especially with injections, where the total volume is important in calculating a dose” says Diane Cousins, RPh, vice president of the Center for the Advancement of Patient Safety at the U.S. Pharmacopeia (USP) in Rockville, MD.

Be clear
A facility’s own labels can cause errors. According to data from the USP MEDMARX® error-reporting system, an organization’s labels on cardiovascular drugs alone contributed to 794 errors between January 2001 and August 2004.

Labeling errors on the
A pharmacist reads 25 mg as he scans the medication label, but his eyes may be deceiving him. The problem is the label actually says 2.5 mg, but the decimal point was printed so lightly that it was difficult to read. That situation underscores one of the potential barriers to complying with JCAHO medication standard MM.4.30, which requires organizations to appropriately label all medications.

“Make sure the labeling clearly states the drug name, strength or concentration, and total vial content, especially with injections, where the total volume is important in calculating a dose” says Diane Cousins, RPh, vice president of the Center for the Advancement of Patient Safety at the U.S. Pharmacopeia (USP) in Rockville, MD.

Small hospitals hold their own
Finding alternative ways to keep pace with big orgs

Drug information sources, contracted services, or on-call pharmacists can help small hospitals aid physicians in the medication-prescribing process if pharmacists cannot work on the floors.

Only 20% of small hospitals—those with 100 beds or fewer—surveyed in the American Society of Health-System Pharmacists’ (ASHP) 2004 National Survey on Pharmacy Practice in Hospital Settings had pharmacists participate in clinical rounds on the floors, says Douglas Scheckelhoff, MS, RPh, director of the ASHP pharmacy practice managers section. That percentage jumps to 80% in larger hospitals.

Working with the physicians and other clinical staff at the bedside has dramatic effects, Scheckelhoff says.

“The pharmacist can provide information at the point of prescribing,” Scheckelhoff says. “They’re able to be more proactive. Trying to do an evaluation in the pharmacy, they’re operating in a much more limited environment.”

Provide reliable sources
If hospital resources prevent the pharmacist from working on the clinical floors and making
Standard MM.4.30

facility’s end can stem from the need to repackage a medication in unit-dose form, Cousins says.

Problems can also arise from unclear labeling, especially with injections and liquid medications, Cousins says. For example, the label may prominently state 5 mg/mL, but the nurse may never see that on the back of the vial the label indicates the total volume is 5 mL. The nurse may draw up the entire contents of the vial, thinking she is getting 5 mg in 1 mL but is actually getting 25 mg, or 5 mL, Cousins says.

Tip: Clearly mark the volume in each medication container.

Placement is key
Labeling medications and medication containers is especially important in the pediatric setting, where many doses are prepared in an oral syringe, Cousins says. In some cases, staff have placed the syringe inside a bag after drawing it up with medication and placed a label on the bag instead of the syringe. If staff take the syringe out of the bag and lay it down, it can be mistaken for another syringe or for a syringe for injection if it is not labeled, Cousins says.

Tip: Affix the medication label directly to the syringe or medication container.

Do your homework
Request labeling samples from a manufacturer before adding a new medication to the formulary, Cousins says. This way the pharmacy and therapeutics committee will be able to determine whether the drug name or label information may be confused with another drug already in stock.

The Pharmaceutical Research and Manufacturers of America is developing a paperless labeling system where labels for all medications would be stored and maintained in a database, says Alan Goldhammer, the association’s associate vice president of regulatory affairs.

The paperless labeling initiative would deliver pharmacists the most current medication labels in a portable document format, or PDF, Goldhammer says. The electronic labels would be easier for pharmacists to read and gather information about the medication and any contraindications, he says. “We’re very excited because we think it’s going to make a very positive contribution to public health,” Goldhammer says.

Standard MM.4.30 at a glance

The organization labels medications appropriately.

Requirements for MM.4.30
- Medications are labeled in a standardized manner according to organization policy, applicable law and regulation, and standards of practice.
- Any time one or more medications are drawn up or prepared for later use, the container must be appropriately labeled.
- At a minimum, all medications are labeled with:
  - drug name, strength, amount (if not apparent from the container)
  - expiration date when not used within 24 hours
  - expiration time when expiration occurs in less than 24 hours
  - for all compounded intravenous admixtures and parenteral nutrition solutions, the label includes the date prepared and the dilutent.
  - for all medications prepared on a patient-specific basis or when the person preparing the medications is not the person administering the medication, the label also includes:
    - patient name
    - patient location
    - directions for use and any applicable cautionary statements either on the label or attached as an accessory label (e.g., “requires refrigeration,” “for IM use only”)
Sample policy for labeling medications for unit-dose distribution

Policy: The unit-dose system requires that all medications be individually labeled before being dispensed. Because not all medications are commercially available in this type of packaging, pharmacy will label all items as being repackaged.

Procedure:
I. If an item that is usually available commercially in unit-dose packaging is out of stock, pharmacy staff will communicate the outage to the inventory control technician and a manager. The pharmacy purchasing/inventory technician will be responsible for ordering the out-of-stock item in bulk from the wholesaler. It will be technical staff’s responsibility to repackage bulk products into unit-dose packages by utilizing the prepack machine.

II. If the medication cannot be prepacked, individual doses dispensed will be labeled according to their type.
   A. Capsules and tablets: generic name, strength per tablet or capsule, manufacturer, trade name, lot number, expiration date, and technician/pharmacist’s initials.
   B. Oral liquids: generic name, strength per milliliter, the dose and the number of milliliters, manufacturer, trade name, lot number, expiration date, any auxiliary labels, and technician/pharmacist’s initials.

III. Use a 12-month expiration date when repackaging.

IV. If tablets and capsules are dispensed in bulk, place an auxiliary label on the amber vial indicating the following: “Caution: Container contains multiple doses.”

V. If the medication is prepacked or poured into a smaller bottle by a technician, the technician will provide both the label and the bulk container to a registered pharmacist to be checked and initialed for accuracy.

VI. For medications that were not unit-dosed,
   A. when either a solid or liquid container comes back in the bin to be refilled, the lot number, manufacturer, and expiration date must match exactly or a new label must be prepared according to the preceding policy and procedure.
   B. a pharmacist will recheck the label and contents of all newly bottled items prior to cart exchange.

VII. When a medication that has been bulk packaged is returned because of discontinuation, the medication and container will both be discarded.

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ASHP survey < p. 1

patient rounds, the pharmacy should provide accurate drug information for prescribers so they can refer to it when making therapeutic decisions, says Scheckelhoff.

An electronic drug-information library or resource would provide an unbiased source of information, Scheckelhoff says. The National Library of Medicine has an online database, www.nlm.nih.gov/databases/ that offers references to journals and drug information.

AHFS Drug Information, Drugdex Information Service, and USP Drug Information are also information resources pharmacists could provide for prescribers.

Keep someone on call
There are also services that review orders after a pharmacy has closed and make licensed pharmacists available for staff questions about medications. Those services could help smaller hospitals aid prescribers if necessary, Scheckelhoff says.

Rxsource, a division of Cardinal Health Inc., and PharmaChek After Hours from MedNovations offer such services. Prices for both Rxsource and PharmaChek After Hours can range from $30,000 to $400,000 depending on the hospital’s size and order volume, representatives from both companies say.

Some hospitals have also begun to offer late-night pharmacists to smaller hospitals without 24-hour coverage. The old-fashioned on-call system also works just as well. “A high percentage of all hospitals have pharmacists available [on call] to answer questions, and they do so 24/7,” Scheckelhoff says.

Back up your needs
Although a movement exists to install technology such as computerized physician order entry (CPOE) to help physicians make prescribing decisions and reduce errors, nothing can replace a live pharmacist, especially when some technology is still expensive and unproven, Scheckelhoff says. “In the long run, it’s probably still cheaper to have the pharmacist in the patient-care area,” he says. “In the future, technology may be at the point to replace pharmacists in the patient-care area, but it’s not there yet.”

Getting leadership to realize the value a pharmacist on the patient-care units brings may be difficult, but once they understand what one could do for the hospital, leaders typically buy into the idea, Scheckelhoff says.

Tip: Use research and numbers to back up your requests.

“There are more data that shows the relation to error reduction and reduced cost, especially in high-risk patients and pediatric patients,” he says. “It’s an easier and easier case to make because there’s good data to back it up.”
Ask the expert

Check with the JCAHO on pharmacy egress questions

Editor’s note: The following question was submitted by a Hospital Pharmacy Regulation Report reader. If you have something you need answered, go to www.hcpro.com/pharmacy and submit a question under the “ask the expert” section or e-mail it to mbashalany@hcpro.com.

Hospital pharmacies are not patient care areas, but do they need to meet Life Safety Code® (LSC) requirements for care areas or business occupancies? Check out the question below, answered by Jennifer Holloman, a fire-protection engineer with Koffel Associates Inc. in Ellicott City, MD, and JCAHO spokesperson Mark Forstneger.

Q: Paragraph 18.1.2.5 of the LSC states “Egress provisions for areas of healthcare facilities that correspond to other occupancies shall meet the corresponding requirements of this Code for such occupancies.” This is further explained in the LSC Handbook, p. 516, as follows: “Spaces used for nonhealthcare purposes, but located within a healthcare facility should have means of egress features designed in accordance with the use of the space.”

We have a nonpatient suite (the pharmacy department) within the healthcare occupancy. This area is not fire separated from the healthcare occupancy with two-hour construction. The overall fire protection requirements of Chapter 18 are applied throughout the suite and surrounding area, and the corridor immediately outside this department meets healthcare occupancy requirements.

Within the pharmacy, there are two intervening spaces from the most remote point in the suite, but the travel distance to reach the means-of-egress door from the suite exceeds 50 ft. The suite also exceeds 2,500 sq ft in area and has only one egress door. The common path of travel within this suite is less than 75 ft.

Within this nonpatient department, do the provisions of Chapter 18 apply with regard to the means of egress within that department, in particular Paragraphs 18.2.5.8, limiting travel distance to the means of egress door from the department, and 18.2.5.3 which requires two means of egress if the “suite” exceeds 2,500 sq ft in area?

Because this suite, or department, more closely resembles a business occupancy, even though not fire separated from the healthcare occupancy, should the means of egress from this suite to the corridor in the healthcare occupancy meet the requirements of Chapter 38 for business occupancies?

A: Holloman: Your interpretation of Paragraph 18.1.2.5 makes sense from a fire-protection standpoint. However, it is not the traditional interpretation as the wording does state “healthcare facility,” not healthcare occupancy.

No discussion is given in this paragraph to the separation requirements of the nonhealthcare occupancy from the healthcare occupancy. You can argue the point, but I suggest that you request approval by JCAHO. Because this is an interpretation issue, a JCAHO surveyor may not agree. The signed agreement from JCAHO will ensure that you are not cited for this arrangement in the future.

Forstneger (All references are from the LSC 101-2000): The healthcare occupancy and pharmacy suite in question does not qualify as a mixed occupancy (lack of two-hour separation). Chapter 38 (New Business Occupancy) does not apply [see 6.1.14.1 & 6.1.14.2; 18.2.5.1(2)].

If the pharmacy is a suite greater than 2,500 sq ft, it must have two separate and remote exits (18.2.5.3). Exits are to be spaced at least half of the overall diagonal of the area to be served, measured from the nearest edge of doors (see 7.5.4.2).

Two intervening spaces are allowed if the travel distance from the remote point to the means-of-egress door is less than or equal to 50 ft. In this situation, the travel distance was stated to exceed this distance. ■
Experts answer six common patient-falls questions

One of the JCAHO’s 2005 National Patient Safety Goals requires hospitals to include a medication assessment as part of a patient’s falls risk evaluation. Rein Tideiksaar, PhD, president of FallPrevent, LLC, and Dave Merryfield, clinical pharmacy manager at Sentara Healthcare in Norfolk, VA, answered questions about patient falls during the recent HCPro, Inc., audioconference “Patient falls and medications: How to comply with the JCAHO’s Patient Safety Goal.” We adapted the answers for better readability.

Q: How can we get our nurses to do a risk assessment, or even to do a medication evaluation as part of a risk assessment?

A: Tideiksaar: There are many tools available. Embed the risk assessment tools into existing risk assessment documents. For example, a risk assessment tool and factors to consider for a fall are included at admission.

Older individuals, for example, can come in with anywhere from 10–15 medications, and it can be a taxing task for nurses to get that information from the patient or family members.

One thing that I have found helpful, at least in the community setting, and I think you can use in the hospital setting, is what’s known as a brown bag. You tell a patient before they come into the hospital to collect all the medications they have and put them in a brown paper bag and bring them in.

Merryfield: It’s a challenge. I was impressed that more than half the participants in our session do have medications included in their falls risk assessment. I think it’s something nurses find cumbersome. You’re not just doing the assessment to prevent falls, you’re doing it with the right mindset (See sidebar on p. 7 for more information).

Q: We are a hospice, and the majority of our patients are on several opioids. Are there any suggestions that you have for our hospice patients?

A: Merryfield: In a nonhospice population, we’re trying to get our patients to the minimum dose possible, and in hospice, it’s usually for a comfort-only situation. There may be things you can do to smooth out the medication regimen; for example, giving them sustained release medications instead of bolus doses.

A lot of it is probably educating the patient and the family, that we’re giving the patient a high dose of medication and there’s a risk of falls involved.

Tideiksaar: Assist patients with their transfers. It’s hard to minimize the medications there. You’re trying to provide comfort for these patients. The goal might not be fall prevention, but the prevention of injurious falls.

Q: What medications would you consider important to prevent falls in pediatric patients?

A: Merryfield: We tend to think of fall prevention in the elderly and not the pediatric patient. If it is a population that is using psychotropic drugs or pediatric oncology with a lot of pain medication, make sure the doses and selection of medications are appropriate to the age and weight and watch the individual’s response to make sure you aren’t oversedating him or her. We don’t normally worry about pediatric patients accumulating medications like we do with the elderly.

Tideiksaar: Most of the falls that occur due to medications in pediatric patients happen because of intravenous medications, and the influence of IV poles leading to falls.

Q: We are studying all medications’ effects on patients who fall, and we’ve noticed one drug in particular with which falls occur most often: a proton pump inhibitor. Have you noticed this in your facility?

A: Merryfield: That is not something that’s been noted in our data. We certainly see a lot of patients on proton pump inhibitors. They tend to be used for
stress ulcer prophylaxis on patients in the intensive care unit or critical care areas who might be at high risk for falls. Some people with ulcers or gastrointestinal bleeds become dehydrated and tend to be at risk for falls.

I’m not sure that I would assume that it’s from the medication itself. It might be an association with the type of patient who’s receiving the medication, but it’s possible that you’ve picked up on something that hasn’t been reported.

**Tideiksaar:** Look at the individual characteristics of the patient to see what risk factors exist. It might be that these individuals have mobility disorders as well or maybe they’re restricting their activities due to fatigue and therefore developing muscle weakness.

**Q:** We’re a psychiatric hospital and, with our pharmacist’s help, we’ve identified that most of our medications put our patients at risk for falls. Is there a risk assessment tool for psychiatric hospitals?

**A:** **Tideiksaar:** A lot of the tools have not been tested on psychiatric populations, so I’m not sure whether they’re valid or reliable for that population. In terms of medications for the psychiatric population, the patients are going to be on a lot of them, and all of them contribute to falls.

Trying to decrease those medications or eliminate them will be difficult. What you need to do is guard against falls and injurious falls and try to guard against those side effects.

**Merryfield:** One of the things that I found to be helpful with patients on psychotropic drugs is education. It can be helpful to a lot of people to explain to them that it’s not because they’re sick, it’s a side effect of the medication. Sometimes we can change medications and eliminate some of the problems.

**Q:** We use the Morse fall scale electronically. Would it be best to have a medication assessment with the trigger medication concurrently by nursing or retrospective by pharmacy?

**A:** **Tideiksaar:** Basically you do your Morse scale assessment and you identify risk. At the same time, you identify all the medications a patient is on and then you make a correlation between the identified risk factors on the Morse scale and the medications a patient is taking.

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**Poll: More than half of hospitals do medication assessment**

**Dave Merryfield,** clinical pharmacy manager at Sentara Healthcare in Norfolk, VA, shared his thoughts on listeners’ responses to polling questions during the recent HCPro audioconference “Patient falls and medications: How to comply with the JCAHO’s Patient Safety Goal.”

**Q:** Does your organization have a medication risk assessment component to your fall risk assessment?

- Yes: 56%
- No: 44%

**Merryfield:** That’s a little better than I would’ve expected. For those of you who have not started to include medication risk assessments, you’re missing out on opportunities to improve the care and safety of patients as well as meet the new JCAHO requirement for this year that you incorporate medications into your fall risk assessment.

**Q:** If you assess for medications, do you take the information and send it to:

- Pharmacists only: 37%
- Physicians only: 25%
- Both pharmacists and physicians: 38%

**Merryfield:** Some of you may not send that information anywhere. I hope you think about including other people other than nursing in the fall risk assessment. Including the pharmacist in this is a good opportunity for us to review medication regimens and identify changes that we could make that would have a positive impact for the patient.

*Editor’s note: Quotes were adapted for readability.*
Medicare changes forcing cancer patients to hospitals

Survey: Organizations find ways to handle volume increase

Hospital infusion centers downsized a few years ago, as Medicare wanted patients to receive their therapy in the outpatient setting. Physicians responded well, and hospitals didn’t complain because their ambulatory payment reimbursement was getting cut.

Hospitals took their smaller spaces to do transfusions and once-a-day antibiotics. Now, they may be unprepared from a facility standpoint to manage the expected shift in cancer care patients to hospitals this year as a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

Nonprofit hospitals may be the hardest hit. Several hospitals that responded to a 2004 survey from HCPro, Inc., the publisher of this newsletter, say that even if they can scramble to find space for infusions so that patients don’t have to wait, they may need to turn to older-generation drugs for infusion therapy.

Moving patients to save money

The switch is a cost-saving measure, but one that comes with consequences as physicians will want to continue to pick the drugs. “And well they should, but we don’t have a choice here,” one infusion center director who responded to the survey told HCPro.

Oncologists like Sal Del Prete, MD, will be paid in 2005 at roughly 70% of the average wholesale price (AWP) of drugs administered in the office setting. Del Prete says this will force him to stop giving infusions, cut nursing and tech staff, and reduce his office space.

Del Prete sent letters to his chemotherapy infusion patients in late September 2004 telling them they need to get their infusions at Stamford (CT) Hospital starting this January. This movement is happening nationwide, and the effect on hospitals is expected to reduce nurse care and lengthen outpatient waits as facilities struggle to handle the capacity. Technically, AWP doesn’t exist this year. A new, still invisible reimbursement system allegedly based more on the true costs of infusions will replace it.

Hospitals ‘nervous’

The average sales price is expected to reduce the maximum allowable reimbursement for doctors like Del Prete well below current and previous levels.

“We’re nervous,” says Faye Satterly, director of Martha Jefferson Hospital’s cancer care center in Charlottesville, VA. The University of Virginia medical center is the only other hospital in the vicinity.

Satterly has been in discussions with physicians about the number of patients they plan to shift to the hospital, but “they don’t want to let that business and those patients go, and they just don’t know what to do yet,” she says. “No one wants this change.”

Satterly suggests hospitals do everything possible to partner with physicians in 2005. At Martha Jefferson, the oncologists are housed inside the hospital as part of a 1992 effort to unify cancer care.

The private-practice model has worked ever since Medicare encouraged outpatient infusion care. Physicians have done a great job embracing this, offering outpatient infusion with newer generation drugs that reduce side effects. Zofran is an example.

Patient case: Zofran

One anonymous patient, who was diagnosed with a complete molar pregnancy, was treated with Methotrexate at Tufts-New England Medical Center in Boston. After each weekly chemotherapy treatment, she received Zofran and Compazine to manage the nausea and pain.

“Compazine really knocked me out for a day at a time,” she says. “I preferred the Zofran.”

But nonprofit hospitals that struggle to meet narrow margins may need to use cheaper medications such
as the older generation Compazine to prevent and control nausea and vomiting.

Satterly says many hospitals may have no choice. Some may strongly suggest that the doctor opt for an inexpensive drug, although Satterly notes the importance of patient care over the dollar.

“We probably won’t be that aggressive in suggesting something cheaper because we don’t operate that way here,” Satterly says. “We may make suggestions—but without force. However, I certainly see where it could happen more and more in many places—hospitals are fighting for their lives.”

Before MMA
Before the Medicare reform law, the government’s ambulatory payment classification system created cuts in payments to hospital-based infusion centers.

“It made it difficult to make a profit, and in a non-profit hospital, that makes it very hard to operate,” Satterly says. “I’m talking about a 2% profit margin because that’s all we really need to invest in capital for labor and new equipment.”

Satterly says her facility hasn’t cemented any contingency plans. “We’re waiting to see what the physicians do,” she says. “We’re at capacity in our infusion center as it is.”

One possibility Satterly has discussed with colleagues is to “take back” the space the hospital rented to the physicians. This may be an option many hospitals must consider. But Satterly doesn’t want it. “It’s not really an option,” she says.

An Idaho hospital echoed the concerns of East Coast hospitals like Martha Jefferson.

“With the change in venue, wait times are one problem we’ll have to deal with, but even if we can find a chair [for the patient], the doctor won’t be there,” said a survey respondent who spoke on the condition of anonymity. “Sure, we can get the doctor on the phone, but this may mean you’ll wait on an order to change something. Flow will be affected.”

Last-resort strategies
Renting space in other buildings in town is an immediate option, according to one hospital in Texas. But this, Satterly says, is difficult because then the care is no longer hospital-based.

“The physician may not be available or, in the event of an unexpected drug reaction, where will the code team be?” she asks.

Home health agencies may be a great option, says Satterly. “But Medicare might not pay for expensive antibiotics—they’ll pay for the nurse, but not the drug,” she says. “That will presumably change in 2006; but even if the patient can afford the drug, tough regulations on home healthcare may need to be changed to make this option easier.”

Online Extra
For more information about the cancer care shift to the hospital setting, visit www.epharminddepth.com.

Upcoming audioconferences:

- **June 21**—Preparing for a CMS Survey (source code A062105)
- **June 28**—Understanding JCAHO Scoring (source code A062805)
- **July 12**—Preparing for an Unannounced Survey (source code A071205)
- **July 21**—Reducing Adverse Drug Events (source code Q072105)

For more information, call customer service at 800/650-6787 and mention the source code for the desired audioconference.
Survey monitor

MO hospital perfect fit for abbreviation compliance

A hands-on approach helped one Missouri hospital receive a compliant score with the JCAHO’s unapproved abbreviations National Patient Safety Goal during its February survey.

Bothwell Regional Health Center in Sedalia, MO, took initiative and created its own list of unapproved abbreviations before the JCAHO mandated its own, says Pharmacy Director Brad Nicholson, PharmD. Staff also received pocket cards to help them remember the hospital’s list.

“We just worked very hard and just went to committee after committee and just reinforced it,” Nicholson says. “We . . . jumped in with both feet.”

In addition to not receiving a citation on the unapproved abbreviations requirement, the JCAHO did not cite Bothwell on any medication management standards; one of the surveyors said he could not remember the last time that happened, Nicholson says.

JCAHO spokesperson Mark Forstneger says the commission does not track which hospitals score perfectly on certain chapters of the accreditation manual.

Take initiative

Bothwell staff knew the JCAHO would release a list of unapproved abbreviations for hospitals to follow, so the organization looked within to make its own, Nicholson says. Although many are on the JCAHO’s list, staff also identified through their own practices abbreviations that could be harmful.

For example, staff identified “d/c,” which could mean “discontinue” or “discharge,” as one dangerous abbreviation, Nicholson says. One instance on an antibiotic order led to confusion regarding “d/c,” when a prescriber used it to mean “discharge” but pharmacists thought it could have meant “discontinue,” he says.

The “d/c” abbreviation is on the JCAHO’s list of additional abbreviations that hospitals may select.

Get P&T involved

Pharmacy staff also call prescribers if they use an unapproved abbreviation and ask for clarification, Nicholson says. They then track each abbreviation use and share with physicians at service meetings and on their basic report cards, he says. “We were . . . proactive with it,” Nicholson says.

The hospital’s pharmacy and therapeutics (P&T) committee reviewed and approved the list of unapproved abbreviations as well as a formal policy. Nicholson also held several meetings with the medical and surgical services physicians to discuss the policy, he says.

Get procedures in line

Surveyors checked the pharmacy’s sterile room and the policies and procedures covering sterile preparations, Nicholson says. They looked at pharmacy staffing, general cleanliness, and workflows as well.

“They were looking for things that did not seem right from their perspective,” Nicholson says.

The JCAHO wanted to make sure Bothwell handled overrides and after-hours pharmacy access correctly. The hospital has specific policies that state nurses may access certain medications if a patient’s condition changes quickly, Nicholson says.

The hospital also uses an after-hours dispensing sheet that requires two signatures when accessing

About the facility: The 180-bed Bothwell Regional Health Center in Sedalia, MO, serves west-central Missouri and treats nearly 54,000 patients each year. The hospital’s pharmacy is open daily from 7 a.m. to 11 p.m.
medications after the pharmacy closes.

**Look outside your department**
The P&T committee and the pharmacy were actively involved in educating staff outside of the pharmacy on the medication management standards.

For example, the P&T committee hung posters containing look-alike and sound-alike drug pairs and the hospital’s list of high-alert medications that would require special attention such as a double check over each automated dispensing unit.

“[Surveyors] thought that was a really neat way to communicate to nursing staff,” Nicholson says. “Continue to educate and communicate on a daily basis. When you have little walled-off kingdoms, that’s where you have problems.”

**Tip:** Collaborate with other departments to develop JCAHO education materials, such as posters or a PowerPoint presentation about medication management.

**Get creative with education**
The Bothwell pharmacy department has 14 employees, but educating all 14 about the JCAHO survey process can be difficult given the different shifts, days off, and other staff commitments, Nicholson says.

To combat that problem, Nicholson made all pharmacy staff a copy of the medication management standards and went through them during staff meetings. He also compiled a “Joint Commission book,” filled with standards, tips from other hospitals, and regulations from the Centers for Medicare & Medicaid Services.

**Tip:** Require all staff to read through a book with the JCAHO standards and survey tips.

Nicholson also compiled a binder of various newsletters and publications with survey tips, and he read that monthly, he says.

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**Four surveyor questions for the pharmacy department**

Surveyors asked pharmacy staff at Bothwell Regional Health Center the following four questions during the hospital’s February survey:

- How do you handle overrides when the pharmacy is closed?
- What are your policies and procedures for operating the sterile room?
- How do you handle antibiotics on your formulary?
- How do you process orders with your digital order communication system?

**Survey tip:** Make sure staff are on the same page with policies and procedures so they can all provide surveyors with the same answers. Put policies and procedures in print and on the hospital’s intranet.

**Quote of note:** “Continue to educate and communicate on a daily basis. When you have little walled-off kingdoms, that’s where you have problems.”—Brad Nicholson, PharmD.

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**Hot spots:** Unapproved abbreviations, infection control, sterile preparation, staffing issues, workflow, after-hours medication access.

**Survey tip:** Make sure staff are on the same page with policies and procedures so they can all provide surveyors with the same answers. Put policies and procedures in print and on the hospital’s intranet.

**Quote of note:** “Continue to educate and communicate on a daily basis. When you have little walled-off kingdoms, that’s where you have problems.”—Brad Nicholson, PharmD.
Quick tip: Six things to consider when contracting with a compounding pharmacy

Thoroughly check a compounding pharmacy’s safety and sterility processes before using their drugs. This will help you comply with the U.S. Pharmacopeia Chapter 797 guidelines on compounding sterile preparations and help you prepare for a JCAHO survey.

“We try to avoid using compounding pharmacies at all costs,” says Todd Donnelly, RPh, manager of health systems services for The Cleveland Clinic Foundation. “When we do use one, we first verify their facility capabilities, qualifications, and quality processes.”

Federal officials announced in March that five cases of the bacterial infection *Serratia marcescens* occurred in patients at a New Jersey hospital who received an IV of magnesium sulfate from the Illinois–based PharMedium Services, LLC.

Individual states currently regulate compounding pharmacies, but the federal government is receiving more pressure from healthcare trade groups to have the FDA regulate the industry.

Until federal regulation occurs, you can use compounding pharmacies safely by following these measures that Donnelly implemented at The Cleveland Clinic:

1. Try to produce the drug yourself if possible
2. Verify the compounding pharmacy’s state licensure
3. Ask for the pharmacy’s qualifications, safety processes, and how it tests sterility
4. Ask for copies of quality-monitoring data
5. Make sure it has patient-specific labeling
6. Have a manager in your hospital’s pharmacy tour the compounding facility

Trouble spot: Some physicians prescribe non-FDA approved compounded drugs without first getting the patient’s consent. If an adverse event related to the medication were to occur, the hospital contracting with the physician could be held accountable.

Solution: Create a policy that requires physicians to check with the hospital’s pharmacy and therapeutics committee before they prescribe a compounded drug.