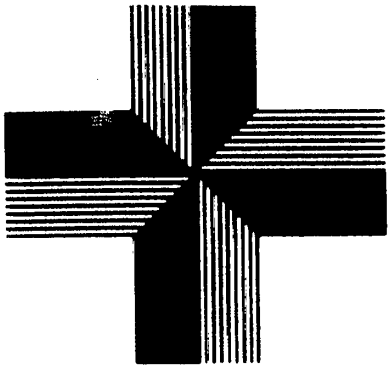

The Marketing of

Professional (Pharmaceutical) Service

A Study of the Service to Private Nursing Homes in U.S.A.

March 1991

THE MARKETING of PROFESSIONAL (PHARMACEUTICAL) SERVICE:

A STUDY of SERVICES to PRIVATE NURSING HOMES in U.S.A.

Travelling Fellowship sponsored by the KINGS FUND COLLEGE and N.H.S.T.A.

HAZEL SOMMERVILLE. B.Sc., M.R.Pharm.S.

Principal Pharmacist, Community Unit
Norwich health Authority

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GLOSSARY of TERMS.

Anti-hypertensive drug.	A drug which is given to lower the patient's blood pressure.
Anti-psychotic drug.	A drug which produces a tranquilising effect without imparing consciousness. Drugs in this group may be used to quieten disturbed patients e.g. Chlorpromazine.
Clinical Pharmacy Service.	The provision of pharmaceutical advice to clinicians regarding effective use of medicines relative to diagnosis and biochemical tests.
Community Services Pharmacist. (C. S. P.)	A pharmacist employed by a health authority to undertake duties that are based in the community.
Community Pharmacist.	A pharmacist providing pharmaceutical services to the community.
Controlled Drug. (C. D.)	A medicine that is controlled by virtue of the Misuse of Drugs Act e.g. Morphine.
Diagnosis Related Groups. (D. R. G.)	The system in U. S. A. of reimbursement of medical care determined by the diagnostic group that the patient is in.
Drug Regimen Review. (D. R. R.)	The equivalent U. S. term for Drug Therapy Monitoring.
Drug Therapy Monitoring.	Assessing a patients complete drug therapy to ensure appropriate treatment, correct dose and to ensure that there are no potential drug problems e.g. drug interactions.
Long Term Care Facility. (L. T. C. F.)	Title given in the U. S. A. to all types of long term care establishments including nursing homes, residential care homes etc.
Non-compliance.	The failure to take medicine in accordance with the directions given by the prescriber.
Over the Counter Medicines. (O. T. C.)	Medicines which can be sold to the general public without a prescription.
Prescription Only Medicines. (P. O. M.)	Medicines which may only be supplied to the general public on prescription.

INTRODUCTION.

The challenge of providing quality professional pharmaceutical services to private nursing homes was born within me when I first undertook an Inspection role for Norwich Health Authority some years ago. The patients who occupy our nursing homes have little to distinguish them from patients within N.H.S. long-stay hospitals, and yet there is little or no provision for them to receive pharmaceutical advice on a regular basis. The number of beds in the private sector is increasing rapidly. Guidance from the National Association of Health Authorities (N.A.H.A.) is that the quality of care within private nursing homes and hospitals should be of comparable standard to that achieved within Acute N.H.S. hospitals. Clearly we have some way to go before this vision becomes reality.

Although I am concerned by the fundamental changes within the National Health Service and the prospect of marketing pharmaceutical services, I do welcome the concept of 'care evaluation'. I share a common committment with managers in other healthcare organisations in that I wish to promote high quality care to patients and particularly those cared for in the 'community' situation. The motivation to care will not cease with the introduction of the internal market. Rather I can forsee widening opportunities to move professional services into previously uncharted areas.

I chose principally to explore the American model because it is based upon private enterprise. A scant report which appeared in the Pharmaceutical Journal in February 1990 gave me the lead to contact the American Society of Consultant Pharmacists (A.S.C.P.), and only then did I become aware of the clinical pharmacy involvement in nursing homes within the U.S.A.. Thus was this project conceived.

There are few consultant pharmacists within the United Kingdom and I have been unable to find literature references to comparable activities in this country. I am sure that there are situations where advice is given, though not always on a contractural basis but as an adjunct to the supply role. Certainly the official guidance from the Royal Pharmaceutical Society of Great Britain is limited to the 'advisory' role and does not define a 'clinical' involvement such as is seen in the United States of America.

This project has developed in three distinct phases. Firstly it seemed essential to gain a general perspective of health care in the U.S.A. In particular it was necessary to understand what nursing homes undertake to provide in terms of care. The second phase involved a detailed study of the consultant pharmacists' activities and how these directly affect patient care. I have also made reference to the way in which consultants market their services in a highly competitive field. Finally I have suggested a model for consultant pharmacist activity in the U.K. by consideration of the limitations we are currently faced with and how such issues have been addressed in the American situation.

SECTION 1. HEALTH CARE in the UNITED STATES of AMERICA.

My initial impressions were twofold: excellence and fragmentation. Both are the result of the ideology of American living: to promote private enterprise and to maintain the rights of individual choice. The existence of quality care is immediately evident and proves beyond doubt that there is the WILL to provide for the health care needs of the nation. Unfortunately it would appear that the WAY has not yet been forged sucessfully.

Throughout the last two decades measures have been introduced to contain health care costs. In the 1970's Richard Nixon introduced the concept of the Health Management Organisation (H.M.O.). He visualised that through H.M.O.'s would emerge a system of competitive internal markets. Such markets would provide benefits of cost management by incentive, reduction of fragmentation and specialisation, elimination of un-necessary surgery and provision of comprehensive care. The aim was to have 1,500 H.M.O. operational within five years providing for the needs of 90% of the population. The scheme failed to materialise mainly because of objections at both federal and state level by the American Medical Association and hospitals who did not wish to see such activities developing in their areas. Private enterprise was unwilling to accept economic competition regulated by the governmment.

During the Reagan administration the concept of economic competition was further advanced but now the federal programme for the elderly -Medicare- was to act as purchaser of services within the limitations of its budget. From this sprang other programmes including some within Medicaid which is the federal programme for the indigent 'under 65' population. In parallel with this activity, large employers began to put out contracts for bid to provide health care for their employees. This has led to the current status of H.M.O. but the evolution has not proceeded to the extent that President Nixon had planned and is not subject to federal or state regulation. The modern H.M.O. concentrates on review of health care usage, case management and systems of quality control.

