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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

MEDICATION ERROR REDUCTION AND WORKFORCE COMMITTEE MEETING MINUTES

DATE:	January 27, 2022
LOCATION:	Teleconference Public Committee Meeting Note: Pursuant to the provisions of Government Code section 11133, neither a public location nor teleconference locations are provided.
COMMITTEE MEMBERS PRESENT:	Nicole Thibeau, Licensee Member, Chair Seung Oh, Licensee Member, Vice Chair Lavanza Butler, Licensee Member Kula Koenig, Public Member Jignesh Patel, Licensee Member
STAFF MEMBERS PRESENT:	Anne Sodergren, Executive Officer Eileen Smiley, DCA Staff Counsel

I. Call to Order, Establishment of Quorum, and General Announcements

Chairperson Thibeau called the meeting to order at 9:00 a.m. Chairperson Thibeau welcomed Kula Koenig to the Board and reminded everyone present that the Board is a consumer protection agency charged with administering and enforcing Pharmacy Law.

The meeting moderator provided instructions on how to participate during the meeting, including the process to provide public comment.

Chairperson Thibeau took roll call. Members present included: Seung Oh, Lavanza Butler, Kula Koenig, Jignesh Patel, and Nicole Thibeau. A quorum was established.

II. Public Comments on Items Not on the Agenda/Agenda Items for Future Meetings

Members of the public were provided the opportunity to provide comments for items not on the agenda; however, none were provided.

Note: Agenda items were taken out of order and reflected in the minutes in the order

the agenda items were taken.

V. Discussion and Consideration of Institute for Safe Medication Practices, Include Resources Available

Chairperson Thibeau welcomed Dr. Rita Jew and Dr. Michael Gaunt to provide a presentation on Institute of State Medication Practices (ISMP) and the resources it provides. Members were provided with background on the ISMP as it was founded in 1994 with a mission of advancing patient safety worldwide by empowering the healthcare community to prevent medication errors. The staff and advisory board include physicians, pharmacists and nurses.

ISMP receives information from the medication error reporting program. ISMP relies on health care providers and consumers to report errors. It is from this data that ISMP disseminates information. The ISMP reporting system is voluntary and is always considered confidential.

ISMP directly influences the work of the FDA through an MOU, including monthly meetings to share information on regulated product issues.

Members were provided information on the tools available for the community ambulatory environment, including an ISMP Medication Safety Alert – Community/Ambulatory Care Newsletter. It is a subscription-based publication. It serves as a warning system and shares lessons learn to be used as a proactive tool as part of its continuous quality improvement program.

Every four months Action Agendas are released that highlight key problems and key recommendations to assess the risks of the problems occurring in their pharmacies. It was recommended that the Board encourage licensees to use this tool and noted that some states offer CE to use the tool.

Members were advised about NAN Alert and Special Alert information that require immediate attention to prevent errors.

Members were provided with information on the ISMP Medication Safety Self-Assessment on multiple topics including one for Community/Ambulatory Pharmacy. It is intended as a tool for the pharmacy to use to assess risk. Members were advised that ISMP is working on developing a self-assessment tool for specialty pharmacy.

In addition to proactive tools, ISMP also provides tools to assist with root cause analysis, to provide key tips on how to complete such an analysis. ISMP offers numerous free resources including an ISMP List of Confused/Drug Names and ISMP

List of High-Alert Medications. ISMP also offers tools for consumers including high-alert medication learning guides.

Members were advised about tools in development included targeted medication safety best practices for community pharmacies. Dr. Gaunt suggested that it may be appropriate to identify a select group of high-alert medications for which counseling, possible scripted, would be required as well as possibly adapting tools for inspectors to use to facilitate safety discussion with licensees.

Chairperson Thibeau thanked Dr. Jew and Dr. Gaunt for their informative presentation. Members were provided with an opportunity to provide comments and expressed appreciation for the presentation.

Members asked about partnership between ISMP and corporate pharmacy chains to use the tools available and was advised that representatives serve on the advisory panel and some chains subscribe to the newsletters. ISMP noted attempts try to build relationships with organizations such as corporate pharmacy chain stores but noted it does not have a close working relationship or active engagement with the corporate pharmacy chains at this point. ISMP tries to build relationships with corporate pharmacy chains.

