Utah State Hospital On-Line Manual
Pharmacy

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Chapter: Pharmacy Services
Section 1: Patient Drug Profiles

Policy

All medication ordered for a patient is recorded into the electronic chart. Orders that cannot be entered electronically may be written on the patient's paper chart.

Procedure

1. All medication ordered for a patient is entered into the hospital's computer drug profiling system.

2. Orders for medications or other products that are unavailable in the database, (e.g. compounds, or products not listed in First DataBank Drug Master) and which cannot be added to the database in a reasonable period of time may be written on the patient's paper chart.

3. New medication orders will be entered by the prescriber or an authorized agent of the prescriber.

4. Medication dispensing records will be maintained in the electronic drug-profiling system when possible, and/or by hard-copy report on file in the pharmacy.

5. Each drug profile will include the following patient-specific information:

    5.1. Patient's Name
    5.2. Unit Location
    5.3. Admitting Physician
    5.4. Primary Diagnosis
    5.5. Secondary diagnosis or diagnoses
    5.6. Age
    5.7. Sex
    5.8. Height
    5.9. Weight
    5.10. Fluid restriction status (if pertinent)
    5.11. Drug allergies or other hypersensitivities

6. Updated information regarding each of the above can be entered on the patient medication profile.

7. Each drug entered into the drug profile includes the following:

    7.1. Prescriber
    7.2. Drug Name
    7.3. Strength or concentration (if pertinent)

7.4. Dosage
7.5. Route of administration
7.6. Dosing frequency
7.7. Start and stop dates
7.8. Reason for prescribing (e.g. diagnosis or diagnoses)
7.9. Special instructions if appropriate

8. When a medication has been discontinued, it is removed from the active section of the medication profile.

9. Important notes pertinent to the patient may be recorded on the Notes Section of the profile. These notes remain part of the patient's permanent computer record.

04/04

Chapter: Pharmacy Services
Section 2: Obtaining Patient Information for Medication Prescribing, Dispensing, and Administration

Policy

It is the policy of Utah State Hospital to obtain patient information necessary to allow for safe, appropriate, and effective use of medications in the process of prescribing, preparing, dispensing, and administering these medications.

Procedure

1. For patients admitted to Utah State Hospital through the Admission, Discharge, and Transfer (ADT) Office, information is obtained by ADT personnel.

    1.1. Information obtained involves patient name, age, sex, current & past medications, current diagnosis or diagnoses, clinical conditions, current clinical problems, significant elements of past medical history, medication allergies and hypersensitivities, including past untoward reactions, and any other pertinent information.

2. ADT Office forwards this information for review to Pharmacy Department, as well as Psychiatric, Medical, Nursing, and other pertinent personnel on the unit to which the patient will be admitted.

3. For patients who are admitted to Utah State Hospital by means other than through the ADT Office, (e.g. to Forensic, Adolescent, Children's, and ARTC units), pertinent information will be gathered by unit personnel.

4. Pertinent information from ADT and other sources (e.g. interview of patient or patient's representatives) is evaluated and entered into the patient's electronic chart by unit personnel (e.g. nurses, physicians, and other care-givers).

5. The Pharmacy Department reviews all admitting information provided by the ADT Office in the ***Pre-Admission Assessment Document***. After reviewing this information, a pharmacist enters information regarding medication allergies and other hyper-sensitivities or untoward reactions into the patient's electronic chart. Questions regarding current medications and medication history are resolved by contact with ADT Office and other pertinent caregivers as needed.

6. Upon receipt of an order for inpatient medication preparation and dispensing, a pharmacist will review and assess important patient information in the computer-generated profiles, as it applies to safe, appropriate, and effective use of medications.

7. Medications are not prepared or dispensed until the Pharmacy Department staff receives at least the following information:

    7.1. Patient name, age, sex
    7.2. Height and approximate weight, as appropriate
    7.3. Current medications
    7.4. Clinical diagnosis
    7.5. Secondary diagnoses, clinical conditions, concurrently-occurring conditions
    7.6. Significant elements of past medical history
    7.7. Medication allergies, sensitivities, past untoward reactions
    7.8. Name of attending physician, ordering physician
    7.9. Pregnancy and lactation status, as appropriate
    7.10. Any other information required for safe medication management , as appropriate

8. Any questions regarding appropriateness of ordered medications or treatments will be resolved by a pharmacist with the prescriber and/or other pertinent personnel before medications are prepared and dispensed.

9. The above listed information is accessible electronically and/or by written record to licensed independent practitioners, pharmacy, nursing, and other clinical staff.

04/04

Chapter: Pharmacy Services
Section 3: Disposal of Unusable Controlled Substances

Policy

It is the policy of Utah State Hospital that all expired or unusable controlled substances are removed from inventory and destroyed.

Procedure

1. All expired or unusable controlled substances found on patient-treatment units shall be removed from stock and sent to the pharmacy.

2. All expired unusable controlled substances found in pharmacy inventory are removed from stock and sequestered.

3. All expired or unusable controlled substances are stored in a separate, secure cabinet in an area designated by the Pharmacy Director. This cabinet is separate from the storage area for other expired or unusable medications.

4. Disposal of expired or unusable controlled substances are done by the following methods:

    4.1. Destruction by an authorized representative of the Utah State Board of Pharmacy, Utah Department of Business Regulation (DOPL). Documentation required by state and federal law will be provided by the representative destroying the controlled substances, or

    4.2. Processing by an agent of a licensed pharmaceutical-returns processing company. This includes removal from pharmacy, or packing in shipping containers for subsequent removal from pharmacy and shipment, to the pharmaceutical-returns processing site. The representative shall provide documentation required by state and federal law.

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Chapter: Pharmacy Services
Section 4: Floor Stock Policy

Policy

Utah State Hospital Pharmacy Department is responsible for control of floor stock medications within this hospital. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital. These policies will be approved by the Pharmacy and Therapeutics Committee.

Procedure

1. Floor Stock: Medications are maintained in medication rooms on patient-care units. These are for use by licensed practitioners with appropriate privileges to administer medications.

    1.1 Only those medications approved by the Pharmacy and Therapeutics Committee for inclusion on the floor stock supply are dispensed and stored as floor stock.
    1.2 Medications contained in floor stock are stored in a secured, locked medication room or cabinet. Responsibility for security of the floor stock rests with the supervising licensed practitioner or nurse overseeing the unit on which the floor stock is stored.
    1.3 Medications contained in floor stock are stored under the conditions listed by the medication manufacturer to ensure stability.
    1.4 Floor stock drugs are requisitioned from the Pharmacy Department by the nurse or practitioner in predetermined quantities sufficient for anticipated needs.
    1.5 As with other medications, all floor stock (medications and chemicals used to prepare medications) are accurately labeled with contents, expiration dates and appropriate warnings.
    1.6 Controlled drugs for floor stock are requisitioned according to the policy on controlled drugs (see Controlled-Substances Pharmacy Policy).

