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Introduction: The two-year, NHS Education for Scotland (NES) post-registration foundation programme supports early career pharmacists in patient-facing sectors of practice. The experiential programme, based on an eight-element competency framework, also includes webinars, online resources, and tutor support. Learners complete an online evidence portfolio and undertake a summative OSCE.

Aim: The aim of this paper is to report the experiences of the community-pharmacist participants, with a focus on the 'fitness-for-purpose' of the programme.

Methods: This was a longitudinal mixed-methods study theoretically underpinned by Miller's triangle and social cognitive theory. Eligible participants were all pharmacists registering for the programme in Scotland in September 2017 and February 2018, all participating Welsh community-pharmacists, and all tutors. Invitation packs were emailed by NES/HEIW staff with names forwarded to researchers following signed consent. Focus groups/interviews (face-to-face or virtual according to participant preference) were undertaken at start, mid-point and exit of programme, to explore expectations (benefits, social gains, professional identify), experiences (challenges, facilitators, meeting of learners' needs) and barriers. Proceedings were digitally recorded, transcribed verbatim and managed using NVivo. Thematic analysis (1) was based on social cognitive theory (transferable behavioural skills and professional attitudes). An inductive analysis additionally identified emergent themes. Participants in Scotland were invited to complete an on-line base-line questionnaire to describe their self-assessed competence against the NES Foundation framework (personal and professional practice, membership of healthcare team, communication, patient centred approach to practice). Data was analysed in SPSS using descriptive statistics. Themes from qualitative and quantitative data were integrated. IRAS ethical approval was not required; NHS Research & Development approval was given.

Results: 96 pharmacists registered for the programme: 18 community-pharmacists in Scotland (11 health boards); 14 community pharmacists in Wales. In Scotland 15 community-pharmacists completed questionnaires: 9 expected an 'increase in confidence' and 11 to provide 'better patient care'. Self-assessed competence against the framework was generally high. Across Scotland and Wales, 12 focus-groups (involving 19 community-pharmacists), 12 community-pharmacist interviews, 10 tutor focus-groups (8 community-pharmacist tutors) and 3 community-pharmacist tutor interviews were conducted.

At midpoint and exit pharmacists and tutors reported increased confidence, the ability to reflect and pride in their achievement. Barriers: included lack of protected time; workload; and lack of support (tutor and employer). There were also programme issues (practicalities of portfolio; workplace-based assessment, no access to medical records); and cultural issues in community-pharmacy ('speed & safety'; lack of recognition). Reasons for dropping out of the programme included: moved geographical area; too experienced; workload pressures; no incentive; no employer support. Four community-pharmacists in Scotland and none in Wales completed the programme.

Conclusion: Study limitations include the small numbers, programme delivery limited to Scotland and Wales, and limited response rate to focus-groups/interviews, exacerbated by COVID19. Overall community pharmacist expectations were met, and they perceived the programme was fit-for-purpose and worthwhile. However, barriers particularly related to the community pharmacy context, may have led to the high drop-out rate. These findings should be considered as the new UK-wide RPS curriculum for foundation pharmacists (2) is implemented in Scotland, to optimise its successful delivery.

References

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A SURVEY OF THE COMMUNITY PHARMACY WORKFORCE'S PREPAREDNESS FOR, AND RESPONSE TO, THE COVID-19 PANDEMIC IN NORTHERN IRELAND

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Introduction: Community pharmacy is one of the most accessible sectors in the health service and played a key role in responding to COVID-19 (1). Efforts to tackle COVID-19 have required an immediate response from the community pharmacy workforce.

Aim: To examine views and experiences of community pharmacists regarding changes in practice/processes in preparation for and response to the COVID-19 pandemic.

Methods: A telephone questionnaire was conducted across a geographically stratified sample of community pharmacists in Northern Ireland (NI). Based on the total number of pharmacies (N=528) and an anticipated response rate of 30%, up to 433 pharmacies were to be contacted to achieve a target sample size of n=130 (sampling fraction 24%). The questionnaire sections comprised: (1) measures taken to prevent COVID-19 infection; (2) response to the pandemic, i.e. immediate actions taken, effect on service provision and new/innovative ways of working; (3) pandemic preparedness; (4) communication with GPs and patients; (5) professional knowledge; (6) recovery and future outlook. Data were coded, entered into SPSS v27, and analysed descriptively. Free-text comments were summarised using thematic analysis.

