



# Implementing the WPQC Quality-Based Best Practices

by





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## General Requirements for WPQC Pharmacy Accreditation

### Accredited pharmacies are expected to:

- Have policies and procedures in place for the WPQC quality-based best practices.
- Be active in providing care for beneficiaries of participating network payer(s).
- Complete software system documentation and billing training as applicable.
- Have a private or semi-private patient care area accessible for providing comprehensive medication review and assessment services.
- Engage in WPQC-related communication, and respond to WPQC evaluation and training requests as applicable.
- Have online and/or up-to-date hardcopy pharmacy information resources available.

## WPQC Quality-Based Best Practices

### Pharmacies are required to have policies and procedures in place for the following quality-based best practices:

1. Performance of a brief medication history on all new patients or patients who fill medications at multiple pharmacies
2. Consistent verification and documentation of allergies and adverse drug reactions.
3. Implementation of a procedure to check all pediatric prescriptions to ensure the prescribed dose is appropriate for age, weight, and condition
4. Implementation of a procedure to ensure the correct product is dispensed and that specific patient engagement strategies are utilized for every patient during consultation
5. Use of at least two unique identifiers for each new prescription order and upon consultation
6. Implementation of a continuous quality improvement (CQI) program for medication risk management
7. Establishment and maintenance of standards for communicating and executing Class I drug recalls and necessary actions pertaining to FDA drug safety alerts

## Quality-Based Best Practices Tools

Tools for each of the best practices can be accessed on the PSW website: [www.pswi.org/WPQC-Resources-and-Manuals](http://www.pswi.org/WPQC-Resources-and-Manuals)



# Implementing the WPQC Quality-Based Best Practices Medication History

Performance of a brief medication history on all new patients or patients who fill medications at multiple pharmacies

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To detect duplicate therapies, drug-drug interactions and/or other problems with prescription and non-prescription medications</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>How do we currently determine if a patient is new or uses multiple pharmacies?</li> <li>What information is important to obtain when gathering a brief medication history?</li> <li>Who performs the history and when do they do it?</li> <li>How do we ensure that the history is as complete as possible?</li> <li>How do we use the brief medication history after it is obtained?</li> <li>Do we document and store the brief histories we gather? Where?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Time</li> <li>Patient identification</li> <li>Patient resistance and lack of information</li> <li>Patient agent at pharmacy unaware of current medications</li> <li>Technician resistance</li> <li>Pharmacy layout and space</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Educate patients and technicians regarding purpose and importance of gathering brief medication histories</li> <li>Train technicians to identify new patients and patients who use multiple pharmacies</li> <li>Create a standardized intake form for technicians to use for all prescription orders. The form prompts the technician to ask if the patient is new or fills prescriptions elsewhere. Other sections on the form can be used for all patients to assess estimated pick-up time, changes to allergies, medications, billing information, or demographic information.</li> <li>Ask new patients to fill out a medication history form while their prescription is being processed and filled. Form should prompt for medications from all sources: prescriptions, OTCs, supplements, samples, medications from foreign sources, mail order, internet, and medications from friends or family.</li> <li>Pertinent information not known by the patient can be obtained from other pharmacies, prescribers, caregivers, or insurance companies</li> <li>Input medication history into computer record (if possible) to help with detecting drug interactions</li> <li>Technician flags the patient's prescriptions to remind the pharmacist to gather and utilize the brief medication history</li> <li>Use history form to assess prescription appropriateness during consultation</li> <li>Scan or store paper copy of medication history for future reference</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>Brief Medication History Form template</li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey</li> </ul>

# Implementing the WPQC Quality-Based Best Practices Allergies and ADRs

Consistent verification and documentation of allergies and adverse drug reactions (ADRs)

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To establish an ongoing process to collect, document and update patient allergy and adverse drug reaction information</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>How do we determine if patients have medication allergies or have had adverse drug reactions?</li> <li>Who determines this information?</li> <li>When and how frequently do we ask for this information?</li> <li>Where do we store this information?</li> <li>How are we making sure that we collect this information for all of our patients?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Time</li> <li>Inconsistency</li> <li>Inadequate documentation capabilities</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Post reminder signage to ask every patient about allergies at every patient encounter</li> <li>Technicians ask about allergies/ADRs every time a new prescription is dropped off (prompted by intake form)</li> <li>Inquire about specific reactions to medications</li> <li>Incorporate allergy assessment into every consultation</li> <li>Assess and document use of medications with cross-reactivity (e.g. reaction to cephalosporin by a patient allergic to penicillin)</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>Brief Medication History Form template</li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey (allergy data collection tool)</li> </ul>

