Select CE

For pharmacy professionals whose continuing professional development plan includes a pharmacy law and/or medication safety component, we offer our annual CE booklet.

Index:

2 23 Recommendations to Optimize Patient Safety and Reduce Medication Errors

ACPE Program Number: 0487-0000-15-004-H05-P knowledge-based activity
0487-0000-15-004-H05-T knowledge-based activity

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Release Date: December 31, 2015
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19 Answer Sheet

Select CE® is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Program Title: **23 Recommendations to Optimize Patient Safety and Reduce Medication Errors**

Target Audience: Pharmacists, Pharmacy Technicians

Release Date: December 31, 2015

Expiration Date: December 31, 2018

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or

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Whether completing this activity hard-copy or online, we need your NABP eProfile ID number and month/day of birth so that we can report your completions to CPE Monitor.

Faculty: Patricia A. Nussle, R.Ph., J.D., is the faculty for this CPE activity. She has developed continuing education programs in pharmacy law and nursing law since 2001. This CE activity was peer-reviewed by Jill Griffith, RPh, PharmD.

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Objectives: At the conclusion of this program, pharmacists should be able to:
1) recognize best practice recommendations to optimize patient safety and reduce medication errors;
2) restate actiions that can be implemented to reduce medication errors.

Objectives: At the conclusion of this program, pharmacy technicians should be able to:
1) recognize best practice recommendations to optimize patient safety and reduce medication errors;
2) restate actions that can be implemented to reduce medication errors.

Questions? Just call us, text us, or email us: (614) 481-8711 or info@selectce.org.

23 Recommendations to Optimize Patient Safety and Reduce Medication Errors

Beginning in 2000, in response to a number of medication errors and medication distribution issues, state boards of pharmacy across the country began to convene committees and work groups to research and report back to the boards about ways to reduce medication errors. Participants in the advisory committees included pharmacy board members, representatives from institutional and retail pharmacy settings, professional associations, colleges of pharmacy, the coalitions to prevent medical errors, state departments of public health and related regulatory agencies. Some boards utilized work done by the National Association of Boards of Pharmacy's 2007-08 Task Force on Continuous Quality Improvement, Peer Review, and Inspecting for Patient Safety and The Institute for Safe Medication Practices.

The final result from at least two (2) of these state advisory committees were very similar 23-point documents setting forth concrete ways pharmacies can *Optimize Patient Safety and Reduce Medication Errors by Implementing Best Practice Recommendations* (hereafter the "Recommendations").[1,2] These Recommendations were designed to be implemented according to the particular needs, available resources, and community served by the pharmacy. The recommendations developed by the advisory committees were based on a review of current literature and recent research on the incidence and causes of medication errors. The advisory committees provided comment and direction regarding the recommendations and forwarded the proposed recommendations to the respective state pharmacy boards for adoption in 2008.

What follows in this CE lesson are 26 Recommendations (the original list of 23 has since been updated to 26 by the State Board of Pharmacy Registration in Massachusetts, and we like their additions) to be considered as standards of professional practice as appropriate by pharmacies to optimize patient safety and reduce medication errors.

The Recommendations cover most pharmacy settings and include a variety of measures that can be implemented immediately and other processes that involve technological and training topics that can be instituted over a longer period of time to improve medication delivery systems. This list is not exclusive of other improvements that may be necessary to a particular pharmacy setting.

We at Select CE strive to offer our learners meaningful information that is directly relevant to their pharmacy practice. In the topic of patient and medication safety, there is a growing body of general patient safety strategies. In this lesson we seek to provide the practicing pharmacist and pharmacy technician with directly relevant patient safety and medication error Recommendations adopted by at least 2 state boards of pharmacy.

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[1] http://www.oregon.gov/pharmacy/pages/patient_safety.aspx

[2] http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/pharmacy-best-practice.pdf

23 Recommendations to Optimize Patient Safety and Reduce Medication Errors

1. Develop policies and procedures providing that incident reports will be completed and submitted to a national database, such as the ISMP Medication Errors Reporting Program (MERP), for each quality-related event (QRE) occurrence. A QRE is defined as any departure from the appropriate dispensing of a prescribed medication that is not corrected prior to the delivery of the medication.

The term “quality-related event” includes variations from the specifications of a prescription, such as wrong drug, wrong strength, wrong directions, and wrong dosage form. The term also includes packaging or warnings that fail to meet recognized standards, the delivery of a medication to the wrong patient, and the failure to detect and appropriately manage a significant actual or potential problem with a patient’s drug therapy.