Despite these attempts to control spending, the current situation is one of escalating costs described as 'Care out of Control'. In 1988 a total of $540 billion was spent on health care in the U.S.A. which is more per capita than any other nation and also more in terms of percentage of the gross national product. Perhaps this is indicative of a Provider-driven system which ultimately drives costs upwards.

1.1. WHO PAYS THE HEALTH CARE BILL?

In America the individual has the right of free choice concerning the nature and extent of health care he wishes to obtain. The care is therefore wholly dependent upon an individual's means which is a complete opposite to the concept of care in the United Kingdom where Health Care is defined as being the right of every citizen. In spite of a dazzling array of health care advertising, options for individual choice are limited.

1.1.1. PRIVATE INDIVIDUAL PAYMENT.

This involves the payment for care as and when it is obtained. If one assumes that an individual either will need only minimal health care, or has infinite resources at his disposal, this is an attractive option. One pays for the services one chooses to have. A visit to the physician attracts a bill and similarly the dispensing of medicines against a Physician's Order is billed to the individual. The potential financial catastophy that could occur should be self evident.

1.1.2. INSURANCE COVER.

The majority of health care costs are covered by insurance programmes and this may be provided either on an individual basis or as part of a contract of employment via H.M.O.

Within this option the choice is diverse. Although the basic deciding factor will relate to the cost, programmes are designed with particular client groups in mind. The industry is highly competitive and invests considerably in marketing. I was able to spend some time with two companies in California both of whom market differing health care plans.

1.1.2.1. BLUE CROSS OF CALIFORNIA.

Blue Cross operates throughout the U.S.A. but my discussions relate to the company in California which, in that state, is the largest purchaser of health care providing overall benefits to 5 million people.

Benefit packages are designed with a distinct population in mind i.e. by Marketing Business Groups.

(i) Age over 65
(ii) Age under 65
(iii) Small group employer (5 - 49 employees)
(iv) Employer of 50 - 1990 employees
(v) Major accounts (over 2000 employees)
(vi) National accounts. Blue Cross is the agency that processes Medicare provision for the State of California. They settle claims in respect of 2 million people.

As in the U.K., most of the insurance policies are subject to limitation relating to pre-existing conditions and also involving some medical screening. A policy may provide comprehensive cover but there are also programmes designed for specific items of care eg. medicines.

Few policies provide benefits for Nursing Home admission and do not attract many subscribers. Insurance cover provides in the main for 'acute' care, specifically excludes 'custodial' care, and recognises the necessity for limited provision of re-habilitation.

A patient who subscribes to a programme for the supply of medicines is entitled to receive them whatever their cicumstances. Hence a nursing home patient can claim payment for drugs while not receiving benefits from a programme that provides for the 'care' element.

Blue Cross does not own hospitals, nursing homes or pharmacies. The company sets up individual contracts with Acute hospitals, Community hospitals and Pharmacies within the context of a Preferred Provider Organisation (P.P.O.). Prescription supply is organised using a 'credit card' system. Subscribers must present their physician's orders to a participating pharmacy where their personal card is used to electronically transmit details of the supply. Payment for the medicines is then made direct to the supplying pharmacist. Re-imbursement is the same for every pharmacy outlet and is dependent upon the drugs supplied. The cheque is in the post within days which compares favourably with the system in the U.K. where re-imbursement takes 3 months.

Any Pharmacy can apply to join the scheme or choose to leave it. At present there are no quality standards imposed except that the Pharmacy must be State Licensed (which does incorporate quality standards). There is no rational location of pharmacies. From 1991 Blue Cross will introduce a Pharmacy audit scheme which will look specifically at quality issues, abuse situations and potential fraud. The pilot scheme will incorporate visits to a set number of pharmacies twice monthly to assess prescriptions. This may be paralleled with the Inspection of Community Pharmacies in U.K. by the Royal Pharmaceutical Society Inspectors but while our own situation is 'professionally led' the Californian system will be 'purchaser led'. It is worthy of note that Blue Cross receive relatively few complaints regarding the Pharmacy service that their clients obtain.

While Blue Cross may be responsible for providing medicines to a nursing home patient it does not fund 'consultancy'.

Blue Cross runs an H.M.O. called CaliforniaCare the aim of which is to provide cost effective care. By establishing health care contracts the parent company controls the cost of services through 167 hospitals with the services of 6000 physicians. The following measures result in the cost containment of medicines:

(i) Drug Formulary - Pharmacy & Therapeutics Committee
(ii) Drug Utilisation Review - Targetting the 'top ten' for less expensive equivalents.
(iii) Education sessions aimed at the Physicians.
(iv) Drug Information - Regular Newsletters and Network Support..
(v) Case Management.

In addition, the company enters into contracts with Pharmaceutical Manufacturers. Drugs are not supplied at discount price but, when targets are met, a bonus is paid directly to the company. Such monies are fed into the company to produce overall benefit to consumer and provider.

In summary, Blue Cross of California can be described as an organisation which sells packages of health care benefits to individuals, employers and to the State. To fulfill these contracts the company purchases the required health care from other sources throughout the State.

1.1.2.2. UNIHEALTH AMERICAN

Unihealth American is a 'regionally integrated healthcare delivery continuum' which owns acute hospitals within California and operates them from a central location. There are two subsidiary H.M.O.'s called 'Pacificare' and 'CareAmerica' and participants in these schemes may have benefits within Nursing Homes. It is one of the country's largest non-profit systems in the health care industry. Although the company does not own nursing homes it is useful to understand the strategy employed in the organisation of private hospitals. There are 11 Medical Centres in this group with a variety of activities.

The status of physicians within hospitals, as within nursing homes (see also Para. 1.3.4. page 15) is very different from the U.K. situation.. Usually a physician applies to have staff priveledges in 4 or 5 hospitals within a restricted radius and these hospitals will not necessarily be within the same company. Staff priveledges allow that physician to admit patients to that hospital. The hospital becomes responsible for the care ordered by the physician and 'bills' the patient accordingly. The physicians' activities are not usually subject to any control mechanism other than 'peer review'. There is a potential conflict of interests in this set-up: the hospital may consider some care un-necessary but is contracted to undertake it and conflict with a physician may result in a loss of business which the hospital cannot afford. However, if a physician inflicts a financial liability on a hospital the staff priveledge may be withdrawn. It is in the best interests of all parties, including the patient, to find a reasonable middle course.

