



ASHP ACCREDITATION STANDARD FOR POSTGRADUATE YEAR ONE (PGY1) PHARMACY RESIDENCY PROGRAMS

Introduction

Purpose of this Standard: the *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs* (hereinafter the Standard) establishes criteria for training pharmacists to achieve professional competence in the delivery of patient-centered care and pharmacy services. A PGY1 pharmacy residency is a prerequisite for postgraduate year two (PGY2) pharmacy residencies.

PGY1 Program Purpose: PGY1 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) pharmacy residency training.

Application of the Standard: the requirements serve as the basis for evaluating a PGY1 residency program for accreditation.

Throughout the Standard use of the auxiliary verbs *will* and *must* implies an absolute requirement, whereas use of *should* and *may* denotes a recommended guideline.

The Standard describes the criteria used in evaluation of practice sites that apply for accreditation. The accreditation program is conducted under the authority of the ASHP Board of Directors and is supported through formal partnerships with several other pharmacy associations. The *ASHP Regulations on Accreditation of Pharmacy Residencies*¹ describes the policies governing the accreditation program and procedures for seeking accreditation.

Overview of the Standards for PGY1 Pharmacy Residencies

The following explains the rationale and importance of the areas selected for inclusion in the standards.

Standard 1: Requirements and Selection of Residents

This Standard is intended to help ensure success of residents and that exemplary pharmacists are identified for further development for the benefit of the profession and contributions to patient care. Therefore, residents must be pharmacists committed to attaining professional competence beyond entry-level practice, committed to attaining the program's educational goals and objectives, and supportive of the organization's mission and values.

Standard 2: Responsibilities of the Program to the Resident

It is important that pharmacy residency programs provide an exemplary environment for residents' learning. This area indicates policies that must be in place to help protect residents and organizations during unusual situations that may arise with residency programs (e.g. extended leaves, dismissal, duty hours).

Standard 3: Design and Conduct of the Residency Program

It is important that residents' training enables them to achieve the purpose, goals, and objectives of the residency program and become more mature, clinically competent practitioners, enabling them to address patients' needs. Proper design and implementation of programs helps ensure successful residency programs.

Standard 4: Requirements of the Residency Program Director and Preceptors

The residency program director (RPD) and preceptors are critical to the residency program's success and effectiveness. Their qualifications and skills are crucial. Therefore, the residency program director and preceptors will be professionally and educationally qualified pharmacists who are committed to providing effective training of residents and being exemplary role models for residents.

Standard 5: Requirements of the Site Conducting the Residency Program

It is important that residents learn to help institute best practices in their future roles; therefore, the organization conducting the residency must meet accreditation standards, regulatory requirements, and other nationally applicable standards, and will have sufficient resources to achieve the purposes of the residency program.

Standard 6: Pharmacy Services

When pharmacy facilities and services provide the learning environment where residents are trained, it is important that they train in exemplary environments. Residents' expectations as they leave residency programs should be to strive for exemplary pharmacy services to improve patient care outcomes. Pharmacy's role in providing effective leadership, quality improvement efforts, appropriate organization, staffing, automation, and collaboration with others to provide safe and effective medication-use systems are reviewed in this section. This section encourages sites to continue to improve and advance pharmacy services and should motivate the profession to continually improve patient care outcomes.

Standard 1: Requirements and Selection of Residents

- 1.1 The residency program director or designee must evaluate the qualifications of applicants to pharmacy residencies through a documented, formal, procedure based on predetermined criteria.
- 1.2 The predetermined criteria and procedure used to evaluate applicants' qualifications must be used by all involved in the evaluation and ranking of applicants.
- 1.3 Applicants to pharmacy residencies must be graduates or candidates for graduation of an Accreditation Council for Pharmacy Education (ACPE) accredited degree program (or one in process of pursuing accreditation) or have a Foreign Pharmacy Graduate Equivalency Committee (FPGEC) certificate from the National Association of Boards of Pharmacy (NABP).
- 1.4 Applicants to pharmacy residencies must be licensed or eligible for licensure in the state or jurisdiction in which the program is conducted.
- 1.5 Consequences of residents' failure to obtain appropriate licensure either prior to or within 90 days of the start date of the residency must be addressed in written policy of the residency program.
- 1.6 Requirements for successful completion and expectations of the residency program must be documented and provided to applicants invited to interview, including policies for professional, family, and sick leaves and the consequences of any such leave on residents' ability to complete the residency program and for dismissal from the residency program.
 - 1.6.a. These policies must be reviewed with residents and be consistent with the organization's human resources policies.

