FINAL/APPROVED

VIRGINIA BOARD OF PHARMACY
MINUTES OF AD HOC COMMITTEE REGARDING CQI PROGRAMS

May 18, 2011
Second Floor
Conference Center

Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

CALL TO ORDER:	The meeting was called to order at 11:45AM.
PRESIDING:	Brandon Yi, Chairman
MEMBERS PRESENT:	John O. Beckner Gill Abernathy Ellen Shinaberry Rick Baxter Tim Musselman Anila Xhixho
MEMBERS ABSENT:	Michelle Lincoln
STAFF PRESENT:	Caroline D. Juran, Executive Director J. Samuel Johnson, Jr., Deputy Executive Director
PUBLIC COMMENTS:	Hunter Jamerson representing EPIC pharmacies stated he would review the committee's decisions with his client, specifically the broad definition for "dispensing error", and offer comment during the regulatory process.
DRAFT REGULATIONS REGARDING CONTINUOUS QUALITY IMPROVEMENT PROGRAMS:	A committee representing various fields of pharmacy practice reviewed information contained in the agenda packet and concluded that HB 2220 requires the drafting of regulations for pharmacies to either implement a continuous quality improvement program or actively report to a patient safety organization. Discussion primarily focused on answering the questions, prepared by staff, regarding possible subject matter for inclusion in the regulations. It was determined that staff will prepare a draft of regulations to be presented to the Committee at a future date that will incorporate any identified subject matter resulting from the discussion. Final draft regulations will be presented to the full Board for consideration on September 22, 2011. The Committee determined the following concepts shall be included in the draft regulations: • Definition of "dispensing error" to mean 1. a variation from the prescriber's prescription drug order, including, but not limited to: ▪ Incorrect drug; ▪ Incorrect drug strength;

- Incorrect dosage form;
- Incorrect patient; or
- inadequate or incorrect packaging, labeling, or directions;

2. a failure to identify and manage:
   - therapeutic duplication;
   - drug-disease contraindications, if known;
   - drug-drug interactions, if known;
   - incorrect drug dosage or duration of drug treatment;
   - drug-allergy interactions; or
   - a clinically significant delay in therapy;
3. a delivery of a medication to the wrong patient or unit, and the failure to detect and appropriately manage a significant actual or potential problem with a patient's drug therapy; and
4. a variation in bulk repackaging or filling of automated counting devices, including, but not limited to:
   - Incorrect drug;
   - Incorrect drug strength;
   - Incorrect dosage form; or
   - Inadequate or incorrect packaging or labeling;

- An immediate requirement to report a dispensing error to the pharmacist on-duty;
- A requirement to initiate documentation of the dispensing error as soon as possible, not to exceed 3 days from determining their occurrence;
- A requirement that the documentation shall include, at a minimum, a description of the event that is sufficient to permit categorization and analysis of the event;
- A requirement that the pharmacist-in-charge or designee shall review each reportable dispensing error, analyze data collected and documented, assess the cause and any factors contributing to the dispensing error, to include any recommendations for remedial changes;
- A requirement to notify patient and prescriber when a patient has self-administered or been administered an incorrect drug;
- Language required for protection from discovery;
- An allowance to rid of the documentation regarding a dispensing error after the quality assurance analysis has been performed;
- A requirement to maintain a record indicating dates when the quality assurance analyses were performed, names of participants, general description of dispensing error, and

corrective actions taken, if any;

- A requirement that the patient safety organization must be credentialed by the Agency for Healthcare Research Quality; and
- A definition of the term "actively reports" means documenting a dispensing error as soon as possible, not to exceed 3 days from determining their occurrence and reporting all reportable dispensing errors to the patient safety organization weekly.

ADJOURN: With all business concluded, the meeting adjourned at approximately 2:30PM.

Caroline D. Juran
Executive Director

Brandon Yi, Chairman

6/8/2011
Date