Recommended Actions:
→ Create a system for reporting medication errors to a national database to promote analysis of the occurrence of the QRE and prevent similar events from recurring.
→ Promote a non-punitive atmosphere for the reporting of medication errors.
→ Voluntarily report QREs to the ISMP Medication Error Reporting Program.

Question 1:

A quality-related event (QRE):

a. is any departure from the appropriate dispensing of a prescribed medication that is not corrected prior to delivery of the medication;
b. includes a wrong drug, wrong strength, wrong directions, or wrong dosage form;
c. includes the failure to detect and appropriately manage a significant actual or potential problem with a patient's drug therapy;
d. all of the above are true.

Question 2:

Recommended actions for QRE's include:

a. mandatory reporting of each medication error to the state board of pharmacy;
b. voluntary reporting of each medication error to the state board of pharmacy;
c. promoting a non-punitive atmosphere for the reporting of medication errors;
d. promoting a system in which all medication errors are analyzed internally, with the results kept within the confines of the pharmacy.

2. Institute a system to review incident reports generated at the pharmacy on a quarterly basis. Perform root cause analysis and include information from such review in quality improvement programs. Reviewers should include pharmacists, pharmacy technicians, and appropriate management personnel.

Recommended Actions:
→ Evaluate the QREs that occurred in the pharmacy on a quarterly basis and identify the root cause of the QREs.
→ Implement improvements/interventions based on the information gathered as part of the root cause analysis.
→ Publicize changes to pharmacy staff.

Question 3:

Recommendation #2 suggests that pharmacies:

a. evaluate the QRE's that occurred in the pharmacy on a quarterly basis and identify the root cause of the QRE's;
b. evaluate the QRE's that occurred in the pharmacy by a team of reviewers that does not include pharmacy technicians;
c. use the QRE's in employee performance reviews;
d. use the QRE's to measure pharmacy management's achievements.

3. Develop and implement an effective workflow plan that is evaluated periodically to maximize effective use of space, equipment and staff.

Recommended Actions:
→ Develop policies and procedures to ensure that the appropriate individuals are completing appropriate tasks.
→ Consider the use of automated devices to aid staff.
→ Explore ways to optimize patient care services (i.e. providing separate area for confidentiality when counseling patients).
→ Evaluate the size of the pharmacy to determine optimum dispensing area.

4. Routinely survey customers regarding quality of care and satisfaction with service.

Recommended Actions:
→ Develop a customer-focused survey to identify areas of improvement.
→ Review the findings of the survey with pharmacy staff to develop solutions to improve patient satisfaction.

5. Develop and implement a comprehensive program of technician-training that requires pharmacy technician trainees to demonstrate competence in functioning as pharmacy technicians and to qualify for registration as pharmacy technicians.

Recommended Actions:
→ Develop a comprehensive pharmacy technician training program and provide a copy of the technician training program to the Board's Technician Training committee for Board approval.
→ Encourage pharmacy technicians registered by the

Question 4:

Recommendation #3 suggests that pharmacies implement an effective workflow plan, and evaluate it periodically. This is so that:

a. the pharmacy ensures that the appropriate individuals are completing appropriate tasks;
b. fewer prescriptions can be dispensed each hour;
c. space, equipment and staff can be minimized;
d. any separate area for patient counseling can be measured by cost per square foot.

Question 5:

Regarding pharmacy technicians, the Recommendations suggest that a pharmacy:

a. develop and implement a comprehensive technician-training program that requires pharmacy technician trainees to demonstrate competence;
b. employ only nationally-certified pharmacy technicians;
c. maintain a technician-to-pharmacist ratio of 2-to-1;
d. require special law-related continuing education activities be completed by all technicians.

Board to meet and maintain certification requirements.
→ Provide continuing education opportunities for pharmacy technicians.

6. Implement a policy requiring that counseling be offered to every patient receiving a prescription, regardless of whether the prescription is new or a refill. During patient counseling, the pharmacist should verify that the patient understands the purpose, proper use and expected outcomes of their drug therapy. Counseling should also include information as to the safe and accurate use of prescribed medications. Educating patients about the safe and effective use of medications promotes patient involvement in their own care and is an important component of any medication error reduction strategy. Patient counseling may have a beneficial impact by reducing the incidence of quality-related events.

