"Part 2: Medication Error Prevention Update"

April 2013

This is our biannual lesson on "Medication Errors." It's been divided into two portions. This is Part 2, and we review techniques & considerations for lessening medication errors. We build on the principles discussed in Part 1. This lesson provides 1.5 hours (0.15 CEUs) of credit, and is intended for pharmacists in all practice settings.

The objectives of this lesson are such that upon completion the participant will be able to:

1. Describe the problems presented by the culture of punishment as a response to medication errors.
2. Discuss the lessons that can be learned from recent cases associated with medication errors in pharmacy.
3. List the requirements of a Continuous Quality Improvement program.
4. Explain steps that can be taken to comply with a board of pharmacy CQI program.

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To obtain continuing education credit for this lesson, you must answer the questions on the quiz (70% correct required), and return the quiz. Should you score less than 70%, you will be asked to repeat the quiz. Computerized records are maintained for each participant.

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Review

In the previous lesson we discussed the outdated culture of punishment, and developed the contemporary model of error prevention which is based on "fix the system; learn from previous events; develop procedures to minimize errors."

As we continue, suggested techniques are presented that can assist in minimizing errors. This lesson builds on the principles discussed in Part 1.

All pharmacy CQI programs should be different, because all pharmacy practices differ to some degree. There is no single "right way" to practice pharmacy, so there is no single "right way" to conduct a pharmacy CQI program. Every pharmacy's P&P manual should be unique; every CQI program should function differently; and every CQI meeting should be conducted in a new and different way so it can lead it to a higher level of success than the meeting before it. Given the basic premise that there is no "generic" program of pharmacy CQI, the recommendations in this lesson are intended to illustrate one possible way to comply with a State's pharmacy CQI rule, such as in Florida. Even within this general template there is room for considerable individual variation based on the unique characteristics of each pharmacy practice site.

Step 1: Select a Quality Team Leader

Every pharmacy should have one person who steps forward and proudly claims to be the single person who is ultimately responsible for the quality of pharmacy practice at that pharmacy. The buck stops with that person. On a day-to-day basis, everyone is responsible for what is done on that day, but the overall responsibility for system design and operation must reside with a single person. Pharmacists, pharmacy technicians, and clerical support staff all must do the best job they can under the circumstances. However, in a pharmacy that has no central person who organizes quality activities, the good efforts of many suffer due to the less-than-good efforts of a few. The quality team leader is responsible for assuring that the system is as good as it can be and that the system is adhered to by pharmacy personnel.

The most logical choice for quality team leader is the prescription department manager or the consultant of record. This is the person who ultimately will be responsible to the Board of Pharmacy for compliance by the pharmacy with the CQI rule requirements. Yet, just as the prescription department manager or the consultant of record may delegate the responsibility to perform other necessary activities within the pharmacy, so may that person delegate the responsibility to oversee the CQI program. There may be a person in the pharmacy who is far better qualified in CQI than the prescription department manager or the consultant of record. It may be that a hospital chain or a community pharmacy chain has a specialist in pharmacy CQI who is the logical choice to take responsibility for meeting the CQI rule requirements, or for exceeding those requirements. Or perhaps an outside consultant best fits this role for a single hospital or pharmacy.

The quality team leader should either have training in CQI or be prepared to undertake self-training in CQI. This is not a burdensome project. There are many excellent live and correspondence continuing education programs that can bring even the novice at CQI up to speed quickly. The role of the quality team leader is not to have all the right answers, but to ask all the right questions. Sometimes the most important question to ask is "Why are we doing it this way?" This is not a technically complex question, but it can result in a series of complex answers that help identify problems and solutions. Learning how to ask good questions and to lead a

discussion of the responses to these questions is really only a matter of taking the time to read two or three critical books that describe the basic processes of error detection and prevention.

The level of participation by management in CQI programs is an open question that should be resolved by each individual pharmacy. In pharmacies that have already established a culture of trust and respect, personnel will have no problems with active management participation in CQI. In other pharmacies, where the blame and shame tradition must be overcome, it might be wise to have minimal management participation at first, with the goal of growth toward full integration of all personnel, including management, into the CQI activities. The responsibility for conduct of CQI is a management responsibility, but the Florida CQI rule does not require that management do CQI for pharmacy personnel. In fact, the spirit of the rule contradicts CQI being done for pharmacy personnel by management and supports this activity as a shared exercise, done by management with pharmacy personnel.

Step 2: Define "Quality-Related Event

In Florida, and other states, the pharmacy CQI rule describes what "Quality-Related Event" must include, but it also specifies that a pharmacy need not limit itself to that definition of QRE. Each pharmacy should decide what definition makes sense based on its own individual needs. For example, a busy pharmacy may receive a telephoned prescription for a patient and then "lose" that prescription. Perhaps this is not the type of problem that is traditionally viewed as an error, but the consequences of this problem adversely affect the quality of drug therapy nonetheless. The patient who requests this prescribed medication will not be able to receive it and use it if the prescriber cannot be located to provide information about the prescription that was previously telephoned to the pharmacy but cannot be found. One pharmacy may prefer to classify this event as a QRE, while another pharmacy would prefer not to. Neither pharmacy would be right or wrong. It is simply a matter of individual preference.

Examples of other "optional" QREs would be the failure to counsel the patient when appropriate, the misspelling of the patient's name, the unauthorized disclosure of confidential information or the refusal to dispense a seemingly suspicious prescription that turned out to be unquestionably valid. This is not a complete list, but it is illustrative of the types of problems that a pharmacy might wish to identify and solve. Each of these problems has the potential to adversely affect the quality of drug therapy. Each of them can lead to embarrassment and time-consuming discussions. The best approach is to avoid such problems. The way to do that is to incorporate them into the CQI process.

Step 3: Describe the Practice Process

Every pharmacy uses a process to dispense medications and provide professional services. Some processes are better defined and better organized than others, but every pharmacy has an identifiable process. It is impossible to improve a pharmacy practice process without knowing what one's practice process is. Defining a practice process makes it possible to standardize some of the more critical elements of pharmacy practice so that all personnel are on the same page as to what is being done. New and temporary pharmacists and pharmacy technicians can understand what is done and how by examining a written description (preferably a diagram or flow chart) of the way pharmacy is practiced at a specific location.

Most pharmacies have "stations" or physical places where professional activities are done. These stations often correspond with a link in the chain of pharmacy practice. At each station there are many tasks performed by a pharmacist or technician prior to the order being

transferred to the next station. Each of these tasks presents an opportunity to succeed or fail. In evaluating a pharmacy practice system, it is absolutely necessary to know each task performed at each station, and to identify which task was performed at a suboptimal level, to know why the system did not function as it should. The worst thing that could happen would be the development of a CQI program that identified non-problems and introduced non-solutions into the practice system.

The exercise of describing the practice process is going to be done in as many different ways as there are pharmacies. Pharmacy personnel who sit down to begin drawing a picture of what they do and when, may be surprised to discover that not everyone agrees on who does what and where. This is a helpful exercise, because it can lead to the identification of problems that may have been unnoticed for a long period of time. In many pharmacies, the stations are identified as follows:

- Receiving the Prescription.
- Data Entry.
- Prospective Drug Use Review.
- Prescription Assembly.
- Final Check.
- Patient Counseling.
- Medication Delivery.

Within each of these stations (and the many others that pharmacies will identify within their practice process), there are specific tasks to perform. The activity of describing the practice process is not complete until consensus is achieved regarding the stations and tasks that comprise the practice of pharmacy at a practice site.

Step 4: Develop a QRE Recording System

It is impossible to know whether things are going well or poorly within a system unless the results of activities within the system are recorded consistently. Pharmacists pride themselves on the high rate of their success. One of the problems pharmacists have had is that they have been too reluctant to "beat their own drum" and show off the high quality of what they do. Pharmacists save lives as a matter of routine, when they correct inaccurately prescribed drug doses, and when they inform a patient's physician of the potentially interacting drug therapy being already prescribed by another physician. These are but two examples of the many, many successes in pharmacy practice that go unrecorded. As part of a CQI program, it might be a good thing to record the patient morbidity averted by alert pharmacists who consult with physicians before filling harmful prescriptions.

The primary measure of success in a pharmacy that complies with a CQI rule like Florida's is technical accuracy in order processing and the identification and management of potential problems with drug therapy. Boards of Pharmacy expect a very high level of success from pharmacies. The public expects a high level of success also. In fact, the public expects 100% success all of the time. When a rare error occurs in pharmacy, there is no point in referencing the many prescriptions that were filled correctly on that day. Nobody who receives an erroneous prescription from a pharmacist cares that everyone else received the correct medication, or

that others had potentially catastrophic prescribing errors corrected by the pharmacist. Any error by a pharmacist is a Quality-Related Event, and all QREs must be documented so they can be prevented from happening again.

