer working conditions from their employers. They wrote, "We do not want to deny access to care; that is not our intent. But the care we provide has to be safe for our patients, your customers. Patient safety is non-negotiable. That is our pharmacist's oath to hold ourselves and our colleagues to the highest moral, ethical and legal conduct, and we intend to keep it."[5]

The performance metrics aimed to increase revenue, that pharmacy staff have to adhere to, are often achieved at the cost of quality patient care.[6,8,10,14-16] These metrics include meeting prescription promise times; the number of daily prescriptions filled and vaccines administered; how fast phones are answered; the number of patient care calls (e.g., medication therapy management [MTM], new drug consultations, delayed prescription pickup, and adherence counseling); the number of patients enrolled for auto-refills, medication synchronization, 90- instead of 30-days prescription supply; the number of store memberships sold; and the number of patient surveys completed. All tasks, including critical steps of ensuring appropriateness of the medication prescribed, which require attention and clinical judgment, are timed and measured against corporate goals for staff evaluations. Consequently, pharmacists find it "nearly impossible to meet all demands without cutting corners," which can hurt patients, and they "are left to choose between their pharmacy oath and their job."[16]

One pharmacist shared with ISMP that on average they are given about 2 minutes to verify each prescription they dispense. During that time, they are expected to ensure that patients

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Dosage on buPROPion packaging may not be intended dose. An organization reported that bu**PROP**ion hydrochloride 75 mg immediate-release tablets (American Health Packaging) include the phrase, "Three Times Daily" on the blister card packaging (**Figure 1**). However, patients may be dosed differently per the prescribing information. For example, to treat major depressive disorder, the dosage and administration section in the package insert recommends 100 mg twice daily as a starting dose but only 75 mg once daily for patients who also have moderate to severe hepatic impairment. If patients or practitioners administer the dose listed on the blister card, it could lead to a patient receiving an incorrect dose which has the potential to cause harm.

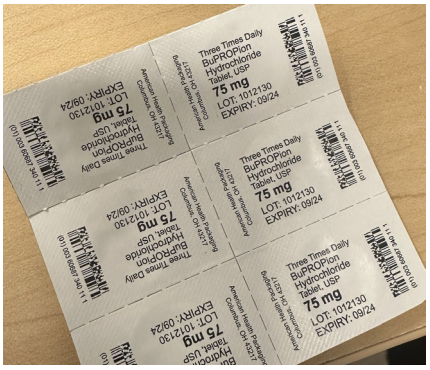

Figure 1. Bu**PROP**ion hydrochloride 75 mg immediate-release tablets includes the phrase, "Three Times Daily" on the blister card packaging, but some patients may require a different dose.

We reached out to the US Food and Drug Administration (FDA) and the manufacturer and recommended the removal of the "Three Times Daily" verbiage on the bu**PROP**ion immediate-release blister card packaging. American Health told us it recently updated the product labeling to match changes to the original manufacturer's product labeling. However, in light of the confusion and considering patient safety, they plan to remove the statement "Three Times Daily" from the immediate-release blister card packaging. Educate staff and patients that

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receive individualized safe and effective medications in accordance with clinical guidance and pharmacy regulations. This entails assessing the appropriateness of the prescription based on the drug pharmacology and pharmacokinetics, indication, dosing, administration directions, drug-drug interactions, patient allergies and contraindications, and drug effects; conducting product verification; clarifying prescriptions with providers; and providing patient education. The pharmacist's clinical tasks require a pharmacist's full attention which is at odds with the time pressures and constant distractions in the pharmacy's fast-paced environment.

Pharmacists also oversee pharmacy operations and all pharmacy staff activities, and perform various other tasks, including answering providers and patients' questions, conducting medication reconciliation, providing over-the-counter (OTC) medication recommendations, taking telephone prescription orders, transferring prescriptions, fixing insurance problems, and troubleshooting technology (e.g., automated vial filling technology) issues. Pharmacy outbound telephone calls to providers, patients, and insurers are numerous and may require multiple follow-up calls and voicemails. Consequently, community pharmacists often feel forced to multitask, verifying prescriptions while engaging in telephone communications, which has contributed to errors.

For example, in one event reported to ISMP, the pharmacy received a prescription for **TRIJARDY XR** (empagliflozin, linagliptin, and met**FORMIN**) 25 mg-5 mg-1,000 mg. During the dispensing process, the pharmacy technician retrieved the wrong strength (5 mg-2.5 mg-1,000 mg) of the drug. The pharmacist did not identify the error during verification as they were distracted while conducting multiple tasks (e.g., answering phone calls while verifying medications). The wrong strength of Trijardy XR was dispensed to the patient, who took the medication for 3 days. The pharmacy identified that the constant stress related to understaffing may have also contributed to the error.