Standard 2: Responsibilities of the Program to the Resident

- 2.1 Programs must be a minimum of twelve months and a full-time practice commitment or equivalent.
 - 2.1.a. Non-traditional residency programs must describe the program's design and length used to meet the required educational competency areas, goals, and objectives.
- 2.2 Programs must comply with the ASHP duty hour standards².
(<http://www.ashp.org/DocLibrary/Accreditation/Regulations-Standards/Duty-Hours.aspx>)
- 2.3 All programs in the ASHP accreditation process must adhere to the *Rules for the ASHP Pharmacy Resident Matching Program*³, unless exempted by the ASHP Commission on Credentialing.
- 2.4 The residency program director (RPD) must provide residents who are accepted into the program with a letter outlining their acceptance to the program.
 - 2.4.a. Information on the pre-employment requirements for their organization (e.g., licensure and human resources requirements, such as drug testing, criminal record check) and other relevant information (e.g., benefits, stipend) must be provided.
 - 2.4.b. Acceptance by residents of these terms and conditions, requirements for successful completion, and expectations of the residency program must be documented prior to the beginning of the residency.

- 2.5 The residency program must provide qualified preceptors to ensure appropriate training, supervision, and guidance to all residents to fulfill the requirements of the standards.
- 2.6 The residency program must provide residents an area in which to work, references, an appropriate level of relevant technology (e.g., clinical information systems, workstations, databases), access to extramural educational opportunities (e.g., a pharmacy association meeting, a regional residency conference), and sufficient financial support to fulfill the responsibilities of the program.
- 2.7 The RPD will award a certificate of residency only to those who complete the program's requirements.
- 2.7.a. Completion of the program's requirements must be documented.
- 2.8 The certificate provided to residents who complete the program's requirements must be issued in accordance with the provisions of the *ASHP Regulations on Accreditation of Pharmacy Residencies*¹, and signed by the RPD and the chief executive officer of the organization or an appropriate executive with ultimate authority over the residency.
- 2.8.a. Reference must be made in the certificate of the residency that the program is accredited by ASHP.
- 2.9 The RPD must maintain the program's compliance with the provisions of the current version of the *ASHP Regulations on Accreditation of Pharmacy Residencies*¹ throughout the accreditation cycle.

Standard 3: Design and Conduct of the Residency Program

3.1 Residency Purpose and Description

The residency program must be designed and conducted in a manner that supports residents in achieving the following purpose and the required educational competency areas, goals, and objectives described in the remainder of the standards.

PGY1 Program Purpose: PGY1 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) pharmacy residency training.

3.2 Competency Areas, Educational Goals and Objectives

- 3.2.a. The program's educational goals and objectives must support achievement of the residency's purpose.
- 3.2.b. The following competency areas and all associated educational goals and objectives⁴ are required by the Standard and must be included in the program's design:
- (1) patient care;
 - (2) advancing practice and improving patient care;
 - (3) leadership and management; and,
 - (4) teaching, education, and dissemination of knowledge.
- 3.2.c. Programs may select additional competency areas that are required for their program. If so, they must be required for all residents in that program. Elective competency areas may be selected for specific residents only.