The data generated through documentation should be maintained in the pharmacy, available to the quality team leader, for use in CQI committee meetings. Either a written record or a computer database may be used for this purpose. Development of a spreadsheet, using one of any number of available off-the-shelf programs is strongly advised. Electronic spreadsheets facilitate the presentation of information to observers in an organized fashion. Under the Florida Board of Pharmacy rule, these data need not be retained after they have been used for CQI purposes and a summarization document has been created.

Step 5: Train Pharmacy Staff in CQI

Pharmacy CQI is not "just common sense." It is a methodic approach to addressing and resolving potential problems. Many American industries have succeeded with CQI or have failed without it. Some staff may resist the implementation of a CQI program saying something like "We're too busy misfilling prescriptions to take the time needed to get it right." These initial resisters will often become the most enthusiastic advocates of the program once they understand it. But understanding may come only with concerted effort.

The Quality Team Leader will have to set aside some time to explain the basics of CQI, the specific process that has been selected for the pharmacy, and the steps necessary for compliance with the process. Homework is a necessary component of this educational exercise. Pharmacy personnel must be asked to "read up" on the program prior to their attendance at an initial educational session. Alternatively, there are Internet websites that include very valuable information about pharmacy CQI, and these may be useful to pharmacy personnel who handle a computer with ease.

To assure success of training, an assessment should be administered to personnel to evaluate the level of understanding of the program. Deficiencies in understanding can be addressed by additional one-on-one advice or counseling.

CQI training never ends. Some of the best CQI training is done on-the-job by the Quality Team Leader who stops by to give a hand and shows just how to do a particularly problematic task. Many pharmacists and technicians learn by doing, and they will particularly value being shown how a task is done in a way that is sensitive to quality improvement factors.

Step 6: Conduct Continuous Quality Improvement Meetings As Needed

CQI meetings need not be long, but they must be conducted at least once every three months. This meeting is the most important, and the most difficult of all the challenges to be faced by the Quality Team Leader. It should be done with great care and concern. The following meeting agenda may be helpful in the conduct of a CQI meeting, although there are many good ways for such a meeting to be run.

Setting the Tone

The very first thing the Quality Team Leader should do is to take control of the situation and establish the serious nature of it. This is not the time for jokes or sarcasm. People who feel that quality is a joke should be invited to explain this feeling to management. These are the salient features of the meeting:

- This is a professional meeting to improve outcomes for patients.
- The focus of this meeting is on the future, and not on the past.
- Everything said at this meeting is to be held in the strictest confidence; there should be no fear of management reprisal as the result of any comments.
- My job is to help you and not punish you. I don't have all of the answers, but I can probably ask some pretty good questions.

Reviewing Facts about Events

Until it is established precisely what happened regarding an error, it is impossible to diagnose what systematic problem may have led to the error. The Quality Team Leader should ask:

- Was the prescription telephoned to the pharmacy, or was it transmitted in writing (paper, fax, or computer)?
- Was the prescription a new prescription or a refill prescription?
- Was the prescription prepared for a person who chose to wait for it, or was it prepared for the "will call" or delivery area?
- Was the prescription prepared for the patient or for the caregiver of the patient?

Reviewing Facts about Environment

The event itself may not be the most relevant factor in determining the cause of an error. It may be that environmental factors significantly contributed to a failure of quality, and only by asking the right questions about the environment will the background problems be identified. The following questions are relevant:

- How many prescriptions were filled on the day the incident occurred?
- How many pharmacists/techs/clerks were working on that day?
- Is it documented that DUR was being done consistently on that day?
- Is it documented that patient counseling was being done consistently on that day?
- Was there anything "special" or unusual about that day?

Staffing Issues

General impressions of the staffing at a pharmacy can lead to conclusions about personnel issues and their possible contribution to error. Important questions to ask include:

- Are the supportive staff hours scheduled properly to efficiently handle peaks in prescription volume?
- Do the pharmacists' schedules provide for sufficient overlap on peak volume days?
- Are all personnel properly trained, especially with regard to pharmacy safety program guidelines?

