Check your unacceptable abbreviations against the JCAHO’s new list

If you’ve already given a list of unacceptable abbreviations to your pharmacy staff, you’ll have to create a new one.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) on November 3 released a list of nine unacceptable drug abbreviations, acronyms, and symbols that will go into effect January 1, 2004. Hospitals must also choose three additional prohibited abbreviations by April 1, 2004.

The JCAHO will give facilities an “in compliance” score if they present a plan to comply fully by the end of 2004. Read the full story at www.jcaho.org under the National Patient Safety Goals frequently asked questions.

For creative ways to educate your staff about the required list of unacceptable abbreviations, HPRR turned to two of your colleagues who shared their ideas.

Get those laminates back
The pharmacy and quality improvement coordinator at Warren Hospital in Phillipsburg, NJ, created laminated cards containing the hospital’s list of unacceptable abbreviations.

JCAHO standard of the month—MM.2.20
Common sense should dictate medication security policies

There are a few secrets to writing more practical policies to help save your staff time and still allow you to comply with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Some statements regarding medication safety, for instance, in the JCAHO standards don’t have to be taken so literally.

For example, JCAHO’s medication standard MM.2.20 says hospitals must secure medications so that unauthorized persons cannot access them.

To “secure” medications, the JCAHO wants you to keep all of them in locked containers in a room or under what they call “constant surveillance” if staff do not lock them up. This is a Centers for Medicare & Medicaid Services (CMS) requirement.

However, when writing your policy for this standard,
Abbreviations

says clinical pharmacy coordinator Priti Merchant, PharmD. The medication use evaluation committee selected candidates for the hospital’s list based on the Institute for Safe Medication Practices (ISMP) list at www.ismp.org and some of the commonly used abbreviations that can lead to medication errors. The pharmacy and therapeutics (P&T) committee then created the final list.

In its original list however, the pharmacy did not cite three abbreviations that are on the JCAHO list, including “Q.D.,” an abbreviation of the Latin for “once daily” (see the box on p. 3 for a complete list of the JCAHO’s unacceptable abbreviations). The pharmacy must now add the three unacceptable abbreviations to its list, Merchant says.

Organizing a committee to research the lists of unacceptable abbreviations is the best way to achieve compliance, says Ben Muoghalu, PharmD, pharmacy director at Provena St. Joseph Medical Center in Joliet, IL.

At a minimum, pharmacists and nursing educators should sit on the committee and research abbreviations that could lead to medication errors at the hospital, he says.

✓ TIP: Solicit physician opinions when selecting your hospital’s unacceptable abbreviations. Physicians will understand what they can and cannot use if they have a part in choosing the unacceptable abbreviations, instead of just reading about them in a memo.

Educate hospital staff

Pharmacy staff must help educate physicians, nurses, and other staff about the unacceptable abbreviations. Merchant says that Warren Hospital’s pharmacy did the following in order to comply:

- Sent staff laminated cards with the abbreviations and posted signs at nursing stations and in the pharmacy to tell people what they can and cannot use when writing a medication order
- Hung posters in the physicians’ lounge to educate staff about the abbreviations

The pharmacy at Provena St. Joseph Medical Center printed a list of unacceptable abbreviations in its pharmacy newsletter, Muoghalu says.

✓ TIP: Speak with physicians and nurses one-on-one to tell them which abbreviations are prohibited. This will help them understand what they cannot use. Provena has made a point of
holding these one-on-one sessions between pharmacists and physicians. “Doctors are creatures of habit,” Muoghalu says. “They’re going to keep doing what they’ve done for the last 20 years.”

**Enforce the rules**

Call the physician if the pharmacy receives a medication order with an unacceptable abbreviation, Muoghalu says. Provena’s pharmacy staff will not fill the order until physicians clarify what they meant by the abbreviation, he says.

At Warren Hospital, the pharmacy takes a similar approach. Pharmacy staff at your facility may want to adapt the following tactics that have proven to be effective at Warren:

- Enter any order with an unapproved abbreviation into your hospital’s error tracking database, Merchant says.
- Contact the physician. If a pharmacist cannot confirm the order, he or she will fill it to prevent a delay in patient care, Merchant says.
- Keep calling physicians until they stop using unacceptable abbreviations.

