JCAHO’s proposed Patient Safety Goals to affect pharmacies

Three proposed revisions to the JCAHO’s National Patient Safety Goals that touch upon bar-coding requirements and drug safety could affect hospital pharmacies in 2005.

The JCAHO released on its Web site a proposed draft of the 2005 National Patient Safety Goals—which include three goals for hospitals—and the board of commissioners is expected to vote on them this summer.

There are three major changes (see p. 3 for the 10 that will affect pharmacy):

- develop a plan to put bar coding in place by 2007
- restrict IV preparation to the pharmacy
- create a list of look-alike and sound-alike drugs

The accreditor typically adopts goals in July and makes them effective January of the following year.

For a complete list of the proposed 2005 goals, go to www.jcaho.org/accredited+organizations/05_npsg_fr.htm and click on the “hospital” link.

Read on to see how the four proposals could affect your pharmacy.

JCAHO to survey for sterile compounding compliance

Four ways to prepare for survey day

Evaluate the medications your pharmacy compounds before you determine whether you need to build a clean room to meet sterile compounding standards.

The U.S. Pharmacopeia (USP) General Chapter 797 (see a summary on p. 6) outlines the equipment and precautions required—including clean rooms—when compounding sterile preparations, such as IV solutions. Clean rooms have special air filters and equipment that maintain a sterile environment for compounding medications.

Beginning July 1, the JCAHO will survey pharmacies for compliance with Chapter 797. According to the April Joint Commission Perspectives, the JCAHO will not focus on Chapter 797 during a
JCAHO’s goals

Bar coding by 2007

The JCAHO would require hospitals to have a bar-code system to identify patients and match them to their medications by January 1, 2007. Bar coding places added financial burdens on hospitals, but it generally costs less than upgrading to electronic medication administration records or computerized physician order entry, says Kasey Thompson, PharmD, director of the practice standards and quality division for the American Society of Health-System Pharmacists (ASHP).

A bar-code system could cost between $200,000 and $1 million depending on the size and age of the building, according to bar-code manufacturer Bridge Medical Inc.’s Web site, www.bridgemedical.com. However, costs could drop as more hospitals adopt bar coding, Thompson says.

“Bar-code technology to identify the patient is something that probably should’ve been implemented 10 years ago,” Thompson says. “It’s safe to say the vast majority of hospitals have plans to implement bar coding within five to 10 years.”

Getting different departments on the same page is one challenge to starting a bar-code system, says Priti Merchant, PharmD, clinical pharmacy coordinator at Warren Hospital in Phillipsburg, NJ. For example, hospitals would need to educate pharmacy staff about bar-coding drugs and teach nurses how to use scanners. The hospital would also need to print patient identification wristbands with bar codes.

Prepare IVs in pharmacy only

One proposed goal would restrict IV-drug preparation to the pharmacy. Pharmacies could opt to use commercially premixed IV fluids in place of or in addition to preparing them in the pharmacy.

Preparing medications in a controlled environment such as the pharmacy is more effective and safe, Thompson says. Quality control is easier because pharmacists are the only ones mixing medications, not nurses or other staff.

Premixed medications tend to cost more, but they could help hospitals without 24-hour coverage, says Thompson. IV fluids would be available in floor stock after hours, and nursing staff would not have to worry about mixing them without pharmacists available.

Warren Hospital pharmacy staff prepare medications in the pharmacy before it closes, Merchant says. They then deliver the medications that staff will use at night to the floors.

“We try to get medications and IVs in the most-ready...
form,” Merchant says. “If you’re making it on the floors, you need something commercially mixed.”

✓ Monitor look-alike and sound-alike drugs
Hospitals would have to maintain a list of sound-alike and look-alike drugs they use under a proposed goal requirement. They would also have to take steps to prevent staff from selecting the wrong drug by mistake.

The pharmacy and therapeutics committee should already be assessing every new drug it adds to the hospital formulary for cost and safety, Thompson says. Make checking to see whether the drug looks or sounds like drugs already on the formulary part of the safety evaluation.

Tip: Conduct a Failure Modes and Effects Analysis when adding new drugs to the formulary. Check automated cabinets, pharmacy stock, and floor stock to make sure drugs aren’t placed in alphabetical order. This will help separate drugs with similar-sounding names, Thompson says.