Workflow Issues

A pharmacy may be able to trace its problems not to workload but to workflow. Pharmacy safety programs are designed to promote a smooth workflow, with defined responsibilities and cooperation between pharmacists, pharmacy technicians and clerical support staff. In evaluating the workflow, ask the following questions:

- Is the primary pharmacy work area or counter organized for accuracy; is it neat and clean?
- Is the pharmacy following a standard workflow, organized into the designated stations?
- Are waiting and will call prescriptions appropriately separated?
- Are stock bottles shelved neatly, with look-alike and sound-alike drugs placed in separate places on the shelves to avoid confusion?

Communication Issues

Most failures of quality in pharmacy are attributable at least in part to problems with communication. In evaluating the cause of errors, pay particular attention to those factors that threaten accuracy in communication. Consider asking these questions:

- Are key data entry and prescription assembly personnel physically separated from people who might interrupt them with distracting questions?
- Are pharmacists evaluating DUR computer edits when a technician detects a significant potential problem?
- Is the telephone equipment of sufficient quality to enable personnel to hear well the voice of those who call the pharmacy?
- Is the IVR equipment of sufficient quality to enable personnel to hear well the messages left for the pharmacist?
- Are procedures being followed to assure that all medicines going into a bag are intended for that patient?
- Are personnel repeating the name of the patient and the name of the physician to the person who picks up prescriptions at the will-call area?

Toward Solutions

Identifying threats to quality based on a record of past errors is half the battle in a pharmacy safety program. Discerning those changes that can be made to reduce the incidence of problems is the follow-through piece that brings it all together. To look forward toward a future pharmacy practice that has eliminated as many problems of the past as is possible, the following questions are useful:

- How will we know that our problems with quality have been solved?
- What are the possible solutions to our problems with quality?
- Of the suggested possible solutions to our problems, which solution is the best and why?

- How will we implement our chosen solution?
- Whose responsibility is it to determine whether our chosen solution has been successful?

Step 7: Implement Changes and Evaluate Results

Sometimes a CQI meeting will conclude that no changes need to be made. This would be an unusual conclusion. In a busy pharmacy, there is always room for improvement. A pharmacy that has had no documented QREs in three months' time is not taking the program seriously. As counterintuitive as it may initially seem, the healthy pharmacy is the pharmacy that has a lot of documented QREs. Each QRE report is an opportunity to learn. The pharmacy that does not document QREs has lost the opportunity to learn and has seriously impaired the ability to improve the quality of pharmacy practice.

A likely conclusion of a CQI meeting is that system changes are unnecessary, and that existing policies are adequate, but that personnel need to recommit to existing policies. There is always a tendency to backslide on even the most sensible and valuable policies. For example, pharmacists and technicians may find it challenging to organize their practices into stations, or to repeat the orders verbally given by physicians, or to call out to patients the names of their physicians when they pick up medication. The value of these measures, having been established through consensus of the group, may need to be repeated on a regular basis.

Sometimes a CQI committee will conclude that fundamental changes in the system must be made. These changes may reflect a specific QRE or cluster of similar QREs. Alternatively the changes may be the result of concerns that a weak link in the practice process has been identified and must be strengthened. While well-intentioned people working together to improve the quality of pharmacy practice usually develop productive suggestions for change, this is not always the case. Some changes may be non-productive, and some may actually be counter-productive. **To determine whether a change has been effective, without having unintended adverse consequences, the Quality Team Leader will have to conduct periodic audits**.

The purpose of audits is to create a longitudinal record of success or failure over time. Auditing the accuracy of prescriptions in the will-call area is one way to do this. Conducting a partner audit at the end of each shift is another way. In partner audit, a technician or pharmacist reviews the front and back of each new prescription to make sure that the computer information matches what has been prescribed. Pharmacist final check audits are another way to discern whether changes are effective. Simply recording the discrepancies when a pharmacist checks an order can lead to a significant conclusion about the effectiveness of a newly implemented program.

PATIENT SAFETY
The Value of CQI

Once established, a CQI program will begin producing good results for pharmacies and patients. Effective CQI reduces pharmacy errors and it promotes beneficial therapeutic outcomes for patients. Because it is a mandatory component in many states, including Florida, CQI is an element of the inspections made of pharmacies in these states by professionals whose job is to assure that the public is being adequately protected. Trial lawyers will also be interested in knowing whether a CQI program existed and was being meaningfully operated, following a tragic dispensing error that has led to patient harm. The point of these oversight activities by both the Board of Pharmacy and the trials lawyers is to try to determine whether a pharmacy

where an error occurred was doing its best to prevent errors, or whether the pharmacy was making no real effort to prevent errors. A pharmacy that has tried hard to prevent errors, but has experienced an unfortunate and inevitable failure of quality, will be relatively forgiven for the regrettable, but unpreventable, consequences. Another pharmacy that has not tried to prevent errors will be less likely to be forgiven for its similar errors that will be viewed as preventable. It is the effort that counts, not the result.