# Implementing the WPQC Quality-Based Best Practices Pediatric Dose-Checking

Implementation of a procedure to check all pediatric prescriptions to ensure the prescribed dose is appropriate for age, weight, and condition

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To identify drug-related problems and standardize pediatric dose-checking</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>Do we verify the dose for every dose-dependent pediatric prescription?</li> <li>How do pharmacy staff flag pediatric prescriptions?</li> <li>When do we determine the patient’s weight (intake, consultation)?</li> <li>How do we obtain a child’s weight?</li> <li>What calculations/resources do we use to ensure correct dosing?</li> <li>How is a dose check documented?</li> <li>After contacting a prescriber, where do we document dose modifications?</li> <li>Do we notify the parent that the dose was checked and/or the doctor was contacted?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Time</li> <li>Difficult to obtain accurate and current weight</li> <li>Prescriber acceptance of suggested changes</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Post signage to remind staff to check pediatric dosing</li> <li>Educate staff to ask for weight and indication at prescription drop-off</li> <li>Train technicians/pharmacists to contact ordering provider on pediatric orders if no weight or indication is present at data entry</li> <li>Reinforce the policy expectations with new staff</li> <li>Write and highlight “age &lt;12” on prescription</li> <li>Use dosing tools, including spreadsheets with embedded equations, for the most commonly prescribed pediatric medications</li> <li>Use a “back check” calculation if no weight is available during verification step</li> <li>Provide “Your Child’s Medicine” checklist to the parent detailing prescriber-authorized dosing changes</li> <li>Document dose check on the back of the prescription</li> <li>Verify weight, appropriate weight-based dosing, length of therapy and product concentrations for new, refill, and e-prescriptions</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>Pediatric dose-check form</li> <li>Example of pediatric back-calculation</li> <li>Your Child’s Medicine form</li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey</li> </ul>



# Implementing the WPQC Quality-Based Best Practices Correct Product Dispensing and Patient Engagement

Implementation of a procedure to ensure the correct product is dispensed and that specific patient engagement strategies are utilized for every patient during consultation

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To identify medication errors, changes in manufacturer, and/or patient confusion by implementing standard checking procedures and patient engagement strategies</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>How do we ensure correct medications are dispensed?</li> <li>How do we ensure our patients are engaged?</li> <li>What resources and techniques do we use to engage patients?</li> <li>How can we more consistently engage patients?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Time</li> <li>Multiple medications</li> <li>Patient and staff resistance</li> <li>Drive-thru, mail order, caregivers</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Use reminder signage for staff</li> <li>Use of show and tell process for all dispensed medications</li> <li>Review name, dose, directions of each medication dispensed to a patient</li> <li>Use open-ended questions</li> <li>Use barcode technology</li> <li>Use auxiliary labels to inform patient of manufacturer change</li> <li>Include the pill color and medication imprint code on the label</li> <li>Build product manufacturer change alerts into the dispensing process</li> <li>Separate consultation area from cash register area</li> <li>Do not ring up medications in the pharmacy</li> <li>Train staff to use standard consultation starter questions based on disease state</li> <li>Ask drive-thru patients to open vial and confirm appearance of medications</li> <li>Perform pharmacist triple check prior to mail-out, delivery or drive-thru</li> <li>Observe how clerkship students incorporate show and tell into consultation</li> <li>Explain to patients, "We're trying something new to protect you."</li> <li>Begin slowly (e.g. 5 prescriptions per day) and increase over time</li> </ul>
<b>Results</b>	<ul style="list-style-type: none"> <li>Changes expectations of patients and staff</li> <li>Decreases the quantity of call-backs later (saves time)</li> <li>WPQC continuous quality improvement programs have indicated that many errors are caught using show and tell and other patient engagement strategies</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>Consultation Starter Document</li> <li>WPQC Show and Tell poster</li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey (Show and tell data collection tool)</li> </ul>



# Implementing the WPQC Quality-Based Best Practices Two Unique Identifiers

Use of at least two unique identifiers for each new prescription order and upon consultation