Unihealth American are attempting to overcome this situation by setting up its own groups of physicians within the company . They have introduced a managed structure of a limited Drug Formulary and Clinical Case Management. In the Annual Report of 1989 the strategic policies outlined would seem to indicate a determination to provide cost effective quality care.

(i) Alligning physician and system interests.
(ii) Establishing a uniform information system across the network.
(iii) Re-positioning the acute care provision to prevent duplication.
(iv) Effective case management.
(v) Development of clinical programmes in line with market demands.
(vi) Applying quality management techniques to clinical service and other aspects of the healthcare service.

Each hospital is serviced by an 'in house' pharmacy. The company joins with other large purchasing consortiums to purchase and dispense medicines at 30-50% below the independent organisation costs. I was amazed to learn that delivery from major drug companies is within 5 hours of the order being placed and certainly within the same day. (Within the U.K. delivery direct from manufacturers can be 7-10 days unless designated an emergency.)

An additional activity of Unihealth American is the operation of 'mail order pharmacy'. Such organisations are common within North America. By operating as a warehouse the pharmacy can generate tremendous savings. Any requests are verified by FAX or Computer.

The packages of care available to clients are not as extensive as those handled by Blue Cross. There is, however, large uptake of available plans (see Table 1). The benefits of these programmes are also available through physicians and hospitals outwith the Unihealth American group of Medical Centres.

Table 1. **MEMBERSHIP of UNIHEALTH AMERICAN (1989)**

Care Plan	No. of Members.
CareAmerica	120,000
Eldermed America	400,000
Pacificare	553,165

Unihealth American can be summed up as being a quality integrated health care organisation which offers care though P.P.O. and H.M.O. membership.

1.1.3. STATE PROVISION.

In 1990 between 31 and 37 million Americans were un-insured so dependency upon state organised health care is significant. In this report I will only make a few observations about MEDICARE and MEDICAID.

1.1.3.1. MEDICARE.

State provision for people over 65 is available through Medicare for those who meet with the scheme's limitations. The system is not open-ended but subject to control at state level. It is often necessary for the elderly to purchase 'top up' insurance to ensure complete cover that they may not be entitled to under the Medicare rules.

Limitation is placed upon duration of hospital care and as a consequence patients are often discharged to nursing homes needing specialist nursing care. It becomes necessary for nursing homes to limit the number of beds devoted to Medicare patients if they are unable to recruit sufficient trained nurses to cope with this type of work.

The overall cost of care is cash limited and this is determined by the Diagnosis Related Group (D.R.G.) in which the patient is classified, and the amount of nursing care that the individual case warrants. There are 476 categories of D.R.G. and any treatments ordered by a physician must be related to one or more of these groups.

1.1.3.2. MEDICAID.

In California this is referred to as MEDICAL.
Medicaid is the provision of care to the indigent under 65's and therefore encompasses the care of children. As with Medicare, the costs are related to D.R.G. and individually assessed care.

Medicaid varies widely between states: in some the care is limitless; in others strictly controlled. In Texas the control of drug supply is stringent (see Appendix IV, Medicaid Drug Plan by State). There is a state formulary and programme of Generic Substitution for certain drugs (The Texas Drug Vendor Programme). A patient will only be funded to the extent of 3 items per month. However, the law requires a pharmacist to dispense drugs as requested by a physician irrespective of the number of items. If this happens, the pharmacist bills the state for the 3 most expensive items and applies to the patient for the remainder of the monies. Most nursing homes and residential establishments set up trust funds to pay for such items. If they do not, the pharmacist supplier simply is not paid.

In the case of both Medicare and Medicaid, a provider of services applies directly to the state or to the state's representative for payment.

1.2. WHO PROVIDES THE CARE?

The U.S.A. system is provider driven but depends ultimately upon individual choice. It is hard to understand the workings of a system that does not revolve around the central axis of a General Practitioner. In the U.K. we expect coordination of health care for the individual irrespective of disease state and have come to depend upon the excellent screening services which we are expected to comply with. It is precisely this lack of coordination that leads to duplication of effort in the U.S.A. and is probably the major cause of fragmentation that I referred to.

Patients do not necessarily assign themselves to one medical practitioner: they visit and consult with specialist practitioners according to the complaint they have at that time. Some physicians deal with general medical issues but most patients will consult with a variety of practitioners and this may be concurrent. Unless a patient is within a hospital or nursing home the care will probably not be coordinated. One basic problem that occurs is the duplication of prescribing i.e. several physicians prescribe the same drug for a patient which could lead to overdosage if different proprietary named products have been supplied.

The provision of hospital based care is likewise uncoordinated. Although there is some state provision the majority of hospitals are privately owned and managed, either within groups of medical centres or as single operators. Attempts are made within group ownership to maximise care in a cost effective way as in the Unihealth American organisation. One cannot help but conclude that each private enterprise is independently striving to implement rationalisation of care.

Physicians choose to practise in particular facilities (ref. para. 1.3.4. page 15) but within H.M.O. a system of contracting with physicians specifically for the organisation is becoming more popular.

1.3. THE PRIVATE NURSING HOME.

Private Nursing Homes in U.S.A. come into the category of Long Term Care Facilities (L.T.C.F.). Such facilities provide care for people who, although they do not need hospital care, are in need of a wide range of medical, nursing and related health and social services. The required services can only be rendered in accordance with state law by licensed practitioners.

1.3.1. ACCREDITATION.

Facilities wishing to participate in the Medicare and Medicaid schemes must comply with the Federal 'Conditions of Participation' as enforced by the appropriate state agency. Federal law imposes minimum requirement standards which must be met in each state and these are supplemented by state requirements which vary considerably from state to state and together are classified as either level A - activities which are specified as necessary or level B - activities which are recommended. An example of the level A requirements is that each L.T.C.F. must have a Drug Regimen Review conducted by a pharmacist every 30 days. Inspections are undertaken by state surveyors twice annually.