Additionally, community pharmacists have seen an increase in requests for vaccine administrations and point-of-care testing (e.g., COVID-19, influenza).[10] However, staffing has not always kept up to accommodate the increase in patient care, leaving the pharmacist racing back and forth to administer vaccines and dispense prescriptions. Under the best conditions, prescriptions awaiting verification can accumulate in work queues. Prescriptions awaiting final verification can also pile up, risking mix-ups of patients' medications.

Pharmacists also take on pharmacy technician tasks due to technician shortages.[17] Adequate pharmacy technician staffing is crucial to enable the pharmacist to spend time on clinical duties and interventions. However, 80% of chain pharmacists considered the technician shortage as severe or very severe in 2022.[3] This shortage resulted from employers cutting technician hours[5]; and technicians resigning due to burnout and being underpaid.[3,5,8]

A survey conducted in 2021 reflected that 75% of pharmacists from various workplaces *disagreed* with the statement, "Sufficient time is allocated for me to safely perform patient care/clinical duties."[18] Additionally, 71% responded, "there were not enough pharmacists working to meet patient care/clinical duties." Another survey in 2022 showed that 85% of chain pharmacists at least *somewhat agreed* that the number of their work activities extends beyond what they were originally hired to do, and 65.9% *strongly agreed* that their work setting would benefit from regulations limiting pharmacist workload.[3]

Safe Practice Recommendations: We know that workplace conditions, including interruptions and rushing through critical tasks, impact medication safety and can contribute to vaccine and medication errors.[9,10,16] Therefore, addressing issues with workplace conditions and environmental factors is crucial to improving patient safety. Retail pharmacies need to consider the following recommendations:[2,4,5,15,19,20]

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although the package states, "Three Times Daily," patients should follow the directions included on the pharmacy prescription label.

Specialty pharmacy shipping and delivery errors. Recently, a specialty pharmacy shared with ISMP that the most commonly reported errors at their pharmacy were related to shipping and delivery of prescriptions. In fact, these errors accounted for approximately half of the internal errors reported. The area of greatest concern is staff choosing the incorrect outbound shipping date, resulting in packages being shipped on incorrect dates.

Currently, the pharmacy uses two different delivery services: a local courier for same day deliveries, and a national shipping carrier for next day deliveries. Each shipper has its own online portal. They identified that the terminology associated with outbound shipment dates varies between the shipping services since one service provides same-day services and the other provides overnight delivery services. Miscommunication among the pharmacy teams has also been identified as a potential contributing factor. Finally, the decentralized and remote call center was undergoing rapid expansion, with many new hires being brought on board.

To help prevent these types of shipping errors, the specialty pharmacy will leverage

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Error-prone abbreviation list updated

We recently updated the ***ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations***, which can be accessed at: www.ismp.org/node/8. These abbreviations, symbols, and dose designations were reported to ISMP through the ***ISMP National Medication Errors Reporting Program*** *(ISMP MERP)* because they have been misinterpreted and involved in harmful or potentially harmful errors. Therefore, they should **NOT** be used in verbal, handwritten, and/or electronic communication.

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Match workload expectations with staffing levels and resources

- Remove productivity-focused performance metrics that can compromise patient safety.
- Prioritize tasks related to prescription dispensing and patient quality outcomes.
- Consider appointment-based and/or pharmacist overlap models for other clinical services (e.g., vaccinations, MTM, patient care calls).
- Remove unnecessary administrative burdens and non-essential workflow tasks.
- Examine prescription volume data periodically to determine appropriate levels of staffing and the use of automated dispensing technology.
- Establish a backup plan for situations when staffing is short.

Decentralize and minimize interruptions/distractions

- Isolate areas for critical steps of the medication dispensing process (e.g., where prescriptions are transcribed, verified, filled, and checked).
- Utilize a call center and/or remote pharmacists to triage phone calls and conduct MTM.
- Use an automated, off-site, centralized dispensing operation for prescription refills.
- Reallocate administrative and non–patient care tasks to support personnel.

Set schedules to support safe practices

- Limit staff to work no more than 12 consecutive hours with at least 8 hours of rest between shifts.
- Require staff to take an uninterrupted 30-minute meal break per 8 hours of work.