Recommended Actions:
→ Dispense or recommend proper measuring devices (e.g. oral dosing spoon) with all liquid medications. Instruct patients or caregivers on how to use the measuring device.
→ Provide written patient drug information materials with all new outpatient prescriptions dispensed.
→ Develop standard counseling procedures that include checks for the following:
→ Right patient
→ Right drug
→ Right drug for this patient
→ Appropriate dosing schedule
→ Appropriate route of administration
→ Correct route of administration for this patient
→ Verification that the patient understands why they are taking the drug
→ Verification that the patient understands how to use the drug

Question 6:

Regarding patient counseling, the Recommendations suggest that a pharmacy implement a policy:

a. requiring that counseling be offered to every patient receiving a prescription, regardless of whether the prescription is new or a refill;
b. in which the pharmacist should verify that the patient understands the purpose, proper use and expected outcomes of their drug therapy;
c. in which patient counseling includes information as to the safe and effective use of prescribed medications;
d. all of the above are suggested by the Recommendations.

7. Develop policies and procedures that insure patient profiles are periodically updated for drug allergies, patient weight, adverse reactions, over-the-counter (OTC) medication usage, and alternative medication/herbal remedy usage.

Recommended Actions:

→ Develop a policy that requires that allergy information be updated when filling or refilling a prescription.

→ Require all new prescriptions include allergy information.

→ Develop a policy of updating patients weight periodically.

→ Ask patients about their use of OTC medications and herbal remedies and document responses in the patient profile.

→ Update patient profiles periodically. Updates should include information on newly developed allergies even if patient is not filling a new prescription.

Question 7:

Regarding patient counseling, the Recommendations suggest that:

a. patient counseling many have a beneficial impact by reducing the incidence of QRE's;
b. educating patients about the safe and effective use of medications is an important component of any medication error reduction strategy;
c. both of the above are true.

Question 8:

Regarding patient counseling, the Recommended Actions include:

a. dispensing or recommending proper measuring devices (e.g., oral dosing spoon) with all liquid medications;
b. instructing patients or caregivers on how to use the measuring device;
c. developing standard counseling procedures that include checks for the right patient, right drug, right drug for this patient, appropriate dosing schedule, appropriate route of administration, correct route of administration for this patient, verification that the patient understands why they are taking the drug, and verification that the patient understands now to use the drug;
d. all of the above are true.

8. Utilize available age and weight adjusted dosing guidelines when appropriate.

Recommended Actions:
→ Verify pediatric dosing to ensure proper dose.
→ Develop pediatric and geriatric specific guidelines for age and weight adjusted dosing.
→ Consider acquiring or utilizing reference materials, textbooks and/or computer software that directly address pediatric and geriatric dosing.
→ When appropriate and necessary, verify that doses are appropriate for the patient.

Question 9:

Regarding patient profiles, the Recommended Actions include:

a. requiring that all new prescriptions include allergy information;
b. requiring that all new prescriptions include the patient's weight;
c. developing a policy that patient profiles be reviewed every six (6) months;
d. developing a policy that allergy information does not need to be updated when refilling a prescription.

Question 10:

Regarding age and weight guidelines, the Recommended Actions include:

a. verifying pediatric dosing to ensure proper dose;
b. developing pediatric and geriatric specific guidelines for age and weight adjusted dosing;
c. developing a policy that prescriptions will not be dispensed unless the patient or caregiver provides an accurate weight of the patient;
d. both a and b are true.

9. Provide adequate and easy access to appropriate reference materials.

Recommended Actions:
→ Provide Internet access to pharmacists to research clinical information.
→ Establish a clinical department to serve as a resource for dispensing pharmacists.
→ In addition to required reference texts, provide additional reference materials, such as computer software programs, relevant to particular practice setting.

10. When necessary and appropriate, question adherence to prescriber directions when a medication intended for chronic use is filled more than three days late or when the medication is reordered earlier than expected.

Recommended Actions:
→ Monitor prescription drug usage among patients with chronic disease states to ensure compliance.
→ Ask the patient if a drug therapy change has occurred and, if needed, contact the prescriber to obtain updated information.
→ Ask patients how they are feeling, paying attention to improvements in the patient's condition as well as adverse effects.

Question 11:

The Recommendations suggest that, when necessary and appropriate, pharmacy professionals should question adherence to prescriber directions. Examples of when to question prescriber directions might include:

a. when a medication is intended for chronic use, and is filled more than 3 days late;
b. when a medication is intended for chronic use, and is reordered earlier than expected;
c. both a and b are correct;
d. neither a or b is correct.

11. Develop written policies and procedures to assure that outdated stock or stock with an expiration date that does not allow sufficient time for dispensing by the pharmacy or use by the patient is segregated from other stock and either prepared for return to the manufacturer or destroyed and documented.