Pharmacy is a pervasively regulated profession, because patients place their lives in the hands of pharmacists and pharmacy owners. Pharmacy regulation is an important component of the profession, because without it there could be a "race to the bottom" led by unscrupulous people whose goal is to generate huge profits without providing sufficient value for what is being paid. Patients would have no choice but to accept such erosion in practice standards, because they can only go to pharmacies to receive pharmaceutical products and services. In exchange for the monopoly over pharmacy practice that is granted to pharmacists by the public, pharmacists agree to be inspected on a regular basis to assure that practice standards are being met. Most pharmacists and pharmacy owners recognize the important role of inspection and regulation, because the oversight provided by inspectors and regulators assures an even playing field among competitors.

A pharmacy's best evidence of compliance with the CQI rule in a state like Florida will be a policy and procedures manual that shows an individualized CQI program for that pharmacy. A generic book that is the same or similar to the book being used by hundreds or thousands of other pharmacies, really is not a policy and procedures manual. It may be a very valuable resource on how to construct a CQI program, and it may contain useful information for inclusion within a policy and procedures manual, but unless the book incorporates the unique characteristics of the individual pharmacy, it is not a policy and procedures manual.

Showing compliance will also require evidence that the established CQI program is actually in operation. The best evidence to show serious operation of a program is the Summarization of Quality-Related Events document mandated by the Board of Pharmacy. A standard form should be created, based on each individual pharmacy's unique needs, to analyze remedial measures undertaken following QREs. These forms must be retained for at least two years at the pharmacy. Along with an individualized and carefully crafted policy and procedures manual, complete and seriously executed summarization documents provide convincing evidence that the pharmacy is not making a game of CQI but instead is trying hard to reflect on the past and improve in the future. Evaluators cannot reasonably ask that pharmacies prevent all errors, but they can reasonably ask that pharmacies try their hardest to prevent errors.

Individual Participation in Quality Improvement

Dr. Tony Grasha, who studied pharmacy error extensively, was fond of saying "you can put a good pharmacist into a bad pharmacy system, and the system will win every time." His point was to emphasize the role of systems in error creation and in error prevention, as well as the futility of aspirations for success by pharmacists who are encumbered by formidable system barriers. Yet he did not mean that pharmacists are powerless victims of systems that create impossible expectations. In fact, he stressed that the pharmacist is a critical component of the pharmacy system, and that each individual pharmacist must play a productive role within the system. A system cannot function effectively to recognize and prevent errors unless the pharmacists in the system are doing their part to promote error recognition and prevention.

To fully participate in the quality improvement activities of a pharmacy practice site,

it may be appropriate for pharmacists arriving on duty to conduct a brief check of systems, similar to what is done by flight crews in commercial aviation. The questions to ask will vary from pharmacist to pharmacist and from practice site to practice site. Here are some examples of the types of checks that could be productive for a pharmacist whose goal is to maximize quality during a pharmacy practice shift.

Personal Checks

- Am I feeling physically and mentally well today?
- Do I possess sufficient knowledge of the drug therapies used at this practice site?
- Do I have the skills necessary to perform the tasks required at this practice site?
- Am I able to free myself of personal distractions today?
- Do I have available the reference materials I need?

System Checks

- Are the policies and procedures for this practice site clearly established?
- Does this practice site have the necessary equipment for pharmacy practice?
- Are the drugs and supplies at this practice site sufficient to meet patient needs?
- Is the physical layout of the practice site uncluttered and organized in a logical flow?
- Is the practice site free of unnecessary distractions?

Communication Checks

- Is there adequate technology to communicate effectively with prescribers and patients?
- Will the counseling area allow for complete and private patient education?
- Are there adequate written materials to use in patient education?
- Am I able to contact trusted colleagues if I need assistance or advice?

Personnel Checks

- Do I have sufficient supportive personnel to assist me?
- Are the pharmacy technicians well-trained and experienced?
- Do the support personnel have a sense of responsibility for their actions?
- Can support personnel appreciate the limits of their role?
- Is there a professional environment that stresses the importance of teamwork?
- Will support personnel ask questions without worrying about looking "stupid"?

