Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX

**Attachment B**

**Cognitive Interview Guide for**

**Draft Pharmacy Survey**

**on Patient Safety Culture**

**File Contents:**

1. **Introduction for telephone cognitive interviews (with oral consent recorded)**
2. **Draft survey questions by potential dimensions and scripted interview probes**

**Not for Circulation**

**2-8-11**

Public reporting burden for this collection of information is estimated to average 90 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

**Pharmacy Survey on Patient Safety Culture**

**Telephone Cognitive Interviews: Introduction and Oral Consent**

Respondent ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respondent job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No. of pharmacists/other staff in pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average number of prescriptions/week:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time of interview: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tape recorded? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hello, my name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I work for Westat, a social science research organization in Rockville, Maryland. Thank you for taking the time to complete and talk about the draft survey items on patient/medication safety in community pharmacies. As noted when we sent you the questions, Westat is developing this survey for the Agency for Healthcare Research and Quality (AHRQ).

I am talking with you today to find out how the survey questions worked for you – for example, were they easy to understand and answer? I am interested in what you think about the questions, and I will be asking you what the questions mean to you. There are no right or wrong comments. Please speak up freely and tell me what you think.

Your responses will be kept confidential to the extent permitted by law, including AHRQ’s confidentiality statute, 42 USC 299c-3(c). I will discuss your responses only with other project team members. We will not include your name or your pharmacy’s name in any written findings reports.

This is a research project and your participation is voluntary. You may skip any question you do not want to answer and you may stop the interview at any point. I expect the interview to take about 1 1/2 hours.

Because I want to pay close attention to what you say, I would like to tape record our interview so that I can listen to it later to see if I missed anything. Is that okay?

**[TURN ON THE RECORDER and Say you need to ask their permission again]: Today is mo/day/year at [time]. Do you agree to participate in the interview and to have it audio recorded?]**

Thank you. Let me explain how this interview will work. We will review the definitions on the first page, then the various sets of items, topic by topic. I will be asking you questions about them. Your comments will help in identifying possible problems. Again, please share your thoughts and don’t hesitate to bring up problems, suggest changes, or say which items you prefer – the whole purpose of this pretest is to improve the items and use the best ones in the survey.

Do you have any questions before we start? Okay, let’s begin.

|  |
| --- |
| **Pharmacy Survey on Patient Safety** |

**SURVEY INSTRUCTIONS**

* This survey asks for your opinions about patient safety in this pharmacy and will take about 20 minutes to complete. In this survey:

**“Patient safety”** is defined as the prevention of patient harm resulting from the processes of health care delivery. In the pharmacy setting, it means that:

* The right patient receives the right medication in the right dose at the right time by the right route, and
* The patient or caregiver understands the purpose and proper use of the medication.

A**“medication mistake or error”**is any type of medication error, mistake, incident, or quality-related event, regardless of whether or not it reaches the patient or results in patient harm.

Medication mistakes or errors may be related to, or include:

* Prescribing,
* Transcribing,
* Dispensing,
* Administering,
* Monitoring (use of medication),
* Unsafe conditions or procedures in the pharmacy, etc.

* If a question does not apply to you or you don’t know the answer, please check “Does Not Apply or Don’t Know.”
* When answering this survey, answer only about the pharmacy location/store where you received this survey.

**Probes**

**Definition of patient safety**

How often do you hear the term “patient safety” in your pharmacy?

In what ways, if any, does this definition of patient safety correspond to how you usually think about patient safety in your pharmacy?

Would you change the definition of patient safety in any way? (How?)

**Definition of medication mistake/error**

 In your pharmacy, what is considered a medication mistake?

(What are some examples of medication mistakes that you have observed in your pharmacy?)

Do the terms *medication mistake* and *medication error* mean the same thing in your pharmacy?

 (If not, how do they differ?) (Which tends to be considered more serious?)

(If mean the same): Which of the two terms do you prefer? (Or is it okay to use both?)

What do staff in your pharmacy usually call medication errors? (medication mistakes?)

 In the definition of medication safety, what does the phrase “reaches the patient” mean to you?