3.3 Resident Learning

3.3.a. Program Structure

- 3.3.a.(1) A written description of the structure of the program must be documented formally.
 - 3.3.a.(1)(a) The description must include required learning experiences and the length of time for each experience.
 - 3.3.a.(1)(b) Elective experiences must also be listed in the program's design.
- 3.3.a.(2) The program's structure must facilitate achievement of the program's educational goals and objectives.
- 3.3.a.(3) The structure must permit residents to gain experience and sufficient practice with diverse patient populations, a variety of disease states, and a range of patient problems.
- 3.3.a.(4) Residency programs that are based in certain practice settings (e.g., long-term care, acute care, ambulatory care, hospice, pediatric hospital, home care) must ensure that the program's learning experiences meet the above requirements for diversity, variety, and complexity.
- 3.3.a.(5) No more than one-third of the twelve-month PGY1 pharmacy residency program may deal with a specific patient disease state and population (e.g., critical care, oncology, cardiology).
- 3.3.a.(6) Residents must spend two thirds or more of the program in direct patient care activities.

3.3.b. Orientation

Residency program directors must orient residents to the residency program.

3.3.c. Learning Experiences

- 3.3.c.(1) Learning experience descriptions must be documented and include:
 - 3.3.c.(1)(a) a general description, including the practice area and the roles of pharmacists in the practice area;
 - 3.3.c.(1)(b) expectations of residents;
 - 3.3.c.(1)(c) educational goals and objectives assigned to the learning experience;
 - 3.3.c.(1)(d) for each objective, a list of learning activities that will its facilitate achievement; and,
 - 3.3.c.(1)(e) a description of evaluations that must be completed by preceptors and residents.
- 3.3.c.(2) Preceptors must orient residents to their learning experience using the learning experience description.
- 3.3.c.(3) During learning experiences, preceptors will use the four preceptor roles as needed based on residents' needs.
- 3.3.c.(4) Residents must progress over the course of the residency to be more efficient, effective, and able to work independently in providing direct patient care.

3.4 Evaluation

The extent of residents' progression toward achievement of the program's required educational goals and objectives must be evaluated.

3.4.a. Initial assessment

- 3.4.a.(1) At the beginning of the residency, the RPD in conjunction with preceptors, must assess each resident's entering knowledge and skills related to the educational goals and objectives.
- 3.4.a.(2) The results of residents' initial assessments must be documented by the program director or designee in each resident's development plan by the end of the orientation period and taken into consideration when determining residents' learning experiences, learning activities, evaluations, and other changes to the program's overall plan.

3.4.b. Formative (on-going, regular) assessment

- 3.4.b.(1) Preceptors must provide on-going feedback to residents about how they are progressing and how they can improve that is frequent, immediate, specific, and constructive.
- 3.4.b.(2) Preceptors must make appropriate adjustments to residents' learning activities in response to information obtained through day-to-day informal observations, interactions, and assessments.

3.4.c. Summative evaluation

- 3.4.c.(1) At the end of each learning experience, residents must receive, and discuss with preceptors, verbal and written assessment on the extent of their progress toward achievement of assigned educational goals and objectives, with reference to specific criteria.
- 3.4.c.(2) For learning experiences greater than or equal to 12 weeks in length, a documented summative evaluation must be completed at least every three months.
- 3.4.c.(3) If more than one preceptor is assigned to a learning experience, all preceptors must provide input into residents' evaluations.
- 3.4.c.(4) For preceptors-in-training, both the preceptor-in-training and the preceptor advisor/coach must sign evaluations.
- 3.4.c.(5) Residents must complete and discuss at least one evaluation of each preceptor at the end of the learning experience.
- 3.4.c.(6) Residents must complete and discuss an evaluation of each learning experience at the end of the learning experience.

3.4.d. Residents' development plans

- 3.4.d.(1) Each resident must have a resident development plan documented by the RPD or designee.
- 3.4.d.(2) On a quarterly basis, the RPD or designee must assess residents' progress and determine if the development plan needs to be adjusted.
- 3.4.d.(3) The development plan and any adjustments must be documented and shared with all preceptors.

