IRB DECLARATION

Dear Editor,

According to both British and American regulations, the following are the categories for exemption from IRB review for the study conducted (from an excerpt of 45 CFR 46).

1. The research carried out meets requirements of exemption in the way it does not include identifiers (the subject initials were the only ones taken) during the questionnaires to maintain anonymity and the pharmacies identified belong to regional or national chains, making subject identification difficult, addresses have not been included, the questionnaire required a signature, however the consent was obtained prior to the signature being provided to ensure that there was understanding of levels of comfort in providing answers. Dispensers work on a shift basis in the UK, again making identification difficult. Also, the research was carried out over 6 months ago, thus compliant to GDPR as most identifiers in the workplace are removed after 6 months. (This does not compromise good healthcare delivery as blame culture is not supported, according to the Berwick review, 2013).
2. The questions within the questionnaire involve the topic of instructional techniques and management methods used within the pharmacy premises, such as dispensation errors, aptitude or cognitive questions, such as concentration levels, and diagnostic questions, such as daily routine activities.
3. The survey does not involve any questions relating to NHS patients and their prescriptions or conditions or any other personal data.
4. Informed consent was obtained according to the (Informed Consent Checklist 1998) where it applies, in which the dispensers as well as the pharmacist were informed, that the questionnaire was being conducted for research and publication and to assess whether it would be helpful for the dispenser, but also in terms of level of comfort/compliance towards the surveys, which were fully met very positively.
5. Confidentiality was maintained after the surveys were conducted until presentation for publication (with signature being the only potential identifier).
6. Informed consent was still carried out with signature and date requested on the survey, to maintain good research standards to obtain valuable responses and for safeguarding the surveyor's level of comfort¹

Sincerely,

The authors

1. Shu L L, Mazar N, Gino F *et al.*, Signing at the beginning makes ethics salient and decreases dishonest self-reports in comparison to signing at the end, *Proc Natl Acad Sci U S A.* 2012; 109(38): 15197–15200.

Welfare of community pharmacy practitioners in Scotland

Commentary

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Abstract: The current role for community pharmacists is the provision of patient-centered healthcare; dispensers assist pharmacists in the initiative, by integrating self-care with patient-centered care. This paper shows precisely how hard it can get for a dispenser to commit errors when ascetic self-care is applied to oneself and later transmitted to patients in an unexclusive way.

Keywords: Community Pharmacy, Wellbeing, Welfare, Dispensation, Patient-centered care.

Community Pharmacy practice includes patient-centered care intending to deliver excellent health outcomes to patients residing in their homes or in other residential settings such as care homes (primary care).

Good community pharmacy practice, in comparison to good hospital clinical pharmacy practice involves not only the optimisation of medicines as outlined in the European Community Pharmacy Blueprint¹, but principally putting the patient first in terms not only of the quality, effectiveness, and safety of the pharmaceutical service being provided, but also in terms of patient satisfaction and positive impact on their quality of life.

Unlike other occupations, where there are often common controversial debates surrounding the designation of what putting the patient first means², community pharmacy teams, including both pharmacists and auxiliary staff such as accredited checking technicians, pharmaceutical technicians, and pharmacy assistants, show a more accurate perception of what the necessities and patient-professional demands require. Pharmacy consultants know where their limits lay and overcome them, by prioritising the administration of healthcare intuitively and almost instinctively thanks to their expertise. Nevertheless, it is known that, unlike many other professionals, the objective and necessity of delivering patient-centred care leads to the pharmacy team's welfare being 'neglected'³. This in itself leads to risks and unproductive work practices.

Yet, self-neglect is often associated with external factors, but in practice, it is often an internal issue⁴. A patient-centred approach can be accommodated to 'fit' the practitioner's desires self-interestedly without any repercussions on ethical misgivings.

In this regard, pharmacists and dispensers are also often patients themselves, and understand the expectation and needs of the patient population. Here, the term "patient" is broadly defined, being that all patients are human, thus all humans are patients.

What with, we are going to elucidate the end result of a small trial (9-15 subjects) on how community pharmacy specialists, particularly dispensers, reacted to a survey regarding welfare

at work. The trial involved a small cohort where data were collected across several community pharmacies across the Midlothian region (Edinburgh) at the end of the workday.

The survey included personal welfare questions about the dispenser's sleep patterns, daily near-misses, what time the near-miss had taken place, whether near lunch or breakfast times (break times), how many breaks were taken and their duration, how busy their pharmacies had been, how long their shifts had lasted and how well they had eaten as well as how many short breaks they had spent seated as opposed to standing, once more with the relative duration. The pharmacies involved a wide range of premises from national and regional chains to small independent groups (e.g. Omnicare, Boots, Honey, Apple, and Tesco; Figure 1; Table I).