Deaconess Hospital in Oklahoma City does not have a list of look-alike and sound-alike drugs, says risk manager Tim O’Kelley, RN. It makes sense to do so, as potential confusion points could be drugs with names such as Cardizem and Cardizem CD, both of which treat chest pain but have different dosage requirements, he says. Warren Hospital’s pharmacy staff place drugs that may sound or look alike in red bins, Merchant says. This alerts staff to double check names when selecting medications from those bins because they could mistake one drug for another. ■

Editor’s note: Stay tuned to future issues of HPRR for updates on the National Patient Safety Goals and what you will need to do if the JCAHO approves them.

Draft 2005 National Patient Safety Goals that may affect pharmacy

Check out some of the goals that could affect pharmacy operations in your hospital if the JCAHO adopts the proposed 2005 National Patient Safety Goals.

- **New Goal 1C**: Develop a plan to identify patients and match patients to their medications and other treatments with bar-code technology by January 1, 2007.
- **Goal 2A (revised)**: Have the person receiving verbal or telephone orders or test results “read back” the complete order or test result.
- **Goal 2B (revised)**: Standardize a list of abbreviations, acronyms, and symbols not to be used in the hospital.
- **Goal 3 (revised)**: Improve the safety of using medications.
- **New Goal 3C**: Prepare IV drugs in the pharmacy only/use premixed IV fluids.
- **New Goal 3D**: Create a list of look-alike and sound-alike drugs used in the hospital and take action to prevent errors that could occur if staff confused the two drugs.
- **New Goal 5B**: Have staff perform a double-check when programming or reprogramming infusion pumps.
- **New Goal 8**: Reconcile medications and other treatments across the continuum of care.
- **New Goal 8A**: Obtain and document a list of the patient’s medications and other treatments upon admission to a new setting. Reconcile medications and other treatments with those at the former care setting.
- **New Goal 8B**: Identify the practitioner responsible for each patient’s care and reconcile each medication and treatment used. Tell all staff treating the patient how to reach the practitioner. ■

Source: www.JCAHO.org.
Sterile compounding compliance

survey but will score the major chapter requirements, such as testing products for sterility, along with applicable JCAHO standards.

The JCAHO will consider organizations in compliance for 2004 if they have plans in place to meet the USP requirements. Surveyors will help educate organizations about the requirements if they are unaware of them at survey time, according to the JCAHO.

What you need to do
Not every organization may need to build a two-room clean area to comply. Chapter 797 specifies that laminar flow workbenches and other systems such as barrier isolators—sterile boxes with holes for staff to put their hands through to compound preparations—may suffice for certain preparations, says Claudia Okeke, RPh, PhD, USP director of information and standards development.

“The hospital has to know what kind of preparation is being made,” Okeke says. “Then, of course, you have to train your personnel accordingly. The biggest concern they [hospitals] have is the JCAHO is using 797 as a model to inspect hospitals.”

State boards of pharmacy may also adopt Chapter 797 as a requirement and hold you responsible for compliance. Most states have not yet done this, Okeke says.

Verify your compliance by doing the following:

1. Check your risk level
Chapter 797 outlines three risk levels: low, medium, and high. Each risk level coincides with different types of preparations, says Doug Wong, PharmD, a consultant with Pharmacy Healthcare Solutions. “By looking at these different potentials for risk, [hospitals] have to look at what the policies are for those levels of risk,” Wong says.

Low-risk compounding includes mixing two sterile products, such as injectables, Okeke says. Low-risk medications also include those that hospitals will use within 24 hours after compounding, she says.

Medium-risk compounding involves mixing multiple sterile products. This is a medium risk because staff could give the product to multiple patients or one patient on multiple occasions and the potential for dose-calculation errors exists, Okeke says.

High-risk compounding includes using a nonsterile drug to compound a preparation that pharmacy staff

USP Chapter 797 and related JCAHO medication standards

<table>
<thead>
<tr>
<th>USP Chapter 797</th>
<th>MM standards</th>
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<tbody>
<tr>
<td>• Written compounding procedures, including quality control checks for proper ingredients and visual inspection of final product</td>
<td>MM.4.20 (safely preparing medications)</td>
</tr>
<tr>
<td>• Sterilizing non-sterile products</td>
<td>MM.4.20 (safely preparing medications)</td>
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<tr>
<td>• Testing product for sterility, potency, etc.</td>
<td>MM.4.20 (safely preparing medications)</td>
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<tr>
<td>• Expiration labeling according to the risk level</td>
<td>MM.4.30 (Labeling medications)</td>
</tr>
<tr>
<td>• Medication packaging and transportation</td>
<td>MM.4.40 (Safely dispensing medications)</td>
</tr>
<tr>
<td>• Re-dispensing compounded sterile preparations</td>
<td>MM.4.80 (Managing returned medications)</td>
</tr>
<tr>
<td>• Watching patients and reporting adverse events</td>
<td>MM.5.10 (reporting) MM.6.10 (monitoring)</td>
</tr>
</tbody>
</table>

Source: Adapted from the April Joint Commission Perspectives.
will eventually sterilize. This category also includes medications compounded but not used for several days or more.

_Tip:_ Review the sterile preparations you compound and compare them to the risk levels in Chapter 797.

The USP risk levels are similar to those found in the American Society of Health-System Pharmacists (ASHP) *Guidelines on Quality Assurance for Pharmacy-Prepared Sterile Preparations*. If hospitals follow the ASHP guidelines, they should comply with Chapter 797, Okeke says.

"Evaluate your needs"

Make sure you read Chapter 797 to understand the requirements for each risk level, says **Philip Schneider, MS, FASHP**, clinical professor and director of the Latiolais Leadership Program at The Ohio State University College of Pharmacy. Once you evaluate the risk level for your compounding practices, you can determine what your facility needs to do to comply with Chapter 797.

"How many people have actually read these standards?" Schneider asks.

"If you look at the diagram of floor plans in the document, there are recommendations for the design of a facility for compounding low- and medium-risk preparations. You do need a separate room for compounding sterile preparations, but it’s not like you have to build an expensive, two-room facility."

Hospitals compounding low- and medium-risk preparations need a buffer zone—the clean area where staff compound sterile preparations—as well as an ante area—where staff store supplies, don sterile gowns, and clean their hands before compounding. The buffer zone and ante area only need a demarcation line or barrier separating the two, not a physical wall.

Hospitals compounding high-risk preparations need a physical wall and doors between a buffer room and an anteroom. No sinks or drains are allowed in the buffer area.

The hospital decides how it wants to do it, Okeke says. "If the hospital does nothing but sterile preparations, it doesn’t need a clean room. If it doesn’t need a clean room, it can get by with barrier isolators."

Barrier isolators may be the best solution for smaller hospitals, Schneider says. Smaller hospitals may not have the funds to renovate part of their facility for a clean room.

_Tip:_ Consider barrier isolators as a cost-effective alternative if you compound low-risk preparations.

3. **Compound in one area**

Chapter 797 affects areas outside of the pharmacy, Wong says. If nurses are involved in compounding sterile preparations in patient care areas, Chapter 797 applies as well, he says.

_Tip:_ Compound all sterile preparations in appropriately designed areas. An appropriate area could include a clean room in the pharmacy or a barrier isolator in a sterile environment if the organization compounds low- or medium-risk preparations, Okeke says.

4. **Educate staff about sterile techniques**

Pharmacy staff responsible for compounding sterile preparations need training on USP Chapter 797 requirements. USP will hold a workshop May 14–15 at its headquarters in Rockville, MD, to train pharmacists in sterile techniques and the other important aspects of the chapter.

Staff who maintain and sterilize the clean room area must receive training in cleaning techniques, according to Chapter 797. Pharmacists need to know how to sample air quality for contamination and ensure that the proper air-particle level exists, Schneider says. To learn more, Schneider suggests purchasing a book that outlines the proper techniques for compounding sterile preparations. ASHP also has a CD-ROM training tool on sterile techniques, he says.

(Editor’s note: For more information about educating staff or to get a copy of Chapter 797, go to www.usp.org or call 800/227-8772.)
USP General Chapter 797 summary

Editor’s note: The following information is adapted from U.S. Pharmacopeia (USP) Chapter 797. For a complete copy of the chapter, call USP at 800/227-8772.

Risk levels
Low-risk conditions:
- Compounding sterile preparations entirely with ISO Class 5 or better air quality using only sterile ingredients or products.

Examples:
- Using sterile needles and syringes to transfer sterile drugs from the manufacturer’s original packaging.
- Manually measuring and mixing no more than three sterile products to compound drug admixtures and nutritional solutions.

Medium-risk conditions:
- Staff combine or pool multiple individual or small doses of sterile products to prepare a compounded sterile product to give to either multiple patients or one patient on multiple occasions.
- The compounding process includes complex aseptic manipulations other than the single-volume transfer.
- The compounding process requires an unusually long duration, such as completing dissolution or homogeneous mixing.
- The compounded sterile preparations do not contain broad-spectrum bacteriostatic substances and staff give them out over several days.
- For a medium-risk preparation, in the absence of passing a sterility test, the storage period cannot exceed 30 hours at room temperature, seven days at cold temperature, and 45 days in a solid frozen state at 20 below zero or colder.

Examples:
- Total parenteral nutrition (TPN) fluids compounded using manual or automated devices that require multiple injections, detachments, and attachments of the nutrient source products to the device or machine to deliver all components to a sterile container.
- Filling infusion and injection device reservoirs with multiple sterile drug products and draining air from the reservoirs before staff dispense the filled device.
- Filling injection and infusion device reservoirs with volumes of sterile drug solutions to give out over several days at temperatures between 25 and 40 degrees.
- Transfer of multiple vials into a single final sterile container or product.

High-risk conditions:
- Staff incorporate nonsterile ingredients or use a nonsterile device before terminal sterilization.
- Sterile ingredients, components, devices, and mixtures are exposed to air quality inferior to ISO Class 5. This includes storage in environments inferior to ISO Class 5 of opened or partially used packages of manufactured sterile products that lack antimicrobial preservatives.
- Nonsterile products are exposed for at least six hours before sterilization.
- For high-risk preparations, in the absence of passing a sterility test, the storage periods cannot exceed the following: 24 hours at controlled room conditions, three days at cold temperatures, and 45 days for solid frozen state at 20 below zero or colder.

Examples:
- Dissolving nonsterile bulk drug and nutrient powders that staff will sterilize to
make solution.
• Sterile ingredients, components, devices, and mixtures are exposed to air quality inferior to ISO Class 5. This includes storage in environment inferior to ISO Class 5 of opened or partially used packages of manufactured sterile products that lack antimicrobial preservatives.
• Staff measure and mix sterile ingredients in nonsterile devices before sterilization.

Training and evaluating aseptic skills
Staff preparing compounded sterile products must have the appropriate training from expert personnel, audio and video instruction, or publications outlining aseptic technique before beginning to prepare products.

Staff shall perform didactic review, written tests, and media-fill tests to assess aseptic skills initially and then at least annually for low- and medium-risk levels and semiannually for high-risk level compounding.

Staff who fail written or media-fill tests must receive immediate instruction and take another exam.

Clean rooms
Low and medium risk:
• Must have an ante area, but a physical wall does not need to separate the ante area from the buffer area.
• Air classification or quality must meet ISO class 8 standards.
• Walls, floors, fixtures, and ceilings should be smooth, impermeable, free of cracks, and nonshedding. Surfaces should be resistant to damage from cleaning and sanitizing agents. Ceiling and wall joints should be coved and caulked.
• If ceilings consist of inlaid panels, the panels should be sealed to the support frame with caulk and should be infused with a polymer to make them impermeable.
• Walls may be panels locked together and sealed or epoxy-coated gypsum board.
• Floors should be overlaid with wide-sheet vinyl flooring with heat-sealed seams and coving at the sidewall.
• The buffer or ante area should contain no sinks or floor drains.

High risk:
• All low- to medium-risk facilities, and the ante area must be a separate room.

Gowning
• Before entering the ante or buffer area, staff should remove outer lab coats, makeup, and jewelry. Staff should thoroughly wash hands and arms to the elbow.
• After drying hands and arms, staff should put on clean, nonsneding uniforms consisting of hair covers, shoe covers, coveralls or knee-length coats fitting snugly at the wrists and zipped or snapped in the front, gloves, and facemasks.

Upon leaving the clean room, the coveralls or coats should be carefully removed and hung outside the entry in the buffer area.

Staff can only use coveralls and coats for one shift.

Staff should discard all other coverings and put on new ones before going back into the clean room.

Barrier isolators
A well-designed barrier isolator is an alternative to an ISO Class 5 (Class 100) laminar airflow workbench device in an ISO Class 8 clean room. Adequate operation, maintenance, monitoring, and control procedures should support the barrier isolator.
You do not need to document an indication for use on each medication order as long as it exists somewhere in the patient’s medical record.

JCAHO medication standard MM.3.10 requires a documented diagnosis, condition, or indication for use for each medication ordered. But that documentation could be somewhere in the patient’s chart, such as in the history and physical (H&P) or progress notes.

“That’s the key: ‘somewhere’ in the medical record,” said Steve Bryant, practice director of accreditation for the Marblehead, MA–based The Greeley Company, a division of HCPro, publisher of this newsletter. “You don’t have to have your physicians write indications for every order.”

Bryant and Greeley consultant Bud Pate, REHS, outlined when you need to include a reason for prescribing a medication with an order during the March 23 audioconference, “Simplify the JCAHO’s Medication Management Standards: An Algorithm for Success.”

Look at the entire chart

Indications for use usually exist somewhere in the patient’s chart, Pate said. Check for them in progress notes and the H&P.

For example, if a patient has the diagnosis “diabetes” listed in the H&P, any medication ordered that caregivers typically prescribe for diabetes would meet the standard, Bryant said. The diagnosis of diabetes explains why someone prescribed the medication.

Tip: Require indications on orders for drugs that may have multiple uses, such as Benadryl or Tylenol.

For example, if a prescriber orders Tylenol PRN, pharmacy and nursing staff need to know what the medication is for because Tylenol could treat pain or fever, Bryant said.

“When you have a PRN—as needed—order it’s important that there be some type of understanding for the nursing staff,” Bryant said. “As needed for what?”

✓ Check your compliance

The standard has one C-level element of performance, meaning the JCAHO will judge compliance based on rates, Pate said. You are not required to audit and show proof that your organization meets the standard, but you may want to take a small sample of medication orders to see whether an indication exists somewhere in the chart, he said.

According to Michael Hoying, RPh, MS, pharmacy director at Fairview Hospital in Cleveland, pharmacy staff check medication orders and charts for indications when they audit for compliance with the JCAHO’s unapproved abbreviations list. If they find an order or a chart without an indication or diagnosis, they notify the clinical manager.

If education fails to improve compliance, pharmacists may have to call physicians for clarification if they receive an order without a reason for prescribing the medication, Hoying noted.

Editor’s note: For more information on how to order a tape of the audioconference “Simplify the JCAHO’s Medication Management Standards: An Algorithm for Success,” go to www.hcmarketplace.com.

Standard MM.3.10 at a glance

Prescribers only order medications necessary to treat a patient’s condition.

Requirement for MM.3.10

A documented diagnosis, condition, or indication for use exists for each prescribed medication.
Medicare update

Medicare codes create drug billing headaches

Watch for brand-name and generic code differences

Be careful when billing Medicare for multiple-source drugs. Make sure your billing system has different codes for the brand-name and generic versions.

The Centers for Medicare & Medicaid Services (CMS) issued separate codes for innovator and non-innovator multiple-source drugs paid under the Outpatient Prospective Payment System (OPPS), meaning you could receive different reimbursement if you use a brand-name drug rather than a generic. CMS issued the codes in Transmittal 112, Change Request 3144 on February 27.

The codes affect billing Medicare for services provided after April 1. Go to www.cms.hhs.gov/manuals/pm_trans/R112CP.pdf for a table of the codes and the different payment rates.

Hospitals enter drug names only once in the charge-master, says Ernest Anderson Jr., MS, pharmacy director at Lahey Clinic in Burlington, MA. The process creates a billing problem because you need to make sure you have the proper code for either the brand-name or generic version of the drug to bill Medicare.

“This isn’t how the system works,” Anderson says. “It doesn’t fit into how hospitals buy drugs, and it doesn’t fit into how we bill.”

Different rates for different drugs

CMS will reimburce innovator multiple-source drugs—brand-name drugs with more than one therapeutic use—at 68% of average wholesale price (AWP). CMS will reimburce noninnovator multiple-source drugs—generic drugs with more than one therapeutic use—at 46% of AWP.

For example, CMS will reimburce hospitals $2.56 for 100 milligrams of the brand version of cyclosporine and $2.41 for the generic, according to the code table in the CMS transmittal.

The codes for each drug are different. The generic cyclosporine uses code J7502, and the brand cyclosporine uses code C9438.

“It’s just a big headache in terms of reimbursement and billing,” says Gary Stein, PhD, director of federal regulatory affairs for American Society of Health-System Pharmacists.

Tip: Make sure you switch the coding in your billing system, depending on whether you use the brand-name, innovator drug or the generic, noninnovator drug, Anderson says.

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Tip: Make sure you switch the coding in your billing system, depending on whether you use the brand-name, innovator drug or the generic, noninnovator drug, Anderson says.

CMS issues three additional drug codes

CMS issued pass-through codes in Transmittal 132, Change Request 3154 to three newly approved drugs effective April 1. The codes are temporary until sufficient cost data exists to develop a reimbursement rate, according to CMS.

The three drugs include

• daptomycin, an injectable antibiotic for staphylococcus infections, which CMS will reimburce at 31 cents for every 1 milligram administered (code C9124)
• risperidone, an injectable antipsychotic, which CMS will reimburce at $131.86 for every 12.5 milligrams administered (code C9125)
• rasburicase, an injectable for high uric acid levels resulting from certain cancer treatments, which CMS will reimburce at $105.54 for every 0.5 milligrams administered (code J2783)

Go to www.cms.hhs.gov/manuals/pm_trans/R132CP.pdf for the complete update.
Survey monitor

JCAHO checks hospital clean room during survey

JCAHO surveyors are looking at hospital clean rooms during surveys, and one of their questions caught a Boston pharmacy director off-guard.

Surveyors will look for compliance with the U.S. Pharmacopeia (USP) Chapter 797 requirements on compounding sterile preparations in a clean environment after July 1 (see related story on p. 1).

While the survey team toured the clean room at Brigham and Women’s Hospital during its February survey, “They asked me whether this is something they should look for in every hospital,” says Bill Churchill, MS, RPh. “I said I didn’t know how to answer the question. I would be concerned that many small hospitals would not have the capability, space, or financial resources to do this.”

For your information only

Although surveyors wanted to see Brigham and Women’s clean room, they did not survey for compliance with compounding sterile preparations and related JCAHO standards, such as safely preparing and dispensing medications, Churchill says.

See a crosswalk of the USP requirements and the related JCAHO medication standards on p. 4.

Brigham and Women’s put itself in place to comply with the new USP requirements when it built its clean room for nearly $340,000 in 1999. The hospital built Class 100, 1,000, and 10,000 environments to compound sterile high-risk medications. The numbers represent the maximum particles per cubic meter of air that exist in that environment.

The hospital is also developing new procedures to increase compliance with Chapter 797, including new pyrogen testing for harmful microbes, Churchill says.

“We were one of the first large academic medical centers to be surveyed,” Churchill says. “They focused in on this in an informational way. They didn’t go after the crosswalk at all.”

Check your sterile products

Surveyors also checked how the pharmacy prepares and dispenses sterile product orders, Churchill says. One of the patient tracers was an oncology patient, and surveyors followed the order from the nursing unit back to the sterile products suite.

Surveyors asked the pharmacist in the oncology unit to walk them through how the pharmacy reviews a medication order and what double-checks exist to prevent an overdose, Churchill says. Brigham and Women’s has a chemotherapy order entry system with multiple safety checks to alert prescribers and pharmacists about a possible overdose. The alerts are linked to certain protocols programmed into the system, he says.

The tracer continued to the pharmacy and the central sterile products room. Surveyors wanted to speak with the pharmacist about how the department prepared the order, filled it, and ensured it was for the correct patient, Churchill says.

