



Accreditation Standard for Postgraduate Year One (PGY1) Community-Based Pharmacy Residency Programs

Prepared jointly by the American Society of Health-System Pharmacists (ASHP) and the American Pharmacists Association (APhA)

Purpose of this Standard: *the Accreditation Standard for Postgraduate Year One (PGY1) Community-Based Pharmacy Residency Programs* (hereinafter the Standard) establishes criteria for systematic training of pharmacists for the purpose of achieving professional competence in the delivery of patient-centered care and in pharmacy services. Its contents delineate the requirements for American Society of Health-System Pharmacists (ASHP)-accreditation of PGY1 community-based pharmacy residencies. A PGY1 pharmacy residency is a prerequisite for postgraduate year two (PGY2) pharmacy residencies.

PGY1 Community-Based Pharmacy Residency Program Purpose: To build upon the Doctor of Pharmacy (PharmD) education and outcomes to develop community-based pharmacist practitioners with diverse patient care, leadership, and education skills who are eligible to pursue advanced training opportunities including postgraduate year two (PGY2) residencies and professional certifications.

Pharmacist residency education and training in community-based practice aims to develop pharmacy leaders who are capable of improving the health of patients within the communities they serve. The primary purpose of this Standard is to foster the development of community-based pharmacist practitioners¹ who are community-focused practice leaders, serving as an access point for care and having the skillset necessary to provide quality generalist patient care services² wherever health and medication needs arise.

Application of the Standard: The requirements serve as the basis for evaluating a PGY1 community-based pharmacy residency program for accreditation. It is recognized that in the application of this Standard, training locations may vary and diverse community-based practices³ may find utility in the use of this Standard. Additionally, because of the diversity of patient populations, service offerings, and

¹ Skelton JB; American Pharmacists Association. Developing a vision and strategic action plan for future community-based residency training. *J Am Pharm Assoc.* In press.

² Generalist patient care services include but are not limited to medication management including the provision of comprehensive medication reviews and follow-up; health and wellness services; immunization services; disease state management services incorporating medication management; care transition services with incorporated medication reconciliation and medication management; and patient-centered medication distribution.

³ A variety of community-based practices may find utility in the use of this Standard including but not limited to community pharmacies, ambulatory care clinics, physician offices, free clinics, federally qualified health centers, employer-based clinics, assisted-living facilities, hospice, home care, and adult/pediatric hospitals with outpatient pharmacies/clinics.

business models, it is recognized that individual practice locations⁴ may be unable to provide all of the Standard's requirements for diversity, variety, and complexity; however, it is intended that the combination of all practice locations used for the training of the individual resident meets the requirements as set forth by the Standard and that each resident has a designated community-based home-base⁵ practice location.

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.

Accreditation of pharmacy residency programs is conducted under the authority of the ASHP Board of Directors and for this Standard is supported through a formal partnership with the American Pharmacists Association (APhA). The *ASHP Regulations on Accreditation of Pharmacy Residencies* sets forth the policies governing the accreditation program and describes the 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 for Resident Selection and Resident Completion of the Program

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.

⁴ Community-based residency practice location is a place where preceptors are training residents. A practice location may consist of one or more places where residents can be trained within a single organization (i.e., a pharmacy chain, a college of pharmacy with clinic pharmacies, a health-system with outpatient/clinic pharmacies).

⁵ Home-base practice location is the place designated as a resident's primary practice site for residency training.

Standard 5: Requirements for Organizational Structure of 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 Practice

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 for Resident Selection and Resident Completion of the Program

- 1.1 The residency program director (RPD) or designee evaluates 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 are used by all involved in the evaluation and ranking of applicants.
- 1.3 Applicants to pharmacy residencies are 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 Examination Committee (FPGEC) certificate from the National Association of Boards of Pharmacy (NABP).
- 1.4 Applicants to pharmacy residencies are 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 ninety days of the start date of the residency are addressed in written policy of the residency program.
- 1.6 Program policies, requirements for successful completion of the program, and expectations of residents in the program are documented.
 - 1.6.a Program policies, requirements for successful completion of the program, and expectations of residents in the program are provided (either in print or electronically) to interviewees prior to the interview date. Applicants are given the opportunity to obtain more information and ask questions during the interview process.

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 Nontraditional residency programs 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 standards.
- 2.3 All programs in the ASHP accreditation process adhere to the *Rules for the ASHP Pharmacy Resident Matching Program*, unless exempted by the ASHP Commission on Credentialing.
- 2.4 The RPD provides 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 and criminal record check) and other relevant information (e.g., benefits, stipend) must be provided.
 - 2.4.b Acceptance by residents of the residency terms and conditions, requirements for successful completion, and expectations of residents in the program are documented prior to the beginning of the residency.

- 2.5 The residency program provides qualified preceptors to ensure appropriate training, supervision, and guidance to all residents to fulfill the requirements of the standards.
- 2.6 The residency program provides residents with an area in which to work, access to references, an appropriate level of relevant technology, access to educational opportunities, and sufficient financial support to fulfill the responsibilities of the program.
- 2.7 The RPD documents residents' successful completion of program requirements.
- 2.8 The RPD issues a certificate only to residents who complete the program's requirements in accordance with the provisions of the *ASHP Regulations on Accreditation of Pharmacy Residencies*.
 - 2.8.a The certificate is signed by the RPD and the chief executive officer of the organization or an appropriate executive with ultimate authority over the residency.
 - 2.8.b When the program has achieved accreditation, appropriate reference is made on the certificate of the residency that the program is accredited by ASHP in partnership with APhA.
- 2.9 The RPD maintains the program's compliance with the provisions of the current version of the *ASHP Regulations on Accreditation of Pharmacy Residencies* throughout the accreditation cycle.

Standard 3: Design and Conduct of the Residency Program

- 3.1 Residency Purpose and Description. The residency program is 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.
 - 3.1.a PGY1 Community-Based Pharmacy Residency Program Purpose. To build upon the doctor of pharmacy (PharmD) education and outcomes to develop community-based pharmacist practitioners with diverse patient care, leadership, and education skills who are eligible to pursue advanced training opportunities including postgraduate year two (PGY2) residencies and professional certifications.
 - 3.1.b Individualized Program Description. Each PGY1 community-based pharmacy residency program establishes, documents, and promotes a brief description of its program that aligns with the universal purpose statement of a PGY1 community-based pharmacy residency program and elaborates on the unique aspects of its program.
- 3.2 Competency Areas, Educational Goals, and Objectives
 - 3.2.a The program's educational goals and objectives support achievement of the residency's purpose.
 - 3.2.b The following competency areas and all associated educational goals and objectives are required by the Standard and must be included in the program's design:
 - 3.2.b.1 patient care.
 - 3.2.b.2 advancing community-based practice.
 - 3.2.b.3 leadership and management.
 - 3.2.b.4 teaching, education, and dissemination of knowledge.
 - 3.2.c Beyond those required in 3.2b, additional educational goals and/or objectives may be included in the program design under required competencies that then become required for all residents in the program.

- 3.2.d For a specific resident, additional educational goals and/or objectives may be added to customize his or her individual training.

3.3 Program Structure and Design

- 3.3.a The structure of the program is established, described, and formally documented.
 - 3.3.a.1 The description includes a list of all required and elective learning experiences.
 - 3.3.a.2 The description includes the type (e.g., longitudinal, rotational, extended, concentrated) of each learning experience.
 - 3.3.a.3 The description includes the duration for each learning experience.
- 3.3.b The program's structure facilitates achievement of the program's educational goals and objectives.
- 3.3.c The program's structure and design facilitate education and training of the resident in patient care (can be accomplished using one or more practice locations) including:
 - 3.3.c.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;
 - 3.3.c.2 health and wellness;
 - 3.3.c.3 immunizations;
 - 3.3.c.4 disease state management incorporating medication management;
 - 3.3.c.5 care transitions incorporating medication reconciliation and medication management; and,
 - 3.3.c.6 patient-centered medication distribution.
- 3.3.d The structure permits residents to gain experience and sufficient practice with diverse patient populations with a variety of disease states and conditions, and diverse range of patients' medication treatments and health-related needs.
 - 3.3.d.1 Residents spend two-thirds or more of the program in patient care activities.
 - 3.3.d.2 Residents spend no more than one-third of the twelve-month PGY1 pharmacy residency program in a practice or environment providing care to a specific patient disease state and population (e.g., monitoring and management of anticoagulation, oncology, HIV, and hepatitis C patients).
 - 3.3.d.3 Residents gain practice and experience in longitudinal patient care delivery and the development of extended patient relationships.
 - 3.3.d.4 Residents function and work as a member of the health care team.
 - 3.3.d.5 Residents provide patient care in settings and environments with and without access to existing sources of complete patient health data.
 - 3.3.d.6 Residents appropriately document patient care in the patient's health care record.
 - 3.3.d.7 Residents use technology including electronic health record functionality.,
 - 3.3.d.8 Residents progress over the course of the residency to become more efficient and effective with the ability to work independently as patient care providers.
- 3.3.e Learning Experience Requirements
 - 3.3.e.1 Learning experience descriptions are documented and include:
 - 3.3.e.1.1 a general learning description synopsis, that includes the practice area and the roles of pharmacists in the practice area;
 - 3.3.e.1.2 expectations of residents;
 - 3.3.e.1.3 educational goals and objectives assigned to the learning experience;
 - 3.3.e.1.4 for each objective, a list of learning activities that will facilitate its achievement; and,

- 3.3.e.1.5 a description of evaluations that are to be completed by preceptors and residents.
 - 3.3.e.2 Program structure includes a residency program orientation learning experience where the RPD or designee orients residents to the residency program.
 - 3.3.e.2.1 For all other learning experiences, preceptors orient residents to their learning experience, including review of the learning experience description.
 - 3.3.e.2.2 The learning experience design requires preceptors to use the four preceptor roles (i.e., instructing, modeling, coaching, facilitating).
- 3.4 Assessment and Evaluation Requirements
- 3.4.a RPD and Preceptor Evaluation Requirements
 - 3.4.a.1 Initial Evaluation
 - 3.4.a.1.1 At the beginning of the residency, the RPD or designee, in conjunction with preceptors, assesses each resident's entering knowledge and skills in relation to the educational goals and objectives.
 - 3.4.a.2 Formative (Ongoing, Regular) Evaluation
 - 3.4.a.2.1 Preceptors provide ongoing, frequent, immediate, specific, and constructive feedback to residents about how they are progressing and how they can improve.
 - 3.4.a.2.2 Preceptors make appropriate adjustments to residents' learning activities in response to information obtained through day-to-day observations, interactions, and assessments.
 - 3.4.a.3 Summative Evaluation
 - 3.4.a.3.1 At the end of each learning experience, preceptors for the learning experience complete and document a criteria-based, summative evaluation of the resident's progress toward achievement of educational goals and objectives assigned to the learning experience.
 - 3.4.a.3.1.1 If more than one preceptor is assigned to a learning experience, all preceptors provide input into the resident's evaluation.
 - 3.4.a.3.1.2 For longitudinal learning experiences greater than twelve weeks but less than six months in length, a documented summative evaluation is completed at least twice, at the midpoint and end of the experience. For those greater than six months, summative evaluations are conducted quarterly (every three months) and at the conclusion of the learning experience.
 - 3.4.a.3.2 The preceptor and resident discuss the summative evaluation and the extent of the resident's progress toward achievement of assigned educational goals and objectives with reference to specific criteria.
 - 3.4.a.3.3 Completed summative evaluations are signed by learning experience preceptors, cosigned by the resident, and reviewed by the RPD or designee.

- 3.4.a.3.3.1 For preceptors-in-training, both the preceptor-in-training, and the preceptor advisor/coach sign evaluations.
- 3.4.b Development Plan Requirements
 - 3.4.b.1 The RPD or designee creates, documents, and maintains a development plan for each resident.
 - 3.4.b.1.1 The RPD or designee creates an initial development plan.
 - 3.4.b.1.1.1 The initial plan is based on the results of the resident's initial evaluation.
 - 3.4.b.1.1.2 The initial plan is completed by the end of the orientation period, but no later than thirty days from the start of the residency.
 - 3.4.b.1.1.3 Adjustments to the resident's learning experiences, learning activities, evaluations, and other changes are documented in the initial plan.
 - 3.4.b.2 Quarterly Update of Development Plan
 - 3.4.b.2.1 On a quarterly basis, the RPD or designee assesses the resident's progress and adjusts the development plan.
 - 3.4.b.3 The development plan and any adjustments are documented and shared with the resident's preceptors.
- 3.4.c Resident Evaluation Requirements
 - 3.4.c.1 Self-Reflections
 - 3.4.c.1.1 Residents complete a written statement of self-reflection at the beginning of the residency to identify learning expectations and desired areas of professional growth.
 - 3.4.c.1.2 Residents complete a written statement of self-reflection at the conclusion of residency to identify competencies achieved, competencies requiring additional attention, and a plan for future professional development.
 - 3.4.c.2 Self- Evaluation
 - 3.4.c.2.1 Residents complete a self-evaluation of their entering knowledge and skills related to the educational goals and objectives.
 - 3.4.c.3 Formative Self-Evaluation
 - 3.4.c.3.1 Residents practice criteria-based, formative self-evaluation for aspects of their routine performance.
 - 3.4.c.4 Summative Self-Evaluation
 - 3.4.c.4.1 The program has a defined plan for the resident to complete and document criteria-based, summative self-evaluation toward achievement of targeted objectives in learning experiences.
 - 3.4.c.4.2 Residents are taught how to perform self-evaluation.
 - 3.4.c.5 Resident Evaluation of Preceptor
 - 3.4.c.5.1 Residents complete at least one evaluation of each preceptor assigned to a learning experience.
 - 3.4.c.5.2 For longitudinal learning experiences greater than twelve weeks in length, preceptor evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.

- 3.4.c.5.3 If one preceptor is assigned to more than one longitudinal learning experience, the resident may complete only one combined evaluation for the individual preceptor.
- 3.4.c.5.4 The preceptor and resident discuss the resident's preceptor evaluation.
- 3.4.c.5.5 Completed preceptor evaluations are signed by the preceptors and reviewed and cosigned by the RPD or designee.
- 3.4.c.6 Learning Experience Evaluations
 - 3.4.c.6.1 Residents complete an evaluation of each learning experience at the end of the learning experience.
 - 3.4.c.6.2 For longitudinal learning experiences greater than twelve weeks in length, learning experience evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.
 - 3.4.c.6.3 The preceptor(s) and resident discuss the learning experience evaluation.
 - 3.4.c.6.4 Completed learning experience evaluations are signed by the preceptor(s) and reviewed and cosigned by the RPD or designee.

3.5 Continuous Residency Program Improvement

- 3.5.a The RPD and the Residency Advisory Committee (RAC) (and partner representatives if applicable), engage in an ongoing process of assessment of the residency program including a formal annual program evaluation.
- 3.5.b The RPD or designee develops and implements 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 community-based pharmacy residency through graduate tracking, an annual review of the program design, and a review of input from each year's graduates.
- 3.5.d 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 has a single RPD who is a pharmacist from a practice location involved in the program or from the sponsoring organization.
 - 4.1.a.1 The RPD establishes and chairs the RAC specific to that program.
 - 4.1.a.2 The RPD may delegate, with oversight, to one or more individuals the administrative duties/activities for the conduct of the residency program.
- 4.1.b Each residency program has a designated sponsoring organization.
 - 4.1.b.1 For residencies conducted by one organization, that organization is the designated sponsoring organization.
 - 4.1.b.2 When a residency is conducted by more than one organization (two organizations in partnership, such as a college of pharmacy, company, or health system), the partners will agree to and designate the sponsoring organization in a formal agreement.

- 4.1.b.2.1 The agreement includes definition of:
 - 4.1.b.2.1.1 responsibilities of all partners;
 - 4.1.b.2.1.2 responsibilities of the RPD; and,
 - 4.1.b.2.1.3 the RPD's accountability to the organizations.

4.2 Residency Program Directors (RPD)

4.2.a Eligibility of the RPD

An RPD is a licensed pharmacist who:

- has completed an ASHP-accredited PGY1 residency and a minimum of three years of pharmacy practice experience in a community or ambulatory practice environment; or,
- has completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience in a community or ambulatory practice environment; or,
- has not completed an ASHP-accredited residency, but has five or more years of pharmacy practice experience in a community or ambulatory practice environment.

4.2.b Qualifications of the RPD

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

- 4.2.b.1 leadership within the pharmacy department or within the organization through a documented record of improvements in and contributions to pharmacy practice;
- 4.2.b.2 demonstration of ongoing professionalism and contribution to the profession; and,
- 4.2.b.3 participation in workgroups or committees within the organization.

4.2.c Leadership Responsibilities of the RPD

RPDs serve as designated and authorized leaders of the residency program and have responsibility for:

- 4.2.c.1 organization and leadership of the RAC that provides guidance for residency program conduct and related issues;
- 4.2.c.2 oversight of the progression of residents within the program and documentation of completed requirements;
- 4.2.c.3 appointment of preceptors for the program;
 - 4.2.c.3.1 RPDs, in cooperation with site coordinators and partnering organization when applicable, identify preceptors for the program.
 - 4.2.c.3.2 RPDs develop and apply criteria consistent with those required by the Standard to qualify preceptors for the program.
 - 4.2.c.3.3 RPDs appoint preceptors once qualified.
 - 4.2.c.3.4 RPDs or designees create and implement an overall preceptor development program and oversee the creation of individual preceptor development plans.
- 4.2.c.4 leadership of continuous residency program improvement in conjunction with the RAC; and,
- 4.2.c.5 collaboration with all partners of the program.

4.3 Pharmacist Preceptors

4.3.a Eligibility of Preceptors

A pharmacist preceptor is a licensed pharmacist who:

- has completed an ASHP-accredited PGY1 residency and a minimum of one year of pharmacy practice experience in a community or ambulatory practice environment; or,
- has completed ASHP-accredited PGY1 and PGY2 residencies with six months of pharmacy practice experience in a community or ambulatory practice environment; or,
- has not completed an ASHP-accredited residency, but has three or more years of pharmacy practice experience in a community or ambulatory practice environment.

4.3.b Qualifications of Preceptors

Preceptors demonstrate the ability to precept residents' learning experiences as evidenced by:

- 4.3.b.1 ability to use preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at the level required by residents;
- 4.3.b.2 ability to assess and provide appropriate feedback on the residents' performance;
- 4.3.b.3 recognition in the area of pharmacy practice for which they serve as preceptors;
- 4.3.b.4 an established, active practice in the area for which they serve as preceptor;
- 4.3.b.5 maintenance of continuity of practice during the time of residents' learning experiences; and,
- 4.3.b.6 ongoing professionalism, including a personal commitment to advancing the profession.

4.3.c Preceptors' Responsibilities

Preceptors serve as role models for learning experiences and they:

- 4.3.c.1 contribute to the success of residents and the program;
- 4.3.c.2 create, implement, and maintain learning experiences in accordance with Standard 3;
- 4.3.c.3 participate actively in the residency program's continuous quality improvement processes;
- 4.3.c.4 demonstrate practice expertise, strive to continuously improve, and instruct the resident in learning experiences using established preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at appropriate levels required by the individual resident;
- 4.3.c.5 adhere to residency program and department policies pertaining to residents and services; and,
- 4.3.c.6 demonstrate commitment to advancing the residency program and pharmacy services.

4.3.d Preceptors-in-Training

- 4.3.d.1 Pharmacists who do not fully meet the qualifications for residency preceptors in sections 4.3.a, 4.3.b, and 4.3.c above are designated as preceptors-in-training.
 - 4.3.d.1.1 Each is assigned an advisor or coach who is a qualified preceptor.
 - 4.3.d.1.2 Each has a documented preceptor development plan to achieve qualifications to become a residency preceptor within two years.

4.4 Non-Pharmacist Preceptors

- 4.4.a When non-pharmacists (e.g., physicians, physician assistants, certified nurse practitioners, administrators) are utilized as preceptors, the RPD and preceptors determine if the resident demonstrates independence as a practitioner to participate in the learning experience.

- 4.4.a.1 If independence as a pharmacist practitioner is required for the resident during the learning experience, the learning experience is scheduled after the RPD and preceptors agree that the resident is adequately prepared to perform at the required level.
- 4.4.a.2 If the learning experience is related to inter-professional training (e.g., acquiring skills and abilities to be taught by other health care professionals such as physical assessment and triage, or if working with individuals with expertise outside patient care), RPD and preceptors determine appropriate scheduling of learning experiences to maximize education and training of the resident.
- 4.4.a.3 The RPD, designee, or other pharmacist preceptors work closely with the non-pharmacist preceptor to select the educational goals and objectives for the learning experience.
- 4.4.a.4 At the end of each learning experience, non-pharmacist preceptors for the learning experience complete and document a criteria-based, summative evaluation of the resident's progress toward achievement of educational goals and objectives assigned to the learning experience.

Standard 5: Requirements for Organizational Structure of the Residency Program

5.1 Requirements for a Sponsoring Organization

- 5.1.a All residency programs must have a sponsoring organization.
- 5.1.b The sponsoring organization maintains authority and responsibility for the quality of the residency program.
- 5.1.c The sponsoring organization ensures that the residency program meets residency accreditation requirements.
- 5.1.d Sponsoring organizations and all partnering organizations have signed agreement(s) that clearly define the responsibilities for all aspects of the residency program.
 - 5.1.d.1 A method of evaluation is in place to ensure that the purpose of the residency and the terms of the agreement are being met.
 - 5.1.d.2 A mechanism is established and documented for achieving consensus among partners on the evaluation and ranking of applicants for the residency.

5.2 Requirements for Practice Locations

- 5.2.a Practice locations compare the quality, safety, and financial viability of the patient care services provided at the location against national professional guidelines and Board of Pharmacy requirements to determine areas for improvement.
- 5.2.b Practice locations have sought and accepted outside appraisal of facilities and patient care practices, when such appraisals are established and recognized. The external appraisal is conducted by a recognized organization appropriate to the individual practice.
- 5.2.c Practice locations are staffed with personnel who are committed to seek excellence in patient care as evidenced by substantial compliance with professionally developed and nationally applied practice and organizational guidelines and standards, and are provided with sufficient resources to adequately conduct the program.

5.3 Requirements for Program's Organizational Structure

- 5.3.a Programs are structured as either a single-site or a multiple-site program.
 - 5.3.a.1 A PGY1 community-based single-site pharmacy residency is a program that is structured so that training occurs within one organizational entity.

- 5.3.a.1.1 All requirements for residency training are achievable within the individual organizational entity practice locations.
- 5.3.a.2 A PGY1 community-based multiple-site pharmacy residency is one in which two or more practice sites, or a sponsoring organization working in cooperation with one or more practice sites (e.g., independent community pharmacy, chain pharmacy, food chain pharmacy, outpatient clinic/facility physician practices, college of pharmacy, or health system) offer a pharmacy residency. A college of pharmacy (COP) is considered a practice location only if the COP has practice locations serving as a home base.
 - 5.3.a.2.1 For multiple-site programs, a site coordinator is appointed to manage and oversee the day-to-day operations of the residency program at each home-base practice location by the RPD in cooperation with the practice location and partnering organization.
 - 5.3.a.2.2 RPD, site coordinators, and the partnering organization, when applicable, work together to appoint and develop pharmacy staff to become preceptors for the program.
 - 5.3.a.2.3 A mechanism is documented for achieving consensus between partners on the evaluation and ranking of applicants for the residency.
 - 5.3.a.2.4 For multiple-site programs, additional practice sites used for training an individual resident beyond the resident's home-base practice site meet the requirements established for pharmacy services in Standard 6.
 - 5.3.a.2.5 Multiple-site residency programs are in compliance with the *ASHP Accreditation Policy for Multiple-Site Residency Programs*.
- 5.3.b Each resident in the program, regardless if single-site or multiple-site, is assigned a specific community-based home-base practice location (site) where he or she spends no less than 40% of his or her time.
 - 5.3.b.1 Home-base practice location (site) meets the patient care services criteria under Standard 6.
 - 5.3.b.2 Multiple residents may be located within a single home-base practice location (site) if the level of services and patient care services are sufficient in diversity, variety, complexity, and quantity to educate and train multiple residents within the practice.

Standard 6: Pharmacy Practice

- 6.1 Pharmacy Practice Structure and Management
 - 6.1.a Pharmacy practice is led and managed by a professional, legally qualified pharmacist.
 - 6.1.b The practice has a well-defined organizational structure that supports the safe and effective provision of services including:
 - 6.1.b.1 mission statement;
 - 6.1.b.2 current policies and procedures that are readily available to staff participating in service provision;
 - 6.1.b.3 descriptions of roles and responsibilities for all categories of pharmacy personnel, including residents;
 - 6.1.b.4 procedures to ensure that medication-use systems (ordering, dispensing, administration, and monitoring) are safe and effective; and,

- 6.1.b.5 procedures to ensure that pharmacists' patient care services are safe, effective, and evidence-based.
 - 6.1.c The practice has a strategic plan and documentation of progress on long-term and short-term goals.
 - 6.1.c.1 For organizations where the pharmacy department is part of a larger practice, the practice strategic planning committee includes pharmacist representatives in the planning of patient care services.
 - 6.1.d The practice is in compliance with all applicable federal, state, and local laws, codes, statutes, and regulations governing pharmacy practice unique to the practice site.
 - 6.1.e The practice is in compliance with current national practice standards and guidelines.
- 6.2 Pharmacy Resources
- Pharmacy practice has sufficient resources required to provide services pursuant to the needs of the patient population of the practice. The practice:
- 6.2.a is designed, constructed, organized, and equipped to promote safe and efficient work;
 - 6.2.b is designed to accommodate confidential patient assessment, counseling, and provision of patient care;
 - 6.2.c has professional, technical, and clerical staff sufficient and diverse enough to ensure that the practice can provide the level of service required by patients served;
 - 6.2.d has access to appropriate medical informatics, patient assessment tools/equipment, and technology necessary to provide the scope of services;
 - 6.2.e has a system to appropriately document patient care and other services of the practice; and,
 - 6.2.f has systems to support the connectivity and interoperability of information systems.
- 6.3 Pharmacy Services
- 6.3.a Pharmacy services, when applicable, extend to all areas of the practice internally and externally to the pharmacy in which medications for patients are prescribed, dispensed, administered, and monitored.
 - 6.3.a.1 Pharmacy services are integrated and provided collaboratively between internal and external areas of the practice.
 - 6.3.b Patient care services are developed and implemented in the practice based on the mission of the practice and an assessment of pharmacist services needed to provide care to patients served by the practice. Patient care services include but are not limited to:
 - 6.3.b.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;
 - 6.3.b.2 health and wellness;
 - 6.3.b.3 immunizations;
 - 6.3.b.4 disease state management incorporating medication management; and
 - 6.3.b.5 care transitions with incorporated medication reconciliation and medication management.
 - 6.3.c The patient-centered dispensing system includes the following components:
 - 6.3.c.1 a system where pharmacists are responsible for the safe and effective procurement, preparation, distribution, and control of all medications used or administered throughout the practice;
 - 6.3.c.2 a system fostering accountability and optimization of safe medication-use system technologies;

- 6.3.c.3 routine patient counseling and education services on medication initiation with any change to medication therapy for high-risk medications and high-risk patients; and,
- 6.3.c.4 evidence-based targeted interventions integrated into the patient-centered dispensing process.

6.4 Pharmacists' Roles/Responsibilities

Pharmacists providing professional services at the practice will:

- 6.4.a manage selection, procurement, storage, and dispensing of medications used within the organization;
- 6.4.b prospectively review, evaluate, and assess the appropriateness and safety of medication prescriptions/orders;
- 6.4.c assist patients with self-care decisions;
- 6.4.d administer medications based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;
- 6.4.e manage adverse drug event monitoring, resolution, reporting, and prevention programs;
- 6.4.f develop and define protocols for the delivery of patient care services;
- 6.4.g follow the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists' Patient Care Process using the principles of evidence-based practice;
- 6.4.h identify and take responsibility for resolution of drug therapy problems;
- 6.4.i perform physical assessments and conduct, order, and interpret laboratory tests based on collaborative practice agreements or other treatment protocols consistent with the law, regulations, and practice policies and procedures;
- 6.4.j participate in initiating, modifying, and discontinuing drug therapy, based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;
- 6.4.k proactively provide education and counseling to patients regarding medications and related products;
- 6.4.l document patient care in the patient's health care record;
- 6.4.m communicate with patients and families as appropriate to address and resolve potential barriers to safe and effective medication use (e.g., literacy, access, language needs);
- 6.4.n collaborate, document, and communicate with physicians, other pharmacists, patients, and other health care professionals as a member of an interprofessional team in the provision of safe, effective, and coordinated patient-centered care;
- 6.4.o provide educational programs about medications, medication therapy, health, and other related matters to patients, caregivers, and health care providers; and,
- 6.4.p participate in projects and activities relating to improving population health.

6.5 Continuous Quality Improvement

- 6.5.a Practice personnel engage in an ongoing process to assess the quality of pharmacy services.
 - 6.5.a.1 The practice has procedures to document, track, evaluate, and report patient care outcomes data.
- 6.5.b Practice personnel develop and implement pharmacy services improvement initiatives in response to assessment results.
- 6.5.c Practice assessment and improvement processes routinely include assessing and developing skills of the practice's staff.

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This Standard replaces the previous *Accreditation Standard for Postgraduate Year One (PGY1) Community Pharmacy Residency Programs* that was approved by the ASHP Board of Directors on September 22, 2006 and the APhA Board of Trustees on September 15, 2006. For existing programs, in operation as of the date of the approval and new programs commencing on July 1, 2016, the implementation of this new Standard will take effect on July 1, 2017. Until that date, the existing Standard approved in September 2006 remains in effect.

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.