“Over time, I think they’ll get tired of us calling them,” Merchant says.

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### Minimum ‘do-not-use’ abbreviation list

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Misinterpretation</th>
<th>Required term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Pharmacists could mistake it for zero, four, or cc.</td>
<td>“Unit”</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Pharmacists could mistake it for IV (intravenous) or 10.</td>
<td>“International unit”</td>
</tr>
<tr>
<td>Q.D., Q.O.D (once daily, every other day)</td>
<td>Pharmacists could mistake the abbreviations for each other. The pharmacist could mistake the period after “Q” for “I,” or mistake “O” for “I.”</td>
<td>“Daily” or “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg), lack of leading zero (.X mg)</td>
<td>Pharmacists may miss the decimal point.</td>
<td>Don’t let prescribers write a zero by itself after a decimal point (X mg), and write a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>MS</td>
<td>Pharmacists may confuse one for another. The abbreviation could also mean morphine sulfate or magnesium sulfate.</td>
<td>“Morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>MSO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MgSO₄</td>
<td></td>
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</tbody>
</table>

*Source: Adapted from The Joint Commission on Accreditation of Healthcare Associations.*
Medication security

know that locking up all medications is impossible. Keep that in mind when defining what secure means for you, says Bud Pate, BA, REHS, executive consultant for Kaiser Permanente hospitals in Southern California.

Consider the following four tips when writing your policies and procedures on medication security:

1. **Don’t lock down all medications**
   Access to the pharmacy is usually controlled through a locked door. Once a person is inside, however, non-controlled medications are stocked on open shelves because staff are there. Extend this same logic to patient care areas.
   
   “It does not mean that somebody has to be assigned to watch the medications,” Pate says.
   
   “A 24-hour Rite Aid is under constant surveillance. There is a check-out person up front to make sure you don’t walk out with the drugs, [but] there aren’t people patrolling the aisles.”

   Many medications in the operating room do not need to be stored in locked drawers because they are not controlled drugs. For example, epinephrine falls into the noncontrolled category and thus staff do not need to store it in a locked drawer, Pate says.

   Try the policies Fairview Hospital in Cleveland has for medications such as plain intravenous (IV) solutions, like water or saline. The hospital stores them in wire racks in view of nursing staff or secretaries, says pharmacy director Michael Hoying, RPh, MS. If the storage area is not locked, but in view of a staff member, it meets the definition of constant surveillance, he says.

   Another tip to help you comply: Adequately staff the materials management department where IV solutions are stored.

   In addition, anesthesia carts may be kept unlocked in certain units, such as the delivery area for when physicians must perform an emergency cesarean section and the anesthesiologist is not present, Pate says. As for emergency medications on a crash cart: Don’t lock the cart, although you may want to use a tamper-proof seal on the outside.

   Staff at Fairview secure most drugs in operating areas and on anesthesia and medication carts with tamper-proof seals, such as shrink wrap, plastic seals, key or combination locks, or fingerprint recognition.

   “In most of our hospital, we consider medications on an anesthesia cart to be under constant surveillance, if they are in an operating or delivery room between cases inside a controlled perioperative or delivery suite,” Pate says.

   At Fairview Hospital, the pharmacy provides emergency cesarean kits and secures them because staff stock controlled drugs in the anesthesia carts and Ohio law requires them to be locked, Hoying says. Pharmacy staff should work with nursing staff, physicians, materials management, and other medical staff members involved to determine areas where staff need frequent access to medications.

   For example, pharmacists should assess areas where staff need medications and should ask nurses and physicians the medications they need available to do their job, Pate says.

   **TIP:** Needs might vary from unit to unit, Pate says. For example, emergency room staff will need quick access to medications to treat incoming patients. Consider such specialized needs when you sit down as a group to discuss this issue.

   2. **Define authorized workers**
   Many hospitals have struggled to define who is authorized to be in areas with medications,
Hoying says. For example, pharmacists are licensed to handle medications in this secure area, and housekeeping staff need access to the pharmacy to clean floors. Even if your pharmacy is open 24 a day hours and someone can monitor access to the pharmacy, your staff need to take precautions.

**TIP:** Don't leave controlled drugs out on the counter, Hoying says. At his pharmacy, anywhere from 10–12 people could have access to the drug. Physically hand the drug to the staff member picking it up. Get his or her signature on a form that says he or she received the controlled substance.