A facility that fails to comply with state regulations may receive:

(i) Deficiency Statement
(ii) Standard Statement
(iii) Condition of Participation.

If the matter is sufficiently serious the state may choose to de-certify the facility but this rarely happens. More commonly the facility is served with a citation in the form of a financial fine and such citations are categorised as being

B - potentially harmful
A - harmfull
AA - causing death.

Much activity now hinges upon O.B.R.A. 1987 (Omnibus Budget Reconciliation Act) which became effective in October 1990 and will be dealt with in greater detail in Section 2. Basically the regulations are concerned with the identification of patient's rights and also Outcomes.

1.3.2. MANAGEMENT OF NURSING HOMES.

All Long Term Care Facilities are managed by an Administrator who is responsible for the overall daily operation of the facility. The Administrator must be licensed by the State Board of Licensure for Nursing Home Administrators but this licensure also varies between states.

The Administrator must be thoroughly versed in state laws governing the facility, must ensure that optimum quality of care is delivered to the patient and that good working conditions are available for employees. However, ultimate responsibility for the facility rests with either the owner or Board of Directors.

1.3.3. THE MEDICAL DIRECTOR.

Every Nursing Home must appoint a Medical Director who will be responsible for the following activities:

(i) Occupational Health for employees.
(ii) Liason between Consultants and Physicians who practice in the facility.
(iii) Coordination of Quality Assurance issues.
(iv) Committee membership - policy making.
(v) Peer review.

It is notable that the Medical Director is not responsible for the individual medical care of patients. The role model may vary with the person appointed: some are very actively involved in the facility while others only maintain the minimum federal requirement.

1.3.4. INDIVIDUAL PHYSICIANS.

As stated in paragraph 1.2. physicians choose the facilities where they wish to have staff priveledges and hence where they wish to place their patients. It is of benefit to both practitioner and facility that agreement is reached concerning the issues of clinical freedom and the extent of clinical accountability that the physician will have. The financial arrangements are such that the physician will claim a fee for services and leave the facility to claim from the patient the cost of care ordered by the physician. It is a tenuous agreement. If a facility limits a physician's clinical judgement too far it will lose business should the physician choose to take his patients elsewhere. Equally, if a physician imposes a financial burden upon the facility by ordering care in excess of that considered reasonable, and which the facility has difficulty in obtaining reimbursment for, the facility will refuse to accept his patients. Administrative staff are increasingly imposing measures upon physicians to protect the facility both financially and legally.

When a physician has a patient within a L.T.C.F. the law requires that physician to visit the patient at least once every 30 days. The physician orders all treatments (including drugs) and care and must sign a repeat order once a month. (Examples of physician's Orders are contained in Appendix V). The orders for drugs may have been given verbally to nursing staff in which case the order must be signed by the physician within 48 hours (see Appendix V (i) b). Once ordered, the drug must be available to the patient within 4 hours (ref. para.2.7). The law is also very specific about the physician's duty to make a response to all communications made by the consultant pharmacist and this is further discussed in Section 2.

1.3.5. DIRECTOR OF NURSING.

The Director of Nursing works closely with the facility's Administrator to ensure quality care for patients. She must ensure staffing levels appropriate to patient needs and conversely must ensure that the case load being admitted is not out of proportion to the nurse staffing levels. Other duties involve the organisation of continuing nurse educational programme as required by federal law and participation in the policy making committees of the facility. The Director of Nursing must be a Registered Nurse (R.N.)

1.3.6. NURSING STAFF.

There is a recruitment problem in the field of nursing and most nurses within L.T.C.F. are either Licensed Vocational Nurses (L.V.N.) or Licensed Practical Nurses (L.P.N.). These grades are lower than R.N. and may be considered as equivalent to the status of S.E.N. in U.K. The staff mix is important in relation to the type of patients that can be cared for. Intravenous (I.V.) therapy can only be commenced by Registered Nurses who have had additional training. The continuing monitoring can be undertaken by L.V.N. provided they have been trained to do so. A nursing home which does not have sufficient R.N.s will not accept patients requiring this specialised nursing care. The topic of I.V. therapy is further discussed in Section 2.

Some states are prepared to license carers specifically to administer medicines and these are termed Medication Aides. A course of instruction is provided by Schools of Nursing. The medication aide I met in Texas is a student waiting to commence a course of study in Pharmacy. This grade of staff is not permitted within the state of California.

As previously mentioned, federal law requires that all nursing staff complete a fixed amount of continuing education each year.

1.3.7. CATEGORIES OF CARE.

In 1985, 600 million patient days of care were delivered in L.T.C.F. compared with 340 million in hospitals. The care that is given may be nursing, personal or residential. When nursing care is provided professional skill is required but this varies according to patients' needs.

1.3.7.1. SKILLED NURSING FACILITY (S.N.F.).

The S.N.F. provides 24 hour continuous nursing care for convalescent patients. Because of the tendency to move patients very quickly out of the acute hospitals, S.N.F. accept patients requiring a high degree of skilled nursing care which may include I.V. therapy and in some instances Total Parenteral Nutrition (T.P.N.). S.N.F. usually accept both Medicare and Medicaid patients.

1.3.7.2. INTERMEDIATE CARE FACILTY (I.C.F.).

The patients cared for in I.C.F. require less skilled nursing care than S.N.F. patients. The facilities provide some medical and nursing services. This level of care caters for people who are not capable of independent living e.g. mentally handicapped. Usually I.C.F. accept patients in the Medicaid programme.

Other levels of care have emerged and include:
Home Health Care
Adult Day Care
Child Care
Mental Health Care
Hospice Care
Respite Care.

1.3.8. FACTS ABOUT FACILITIES.

American nursing homes are generally speaking much larger than their British equivalents. The average number of beds per nursing home is 100 but some are as large as 500 beds. The last two decades have seen a vast increase in available beds for long term care which are represented in Table 2, and Table 3 shows the breakdown of long term beds in 1989. At the present time, bed occupancy in nursing homes is 91.8%.

Table 2. GROWTH in LONG TERM FACILITIES in U.S.A..

YEAR	No. of Facilities.	Total No. of Beds.
1969	15,000	900,000
1984	26.000	1,700,000

It is projected that by the year 2010 a total of 2.8 million beds will be necessary due to an aging population.

Table 3. U.S. LONG TERM CARE FACILITIES.