2. Inspection: All floor stock supplies within the hospital are inspected monthly by a pharmacist, or a designee of the Pharmacy Director. A report of inspection is maintained by the Pharmacy Department. Reports of discrepancies are shared with the supervising professional of the units involved, and others as appropriate.

3. Expired, damaged and/or contaminated floor stock supplies are removed from drug storage areas within the hospital during the Pharmacy inspection and are returned to the Pharmacy Department for proper disposal.

4. Expired, damaged and/or contaminated floor stock supplies are stored in an isolated area in the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs remain there until proper disposal or pick up can be made.

Chapter: Pharmacy Services
Section 5: Controlled Substances – Management in Pharmacy

Policy

- The Pharmacy Department is responsible for the proper safeguarding of controlled substances within Utah State Hospital.
- The Pharmacy Department is responsible for the purchase, storage, accountability, and proper dispensing of controlled substances.
- All applicable state and federal laws governing the handling of controlled substances are enforced.

Procedure

1. Pharmacy Procurement:

    1.1. Ordering of controlled substances for the hospital as a whole is performed by the Pharmacy Director of his/her designee.
    1.2. A list of persons authorized to sign DEA order forms (Form 222) for the purchase of Schedule II controlled substances is attached at the end of this policy.

2. Pharmacy Receipt of Controlled Substances:

    2.1. Upon receipt of controlled substances, a pharmacist or pharmacy technician opens the package and verifies the identification, quantity, and condition of the package contents.
    2.2. For all Schedule-II controlled substances, a pharmacist fills out the retained copy of the DEA Form 222, indicating the quantity received, dates received, and signature.
    2.3. A photocopy of the wholesaler's invoice is attached to the retained copy of the DEA Form 222 and filed.
    2.4. Discrepancies in shipment are identified and reported to the Pharmacy Director. The entire shipment, including the exterior shipping container, is segregated in a secure storage area within the Pharmacy Department, pending disposition of investigation.

3. Pharmacy Storage:

    3.1. All Schedule-II controlled substances are stored in a secure pharmacy area in locked cabinets.

3.2. Keys to these cabinets are kept only by the Pharmacy Director and other pharmacists.
3.3. Access to locked Schedule-II cabinets is restricted to pharmacists, or pharmacy technicians under a pharmacist's supervision.
3.4. Schedule III, IV, and V substances are distributed among the general pharmacy inventory in secure medication storage areas.
3.5. Access is limited to pharmacists and Pharmacy Department personnel under the direct supervision of a pharmacist.
3.6. Access to medication storage areas is given to others (e.g. environmental services or maintenance personnel), under direct supervision of a pharmacist, if legitimate need exists, and shall be constantly monitored.
3.7. All expired or unusable controlled substances are stored in a separate, secure cabinet in an area designated by the Pharmacy Director. This cabinet shall be separate from the storage area for other expired or unusable medications.

4. Dispensing to Patient-Care Units (for in-house use):

4.1. All Schedule II, III, IV and V drugs for in-patient use are dispensed to the patient care units as secured floor stock.
4.2. To replenish stock controlled substances, nursing personnel check inventory levels in the medication room daily. Controlled substances for in-patient use are ordered electronically as floor stock using the *Ward Stock/Controlled-Drug* order program. The quantity ordered is the amount necessary to meet the unit's needs for approximately one week. The Pharmacy Department fills orders based upon the time received.
4.3. Order requests for controlled substances are processed electronically by a pharmacist or pharmacy technician.

4.3.1. The following information is recorded by electronic processing:

4.3.1.1. The treatment unit requesting the order
4.3.1.2. The person entering the request
4.3.1.3. The time and date of the request
4.3.1.4. Controlled substance and quantity requested
4.3.1.5. The pharmacist or technician processing the order
4.3.1.6. The pharmacist or technician dispensing the order
4.3.1.7. The person receiving the order from the pharmacy
4.3.1.8. The date the usage-documentation sheet is returned to the pharmacy
4.3.1.9. The quantity of any controlled substance returned to the pharmacy

4.4. The electronic program generates a dispensing list, labels, and usage documentation sheets.
4.5. The dispensing list ***Pharmacy Order Form for Controlled Substances*** is used for documentation of dispensing and receipt of order by unit.

4.5.1. The dispensing list is signed and dated by the pharmacist or pharmacy technician dispensing the order.

4.5.2. A pharmacist checks each package dispensed and initials each line item on the dispensing list to verify accuracy of content and quantity.

4.5.3. All orders dispensed by a pharmacy technician are checked and signed by a pharmacist.

4.5.4. The nurse or authorized representative receiving a controlled substance order from the pharmacy checks each package, and initials each line item on the dispensing list to verify accuracy of content and quantity. If a nurse is unavailable to verify accuracy and content of each package, the medication is not transferred to the unit.

4.5.5. The dispensing list is legibly signed by the nurse or authorized representative to indicate the order was received. Any order discrepancies are resolved before the medication is transferred to the unit.

4.6. Orders are sent to patient-care areas with numbered usage-documentation sheets titled ***Utah State Hospital Controlled-Drug Sheet***.

4.6.1. After packages of controlled substances are used, the completed usage-documentation sheet is returned to the pharmacy, and a photocopy kept by the unit nursing director for a period of one year.

4.6.2. Any controlled substances returned to the pharmacy are documented on the usage sheet.

4.6.3. The Pharmacy Department retains copies of the dispensing list ***Pharmacy Order Form for Controlled Substances*** and the usage sheet for a period of five years.

4.7. Orders are sent to patient-care areas with numbered usage-documentation sheets titled ***Utah State Hospital Controlled-Drug Sheet***.

5. Dispensing to Patient-Care Units (for in-house use):

5.1. The *Ward Stock / Controlled-Drug* order program is audited at least monthly by pharmacy staff to verify receipt of usage-documentation sheets for all orders dispensed. Any discrepancies are reported to the Pharmacy Director for reconciliation.

6. Delivery or Transport of Controlled Substances Between Pharmacy Department and Treatment Units

6.1. All controlled substances transported between the pharmacy and treatment units are transported in a secure container (e.g. a zippered bag), as defined by the Pharmacy & Therapeutics Committee, and agreed upon with USH Executive Staff.