3.5 Continuous Residency Program Improvement

- 3.5.a. The RPD, residency advisory committee (RAC), and pharmacy executive must engage in an on-going process of assessment of the residency program including a formal annual program evaluation.
- 3.5.b. The RPD or designee must develop and implement program improvement activities to respond to the results of the assessment of the residency program.
- 3.5.c. The residency program's continuous quality improvement process must evaluate whether residents fulfill the purpose of a PGY1 pharmacy residency program through graduate tracking.
 - 3.5.c.(1) Information tracked must include initial employment, and may include changes in employment, board certification, surveys of past graduates, or other applicable information.

Standard 4: Requirements of the Residency Program Director and Preceptors

4.1 Program Leadership Requirements

- 4.1.a. Each residency program must have a single residency program director (RPD) who must be a pharmacist from a practice site involved in the program or from the sponsoring organization.
- 4.1.b. The RPD must establish and chair a residency advisory committee (RAC) specific to that program.
- 4.1.c. The RPD may delegate, with oversight, to one or more individuals [(e.g., residency program coordinator(s))] administrative duties/activities for the conduct of the residency program.
- 4.1.d. For residencies conducted by more than one organization (e.g., two organizations in a partnership) or residencies offered by a sponsoring organization (e.g., a college of pharmacy, hospital) in cooperation with one or more practice sites:
 - 4.1.e.(1) A single RPD must be designated in writing by responsible representatives of each participating organization.
 - 4.1.e.(2) The agreement must include definition of:
 - 4.1.e.(2)(a) responsibilities of the RPD; and,
 - 4.1.e.(2)(b) RPD's accountability to the organizations and/or practice site(s).

4.2 Residency Program Directors' Eligibility

RPDs must be licensed pharmacists who:

- have completed an ASHP-accredited PGY1 residency followed by a minimum of three years of pharmacy practice experience; or
- have completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience; or
- without completion of an ASHP-accredited residency, have five or more years of pharmacy practice experience.

4.3 Residency Program Directors' Qualifications

RPDs serve as role models for pharmacy practice, as evidenced by:

- 4.3.a. leadership within the pharmacy department or within the organization, through a documented record of improvements in and contributions to pharmacy practice;
- 4.3.b. demonstrating ongoing professionalism and contribution to the profession;

- 4.3.c. representing pharmacy on appropriate drug policy and other committees of the pharmacy department or within the organization; and,

4.4 Residency Program Leadership Responsibilities

RPDs serve as organizationally authorized leaders of residency programs and have responsibility for:

- 4.4.a. organization and leadership of a residency advisory committee that provides guidance for residency program conduct and related issues;
- 4.4.b. oversight of the progression of residents within the program and documentation of completed requirements;
- 4.4.c. implementing use of criteria for appointment and reappointment of preceptors;
- 4.4.d. evaluation, skills assessment, and development of preceptors in the program;
- 4.4.e. creating and implementing a preceptor development plan for the residency program;
- 4.4.f. continuous residency program improvement in conjunction with the residency advisory committee; and,
- 4.4.g. working with pharmacy administration.

4.5 Appointment or Selection of Residency Program Preceptors

- 4.5.a. Organizations shall allow residency program directors to appoint and develop pharmacy staff to become preceptors for the program.
- 4.5.b. RPDs shall develop and apply criteria for preceptors consistent with those required by the Standard.

4.6 Pharmacist Preceptors' Eligibility

Pharmacist preceptors must be licensed pharmacists who:

- have completed an ASHP-accredited PGY1 residency followed by a minimum of one year of pharmacy practice experience; or
- have completed an ASHP-accredited PGY1 residency followed by an ASHP-accredited PGY2 residency and a minimum of six months of pharmacy practice experience; or
- without completion of an ASHP-accredited residency, have three or more years of pharmacy practice experience.

4.7 Preceptors' Responsibilities

Preceptors serve as role models for learning experiences. They must:

- 4.7.a. contribute to the success of residents and the program;
- 4.7.b. provide learning experiences in accordance with Standard 3;
- 4.7.c. participate actively in the residency program's continuous quality improvement processes;
- 4.7.d. demonstrate practice expertise, preceptor skills, and strive to continuously improve;
- 4.7.e. adhere to residency program and department policies pertaining to residents and services; and,
- 4.7.f. demonstrate commitment to advancing the residency program and pharmacy services.