Members were advised that reporting to ISMP is completely voluntary and that there are no Boards that require mandatory reporting to the ISMP. It was suggested that the Board may want to check the requirements for Massachusetts. ISPM has received reports from Massachusetts that indicated the report was required by the Massachusetts Board to report to ISMP. Dr. Gaunt indicated Virginia was at one point requesting or requiring pharmacies to work with a certified patient safety organization as ISMP was receiving many inquiries from Virginia-based pharmacies.

Members were advised that ISMP does not currently have vaccine specific materials but noted it is included in some of the other areas of the self-assessment tool. ISMP does consider staffing information if the information is provided, some of which staffing or the volume of the prescriptions filled for the day may be a contributing factor. Dr. Jew noted alarm at the number of consumer reports received indicating that pharmacist appear overworked and the fractured response received by consumers from pharmacists because of the stress.

Members also inquired about how the information is available for pharmacists. ISMP indicates it is more effective getting information out to the hospital and health systems pharmacists in the acute care setting noting that it does not have a great a presence in the community pharmacy. Most efforts are through newsletters and word of mouth.

Members underscored the value of the work done by the ISMP. Members questioned how to mitigate the staffing challenges and if there are opportunities for the Communication and Public Education Committee to highlight the efforts of ISMP.

ISMP noted the need for dedicated time to perform vaccine related functions, noting that distractions play a role in errors. It was suggested that pharmacies consider having designated timeframes for vaccines with dedicated staff to provide those vaccines.

Members inquired about the quality assurances (QA) reporting process and how effective such a process is in preventing future errors. Members were advised they are not aware of such data. It was noted that the value of the QA is undermined if it was not a good faith process noting that for a program to be effective there needs to be a follow-up plan to assess if the changes identified and put into practice and trend the data to identify if there is improvement.

Members were advised that new healthcare professionals generally do not have the means to learn and practice continuous improvement process resulting in some new practitioners without training on how to implement such a process. ISMP representatives noted this was not being taught in schools and as a result new practitioners are not well prepared to perform this medication safety function. New practitioners are required to learn from employers and effectiveness is dependent on the employer's program.

Members were advised that acute care settings have better focus on continuous process and quality improvement, error reduction or error identification. In the community pharmacy, there is more diversity in what is taught. Most information provided was noted as anecdotal rather than data. This needs to be taught in school to prepare the licensed healthcare professional for their first day of practice. Dr. Jew stated the preference would be for every school of pharmacy to teach a medication safety course in the curriculum.

Dr. Jew noted the cultural difference in an institutional and community pharmacy related to medication safety. She stated there is an awareness of how to prevent medication errors from happening and a safety culture in an institutional setting versus a community setting. Installation of the culture of safety must be done in the community setting so there is an understanding and educating to prevent errors from happening.

Members were advised some of the causes of medication errors include patients receiving another patient's medication. Consumers frequently report wrong counts of medications, wrong dose, and wrong drug. Root causes of errors are difficult to determine or have the data to determine.

Members of the public were provided the opportunity to provide public comment.

Members heard comments requesting how many errors are because of the pharmacist being overworked and how often they are resistant to actually reporting it.

The committee received comments indicating members take medication errors very seriously and suggested hearing about patient safety organizations as a future agenda item.

Public comment was received from a pharmacist noting touchpoints at point of sales with tiers of safety and concerns that reporting will result in retaliation in community settings. Dr. Jew noted the need for a culture of safety where people feel empowered to report errors.

Chairperson thanked Dr. Jew and Dr. Gaunt for their presentation and time.

Members took a break from 10:27 a.m. to 10:37 a.m. Prior to the meeting resuming, a roll call was taken. Members present included: Seung Oh, Cheryl Butler, Kula Koenig, Jignesh Patel, and Nicole Thibeau. A quorum was established.

III. Discussion and Consideration of Results of Workforce Survey

Chairperson Thibeau reminded members during the December 2021 Board meeting, a presentation on the results of the workforce survey conducted by the Board was received. Dr. Thibeau asked Executive Officer Sodergren to review the survey results today and noted the presentation was included in the meeting materials.

Ms. Sodergren provided the survey focused on pharmacists reporting working in a chain or independent pharmacy environment in California and reviewed the demographics of the people taking the survey about their role as pharmacist-in-charge (PIC). The survey inquired about average prescription volume during shifts, services provided at the pharmacy, requirement to perform the services, and number of immunizations administered during a typical work shift.