Now, let’s move on to the survey items. **1. Common Mistakes in This Pharmacy**

The following items describe common dispensing mistakes that may happen in pharmacies. **In your best estimate, how often did the following things happen in this pharmacy over the past 12 months?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Daily**⯆ | **Weekly**⯆ | **Monthly**⯆ | **Several times in the past 12 months⯆** | **Once or twice in the past 12 months**⯆ | **Not in the past 12 months**⯆ | **Does Not Apply or Don’t Know**⯆ |
|  |
| 1. Not noticing changes in a prescription (e.g., change in strength, dose)
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Incorrect data entry of prescription information
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Grabbing the wrong drug from the shelf
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Not double-checking high-alert medications before dispensing
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Insufficient checking of patient ID information at time of pickup
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |

**Probes**

How easy or difficult was it to answer this first set of items? (Why?)

In item 4, what does “high-alert medications” mean to you?

When staff make the kinds of mistakes listed here, who usually knows about them?

For item 6, you [listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/did not list anything]. Can you say more about that?**2. Reasons Dispensing Mistakes Happen**

The following items describe reasons dispensing mistakes may happen. **Over the past 12 months, how often has this pharmacy had problems with the following:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Daily**⯆ | **Weekly**⯆ | **Monthly**⯆ | **Several times in the past 12 months⯆** | **Once or twice in the past 12 months**⯆ | **Not in the past 12 months**⯆ | **Does Not Apply or Don’t Know**⯆ |
|  |
| 1. Unclear handwriting on paper prescriptions?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Look-alike/sound-alike drugs?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Interruptions/distractions (phone calls, faxes, customers, etc.)?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Technology or equipment?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Technicians not asking a pharmacist for help or clarification?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Too many prescriptions to fill given the number of staff?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. The physical environment (e.g., lighting, noise, limited space)?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Insufficient knowledge about new medications?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Inadequate work breaks?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Expired medications not removed from stock?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |
| 1. Other? (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎9 |

**Probes**

How easy or difficult was it to answer this set of items? (Why?)

Were any items confusing or unclear to you?

For item 4, what were you thinking about when you answered?

For item 10, you [listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/did not list anything]. Can you say more about that?**3. Resolving Problems with Prescriptions**

**Pharmacies often have to interact with others to resolve prescription issues. Over the past 12 months, how often has this pharmacy had problems in providing information to, or getting information from, the following persons or organizations:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Problems Daily**⯆ |  **Problems Weekly**⯆ | **Problems Monthly****⯆** |  **Problems several times in the past 12 months⯆** | **Problems once or twice in the past 12 months**⯆ | **No** **problems** **in the****past 12** **months**⯆ | **Does Not Apply or Don’t** **Know**⯆ |
| 1. Prescribers/providers/medical offices?
 | 🞎1 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎6 | 🞎99 |
| 1. Hospital emergency departments?
 | 🞎1 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎6 | 🞎99 |
| 1. Other pharmacies?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Insurers/insurance companies/ pharmacy benefit managers (PBMs)?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Suppliers/wholesalers?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Patients, their family members, or representatives?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Corporate office/pharmacy owner? …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Nursing homes?
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |
| 1. Other? (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎6 | 🞎99 |

**Probes**

How easy or hard was it to answer this set of items?

(Probe as necessary depending on answers)

[IF LISTED OTHER]: For item 9, you listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Can you say more about that?**4. Teamwork**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. Staff in this pharmacy clearly understand their roles and responsibilities
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff treat each other with respect
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When a lot of work needs to be done quickly, staff work as a team to get the work done
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff help one another during busy times
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. There is a good working relationship among all staff
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. In this pharmacy, we emphasize teamwork
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

[DURING DISCUSSION OF REMAINING DIMENSIONS, NOTE IF THE RESPONDENT (R) USES FREQUENCY TERMS TO ANSWER AGREE/DISAGREE QUESTIONS AND VICE VERSA]

[GENERAL NOTE FOR ALL ITEMS: IF SOMEONE ANSWERS DOES NOT APPLY/DON’T KNOW, ALWAYS PROBE ON WHY THEY CHOSE THAT RESPONSE.]

For item 1, how do staff learn their roles and responsibilities?

For item 3, can you give me an example?

Why did you say \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for item 5?

For item 6, can you say more about your answer?

**PROBE ON ANY ITEMS R RATED NEGATIVELY** (Tell me more about why you said \_\_\_\_\_\_\_\_\_)**5. Handoffs Within and Across Shifts**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t** **Know**⯆ |
| 1. In this pharmacy, important prescription information is often lost from one shift to the next shift.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. The status of problematic prescriptions is well communicated across shifts
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff clearly, completely, and accurately communicate important prescription information to staff on the next shift.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We have clear expectations about exchanging important prescription information across shifts
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We have standard procedures for communicating prescription information across shifts
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We sometimes forget to communicate important prescription information to other pharmacy staff
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Within a shift, staff handling the same prescription make sure to share important information
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

In Q1, what did you think about when you read “from one shift to the next”?