Your hospital should list the people it wants authorized to be in the presence of various medications. Decide who should have authorization based on job duties.

For example, authorize housekeepers to be alone with noncontrolled substances between cases in the operating room. Banning housekeeping from operating areas would interfere with the daily operations of the hospital because those areas must be kept clean.

**TIP:** To help determine who goes on your list make two columns on a page. In one column, list all the workers who have access to certain areas and those who don't. Separate them by unit if that helps. Next, in a separate column, comment on how the worker's access—or lack of it—will affect daily operations, Pate says.

**TIP:** Educate nonlicensed staff members about the hospital's medication security policies.

**Secure your narcotics**

You must keep controlled drugs, such as narcotics, secure to prevent theft. Schedule II substances, such as OxyContin, morphine, and hydromorphone, fall into this category. Fairview Hospital stores some medications in locked areas where people are always present, Hoying says.

However, the facility does not rely on staffing alone. It holds inventory checks and has a specific procedure for identifying missing stock. Read more about how it works on p. 7.

Five years ago, someone used a crowbar at Fairview Hospital to break into a controlled stockroom after the staff left for the night, Hoying says.

As a result, if nonauthorized workers can access an area when it's closed, staff members no longer store drugs there, Hoying says.

However, they will store drugs in areas that close—like Fairview’s oncology clinic—if there is no way for someone to access the area when it is closed, Hoying says.

Fairview’s oncology clinic is separate from inpatient care areas The hospital stores controlled drugs in the oncology department pharmacy because there is no direct access to it during closing hours, he says.

**Know your lock codes**

The majority of Fairview Hospital's medication stock on patient units is kept in locked medication rooms, Hoying says. Each room has a punch lock that requires staff to enter a code to gain access.

**TIP:** Nurses and other authorized staff must learn the access code to medication rooms and keep it confidential. Tell staff not to write the codes on the wall or near the door, and to change the code if you feel unauthorized people have learned it, Hoying says.

Fairview Hospital also stores some medications in automated Pyxis medication storage cabinets. The hospital’s Pyxis units require staff to scan a badge that has their thumbprint on it, Hoying says.

Don't use Pyxis throughout the organization to store controlled drugs—that would be overkill to meet the requirements, Pate says. Rely on a combination of measures, such as Pyxis, locked rooms, and constant surveillance storage. This works well at Fairview Hospital and meets their financial needs, Hoying says.
Standard MM.2.20 at a glance

Editor’s note: HPRR explains the bolded requirements in the December JCAHO standard of the month.

Standard MM.2.20
Hospitals safely store medications.

Requirements for MM.2.20
• Hospitals stock or store approved medications only.
• Hospitals store medications in conditions that ensure stability.
• The hospital’s policy prevents unauthorized access to medications. The Centers for Medicare & Medicaid Services defines “secured” as storing all medications in locked containers in a room or keeping them under “constant surveillance.”
• Hospitals store controlled substances to prevent theft.
• Hospitals keep all expired, damaged, or contaminated medications separate until they are removed.
• Hospitals keep sound-alike and look-alike drugs separated to prevent confusion.
• Hospitals label the contents, expiration dates, and warnings for all chemicals used in medication preparation.
• Hospitals keep drug concentrations standardized.
• Hospitals remove concentrated electrolytes from patient care areas unless they must be available for treatment or staff members can prevent accidental administration.
• Hospitals keep medications in ready-to-administer forms in patient care areas.
• Hospitals periodically inspect medication storage areas.

Discrepancy in narcotic count report

Unit: ___________________ Date: ___________________
Time discrepancy noted: __________
Registered nurses counting: ______________________________
________________________________

Nursing section:

What is the discrepancy?
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

What was done to locate the source of the discrepancy?
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Pharmacy follow-up notes:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Source: Fairview Hospital, Cleveland. Reprinted with permission.
Four steps to investigate missing medication cases

To help make sure the medication stock matches your day’s orders and you have a procedure to deal with missing medications, look at how one Cleveland hospital investigated missing medication cases.

Fairview Hospital requires every shift to check for discrepancies in medication orders. Before a shift ends, nurses and other staff members need to check medication orders to make sure that the day’s record matches the stock, says pharmacy director Michael Hoying, RPh, MS.

