



**PHARMACISTS BOARD OF QUEENSLAND
GUIDELINES ON APPROPRIATE WORKLOADS FOR PHARMACISTS**

Adopted: 25 July 2007

Commencement date: 6 February 2008

The purpose of this document is to provide guidance to registrants on appropriate workloads in the interests of patient safety and maintenance of high professional standards.

These guidelines should be read in conjunction with the relevant legislation listed below:

Pharmacists Registration Act 2001 (the Act)

Pharmacists Registration Regulation 2001 (the Regulation)

Health Practitioners (Professional Standards) Act 1999

The State (Qld) legislation is available for download from www.legislation.qld.gov.au.

1. BACKGROUND

The Board is aware of recent calls for regulatory authorities to set mandatory standards for maximum pharmacist workloads and that many pharmacists would support more direction on the issue from the Boards.

There are many problems in mandating maximum dispensing volumes and as such is a simplistic approach to a complex issue. Debate has ensued about whether it is possible to develop absolute and enforceable standards for safe dispensing. Concern has also been expressed that setting a figure as a ceiling on dispensing rates may be misinterpreted as a benchmark or target, resulting in pressure for pharmacists to achieve this rate in circumstances where it is not appropriate.

The Board is of the opinion that determining safe workloads is dependent on many factors¹ including the:

- number and experience of pharmacists
- number and training of dispensary/ pharmacy assistants
- number of dispensing stations in use
- design of the dispensary
- nature of the prescriptions being processed
- number of dose administration aids being packed
- proportion of scripts which require counselling



Identified contributing factors to dispensing error include^{1,2,3}

- heavy prescription loads
- extremely low prescription loads
- emphasis on meeting administrative obligations
- interruptions and distractions
- pressure from patients
- tiredness
- poor lighting
- similarity in drug names
- similarity in packaging
- adjacent storage of drugs with similar names
- inadequate breaks

Workload imposes pressure to dispense quickly, often at the expense of good dispensing practice. Failure to take due care and attention, omitting essential checking and scanning processes and abandonment of medication review and counselling components of the dispensing process can compromise overall patient safety.

When investigating complaints the Board reviews dispensing volumes and staffing levels. The Board would be concerned if pharmacists were consistently dispensing in excess of 150 prescriptions per 8-hr day per pharmacist on an ongoing basis and working long hours (eg. more than 60 hrs/week per pharmacist) without evidence of sufficient strategies or teamwork in place to ensure that the quality and safety of the services they provide were not compromised. Adequately trained support staff, implementation of dispensing quality standards, a planned dispensary layout and use of bar-code scanning technology would support a higher dispensing throughput.

Pharmacists should review their activities to ensure that their workload enables them to meet the relevant competency standards as described in the Competency Standards for Pharmacists in Australia 2003 with specific reference to “manage work issues and interpersonal relationships in pharmacy practice” and “apply organisational skills in the practice of pharmacy”. Both standards are relevant to, and in the latter case specific to workload.⁴

Guidelines for safe practice and good dispensing may also be found in publications and websites of Pharmacy Defence Ltd and of the professional organisations. The various statements and standards (whilst not compulsory) are consistent. The Board would hold that there are sufficient published standards and guidelines to leave no doubt as to what constitutes satisfactory and safe professional conduct.⁴



Whilst not mandating workload limits based on an hourly or daily prescription dispensing rates the Board commends the following strategies to manage safety and quality in the pharmacy⁵:

- Optimise the work environment - e.g. reduce noise, minimize annoying and unnecessary interruptions and change shifts to reduce worker fatigue;
- Train for teamwork - teamwork encourages communication and coordination of effort and can provide valuable support to team members;
- Drive out fear - enhance awareness of the potential for errors and encourage error reporting by creating a supportive environment;
- Increase feedback - e.g. feedback on the causes for adverse events can assist health professionals to 'self-correct' to prevent recurrence;
- Obtain leadership commitment - management action and support at all levels is a prerequisite for achieving organisational change; and
- Improve direct communication.

2. GUIDELINES

1. The Board expects registrants to observe safe and sustainable workloads, in the interests of patient safety and maintenance of high professional standards.
2. Pharmacists should maintain safe dispensing procedures at all times and should not allow workload pressures to compromise this obligation.
3. In all circumstances each pharmacist is responsible for their own professional activities and should not compromise their obligation to safeguard the health and wellbeing of their clients and the community.
4. Ultimately each individual pharmacist should exercise their professional judgement on whether they are practising in a safe manner or not.
5. The Board expects pharmacists to reflect on their practice with 'duty of care' as the overriding mandate at all times – even in the face of pressure from the owner or manager of the pharmacy.
6. Pharmacy proprietors should review their services on a regular basis to ensure that they are adequately resourced.
7. Evidence of consistent and ongoing under-resourcing of professional pharmacy services could be considered by the Board as unsatisfactory professional conduct.
8. Each pharmacy must have in place and must implement suitable quality standards/ protocols for the pharmacy that support best professional practice.

References

1. Safe workloads. Pharmacists Board of Tasmania Newsletter May 2007.
2. Peterson G, Wu M and Bergin J. Pharmacists' attitudes towards dispensing errors: their causes and prevention. *Journal of Clinical Pharmacy and Therapeutics*, 24 57-71 (1999).
3. Newgreen D, Pressley J, Marty S. A survey of dispensing errors reported to the Pharmacy Board of Victoria, July 1998 to December 2004. *Australian Pharmacist* 2005; 24(8): 303 -307.
4. Frost E. Pharmacist Workloads. 1 June 2007.
5. Guideline for managing pharmacy systems for quality and safety. Pharmaceutical Society of Australia November 2002. Accessed on 5/7/2007 at http://psa.advsol.com.au/scriptcontent/Custom/MC_ShowPage.cfm?page=163.