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To ensure that patient data is correct and the correct patient receives the correct medication</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>In addition to patient name, what other patient identifiers do we use?</li> <li>At what steps in our workflow do we check for two identifiers?</li> <li>What do we do with prescriptions that do not contain two unique identifiers?</li> <li>How do we incorporate unique identifiers into patient consults?</li> <li>How do we receive ensure two unique identifiers are used with verbal orders?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Time</li> <li>Prescriber and ancillary staff resistance</li> <li>Patient resistance especially in smaller communities</li> <li>Documentation</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Maintain clear expectations requiring all staff to request 2 unique identifiers regardless of relationship with patient</li> <li>Provide staff training and practice with scripted phrasing (e.g., “Because your safety is our priority, could you please state your first and last name and tell me your date of birth?”)</li> <li>Technician verifies name and one other identifier at prescription intake</li> <li>Technician and pharmacist verify two patient identifiers during preparation, verification, when ringing up prescription, and during consultation</li> <li>Request two identifiers for verbal prescriptions and read back identifiers and prescription to prescriber or prescriber’s agent</li> <li>Contact prescriber if two identifiers are not provided on prescription orders</li> <li>Explain importance of correct patient identification to patients and staff</li> <li>Post reminder signage for staff</li> </ul>
<b>Tools Available</b>	—
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey</li> </ul>



# Implementing the WPQC Quality-Based Best Practices Continuous Quality Improvement

Implementation of a continuous quality improvement (CQI) program for medication risk management

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To establish a system in order to identify and evaluate quality-related events and improve patient safety</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>How do we record errors &amp; near misses?</li> <li>Who identifies and records errors &amp; near misses?</li> <li>Do we differentiate between errors &amp; near misses (quality-related events)?</li> <li>How do we analyze reported quality-related events?</li> <li>How do we address quality-related events with staff?</li> <li>How do we decide on system changes to implement?</li> <li>How do we communicate the decision to implement system changes?</li> <li>How do we encourage quality-related event reporting?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Error &amp; near miss (both quality-related events) definitions differ</li> <li>Inconsistent documentation of all quality-related events</li> <li>Full CQI process (to include analysis &amp; communication) is time consuming</li> <li>CQI documentation systems and capabilities differ depending on setting</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Perform a root cause analysis following event documentation</li> <li>Use a collaborative approach to include all staff (pharmacists, technicians, students, clerks) in documenting and determining potential solutions and system changes to prevent future quality-related events</li> <li>Hold regular staff meetings for team communication</li> <li>Designate a lead individual for CQI implementation</li> <li>Encourage reporting: a shift from “errors” to “near misses” can indicate system changes that potentially prevented “near misses” from becoming “errors.”</li> <li>Provide incentives for recording quality related events (performance evaluation criteria, notes of appreciation, gift certificates, rewards for team effort, and raffles)</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>Quality-related events log</li> <li>Pharmacy Quality Commitment® system <a href="http://www.pqc.net/">http://www.pqc.net/</a></li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey</li> </ul>



# Implementing the WPQC Quality-Based Best Practices Recalls and Safety Alerts

Establish and maintain standards for communicating and executing Class I drug recalls and necessary actions pertaining to FDA drug safety alerts

<b>Purpose</b>	<ul style="list-style-type: none"> <li>To ensure the safety of medications that reach the hands of the patient and ensure that patients are alerted if a medication has been recalled</li> </ul>
<b>Pharmacy Assessment Questions</b>	<ul style="list-style-type: none"> <li>How do we differentiate between relevant and irrelevant alerts specific to our pharmacy practice?</li> <li>How do we disseminate information to our staff, patients, and prescribers?</li> <li>Who is responsible for implementation of the process?</li> <li>Do we maintain records of recalls, safety alerts, and actions taken in one location?</li> </ul>
<b>Barriers to Implementation</b>	<ul style="list-style-type: none"> <li>Multiple alerts are often issued daily</li> <li>Confusion between FDA safety alerts and FDA MedWatch program</li> <li>Determining relevance of alerts</li> <li>Lot numbers are not recorded in a patient-specific manner</li> </ul>
<b>Best Practices</b>	<ul style="list-style-type: none"> <li>Designate a lead individual to monitor recalls and safety alerts</li> <li>Create a binder for FDA safety alerts. A table on the cover sheet allows the managing pharmacist to classify each alert as low, medium or high impact for the specific site. The action taken is recorded on the cover sheet. All pharmacists and technicians are required to sign off on each item to ensure that actions to be taken are noted and implemented by all.</li> <li>Create standardized patient and prescriber forms that include information about the recall and specific directions for next steps (e.g. digoxin recalls; prescribers in some cases were asked to check digoxin levels and serum creatinine).</li> </ul>
<b>Tools Available</b>	<ul style="list-style-type: none"> <li>FDA alerts (listserv)</li> <li>Recall and safety alert documentation template</li> </ul>
<b>Measurement</b>	<ul style="list-style-type: none"> <li>Ongoing quality assurance survey</li> </ul>