Facility.	Total No. of Beds.
Nursing Homes	1,500,000
Residential Care Facility	202,000
Hospital L.T.C.	61,000

1.3.9. CLIENTELE.

The elderly represent 10% of the total population and yet they consume 30% of the total health care costs and 25% of the drug care costs. By far the highest proportion of L.T.C.F. beds are occupied by the over 85's. Statistics obtained in 1982 show the L.T.C.F. population by age (Table 4).

Table 4. L.T.C.F. POPULATION BY AGE.

Age.	% of Population in L.T.C.F.
65 - 74	1.5%
75 - 84	6.0%
85 +	23.0%

The female population outnumbers the male population by 2 to 1. The differences in social structure and life expectancy between ethnic groups probably accounts for the very high proportion of 'white' patients.

Referral of patients may be by physicians, other hospitals or social services. Very few homes accept only privately funded patients but maintain a mixture of private and public funded beds. There may be limitations placed upon the availability of Medicare beds as these patients require more intensive nursing care. Care is provided as needed irrespective of how the bill is paid, though the nursing homes which take higher proportions of public funded patients may have less to expend on luxury fittings.

1.3.10 PHILOSOPHY OF CARE.

Provision of health care is highly competitive. Nursing homes aim to provide quality care that will attract clientele by reputation rather than resorting to direct advertising. The cost of the care is of less importance since it is passed on to the consumer. The Administrator and Director of Nursing actively promote the facility by allocating whatever time is necessary to prospective patients and their relatives. Quality long term care requires well-equipped facilities and adequate staffing levels. Any problems that occur in the delivery of care are generally caused by the problems of recruitment of skilled professionals.

In some instances nursing home groups establish a network of support services to ensure quality standards as exemplified by Healthcare Network (see para. 2.1.2., page 26).

The care philosophy of the American Health Care Association sums up the attitude of health care professionals that I spoke with:

> **'... to preserve the dignity and worth of every individual and to meet the total emotional, physical, social and spiritual needs of the residents.'**

SECTION 2. PROFESSIONAL PHARMACEUTICAL SERVICES.

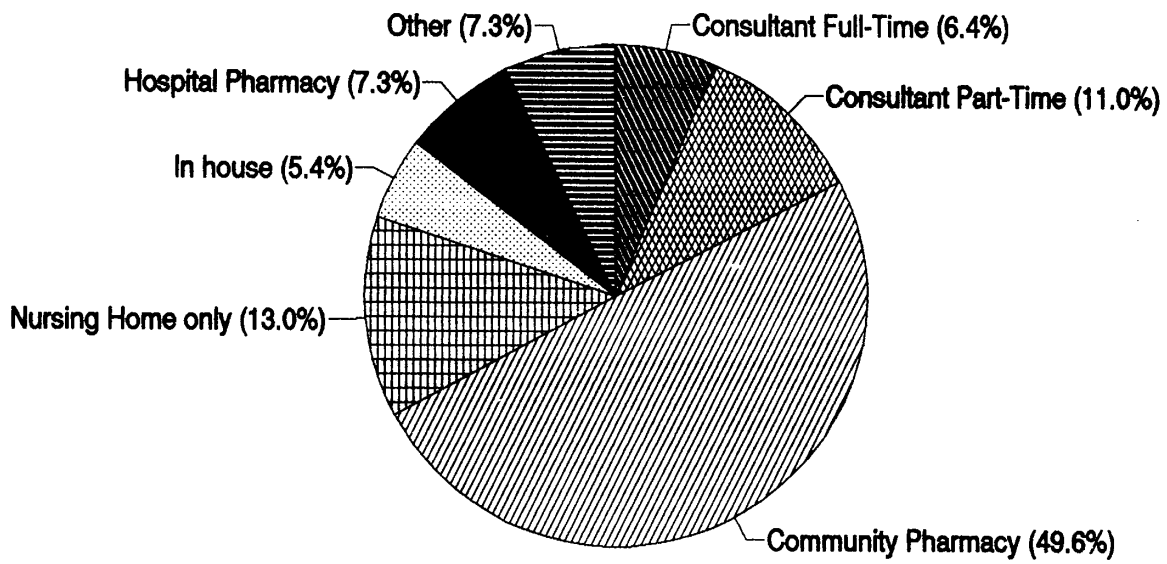
My principal aim in travelling to Texas and California was to observe at first hand the practice of consultant pharmacy as it applies to private nursing homes in the U.S.A. Although I had received some literature prior to the trip I was totally unprepared for such sophisticated practice of clinical pharmacy in a community setting, particularly since the U.K. situation in N.H.S. hospitals has not yet developed to such a degree. Consultant pharmacist activities are not confined to nursing homes but are becoming established in the prison service, home health agencies, hospices and mental institutions to name but a few.

Consultant Pharmacists are highly respected members of the health care team. Legislators have come to understand their potential for saving dollars and thus consultancy is actively backed by federal law. Ironically, pharmacists become victims of their own sucess: the reduction in numbers of prescriptions per patient results in loss of business. There is no evidence to suggest that pharmacists are anything other than entirely ethical in their approach to this. The consultants I spoke with shared a common committment to provide the best pharmaceutical care for the individual patient. This seems to have been achieved by seperating the role of supplier and consultant. The two goups that I visited, Instacare Pharmacy Services (Texas) and HealthCare Network (California), have both established distinct roles: consultant pharmacists do not undertake dispensing or supply duties and the pharmacists employed to manage the supply bases do not usually participate in consultancy activities.

The American Society of Consultant Pharmacists (A.S.C.P.) is the professional association, founded 21 years ago, to which many of the consultant pharmacists are affiliated. A.S.C.P. works in close conjunction with the American Pharmaceutical Association (A.P.A.) and the American Society of Hospital Pharmacists (A.S.H.P.) in proposing legislation and setting Quality Standards for the profession as a whole. The membership of A.S.C.P. has increased enormously in the last decade and now numbers more than 3000. The society undertakes an extensive educational programme through its annual meetings and midyear conferences which feature sessions concerning the latest research, clinical information and management techniques. In addition to this there is a home study programme in the Long Term Care Certificate Programme. This education is accepted as an authentic part of pharmacist's continuing education programme (as required by state law). During my visit I attended the Annual Conference held in San Antonio, Texas, and much of the theoretical material springs from this source. (see Appendix I for details of sessions attended). A.S.C.P. publishes a monthly journal aptly named 'Consultant Pharmacist'.
During the 1990 meeting a new research foundation was inaugurated with the aim of studying drug utilisation in the elderly population within L.T.C.F. It is worthy of note that A.S.C.P. has established representation in the U.S. Congress and government agencies. It is therefore well placed to have a direct impact upon legislation relating to pharmaceutical issues.