What prescription information were you thinking about?

For Q2, what are some examples of this? How is this done in this pharmacy?

For Q3, please tell me more about your answer. (If answers for Q1 and Q3 differ, probe on why.)

[IF R GAVE DIFFERENT ANSWERS FOR 4 AND 5]: Can you tell more about your answers for items 4 and 5. (Find out in what ways R considers them different)

[IF R GAVE THE SAME ANSWERS FOR 4 AND 5]: Can you tell more about your answers for items 4 and 5. (Find out if R thinks these items are asking about different things and, if so, what they are)

In Item 6, why are staff likely to forget to share information?

In Item 7, what is an example of important information?

We talked about Teamwork earlier. Do you think this type of communication is part of teamwork? (Why?)

**6. Staff Training and Skills**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. All staff get adequate on-the-job training in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Technicians in this pharmacy receive the training they need to do their jobs
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy staff get special training on medication error prevention
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Technicians and clerks understand when it is necessary to refer patients to a pharmacist for assistance
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff who are new to this pharmacy receive adequate orientation
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff in this pharmacy have the skills they need
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, you said \_\_\_\_\_\_\_\_\_\_\_\_. Can you tell about your answer.

(What staff were you thinking about?)

(How do you define adequate training?)

For Q2, what training were you thinking about?

Tell me about your answer.

For Q3, in your own words, what is medication error prevention?

Tell me about your answer.

[(IF SA/A): Please describe the training?]

For Q4, what does “clerks” mean to you? (Do you use them? If so, what is their job title?)

Please cite an example of this happening.

For Q5, what do you think this question is asking?

(What would be adequate orientation?)

How did you arrive at your answer?

For Q6, please tell me about how you arrived at your answer.

(What staff was R thinking about?)

Probe on response scale: Would it have been easier to answer these items if the response options had been never, rarely, sometimes, most of the time, and always?

**7. Staffing**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following happen in this pharmacy?** | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. We have enough staff to handle the workload
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When we use temporary/floater staff, we have problems with our work process
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacists have enough technicians to help get the work done
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We have good backup plans for pharmacists who go on vacation or take extended leave
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We have good backup coverage for technicians who call in sick
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, tell me about your answer.

(Were you thinking of pharmacists when you answered?)

(What does workload mean to you?)

For Q2, how familiar are you with the term floater?

You answered\_\_\_\_\_\_\_\_\_\_\_\_. Tell me more about that.

(What work process were you thinking about?

For Q3, IF RESPONSE IS NEVER, RARELY, OR ALWAYS, PROBE ON ANSWER.

For Q4, tell me more about your answer. [Pay attention to whether they just “handle the situation” versus plan and make arrangements for substitutes.]

Would your answer differ for backup plans for pharmacists on vacation vs. pharmacists who call in sick?

Would your answer be the same if this question had asked about “backup coverage”?

For Q5, same probes as for Q4 but ask about technicians (*plans* versus *coverage*).

General probe: How easy or hard was it to answer these questions? (Why?)**8. Work Pressure and Pace**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following happen in this pharmacy?** | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. We have too many prescriptions to dispense for the number of staff …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We work in “crisis mode” trying to do too much, too quickly …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We feel rushed when dispensing prescriptions
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Technicians take adequate breaks during their shifts
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacists take adequate breaks during their shifts
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, you said \_\_\_\_\_\_\_\_\_\_. How did you arrive at that answer?

For Q2, tell me more about your answer.

For Q3, whom were you thinking about when you read “we”?

IF SA/A: What makes staff feel rushed?

IF SD/D/Neither: Why did you say \_\_\_\_\_\_\_\_?

For Q4, tell me about your answer

(How do you interpret adequate break?)

(Does someone make sure technicians take adequate breaks?)

For Q5, How are breaks scheduled for pharmacists?

Does someone make sure they take breaks?

**9. Compliance with Procedures**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following happen in this pharmacy?** | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. When staff do not follow pharmacy procedures, another staff member brings it to their attention  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 2. Pharmacy staff double check their own work  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 3. Staff follow established procedures to dispense prescriptions  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 4. Staff are monitored to make sure they follow standard procedures  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 5. Staff use shortcuts that are not as safe as following standard procedures  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, what procedures were you thinking about?