Pharmacy staff pointed out their department’s policy for sterile product preparation, the new pharmacy bar-code system, and the IV label printing units, Churchill says.

Watch your policies

Expect surveyors to be meticulous when reviewing

About the facility: Brigham and Women’s Hospital is a 720-bed hospital in Boston with 24-hour pharmacy coverage. It opened at its current location in 1980, six years after the merger of Boston Hospital for Women, Peter Bent Brigham Hospital, and Robert Breck Brigham Hospital. It is one of the major teaching hospitals for Harvard Medical School.
policies and procedures. Surveyors returned to the pharmacy to speak about drug samples after watching a patient receive a sample medication in the ambulatory unit, Churchill says.

Brigham and Women’s allows the use of drug samples. However, the pharmacy and therapeutics (P&T) committee must review the samples, and only the practices that request the samples may use them.

Surveyors asked the physician and nurse in the ambulatory unit about the hospital’s policy. After they explained the policy, surveyors went to the pharmacy to check for proof that the P&T committee approved the sample in question, Churchill says.

“That was very thorough,” Churchill says. “Fortunately, we had that documentation.”

Reinforcing lessons
Brigham and Women’s made a concerted effort to educate staff about key points surveyors might touch upon during their visit, Churchill says.

For example, he wanted staff to know that surveyors might ask them about the hospital’s policy on reviewing medication orders or what safety measures exist for high-risk medications.

Prior to survey, staff received daily or weekly e-mails on hot survey or JCAHO topics, Churchill says. He also shared any JCAHO-related articles from journals or newsletters with staff.

The survey preparation process was more about reminding staff about policies than educating them because anything could occur during the tracer portion of the survey, Churchill says.

“It was preparing them so in the context of any particular question, they would feel confident and comfortable giving an answer,” Churchill says.

“There’s no way of knowing what patient [surveyors] will look at or what questions might come up. They could show up in the pharmacy at any time and ask anything.”

Six surveyor questions all pharmacy staff should know

Check out these six questions that surveyors asked pharmacy staff at Brigham and Women’s Hospital in Boston during its February survey.

1. Is it possible to enter a dose that is higher than it should be in the order entry system?
2. Do you review all medication orders?
3. What is your policy regarding drug samples?
4. How are pharmacy technicians trained to operate bar-code repackaging machines?
5. What are you doing to increase medication error reporting?
6. How do you assess staff competency?

Survey at a glance

**Hot spots:** Preparing chemotherapy orders, controlling drug samples, compounding sterile preparations

**Critical advice:** Keep thorough documentation of an event if your policies and procedures require it. Documentation is important, especially if surveyors ask why staff did something a certain way.

**Survey tip:** Remind staff about hot JCAHO topics during survey preparation. Make sure they will be able to answer surveyor questions.

**Quote of note:** “There’s no way of knowing what patient they will look at. They could show up in the pharmacy at any time and ask anything.”
Quick tip: Know your state’s laws when mailing prescriptions to patients

Check with state and local authorities for applicable laws if your pharmacy mails prescription drugs to a patient’s home.

The federal government allows pharmacies to mail prescription drugs—including controlled narcotics—to a patient, but states may have their own laws about mailing drugs as well, says Tim Benedict, RPh, assistant executive director of the Ohio State Board of Pharmacy.

For example, if you mail prescriptions to a patient in another state, you may need a pharmacy license in both your state and the state in which the patient resides, Benedict says. Most states have this requirement, so check to make sure you have a license in the state to which you mail the prescription.

Tip: Check your state laws to see what you can mail and whether you have the proper licenses.

“Check with your local authorities,” Benedict says. “Mailing drugs is a very common practice today. A lot of common sense goes into this.”

Common sense includes using only your street address, city, state, and ZIP code in the return address and not your pharmacy name, Benedict says. This will help guard against theft, as someone may see the package is from a pharmacy and steal the medications.

“It’s just not a good idea to identify yourself as a pharmacy,” Benedict says. “You’re asking for someone to rip off your product.”

You can mail medications in standard mail packages that will not open once sealed unless you cut them open. Pharmacy benefits manager Medco Health Solutions Inc. uses such packages in its mail-order business, Benedict says.

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