Recommended Actions:
→ Periodically inspect the expiration date on the medication stock bottles.
→ Periodically inspect the expiration date on the medication containers in the refrigerator or freezer.
→ Identify short dated items with a colored label indicating expiration date.
→ Check expiration dates on all products prior to completing the filling and dispensing of medication.

12. Adopt written policies and procedures pertaining to the handling of filled prescription orders waiting for pick-up by a patient or patient representative.

Recommended Actions:
→ Verify the patient's name, address, and date of birth when prescription orders are picked up.

Question 12:

To prevent outdated medication from being dispensed to a patient, the Recommendations suggest:

a. inspecting the expiration dates on medication stock bottles every 3 months;
b. inspecting the expiration dates of refrigerated/freezer items every 4 months;
c. identifying short-dated medications with a different colored label for each drug manufacturer the product came from;
d. checking the expiration date on all products prior to completing the filling and dispensing of medication.

Question 13:

To properly handle prescription orders waiting for pick-up by a patient or patient representative, the Recommendations suggest that the pharmacy professional verify the following when prescription orders are picked up:

a. patient's name;
b. patient's address;
c. patient's date of birth;
d. all of the above.

Question 14:

When a prescription is not picked up, and the contents are to be returned to stock, the Recommendations are that only a pharmacist may return medication to stock with appropriate checks.

a. True;
b. False.

13. Adopt written policies and procedures relating to the return of unclaimed prescriptions to stock.

Recommended Actions:
→ Adopt a policy that only a pharmacist may return medication to the stock with appropriate checks.

14. Develop procedures to ensure drug recalls are acted upon in a timely manner.

Recommended Actions:
→ Adopt procedure that personnel receiving recall notice are required to immediately bring the recall notification to the pharmacist's attention.

15. Explore the reasons for out of stock items.

Recommended Actions:
→ Collect data and analyze trends related to out of stock items.
→ Utilize a computer program employing maximum/ minimum strategy to determine inventory.
→ Consider auto replenishment technology.
→ Refer to the FDA shortage list

16. Adopt a policy allowing for continuation of therapy for out of stock or unavailable items.

Recommended Actions:
→ Inform patient or caregiver that the medication is out of stock or unavailable.
→ If known, inform patient or caregiver when the medication would be available.
→ Offer to make arrangements for the patient or caregiver to pick up the medication at another location.
→ If the availability from manufacturer will result in interruption of therapy, offer to call the physician to discuss a change in therapy.

Question 15:

For out of stock or unavailable medications, the Recommendations suggest that the pharmacy professional:

a. inform the patient or caregiver that the medication is out of stock;
b. offer to call around to other local pharmacies to see if you can locate any stock;
c. offer to call the patient's physician to discuss a change in therapy, if the patient's therapy will be interrupted because the medication is out of stock;
d. all of the above.

17. Adopt a policy allowing pharmacists up to a thirty-minute lunch break when they work six or more hours in a day.

Recommended Actions:
→ Develop policies and procedures regarding the operation of the pharmacy during the temporary absence of the pharmacist for breaks and meal periods in accordance with policies of the Board of Registration in Pharmacy.
→ Develop policies and procedures detailing the authorized duties of ancillary staff during temporary absences of the pharmacist, the pharmacist's responsibilities for checking all work performed by ancillary staff, and the pharmacist's responsibility for maintaining the security of the pharmacy.

18. Develop policies and procedures regarding proper staffing.

Recommended Actions:
→ Periodically review staffing requirements to assure adequate availability of professional, technical and clerical staff.
→ Ensure that available and competent staff is available during periods of high activity.

Question 16:

Two of the Recommendation are in regards to staffing the pharmacy. These Recommendations suggest that pharmacies:

a. adopt a policy allowing pharmacists up to a thirty-minute lunch break when they work four or more hours in a day;
b. adopt a policy and procedure to bring in relief pharmacists to cover the lunch breaks;
c. adopt a policy and procedure to transfer responsibility for securing the pharmacy to ancillary staff during the pharmacist's lunch breaks;
d. develop policies and procedures to ensure that competent staff is available during periods of high activity.

19. Utilize interpreters as necessary.

Recommended Actions:
→ Employ individuals who can speak a second language.
→ Learn a second language.
→ Engage an interpreter service (such as AT&T).

20. Develop policies and procedures, which continually improve pharmacy practice by incorporating strategies to optimize therapeutic outcomes.