Who came to mind when you read the word “someone”?

How would someone bring it to the attention of staff?

Tell me about your answer.

For Q2, in your own words, what is this item saying?

(What shortcuts were you thinking about?)

Do you think it is safe to take any shortcuts? (Why?)

[IF R HAS PROBLEMS WITH THIS ITEM, ASK ABOUT FOLLOWING]: Staff follow standard procedures without taking shortcuts.

For Q3, say more your answer.

Please describe typical tasks with step-by-step procedures.

For Q4, what pharmacy staff were you thinking about?

IF A/SA: How do they double check their own work? (Is this something they are trained to do?)

For Q5, What does it mean to follow established procedures?

(Who determines what procedures are followed?)

ForQ6, in your own words, what is this item saying?

(What shortcuts were you thinking about?)**10. Communication Openness**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following happen in this pharmacy?** | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. Staff freely speak up to a supervisor if they see something that may negatively affect patient care.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. It is easy for staff to speak up to a supervisor about patient safety concerns.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff feel comfortable asking questions when they are unsure about something
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff ideas and suggestions are valued in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When patient safety issues occur in this pharmacy, staff discuss them
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, In your own words, what is this item saying?

(What staff were you thinking about?)

(What does the phrase “freely speak up” mean to you?)

(What supervisor were you thinking about?)

 (What if we said “freely speak up to a supervisor or someone in authority – would that be better?)

(What’s an example of something that may negatively affect patient care?)

For Q2, what concerns were you thinking about?

What supervisors were you thinking about?

For Q3, in your own words, what is item 3 saying?

Please give an example of this.

For Q4, can you tell me more about your answer?

For Q5, can you tell me more about your answer?

(What staff were you thinking about?)

(IF SA/A: What issues do staff discuss?) (When do they discuss them – during the day, at meetings?)

(How often do they discuss them?)

**11. Physical Space and Environment**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t** **Know**⯆ |
| 1. This pharmacy is well organized
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. This pharmacy is free of clutter
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. It is easy for staff new to this pharmacy to find what they need
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. The physical layout of this pharmacy supports good work flow
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Our patient counseling area is private enough for confidential discussions
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. In this pharmacy, interruptions/distractions (from phone calls, faxes, customers, etc.) make it difficult to dispense accurately
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, tell me more about your answer.

(What does a well-organized pharmacy mean to you?)

For Q2, what clutter were you thinking about?

(Are there times when there is always some clutter and times when it is not cluttered?

How does clutter affect patient safety?

 (How important is it to that your pharmacy be free of clutter?)

For Q3, please tell me in your own words what this item is saying.

Whom were you thinking about when you read “staff new to this pharmacy”?

You answered \_\_\_\_\_\_\_\_. Please say more about that.

For Q4, what does “good work flow” mean to you?

Please give me an example of how your pharmacy’s physical layout [does/does not] support good work flow.

For Q5, please describe your patient counseling area.

[IF HAVE A DESIGNATED COUNSELING AREA]: When counseling is provided, how often is it done in this counseling area? (Is it ever done elsewhere? If so, why? Is that area private?)

For Q6, Tell me more about your answer.

(What distractions were you thinking about in your pharmacy?) In what ways do interruptions and distractions make it difficult to dispense accurately?

 Could something be done to reduce the interruptions/distractions?

**12. Patient Counseling**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t** **Know**⯆ |
| 1. Our pharmacists spend enough time talking to patients about how to use their medications.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Our pharmacists always tell patients important information about their new prescriptions.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Our pharmacists do not counsel patients as often as they should
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We encourage patients to talk to pharmacists about their medications
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Our pharmacists are thorough when talking to patients about their new prescriptions
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Our pharmacists spend enough time talking to patients about possible side effects from their medications.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, What is this item saying?

How did you decide on your answer?

How often do pharmacists talk to patients one-on-one?

For Q2, Why did you answer\_\_\_\_?

When you read “new prescriptions,” what were you thinking about?

For Q3, Tell me more about your answer.

For Q4, [IF A/SA]: How do you encourage them?

[IF D/SD/Neither]: Why did you say \_\_\_\_\_\_\_\_?

For Q5, Tell me more about your answer.

For Q6, what may keep pharmacist from spending enough time talking about side effects?.