Establish a Just Culture

- Provide a safe and supportive culture and environment for staff to raise concerns regarding workplace issues. To facilitate this cultural transformation, implement a fair and Just Culture (www.ismp.org/node/24787, www.ismp.org/node/670, www.ismp.org/node/18547), ensure respectful management of serious adverse events (www.ismp.org/ext/857), and transparency so staff feel safe speaking up about safety issues without fear of reprisal.
- Error rates are not used as a performance indicator nor are they used for internal (pharmacist-to-pharmacist) or external (pharmacy-to-pharmacy) comparisons.
- Encourage error reporting to address system-based issues.
- Survey staff anonymously and confidentially every 2 to 3 years to assess their perceptions about the workplace culture, and how the culture has impacted them, their patients, and the organization. Use the findings to create an action plan and drive improvements.

Provide leadership support for staff well-being

- Encourage and listen to workplace concerns. Leaders should set the tone of mutual respect for

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computerized decision support as they transition to a new clinical management software system. They are also considering adding an alert on the screen, such as, "Next day delivery" when the national shipping carrier is selected. They will also explore modifying the terminology of the shipping dates to guide correct date selection. Other strategies to help prevent shipping and delivery errors can be found in the article, *Shipping and delivery errors—Part II* published in the May 2023 issue of this newsletter.

Confusing names of oral contraceptives. An outpatient pharmacy recently received a prescription for the oral contraceptive **BLISOVI 24 FE** (norethindrone acetate and ethinyl estradiol tablets and ferrous fumarate tablets). However, the pharmacy dispensed **BLISOVI FE 1/20**, which includes the same ingredients but contained in different numbers of tablets respectively. Each blister pack of Blisovi 24 FE contains a total of 28 tablets; 24 white to off-white tablets each containing 1 mg of norethindrone acetate and 0.2 mg of ethinyl estradiol; and 4 brown tablets each containing 75 mg of ferrous fumarate. Blisovi Fe 1/20 blister packs also contain 28 tablets, but have 21 yellow tablets of norethindrone acetate 1 mg and ethinyl estradiol 0.2 mg, and 7 brown tablets of ferrous fumarate 75 mg.

During their investigation, the pharmacy identified that staff were unfamiliar with these branded generic oral contraceptives. Also, like so many oral contraceptives, the drug names are almost identical, only differing in their drug name suffixes (i.e., 24 Fe and Fe 1/20). Please alert your colleagues to this look-alike name pair. Utilize barcode scanning during dispensing and final pharmacist verification to ensure the correct product has been retrieved.

Dropping the ball on drop-ship medications. While most medications are routinely ordered through a wholesaler, some require special order and drop shipment directly from the manufacturer or wholesaler. In one event reported to ISMP, the clinical pharmacy team planned to fill **OCALIVA**

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the contributions of all staff; remain open to questions and new ideas; maintain an ongoing dialogue with the entire organization; and reward outstanding examples of collaborative teamwork, respectful communication, and positive interpersonal skills.

- Ensure that managers have an adequate understanding of pharmacy staff roles and pharmacy practice and regulations.

- Provide employee assistance programs and allow for time away to attend appointments related to mental health well-being.

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(obeticholic acid), a medication used for primary biliary cholangitis, for one of their patients. Ocaliva is a special order and drop-ship medication, so the clinical team emailed the specialty pharmacy's purchasing team requesting that they order it. The email order request was missed by the purchasing team, and the medication was not in stock on the date it was planned to ship. Fortunately, the pharmacy had a small supply of tablets in an opened bottle and were able to send a partial fill of the prescription to the patient on the intended ship date. The pharmacy followed up sending the remainder once the drop-ship order was received. The pharmacy attributed the error to a breakdown in communication (i.e., the missed email) and the lack of standardized processes for special-order and drop-ship medications.

To prevent this type of error, establish and follow a standardized process to order, receive, and store drop-ship medications. Establish a standard method of communication among pharmacy team members accounting for people who may be off and including a process to confirm receipt of the request. This may require avoiding communicating inventory needs via email, since it may not be consistently reliable. If possible, enable your dispensing system to identify medications not in stock and trigger placement of the order. Schedule and order special-order medications in advance to allow time to receive medications before the date they are to be shipped to the patient.

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Report medication and vaccine errors to ISMP: Please call 1-800-FAIL-SAF(E), or visit www.ismp.org/report-medication-error. ISMP guarantees the confidentiality of information received and respects the reporters' wishes regarding the level of detail included in publications.

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