The findings of the questionnaires were that only one of the dispensers had been involved in dispensing errors or near-miss incidents. Interestingly these were both preprandial, occurred almost simultaneously, approximately two hours before her lunch, but three hours after her breakfast. Furthermore, our study shows that concentration recovery after a disruptive event had no impact on the likelihood of committing an error.

This small trial demonstrates that the welfare needs of pharmacy professionals and those of patients are perfectly fitting. Consequently, taking multiple pauses, even short, sleeping eight hours and eating perceptively, which constitute good self-care, are indispensable for a good healthcare delivery.

In conclusion, the administration of good patient-centred healthcare and dispenser or pharmacist-centred self-care are closely connected and are not mutually exclusive.

Disclosure of conflict of interest

The authors declare no conflict of interest.

Ethical disclosure

The study is compliant with the Declaration of Helsinki.

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of Traumatic Personal Experiences and Maladaptive Behaviors in Cognitively
Intact Older Adults, *J Am Geriatr Soc.*, 2016; 64(11): e195–e200.

APPENDIX II. TABLES

Table 1. Pharmacy dispensers end of day questionnaire responses analysed across the City of Edinburgh, Midlothian, UK (October 2018).

Name Initial	Day of the Week	Sleep hours	Breakfast	Lunch	Dinner	Busy or quiet	No breaks (exc. Lunch)	Break Hours (h)	Break at quiet hours	Sitting	Total breaks	Disp. errors	Time of Break (i.s.*) in hours	Total No Dispensers	Recovery time after interruptions (min)	Pharmacy Branch
AB	Thursday	8	Yes	Yes	Yes	Quiet	0	0.5	Yes	Yes	1	2 ⁺	5	2	1-2	Apple
AW	Friday	8	Yes	Yes	Yes	Very busy	0	0.5	No	Yes	1	0		2-3	0.5	Honey
SW	Thursday	7	Yes	Yes	Yes	Avg	0	0.5	No	Yes	1	0		2	0.5	Honey
NG	Thursday	8	No	Yes	Yes	Quiet	0	0.5	Yes	Yes	1	0	4	2	2 -5	Apple
JR	Friday	8	Yes	Yes	Yes	Very busy	0	1	No	Yes	1	0	6-5	1-2	0.5	Boots
DC	Friday	6	No	Yes	Yes	Avg	1	0.5	No	Yes	2	0	4	2-3		Tesco
LS	Thursday	7	No	No	Yes	Avg	1	0.25	No	No	2	0		3		Tesco
TH	Thursday	7	Yes	Yes	Yes	Busy	0	0.25	No	Yes	1	0	5.5	3		Honey
SR	Saturday	6	No	No	Yes	Avg	1	0.25	Yes	Yes	1	0		2		Omnicare
AB	Saturday	8	Yes	Yes	Yes	Very quiet	1	0.25	Yes	No	1	0		2	5	Omnicare

⁺the 2 dispensation errors occurred 2 hour preprandial

* i.s.=into shift, corresponding to time worked prior to break.

Appendix III. FIGURES

PHARMACY DISPENSERS END OF DAY QUESTIONNAIRE

Initials: _____

Date ____/____/____

Day of the week: Mon [] Tue [] Wed [] Thu [] Fri [] Sat [] Sun []

1) How many hours in total did you rest last night?

2) Did you have breakfast, lunch (today) and dinner (night before this shift)?

3) How busy was your branch today?

[a] very busy (no quiet moments)

[b] busy (1-3 quiet moments lasting at least 5 minutes) [c] average (busy 1/2 of the hrs your shift covered)

[d] quiet (~20 patients-customers served every 4 hrs) [e] very quiet (1-10 patients-customers served every 4 h)

4) How many breaks did you have aside of lunch and how long did each of them last (Did each last at least 5-15 minutes)?

5) Was each of the breaks taken during "a quiet moment" of the day?

6) How long did your lunch break last (Did it last at least 30 minutes)? _____

7) How long after the first [a] break or [b] breakfast (please indicate) did your lunch take place?

8) Did you sit during your lunch and other breaks? [Yes] / [No]

9) Did you have at least 2 breaks (including lunch) throughout your working hours where you were sitting? If not, explain why.

10) How many dispensation errors are you certain of making today? _____

11) How many hours after your breakfast/lunch/break did you make that mistake (approximately)?

12) To avoid concentration errors, what did you eat prior to your mistake being made?

13) How many other dispensers work with you? _____

14) If the mistake was a concentration error, how many times did your mind drift away from the medications (not counting interruptions)?

15) How long does it take you to concentrate after being interrupted?

Signed: _____