**13. Communication about Mistakes**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How often do the following happen in this pharmacy?** | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. In this pharmacy, we talk about ways to prevent mistakes from happening again.  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 2. Staff are told about errors that happen in this pharmacy.  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 3. Staff in this pharmacy discuss dispensing mistakes  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 4. Staff who see another staff member making a dispensing mistake will talk to the person about it   | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 5. We discuss how errors that have occurred in other pharmacies can be prevented in our pharmacy  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

PAY ATTENTION TO HOW R INTERPRETS “MISTAKES” AND “ERROR” IN THESE ITEMS.

For Q1, what does “talk about” mean?

What mistakes were you thinking about?

(If thinking only about mistakes that reach the patient): Do you discuss mistakes that are caught and fixed before they reach the patient? ( IF YES: Can you give me some examples?) (What word would you use to describe those types of things?)

You answered \_\_\_\_\_\_\_\_\_. Tell me more about why you said that.

For Q2, How did you arrive at your answer?

(What errors were you thinking about?)

 (If only errors that reach the patient: Are staff informed about mistakes that are made but fixed before they reach the patient? IF YES: Say more about that.

 [IF SOMETIMES, MOST, ALWAYS]: Who informs staff about errors?

For Q3, Please say more about your answer.

(What dispensing mistakes were you thinking about?)

NOTE IF R BRINGS UP HIPPA AND CONFIDENTIALITY

For Q4, In your own words, what is this question saying?

What mistakes were you thinking about? (Can you give an example of someone pointing out mistakes?)

For Q5, In your own words, what is this statement saying? Tell me more about your answer. (IF R SAYS THIS HAPPENS: How do you learn about errors in other pharmacies?)

**14. Response to Mistakes**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. All staff are treated fairly when they make mistakes
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff feel like their mistakes are held against them
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When a pharmacy error is reported, it feels like the person is being reported, not the problem …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When an error reaches the patient, management looks for possible problems with our procedures …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When staff make mistakes, pharmacy supervisors/managers respond fairly
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. This pharmacy helps staff learn from their unintended mistakes rather than punishing them. .
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy supervisors/managers respond to mistakes by talking to staff about patient safety.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We look at staff actions and the way we do things to understand why mistakes happen in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When staff make a mistake that leads to patient harm, they are offered counseling as a support
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

For Q1, In your own words, what is this item saying?

(What mistakes were you thinking about?)

(What does “treated fairly” mean to you?)

For Q2, Can you tell me more about your answer?

(What staff were you thinking about?)

(What mistakes were you thinking about?)

 For Q3, in your own words, what is item 3 saying?

(What kinds of pharmacy errors were you thinking about?)

What kinds of errors are reported?

(What makes them the type of errors that someone reports?)

Who reports errors?

To whom do they report the errors?

For Q4, in your own words, what is this item saying?

(Who is management?)

(What does reach the patient mean to you?)

(What errors were you thinking about?)

For Q5, tell me how you arrived at your answer.

(What supervisors/managers were you thinking about?)

For Q6, Tell me more about your answer.

(Any examples?)

For Q7, Tell me more about your answer.

(Ask for examples.)

For Q8, In your own words, what is this item saying?

Tell me more about your answer.

For Q9, Tell me more about your answer.

(Have you ever known this to happen? – [IF YES]: tell me more about that)?

**15. Organizational Learning—Continuous Improvement**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. In this pharmacy, we are actively doing things to improve patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Mistakes have led to positive changes in this pharmacy …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When the same mistake keeps happening, we change the way we do things
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When a mistake happens, we try to figure out what problems in the work process led to the mistake
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We are good at changing processes to make sure the same problems don’t happen again …………………………………
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. When changes are needed to improve patient safety, we make the changes.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Staff understand that reporting mistakes is important to patient safety improvement
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, Tell me more about your answer.

IF A/SA: Please describe some examples of things your pharmacy is doing.

For Q2, Tell me more about your answer.

IF A/SA: What positive changes have occurred?

(How did they come about?)

For Q3, Tell me more about your answer.

(Ask for an example)

For Q4, in your own words, what is this item saying?.

(What does “work process” mean to you?)

IF A/SA: How did you figure out the problems?

For Q5, Why did you say \_\_\_\_\_\_\_\_\_\_\_?

(What processes were you thinking about?)

IF A/SA]: Please describe some examples of this.

(Who initiated the changes?)

For Q6, In your own words, what is this item saying?

Can you tell me more about your answer?

 IF A/SA: Please describe some examples of this.