Ms. Sodergren provided at the presentation of the workforce survey results at December 2021 Board Meeting, Dr. Montez highlighted the following question was statistically significant: Do you believe you have sufficient time to provide adequate screening prior to administration of immunization? The results revealed 78 percent of chain store pharmacists versus 44 percent of independent pharmacists do not believe they have adequate time to perform screening prior to administration immunization.

Ms. Sodergren reported the survey focused on workload metrics used, work queue that monitors the wait time for prescriptions, and average number of medication errors that occurs in a month. Ms. Sodergren noted Dr. Montez reported there appears to be a slight correlation between prescription volume and the number of medications errors that were found. Dr. Montez had indicated the greater the volume of prescriptions, the greater number of errors but that further analysis would be needed to determine the strength of the correlation.

Ms. Sodergren noted when asked about sufficient time for providing appropriate patient consultation, 83 percent of the chain pharmacists versus 32 percent of the independent pharmacists answered no. When asked if staffing is appropriate, 91 percent of chain pharmacists responded no to 37 percent of independent pharmacists with the same response. Ms. Sodergren provided the survey results help to paint a picture of the perceived environment in chain and independent pharmacy practices.

Chairperson Thibeau noted the data reflected represents individuals' beliefs in response to questions but was troubled by some of the findings, including the extremely high percentage of pharmacists working in a community chain pharmacy that responded that they do not believe they have sufficient time to provide adequate screening prior to administration of immunizations. Dr. Thibeau added equally troubling was the very high percentage of pharmacists working in a community chain pharmacy that indicated they do not believe they have sufficient time to provide appropriate patient consultation as well as that 91% of pharmacists working in community chain pharmacy do not believe the pharmacy staff is appropriate to ensure adequate patient care. She asked as the meeting continued, members keep these survey results in mind.

Members of the committee were provided the opportunity to provide comments

Member Oh suggested that the committee perform a more in-depth survey suggesting a secondary survey as a majority of pharmacists think they do not have sufficient time to check accuracy or provide consultation. Member Patel suggested researching the number of medication errors received by the Board from 2019 to present.

Member Butler indicated that the findings are not a surprise based on her observations and Member Koenig noting the same.

Member Koenig questioned what the appropriate number of pharmacy staffing is to reduce medication errors. Member Patel suggested it could be found by conducting industry engineering by looking at the number of tasks and number of steps taken. Committee Oh noted interest in understanding how current staffing is established.

Members of the public were provided with the opportunity to provide public comment.

Public comment suggested the current pressure the pharmacy workforce is under and interest in providing tools, training, adding staff to help alleviate the pressure, enhancing workflow, adjusting store hours, adding human resources to hiring adjusting hours of operations, cross-train employees to assist in the pharmacy, as well as adding salary increases, bonuses and free daycare. The committee was urged to explore these options rather than add administrative requirements that take away from patient care. Also recommended was expanding the duties of a pharmacy technicians and increase the staffing ratio for pharmacy technicians.

Comment was received suggesting that leadership at retail level are encouraging statistics demonstrated by the survey using quotas resulting in challenges with oversight of pharmacy technicians. Root cause needs to be addressed at the pharmacy leadership level.

The committee heard comment about a concern that pharmacists fear retaliation by employers and do not provide comments during meetings. It was suggested that the Board make it easier for individual pharmacists to have freedom to state what is going on and protect them, either through whistleblower protections or something similar.

A commenter who was a staff pharmacy at a grocery chain, commented the results of survey are not surprising and supported a follow up survey inquiring about technician ratio and how many staff work at a shift in a store. It was suggested expansion of technician roles could create additional challenges for pharmacists.

Member Butler indicated that another survey could be done but indicated that another survey would not reveal in different results. Member Patel noted there may be a workforce shortage and cited recruitment efforts. Dr. Patel suggested pharmacy technicians may need to be empowered to do more and changes to ratios.

IV. Discussion and Consideration of the January 2022 Pharmacist Well-Being Index State Report

Chairperson Thibeau Members referenced the January 2022 Pharmacist Well-Being Index State report and the published research, Ability of the Well-Being Index to Identify Pharmacist Distress are included in meeting materials. Dr. Thibeau noted the key findings of the researched were detailed out. Dr. Thibeau noted most related to the committee was the reported information indicating pharmacists identified as being at a risk of high distress are, among other things, at a 2-fold

higher risk of medication errors. Dr. Thibeau inquired of members if it would be beneficial to continue to monitor the state reports at future meetings and to request a presentation from APhA on the well-being index.