Staff must check locked cabinets and storage areas, as well as Pyxis automated medication cabinets. Checking the Pyxis cabinets is crucial because some staff members may rely too heavily on its automation and restricted access in accounting for medications, Hoying says. Even with the automation, errors can occur and medications can be misplaced.

If staff members notice medications missing, they take the following steps when beginning an investigation:

1. Staff check to see whether someone took too much of one medication by accident. For example, a nurse could accidentally take two doses instead of the one that was ordered and documented, Hoying says. Nearly 99% of missing medications can be explained by mistakes, he says.

2. Staff members fill out a narcotic discrepancy report if no accident or explanation is found in the preliminary investigation (see a sample form on p. 6). The report should note the medication missing and who recently accessed the medication storage unit. The pharmacy then looks at the report to see who was the last to access it.

3. The pharmacy checks the amount missing, Hoying says. If small doses are missing (e.g., one or two), the report is put into a file to see if a trend develops. If a large or abnormal number of doses is missing, state law requires the pharmacy to report the lost medications to the police and the local Drug Enforcement Administration office.

4. The pharmacy reports the type of medication missing, the names of people who recently accessed the medication, and any other pertinent information to help authorities. For example, if a pack of Percocet goes missing, that must be reported, Hoying says.

Some organizations have automated software to analyze Pyxis access, using statistics to identify a staff member to audit for medication diversion, Hoying says. Pyxis users can purchase software for around $5,000 and a monthly user fee, he says.
Staff cooperation is essential when drug reps visit

At the Hospital of the University of Pennsylvania, physicians and pharmacists meet with drug representatives in administrative offices and conference rooms separate from the inpatient pharmacy and inpatient care areas. This reduces the contact that drug representatives may have with patient information in charts and on computer screens.

“A patient care areas] is just not a place for salespeople to be,” says Richard Demers, MS, RPh, assistant hospital director and pharmacy director at the Philadelphia-based hospital.

The privacy regulation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires hospitals to protect patient information with more rigorous rules than most state confidentiality laws.

At Mission St. Joseph’s Health System in Asheville, NC, drug reps may filter through nursing units, but only when they have an appointment with staff, says pharmacy director Ellen Williams, MBA, RPh.

Some drug representatives have simply walked into the nursing unit here and claimed to have an appointment, she says. In these cases, drug representatives are typically asked to leave the hospital.

Drug representatives may have to give advance notice, Williams says of a new policy under consideration. What’s more, system administrators may have to approve the appointment based on the visit’s nature, such as a sales visit or to educate staff about a drug. The policy change will require cooperation from all staff members.

Physicians, nurses, and pharmacists must all agree on where and when a drug representative may visit to ensure that the policy will work, she says.

Designate a meeting place

Drug representatives may go into patient care areas at both the Hospital of the University of Pennsylvania and Mission St. Joseph’s Health System if a physician accompanies them to talk about a procedure. They must sign a confidentiality agreement at the University of Pennsylvania, and agree in a statement that they will not repeat any protected health information they obtained during their visit, Demers says.

Mission St. Joseph’s takes perhaps a tougher stance on handling drug representatives. For example, a firm policy requires representatives to sign a confidentiality agreement and take a HIPAA training course, which covers a number of rules, including the following:

- Do not talk about patients
- Do not leave patient information visible on a computer screen
- Shred documents containing patient information

Requiring drug representatives to take that course usually deters them from wanting to watch a physician during a procedure because of the preparation time involved, Williams says.

TIP: Limit drug representatives to conference rooms, offices, or other designated meeting places away from care areas.

Some staff members continue to invite drug representatives into prohibited areas, and that has a two-pronged effect: The policy will become ineffective and other staff members will follow suit—making it more difficult for the hospital to enforce the rules.

If your hospital prohibits drug representatives from inpatient care areas, make sure your staff enforces the policy to its fullest extent, says Demers.

“If physicians and pharmacists continue to invite people in, then we will continue to have problems,” Demers says. “Everyone has to be part of the solution.”

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Republican House and Senate leaders appealed for a calm and rationale discussion as the Medicare debate continued past the October 17 deadline.

