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Continuous Quality Assurance Programs in Pharmacies

Recent studies on the prevalence of medication errors have brought increased attention to continuous quality improvement (CQI) in healthcare in North America. These reports have identified the need for increased efforts to create a safer healthcare delivery system.[1]

In 2015, as part of its commitment to CQI, the College introduced enhancements to the long-standing pharmacy inspection process. Now referred to as practice assessments, the new process is designed to increase adherence to both pharmacy operational and individual practice standards. In an ongoing effort to improve patient safety, community pharmacies are required to implement a mandatory standardized continuous quality assurance program that enables enhancement of the safety culture of pharmacies.

Continuous quality improvement (CQI) involves an ongoing and systematic examination of an organization's work processes to identify and address the root causes of quality issues and implement corresponding changes.[2] Effective CQI programs involve implementation of quality improvements as a result of both proactive review of work processes to identify areas of risk and retrospective review of specific medication incidents. The objective of CQI is to ensure that all practitioners learn from medication incidents and review and enhance their policies and procedures to reduce the chances of recurrence, thereby improving patient safety.

According to the Standards of Practice, all pharmacists and pharmacy technicians have the responsibility and obligation to manage medication incidents and address unsafe practices. This includes documenting and communicating all medication incidents and near misses with the rest of the staff in the pharmacy, and as appropriate to the patient and other health care providers if the incident reaches the patient. It is the responsibility of the Designated Manager (DM) to ensure that there is an appropriate mechanism in place for this to occur, and that learnings are continuously being documented, identified and applied to improve processes within the pharmacy.

To achieve safer care for patients, CQI must focus on both systemic improvements and the tasks that individual practitioners perform. The CQI model supports shared accountability; it holds pharmacies accountable for the systems they design and for how they respond to staff behaviours fairly and justly. It holds pharmacy professionals accountable for the quality of their choices and for reporting both their errors and system vulnerabilities. To enable a culture that supports learning and accountability over blame and punishment, individuals must be comfortable to discuss medication incidents without fear of punitive outcomes.

A critical element in safe medication practices is the sharing of lessons learned from medication incidents through medication error and near miss reporting, to support sustainable changes in practise. Using the lessons learned from both medication incidents and near misses enables continuous process improvements to minimize errors and maximize health outcomes to improve the quality of care provided in pharmacies.

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[1] A Systemic Review of Medication Errors. International Journal of Drug Development and Research (2015). Retrieved on January 31, 2016 from http://www.ijddr.in/drug-development/a-systematic-review-on-medication-errors.php?aid=7947

[2] Boyle TA, Bishop AC, Duggan K, Reid C, Mahaffey T, MacKinnon NJ, et al. Keeping the "continuous" in continuous quality improvement: Exploring perceived outcomes of CQI program use in community pharmacy. *Res Social Adm Pharm* 2014 Jan-Feb; 10(1): 45-57.

The required components of an effective standardized quality assurance program for pharmacies addresses both medication errors that reach the patient as well as near misses that are intercepted prior to dispensing, and must achieve all of the following four elements:

Report

- Enable and require *anonymous* reporting of all medication incidents by pharmacy professionals to a specified independent, objective third-party organization for population of an aggregate incident database to identify issues and trends to support patient safety improvement.

Document

- Require pharmacy professionals to document appropriate details of medication incidents and near misses in a timely manner to support the accurateness of information reported.
- Document CQI plans and outcomes of staff communications and quality improvements implemented.

Analyze

- Necessitate that when a medication incident occurs pharmacy professionals analyze the error in a timely manner for causal factors and commit to taking appropriate steps to minimize the likelihood of recurrence of the incident.
- Require completion of a medication safety self-assessment (MSSA) within the first year of implementation of the Standard, then at least every 2-3 years. The Designated Manager may determine an MSSA is required more frequently if a significant change occurs in the pharmacy.
- Analyze individual and aggregate data to inform the development of quality improvement initiatives.

Share Learning

- Require prompt communication of appropriate details of a medication incident to all pharmacy staff, including causal factors of the error and actions taken to reduce the likelihood of recurrence.
- Ensure the scheduling of regular CQI communication with pharmacy staff to educate pharmacy team members on medication safety, encourage open dialogue on medication incidents, complete an MSSA, and develop and monitor quality improvement plans.
- Support the development and monitoring of CQI plans, outcomes of CQI communications and quality improvements implemented.