7. Dispensing to Patients (for patient leave or discharge)

7.1. Controlled substances for patients on leave or being discharged will be ordered and dispensed in the patient's name, rather than as floor stock.

7.2. Controlled substances for patients going on leave or being discharged are ordered electronically by nursing personnel.

7.2.1. The quantity ordered does not exceed the amount needed for the length of the patent's leave.

7.2.2. Quantities for discharge do not exceed a two-week supply. Exceptions must be approved by the Pharmacy Director. The Pharmacy Department fills orders based upon the time received. Controlled substances for patients on leave or being discharged are ordered and dispensed in the patient's name, rather than as floor stock.

7.3. Order requests for controlled substances are processed electronically by a pharmacist or pharmacy technician.

7.3.1. The electronic program generates a dispensing list and labels.

7.3.2. Leave or discharge controlled substances are dispensed in child-proof containers, and be labeled with patient instructions, and will include any appropriate accessory labels.

7.3.3. The dispensing list is signed and dated by the pharmacist or pharmacy technician dispensing the order.

7.3.4. All leave or discharge orders dispensed by a pharmacy technician are checked and signed by a pharmacist.

7.3.4.1. A pharmacist checks each package dispensed and initials each line item on the dispensing list to verify accuracy of content, quantity, and patient instructions.

7.3.5. All leave or discharge orders dispensed by a pharmacist are double-checked by another pharmacist.

7.3.5.1. A pharmacist checks each package dispensed and initials each line item on the dispensing list to verify accuracy of content, quantity, and patient instructions.

7.4. Controlled Substance Orders dispensed for patient leave or discharge are documented on the form "***USH Leave or Discharge Controlled Substances Tracking Sheet"***.

7.4.1. A pharmacist or pharmacy technician initials each line item on the tracking sheet to verify accuracy of content and quantity.

7.4.2. The nurse or authorized representative receiving a controlled substance order from the pharmacy for patient leave or discharge checks each package, and initials each line item on the "***USH Leave or Discharge Controlled Substances Tracking Sheet"*** to verify accuracy of content and quantity.

7.4.3. This form is returned to the pharmacy when a patient returns from leave, or after the patient is discharged, and is filed with the patient's medication orders.

8. Storage on Patient-Care Units:

8.1. Controlled substances on patient-care units are kept in a locked cabinet, drawer, or cart within the locked medication room. Controlled substances requiring refrigeration are kept within a locked box within the medication refrigerator. Access to controlled substances is limited to licensed nursing personnel and pharmacists.

8.2. All controlled substances are inventoried by nursing personnel at each change-of shift. Any discrepancies are immediately reported to the Unit Nursing Director, Director of Nursing, and the Pharmacy Director for resolution.

9. Inventory System:

9.1. A biannual inventory of all controlled substances is taken by a designated pharmacist and/or pharmacy technicians, and is kept on file in the Pharmacy Department pursuant to state and federal laws.

10. Suspected Tampering of Controlled Drugs:

10.1. Whenever a pharmacist or pharmacy technician discovers an irregularity, i.e., tampering, with the controlled substances in the pharmacy, the Pharmacy Director must be immediately notified.

10.2. The Pharmacy Director or designated pharmacist separates the suspected drugs from the other drugs. An incident report is generated pending further investigation if necessary.

11. Hospital pharmacists are authorized to sign DEA Form 222 or use electronic ordering for the purchase of Schedule II Controlled Substances.

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Chapter: Pharmacy Services
Section 6: Controlled Substance Management on Patient Care Units

Policy

Adequate control, dispensing and accountability of all controlled substances in conformity with state and federal regulations are ensured.

Procedure

1. Security

    1.1 When not in use, the controlled substances storage area on each patient care unit is kept double-locked and secure at all times.
    1.2 Keys to the controlled substances are only be carried by a nurse approved to pass medications. At no time are the keys to be released to an unauthorized person.

2. Ordering Controlled Substances:

    2.1 Controlled substances for in-patient use shall be ordered electronically as floor stock using the *Ward Stock/Controlled-Drug* order program. The quantity ordered should be the amount necessary to meet the unit's needs for approximately one week. The Pharmacy Department fills orders based upon the time received.
    2.2 Controlled substances for patients on leave or being discharged are ordered electronically in the patient's name, rather than as floor stock.
    2.3 The nurse or authorized representative receiving a controlled substance order from the pharmacy checks each package, and initial each line item on the dispensing list to verify accuracy of content and quantity.
    2.4 The nurse accepting the controlled substance(s) ensures the amount is entered onto the Controlled Substance log on the treatment unit according to nursing policy.

3. Accountability:

    3.1 Controlled substances are counted at the change of each shift by both the licensed nurse leaving the shift and the nurse coming on duty. Both nurses sign the Controlled Substances Disposition Sheet thereby verifying that the count is correct.
    3.2 These controlled substances are administered only to inpatients within the hospital upon the written order of an authorized prescriber licensed to prescribe controlled substances.

3.3 The Pharmacy Department is responsible for the accountability of all controlled substances until a nurse signs for the drug(s). Any discrepancy occurring after receipt of the drug(s) is the responsibility of the nursing staff.

4. Wastage:

4.1 In the event of a controlled substance being discarded or wasted (all or part of an issued dose), the signatures of two (2) nurses, or one (1) nurse and the Pharmacist, is required on the controlled substances administration record are required.

5. Suspected Tampering of Controlled Drugs:

5.1 It is the responsibility of each patient care unit to control and maintain the integrity of all controlled drugs and to make a regular inventory of such drugs during the time they are stored on the unit. When any irregularities, such as tampering, are suspected, the Pharmacy Department is responsible for the evaluation and proper disposition of the drugs in question.

5.2 Whenever a nurse discovers an irregularity, i.e., tampering, with the controlled substances on the patient care unit, he/she is responsible for immediately notifying the Unit Nursing Director/SSRN about the suspected tampering.

5.3 The UND or SSRN notified the Director of Nursing and pharmacy of the suspected tampering.

5.4 A UND, SSRN, or nursing administrator confiscates the suspected drugs and turn them into the Pharmacy Director.

6. Discrepancy:

6.1 Whenever a discrepancy occurs in the count of a controlled substance, or a suspected tampering occurs, the Unit Nursing Director or SSRN is notified immediately. Every effort is made by off-going shift to trace and correct the discrepancy before anyone involved leaves the premises. Any discrepancy requires the parties involved to note the discrepancy on the accountability sheet (e.g. *Utah State Hospital Controlled-Drug Sheet*) and notify the Pharmacy Director and the Director of Nursing or SSRN.