DIAGRAM 1.

ACSP MEMBER PRACTICE DESCRIPTION



2.1. CONSULTANT PHARMACIST PROFILE.

Consultant pharmacists provide wide ranging professional pharmaceutical services to L.T.C.F. and in this Section I will try to give a brief insight into this activity. Consultant Pharmacy in the U.S.A. is a well developed practice of 'clinical pharmacy' which is substantially further ahead than the U.K. provision within N.H.S. hospitals. There is no equivalent service to the 'community' in the U.K.

The driving force in this development would seem to rest with the federal law requiring that L.T.C.F. employ a pharmacist to review drug therapy once every 30 days. I do not doubt that A.S.C.P. has been instrumental at government level in promoting this legislation.

Much of the consultant activity is designed to ensure that the facility is able to meet with the State Surveyor's requirements and in some respects mimics the accreditation process. The consultant is on site for a limited number of hours each month but in addition to the contracted hours he is deemed to have a continuing responsibility for all pharmaceutical matters on a 24 hour basis. For the consultant who has a work load of 1,000 beds in perhaps 10 nursing homes the work is to say the least demanding!

Consultant pharmacists come from all areas of the profession (see Diagram 1, page 20). The 1985 survey by A.S.C.P. showed that nearly half of those responding to the questionaire are actively involved in a community pharmacy; 5% provide services from a nursing home 'in-house' pharmacy, and only 6% described themselves as full-time consultants (which was defined as consulting being the primary source of income and not dispensing services).

Of growing importance is the pharmacy which is set up solely to serve nursing homes. The two companies that I was introduced to by A.S.C.P. are within this category and I would like to seperately describe their set-up.

2.1.1. INSTACARE PHARMACY SERVICES.

Instacare is a subsidiary of the Eckerd Organisation and was set up by a founder member of A.S.C.P. There are a number of branches within Texas and in other states on the eastern seaboard. The organisation has developed centralised policy making and quality assurance programmes.

Instacare offers a wide selection of services to nursing homes:

(i) Medicine supply, prescription and 'over the counter' lines.
(ii) Enteral Feeding supplies.
(iii) Oxygen equipment (but not medical gasses).
(iv) I.V. Additive supply.
(v) Documentation.
(vi) Consultancy services.

The San Antonio branch has recently moved into new custom biult premises which comprises a warehouse storage area, large dipensing and assembly area, conference room, computer room and ample office provision. They currently have contracts with 29 facilities which include nursing homes, mental health/retardation centres and residential/boarding establishments but do not supply to the general public.

Plate 1

INSTACARE PHARMACY

Drug Cart

There are seven full time pharmacists: three are employed solely as consultants; two within the dispensary situation. Each branch has a full time pharmacist marketing manager to promote Instacare services. The emphasis is focussed not only on the importance of attracting new contracts but also on ensuring that existing contracts are being delivered to the satisfaction of the customer. Marketing is not left solely to the designated manager. All of the employees, and paticularly the consultants, are constantly promoting the company and I was particularly pleased to note good team spirit and a committment to the Instacare philosophy of care :

' Committed to services that help protect clients, medical profession and patients '

They do not target particular L.T.C.F. client groups. Contracts are obtained as and when they become available. The facilities may either be privately owned or part of a larger network. The marketing manager makes 'cold' visits as well as pre-arranged calls to discuss the available services. There is no security of tenure as the contracts can be cancelled at any time if the facility is not happy with the service. Competition comes from independent pharmacists but in the San Antonio area there are no other operatives on the same scale as Instacare.

As in other businesses, Instacare makes use of 'loss leaders'. The nursing homes who contract for consultancy services are provided with a Medication Cart (Plate 1, page 22) and more attractive terms are available if the company also supplies medicines. However, each service to the facility is costed seperately. The supply service usually attracts a flat rate fee per patient (in addition to the cost of the medicines) but when the consultancy is provided by Instacare, this flat rate is discounted.

As new contracts are obtained, further pharmacists are employed though often the existing pharmacists will cover an additional workload in the interim. The caseload is similar to the national average of 1,000 beds per full time pharmacist.

The medicines supplied are in a modified unit dosage form using a blister-pack system (Plate 2, page 25). Each card provides 32 dosage units in light resistant bubbles with a double backing (one of which is foil). The dispensed unit is given a 12 month expiry date which is in line with the quality assurance data provided by the card manufacturer. The card is shaded in progressively darker shades of blue to indicate re-order levels. The computer generated label giving details of patient's name, dosage and frequency is attached to the card prior to issue and for re-ordering purposes is peeled off and attached to the order form.

Supplies to the facilities are delivered twice daily by one of the branch's six vehicles. The furthest nursing home is 150 miles distant and in this case the supply is made daily with a night run. Each facility is provided with an Emergency Drug Box and this is further discussed in 2.7. The supplies may include some 'over the counter' lines which a facility is required to keep if care is for patients in the Medicare/Medicaid programmes. The range of goods is similar to that available in a community pharmacy (Plate 3, page 25).

Instacare is currently clarifying its consultant activities so that each consultant will undertake the same working practice. A major step to achieve this has been the drawing up of common documentation throughout the company. Although there is a great deal of paperwork for the consultants to complete the issues raised give an indication of the quality standards that Instacare are promoting. Appendix V contains copies of many of these documents and their use is explained further in 2.10.

One of the services that Instacare sell to facilities is the computerised production of necessary records. This activity is centralised in Houston, Texas. I was most interested to see that the charts relate to all treatment and personal care as well as providing a record chart for the administration of medicines. Appendix V (ii) a, b, &c are examples of this type of documentation. This service is comprehensive but is not without problems. All input is by personell who have no knowledge of the facility or individual patients except the information supplied to them. The set-up depends totally upon the timely provision of accurate information.