Republican Representative Billy Tauzin of Louisiana and Bill Thomas of California joined Senator Chuck Grassley, R-IA, in calling for continued discussion after 39 Senate Democrats, one Republican, and one independent sent a letter to President Bush expressing opposition to several key proposals, including the premium support provision, says Bill Sarraille, a partner with the Washington, DC–based law firm Sidley, Austin, Brown, & Wood, LLP.

The premium support provision would allow Medicare beneficiaries to select insurance from various plans, with the federal government paying a portion of the premium. Senator Olympia Snowe, R-ME, and Senator Jim Jeffords, I-VT, joined in the opposition to premium support, saying changes are necessary before the bill can pass, Sarraille says.

The opposition letter came days after Republicans said major breakthroughs were made and a resolution to the debate could be expected, Sarraille says. Congress may have to rework the bill to pick up additional votes if lawmakers don’t pass it before Thanksgiving and Christmas without an agreement, he says.

“That’s a daunting prospect,” Sarraille says. “The ability to get something done evaporates quickly.”

The number of those opposed to some provisions is significant because 60 senators are needed to end a filibuster that could delay debate on the bill. With 41 stating opposition to key provisions, a cloture vote would fall one senator short.

The prescription drug importation provision remains controversial as well, Sarraille says. While it has moved to background discussions in the congressional conference committee, more state officials have recently expressed interest in importing prescription drugs for state employees to lower the taxpayer burden, he says.

Massachusetts and Minnesota officials are among the most recent to have expressed interest in importing drugs from foreign sources. A basic struggle still remains between price concerns and patient safety issues, Sarraille says.

The Food and Drug Administration opposes drug importation, saying it cannot guarantee the safety of drugs outside of U.S. regulatory control.
Survey monitor

Basics help Massachusetts hospital in survey

Maintaining medication refrigerator logs and quality assurance records for eye wash stations will impress Joint Commission surveyors just as much as discussing major performance improvement goals at your pharmacy. That’s why it’s important to continually press pharmacy staff to not let the small details slip by, such as inspecting safety features like eye wash stations and laminar flow hoods. This will not only make the JCAHO happy, but to keep your medications systems organized.

Pharmacy staff at Massachusetts General Hospital (MGH) learned during their September survey that the JCAHO wants them to pay as much attention to recording refrigerator temperatures in a log as they do to going on rounds with caregivers.

During past surveys, Meg Clapp, RPh, the pharmacy director at MGH, spoke to surveyors at length about the pharmacy’s achievements.

During this fall’s survey, surveyors spent less time with Clapp and more time walking through the pharmacy and talking with staff members, she says. “The devil was in the details,” Clapp says. “You cannot just rely on showcasing the great things you’ve done.”

This change of approach is partly due to the accreditor’s shift in philosophy to physically observing caregivers treating patients and talking to them about it, rather than gather in a boardroom with senior leaders.

How surveyors looked at record keeping
Surveyors examined the pharmacy’s refrigeration logs, making sure staff members recorded the date, time, and temperature when they checked the refrigerators, Clapp says.

Surveyors also looked at the quality assurance sheets noting that pharmacy staff inspected eye wash stations and laminar flow hoods to ensure that they worked properly and had been inspected, Clapp says. These are major safety features for a pharmacy, which is why the JCAHO will pay attention to them when visiting a facility. “If you didn’t document it, it didn’t happen,” Clapp says. “It’s working on making sure every ‘i’ is dotted and every ‘t’ is crossed.”

Examining safety
Surveyors also wanted to know how MGH conducted a fire drill. The pharmacy has moved since its last survey and for security reasons is still trying to determine the best way to evacuate the building during a fire drill because its new location has no windows, Clapp says.

For the time being, pharmacy staff do not have to evacuate the building, but the policy will most likely change in the future, she says. Surveyors asked pharmacy staff about the fire drill procedure. Even though the pharmacy evacuation policy is still in the works, surveyors were pleased to hear that staff understood what the policy was at the time, Clapp says.

Avoid confusion
MGH staff performed a mock survey, helping them to understand the kinds of questions that surveyors will ask of them. For example, surveyors asked pharmacy staff how they knew they were competent to perform their jobs. The hospital prepared for this question

Note: The JCAHO’s Shared Visions—New Pathways™ new survey process takes effect next month. Stay tuned for upcoming issues on how the sweeping Joint Commission accreditation changes will affect your pharmacy. Visit www.jcaho.org to read more about Shared Visions—New Pathway.