6.2 In the event the discrepancy cannot be rectified, the complete facts are documented on an Incident Report. The Unit Nursing Director ensures that the incident report documents all the facts and the names of all personnel that may have been involved.

7. Administration / Recording:

7.1 When medication is removed from stock, the *Utah State Hospital Controlled-Drug Sheet* is completed to indicate date, time, quantity administered, patient's name and unit, and signed by the nurse administering the medication. Proper entry with two (2) signatures of licensed nurses is made for any wastage.

Chapter: Pharmacy Services
Section 7: Drug Inventory Control

Policy

Inventory control of medications at Utah State Hospital is the responsibility of the Pharmacy Department. Policies and procedures are designed to ensure proper and secure storage of medications throughout the hospital. These policies are approved by the Pharmacy and Therapeutics Committee.

Procedure

1. Medications are stored under proper conditions of temperature, humidity, and light as stated by the medication manufacturer to assure stability.

    1.1 Room temperature of the pharmacy and all medication storage rooms are maintained at **59-86° Fahrenheit** (*United States Pharmacopoeia* Room Temperature).
    1.2 The pharmacy and all medication storage rooms are kept free from excessive humidity.
    1.3 Medications are stored away from direct sunlight, heat, or moisture sources.
    1.4 Medications requiring special storage conditions (e.g. refrigeration) are stored according to the manufacturer's storage recommendations as indicated on the package.
    1.5 Medications requiring storage conditions other than room temperature (e.g. refrigeration), are labeled by the pharmacy with appropriate storage requirements when dispensed.
    1.6 If medication room conditions on patient-care units deviate from appropriate temperature, humidity, or light requirements, this deviation is reported immediately to the Pharmacy Department for evaluation and resolution.
    1.7 Medication refrigerators on patient-care units have their temperatures checked daily by a nurse, and the results recorded. Medication refrigeration temperatures are maintained at **36-46° Fahrenheit** (*United States Pharmacopoeia* standard). If the refrigerator temperature falls outside this range, it is reported immediately to the Pharmacy Department and Facilities Department for evaluation and resolution.
    1.8 If an electrical power failure occurs and a medication refrigerator is without power for more than two hours, its temperature is checked. If this temperature falls outside the accepted range, it is reported immediately to the Pharmacy Department for evaluation and resolution. If necessary, contents of a medication refrigerator on a patient-care unit will be transferred to a pharmacy refrigerator until the medication room refrigerator is operating properly.
    1.9 Medication refrigerator(s) in the Pharmacy Department have their temperature(s) checked monthly. A record of monitoring will be posted on the outside of each refrigerator. Temperatures must be maintained at **36-46° Fahrenheit**. If the

refrigerator temperature falls outside this range, it is reported immediately to the Pharmacy Director.

1.10 To maintain integrity of refrigerated items, the Pharmacy Department has a backup generator to provide uninterrupted electrical power to the medication refrigerator(s) if a power failure occurs.

2. Medications are stored in a secure manner.

2.1 The Pharmacy Department is locked at all times. Access is limited to pharmacists and Pharmacy Department personnel under the direct supervision of a pharmacist.

2.2 Access to others, under direct supervision of a pharmacist, is given if legitimate need exists (e.g. environmental services or maintenance personnel), and shall be constantly monitored.

2.3 Medication rooms on patient-care units are locked. Access is limited to licensed nursing personnel and pharmacists.

2.4 Controlled substances on patient-care units are kept in a locked cabinet, drawer, or cart within the locked medication room. Controlled substances requiring refrigeration are kept within a locked box within the medication refrigerator. Access to controlled substances is limited to licensed nursing personnel and pharmacists.

2.5 All high-risk drugs and drugs with increased potential for dispensing error due to look-alike/sound-alike names will be stored in the Pharmacy Department in shelf boxes with distinctive labeling (e.g. "tall man" lettering, color coding, secondary caution labels, or combinations of these) and are physically segregated from other medications with which they may be confused, thereby alerting staff to take additional dispensing precautions.

2.6 All high-risk drugs and drugs with increased potential for administration error due to look-alike/sound-alike names are labeled with distinctive labeling (e.g. "tall man" lettering, color coding, secondary caution labels, or combinations of these), thereby alerting staff to take additional administration precautions.

3. Inspection:

3.1 All drug storage areas within the hospital are inspected monthly by a pharmacist, or a designee of the Pharmacy Director. A report of inspection is maintained by the Pharmacy Department. Reports of discrepancies are shared with the supervising nurse of the units involved, and/or Director of Nursing.

3.2 Expired, damaged and/or contaminated medications are removed from drug storage areas within the hospital during the pharmacy inspection and are returned to the Pharmacy Department for proper disposal.

3.3 Nurses may also remove damaged and/or contaminated medications from medications rooms on patient-treatment areas, and return them to the Pharmacy Department for proper disposal.

3.4 Expired, damaged and/or contaminated medications are stored in an isolated area in the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs remain there until proper disposal or pick up can be made.

Chapter: Pharmacy Services
Section 8: Emergency Medications

Policy

This hospital maintains mobile supplies of emergency equipment and medications located in crash carts and portable emergency medication boxes in patient care areas. The participants of the Pharmacy and Therapeutics Committee, which include licensed independent practitioners, members of the administration, nursing and pharmacy staff, determines which medications will be stocked in these carts and portable boxes in unit dose, age-specific and ready-to-administer forms, whenever possible per hospital policy. The Pharmacy Department is responsible for the overall integrity and security of medications contained in the crash carts and portable boxes.

Procedure

1. The emergency drug supply is stored in a clearly marked portable container, which is sealed by the Pharmacist with a seal which must be broken to gain access to the drugs. The contents of the container are listed on the outside cover and include the earliest expiration date of the drugs within.

2. The Pharmacy Department seals the emergency medication container with a numbered “break-away” lock to secure the medications in the container. The Pharmacy Department will maintain a record of which lock numbers have been assigned to the emergency medication containers.

3. The nurse or licensed healthcare professional reports to pharmacy when medication is used from the emergency drug supply. The Pharmacist inspects the drug supply monthly as part of a monthly unit inspection, including the number of the lock/seal assigned to the specific emergency medication container.

4. All used emergency medication containers when returned to the Pharmacy Department receives highest priority in restocking, resealing and replacing to the appropriate patient care unit. The priority this process receives is consistent with the priority of the filling of all STAT medications.