For Q7, In your own words, what is this statement saying?

What mistakes were you thinking about?

**16. Your Pharmacy Supervisor’s/Manager’s Support for Patient Safety**

 **►16a. Do you report to a supervisor/manager who works regularly in this pharmacy?**

 **🞎** Yes **🡪 *Answer items 1-7 below***

 **🞎** No **🡪 *Skip to Section 17***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. My supervisor/manager in this pharmacy tells staff they have done a good job when they follow safe dispensing procedures
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor/manager in this pharmacy listens to staff ideas and suggestions about patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor/manager in this pharmacy addresses patient safety problems to make sure they do not happen again
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor/manager in this pharmacy pays close attention to all dispensing mistakes made by staff
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor/manager in this pharmacy encourages staff to suggest ways to improve patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor/manager pays attention to patient safety only after a serious error occurs
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. My supervisor’s/manager’s actions demonstrate that patient safety is a top priority in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, Tell me more about your answer.

(What supervisors/managers were you thinking about?)

For Q2, Can you give me some examples?

For Q3, Tell me more about your answer?

(Examples?)

For Q4, How aware are supervisors of mistakes made by staff?

(Are they aware of the mistakes that staff catch and fix themselves?)

For Q5, Tell me more.

(Examples?)

For Q6, Tell me more about your answer.

(What serious errors were you thinking about?)

For Q7, Tell me why you answered\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**17. Pharmacy Management Support for Patient Safety**

**A. Are you an owner of this pharmacy?**

🞎1 Yes 🡪 ***Skip to Section 18***

🞎2 No 🡪 ***Answer items 1-8 below after reading the definition of pharmacy management***

**Pharmacy management includes persons who make important financial decisions about technology and business goals for this pharmacy. Management may include the pharmacy owner(s), district or area management, or corporate management.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements about your pharmacy management?** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. Pharmacy management listens to pharmacy staff ideas and suggestions about patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy management addresses patient safety problems to make sure they do not happen again
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy management pays attention to staff suggestions for improving patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy management pays attention to patient safety only after a serious error occurs
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. The actions of pharmacy management demonstrate that patient safety is a top priority
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy management emphasizes customer wait time more than patient safety..
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Pharmacy management places more emphasis on sales than on patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, can you give me some examples?

For Q2, tell me more about your answer?

(Examples?)

For Q3, why did you say\_\_\_\_\_\_?

(Listen for/ask for examples that support the answer)

For Q4, tell me more about your answer.

(What serious errors were you thinking about?)

For Q5, IF A/SA: Can you give some examples?

IF D/SA/NEITHER: Tell me more about your answer.

For Q6, tell me more about your answer.

For Q7, In your own words, what is this statement saying?

(When you read “prescription sales” what were you thinking about?)

How did you arrive at your answer?

How did you interpret patient safety?

**18. Frequency of Reporting Dispensing Mistakes**

**How often do pharmacy staff report the following types of dispensing mistakes to someone?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Never**⯆ | **Rarely**⯆ | **Some-****times⯆** | **Most of the time**⯆ | **Always**⯆ | **Does Not Apply or Don’t Know**⯆ |
| 1. When a dispensing mistake harms a patient, how often is it reported to management?  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 2. When a dispensing mistake reaches the patient and could cause harm but does not, how often is it reported to management?  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 3. When a dispensing mistake reaches the patient but has no potential to harm the patient, how often is it reported to management?  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 4. When a dispensing mistake could have harmed the patient but is corrected before the medication leaves the pharmacy, how often is it reported to a supervisor?  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 5. When a dispensing mistake that has no potential to harm the patient is corrected before the medication leaves the pharmacy, how often is it reported to a supervisor?  | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, in your own words, what is this item saying?

What are some possible examples?

What staff in the pharmacy would know about this type of mistake? (How would they know?)

For Q2, what would be examples of this type of problem?

Again, who in the pharmacy would know about this and be able to answer the survey question?

For Q3, in your opinion, how does this situation differ from that in item 2?

What are some examples of this type of situation?

Who in the pharmacy would know about these types of mistakes?

For Q4, How did you come up with your answer to this question?

What kinds of mistakes were you thinking about?

What supervisor were you thinking about?

Is this question easy or hard to answer? (Tell me more)

(Who in the pharmacy would know about this type of mistake and how often it happens?)

