Background

Program evaluation analyzes performance through a systematic collection of information. Its purpose is to ensure continuous quality improvement (CQI) of the program/project being evaluated.

Objective

To offer recommendations to pharmacy administrators about how a routine program evaluation process can facilitate CQI in pharmacy practice.

Methods

We performed a literature review and applied a program evaluation process to a standardized CQI program in pharmacy practice:

- anonymous medication incident reporting
- a routine medication safety self-assessment
- regular staff meetings for planning and monitoring CQI action plans

Every effective program evaluation begins with the development of a logic model. Logic model is a flow chart that illustrates the association between activities and outcomes, and also demonstrates their cause-effect relationships.

Conclusion

CQI activities encourage and support pharmacy professionals to review and reflect on medication incidents. Program evaluation assesses the effectiveness of CQI activities in achieving the desired patient safety and/or patient care outcomes. The outputs are tangible, allowing for quantitative measurement. For example:

- Number of incidents reported
- Number / frequency of CQI meetings
- Number of new workflow implementations reflecting recent recommendations

The results can be evaluated qualitatively, but qualitative assessments usually carry a higher logistical burden to adequately analyze. Incorporation of program evaluation to complement CQI activities can help solidify and improve overall safety and effectiveness in pharmacy practice.

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REFERENCES:


DISCLOSURES:

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Results: Logic Model Components & CQI Evaluation Example

Activities

What we do; the main actions of the project

Evaluation & Self-assessments

Incident Reporting

Learning Platform

Outputs

What we produce; tangible products or services that can be measured

• Annual medication safety self-assessments
• Reflection components
• CQI documentation
• Statistical incident analyses
• Aggregate data comparison

• Anonymous medication incident reports
• CQI documentation
• Statistical incident analyses
• Aggregate data comparison

• Staff education sessions
• Implementing new safety practices or CQI activities

Results

Why we do it

IMMEDIATE: Changes that result directly from outputs

Better understanding and appreciation for CQI and medication safety

INTERMEDIATE: Changes that result from immediate

Improved performance evaluation

Increased safety culture

Improved medication safety practices

FINAL: Changes that result from intermediate

Reduction in preventable harm from medications

Improved patient outcomes & satisfaction

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