Member Oh, indicated a presentation from APhA would be helpful about the well-being index as well as other efforts undertaken by APhA. Members Butler, Patel, Thibeau spoke in support of a presentation and the need to continue to monitor the report.

Members of the public were provided with the opportunity to provide public comment; however, none were provided.

VI. Discussion and Consideration of Sample Case Investigations Involving Medication Errors

Chairperson Thibeau requested staff prepare sample case investigations as the information may help the committee to understand about the different types of medication errors.

Ms. Sodergren provided high level data previously reported. She noted for immunization errors are seen where a patient goes for a COVID-19 vaccine for a specific manufacturer and receives a different manufacturer vaccine. In these cases, the Board looks to the FDA for required process and find that there may have been the wrong manufacturer for the 2nd dose or an age-related issue where a vaccine wasn't approved for the specific age group. The Board is also seeing where the wrong type of vaccine is received (e.g., wanted shingles vaccine and received COVID vaccines), vaccine is given with a used needle, or the vaccines aren't maintained appropriately. Ms. Sodergren reminded the pharmacists are required to provide the consultation, not pharmacy technicians.

Ms. Sodergren reported the Board sees errors related to the automatic refill program where there is failure to discontinue a prescription when a new prescription for the same class is prescribed, failure to perform DUR to detect duplicate therapy, request renewal of medication no longer taken, and over-riding drug-drug warning during data verification and/or prescription verification without reviewing the patient's medication profile for duplicate therapy.

Ms. Sodergren referred to the Board newsletter articles that provide an overview of a past medication error with a conclusion and discussion. These case studies are provided with the intent of developing awareness and proactive thinking for preventing such an occurrence.

Members were provided the opportunity to comment.

President Oh noted how difficult it was to reach the prescriber to resolve issues to facilitate communication and minimize DUR errors. Dr. Oh suggested working with the prescribers' Boards on how to work together. Dr. Oh noted concern with vaccine errors.

Member Patel also noted hinderance of the ability of pharmacists to speak with a prescriber in a community pharmacy whereas in a hospital, pharmacists have authority to do some changes. Dr. Patel noted having to talk to the prescriber is a barrier.

Member Butler expressed concern with a pharmacist using the same needle and inquired what would cause this error.

Member Koenig questioned if it is appropriate to expand scope given current workload challenges.

Chairperson Thibeau acknowledged that there are some pharmacists encounter angry prescribers when asked questions and noted a shared expectation would be helpful between the prescriber and pharmacist. Dr. Thibeau noted clinics are community pharmacies with medical records but is still required to go through the prescriber. Dr. Thibeau suggested education to patients about auto-refill programs to assist the consumer.

Members of the public were provided with the opportunity to provide public comment. The committee heard a comment a prescription can't be moved forward without DUR but with hundreds of prescriptions can see how the step for flagged duplicate therapy can be overlooks.

Public comment was received indicating it made sense to engage with other licensee boards to address the communication issues and prescriber education.

VII. Discussion and Consideration of Next Steps for the Committee

Chairperson Thibeau invited members to provide thoughts on how to move forward as a committee. Dr. Thibeau noted understanding that NABP will be releasing a task force report on workforce. Dr. Thibeau suggested that the committee request a presentation from NABP on the task force findings as well as information on efforts at the national level. Another area that may be interesting to explore given some of the information we received, is perhaps a presentation of sample case summaries focusing on medication errors that could have been avoided if patient consultation was provided.

Members were provided the opportunity to comment.

President Oh requested promoting the meetings to hear from more pharmacists and solicit their feedback as well as listening sessions. Member Patel expressed interest in hearing from NABP and report findings/actions about what the committee can do. Member Koenig inquired if the national survey to be shared will assist in determining staffing requirements. Ms. Sodergren advised it is unknown at the time because the survey has not been released yet. Ms. Sodergren suggested asking NABP to provide what is happening at the national level. Chairperson Thibeau agreed that would be helpful. Member Butler requested to bring APHA to the next meeting and let pharmacists know the Board works with ISMP. Dr. Thibeau suggested an anonymous way to have pharmacists inform the Board and provide feedback.

Members of the public were provided the opportunity to comment.

Public comment was heard in support of requesting NABP to attend the next meeting and stated NABP has a lot of resources.

Chairperson Thibeau noted the next meeting is scheduled for April 20, 2022.

The meeting adjourned at 11:47 a.m.