Management Checks

- Has management created a culture of quality at this practice site?
- Is there a clear understanding of who is in charge of the pharmacy?

- Do I know to whom I answer in the chain of command today?
- Is management available to me if I have questions or comments today?
- Do I feel that I have the necessary support of management to succeed today?

This is not intended as an exhaustive, or even exemplary, list of what any individual pharmacist should or may include in a checklist. The idea is that no pharmacist should practice at a time when the pharmacist is not fully up to the challenge of patient care, and no pharmacy practice site should fail to provide the pharmacist with the support necessary to prevent errors. Whether to use a checklist, what questions to ask in the checklist, how to evaluate the answers to the questions in the checklist, and when to decide that the day, time, place, and person don't check out as adequate for success in the pharmacy, are issues to be addressed individually by each pharmacist. Just as the captain of a commercial airliner may determine that a scheduled flight cannot safely operate, much to the inconvenience and even anger of passengers, a pharmacist may decide that a pharmacy practice site cannot function safely until specifically identified deficiencies have been corrected.

Conclusion

Patient safety is a shared responsibility. Those who build, equip, and manage pharmacy practice sites, those who work within them, those who regulate them, and those who educate pharmacists and other pharmacy staff, all must rise to the occasion and do their best to reduce the occurrence of errors. This can be done within the framework of continuous quality improvement. While pharmacy practice cannot be free of error, because humans are imperfect, pharmacy can constantly enhance its performance by learning from the past and improving in the future.

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LESSON EVALUATION

Please fill out this section as a means of evaluating this lesson. The information will aid us in improving future efforts. Either circle the appropriate evaluation answer, or rate the item from 1 to 7 (1 is the lowest rating; 7 is the highest).

1. Does the program meet the learning objectives?

Describe the culture of punishment as a response to drug errors	YES	NO
Discuss the lessons that can be learned from recent drug errors cases	YES	NO
List requirements of a CGI Program	YES	NO
Explain steps that can be taken to comply with a board approved CQI program	YES	NO

2. Was the program independent & non-commercial YES NO

	Poor			Average			Excellent
3. Relevance of topic	1	2	3	4	5	6	7

4. What did you like most about this lesson?_____
5. What did you like least about this lesson?_____

Please Mark the Correct Answer(s)

1. **What is a "Quality Team Leader?"**
   A. Person responsible for morale & goodwill in the pharmacy
   B. Person responsible for ordering controlled substances
   C. Person who provides patient counseling
   D. Person responsible for quality of pharmacy prac tice in the pharmacy

2. **2. The Quality Team Leader's main job is:**
   A. Report CQEs to board of pharmacy
   B. Have all the correct answers
   C. Punish pharmacy staff who make errors
   D. Ask the correct questions

3. **The "Practice Process" document:**
   A. Describes how pharmacy is practiced in your location
   B. Specifically describes how controlled substances are maintained
   C. Provides language regarding punitive approaches to errors made
   D. All of these

4. **What is true regarding CQI?**
   A. It's all common sense
   B. Training is responsibility of Quality Team Leader
   C. Success of CQI is directly proportionate to training
   D. Assessments of staff are necessary
   E. B, C &D

5. **Pharmacy CQI is "just common sense"**
   A. True B. False

6. **In a state like Florida, how long must a Summarization of Quality Related Events be maintained?**
   A. 1 year
   B. 2 years
   C. 3 years
   D. 5 years

7. **A good first step in the development of a CQI program is to select a quality team leader.**
   A. True B. False

8. **Records maintained as a component of a CQI program should be considered confidential.**
   A. True B. False

9. **What should be the stated purpose of the CQI team meeting?**
   A. To blame prescribers for their errors
   B. To blame pharmacists for their errors
   C. To blame pharmacy technicians for their errors
   D. To improve patient care

10. **What checks must a pharmacist want to conduct if his/her goal is to maximize quality during a pharmacy practice shift?**
    A. Personal Checks
    B. Process Checks
    C. Communication Checks
    D. All of these

Contributing Author
David D. Brushwood, RPh, JD
Professor, Healthcare Administration
University of Florida College of Pharmacy
Gainesville, FL

Executive Editor
William J. Feinberg,
BS Pharm, MBA

Fax 847-945-5037

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