Recommended Actions:
→ Consider disease state management programs and certification programs to enhance delivery of pharmaceutical care.
→ Initiate a program to monitor HbA1C levels of diabetic patients.
→ Counsel patients with diabetes regarding proper injection techniques and the proper use of glucose monitoring equipment, insulin, syringes, and insulin pens.
→ Implement a program to encourage high-risk patients to have cholesterol levels evaluated.
→ Encourage patients with asthma to demonstrate proper use of Metered Dose Inhalers (MDIs), spacers, and peak-flow meters.
→ Institute and promote procedures to determine if patients utilizing chronic care medications are adhering to prescribed medical regimens.
→ Develop a plan for the acquisition of adherence software within an acceptable time frame.
→ Provide counseling and conduct activities to help increase immunization rates for patients at high risk for pneumonia and influenza.

Question 17:

Recommendation #20 suggest that pharmacies continually improve pharmacy practice by incorporating strategies to optimize therapeutic outcomes. Such strategies could include:

a. for diabetic patients, initiating a program to measure HbA1C levels;
b. for patients with asthma, encourage patients to demonstrate to you that they know how to properly use their inhaler, spacer, or peak-flow meter;
c. for patients on chronic care medications, institute and promote procedures to help you determine if patients are adhering to their prescribed regimens;
d. all of the above are strategies that pharmacies should consider to continually improve pharmacy practice.

21. Develop policies and procedures, which continually insure the integrity of Biologicals and Pharmaceuticals.

Recommended Action:
→ Consider maintaining a daily temperature log on file to insure proper storage of biologicals and refrigerated pharmaceuticals

22 Develop and implement written policies and procedures that enhance anti-counterfeiting measures regarding the receipt, storage and security of controlled substances.

Recommended Action:
→ Visually examine all deliveries promptly on receipt to identity contents and determine if any contaminated, damaged, misbranded, expired and or suspected counterfeit drugs or devices are included in the shipment.
→ Quarantine any drugs or devices found to be unacceptable for further examination and determination.
→ Inspect medication during final verification to assure product accuracy and integrity.
→Request wholesalers to certify that all medications delivered to the pharmacy, not accompanied by a pedigree, are purchased directly from the manufacturer.
→ Report suspected counterfeit medications to MedWatch (the FDA Safety Information and Adverse Event Reporting Program), the Board and appropriate law enforcement authorities within three business days.
→ Educate consumers about the risks of counterfeit medications.
→ Encourage consumers to promptly consult with health care professionals if they suspect that their medication is counterfeit.
→ Remind consumers to be aware of noticeable differences in their medications or packaging and the occurrence of any adverse events.
→ Alert consumers to the important role pharmacists play in identifying, reporting and responding to counterfeit drug events.
→ Advise consumers to make online medication purchases from pharmacies that have obtained the Verified Internet Pharmacy Practice Site (VIPPS) seal from the National Association of Boards of Pharmacy (NABP).
→ Maintain records of counterfeit reports from manufacturers and other sources for a minimum three-year period.

Question 18:

In regards to controlled substances, the Recommendations suggest that pharmacies develop and implement written policies and procedures that:

a. enhance anti-counterfeiting measures regarding the receipt, storage and security of controlled substances;
b. encourage patients to never make online purchases of controlled substances;
c. require the pharmacy to report any suspected counterfeit medications to authorities within 24 hours;
d. require only a pharmacist to visually examine all deliveries promptly on receipt to identify contents and determine if any contaminated, damaged, misbranded, expired or suspected counterfeit drugs are included in each shipment.

23. Develop and implement written policies and procedures regarding the identification of medication when requested by a consumer/patient or medical professional. Resources for Non-Emergency Product Identification Requests.

[If emergency, call poison control center at 1-800-222-1222]

Recommended Actions:

1. When a prescription is associated with the medication to be identified.
   a. Verify the prescription content with the original copy of the prescription dispensed making sure that the markings on the unidentified medication match the prescription medication dispensed and is identified from the original prescription.
   b. If unidentified medication cannot be verified then refer to procedure #2.

2. Identification of a medication with manufacturer's code and/or NDC code or other marking(s) on the product.
   a. Utilize available resources and references (Reference/Resource) to identify medication by manufacturers' identification codes, NDC code, or drug name.
   b. If medication cannot be identified then refer to procedure #3.

3. Identification of a medication that has no markings and/or is a formulation (liquid) that is not positively identifiable.
   a. Call the poison control center and describe medication and indication for use if known. (EMERGENCY SITUATION)
   b. In non-emergency situations, obtain services for laboratory product analysis.

