Standards of Practice

Continuous Quality Assurance Programs in Community Pharmacies

Introduction

Given community pharmacy's key role in the medication management segment of the health care process, an effective continuous quality improvement (CQI) process for community pharmacies that is both proactive and responsive, and that enables enhancement of the safety culture of the pharmacy as well as its practices, can be expected to have a substantial impact on patient safety.

Recognizing the importance of continuous quality improvement (CQI) in enabling pharmacies to provide optimal patient care, the Practice Regulations to the Pharmacy Act includes a requirement for pharmacies in Nova Scotia to establish and maintain a continuing, documented quality assurance program.

In consideration of the existing evidence on best practice in the area of CQI, including the results from the SafetyNET project, the NSCP has identified the required components of an effective quality assurance program, and community pharmacies in Nova Scotia will be assessed for compliance with the Practice Regulations against this standard. While it is recommended that each pharmacy identifies a staff member who will act as a quality assurance (QA) coordinator and oversee the undertaking of the activities described in these standards, it is the responsibility of the pharmacy manager to ensure that the pharmacy develops, maintains and enforces policies and procedures to comply with these standards of practice.

Purpose

To provide a standard for an effective CQI process for community pharmacies that ensures pharmacies engage in active enhancement of the safety and quality of their professional services and practices both on a regular, ongoing basis as well as in response to quality related events (QREs). QREs include known, alleged or suspected medication errors that reach the patient as well as those that are intercepted prior to dispensing.

Standard

A CQI process that fulfills a pharmacy's legislated requirements as set out in the Practice Regulations achieves the following:

1) Monitors staff performance, equipment, facilities and adherence to standards of practice.
2) Manages known, alleged and suspected medication errors that reach the patient consistent with the best practices for this activity undertaken by others in the profession, including:
    i. Taking appropriate and necessary action to optimize patient care, including prompt consultation with the patient's other health care provider(s) for determination of appropriate action to minimize negative impact on the patient.
    ii. Ensuring the management of error process is appropriately communicated to the patient.
    iii. Ensuring the management of error minimizes undue stress and frustration for the patient.

iv.   Ensuring the management of error should include an apology (as enabled by the *Apology Act*) in which the pharmacist acknowledges the negative impact to the patient, and commits to taking the steps appropriate to minimize the likelihood of recurrence of the incident.

v.   Promptly analyzing the error for causal factors.

vi.   Communicating to the patient the causal factors of the error when appropriate, and actions taken to reduce the likelihood of recurrence.

vii.   Documenting the details of the known, alleged or suspected error or discrepancy promptly and thoroughly, including statements from all pharmacy staff involved and the steps taken to resolve the problem.

viii.   Communicating to all pharmacy staff the appropriate details of the error, including the causal factors of the error and actions taken to reduce the likelihood of recurrence.

3) Enables and requires anonymous reporting of quality related events (QREs) to an independent, objective third party organization for population of a national aggregate database from which learnings arising from trends and patterns can be communicated across the profession.

(NOTE: QREs include errors that reach the patient as well as those that are intercepted prior to dispensing. The extent to which intercepted errors are reported will be a professional judgment decision of the pharmacy manager in consideration of the nature of the intercepted error, its implication for patient safety and the extent to which it is recurring).

4) Encourages open dialogue on QREs between pharmacy staff and management through quarterly review of the pharmacy's aggregate QRE data (e.g. total number of incidents, type of incidents, etc.).
5) Documents quality improvements made as a result of the quarterly CQI meetings of staff.
6) Requires completion of a medication safety self-assessment annually, and monitoring the progress of the resulting enhancement plan at quarterly CQI meetings.
7) Includes provisions to protect the confidentiality of information relating to specific patients.
8) Achieves the purposes of an effective CQI program as described at the beginning of this document through ongoing education of pharmacy staff on the current best practices in QRE management and adoption of these practices, with the goal of discouraging punitive identification or other approaches that are detrimental to reporting and learning.

References

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Resources

The information about the following *Institute for Safe Medication Practices Canada* (ISMP) tools is being provided as a reference for pharmacists and pharmacies desiring assistance in identifying resources to assist them in achieving compliance with the NSCP *Standards of Practice for Continuous Quality Assurance Programs in Community Pharmacies,* specifically standards # 3 and # 6.

Standard # 3:
Community Pharmacy Incident Reporting (CPhIR) Program

Medication incidents are often under-reported. CPhIR will provide community pharmacies with the ability to document, anonymously report and analyze contributing factors (e.g. miscommunication, staffing, and education) that can cause errors in the medication-use system. From the data reported and through understanding of the contributing factors, the pharmacy team can develop and implement system-based strategies for quality improvement and prevent potential errors from occurring again in the future.

Link: http://www.cphir.ca
Cost: http://www.ismp-canada.org/products/
   o $325 (annual rate)

(Pharmacies can test using CPhIR by accessing the CPhIR Training Site at http://www.cphir.ca/training. Login with the username = testuser and password = testuser. There is also a Training Centre (see top menu bar after login) with a self-directed video clip on how to use CPhIR)

 Standard # 6

Medication Safety Self-Assessment® for Community/Ambulatory Pharmacy (MSSA-CAP)

The Institute for Safe Medication Practices Canada (ISMP Canada) MSSA-CAP is designed to:
   o   Heighten awareness of the distinguishing characteristics of a safe medication system in community pharmacy practice;
   o   Act as a quality improvement tool;
   o   Create a baseline of a pharmacy's efforts to enhance the safety of medication use and evaluate these efforts over time.

The self-assessment tool is divided into 10 key elements that most significantly influence safe medication use. Each key element is defined by one or more core distinguishing characteristics of a safe medication system. Representative self-assessment item are provided to help pharmacies evaluate the degree to which their practice meets each of the core distinguishing characteristics. For example, under the Key Element of Patient Information, there is one core distinguishing characteristic followed by 6 self-assessment item that represent practices that enhance medication system safety in that area. The pharmacy team completing this tool rates the level of implementation in the pharmacy for each self-assessment item.

Link: http://www.ismp-canada.org/amssa/
Cost: http://www.ismp-canada.org/products/
   o $35 for the document
   o $325 for the program (annual rate)

ISMP Canada Offer to Nova Scotia Pharmacies

ISMP is pleased to offer a combined rate of $550 per year for the first year of subscription to both MSSA and CPhIR. This is equivalent to a saving of 20% (or $135 saving from the original total of $685).