Nova Scotia
College of
Pharmacists

STANDARDS OF PRACTICE:
Continuous Quality Assurance Programs in Community Pharmacies

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Introduction

Given community pharmacy's key role in the medication management segment of the health care system, 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-Rx 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 section 22 of the *Pharmacy Practice Regulations* includes the following:

1. Monitors and documents staff performance, adequacy of staffing levels, 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 process of error management is appropriately communicated to the patient.
    iii. Ensuring the management of an error minimizes undue stress and frustration for the patient.
    iv. Ensuring the management of error includes 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. Requires reporting of quality related events (QREs)[1] to a database that contributes to the Canadian Medication Incident Reporting and Prevention System (CMIRPS) National Incident Data Repository for Community Pharmacies, and enables this reporting to be anonymous.[2,3]

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 quarterly CQI meetings with 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.

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[1] Quality Related Events (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.

[2] Enabling anonymous reporting means that the pharmacy must have a process by which practitioners have the ability to report all QREs anonymously (no identifying information about the patient, reporter, or individual staff member(s) involved is collected) and that this process is as equally promoted and supported as the in-house reporting system.

[3] Any data that is transmitted to the CMIRPS National Incident Data Repository for Community Pharmacies must be anonymized so that no identifying information about the patient, reporter, or individual staff member(s) involved in the QRE is transmitted.

References

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