Chapter: Pharmacy Services
Section 9: Patient's Own Medications (Storage and Destruction)

Policy

Medications that have been brought in by patients at admission are sent home with the family, or the medications are stored in the Pharmacy Department in a specified location and according to a specific procedure.

Procedure

1. Drugs that are not to be used during the patient's stay at the hospital are given to the patient's family to take home, when possible.

2. In the event that the medications cannot be sent home, the medications are placed in a bag, marked with the patient's name and sent to the Pharmacy. The Pharmacist (or Nursing Supervisor, after normal Pharmacy hours) places the labeled bag of medications in a separate area marked "patients own medications" away from all other pharmacy stock.

3. The medications are logged into the Patient's Own Medication Log on the appropriate form with date, name of patient, name and strength of drug and prescription number.

4. If the patient or patient's representative or nurse picks up the medication, he/she signs the logbook upon return of the medications to the family.

5. Destruction of Patient's Own Medication:

   5.1 Patient's own medication is preferably returned to the patient's family at admission.
   5.2 If the medication is unable to be returned to the family, it is sent to the Pharmacy Department for storage.
   5.3 If the medications are not claimed within 30 days after discharge, they are destroyed in the following manner:

      5.3.1 Drugs listed in Schedule II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended, are destroyed in the presence of two (2) pharmacists employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the required witnesses shall be recorded in the Patient's Own Medication Log. The log shall be retained for at least three (3) years.

5.3.2 Drugs not listed under Schedule II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, are destroyed in the presence of a pharmacist and noted in the Patient's Own Medication Log.

5.3.3 Drugs may also be sent to drug disposal companies.

Chapter: Pharmacy Services
Section 10: Patient's Own Medication (Usage, Storage, and Destruction)

Policy

Medications brought into Utah State Hospital by the patient, patient's family, or guardian, may be utilized by the patient if the following criteria are met.

1. The medications are ordered by a Utah State Hospital authorized prescriber with privileges to prescribe the medication, and

2. An order is entered into the patient's chart (electronic or written) for each medication.

   2.1 The medication container(s) are clearly and properly labeled.
   2.2 The contents of the container(s) have been examined, positively identified and the integrity evaluated.

3. Patient's own medication may be used for non-formulary medication orders.

Procedure

1. Medications brought into Utah State Hospital by the patient, patient's family, or guardian, are listed on a form giving the following information:

   1.1 Patient's name
   1.2 Name of medication(s)
   1.3 Strength or concentration (if applicable)
   1.4 Quantity
   1.5 Date and time received
   1.6 Identification of the nurse or nurses receiving the medication(s)
   1.7 Any pertinent comments

2. This form, along with the corresponding medication(s), is brought to the pharmacy for positive identification of medication(s) by a pharmacist. A pharmacist initials and dates each line of medication listed, verifying the identity of the medication.

3. If the pharmacy is closed, and identification by a pharmacist cannot be made before the medication is needed for administration, the medication identification may be made by two nurses, or a nurse and an authorized prescriber. Identification can be made by:

   3.1 Comparing the patient's medication with other medication properly labeled by the drug manufacturer or packager, or the Pharmacy Department, using appearance (e.g. size, shape, color) and medication imprint code (for tablets or capsules), or

3.2 Other means or identification, including, but not limited to:

3.2.1 Gold Standard Clinical Pharmacology Online at http://cpip.gsm.com/
3.2.2 PDR (Physician's Desk Reference)
3.2.3 Identidex
3.2.4 Indent-A-Drug Reference
3.2.5 Electronic sources, such as http://rxlist.com/interact.htm#keyword (Rx List ADVANCED search). This allows you to search by imprint code under the title ***RxList-ID Imprint Code Identification***.
3.2.6 Verification by contacting University of Utah Drug Information Services

The University of Utah
Drug Information Service
Dept of Pharmacy Services
421 Wakara Way, Suite 204
Salt Lake City, UT 84108

(801) 581-2073 phone
(801) 585-6688 fax
Drug.Info@hsc.utah.edu

4. Medications identified by means other than inspection and verification by a pharmacist, are documented on the form as to persons and methods used for identification.

5. Medications not positively identified, or medications of questionable integrity are not being administered to the patient under any circumstances.

6. Medication(s) that are to be used by the patient may be taken back to the unit, stored in the medication room, and administered to the patient.

7. Medications that are not to be used by the patient will be labeled and stored in the pharmacy. These may be returned to the patient at discharge, if appropriate. If it appears likely that the patient's stay will be short, and the patient will be discharged at a time when the pharmacy is closed, these medications may be stored in the medication room on the treatment unit.

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Chapter: Pharmacy Services
Section 11: Monitoring Effects of Medications on Patients

Policy

1. The effects of medications on patients are monitored to assess the effectiveness of medication therapy, and to minimize the occurrence of adverse events. Each patient's response to medication administered is monitored according to his or her clinical needs. Ongoing patient-medication monitoring involves a collaborative approach among physicians, nurses, pharmacists, and the patient, family or other caregivers.

2. Monitoring addresses patient response to medication, and actual or potential medication-related problems. The results of patient-medication monitoring are used to improve the patient's medication regimen and/or other clinical care and treatment processes.

Procedure

1. Direct patient-care providers (physicians, nursing staff), and others as appropriate monitor and assess the effect of medications on the patient. Pharmacists may be consulted for specific monitoring parameters.

2. Monitoring and assessing the effect of the medication includes, but is not limited to:

   2.1 Direct observation of the patient during assessments, evaluations, or other patient contact to determine the patient's response to the medication administered, and any problems or adverse effects associated with the medication.

   2.2 Review of:

      2.2.1 Results of clinical diagnostic studies
      2.2.2 Results of clinical laboratory values/levels
      2.2.3 The medication profile
      2.2.4 Current clinically-related data about the patient's condition and progress, as documented in the medical record (i.e., medical staff, nursing and other discipline's progress notes, notations on care plans, consultation reports).

   2.3 Information about the patient's own perceptions about medication side effects, perceived efficacy and/or sensitivities the patient may have to the medication.

3. First-Dose Monitoring

3.1 When the patient is given a medication that is new to the patient, special attention is given to monitoring the effects of the first dose or doses, since adverse events are most-likely to occur early in the course of therapy.

3.2 The prescriber indicates on the comments section of the medication order to "monitor effects of first dose", or other similar instructions.

3.3 Monitoring is dictated by parameters in written protocols (as attached to medication orders), specific prescriber instructions, or pharmacist instructions as printed on the medication order appearing on the MAR (medication administration record).