4.8 Preceptors' Qualifications

Preceptors must demonstrate the ability to precept residents' learning experiences by meeting one or more qualifying characteristics in all of the following five areas:

- 4.8.a. demonstrating the ability to precept residents' learning experiences by use of clinical teaching roles (i.e., instructing, modeling, coaching, facilitating) at the level required by residents;
- 4.8.b. the ability to assess residents' performance;

- 4.8.c. recognition in the area of pharmacy practice for which they serve as preceptors;
- 4.8.d. an established, active practice in the area for which they serve as preceptor;
- 4.8.e. maintenance of continuity of practice during the time of residents' learning experiences; and,
- 4.8.f. ongoing professionalism, including a personal commitment to advancing the profession.

4.9 Preceptors-in-Training

- 4.9.a. Pharmacists new to precepting who do not meet the qualifications for residency preceptors in sections 4.6, 4.7, and 4.8 above (also known as preceptors-in-training) must:
 - 4.9.a.(1) be assigned an advisor or coach who is a qualified preceptor; and,
 - 4.9.a.(2) have a documented preceptor development plan to meet the qualifications for becoming a residency preceptor within two years.

4.10 Non-pharmacist preceptors

When non-pharmacists (e.g., physicians, physician assistants, certified nurse practitioners) are utilized as preceptors:

- 4.10.a. the learning experience must be scheduled after the RPD and preceptors agree that residents are ready for independent practice; and,
- 4.10.b. a pharmacist preceptor works closely with the non-pharmacist preceptor to select the educational goals and objectives for the learning experience.

Standard 5: Requirements of the Sponsoring Organization and Practice Site(s) Conducting the Residency Program

- 5.1 As appropriate, residency programs must be conducted only in practice settings that have sought and accepted outside appraisal of facilities and patient care practices. The external appraisal must be conducted by a recognized organization appropriate to the practice setting.
- 5.2 Residency programs must be conducted only in those practice settings where staff are committed to seek excellence in patient care as evidenced by substantial compliance with professionally developed and nationally applied practice and operational standards.
- 5.3 Two or more practice sites, or a sponsoring organization working in cooperation with one or more practice sites (e.g., college of pharmacy, health system), may offer a pharmacy residency.
 - 5.3.a. Sponsoring organizations must maintain authority and responsibility for the quality of their residency programs.
 - 5.3.b. Sponsoring organizations may delegate day-to-day responsibility for the residency program to a practice site; however, the sponsoring organization must ensure that the residency program meets accreditation requirements.
 - 5.3.b.(1) Some method of evaluation must be in place to ensure the purpose of the residency and the terms of the agreement are being met.
 - 5.3.c. A mechanism must be documented that designates and empowers an individual to be responsible for directing the residency program and for achieving consensus on the evaluation and ranking of applicants for the residency.
 - 5.3.d. Sponsoring organizations and practice sites must have signed agreement(s) that define clearly the responsibilities for all aspects of the residency program.
 - 5.3.e. Each of the practice sites that provide residency training must meet the requirements set forth in Standard 5.2 and the pharmacy's service requirements in Standard 6.

5.4 Multiple-site residency programs must be in compliance with the *ASHP Accreditation Policy for Multiple-Site Residency Programs*⁵.

Standard 6: Pharmacy Services

The most current edition of the ASHP *Best Practices for Health-System Pharmacy*, available at www.ashp.org, and, when necessary, other pharmacy association guides to professional practice and other relevant standards (e.g. NIOSH, OSHA, EPA) that apply to specific practice sites will be used to evaluate any patient care sites or other practice operations providing pharmacy residency training.

6.1 Pharmacist Executive

The pharmacy must be led and managed by a professional, legally qualified pharmacist.

6.2 The pharmacy must be an integral part of the health-care delivery system at the practice site in which the residency program is offered, as evidenced by the following:

- 6.2.a. the scope and quality of pharmacy services provided to patients at the practice site is based upon the mission of the pharmacy department and an assessment of pharmacy services needed to provide care to patients served by the practice site;
- 6.2.b. the practice site includes pharmacy in the planning of patient care services;
- 6.2.c. the scope of pharmacy services is documented and evidenced in practice and quality measures;
- 6.2.d. pharmacy services extend to all areas of the practice site in which medications for patients are prescribed, dispensed, administered, and monitored;
- 6.2.e. pharmacists are responsible for the procurement, preparation, distribution, and control of all medications used; and,
- 6.2.f. pharmacists are responsible for collaborating with other health professionals to ensure safe medication-use systems and optimal drug therapy.

6.3 The pharmacist executive must provide effective leadership and management for the achievement of short- and long-term goals of the pharmacy and the organization for medication-use and medication-use policies.

6.4 The pharmacist executive must ensure that the following elements associated with a well-managed pharmacy are in place (as appropriate to the practice setting):

- 6.4.a. a pharmacy mission statement;
- 6.4.b. a well-defined pharmacy organizational structure;
- 6.4.c. current policies and procedures which are available readily to staff participating in service provision;
- 6.4.d. position descriptions for all categories of pharmacy personnel, including residents;
- 6.4.e. procedures to document patient care outcomes data;
- 6.4.f. procedures to ensure medication-use systems (ordering, dispensing, administration, and monitoring) are safe and effective;
- 6.4.g. procedures to ensure clinical pharmacy services are safe and effective; and,
- 6.4.h. a staff complement that is competent to perform the duties and responsibilities assigned (e.g., clinical and distributive services).

6.5 Pharmacy leaders ensure pharmacy's compliance with:

- 6.5.a. all applicable contemporary federal, state, and local laws, codes, statutes, and regulations governing pharmacy practice unique to the practice site; and,
- 6.5.b. current national practice standards and guidelines.

6.6 The medication distribution system includes the following components (as applicable to the practice setting):

- 6.6.a. effective use of personnel (e.g., technicians);
- 6.6.b. a unit-dose drug distribution service;
- 6.6.c. an intravenous admixture and sterile product service;
- 6.6.d. a research pharmacy including an investigational drug service;
- 6.6.e. an extemporaneous compounding service;
- 6.6.f. a system for handling hazardous drugs;
- 6.6.g. a system for the safe use of all medications, (e.g., drug samples, high alert, look-alike/sound-alike, emergency preparedness programs, medical emergencies);
- 6.6.h. a secure system for the use of controlled substances;
- 6.6.i. a controlled floor-stock system for medications administered;
- 6.6.j. an outpatient drug distribution service including a patient assessment and counseling area; and,
- 6.6.k. a system ensuring accountability and optimization for the use of safe medication-use system technologies.

6.7 The following patient care services and activities are provided by pharmacists in collaboration with other health-care professionals to optimize medication therapy for patients:

- 6.7.a. membership on interdisciplinary teams in patient care areas;
- 6.7.b. prospective participation in the development of individualized medication regimens and treatment plans;
- 6.7.c. implementation and monitoring of treatment plans for patients;
- 6.7.d. identification and responsibility for resolution of medication-related problems;
- 6.7.e. review of the appropriateness and safety of medication prescriptions/orders;
- 6.7.f. development of treatment protocols, care bundles, order sets, and other systematic approaches to therapies involving medications for patients;
- 6.7.g. participation as a provider of individual and population-based patient care services and disease state management, initiating and modifying drug therapy, based on collaborative practice agreements or other treatment protocols;
- 6.7.h. a system to identify appropriately trained and experienced pharmacists and ensure quality care is provided, including when pharmacists are practicing under collaborative practice agreements (e.g., complete credentialing and privileging for pharmacists providing patient care service);
- 6.7.i. documentation of significant patient care recommendations and resulting actions, treatment plans, and progress notes in the appropriate section of patients' permanent medical records;
- 6.7.j. medication administration consistent with laws, regulations, and practice site policy;
- 6.7.k. disease prevention and wellness promotion programs (e.g., smoking cessation, immunization);
- 6.7.l. a system to ensure and support continuity-of-care during patient care transitions; and,
- 6.7.m. drug use policy activities including, but not limited to, the following (as applicable to the practice setting):
 - 6.7.m.(1) developing and maintaining an evidence-based formulary;

- 6.7.m.(2) educating health care providers on timely medication-related matters and medication policies;
- 6.7.m.(3) development and monitoring of evidence-based medication-use guidelines, policies, and order sets;
- 6.7.m.(4) managing adverse drug event monitoring, resolution, reporting, and prevention programs; and,
- 6.7.m.(5) managing selection, procurement, storage, and dispensing of medications used within the organization.

6.8 The pharmacy practice must have personnel, facilities, and other resources to carry out a broad scope of pharmacy services (as applicable to the practice setting). The pharmacy's:

- 6.8.a.(1) facilities are designed, constructed, organized, and equipped to promote safe and efficient work;
- 6.8.a.(2) professional, technical, and clerical staff complement is sufficient and diverse enough to ensure that the department can provide the level of service required by all patients served; and,
- 6.8.a.(3) resources can accommodate the training of the current and future workforce (e.g., residents, students, technicians, and others).

6.9 Continuous Quality Improvement

- 6.9.a. Pharmacy department personnel must engage in an on-going process to assess the quality of pharmacy services.
- 6.9.b. Pharmacy department personnel must develop and implement pharmacy services improvement initiatives to respond to assessment results.
- 6.9.c. The pharmacy department's assessment and improvement process must include assessing and developing skills of the of pharmacy department's staff.

Glossary

Assessment. Measurement of progress on achievement of educational objectives.

Certification. A voluntary process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that organization. This formal recognition is granted to designate to the public that the individual has attained the requisite level of knowledge, skill, or experience in a well-defined, often specialized, area of the total discipline. Certification usually requires initial assessment and periodic reassessments of the individual's qualifications.

Clinical pharmacist. Clinical pharmacists work directly with doctors, other health professionals, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes. (*American College of Clinical Pharmacists*)

Competency area. Category of residency graduates' capabilities.

Complex condition. Patients with complex conditions are those who are being treated with high-risk medications, high numbers of medications, and/or have multiple disease states.

Criteria. Specific, qualitative comments that describe competent performance for each objective.

Educational Goal. Broad statement of abilities.

Educational Objective. Observable, measurable statement describing what residents will be able to do as a result of participating in the residency program.

Evaluation. Judgment regarding quality of learning.

Formative assessment. On-going feedback to residents regarding their progress on achievement of educational objectives for the purpose of improving learning.

Interdisciplinary team. A team composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods. The team members integrate their observations, bodies of expertise, and spheres of decision making to coordinate, collaborate, and communicate with one another in order to optimize care for a patient or group of patients. (Institute of Medicine. *Health professions education: a bridge to quality*. Washington, DC: The National Academy Press; 2001.)

Multiple-site residency. A residency site structure in which multiple organizations or practice sites are involved in the residency program. Examples include programs in which: residents spend greater than 25% of the program away from the sponsoring organization/main site at another single site; or there are multiple residents in a program and they are home-based in separate sites.

1. To run a multiple-site residency there must be a compelling reason for offering the training in a multiple-site format (that is, the program is improved substantially in some manner). For example:

- a. RPD has expertise, however the site needs development (for example, site has a good variety of patients, and potentially good preceptors, however the preceptors may need some oversight related to the residency program; or services need to be more fully developed);
 - b. quality of preceptorship is enhanced by adding multiple sites;
 - c. increased variety of patients/disease states to allow wider scope of patient interactions for residents;
 - d. increased administrative efficiency to develop more sites to handle more residents across multiple sites/geographic areas;
 - e. synergy of the multiple sites increases the quality of the overall program;
 - f. allows the program to meet all of the requirements (that could not be done in a single site alone); and,
 - g. ability to increase the number of residents in a quality program.
2. A multiple-site residency program conducted in multiple hospitals that are part of a health-system that is considering CMS pass-through funding should conduct a thorough review of 42CFR413.85 and have a discussion with the finance department to ensure eligibility for CMS funding.
3. In a multiple-site residency program, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program. This includes:
- a. designating a single residency program director (RPD);
 - b. establishing a common residency purpose statement to which all residents at all sites are trained;
 - c. ensuring a program structure and consistent required learning experiences;
 - d. ensuring the required learning experiences are comparable in scope, depth, and complexity for all residents, if home based at separate sites;
 - e. ensuring a uniform evaluation process and common evaluation tools are used across all sites;
 - f. ensuring there are consistent requirements for successful completion of the program;
 - g. designating a site coordinator to oversee and coordinate the program's implementation at each site that is used for more than 25% of the learning experiences in the program (for one or more residents); and,
 - h. ensuring the program has an established, formalized approach to communication that includes at a minimum the RPD and site coordinators to coordinate the conduct of the program across all sites.

Non-traditional residency: Residency program that meets requirements of a 12-month residency program in a different timeframe.

Pharmacist Executive. The person who has ultimate responsibility for the residency practice site/pharmacy in which the residency program is conducted. (In some settings this person is referred to, for example, as the *director of pharmacy*, the *pharmacist-in-charge*, the *chief of pharmacy services*) In a multiple-site residency, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program.

Preceptor. An expert pharmacist who gives practical experience and training to a pharmacy resident. Preceptors have responsibility for the evaluation of residents' performance.

Preceptor-in-training. Pharmacists who are new to precepting residents who have not yet met the qualification for a preceptor in an accredited program. Through coaching and a development plan, they may be a preceptor for a learning experience and become full preceptors within two years.

Residency program director. The pharmacist responsible for direction, conduct, and oversight of the residency program. In a multiple-site residency, the residency program director is a pharmacist designated in a written agreement between the sponsoring organization and all of the program sites.

Resident's Development Plan. Record of modifications to residents' program based on their learning needs.

Self-evaluation. A process of reflecting on one's progress on learning and/or performance to determine strengths, weaknesses, and actions to address them.

Service commitments. Clinical and operational practice activities. May be defined in terms of the number of hours, types of activities, and a set of educational goals and objectives.

Single-site residency. A residency site structure in which the practice site assumes total responsibility for the residency program. In a single-site residency, the majority of the resident's training program occurs at the site; however, the resident may spend assigned time in short elective learning experiences off-site.

Site. The actual practice location where the residency experience occurs.

Site Coordinator. A preceptor in a multiple-site residency program who is designated to oversee and coordinate the program's implementation at an individual site that is used for more than 25% of the learning experiences. This individual may also serve as a preceptor in the program. A site coordinator must:

1. be a licensed pharmacist who meets the minimum requirements to serve as a preceptor (meets the criteria identified in Principle 5.9 of the appropriate pharmacy residency accreditation standard);
2. practice at the site at least ten hours per week;
3. have the ability to teach effectively in a clinical practice environment; and,
4. have the ability to direct and monitor residents' and preceptors' activities at the site (with the RPD's direction).

Sponsoring organization. The organization assuming ultimate responsibility for the coordination and administration of the residency program. The sponsoring organization is charged with ensuring that residents' experiences are educationally sound and are conducted in a quality practice environment. The sponsoring organization is also responsible for submitting the accreditation application and ensuring periodic evaluations are conducted. If several organizations share responsibility for the financial and management aspects of the residency (e.g., school of pharmacy, health-system, and individual site), the organizations must mutually designate one organization as the sponsoring organization.

Staffing. See "Service commitments."

Summative evaluation. Final judgment and determination regarding quality of learning.

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Approved by the ASHP Board of Directors September 19, 2014. Developed by the ASHP Commission on Credentialing. This standard replaces the previous *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs* approved by the ASHP Board of Directors on September 23, 2005. For existing programs this revision of the accreditation standard takes effect July 1, 2016. Until that time the current standard, which was approved September 23, 2005, is in force.

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