When a patient is admitted to the nursing home a Physician's order is completed and signed. A copy of this is supplied to Instacare for production of the patient's overall care plan ((i) a). This document is a prime record of the patient's diagnosis, medication, diet and personal care. As each month's order is generated it must be signed by the physician who instituted the care. From this set of orders Instacare produces the recording charts already referred to and on which the nursing staff sign that care has been given. If the orders are altered or cancelled there must be a good communication link with Houston to ensure that the order available for signature is in fact relevant. Medication order changes are communicated using a triplicate form((i)b). The top copy is sent to the physician for signature; the second copy is sent to Instacare for dispensing of the item and alteration to computer orders; the third copy is retained in the patient's notes. It is the duty of the consultant pharmacist to ensure that verbal orders have been signed by the physician.

The visits of consultant pharmacist and physician do not normally coincide and Instacare are using a triplicate communication form ((iii) b) which has a pre-printed section for the physician's reply. A copy will stay with the patient's notes and the third copy is sent to the Administrator. The purpose of this is two-fold: to ensure that the Administrator is aware that the pharmacist is conducting the review as contracted and also to make the Administrator aware of potential problems.

The documentation of consultant activity is dealt with more comprehensively in 2.10. Instacare have adopted a style of data collection that results in the provision of absolute statements of activity e.g. % error rate in the administration of medicines, % deficiency in the provision of storage. The collection of data is itself time consuming.

Drug information is made available to the nursing homes on a regular basis through the newsletter 'MEDS' ((vi) c) and through special features e.g. 'Tips on Reducing Medication Errors' ((vi) a). The conference room will be used for educational sessions. The dissemination of information and the organisation of the educational events usually falls within the sphere of the marketing manager.

PLATE 2.

INSTACARE PHARMACY.

Storage Racks of pre-packed
Unit Dosage Blister Packs.

PLATE 3.

INSTACARE PHARMACY.

Traditionally packaged
O.T.C. Medicines.

2.1.2. HEALTHCARE NETWORK.

Healthcare Network is a subsidiary of Care Enterprises, a healthcare provider with activities in four states. The group owns 70 S.N.F. with more than 7,100 beds and has developed its own network of healthcare providers. This includes five healthcare pharmacies that undertake to service L.T.C.F. only, and do not deal with the general public. The pharmacies are of course able to offer services to nursing homes other than those in the Care Enterprises group

The pharmacies in the group are further complimented by Dieticians, particularly in relation to Enteral Feeding, and Nurse experts in Intra-Venous Therapy. Each pharmacy has an I.V. pharmacist and I.V. nurse specialist who work in close conjunction. The pharmacist is responsible for the preparation of all I.V. additives and T.P.N. The nurse specialist maintains a weekly audit of I.V. in the S.N.F. and provides in-service training to staff. This service is not available to facilities outwith the Care Enterprise Group.

I.V. therapy is used within S.N.F. to a greater extent than we are accustomed to in the U.K. particularly for the administration of antibiotics. It is normal practice for I.V. to be initiated in hospital, and when the patient is transfered to a L.T.C.F. is continued. T.P.N. is used for the continuing care of patients with carcinoma of the gastro-intestinal tract rather than post-operative nutrition. It is important that the consultant liases with other specialist services. I was priviledged to meet with representatives of all three disciplines and found the team approach refreshing.

The marketing of pharmaceutical services is at local pharmacy level and relates to both the supply function and to consulting services. They supply a Medication Cart similar to the Instacare model and dispense medicines in a similar modified unit dosage blister pack. In fact the practicalities of supplying a service is much the same as that described for Instacare. I visited the Culver City (Los Angeles) branch. Every facility receives a daily delivery of necessary re-fills and a second delivery if the pharmacy receives a request for new items. An Emergency Box system is operational. The hours of opening are somewhat different to those in the U.K. I left the branch at 8.30p.m. and the staff showed no signs of stopping work!

As with Instacare, there is a committment to training and active provision of drug information examples of which are also contained in Appendix VI ((viii) a,b). Their use of documentation has a slightly different emphasis and is designed more to give a generalised view of a situation rather than an absolute % figure as can be seen in relation to Evaluation of Staff Performance (ref. para.2.5.).

In total the Healthcare pharmacies serve 10,000 beds and employ 15 consultants although these are not all full-time. Each full-time consultant has a caseload of 1,000 to 1,200 beds and is expected to service 50 beds in one day. Facilities are charged for the consultancy on the basis of maximum bed occupancy allowing 6 hours per month for 50 beds.

Healthcare Network has appointed a pharmacist Director of Quality Assurance. Her influence spans the entire organisation in addition to the consultant pharmacist activities that she undertakes. The company's consultant pharmacists regularly meet with her and they corporately discuss such issues as documentation and current legislation. In this way quality standards are set and implemented.

Consultants are appraised by peer review using standardised forms. The individual job description states the expected standards of service in measurable terms and this is linked to the appraisal process. There is a shortage of pharmacists in California and recruitment is a problem. If there are not enough pharmacists, the remaining staff have to work harder! It is necessary for consultants to make careful plans for annual leave so that the work continues. As the law requires a visit every 30 days this must be acomplished or the facility will look elsewhere for its consultant. One consultant described the necessity to take two weeks leave strategically placed at the end of one month and the beginning of the next.

The Care Enterprises group is active in marketing and has produced very attractive individual glossy leaflets for each of it's services. They do not only feature the actual service but emphasise the supportive features of their programmes. As an example, the I.V. programme indicates benefits of staff certification, provision of up to date equipment, pharmacokinetic drug monitoring, specialist R.N. support, I.V. additive service, policy and procedure manual, third party insurance cover and the support of a clinical pharmacist (the consultant pharmacist).

The marketing feature is undoubtably quality. The consultants seek to enforce quality standards in the facilities. If a nursing home has established standards the consultant will reinforce them. If the standards are considered to be inadequate the consultant will introduce the policies that have been drawn up centrally by Healthcare Network. The claims made concerning policy and procedure manuals are

(i) Developed by an inter-disciplinary team
(ii) Systems oriented.
(iii) Written to provide quality assurance monitoring
(iv) Integrated with the educational programme
(v) Coordinated with the internal operations manual
(vi) Revised yearly.

and relate to medicines, oxygen, enteral feeding and I.V. Activity is measured against these standards and therefore there is a continuous monitoring of quality issues.