24. Develop policies and procedures to document pharmacist initiated interventions to provide a record of accountability that can be retrieved, reviewed or acted upon at a future date. Properly documented interventions can be utilized to change unsafe practices, correct repetitive faults in the prescription fulfillment process and/or change the outcome of a patient's treatment.

Recommended Actions:

→ Create a system (manual or electronic) for documenting pharmacist initiated interventions.
→ Provide necessary training and resources to promote a pharmacist initiated intervention program.
→ Implement improvements based on information gathered from an intervention program.

25. Develop a policy and procedure providing for immediate notification of patient or patient's representative upon discovery of significant QRE (medication error) and effective communication of seriousness of the event and verification of completion of pharmacy personnel training related to such policy and procedure.

Recommended Actions:

→ Create a system for a pharmacist to notify, upon discovery of a significant QRE (medication error), the patient or patient's representative of remedial action to overt ingestion or potential harm.

→ Provide necessary training and resources to the pharmacist on the proper methods of immediate patient notification to prevent adverse medication events.
→ Document communication (manual or electronic) based on information gathered from the incident.

26. Develop policies and procedures to ensure the proper storage of refrigerated and frozen medications. Provide ongoing education on the importance of proper storage of medications requiring refrigeration.

Recommended Actions:
Educate pharmacists and other pharmacy personnel regarding the importance of proper storage of refrigerated and frozen medications.
→ Review board rule or policy regarding the proper storage of refrigerated and frozen medications in a pharmacy.
→ Review current refrigeration standards established by Centers of Disease Control and Prevention (CDC), United States Pharmacopoeia (USP) and state health departments.
→ Document communication (manual or electronic) based on information gathered from the incident.

Question 19:

The Recommendations suggest that policies and procedures be developed to document pharmacist-initiated interventions. This is:

a. to provide a record of accountability that can be retrieved, reviewed or acted upon at a future date;
b. because properly documented interventions can be utilized to change unsafe practices;
c. because properly documented interventions can be utilized to assign the proper degree of personal fault to identified pharmacists and pharmacy technicians;
d. both a and b are true.

Question 20:

In advance of significant QREs (medication errors), the Recommendations suggest that pharmacies:

a. develop a policy to immediately notify pharmacy management of the QRE;
b. develop a policy to immediately notify the patient or patient's representative, and provide training to the pharmacist on the proper methods of immediate patient notification;
c. provide training and resources to all employees ensure the particular QRE does not re-occur;
d. provide training and resources to the pharmacist and/or pharmacy technician that participated in the QRE.

Return this ANSWER SHEET with the $20.00 Program Fee payable to:

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NAME:	Pharmacist? Yes/No
ADDRESS:	Technician? Yes/No
CITY, STATE and ZIP:	
EMAIL:	
NABP e-Profile #:	Month and Day of Birth:

ANSWERS: 23 Recommendations to Optimize Patient Safety and Reduce Medication Errors

1.	a	b	c	d	11.	a	b	c	d
2.	a	b	c	d	12.	a	b	c	d
3.	a	b	c	d	13.	a	b	c	d
4.	a	b	c	d	14.	a	b		
5.	a	b	c	d	15.	a	b	c	d
6.	a	b	c	d	16.	a	b	c	d
7.	a	b	c		17.	a	b	c	d
8.	a	b	c	d	18.	a	b	c	d
9.	a	b	c	d	19.	a	b	c	d
10.	a	b	c	d	20.	a	b	c	d

21. After completing this program, I am able to recognize best practice recommendations to optimize patient safety and reduce medication errors; YES SOMEWHAT NO
22. After completing this program, I am able to restate actions that can be implemented to reduce medication errors; YES SOMEWHAT NO
23. This CE activity met my educational needs: YES SOMEWHAT NO
24. The author was organized in the written materials: YES SOMEWHAT NO
25. The learning material was useful: YES SOMEWHAT NO
26. The teaching and learning methods, (tests, questions, cases) including active learning, were effective: YES SOMEWHAT NO
27. The learning assessment (the post-test) was appropriate: YES SOMEWHAT NO
28. The test questions were relevant to the CE activity: YES SOMEWHAT NO
29. The test questions were at an appropriate level of difficulty: YES SOMEWHAT NO
30. The activity was presented in a fair and unbiased manner: YES SOMEWHAT NO
31. If you perceived any bias or commercialism, please describe, or want to make any other suggestions, please tell us:____

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