CQI Summarization

General Information	
Pharmacy Name:	License/Accreditation/Permit No.:
Address:	Phone/Fax No.:
Email:	
Time Period of report (mm/yyyy – mm/yyyy):	

Safety Self-Assessment
Date of last completed self-assessment: (dd/mm/yyyy):
Number of individuals who participated in the completion of the self-assessment:
Dates of follow-up discussion with staff:
Was the analysis of the self-assessment results completed? (Y/N) _____ If Yes, when? _____

Medication Incident Reporting
Number of medication incidents reported each month: Jan ____ Feb ____ Mar _____ Apr ____ May ____ Jun ____ Jul ____ Aug ____ Sep ____ Oct ____ Nov ____ Dec ____ Who primarily enters medication incident data? ☐ Person who discovers medication incidents ☐ Pharmacist ☐ Pharmacy Technician ☐ Pharmacy Assistant ☐ Student

CQI Meetings				
Date of meeting (dd/mm/yyyy)				

Number of participants				
Length of meeting				
Number of medication incidents and near-miss events reviewed (individual or as part of a summary review of the total)				
Number of improvement plans made				
Number of previous improvement plans reviewed				

Staff Education

Have staff CQI education activities taken place*? (Y/N) _____

*(These can include independent study lessons, etc.)

If Yes, when? (dd/mm/yyyy) _____ / _____ / _____

Please Provide a short description of what was covered

Pharmacy Managers signature:	Date: