APPENDIX B

Example Forms

Robert C. Jordin

EXAMPLE 6-1

SUGGESTED ACTIVITY FREQUENCY CHART

Minimum Frequency:

S = Each Shift
D = Daily
W = Weekly
M = Monthly
Q = Quarterly
6M = Every 6 Months
Y = Yearly
2Y = Every 2 Years
3 Y= Every 3 Years
ON = Ongoing
AR = As Required

ACTIVITY	S	D	W	M	Q	6M	Y	2Y	3Y	ON	AR
Pharmacy Operational–Focused Activities											
Licensure verification							X				
Job description updating							X				
Performance evaluation							X				
Competency assessment							1				1
Staff orientation											X
Pharmacy staff meetings			2	2							
In-service programs for pharmacy				X							
In-service programs for nursing					X						
In-service programs for medical staff						X					
Emergency medication inspections	3	3		3							
Controlled substances inventories							4	4			
Controlled substance diversion audits										X	
Refrigerator, freezer, and warmer temperature checks		X									
Refrigerator inspections				X							
Medication area inspections				X							
Medication Formulary, Programs, and Policy-Focused Activities											
Pharmacy and Therapeutic committee meetings				5	5						
Policy and procedure review, revisions, and approvals							X				
Policy and procedure approval							X				
Formulary approval							X				
Formulary additions/deletions (updating)					X						
Medication-use evaluations					X						
Performance improvement activity										X	
Medication use improvement activity										X	
Antimicrobial stewardship performance improvement documentation										X	
Hazardous drug assessment of risk review of list of medications, dose forms, and update, and approval							X				6
Look-alike/sound-alike list review, revise, and approval							X				
Compounding-Focused Activities											
IV hood cleaning	X										
Prefilter cleaning or changing					X	X					
Primary engineering control certification						X					
Nonviable environmental monitoring for buffer and ante area						X					
Viable environmental monitoring for buffer and ante area						X					
Surface sampling (all areas)				7							
Sterile compounding staff competencies							7				
Sterile compounding staff media tests						7					
Standard operating procedures							X				

1. Before or soon after hiring, before performing new tasks, and yearly.
2. Monthly staff meetings are the suggested minimum. Weekly meetings may be more appropriate.
3. Monthly inspections by pharmacy; at least daily inspections by those who use the drugs.
4. DEA requires a biennial inventory. Some states require annual inventories. Time of year varies.
5. Quarterly is the minimum frequency. Some hospitals may need more frequent meetings (e.g., monthly).
6. Update as required based on new medications or dosage forms used within the facility.
7. Guidance based on draft USP General Chapter <797> regulations.

EXAMPLE 7-1

POLICY AND PROCEDURE FOR NONFORMULARY MEDICATION REQUESTS

Page number _____ of _____
Policy number _____

DEPARTMENT: Pharmacy

SUBJECT: Nonformulary Medication Requests

ISSUED BY: Pharmacy and Therapeutics Committee

REVIEWED: _____ _____
Director of Pharmacy Date

APPROVED: _____ _____
For the Medical Staff Date

PURPOSE

The purpose of this policy and procedure is to provide for the procurement of medications that are not in the facility's formulary.

BACKGROUND

The formulary lists medications that have been approved by the medical staff for use in this facility. Prescribers must use formulary medications when possible.

POLICY

Nonformulary medications shall be used in this facility only after the prescriber has determined that a formulary medication is not appropriate. However, a prescriber shall NOT use a medication that the medical staff has specifically prohibited from use in this facility.

PROCEDURE

Nonformulary Medication Request Form—A request for a nonformulary medication shall be made on a Nonformulary Medication Request form (available at nursing units and from the pharmacy). A separate request form shall be completed for each nonformulary medication ordered. The completed form(s) shall be forwarded to the pharmacy.

Review by a Pharmacist—A pharmacist shall review the request. If, in the opinion of the pharmacist, there is an appropriate alternative medication on the formulary, the pharmacist shall inform the prescriber of the alternative. The pharmacist shall indicate the following on the request form: the suggested alternative(s) and the action taken by the pharmacy to obtain the medication.

Procurement of a Nonformulary Medication—If an alternative medication is not acceptable, the pharmacy shall obtain the nonformulary medication from another facility, community pharmacy, or other approved source. The pharmacy shall obtain a supply of the medication sufficient to meet the anticipated needs of the patient for whom it is ordered. If the nonformulary medication cannot be obtained within 4 hours, the pharmacy shall notify the prescriber and nursing service.

Requests for Addition to the Formulary—Completion of a Nonformulary Medication Request form does not constitute a request for addition of the medication to the formulary. A request may be made on a Request for Formulary Addition form, which is available from the pharmacy.

EXAMPLE 7-2

VERIFICATION OF LICENSURE/REGISTRATION/CERTIFICATION FOR PHARMACY PERSONNEL

The primary source (agency issuing license/registration/certification) verified that the individual's license, registration or certification numbers listed below are current, valid, do not have any disciplinary action pending, and authorized to practice pharmacy as of the date noted below.

NAME	PHARMACIST OR TECHNICIAN	PRIMARY SOURCE	DATE VERIFIED	VERIFIED BY	NOTES

EXAMPLE 7-3

POWER OF ATTORNEY FOR DEA FORM 222 AND ELECTRONIC ORDERS

(Name of registrant) _____

(Address of registrant) _____

_____

(DEA registration number) _____

I, _____ (name of person granting power), the undersigned, who am authorized to sign the current application for registration of the above-named registrant under the Controlled Substances Act or Controlled Substances Import and Export Act, have made, constituted, and appointed, and by those present, do make, constitute, and appoint _____ (name of attorney-in-fact), my true and lawful attorney for me in my name, place, and stead, to execute applications for Forms 222 and to sign orders for Schedule I and II controlled substances, whether these orders be on Form 222 or electronic, in accordance with 21 U.S.C. 828 and Part 1305 of Title 21 of the Code of Federal Regulations. I hereby ratify and confirm all that said attorney must lawfully do or cause to be done by virtue hereof.

_____ (Signature of person granting power)

I, _____ (name of attorney-in-fact), hereby affirm that I am the person named herein as attorney-in-fact and that the signature affixed hereto is my signature.

_____ (Signature of attorney-in-fact)

Witnesses:

1. _____ (Signature of witness)

2. _____ (Signature of witness)

Signed and dated on _____ (current date).

Notice of Revocation—to be completed only when power of attorney is revoked

The foregoing power of attorney is hereby revoked by the undersigned, who is authorized to sign the current application for registration of the above-named registrant under the Controlled Substances Act or the Controlled Substances Import and Export Act. Written notice of this revocation has been given to the attorney-in-fact _____ this same day.

_____ (Signature of person revoking power)

Witnesses:

1. _____ (Signature of witness)

2. _____ (Signature of witness)

Signed and dated on _____ (current date).

EXAMPLE 7-4

MEDICAL STAFF INFORMATION RECORD

The pharmacy is required to maintain information relating to the medical staff (including a means of identifying the signatures of practitioners and their Drug Enforcement Administration [DEA] numbers).

Please provide the following information and return this form to the pharmacy.

NAME _____

ADDRESS _____

_____

_____

_____

_____

SERVICE/DEPARTMENT _____

TELEPHONE **Office** _____

Home _____

Mobile _____

Fax _____

E-MAIL ADDRESS _____

STATE LICENSE NUMBER _____

DEA NUMBER _____
(Or hospital assigned number)

CONTROLLED SUBSTANCE LICENSE (STATE OR OTHER) _____

APPROVED SCHEDULES PRESCRIBERS MAY PRESCRIBE
(Circle all that apply)

2 2N 3 3N 4 5

SAMPLE SIGNATURE _____
(For signing drug orders)

EXAMPLE 8-1

CONFIDENTIALITY OF PATIENT INFORMATION AGREEMENT

I, _____, understand that patients have a need and right to confidentiality.

I also understand that:

- Discussions relating to patients must be out of the hearing ranges of staff, visitors, other patients, and individuals who do not have a need or reason to know information.
- Medication orders, pharmacy patient profiles, labels, meeting minutes, and other patient-related documents (i.e., those that contain patient' names or identifying numbers, or information related to patients' status, treatment, diagnosis, and medications) must be securely stored and access restricted to those who have a legitimate need or reason to know and use the information therein.
- Disposal of patient-related documents must guarantee confidentiality. Patient-related documents must not be placed in regular trash of disposal.
- E-mail, text, and other electronic communication pose a particular risk of inadvertent dissemination inside and outside the facility.
- Patient-related information must not be released to the news media or unauthorized individuals, firms, and agencies. Requests for information must be forwarded to the facility's administration.

I hereby affirm that I will protect the confidentiality of patient-related information.

_____ _____

Signature Date

EXAMPLE 8-2

FORMULARY ADDITION REQUEST FORM

Please complete the form, provide supportive references, and return to the Director of Pharmacy. Copies of the request and references will be distributed to the Committee. The Committee meets on a monthly basis. You will be asked to attend the meeting and present the request. The Committee will vote on the change in inventory after review of all information is completed. Please print legibly.

DRUG REQUESTED:

Generic Name _____

FDA-Approval Status _____

Black Box Warning _____

DESCRIPTION:

FDA-Approved Indication(s) _____

Request for Other Than FDA-Approved Indications _____

_____

Is there a drug similar to this currently on formulary? Yes No If so, which? _____

If yes, are you proposing this drug as a replacement? Yes No If so, which? _____

CLINICAL TRIALS (brief overview with copies of studies): _____

_____

_____

_____

RISKS (including propensity for medications errors, abuse potential and/or Sentinel Events): _____

_____

ADVERSE EFFECTS: _____

_____

DOSAGE & ADMINISTRATION (include species and cite reference): _____

_____

_____

_____

COST ANALYSIS (brief overview with copies of studies): _____

_____

_____

FACTORS:

What do you believe are the relevant factors in requesting this drug as opposed to using drugs available already? (*circle all that apply)*

1) The drug is FDA-approved for the proposed indication where the others are not.

2) The drug is more clinically efficacious.

3) The drug has an improved side effect profile.

4) The drug is more convenient.

5) The drug costs less.

6) The drug is more cost effective.

7) Other: _____

AVAILABILITY:

How should the drug be offered?

1) Available to all providers

2) Restricted to a service

3) Restricted to specific providers—list: _____

4) Restricted to a treatment protocol

ANTICIPATED USAGE:

1) It is a continuous-use product.

2) It is a seasonal product. During what months is it used? _____

3) How much of the drug should be on hand? _____

CONFLICT OF INTEREST DISCLOSURE:

Has the requester received any grants, current or pending, to support research on this or any product associated with the company manufacturing, repackaging, marketing, or distributing of this drug?

Yes No

Has any member of the requester's service/section received any grants, current or pending, to support research on this or any product associated with the company manufacturing, repackaging, marketing, or distributing of this drug?

Yes No

Has the requester, any member of his/her family, or any organization in which the requester serves as an officer, director, trustee, general partner, employee, or consultant received gifts of training, transportation, or honoraria, or manufacturing, repackaging, marketing, or distributing of this drug?

Yes No

SIGNATURE OF REQUESTER: _____ PRINTED: _____ DATE: _____

PHONE #: _____ E-MAIL ADDRESS: _____

SIGNATURE OF SERVICE/SECTION CHIEF: _____

EXAMPLE 8-3

NONFORMULARY MEDICATION REQUEST FORM

Completion of this form does **NOT** constitute a request for addition of this medication to the formulary. Proposals for addition to the formulary must be made on a Request for Formulary Addition form, which is available from the pharmacy.

PATIENT NAME _____ PATIENT NUMBER _____

LOCATION _____ DATE _____

A separate request must be completed for each patient for whom the following medication is prescribed.

MEDICATION REQUESTED

GENERIC NAME _____

TRADE NAME(S)/MANUFACTURER(S) _____

DOSAGE FORM _____ ROUTE _____

DOSE PRESCRIBED _____ FREQUENCY _____

BLACK BOX WARNINGS _____

EXPECTED DURATION OF THERAPY WITH THIS MEDICATION (the pharmacy will obtain an initial supply sufficient to treat this patient for the expected duration of therapy) _____

REASON FOR USING THIS MEDICATION RATHER THAN ONE LISTED IN THE FORMULARY

__ No equivalent formulary medication available

__ Patient failed therapy with alternative medications

__ Patient had adverse effect from alternative medications

__ Alternative medications unacceptable

__ Other _____

I understand that the above medication has not been accepted by the medical staff for use in this facility and is not listed in the formulary. I further understand that since this medication must be obtained from outside the facility, its procurement might be delayed. If the expected delay will exceed eight hours, I will be so notified.

I anticipate a recurring need for this medication. Yes _____ No _____

_____ Date: _____

Signature of requesting practitioner

_____ E-mail: _____

Print name

Phone #: _____

PHARMACY USE ONLY

COST OF NONFORMULARY MEDICATION _____

ALTERNATIVE MEDICATION SUGGESTED BY PHARMACY _____

SUGGESTED BY (PHARMACIST) _____ DATE/TIME _____

OUTCOME/COMMENTS _____

EXAMPLE 8-4

NONFORMULARY MEDICATION SUMMARY

DATE	MEDICATION	PRESCRIBER	REASON	DATE PRESENTED TO P&T COMMITTEE

EXAMPLE 8-5

NOTIFICATION OF SHORTAGE AND OUTAGE

DATE OF NOTIFICATION	UNAVAILABLE MEDICATION	CURRENT INVENTORY STATUS	PHARMACY AND THERAPEUTICS COMMITTEE NOTIFIED	COMMUNICATION SENT TO PRESCRIBERS AND STAFF (SEE ATTACHED)	RESOLUTION DATE	STATUS

EXAMPLE 8-6

REFRIGERATOR/FREEZER/WARMER
MONTHLY TEMPERATURE LOG

Place an "X" in a box to the right to indicate the type of use.
If warmer, note acceptable range

	Medication: 2–8°C, 36–46°F
	Freezer: –25 to –10°C, –13 to 14°F
	Warmer

UNIT: _____ MONTH: _____

LOCATION/ROOM#: _____ YEAR: _____

Note corrective action if temperature is not within the acceptable range (e.g., adjust temperature, replace thermometer, or call Facilities Management (date/time). Notify pharmacy if out of range.

DATE	TEMP	NAME	ACTION TAKEN	CLEAN DATE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

COMMENTS: _____

EXAMPLE 8-7

MONTHLY REFRIGERATOR TEMPERATURE GRAPH LOG

DEPARTMENT _____ LOCATION _____ MONTH _____ YEAR _____

Temperatures will be logged on the days the department is open for business.

F°	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
49°																															
48°																															
47°																															
46°																															
45°																															
44°																															
43°																															
42°																															
41°																															
40°																															
39°																															
38°																															
37°																															
36°																															
35°																															
34°																															
33°																															

Temperature Range: Refrigerator = 2–8°C, 36–46°F. Shaded areas = out of range temperatures.

Note: If not within acceptable range, call the Pharmacy and Facilities Management. Note time the call is made. Corrective action must be noted (e.g., turned temperature down, replaced thermometer, etc.).

DATE	❑ PHARMACY NOTIFIED	❑ MAINTENANCE NOTIFIED, IF APPLICABLE	CORRECTIVE ACTION/COMMENTS

EXAMPLE 8-8

MONTHLY FREEZER TEMPERATURE GRAPH LOG

DEPARTMENT _____ LOCATION _____ MONTH _____ YEAR _____

Temperatures will be logged on the days the department is open for business.

F°	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
20°																															
18°																															
16°																															
14°																															
12°																															
10°																															
8°																															
6°																															
4°																															
2°																															
0°																															
–2°																															
–4°																															
–8°																															
–10°																															
–12°																															

Temperature Range: Freezer = –25°C to –10°C, –13°F to 14°F. Shaded areas = out of range temperatures.

Note: If not within acceptable range, call Pharmacy and Facilities Management. Note time the call is made. Corrective action must be noted (e.g., turned temperature down, replaced thermometer, etc.).

DATE	❑ PHARMACY NOTIFIED	❑ MAINTENANCE NOTIFIED, IF APPLICABLE	CORRECTIVE ACTION/COMMENTS

EXAMPLE 8-9

CONTROLLED SUBSTANCES INVENTORY COVER PAGE

Name of Registrant: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DEA Registration Number: _____

Date of Inventory: _____

Inventory taken at: Opening of business

Close of business

Actual Time Completed: _____

_____

Signature of Person Taking Inventory

_____

Signature of Pharmacist-In-Charge

Note: Retain this inventory at the above address for at least 2 years.

Some states require additional information to the above. Consult state board of pharmacy.

EXAMPLE 8-10

CONTROLLED SUBSTANCES BIENNIAL INVENTORY RECORD

Check *only one* of the following: Schedule II ___ Schedules III, IV, and V ___

DRUG	DOSAGE FORM	STRENGTH	UNIT SIZE	NUMBER OF COMMERCIAL UNITS	MANUFACTURER	ACTUAL COUNT

EXAMPLE 8-11

OMB APPROVAL NO. 1117-0007

U. S. DEPARTMENT OF JUSTICE – DRUG ENFORCEMENT ADMINISTRATION

REGISTRANT RECORD OF CONTROLLED SUBSTANCES DESTROYED

FORM DEA-41

A. REGISTRANT INFORMATION

Registered Name:		DEA Registration Number:
Registered Address:		
City:	State:	Zip Code:
Telephone Number:		Contact Name:

B. ITEM DESTROYED

1. Inventory

	National Drug Code or DEA Controlled Substances Code Number	Batch Number	Name of Substance	Strength	Form	Pkg. Qty.	Number of Full Pkgs.	Partial Pkg. Count	Total Destroyed
Examples	***16590-598-60***	***N/A***	***Kadian***	***60mg***	***Capsules***	***60***	***2***	***0***	***120 Capsules***
	0555-0767-02	***N/A***	***Adderall***	***5mg***	***Tablet***	***100***	***0***	***83***	***83 Tablets***
	9050	***B02120312***	***Codeine***	***N/A***	***Bulk***	***1.25 kg***	***N/A***	***N/A***	***1.25 kg***
1.									
2.									
3.									
4.									
5.									
6.									
7.									

2. Collected Substances

	Returned Mail-Back Package	Sealed Inner Liner	Unique Identification Number	Size of Sealed Inner Liner	Quantity of Packages(s)/Liner(s) Destroyed
Examples	***X***		***MBP1106, MBP1108 - MBP1110, MBP112***	***N/A***	***5***
		X	***CRL1007 - CRL1027***	***15 gallon***	***21***
		X	***CRL1201***	***5 gallon***	***1***
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Form DEA-41 *See instructions on reverse (page 2) of form.*

EXAMPLE 8-11 (continued)

DEA-41 Pg. 2

C. METHOD OF DESTRUCTION

Date of Destruction:	Method of Destruction:	
Location or Business Name:		
Address:		
City:	State:	Zip Code:

D. WITNESSES

I declare under penalty of perjury, pursuant to 18 U.S.C. 1001, that I personally witnessed the destruction of the above-described controlled substances to a non-retrievable state and that all of the above is true and correct.

Printed name of first authorized employee witness:	Signature of first witness:	Date:
Printed name of second authorized employee witness:	Signature of second witness:	Date:

E. INSTRUCTIONS

1. Section A. REGISTRANT INFORMATION: The registrant destroying the controlled substance(s) shall provide their DEA registration number and the name and address indicated on their valid DEA registration, in addition to a current telephone number and a contact name, if different from the name on the valid DEA registration.
2. Section B. (1) Inventory: This part shall be used by registrants destroying lawfully possessed controlled substances, other than those described in Section B(2). In each row, indicate the National Drug Code (NDC) for the controlled substance destroyed, or if the substance has no NDC, indicate the DEA Controlled Substances Code Number for the substance; if the substance destroyed is in bulk form, indicate the batch number, if available. In each row, indicate the name, strength, and form of the controlled substance destroyed, and the number of capsules, tablets, etc., that are in a full package (pkg. qty.). If destroying the full quantity of the controlled substance, indicate the number of packages destroyed (number of full pkgs.). If destroying a partial package, indicate the partial count of the capsules, tablets, etc. destroyed (partial pkg. count). If destroying a controlled substance in bulk form, indicate that the substance is in bulk form (form) and the weight of the substance destroyed (pkg. qty.). In each row, indicate the total number of each controlled substance destroyed (total destroyed).
3. Section B. (2) Collected Substances: This part shall be used by registrants destroying controlled substances obtained through an authorized collection activity in accordance with 21 U.S.C. 822(g). In each row, indicate whether registrant is destroying a mail-back package or an inner liner. If destroying a mail-back package, enter each unique identification number separated by a comma and/or as a list in a sequential range and total quantity of packages being destroyed. If destroying an inner liner, enter each unique identification number separated by a comma and/or as a list in a sequential range based on the size of the liners destroyed and the total quantity of inner liners being destroyed. In the case of mail-back packages or inner liners received from a law enforcement agency which do not have a unique identification number or clearly marked size, include the name of the law enforcement agency and, if known, the size of the inner liner or package. DO NOT OPEN ANY MAIL-BACK PACKAGE OR INNER LINER; AN INVENTORY OF THE CONTENTS OF THE PACKAGES OR LINERS IS PROHIBITED BY LAW AND IS NOT REQUIRED BY THIS FORM.
4. If additional space is needed for items destroyed in Section B, attach to this form additional page(s) containing the requested information for each controlled substance destroyed.
5. Section C. METHOD OF DESTRUCTION: Provide the date, location, and method of destruction. The method of destruction must render the controlled substance to a state of non-retrievable and meet all applicable destruction requirements.
6. Section D. WITNESSES: Two authorized employees must declare by signature, under penalty of perjury, that such employees personally witnessed the destruction of the controlled substances listed in Section B in the manner described in Section C.
7. You are not required to submit this form to DEA, unless requested to do so. This form must be kept as a record of destruction and be available by the registrant for at least two years in accordance with 21 U.S.C. 827.

Paperwork Reduction Act Statement: The information collected on this form is necessary for DEA registrants to record controlled substances destroyed in accordance with the Controlled Substances Act (CSA). The records that DEA registrants maintain in accordance with the CSA must be kept and be available, for at least two years, for inspection and copying by officers or employees of the United States authorized by the Attorney General. 21 U.S.C. 827. DEA estimates that it will take approximately 30 minutes to complete this form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The completion of this form by DEA registrants that destroy controlled substances is mandatory in accordance with 21 U.S.C. 827. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Comments regarding this information collection, including suggestions for reducing the burden estimate, should be directed to the Drug Enforcement Administration, DEA Federal Register Representative/ODL, 8701 Morrissette Drive, Springfield, Virginia 22152.

EXAMPLE 8-12

MEDICATION SAMPLE RECEIVING AND DISPENSING LOG

Medication/strength _____

Manufacturer _____ Lot # _____ Expiration date _____

INITIAL DATE/RECEIVED:		QUANTITY:			
DATE	**PATIENT NAME**	**ADDITIONAL HOSPITAL ID**	**PRESCRIBER**	**AMOUNT Rec(+) / Disp (-)**	**BALANCE**

EXAMPLE 8-13

MEDICATION PREPACKAGING LOG

Instructions: Complete all necessary information. Label must have medication name, strength, dosage form, manufacturer's name, pharmacy lot# and beyond-use date (BUD). Beyond-use date = 6 months from date packaged unless the manufacturer's expiration date is less than this or packaging material stability data indicates it is less than 6 months.

LABEL (INCLUDING BUD)	DATE PACKAGED	MANUFACTURER'S			AMOUNT PER UNIT	NUMBER UNITS PACKAGED	PACKAGED BY	CHECKED BY RPh
		NAME	LOT NO.	EXP. DATE				

EXAMPLE 8-14

MEDICATION AREA INSPECTION

Location _____ Month/Year _____

	YES	NO	N/A	REMARKS
MEDICATION PREPARATION AREA				
Medication prep area is clean, neat, and well organized.				
IV preparation area is clean, uncluttered and functionally separate.				
PATIENT AND STOCK MEDICATIONS				
Only authorized medications are present. (There is no excess stock, unauthorized storage areas or unidentified patient medications.)				
All medications are locked.				
Tops of automated dispensing cabinets and med carts are free of medications.				
Medications to be returned to pharmacy are in the authorized location.				
All medications are within their expiration or beyond-use date. (Check bulk supplies, refrigerator, etc.)				
Check of two patient records and medications (automated dispensing cabinets, med drawer, MAR, chart) matched.				
Check of two MARs show nursing reconciliation documentation.				
Check of automated dispensing cabinets for two items reveal correct count and within expiration date.				
Internal and external bulk stock is separated.				
Check of emergency medications cart log reveals the log is complete, lock is in place, and no expired medications, and no expired supplies are on top of cart.				
CONTROLLED SUBSTANCES				
Automated dispensing cabinets and manual systems are free of discrepancies.				
REFRIGERATOR				
Refrigerator temperature is between 2–8°C. (36–46°F) Note temperature:				
Freezer temperature is between –25°C to –10°C. (–13°F to 14°F) Note temperature: Note freezer drugs:				
Refrigerators/freezers containing vaccines are monitored constantly or check twice a day.				
Refrigerator is clean.				
Refrigerator and freezer are medical grade; freezer is free from frost.				
Refrigerator and freezer logs are complete for every day this month.				
Only drugs are stored in the refrigerator and freezer. (No food, lab reagents or specimens are allowed.)				
Floor-stock insulins are in the appropriate bin.				
MISCELLANEOUS				
Single-dose vials are destroyed after one entry.				
Multiple-dose vials are dated with the beyond use date of within 28 days (or shorter date if appropriate).				
Nursing can access formulary.				
Nursing can access electronic references and there is at least one printed reference (current within 3 years) available.				
Saline syringes are appropriately stored.				
The necessary changes have been made since the last inspection. Note:				

CORRECTIVE ACTIONS FOR ANY "NO" _____

_____ _____

Pharmacy signature/date Care unit signature/date

EXAMPLE 8-15

MEDICATION AREA INSPECTION—CLINICS

Location _____ Month/Year _____

	YES	NO	N/A	REMARKS
STOCK MEDICATIONS				
Only authorized medications are present. (There is no excess stock, unauthorized storage areas or unidentified patient medications.)				
All medications are locked.				
Medications in treatment rooms are locked.				
Medications to be returned to pharmacy are in the authorized location.				
All medications are within their expiration or beyond-use date. (Check bulk supplies, refrigerator, etc.)				
Internal and external bulk stock is separated.				
Check of emergency medications carts' log reveals the log is complete, lock is in place, and no expired medications, and no expired supplies are on top of cart.				
MEDICATION PREPARATION AREA				
Medication prep area is clean, neat, and well organized.				
IV preparation area is clean, uncluttered, and functionally separate.				
SAMPLE MEDICATIONS				
Sample cabinet/room is locked and accessible only to licensed individuals in the practice.				
Log is complete (check two items).				
Samples present reflect appropriate medications for type of practice.				
No controlled substances are present.				
All medications are within their expiration date.				
CONTROLLED SUBSTANCES				
Controlled substance records are complete. (Check count for two items.)				
Wastage is appropriately documented.				
REFRIGERATOR				
Refrigerator temperature is between 2–8°C. (36–46°F) Note temperature:				
Freezer temperature is between –25°C to –10°C. (–13°F and 14°F) Note temperature: Note freezer drugs:				
Refrigerators/freezers containing vaccines are monitored constantly or check twice a day.				
Refrigerator is clean.				
Refrigerator and freezer are medical grade; freezer is free from frost.				
High/low thermometer is properly reset.				
Refrigerator and freezer logs are complete for every day this month.				
Only drugs are stored in the refrigerator and freezer. (No food, lab reagents or specimens are allowed.)				
MISCELLANEOUS				
Single-dose vials are destroyed after one entry.				
Multiple-dose vials are dated with beyond use date within 28 days (or shorted date if appropriate).				
Saline syringes are appropriately stored.				
References are current.				
The necessary changes have been made since the last inspection. Note:				

CORRECTIVE ACTIONS FOR ANY "NO" _____

_____

_____

_____ _____

Pharmacy signature/date Clinic signature/date

EXAMPLE 8-16

INSPECTION ASSIGNMENT GRID

Year ____________

AREA	ASSIGNED TO	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

EXAMPLE 8-17

EMERGENCY MEDICATION CONTAINER INSPECTION RECORD

UNIT: _____ Month/Year: _____

Type of Container (check one): Adult _____ Pediatric _____ Neonatal _____ Hyperthermia _____ Other (describe) _____

Complete each day. Mark CLOSED if department is not open. File completed log in manager's office.

