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Original Research

Restructuring supervision and reconfiguration of skill mix in community pharmacy: Classification of perceived safety and risk

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Abstract

Background: Broadening the range of services provided through community pharmacy increases workloads for pharmacists that could be alleviated by reconfiguring roles within the pharmacy team.
Objectives: To examine pharmacists' and pharmacy technicians (PTs)' perceptions of how safe it would be for support staff to undertake a range of pharmacy activities during a pharmacist's absence. Views on supervision, support staff roles, competency and responsibility were also sought.
Methods: Informed by nominal group discussions, a questionnaire was developed and distributed to a random sample of 1500 pharmacists and 1500 PTs registered in England. Whilst focused on community pharmacy practice, hospital pharmacy respondents were included, as more advanced skill mix models may provide valuable insights. Respondents were asked to rank a list of 22 pharmacy activities in terms of perceived risk and safety of these activities being performed by support staff during a pharmacist's absence. Descriptive and comparative statistic analyses were conducted.
Results: Six-hundred-and-forty-two pharmacists (43.2%) and 854 PTs (57.3%) responded; the majority worked in community pharmacy. Dependent on agreement levels with perceived safety, from community pharmacists and PTs, and hospital pharmacists and PTs, the 22 activities were grouped into 'safe' ($n = 7$), 'borderline' ($n = 9$) and 'unsafe' ($n = 6$). Activities such as assembly and labeling were considered 'safe,' clinical activities were considered 'unsafe.' There were clear differences between pharmacists and PTs, and sectors (community pharmacy vs. hospital). Community pharmacists were most cautious (particularly mobile and portfolio pharmacists) about which activities they felt support staff could safely perform; PTs in both sectors felt significantly more confident performing particularly technical activities than pharmacists.
Conclusion: This paper presents novel empirical evidence informing the categorization of pharmacy activities into 'safe,' 'borderline' or 'unsafe.' 'Borderline' activities will deserve particular attention, especially where they are part of processes, e.g. dispensing. This categorization could help inform

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reconfiguration of skill mix in community pharmacy and thus make an important contribution to the rebalancing medicines legislation agenda and pharmacist supervision.

Keywords: Community pharmacy; Role delegation; Scope of practice; Role substitution; Supervision; Pharmacy technician; Professional accountability

Background

Community pharmacists internationally now offer increasing levels and ranges of clinical, diagnostic and public health services in keeping with the profession's growing involvement in patient-focused activities. There is evidence that as a consequence of the delivery of these new services, pharmacists may experience substantial increases in workload, high levels of work pressure,[1,2] and conflicting priorities, all factors which may have patient safety implications.[3–8]

To manage this growing workload and enable further service development, it is becoming paramount that the pharmacy team are used at maximum professional capacity. Besides pharmacists, the pharmacy team includes medicines counter assistants (in community/retail pharmacy), pharmacy assistants, and pharmacy technicians (PTs),[9] the latter being the highest qualified member of pharmacy support staff. While certification, regulation and registration have been called for, implementation and specific requirements differ across the United States (US).[10,11] In Great Britain, PTs have been required to register with the pharmacy regulator, the General Pharmaceutical Council (GPhC), since 2011, and now form a second group of regulated pharmacy professionals, alongside pharmacists. Concerns have been raised, however, about the level of competence of support staff and the extent to which this might limit safe and effective skill mix and role reconfiguration, with pharmacists in particular voicing unease.[12–19] Addressing these concerns is of paramount importance if service delivery is to be redesigned around the needs of patients in such a way as to not add to the workload of highly pressurized pharmacy teams.

Internationally there is surprising diversity in the operation of community pharmacies. In some countries, such as the United Kingdom (UK) and United States (US), all pharmaceutical services are required to be undertaken or supervised by the pharmacist in charge (therefore requiring the pharmacist to be on the pharmacy premises all or most of the time). In some European countries, there is much more flexibility in pharmacists exercising their responsibility and delegating to pharmacy staff.[20] In Denmark and the Netherlands, for example, qualified pharmacy technicians, or their equivalent, routinely undertake the dispensing of prescription medicines in community pharmacy, without direct pharmacist supervision. In these countries, there is effective professional collaboration between physicians and pharmacists practising in primary care, often supported by integrated patient databases. Electronic transfer of prescriptions and original pack dispensing with barcode reconciliation are normal practice.

In the UK, the Responsible Pharmacist (RP) regulations make it a requirement that an RP is appointed in each community pharmacy. A legal duty is placed on the RP "to ensure the safe and effective running of the pharmacy in relation to the retail sale and supply of all medicines" (not other services, such as diagnostics).[21] However, the RP regulations also allow the named 'responsible pharmacist' to be absent from the pharmacy for a maximum of 2 h per day, with the intention of enabling pharmacists to provide clinical services to patients and other health care professionals away from the registered pharmacy premises. Medicines available for general sale (also known as general sales list, GSL), i.e. those which are also available through retail outlets other than pharmacies, can be sold during this absence. However, the longstanding requirement for sales of Pharmacy (P) medicines, i.e. medicines whose sales are legally restricted to pharmacies, and the dispensing of all prescription-only medicines (POM) to be supervised by a pharmacist who is physically present remains unchanged. Ultimately, this means that during the absence of an RP, and without another, second, pharmacist present, most core pharmacy functions still cannot be performed legally.

However, the need to free pharmacists and allow them to focus on the delivery of clinical, patient-centered services has been widely