Results: One hundred and thirty community pharmacists (175 approached) completed the questionnaire (74% response rate). Pharmacists responded comprehensively to implementing infection control measures, e.g. management of social distancing in the shop (n=125, 96.2%), making adjustments to premises, e.g. barriers/screens (n=124, 95.4%), while maintaining medicines supply (n=130, 100.0%) and advice to patients (n=121,

93.1%). Patient-facing services such as minor ailments and smoking cessation were initially stopped by 115 (88.5%) and 93 (71.5%) pharmacies respectively during the first wave of the pandemic (March-May 2020); by the second wave (Sep-Dec 2020), modified services had resumed in 121 (93.1%) and 104 (79.9%) pharmacies respectively. Newly commissioned services were provided, e.g. emergency supply service (n=121, 93.1%), flu vaccination for healthcare workers (n=101, 77.7%) and volunteer deliveries to vulnerable people (n=71, 54.6%); new initiatives were developed, e.g. measures to flag/assist patients with sensitive issues (n=73, 56.2%). Pharmacies with a business continuity plan increased from 85 (65.4%) pre-pandemic to 101 (77.7%) during the second wave. Free-text responses indicated how pharmacists adapted practice in the front line to reassure and advise the public and maintain essential medicines supply. Pharmacists were least prepared for the increased workload and patients' challenging behaviour, but 126 (96.9%) reported that they felt better prepared during the second wave. Telephone was the main method of communication with patients (n=107, 82.3%) and GPs (n=114, 87.7%). Pharmacists felt they had sufficient training resources available (n=113, 86.9%) to maintain professional knowledge. Pharmacists agreed/strongly agreed that they would be able to re-establish normal services (n=114, 87.7%), were willing to administer COVID-19 vaccines (n=105, 80.7%) and provide COVID-19 testing (n=79, 60.8%) in the future.

Conclusion: The high response rate is a strength of the study, but the impact is limited by not including patients or service commissioners. The pharmacy workforce remained accessible and maintained supply of essential medicines and advice to patients throughout the pandemic. Provision of modified and additional services such as vaccination reinforced the clinical and public health role of pharmacy.

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Oral papers 8: Extended roles for pharmacists

WITH A NEW ROLE COMES NEW RESPONSIBILITIES: INTERVIEWS TO EXPLORE WHAT EMERGENCY DEPARTMENT PHARMACIST PRACTITIONERS KNOW AND UNDERSTAND ABOUT PATIENT SAFEGUARDING

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Introduction: In the UK, pharmacists with additional clinical skills now work in emergency departments (1). Known as Emergency Department Pharmacist Practitioners (EDPPs), the role was developed in response to a shortage of doctors and nurses. EDPPs carry out activities typical of traditional hospital pharmacists, but also novel 'practitioner' activities such as examining patients. They also may act as designated care providers with overall responsibility for patients, which includes

a responsibility to safeguard patients (children and vulnerable adults) from harm – as is required of other healthcare professionals who take on that role. The initial safeguarding process comprises four stages: recognition, ensuring safety, documentation and escalation. Professional competence, i.e. to safeguard patients, is underpinned by knowledge of the subject, but also the ability to apply that knowledge (2).

Aim: To investigate what EDPPs know and understand about safeguarding vulnerable children and adults.

Methods: Past and current students of an 'Advanced Specialist Training in Emergency Medicine' programme, which delivers additional clinical skills to pharmacists, were interviewed to explore their knowledge and understanding of safeguarding. Interview questions were developed from review of relevant literature, as were four vignettes which were used to further explore participants' understanding i.e. apply their knowledge of safeguarding to realistic scenarios. Vignettes concerned victims of: theft, sexual abuse, physical abuse and a medication error. A Social Worker reviewed the vignettes for plausibility, suggesting changes e.g. to victim characteristics. The interview schedule and vignettes were then piloted by two acute medicine pharmacists. For analysis, interview transcripts were reviewed with template analysis used to code data to four *a priori* themes (stages of the initial safeguarding process), and new themes that emerged throughout the process.

Results: Thirteen EDPPs were interviewed (four in 2016, and then a further nine in 2019 following delays due to competing research commitments). In addition to the four *a priori* themes, a further six themes were identified: scope of safeguarding; responsibility to safeguard; resources and setting; education, training and experiential learning; multidisciplinary working and communication; and culture. Overall, participants had a broad and often detailed knowledge of safeguarding. All four stages were frequently described which demonstrates EDPPs awareness of how safeguarding concerns are both recognised and responded to. Somewhat unsurprisingly, participants were generally more comfortable when responding to medicines related concerns although whether these should be reported via safeguarding or error systems is currently unclear. Several participants were more involved with the formal escalation of issues, and one participant had safeguarding issues escalated to them and had given evidence in court.

Conclusion: Although interview phases were three years apart, no thematic differences were identified between these phases and thematic saturation was also achieved. EDPPs interviewed were aware of the different types of maltreatment and the safeguarding process. Safeguarding training for pharmacists should include a focus on the importance of good inter-professional communication. Training should also include information about the types of medication error (e.g. type and severity) that require escalation via safeguarding, but these first need to be confirmed through future research.

References

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