About the facility: The 868-bed Massachusetts General Hospital is the oldest and largest hospital in New England. The facility is one of Harvard University’s teaching hospitals, and serves nearly 1.2 million patients at the main hospital and four centers in Boston and its immediate suburbs.
because it can be difficult to explain one’s job description and qualifications, Clapp says. The pharmacy coached its employees and other hospital staff on medication administration and other drug topics, Clapp says. This way, if a surveyor asked an employee about drug administration and the employee had trouble answering it, another staff member could join in and help answer the question, she says. “We did anything to avoid a deer-in-headlights look,” Clapp says.

Surveyors looked in pharmacy staff files to check credentialing, licensing, and education, Clapp says. They checked for current state licenses, confirmation that staff have taken competency exams, and evidence that they keep up with continuing education, she says.

**TIP:** Maintain up-to-date records on all your pharmacy staff, including current licenses, competency assessments, education credits, and any other relevant human resources information.

A surveyor randomly pulled the file of a resident pharmacist, who happened to have one of the best records in the department, Clapp says. The record was neat and included the required items, she says.

**Expect the unexpected**

Clapp received a surprise during the survey when a surveyor came to the pharmacy at 5:30 a.m. and began questioning staff. Surveyors came unannounced to the pharmacy during MGH's last survey, but Clapp was surprised that they made the visit that early in the morning this time, she says.

One of Clapp’s veteran employees of nearly 30 years was on duty that night and began answering questions about log books and pharmacy procedure. Clapp credits the mock survey for helping her staff respond to the questioning during the surprise visit.

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**Surveyor questions for the pharmacy department**

Check out the following questions that surveyors asked pharmacy staff at Massachusetts General Hospital in Boston during their survey in September.

- How do you know you’re competent to do your job?
- How do you take care of different age groups?
- How often and how do you conduct a fire drill?
- Do you have your quality assurance sheets for eye wash stations?
- How do you document your refrigeration checks?

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**Survey at a glance**

**Hot spots:** Quality assurance, document refrigeration logs, age-specific care, and fire drills

**Critical advice:** Expect a surveyor to arrive at any time. A surveyor showed up at Massachusetts General Hospital’s pharmacy at 5:30 a.m.

**Survey tip:** Document procedures and activities in the pharmacy. This will help at survey time, allowing surveyors to see what goes on every day.

**Quote of note:** “They wanted to make sure we didn’t forget any detail. It’s almost like we got back to basics.”
HIPAA quick tip: Protect faxed patient information to comply with privacy rule

Your facility could violate the Health Insurance Portability and Accountability Act (HIPAA) of 1996 if faxed patient information falls into the wrong hands.

The privacy rule considers faxed information to be the same as written, spoken, or electronic communication methods: It is privileged information. HIPAA does not specifically address faxing patient information, so take the necessary steps before sending a fax to make sure you remain in compliance.

For example, a physician calls the pharmacy and asks you to fax a patient’s medication record to his office. It is evening, his office is closed, and no one will be able to pick up the fax until the morning. What should you do?

Don’t send the fax to an unattended machine unless the doctor assures you that the machine is in a locked room or has a locked cover. If the fax machine is out in the open, arrange to fax the report during regular business hours, when a staff member at the office can wait and pick it up immediately.

If you know you will receive a fax that contains patient information, tell the person faxing the information to warn you ahead of time so you can be present to receive it. Likewise, notify the person to whom you are sending information that a fax is on the way.

Do not let faxed patient information lie around unattended on a fax machine. Remove it from the machine immediately before others can see it.

TIP: Check your pharmacy’s policies and procedures with regard to faxing patient information. Contact your privacy official for guidance and assistance.

Editor’s note: This article was excerpted from HCPro’s HIPAA Training Handbook for Pharmacy Staff. For ordering information, go to www.hcmarketplace.com/Prod.cfm?id=1594 or call customer service at 877/727-1728.

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For news and story ideas:
Contact Editorial Assistant Matt Bashalany
• Phone: 781/639-1872, ext. 3726
• Mail: 200 Hoods Lane, Marblehead, MA 01945
• E-mail: mbashalany@hcpro.com
• Fax: 781/639-2982

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