CART/BOX #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NEW # Circle date received																															
Seal #																															
Verify seal and #																															
Defib—plugged																															
Defib—battery																															
Broselow tape (most current)																															
CPR backboard																															
Defib pads in date																															
Box of medium gloves																															
Box of fluid shield masks																															
Oxygen—min 500 psi																															
Secure sharps box																															
Oral airway																															
Checked by (initials) Initials and signature log on reverse																															

EXAMPLE 8-18

PATIENT'S PERSONAL MEDICATIONS STORAGE RECORD

If the medications are not to be used during the patient's stay in the facility, they should be given to the patient's family. If these medications must be retained in the facility, they shall be inventoried, packaged, sealed, and labeled with the patient's name, and stored until returned to the patient at the time of discharge.

PATIENT NAME _____ **LOCATION** _____

PATIENT NUMBER _____ **DATE** _____

ADMITTING PHYSICIAN _____

RX NUMBER	MEDICATION	QUANTITY	NOTES

MEDICATIONS IDENTIFIED AND COUNTED BY _____

PATIENT SIGNATURE _____

EXAMPLE 8-19

RECEIPT AND DISPOSAL OF PATIENTS' PERSONAL MEDICATIONS RECORD

PATIENT _____ **PATIENT NUMBER/HOSPITAL ID** _____ **LOCATION** _____

ADDRESS _____

_____

ATTENDING PHYSICIAN _____ **DATE** _____

PRESCRIPTION NUMBER	MEDICATION NAME	QUANTITY	RECEIVED BY (SIGNATURE)	DATE OF DISPOSAL	DISPOSAL METHOD	RETURNED OR DESTROYED BY (SIGNATURE)	NOTES

Patient's personal medications shall be stored securely and the appropriate information recorded above. Medications shall be returned to the patient, patient's family, or other authorized person upon discharge unless otherwise directed by a physician. Medications that are not returned shall be retained for 30 days after discharge. Medications on hand 30 days after discharge shall be destroyed.

Disposal Method: 1 = Returned to Patient 2 = Returned to Family 3 = Returned to Other Authorized Person 4 = Not Returned 5 = Destroyed

I acknowledge receipt of the above medications (with exceptions noted) _____ Date Returned _____

Signature of Person to Whom Medications Were Returned

EXAMPLE 8-20

INTERVENTION LOG

MONITORING PERIOD _____ **PAGE** _____ **OF** _____

REASON CODES: 1. Medication 2. Dose/Strength 3. Route 4. Change Frequency/Rate 5. Allergy 6. Adverse Drug Reaction 7. Interaction 8. Diagnosis/Contraindication 9. Incomplete Order 10. Duplicate Order 11. Nonformulary Medication 12. Restricted Medication

RECOMMENDATION CODES: 1. Change Medication 2. Change Dose/Strength 3. Change Route 4. Change Frequency/Rate 5. Discontinue Medication

DATE	PATIENT NAME/NUMBER	PRESCRIBER	REASON FOR INTERVENTION	PHARMACIST RECOMMENDATION	ACCEPTED Y/N	OUTCOME/COMMENT

EXAMPLE 8-21

PHARMACY COMPETENCY CHECKLIST AND AFTER-HOURS MEDICATION RETRIEVAL

Name: _____ Title: _____

Method of Evaluation

☐ Actual Event ☐ Postevent Discussion ☐Demonstration

Actual Event:	Reviewer evaluates individual during actual patient care
Postevent Discussion:	Reviewer debriefs individual after an actual patient care event
Demonstration:	Individual demonstrates knowledge, skill, and judgement to reviewer

Criteria	**Competence Components** *(check all that apply)*			**Demonstrated Correctly**
	Knowledge	**Skill**	**Judgement**	*Reviewer's Initials*
Demonstrates ability to identify and locate the following items and areas: • Primary retrieval area • Tablets/capsules • Oral liquids • Injectables/parenterals • Topicals • Ophthalmics/otics • Refrigerated medications • Outdated medications • Code cart medications • Controlled substances				
Demonstrates ability to prepare IV products in an aseptic manner and use the following correctly: • Prepares only for immediate use • Incompatibility/stability charts and tables • Completed immediate preparation competency				
Knows pharmacy hours of operation: • Weekdays • Weekends • Holidays				

EXAMPLE 8-21 (continued)

Can locate necessary phone numbers if after-hours assistance is needed: • Pharmacist on-call • Remote order-entry service				
Understands and can state the importance of after-hours medication stock security: • Access to after-hours medication stock • Keys/security codes				
Understands regulations and policies relating to: • Required elements of medication order review • Relabeling medications • Physician dispensing (in emergency room) • Handling patients' personal medications • Medication error report form • ADR report form				
Completes all necessary documentation before removing medications from the after-hours medication stock: • After-hours medication retrieval log				
Understands and documents the required checks (i.e., verifies) medications per pharmacy policy: • Each medication removed is checked by another authorized individual for: • Correct medication • Correct dose • Correct dosage form • Patient allergies				
Understands and demonstrates how to use the formulary properly: • Hospital formulary • Nonformulary request • Therapeutic interchange lists				

Reviewer: _____ Date: _____

EXAMPLE 8-22

INDIVIDUALS AUTHORIZED TO REMOVE MEDICATIONS FROM AFTER-HOURS STOCK

When medications are not available after-hours, the following persons may remove them from the after-hours stock. The amount removed should be sufficient to meet immediate therapeutic needs and should not exceed the amount needed to last until a pharmacist is available.

The person who removes a medication must enter the following information in the after-hours log:

- Name of the patient (first and last name), hospital identification #, and room number
- Time of order
- Name of medication
- Medication strength
- Dosage form removed (tablet, capsule, suspension, ampoules, injections, etc.)
- Dose prescribed (1 three times a day, 2 at bedtime, 50 mg every four hours, etc.)
- Amount removed
- Name of prescribing physician
- Time and date of removal
- Signature and title of person making removal

NAME (print or type)	TITLE	SIGNATURE	DATE ORIENTATION COMPLETED

Example 8-23

AFTER-HOURS PHARMACY LOG

Record last name and at least the first initial. Do not use ditto marks. A pharmacist must verify the removal as soon as possible.

DATE	TIME	ROOM	PATIENT NAME (LAST NAME AND FIRST INITIAL)	DRUG NAME	STRENGTH	DOSAGE FORM	DOSE PRESCRIBED	AMOUNT REMOVED	PRESCRIBER	REMOVED BY (SIGNATURE AND WITNESS)	RPH INITIALS FOR VALID ORDER	INCOMPLETE ORDER
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												
REASON FOR REMOVAL: ☐ ☐ STAT Order ☐"NOW" Order ☐ Drug not stocked in ADC ☐ >2 hr. delay in order entry ☐Other												

EXAMPLE 8-24

RECALLED MEDICATION RECORD

MEDICATION _____ RECALL DATE _____

AREAS INSPECTED	DATE INSPECTED	NUMBER FOUND	BY	NOTES

EXAMPLE 8-25

MEDICATION ERROR REPORT

PATIENT NAME/IDENTIFICATION NUMBER _____ **LOCATION** _____
AGE OR DOB ____ **SEX** ____ **PHYSICIAN** _____
MEDICATIONS INVOLVED _____

DESCRIPTION OF ERROR _____

DATE AND TIME OF ERROR _____
DATE AND TIME PHYSICIAN NOTIFIED (and how notified)

PHYSICIAN'S INSTRUCTIONS _____

ACTION TAKEN _____

SEVERITY OF ERROR

NCC MERP CATEGORY	RESULT
No Error	
Category A	Circumstances or events that have the capacity to cause error.
Error, No Harm	
Category B	An error occurred but the medication did not reach the patient. (An "error of omission" does reach the patient.)
Category C	An error occurred that reached the patient but did not cause patient harm.
Category D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.
Error, Harm	
Category E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention.
Category F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
Category G	An error occurred that may have contributed to or resulted in permanent patient harm.
Category H	An error occurred that required intervention necessary to sustain life.
Error, Death	
Category I	An error occurred that may have contributed to or resulted in the patient's death.

TYPE OF ERROR

__ Prescribing error
__ Omission error
__ Wrong-time error
__ Unauthorized medication error
__ Improper dose error
__ Wrong dosage-form error
__ Wrong medication-preparation error
__ Wrong administration-technique error
__ Deteriorated medication error
__ Monitoring error
__ Compliance error
__ Other medication error

EXAMPLE 8-25 (continued)

CAUSE(S) OF ERROR

Failed communication	Poor handwriting Inaccurate transcription of orders Medications with similar names Inappropriate use of zeroes and decimal points Use of metric and apothecary systems Use of inappropriate abbreviations Ambiguous or incomplete orders Other _____
Poor medication distribution practices	Unlabeled and mislabeled medications Improper storage practices Unlimited access to medications and pharmacy Improper use of dispensing equipment Other _____
Dose miscalculations	Failure to stock standardized concentrations and commercially premixed products Other _____
Problems related to medication and medication devices	Labeling and packaging problems Device design issues Other _____
Incorrect administration of medication	Failure to check or improper patient identification Wrong route administration Other _____
Lack of patient education	Patients not involved Patients do not understand their medications Other _____
Other causes	

HOW ERROR COULD HAVE BEEN PREVENTED _____

_____

_____

_____

_____

PERSON(S) HAVING KNOWLEDGE OF THE ERROR _____

_____

_____

PERSON COMPLETING THIS FORM _____

ORIGINAL:

COPY:

THIS REPORT SHALL *NOT* BE PLACED IN THE PATIENT'S MEDICAL RECORD.

EXAMPLE 8-26

ADVERSE DRUG REACTION REPORT

REPORT (check one): _____ Concurrent _____ Retrospective
METHOD OF IDENTIFICATION (check all that apply): _____ Orders _____ ADR card _____ MUE _____ MAR
_____ Radiology _____ Quality Management _____ Other: _____

PATIENT NAME: _____ **MR #:** _____ **ROOM #** _____

AGE OR DOB_____ **SEX** _____ **WT (kg)** _____ **HT** _____ **ADMIT DATE:** _____ **DISCHARGE DATE:** _____

ATTENDING PHYSICIAN: _____ **MEDICAL SERVICE**: _____

REASON FOR ADMIT/DIAGNOSES: _____

SECONDARY DIAGNOSES: _____

MEDICAL HISTORY: _____

ALLERGIES (on admission): _____ **added during stay:** _____

DATE OF REACTION: _____ **TIME OF REACTION:** _____

ORDERING PHYSICIAN AWARE OF ADR? _____ **YES** _____ **NO (IF NO, DATE NOTIFIED)** _____

DESCRIPTION OF REACTION: _____

RELEVANT LABS: _____

TREATMENT (check all that apply): _____ No treatment _____ Discontinue suspect medication(s) _____ Adjust dose, route, frequency

_____ Treatment w/ medications (list): _____

_____ Switch to alternative agent (list): _____

_____ Other medical treatment (list): _____

OUTCOME: _____ Resolved without sequelae _____ Resolving _____ Ongoing
_____ Permanent disability/damage _____ Death _____ Unknown

INCREASED LENGTH OF STAY? _____ YES _____ NO

DRUG REGIMEN AT REACTION TIME (use generic names):

MEDICATION/DOSE/ROUTE/SCHEDULE	DATE STARTED	DATE STOPPED	TIME OF LAST DOSE	MANUFACTURER

EXAMPLE 8-26 (continued)

SUSPECTED DRUG(S): 1. _____ 2. _____
(use generic names) 3. _____ 4. _____

ASSESSMENT OF ADR:

1. **REACTION TYPE** (check one):

_____ A = Exaggerated pharmacological action (exaggerated, but otherwise normal pharmacological action of a drug given in the usual therapeutic doses)

_____ B = Unpredicted/unexpected reaction (not to be expected from the known pharmacological actions of a drug given in usual therapeutic doses)

2. **REACTION SEVERITY** (check one):

_____ 1 = Severe (life threatening, death, permanent injury)

_____ 2 = Moderate (medical treatment, prolongs hospitalization)

_____ 3 = Minor (no medical treatment)

3. **AVOIDABLE/PREVENTABLE:**

_____ YES _____ NO Suspected drug(s) were inappropriate for patient's condition?
_____ YES _____ NO Dose, route, frequency were inappropriate for age, weight, lab tests, and disease state?
_____ YES _____ NO Necessary monitoring/lab tests were not performed?
_____ YES _____ NO Patient had a history of allergy to the drug(s)?
_____ YES _____ NO Drug interaction was involved in the reaction?
_____ YES _____ NO Toxic serum drug level was documented?
_____ YES _____ NO Patient was not compliant with drug therapy?

3. **PROBABILITY**

Consider using a published algorithm such as Naranjo CA et al. *Clin Pharmacol Ther.* 1981 ;30:239-45.

Check one: ____ Definite ____ Probable ____ Possible ____ Doubtful

REPORT BY: _____ TITLE _____ DATE _____

FOR ADMINISTRATIVE USE ONLY: REVIEWED BY: _____

DATE: _____ REPORT TO: _____P&T Committee _____FDA

EXAMPLE 8-27

NOTICE OF DRUG REACTION FORM

Date _____

Dear _____:

You had a reaction to _____ when you were a patient in this facility. The signs and symptoms of your reaction included the following:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Other medications are similar to the medication that caused your reaction. You may have a reaction to these medications as well. Your physician or pharmacist can advise you of the appropriate precautions to take.

You should show this letter to physicians or dentists who treat you, pharmacists who fill your prescriptions, and to persons who admit you to this or other medical facilities so they can note the reaction in your medical record.

Sincerely,

_____

EXAMPLE 8-28

ADVERSE DRUG REACTION SUMMARY

YEAR _____ **PAGE** _____ **OF** _____

DRUG	DATE	REACTION	PROBABILITY	SEVERITY	PREVENTABILITY	ACTION	RECORDED	FDA REPORT

Probability: (**Def**)inite, (**Pro**)bable, (**Pos**)sible, (**Dou**)btful
Severity: **0 1 2 3 4 5**
Preventability (**Y**)es or (**N**)o
Action Taken: Describe action(s) taken
Recorded: Reaction recorded on patient's medical record (**Y**)es or (**N**)o
FDA Report: Report sent to FDA (**Y**)es or (**N**)o, and date sent

EXAMPLE 8-29

ADVERSE DRUG REACTION RATES

YEAR _____ **PAGE** _____ **OF** _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Total admissions													
Total suspected reactions reported													
Rate per 100 admissions													
Total reactions confirmed													
Rate per 100 admissions													
Total serious reactions													
Rate per 100 admissions													

MONTHLY ADVERSE DRUG REACTION SUMMARY

Enter type of reaction and number of reactions for each drug per month.

DRUG	REACTION	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL

EXAMPLE 10-1

LAMINAR AIRFLOW WORKBENCH CLEANING RECORD

Daily and Monthly Cleaning Log for _____ (Month) _____ (Year)

Routine cleaning throughout compounding day will follow department policy. Daily or less frequent cleaning will be documented below.
See SOP for details. Initial date and indicate initials and signature on back of this form.

FREQUENCY AND AREA	BY	SOLUTIONS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Daily—beginning of shift Clean/disinfect PECs	Compounding personnel	Detergent → sIPA																
Daily—end of shift Clean/disinfect LAFW/CAI	Compounding personnel	Detergent → sIPA																
Daily—end of shift Decontaminate/clean/disinfect BSC/CACI	Compounding personnel	Oxidizer → detergent → sIPA																
Daily—Sunday through Friday Clean/disinfect easily cleanable surfaces (carts/counters/pass-through)	Compounding personnel	Detergent and rinse																
Daily—Sunday through Friday Mop floors	Compounding personnel or environmental services	Detergent and rinse																
Daily on Saturday Mop floors	Compounding personnel or environmental services	Oxidizer → detergent and rinse																
Weekly Decontaminate/clean/disinfect BSC/CACI/CVE work tray	Compounding personnel	Oxidizer → detergent → sIPA																
Monthly Clean shelves	Compounding personnel	Detergent and rinse																
Monthly Mop walls	Compounding personnel or environmental services	Detergent and rinse																
Monthly Mop ceiling	Compounding personnel or environmental services	Detergent and rinse																

Example 10-1 (continued)

FREQUENCY AND AREA	BY	SOLUTIONS	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Daily—beginning of shift Clean/disinfect PECs	Compounding personnel	Detergent → sIPA															
Daily—end of shift Clean/disinfect LAFW/CAI	Compounding personnel	Detergent → sIPA															
Daily—end of shift Decontaminate/clean/disinfect BSC/CACI	Compounding personnel	Oxidizer → detergent → sIPA															
Daily, Sunday through Friday Clean/disinfect easily cleanable surfaces (carts/counters/pass-through)	Compounding personnel	Detergent and rinse															
Daily, Sunday through Friday Mop floors	Compounding personnel or environmental services	Detergent and rinse															
Daily on Saturday Mop floors	Compounding personnel or environmental services	Oxidizer → detergent and rinse															
Weekly Decontaminate/clean/disinfect BSC/ CACI/ CVE work tray	Compounding personnel	Oxidizer → detergent → sIPA															
Monthly Clean shelves	Compounding personnel	Detergent and rinse															
Monthly Mop walls	Compounding personnel or environmental services	Detergent and rinse															
Monthly Mop ceiling	Compounding personnel or environmental services	Detergent and rinse															

EXAMPLE 12-1

ORIENTATION RECORD

(Attach supporting documentation as needed)

Employee _____

The Organization

Review of Organization

Administration	_____	Nursing	_____
Department heads	_____	Pharmacy	_____
Medical staff	_____	Ancillary staff	_____

Organizational Policies and Procedures

Patient rights and ethics	_____
Confidentiality of patient information	_____
Cultural diversity and sensitivity	_____
Emergency management	_____
Fire safety	_____
Security	_____
Patient safety program	_____
Infection prevention	_____
Employee health policy	_____
Other applicable policies and procedures (as assigned)	_____

Tour of Facility (to include at least the areas listed below)

Eating areas/lounges	_____	Restrooms	_____
Nonsmoking areas	_____	Smoking areas	_____
Emergency dept.	_____	Other areas	_____

Organization Orientation Program Completed _____

The Pharmacy

Pharmacy Hours

Breaks (meals, rest)	_____	Weekday	_____
Holiday	_____	Weekend	_____

After-Hours Pharmacy Services _____

Personnel Information

Absenteeism	_____	Performance evaluation	_____
Benefits	_____	Personal phone calls	_____
Dress code	_____	Sick leave	_____
Holidays	_____	Smoking	_____
Insurance	_____	Tardiness	_____
Lockers	_____	Timecards	_____

EXAMPLE 12-1 (continued)

Overtime	_____	Vacation	_____
Pay rate	_____	Work schedule	_____
Review of Job Description	_____		
Employee Is Enrolled in Benefit Program	_____		
Payroll Documents Are Complete	_____		
Introduction to the Pharmacy Staff	_____		
Director of pharmacy	_____	Pharmacists	_____
Part-time staff	_____	Support staff	_____
Tour of Pharmacy Areas			
Automated distribution systems	_____	Repackaging/compounding	_____
Emergency drugs	_____	Refrigerators	_____
Investigational drugs	_____	Sterile compounding	_____
Main pharmacy	_____	Storage	_____
Office area	_____	Purchasing/receiving	_____
Outdated drugs	_____	Other areas	_____
Basic Security Requirements			
Confidential materials	_____	Pharmacy areas	_____
Controlled substances	_____	Other drugs	_____
Automated distribution equipment	_____	Computers	_____
Continuing Education			
Attendance at meetings and/or in-service programs			_____
Medical staff/nursing education provided by pharmacy			_____
Records/documentation of attendance			_____
Responsibility of professional staff to conduct programs			_____
Subsequent training			_____
Pharmacy Policy and Procedure Manual			
(Read the following policies or sections now—others later.)			
Emergency management			_____
Hazardous materials (handling)			_____
Incident reporting			_____
Infection prevention			_____
Responsibilities and duties in a medical emergency (“code”)			_____
Safety			_____
Security			_____
Other policies and procedures (as assigned)			_____

EXAMPLE 12-1 (continued)

Medication Safety……

Basic medication safety _____

Adverse drug reaction reports _____

Medication error reports _____

Orientation to Job Duties and Responsibilities (as applicable)

Purchasing/receiving	_____	Inventory control	_____
Automated distribution equipment	_____	Order review and entry	_____
Repackaging	_____	Emergency drugs	_____
Dispensing	_____	Formulary	_____
Sterile compounding	_____	Nonsterile compounding	_____
Medication therapy management	_____	Nutrition support	_____
Antimicrobial stewardship	_____	Pharmacokinetic dosing	_____
Drug information	_____	Education programs	_____
Other (as assigned)	_____		

Employee Acknowledgment

I have completed the above orientation and am aware of my responsibilities and duties. I understand that pharmacy and facility policies are established to promote quality patient care and to ensure the health and safety of patients and staff.

I further understand that there are potential occupational health and safety risks associated with my duties. I have read and fully understand the pharmacy policies and procedures relating to infection control, safety, emergency preparedness, and handling of hazardous materials and agree to comply with these policies and procedures as well as all other applicable policies and procedures of the facility.

Completed _____ **Date** _____

Employee Signature

Certified by _____ **Date** _____

Supervisor

EXAMPLE 12-2

EDUCATION PROGRAM/MEETING RECORD

FACILITY _____ **DATE(S)** _____

LENGTH (HOURS/MINUTES) _____ **TIME(S)** _____

FOR: Medical Staff _____ Nursing _____ Pharmacy _____ Other _____

SUMMARY OF PROGRAM AND/OR MEETING TOPIC _____

_____

_____

_____

_____

Attach Handouts and Meeting Materials

SPEAKER, CHAIRPERSON, AND/OR INSTRUCTORS _____

_____

_____

_____

CONTINUING EDUCATION CREDIT _____

ATTENDEES

NAME AND TITLE OR DEPARTMENT	NAME AND TITLE OR DEPARTMENT

Use reverse side and/or attach additional information, if necessary.

For the Pharmacy _____ Date _____

EXAMPLE 12-3

PHARMACY EDUCATION AND TRAINING PROGRAM RECORD

NAME OF PROGRAM: _____

OBJECTIVE(S): _____

_____

RELATIONSHIP TO JOB PERFORMANCE: _____

DATE(S) OF PROGRAM: _____ **LENGTH OF PROGRAM:** _____

NAME OF PRESENTER: _____ **COMPANY SPONSOR:** _____

METHOD OF PRESENTATION: _____

GROUP(S) ATTENDING: ___ **PHARMACISTS** ___ **TECHNICIANS** ___ **SUPPORT STAFF**

THOSE IN ATTENDANCE:

NAME	JOB TITLE

EXAMPLE 12-4

CONTINUING EDUCATION RECORD

SOURCE CODES:

In-service (pharmacy)..... 1
In-service (medical staff) 2
In-service (other department)..... 3
Home Study 4
Journal Articles 5
Seminars, Conferences, etc. (outside facility)..... 6

NAME _____ **POSITION** _____

DATE	SUBJECT/TITLE	SOURCE CODE	NUMBER OF CREDITS*

*Contact hours or CEUs if applicable.

EXAMPLE 12-5

SKILLS TEST FOR PEDIATRIC AND ADOLESCENT PATIENTS

Name: _____ **Date:** _____

Use the following case report to answer questions 1 through 5.

D. M. is a 4-year-old, 37-pound male brought to the outpatient pediatric clinic this morning. His mother indicates that he developed a cold with nasal congestion, fever, and cough 3 days ago. In the last 24 hours, D. M. has become increasingly irritable with episodes of crying and pulling on his right ear and was unable to sleep last night. His mother has been administering acetaminophen for his fever.

On examination of D. M.'s right ear, he begins crying loudly and resists examination. The tympanic membrane is bulging and opaque with some inflammation. Nasal congestion and rhinorrhea are also present. D. M.'s temperature is 101°F. There are also crusted erythematous lesions on his face and neck. His mother says the areas have been present about a week and that D. M. constantly scratches them. D. M. has no known allergies.

D. M.'s physician diagnoses acute otitis media and atopic dermatitis and prescribes the following medications:

- Augmentin ES-600 90 mg amoxicillin component/kg/day PO given in divided doses every 12 hours for 10 days
- Antipyrine/benzocaine otic drops two to four drops in right ear every 2 hours PRN ear pain
- Hydrocortisone 0.5% cream twice daily to rash on face and neck

__ 1. How many milligrams of amoxicillin clavulanate (amoxicillin component) are needed for one dose?
   a. 757 mg
   b. 1,514 mg
   c. 1,665 mg
   d. 3,300 mg

__ 2. Augmentin ES-600 is available in a 600 mg (amoxicillin component) per 5 mL suspension. How many milliliters are needed for one dose?
   a. 1.3 mL
   b. 6.3 mL
   c. 12.6 mL
   d. 25 mL

__ 3. Which of the following medications is appropriate for treating fever in this patient?
   a. Ibuprofen
   b. Aspirin
   c. Acetaminophen
   d. a and c

__ 4. D. M.'s physician orders acetaminophen 250 mg PO every 4 to 6 hours as needed for fever or pain. Which of the following dosage forms of acetaminophen would be appropriate for this patient's age group?
   a. Chewable tablets
   b. Oral liquid
   c. Capsules
   d. a and b

__ 5. The physician gives instructions to D. M.'s mother to apply the hydrocortisone cream sparingly and as directed to the areas of dermatitis. Why is this precaution necessary?
   a. Hydrocortisone is an expensive medication.
   b. The physician does not think the medication is effective for dermatitis.
   c. Systemic absorption of medications through the skin is increased in young children compared to adults and may result in adverse effects.

Use the following case report to answer questions 6 through 8.

A 6-year-old female (height: 45 inches, weight: 45 pounds) has been admitted with suspected meningitis. The physician would like to order empiric coverage with ceftriaxone and vancomycin.

EXAMPLE 12-5 (continued)

__ 6. Which of the following methods of drug dosing in pediatric patients is the *least* dependable?
   a. Dosage calculations based on Young's rule
   b. Dosages based on pharmacokinetic data
   c. Dosages based on BSA
   d. Dosing information found in pediatric dosage publications

__ 7. After checking appropriate references, the physician orders ceftriaxone 100 mg/kg IV once daily and vancomycin 60 mg/kg/day in four divided doses. Which of the following are the correct dosages of these medications for this patient? (Round to the closest 100 mg.)
   a. Ceftriaxone 2,000 mg IV once daily and vancomycin 300 mg IV every 6 hours
   b. Ceftriaxone 2,000 mg IV once daily and vancomycin 150 mg IV every 6 hours
   c. Ceftriaxone 2,000 mg IV twice daily and vancomycin 300 mg IV every 4 hours
   d. Ceftriaxone 1,000 mg IV once daily and vancomycin 300 mg IV every 6 hours

__ 8. Which of the following IV delivery systems is appropriate for this patient's age group?
   a. IV push
   b. IV syringe pumps
   c. IV infusion pumps
   d. All of the above

__ 9. Which of the following are important factors to consider when preparing and administering medications to pediatric patients?
   a. Selection of correct syringe size
   b. Fluid volume
   c. Accuracy of dilutions
   d. All of the above

__ 10. Which of the following precautions can minimize the potential for medication-related problems in pediatric patients?
   a. Including the dose per weight on medication orders
   b. Dispensing oral liquid medications in unit-dose oral syringes
   c. Ordering oral liquid medications by volume
   d. a and b

Use the following case report to answer questions 11 and 12.

A 10-year-old, 75-pound female has been admitted to the intensive care unit following a motor vehicle accident. Her physician has ordered a dopamine drip to be administered at a rate of 10 mcg/kg/min.

__ 11. At what rate (mL/hr) should a dopamine solution (200 mg in 250 mL) be infused?
   a. 0.9 mL/hr
   b. 25 mL/hr
   c. 56 mL/hr
   d. 81 mL/hr

__ 12. Use the Holliday-Segar method to determine total daily fluid intake from all sources for this patient.
   a. 890 mL/day
   b. 1,780 mL/day
   c. 2,600 mL/day
   d. 3,560 mL/day

EXAMPLE 12-5 (continued)

Use the following case report to answer questions 13 through 15.

A 6-year-old, male (height: 46 inches, weight 53 pounds) has been diagnosed with acute lymphocytic leukemia (ALL). He is currently entering the third week of remission induction therapy. The oncologist orders the following antineoplastic agents:

- Vincristine 1.5 mg/m^2 IV one dose today
- Daunorubicin 25 mg/m^2 IV one dose today

__ 13. Calculate the patient's body surface area (BSA).
   a. 0.82 m^2
   b. 0.88 m^2
   c. 0.93 m^2
   d. 1.2 m^2

__ 14. How many milligrams of vincristine are needed for today's dose (round to first decimal place)?
   a. 1.2 mg
   b. 1.3 mg
   c. 1.4 mg
   d. 1.8 mg

__ 15. How many milligrams of daunorubicin are needed for today's dose (round to whole number)?
   a. 21 mg
   b. 22 mg
   c. 23 mg
   d. 30 mg

__ 16. Which of the following medication-related problems may occur in pediatric and adolescent patients?
   a. Drug interactions (i.e., drug–drug, drug–food, drug–lab)
   b. Therapeutic duplication
   c. Inappropriate drug selection
   d. a, b, and c

__ 17. Which of the following factors places pediatric patients at increased risk of ADRs?
   a. Different and changing pharmacokinetic parameters between patients at various ages and stages of maturational development
   b. Nonadherence to medication therapies
   c. Need for minimal calculations
   d. a and b

Competence certified by: _____ Date: _____

EXAMPLE 12-6

SKILLS DEMONSTRATION CHECKLIST FOR PEDIATRIC AND ADOLESCENT PATIENTS

Name: _____ **Date:** _____

KNOWLEDGE AND SKILLS	YES	NO
Differentiates between drug absorption, distribution, metabolism, and elimination for pediatric and adolescent patients versus adult patients and how these processes mature		
Explains how disease processes impact medication therapy		
Lists medications that are potentially lethal in pediatric and adolescent patients if prepared or administered inappropriately		
Describes precautions to prevent errors		
Does not store adult-only concentrations and multiple-dose vials containing lethal amounts of medications in pediatric and adolescent patient care areas		
Explains why younger children have an increased potential for ADRs		
Identifies potential sources of ADRs and implements precautions to reduce the incidence and severity of ADRs		
Accurately prepares extemporaneous formulations and dilutions of commercially available products by using appropriate procedures		
Calculates drug dosages using information in the product information and pediatric dosage publications (when available)		
Uses BSA rather than dosing rules when calculating doses for pediatric patients		
Uses appropriate medication formulations, dosage forms, and routes and methods of administration for pediatric and adolescent patients		
Explains how medications may be retained in administration devices, the implications for the patient and makes recommendations to prevent retention		
Explains the potential for fluid overload from IV administration and makes recommendations to prevent fluid overload		
Demonstrates knowledge of the following IV delivery systems: IV push, IV piggyback, IV infusion, and syringe pumps		
Takes necessary steps to prevent drug–drug, drug–food, drug–laboratory test, and drug–disease interactions and monitors for evidence of ADRs, overdosage, and other drug-related problems in pediatric and adolescent patients		
Monitors medication therapy and makes recommendations to manage medication-related problems, ensuring positive therapeutic outcomes for pediatric and adolescent patients		
NOTES		

Competence certified by: _____ **Date:** _____

EXAMPLE 12-7

SAMPLE JOB DESCRIPTION AND COMPETENCE ASSESSMENT FOR STAFF PHARMACISTS

Type of Evaluation: ____New Employee Evaluation ____Annual Evaluation ____ Self-Assessment

Employee Name: _____ **Date:** _____

Job Title/Position: Staff Pharmacist

Job Summary: Staff pharmacists fill orders for medications, monitor patient medication therapies, provide drug information, and supervise and direct support personnel. In the absence of the pharmacy manager, a staff pharmacist may be required to assume the essential responsibilities and perform the duties of the pharmacy manager.

Reports to: Director of Pharmacy

Supervises: All pharmacy support personnel

Education: Graduate of an ACPE-accredited School of Pharmacy with a BS Pharmacy degree

Licenses: Currently licensed to practice pharmacy in the state of _____

Experience: Health-system experience preferred, but not required

Work Schedule: Minimum of 40 hours per week, but hours may be long and irregular, including evenings, weekends, and holidays as necessary

Physical Requirements: Repetitive use of hands and fingers (e.g., preparing IV admixtures, use of a computer keyboard); may require lifting and carrying light loads (up to 40 lb), including boxes, equipment, unit-dose cassettes, and IV solutions and stooping or kneeling (e.g., to pick up items from the floor, to remove and replace items on lower shelves, and to file documents in lower file drawers); sitting, walking, or standing for long periods of time (4–8 hours) is often necessary; must be able to physically operate the equipment used for the job

Critical Demands: Ability to work independently with minimal direct supervision; work cooperatively with health-system and pharmacy staff; handle frequent interruptions and adapt to changes in workload and work schedule; set priorities, make critical decisions, and respond quickly to emergency requests; exercise sound professional judgment; communicate effectively (orally and in writing); and meet the pharmaceutical care needs of the patient populations served by the organization

Occupational Hazards: Potential for exposure to infectious patients or materials and hazardous and toxic substances (including chemotherapy, cytotoxic drugs, and cleaning solutions); potential for sticks or cuts by needles and other sharp items; potential for musculoskeletal injuries if proper lifting and carrying techniques are not used

I. Principal Duties/Responsibilities **Scoring Guide: 2 = Meets Standards 0 = Does Not Meet Standards**

Performance Criteria/Standards	Rating	Comments
A. Prepares and dispenses medication orders per physician request according to established policies, procedures, and protocols		
Interprets medication orders (verbal and written) and transcribes to computerized patient medication profiles accurately; maintains accurate, complete patient medication profiles		
Prepares and dispenses medications, including sterile, chemotherapy, and parenteral nutrition preparations safely and accurately using appropriate techniques		
Issues controlled substances to patient care areas and maintains records as required by law		

EXAMPLE 12-7 (continued)

Performance Criteria/Standards	Rating	Comments
B. Ensures safe, appropriate, cost-effective medication therapies for patients according to established policies, procedures, and protocols		
Monitors medication therapy regimens for contraindications, drug–drug interactions, drug–food interactions, drug–laboratory test interactions, allergies, appropriateness of drug and dose, and therapeutic duplications		
Assists with pharmacokinetics consult service and drug dosing per organizational protocol		
Reviews/interprets culture and susceptibility data for antibiotic appropriateness and recommends changes as needed		
Reads, extracts, and interprets information in patient charts accurately		
Detects and reports suspected adverse drug reactions and medication errors accurately and in a timely manner		
Sustains the formulary by minimizing nonformulary procurements, utilizing therapeutic substitution protocols, and promoting rational medication therapy selection		
Provides clinical consultation and clarification to practitioners; recommends evidence-based medication therapy regimens and monitoring plans; and suggests appropriate, cost-effective therapeutic alternatives to medical staff as needed		
Provides accurate, adequate, and timely drug information to the professional staff		
Provides drug information to patients and their families		
Documents all clinical activities and interventions accurately and completely		
Participates in the quality improvement and medication-use review activities of the department; collects data; conducts quality monitors and inspections; and maintains logs, records, and other documentation as assigned		
Participates in the development and presentation of orientation, education, and training programs to the pharmacy, medical, nursing, and other staffs		
C. Contributes to the quality and effective operation of the department		
Supervises and directs pharmacy support personnel; verifies the daily activities of pharmacy technicians; and participates in the performance appraisal of pharmacy support personnel		
Works independently with minimal supervision; organizes and prioritizes work assignments; and ensures pharmacy services are provided in a timely manner		
Completes and documents inspections of all assigned medication storage areas at least monthly; identifies and replaces outdated and unusable medications		
Answers the telephone, identifying self and department; directs calls to appropriate personnel; and answers requests at the window		
Keeps pharmacy areas and equipment clean, neat, and well-organized		
Performs essential duties of the pharmacy director in his or her absence		
D. Maintains competence required for current job title/position		
Maintains current pharmacist licensure		
Attends pharmacy staff meetings		
Attends orientation, education, and training programs; reviews literature and other materials pertinent to the practice of pharmacy		

EXAMPLE 12-7 (continued)

Performance Criteria/Standards	Rating	Comments
Completes all competence/skills assessment requirements (see attached competence assessment/skills list)		
E. Performs other duties as assigned by supervisor		
TOTAL POINTS (maximum available points = 52)		

II. Departmental Standards **Scoring Guide: 2 = Meets Standards 0 = Does Not Meet Standards**

Performance Criteria/Standards	Rating	Comments
Is punctual and dependable; reports to work as scheduled; fulfills on-call obligations per prearranged schedule; absenteeism and tardiness are within policy guidelines		
Maintains a neat, professional, well-groomed appearance; observes pharmacy dress code; and wears identification badge at all times		
Performs work within specified time frames; adapts positively to frequent interruptions and changes in workload and/or work schedule		
Provides courteous, cooperative, and timely service to patients, visitors, and staff members; demonstrates good oral and written communication		
Works cooperatively with all staff members; voices concerns and suggestions to appropriate persons in a positive manner		
Demonstrates sound professional judgment consistent with clinical/academic background		
Maintains strict confidentiality of patient, visitor, and employee information; complies with the HIPAA Privacy Rule standards		
Fosters a team environment by providing orientation and training to new team members; assists coworkers in tasks, as time permits		
Adheres to health-system and departmental policies and procedures; complies with all requirements related to risk management, safety, medication-use safety, security, fire safety, and infection control; and complies with all applicable federal/state/local laws, rules, and regulations		
TOTAL POINTS (maximum available points = 18)		

III. Organizational Standards **Scoring Guide: 2 = Meets Standards 0 = Does Not Meet Standards**

Performance Criteria/Standards	Rating	Comments
Performance demonstrates efforts to improve patient satisfaction, lower costs, improve quality, and promote safety		
Understands and meets customers' needs and expectations; the patient and family members always come first		
Demonstrates the ability to address problems in a group setting using tools and techniques for identification and resolution of problems		
Demonstrates the values and behaviors of the organization		
TOTAL POINTS (maximum available points = 8)		

EXAMPLE 12-7 (continued)

IV. Goals and Accomplishments **Scoring Guide:** **4 = Goals Met *And* Special Accomplishments Achieved**

2 = Goals Met

0 = Did Not Achieve Set Goals

A. Describe status of goals set at previous evaluation.

B. Describe special accomplishments achieved since previous evaluation.

TOTAL POINTS (maximum available points = 4)

V. Scoring

Performance Criteria/Standards	Total Points Available	Employee Score
Principal duties/responsibilities	52	
Departmental standards	18	
Organizational standards	8	
Goals and accomplishments	4	
TOTAL SCORE	82	

SCORING GUIDELINES:

_____ points	Exceptional performance
_____ points	Exceeds standards
_____ points	Consistently meets standards
_____ points	Improvement required*
_____ points	Does not meet standards*
	*Requires action plan.

ACTION TAKEN:

1. None at this time _____
2. Extended probation _____ days
3. Corrective action _____

Type: _____

Action: _____

EXAMPLE 12-7 (continued)

PERFORMANCE GOALS AND OBJECTIVES:

Provide assessment of own needs for growth and development. Develop a plan to meet educational and professional growth within the next 12 months.

COMMENTS:

A. Supervisor's comments:

B. Employee's comments:

Employee's signature: Date:

Supervisor's signature: Date:

Pharmacy Department Competence Checklist for Staff Pharmacist

Employee Name: _____

Knowledge/Skills	Date	Method of Assessment	Name of Evaluator	Rating
Initial skills				
Confidentiality and patient rights				
Safety				
Medication-use safety				
Fire safety				
Security				
Hazardous materials				
Emergency management				
Infection prevention				
Compounded sterile preparations				
Compounded hazardous drug preparations				
Compounded nonsterile preparations				
Pharmaceutical care needs of neonatal and infant patients				

EXAMPLE 12-7 (continued)

Knowledge/Skills	Date	Method of Assessment	Name of Evaluator	Rating
Pharmaceutical care needs of pediatric and adolescent patients				
Pharmaceutical care needs of adult patients				
Pharmaceutical care needs of geriatric patients				
Pharmaceutical care needs of obstetric patients				
Pharmaceutical care needs of oncology patients				
Pharmaceutical care needs of psychiatric patients				
Pharmaceutical care needs of skilled nursing patients				
Adult enteral nutrition				
Adult parenteral nutrition				
Medication therapy management				
Renal dosing				
Hepatic dosing				
Intravenous to oral therapy conversion				
Anticoagulant therapy management				
Antibiotic therapy streamlining				
Emergency drug therapy				
Pain management				
Pharmacokinetics				
Patient counseling				
Adverse drug reaction reporting				
Medication area inspections				
Information management				
Repacking medications				
Controlled substances				

EXAMPLE 12-7 (continued)

Equipment	Date	Method of Assessment	Name of Evaluator	Rating
Automated compounding equipment				
Automated distribution equipment				
Barcode scanning equipment				
Medication repacking equipment				
Laminar airflow workbench				
Biological safety cabinet				
Pharmacy balance				
Pharmacy computer				
Computer printer				
Word processing software				
Spreadsheet software				
Database software				
Graphics/presentation software				

Method of Assessment		Method of Rating
O Direct observation	P Peer review	C Performs competently
V Verbal response	Q QA findings	A Performs with assistance*
S Skill demonstration	C Continuing education	N Does not perform competently*
T Testing		

*Requires action plan.

PHARMACIST LICENSURE VALIDATION:

License Number: _____ Expiration Date: _____

Date of Validation: _____

_____ _____

Employee's signature: Date:

_____ _____

Supervisor's signature: Date:

(Attach to employee's performance evaluation.)

EXAMPLE 12-7 (continued)

Action Plan to Correct Deficiencies Identified in Job-Specific Performance Evaluation

Employee Name: _____ **Title:** _____

Employee has not met the following performance standards/criteria/competencies:

1.

2.

3.

Retraining in the following areas will occur within the specified time frame:

1.

2.

3.

Reevaluation of deficiencies will occur.

Additional comments:

Employee's signature _____ **Date** _____

Supervisor's signature _____ **Date** _____

(Retain with performance evaluation in employee's departmental personnel file.)

EXAMPLE 15-1

EXAMPLE OF PHARMACY AND THERAPEUTICS COMMITTEE MINUTES

Date of Meeting

TOPIC	FINDINGS/DISCUSSION	RECOMMENDATIONS/ACTION
Call to order	The meeting was called to order at *TIME* by *PHYSICIAN*, Chairman. A quorum was present.	
Attendance	The attendance list was signed by those attending and is attached to these minutes.	
Minutes of last meeting	The minutes of the MONTH meeting were approved as distributed.	
Medical executive committee action	The medical executive committee approved the following action items from the last P&T meeting: • *LIST*	
Formulary		
Additions	The committee approves the indications for use of the medications.	
Deletions		
Changes		
Emerging safety data	The FDA released a black box warning for the following formulary agents: *LIST*. The committee voted to:	
Annual review	The 201X formulary was approved.	
Nonformulary		
Policies and procedures		
Floor stock		
Emergency medications		
Investigational drugs		
Annual review	The committee approved the current policies and procedures regarding medication management, including high-alert, look-alike/sound-alike, and hazardous drugs.	
Medication safety		
Medication errors	The *QUARTER* medication error summary was presented to the committee.	

EXAMPLE 15-1 (continued)

ADRs	*NUMBER* ADRs were reported in *QUARTER*. A preventability assessment was performed on each. The pharmacy was directed to send *SPECIFICS* to the FDA.	
Joint Commission Sentinel Event Alert		
ISMP Medication Safety Alert!		
Marketplace		
Recalls		
Shortages		
Medication use		
MUEs		
Protocols		
Review and approval of preprinted and electronic standing orders, order sets, and protocols		
Antibiogram		
Pharmacist interventions		
Other performance improvement activities		
Evaluation of drug cost information		
Items requiring further approval	The following items approved during this meeting will be forwarded to the medical executive committee for final action: • *LIST*	
Next meeting	The next meeting will be held on *DATE* at *TIME* in *LOCATION*.	
Adjournment	The meeting was adjourned at *TIME*.	

_____ _____

Physician Chairman Pharmacist Secretary