For Q5, In your own words, what is this question asking? (note if they are thinking about common mistakes, not mistakes that reach the patient)

(What mistakes were you thinking about?)

Again, for this question, what supervisor were you thinking about?**19. Overall Perceptions of Patient Safety**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **How much do you agree or disagree with the following statements?****Think about this pharmacy when answering:** | **StronglyDisagree**⯆ | **Disagree**⯆ | **Neither****Agree nor Disagree⯆** | **Agree**⯆ | **StronglyAgree**⯆ | **Does Not Apply or Don’t** **Know**⯆ |
| 1. We have problems with dispensing accuracy in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. We need to do a better job of preventing common mistakes in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. Filling prescriptions too quickly leads to dispensing mistakes in this pharmacy
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. In this pharmacy, all staff are on the alert for possible patient safety problems
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. This pharmacy dispenses too many prescriptions to ensure patient safety.
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |
| 1. In this pharmacy, staff members are valued as equal partners in improving patient safety
 | 🞎1 | 🞎2 | 🞎3 | 🞎4 | 🞎5 | 🞎99 |

**Probes**

For Q1, What problems were you thinking about?

Tell me more about your answer.

For Q2, In your own words, what is this item saying?

Why did you answer\_\_\_\_\_\_\_\_\_\_\_\_?

For Q3, Please say more about your answer.

(What types of mistakes is R thinking about?)

For Q4, In your own words, what is this item saying?

 You answered \_\_\_\_\_\_\_\_\_\_\_\_\_\_. Tell me more about that.

IF A/SA: What is an example of staff being on the alert?

For Q5, in your own words, what is this item saying?

Tell me more about our answer.

For Q6, tell me more about your answer.

(check for examples)**20. Overall Rating on Patient Safety**

**How do you rate this pharmacy on patient safety? Think back on the survey topics and the definition of patient safety—dispensing the right medication accurately and making sure patients understand their medications and how to use them.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Poor**▼ | **Fair**▼ | **Good**▼ | **Very good**▼ | **Excellent**▼ |
|  🞎1 |  🞎2 |  🞎3 |  🞎4 |  🞎5 |

**Probes**

For this rating question, how did you decide on your answer – what were you thinking about?

Do you think the question captures what staff in your pharmacy should think about when they rate this pharmacy on patient safety? IF NO, how would you suggest we revise the rating question?

How hard or easy was it to answer this rating question?**21. Background Questions**

**1. How long have you worked in this pharmacy?**

|  |  |
| --- | --- |
| 🞎a. Less than 6 months | 🞎d. 3 years to less than 6 years |
| 🞎b. 6 months to less than 1 year | 🞎e. 6 years to less than 12 years |
| 🞎c. 1 year to less than 3 years | 🞎f. 12 years or more |

**2. Typically, how many hours per week do you work in this pharmacy?**

|  |  |
| --- | --- |
| 🞎a. 1 to 16 hours per week |  |
| 🞎b. 17 to 31 hours per week |  |
| 🞎c. 32 to 40 hours per week🞎d. 41 or more hours per week |  |

**3. What is your position in this pharmacy? Check ONE category that best applies to your job.**

|  |
| --- |
| 🞎a. Pharmacist (including pharmacy manager, lead pharmacist, pharmacist-in-charge, staff pharmacist)  |
| 🞎b. Pharmacy technician (including lead technician and staff technician) |
| 🞎c. Pharmacy clerk |
| 🞎d. Pharmacy student intern/extern |
| 🞎e. None of the above (Please write your job title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**4. Are you working now as a temporary or floater staff member in this pharmacy?**

|  |
| --- |
| 🞎a. Yes |
| 🞎b. No |

1. **How long have you worked in a community/retail pharmacy setting?**

|  |  |
| --- | --- |
| 🞎a. Less than 1 year | 🞎d. 10 years to less than 15 years |
| 🞎b. 1 year to less than 5 years | 🞎e. 15 years to less than 20 years  |
| 🞎c. 5 years to less than 10 years | 🞎f. 20 years or more |
| **Probe**How hard or easy was it to answer the background questions? |

**22. Your Comments**

**Please feel free to write any comments about how things are done in your pharmacy that affect patient safety.**

**Closing Probes**

That’s all of my questions for today. Do you have any additional comments about the items we talked about?

Any suggestions for improving them?

Thank you again for helping us out today.

**TURN OFF RECORDER**

To show our appreciation for your time and help, we will send you a check for $100. Please [confirm/tell me] your mailing address: