Quality Assurance Plan for APRNs with Prescriptive Authority

Name of APRN:_________________________________ License #: ______________

National Certification:____

Practice Name:____

Purpose: In accordance with the Arkansas State Board of Nursing requirements for APRN Prescriptive Authority, this document describes the process for reviewing the APRN's prescriptive practices for quality assurance purposes. A retrospective medical record review allows for the identification of potential areas of concern in order to develop a corrective action plan and follow-up.

Process: For the retrospective medical record review, the Collaborating Physician(s) will review _______% of the medical records for patients under the care of the APRN. This review will occur on a quarterly basis, not to exceed 25 charts per quarter. The selection of the charts to review will be proportionally representative of the APRN's total practice in terms of treatment settings, patient age group, and patient diagnostic grouping. Charts may also be selected based on specific diseases and treatment plans. Patient interviews may also be incorporated to demonstrate patient satisfaction with the APRN's care.

The completed QA Plan will be kept in the APRN's file in Human Resources. This Quality Assurance Plan will be reviewed, signed, and dated on an annual basis. Please add an additional signature page for collaborating physicians if applicable.

Corrective Action: When an area of concern has been identified by the APRN or Collaborating Physician(s), at least one of the following actions will be taken by the APRN to improve clinical education in that area:

1. The APRN will attend a continuing education program that addresses the area of concern within 60 days.
2. The APRN will review literature published within the last 5 years relative to the issue and write a synopsis of the material reviewed, including how the material will strengthen the area of concern.
3. The APRN will undergo and document training with the Collaborating Physician(s) until necessary knowledge has been acquired and/or skills developed.

_______________________________________ ___________________________

(Signature of APRN) *(Date Signed)*

_______________________________________ ___________________________

(Signature of Collaborating Physician) *(Date Signed)*

APRNs with prescriptive authority shall provide a copy (with signatures) of this QA Plan (along with a copy of the Collaborating Practice Agreement) to the AR State Board of Nursing (ASBN): with submission of a new collaborative practice agreement, for renewal of APRN license, or as requested. Completed forms should be safely stored in the APRN's employee file for documentation of compliance to the QA Plan.