3.4 If the patient is to be monitored for effects or adverse reactions of medications without protocols, or for effects not specifically mentioned in protocols, (e.g. rash, excessive sedation, orthostatic hypotension, allergic reaction, etc.), the prescriber so indicates these additional monitoring parameters in the comments section of the medication order.

3.5 The nurse observes the patient for any untoward reaction or patient perception of medication effect after the first dose is given. If any monitoring parameters are specifically indicated on the order, the patient is additionally monitored for those specific effects.

3.6 Occurrence of any untoward or suspected untoward reaction is reported to the prescribing clinician, and documented in the notes section of the patient's chart.

3.7 Depending on the severity of any untoward or suspected untoward reaction, the medication may be discontinued, or continued with further monitoring as appropriate.

3.8 The patient receives a test dose for medications when both appropriate and available (i.e., some categories of antibiotics or depot drugs) for medications given on a first time basis in an effort to identify an adverse drug reaction, allergy or sensitivity to the medication.

3.9 To prevent unnecessary side effects or adverse reactions, other clinical laboratory studies (e.g. renal or hepatic function tests) may be ordered as appropriate to monitor the patient’s reaction to medications, and make appropriate dosing adjustments.

4. The information obtained through patient-medication monitoring and assessment is documented in the patient’s electronic medical record.

5. If no untoward reaction(s) or patient perception of untoward reactions occurs with the first dose, there is no requirement to document this. However, a note to this fact may be entered into the patient record to document that monitoring for first-dose effect was performed.

Chapter: Pharmacy Service
Section 12: Therapeutic Drug Monitoring

Policy

The Pharmacy and Therapeutics Committee establishes drug-therapy monitoring protocols as indicated. These protocols will be available to all appropriate hospital personnel at the time of ordering of protocol medications. Medications requiring protocols will be identified on the electronic-ordering system at time of order entry.

Procedure

1. Protocols are added to the electronic order system as approved by the Pharmacy and Therapeutics Committee.

2. Protocols indicate monitoring parameters, including laboratory tests required, and their frequency and duration of monitoring.

3. Based on pharmacists' monitoring of patient's parameters, any modifications to therapy are discussed by the pharmacist and prescriber. The prescriber may order any additional monitoring as indicated.

Chapter: Pharmacy Services
Section 13: Pharmacist's Therapeutic Intervention

Policy

Patients have their medication profiles reviewed by a pharmacist at the time a medication is originally prescribed, or the order modified.

Procedure

1. At the time a medication is entered into the electronic order-entry system, a pharmacist reviews the order for potential drug interactions, therapeutic duplication, proper dosage, appropriateness for the patient's condition, and to ensure appropriate monitoring of the medication is performed. The pharmacist electronically validates the order.

2. Protocols for certain medications or classes of medications exist, and are found in nursing policies and procedures.

3. For medications requiring specific monitoring other than that specified in protocols, (e.g. laboratory tests, clinical observation of patient, vital signs, etc.), or other monitoring in addition to that specified by the protocols, the pharmacist contacts the prescriber to ensure that appropriate monitoring occurs.

4. A pharmacist may intervene in the drug-therapy process at any step if he or she has any concerns regarding the appropriateness of any aspect of the drug therapy. The prescriber, and/or others involved may be contacted to resolve any issues of concern.

5. Pharmacists shall document therapeutic interventions, and include the date, time, patient name, person or persons contacted, and a brief summary of the intervention and its results. This documentation can be entered in the electronic chart under the "alerts" section; it can also be documented in a log kept in the pharmacy department. If the pharmacist considers the intervention especially significant, he or she files a copy in the patient's medication folder kept in the Pharmacy Department.

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Chapter: Pharmacy Services
Section 14: Medication Errors

Policy

1. Utah State Hospital has a process to monitor and respond to actual or potential medication errors. All actual or potential errors identified will be reported through the Utah State Hospital ***Patient Incident Reporting System*** (PIRS). Reporting of errors is encouraged by using a non-punitive system.

2. All medication error reports are reviewed by the Pharmacy and Therapeutics Committee.

Definitions

1. Medication errors are categorized according to criteria defined by the ***National Coordinating Council for Medication Error Reduction and Prevention*** (NCCMERP):

   1.1 NO ERROR

      1.1.1 Category A – Circumstances or events that have the capacity to cause error.

   1.2 ERROR, NO HARM

      1.2.1 (Note: Harm is defined as temporary or permanent impairment of the physical, emotional, or psychological function or structure or the body and/or pain resulting there from requiring intervention).

      1.2.2 Category B – An error occurred but the error did not reach the patient (Note: An “error of omission” does reach the patient).

      1.2.3 Category C – An error occurred that reached the patient, but did not cause patient harm.

         1.2.3.1 Medication reaches the patient and is administered.
         1.2.3.2 Medication reaches the patient but *not* administered.

      1.2.4 Category D – An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

   1.3 ERROR, HARM

      1.3.1 Category E – An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.

1.3.2 Category F – An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.

1.3.3 Category G – An error occurred that may have contributed to or resulted in permanent patient harm.

1.3.4 Category H – An error occurred that required intervention necessary to sustain life.

1.4 ERROR, DEATH

1.4.1 Category I – An error occurred that may have contributed to or resulted in the patient's death.

Procedure

1. Error Reporting

1.1 When a medication error occurs, the practitioner discovering the error does the following:

1.1.1 Notify the patient's primary physician (and others as appropriate)
1.1.2 Evaluate the patient
1.1.3 Perform any necessary clinical interventions
1.1.4 Report the error in the ***Patient Incident Reporting System -*** The following information will be entered in the appropriate areas:

1.1.4.1 Patient Identification and Unit
1.1.4.2 Activity Date and Location
1.1.4.3 Activity Description (brief narrative)
1.1.4.4 Category / Outcome (NCCMERP Categories A through I)
1.1.4.5 Error Type (no error, prescribing, dispensing, administration, complex)
1.1.4.6 Number of Occurrences
1.1.4.7 Error Identified by
1.1.4.8 Error Made by
1.1.4.9 Causes of Error (if known)
1.1.4.10 Type of Error
1.1.4.11 Contributing Factors (if known)
1.1.4.12 Medication(s) Involved
1.1.4.13 Persons perpetuating (furthering) the initial error, and locations where error perpetuated

2. Error Evaluation and Follow-Up

2.1 Unit Nursing Directors review medication errors reported in PIRS for their units.

2.1.1 Appropriate comments are entered in the follow-up sections of PIRS.
2.1.2 Circumstances leading to errors are identified and corrected when appropriate.

2.2 Other administrative personnel review medication errors at their discretion.

2.2.1 Appropriate comments are entered in the follow-up sections of PIRS.
2.2.2 Circumstances leading to errors are identified and corrected when appropriate.

2.3 The Pharmacy Director reviews medication errors reported in PIRS.

2.3.1 Appropriate comments are entered in the follow-up sections of PIRS.
2.3.2 Circumstances leading to errors are identified and corrected when appropriate.
2.3.3 Reports for Pharmacy and Therapeutics Committee are compiled for committee review.

2.4 The Pharmacy and Therapeutics Committee reviews mediation error reports, and identify trends or concerns.

2.4.1 The committee reports any concerns to the appropriate departments, e.g. Quality Resources, Risk Management, Nursing Administration, Medicine, Pharmacy, or others.
2.4.2 The committee makes recommendations as necessary to reduce or prevent future medication errors.

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Chapter: Pharmacy Services
Section 15: Adverse Drug Reaction (ADR)

Policy

As part of Utah State Hospital's evaluation of medication use, all significant adverse drug reactions (ADR) are reviewed by the Pharmacy and Therapeutics Committee.

The purposes of reviews are to:

- Assess the safety of drug therapies; especially new ones.
- Educate healthcare professionals on drug effects, and increase awareness of adverse drug reactions.
- Identify and measure trends.
- Identify and implement ways of minimizing preventable ADR's.
- Provide data for quality improvement and drug-usage evaluation programs.

Definition:

An adverse drug reaction is defined as:

"Any response to a drug that is undesired, unintended, and that occurs at doses accepted in medical practice."

Procedure:

1. Responsibility to report ADR's:

   1.1 All adverse drug reactions, or suspected adverse drug reactions, are reported by the physician, nurse practitioner, or pharmacist who first suspects the reaction.

      1.1.1 The patient's primary physician shall be notified of all suspected ADR's.
      1.1.2 If the suspected medication is prescribed by someone else, that prescriber is also notified.

2. Identification of ADR's:

   2.1 Adverse drug reactions are identified by the following methods:

      2.1.1 Reporting of ADR's by practitioners
      2.1.2 Monitoring the use of "tracer" drugs that are used to treat common adverse drug reaction (i.e., orders for immediate doses of antihistamines, epinephrine, corticosteroids, opiate antagonists, romazicon, vitamin K preparations, benztropine, and others). This may be done by periodic chart review or by pharmacist inquiry when

medication orders for these “tracer” drugs are received by the pharmacy.

2.1.3 Spontaneous or retrospective medical record or chart review; particularly for medications with high risk for adverse drug reactions.

3. Methods of Reporting:

3.1 Adverse drug reactions or suspected adverse drug reactions are reported in one of the following ways:

3.1.1 Written:

3.1.1.1 Adverse drug reactions are reported using the report form USH Suspected ADVERSE DRUG REACTION Reporting Form located on the computer network at f:\users\all\pharmacy\wdata\USH_6103ADR Reporting Form.doc.

3.1.2 Telephone:

3.1.2.1 Adverse drug reactions may be reported by calling the Pharmacy Department at 344-4600, 344-4601, or 344-4602 and asking for a pharmacist. The pharmacist completes the form.

3.1.3 E-mail:

3.1.3.1 An e-mail can be sent to the pharmacy department, or an individual pharmacist, giving the basic details; a pharmacist will complete the form and follow-up.

4. Evaluation of ADR Reports:

4.1 All ADR reports are evaluated by a pharmacist.

4.2 ADR Reports and summaries of findings are reviewed by the Pharmacy and Therapeutics Committee.

4.3 The Pharmacy and Therapeutics Committee may recommend further analysis in drug use evaluation programs and other quality improvement efforts.

4.4 Drugs which are frequently encountered in adverse drug reaction analysis may be targeted for further evaluation and/or education efforts of staff.

4.5 The reporting of an ADR will not be construed to indicate wrongdoing on the part of any individual. However, if the Pharmacy and Therapeutics Committee determines that the findings may be relevant to an individual’s performance, the adverse drug reaction report will be forwarded to the medical service for peer

review in accordance with the standards on renewing and revising clinical privileges.

5. Adverse Drug Reactions Reportable to the FDA (Food and Drug Administration)

5.1 ADR's meeting one of the following criteria are reported to the FDA's *Med Watch* Program:

5.1.1 The suspected drug has been on the market for less than two years.
5.1.2 The reaction is not listed in the package insert.
5.1.3 The reaction is attributed to an investigational drug.
5.1.4 The reaction contributed to the death of the patient.
5.1.5 The reaction was life-threatening or permanently disabling.

5.2 Reporting may be done in the following manner:

5.2.1 Using the FDA Med Watch Form 3500 (or the most currently available update of this form located at http://www.fda.gov/medwatch/SAFETY/3500.pdf
5.2.2 Online reporting at https://www.accessdata.fda.gov/scripts/medwatch/

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Chapter: Pharmacy Services
Section 16: Licensure and Professional Standards

Policy

The Pharmacy Department at USH operates within all applicable state and federal laws, regulations and licensure requirements. In matters of professional judgment or practice standards, the *American Society of Health-System Pharmacists* (ASHP) and the *Joint Commission on Accreditation of Healthcare Organizations* (JCAHO) recommendations are given first consideration and priority.

Procedure

1. Pharmacists employed at Utah State Hospital are licensed to practice pharmacy in the State of Utah, and to dispense controlled substances.

    1.1 Copies of current licenses are conspicuously displayed in the Pharmacy Department.
    1.2 Photocopies of current licenses are on file in individual personnel folders in the Human Resources Department. Upon expiration of license, new photocopies are furnished.

2. Pharmacy technicians employed at Utah State Hospital are licensed to perform pharmacy technician duties in the State of Utah.

    2.1 Copies of current licenses are displayed in the Pharmacy Department.
    2.2 Photocopies of current licenses are on file in individual personnel files in the Human Resources Department.

3. Pharmacists and pharmacy technicians comply with all applicable laws and regulations, including those in the Code of Federal Regulations, the Federal Controlled-Substance Act, the Utah Pharmacy Practice Act, the Utah Pharmacy Practice Rules, the Utah Controlled-Substance Act, and any additional applicable laws and regulations.

4. The Pharmacy Department of Utah State Hospital maintains a current State of Utah Hospital Pharmacy License and Controlled Substance License.

    4.1 These licenses are displayed in the Pharmacy Department.

5. The Pharmacy Department of Utah State Hospital complies with all laws, regulations and requirements of the Drug Enforcement Administration (DEA).

    5.1 Utah State Hospital maintains current and valid registration with DEA. The registration certificate is displayed in the Pharmacy Department.

5.2 All pertinent required records are maintained by the Pharmacy Department, including order forms (DEA-222), disposal (DEA-41), loss (DEA-106) and the biannual inventory.

6. Current copies of the Code of Federal Regulations, the Federal Controlled-Substance Act, the Utah Pharmacy Practice Act, the Utah Pharmacy Practice Rules, the Utah Controlled-Substance Act, are maintained in the Pharmacy Department, either in hard-copy, or easily-retrievable electronic format.

7. Utah State Hospital pharmacists and pharmacy technicians have an annual Competency Assessment, based upon measurable criteria determined at annual evaluation.

7.1 Copies of the annual completed Competency Assessment, and Competency Assessment Plan for the coming year are filed in the individual personnel file in the Human Resource Department.

8. Utah State Hospital pharmacists and pharmacy technicians have an annual Performance Evaluation based upon measurable criteria determined at annual evaluation, and listed in the individual Performance Management Plan.

8.1 Copies of the annual *Performance Evaluation*, and the *Performance Management Plan* for the coming year are filed in the individual personnel file in the Human Resources Department.

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Chapter: Pharmacy Services
Section 17: Medication Management Program

Policy

1. The Pharmacy and Therapeutics Committee maintains a Medication Management Program to provide for safe and optimal use of medications. This program includes routine evaluation of current literature for new medications, new technologies, and best practices; especially those demonstrated to enhance patient safety in other organizations. The Medication Management Program routinely evaluates medication errors, adverse drug reactions, and other areas of potential risk points, and identifies areas to improve patient safety, and the overall use of medications.

   1.1 For this program the definition of medication includes:

   1.1.1 Prescription medications
   1.1.2 Sample medications
   1.1.3 Herbal remedies
   1.1.4 Vitamins
   1.1.5 Nutraceuticals (substances not controlled by the FDA, not proven beneficial by authoritative sources)
   1.1.6 Over-the-counter drugs
   1.1.7 Vaccines
   1.1.8 Respiratory therapy treatments
   1.1.9 Intravenous solutions (plain, with electrolytes and/or other drugs)
   1.1.10 Any product designated by the FDA as a drug

2. The Medication Management Program focuses on identification and measurement of processes that are high-volume, high-risk, problem-prone, and patient-safety related, with the goal of improving patient outcomes, reducing the occurrence of medication errors, and reducing medication-related adverse patient outcomes.

3. The Pharmacy Director or his/her designee reports medication errors, adverse drug reactions, FDA and/or drug-company warnings, and other information pertinent to identifying risk factors, and areas for improvement in patient safety and treatment outcomes relative to medication use to the Pharmacy and Therapeutics Committee. The P&T Committee evaluates this information, and makes recommendations to the appropriate departments or disciplines. Policies, procedures, and practices are modified as appropriate to implement these recommendations.

4. The Nursing Department or its representative to the P&T Committee reports any areas of concern regarding medication use to the Pharmacy and Therapeutics Committee. The P&T Committee evaluates this information, and makes recommendations to the appropriate departments or disciplines. Policies, procedures, and practices are modified as appropriate to implement these recommendations.

5. Medical Staff or its representatives to the P&T Committee report any areas of concern regarding medication use to the Pharmacy and Therapeutics Committee. The P&T Committee evaluates this information, and makes recommendations to the appropriate departments or disciplines. Policies, procedures, and practices are modified as appropriate to implement these recommendations.

Procedure

1. The Pharmacy and Therapeutics Committee routinely evaluate medication use in the following areas:

    1.1 Selection and procurement
    1.2 Maintenance of adequate medication inventory
    1.3 Drug floor stock distribution
    1.4 Storage
    1.5 Ordering and transcribing
    1.6 Preparing and dispensing
    1.7 Administration
    1.8 Monitoring the effects and side effects on patients
    1.9 Drug utilization monitoring and evaluation
    1.10 Providing of drug information to the staff
    1.11 Patient/family/staff counseling and education
    1.12 Providing formal and informal in-service to the nursing and other staff licensed to administer medications
    1.13 Management of Human Resources (i.e., licensure requirements and entry level qualifications)
    1.14 Patient outcomes; long and short range continuing education
    1.15 Technical quality control activities
    1.16 Adverse drug reactions

2. Drug Usage Evaluation (DUE) studies are routinely performed, and the results evaluated by the Pharmacy and Therapeutics Committee. The P&T Committee may identify certain areas of concern for DUE studies, and refer them to the Quality Resources department for study. Special emphasis is given medications that are high-volume, high-risk, problem-prone, and patient-safety related. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee forwards recommendations to the appropriate departments or areas to correct or improve medication use.

3. Practitioner-specific outcomes related to medication use may be evaluated by the Pharmacy and Therapeutics Committee. The evaluation review may be included in the practitioner's quality and competency profile for renewal of clinical privileges.

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Chapter: Pharmacy Services
Section 18: Medication Recall

Policy

The Pharmacy Department maintains a system whereby drugs subject to recall or discontinuation by the manufacturer or the FDA can be immediately identified, removed from active inventor, and sequestered. The system includes drugs dispensed to both inpatients and outpatients.

Procedure

1. The Pharmacy Department is notified of a manufacturer's or the FDA's recall or medication discontinuation proceedings through direct mail, the wholesaler's notification, a written or electronic FDA Safety Alert or Recall notification. A chronological file of such notifications, alerts and recall notices is maintained for at least one (1) year.

2. When the Pharmacy receives information about a medication recall or discontinuation by the manufacturer or the FDA for safety reasons, all individuals ordering, dispensing and/or administering recalled or discontinued medications are notified.

3. The Pharmacy Director or his/her designee removes all lots of recalled or discontinued drugs if found to be in inventory within 24 hours of receiving the recall/discontinuation notice. The recalled/discontinued drugs are sequestered in an area labeled for recalled/discontinued drugs until the drug is packaged and returned per manufacturer's instructions. A record of actions taken is written on the recall/discontinuation notice; including none found in inventory and the date the action was taken. The notice is forwarded to the Pharmacy Department Director upon completion of the recall/discontinuation action.

4. All drug storage areas of the hospital are inspected by pharmacy staff when a recall is issued. A recall/discontinuation record is completed as each area is inspected.

5. If the recalled drug has been dispensed to recently discharged or trial leave patients, the pharmacy department will consider the need to contact those individuals. If necessary, the Pharmacy Department will notify the recently discharged or trial leave patients directly and provide appropriate follow-up information.

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