2.2. POLICY and PROCEDURE DEVELOPMENT.

The consultant pharmacist is part of the team which sets policy and procedures for the nursing home. The team must also include the Medical Director, Administrator and Director of Nursing.

The policy and procedure manual is an important tool which is used both for the instruction of new staff and as a standard by which work performance is judged. It is subject to periodic review. The layout for the policy and procedure manual may be represented as follows:

(i) Arrangements for Pharmaceutical Services.
- provider of services
- hours of service, after hours emergency telephone numbers.
- procedure to contact consultant regarding changes in prescriptions

(ii) Pharmaceutical Services committee.
- membership
- functions

(iii) Physicians orders for medication.
- verbal orders, written orders
- practical aspects of obtaining repeat orders.

(iv) Physicians orders to discontinue medication (stop orders).

(v) The supply of medicines.
- how this is achieved
- repeat supplies
- labelling of medicines.

(vi) Storage of medicines.

(vii) Administration of medicines and the records required.

(viii) Controlled drugs, storage and records.

(ix) Supply of Emergency drugs.

(x) Drug Regimen Review.

2.3. NURSING HOME COMMITTEES

All facilities that participate in Medicare and Medicaid programmes are required to set up committees to oversee all aspects of pharmaceutical services and it is essential that the consultant participates fully in these.

The Pharmacy and Therapeutics Committee sets the policy and procedure manual as outlined in 2.2. A futher important function for this group is to receive and act upon the quarterly report produced by the consultant pharmacist. An example of such a report is included in Appendix VI (vii).

In S.N.F. a further committee for Infection Control must also be convened. The pharmacist brings to this group his expertise in the best use of antibiotics and anti-infectives as well as knowledge concerning the effective use of disinfectants.

2.4. INSPECTION of STORAGE FACILITIES.

In America this is referred to as the Nursing Station Inspection. Regulations concerning storage are the same as those issued by N.A.H.A. in the U.K.

(i) All medicines must be stored in locked cupboards.
(ii) Access to medicines is resticted to authorised personell
(iii) Internal medicines to be stored seperately from external medicines.
(iv) Each patients medicines to be arranged seperately.
(v) A locked refrigerator required for medicines requiring refrigeration.
(vi) Seperate storage in double locked compartment for Controlled drugs.

A.S.C.P. suggest that this inspection should be conducted monthly though this is probably not the case. Certainly the inspection features in the quarterly report. The consultant pharmacist is responsible for ensuring that problems are corrected. The inspection will probably include a check of discontinued or Out of Date medicines which require destruction. It is anticipated that the Director of Nursing will give full cooperation and support to the consultant pharmacist. (Appendix III (iii) c, Medication Station Checklist).

2.5. EVALUATION of STAFF PERFORMANCE.

A great emphasis is placed upon evaluating whether medicines are given to patients correctly. Although the administration of medicines is a Nursing responsibility, pharmacists are concerned to ensure that each patient receives the correct drug in the correct dose at the correct time. This procedure involves observation of the nurse administering medicines which is a stressful activity for both the observer and the observed. The resultant evaluation is expressed by some as an absolute figure of error by observing the total medication round, and by others as a relative generalisation commenting on the nurse technique after observing administration to a few patients. I was concerned to learn that despite the high profile this is given, error rates are usually in the region of 10% and may be as high as 40%. This candidly means that on a regular basis nursing staff make an error in technique with one in every ten doses given. The type of criteria that are considered may include the following:

(i) Correct procedure.
(ii) Verification of medication.
(iii) Clean technique.
(iv) Identification of patient prior to administration.
(v) Nurse observes the patient swallow medication.
(vi) Nurse offers sufficient fluid with the medication.
(vii) Appropriate use of P.R.N. medicines.
(ix) Security of the drug trolley maintained during round.
(x) Documentation of dose administered and refusals.
(xi) Dose administered accurately.

This list is not comprehensive. Further examples are given in Appendix V & VI.

The resultant data is used as a management tool for training and would be made available to the Director of Nursing. It then becomes the responsibility of the D.N. to rectify any perceived problems relating to medicine administration.

Further evaluation of staff performance is referred to in para. 2.10., Drug Therapy Monitoring. Federal indicators recommend that monitoring is appropriate if a patient is receiving a particular drug e.g. monitoring of blood pressure in patients receiving antihypertensive drugs. It is the pharmacist's responsibility to ensure that nursing staff are indeed making the necessary observations.

2.6. DRUG DISTRIBUTION SYSTEM.

The law relating to supply of medicines is markedly different to the U.K. situation. Medicines are dispensed by verbal or written order from nursing staff without the original physician's order. The pharmacist must take the verbal order, check the computer order before dispensing and attach the label to the dispened item. The actual prescription can be checked on site by the consultant pharmacist.

Although there are still some pharmacists dispensing medicines in a traditional manner the trend in the U.S.A. is to provide modified unit dose systems. The two companies I visited supply such systems as a marketing feature for the Consultancy service. Of course the pharmacy consultant does not have a monopoly of the pharmaceutical supply due to the issues of patient choice as described in Section 1. However, if the consultant operates from a supply base it is very likely that the majority of patients will be supplied from his company.

The sytems are similarly designed and consist of blister packaged tablets/capsules presented on a card of between 28 and 32 dosage units. These are filled and heat sealed in the supplying pharmacy and a label attached to the top of the card. There are no markings of a) day of the week or b) time of day. This is simply a sophisticated pre-pack container, the contents of which can be conveniently and hygienically removed one at a time.

These 'cards' of medicines are stored within the Drug Cart as referred to in 2.1.1. The storage is comprised of a filing system within one of the drawers on the Cart. Cardboard dividers detailing the patient's name are placed to segregate each patients medicines (Appendix VI (ii)). There are different files relative to the administration round that a medicine is required for. The whole drug cart is moved from room to room and doses are given directly from the original 'container' which has all the relevant details of dosage included on the label.

The practical aspects of dispensing are made very easy using this type of system. Each card carries sufficient unit doses to provide for one dose daily for one month. If a patient is receiving a medicine three times daily, the pharmacist dispenses three cards and each of these is filed in the appropriate section of the drug cart relating to the dosage times.

In addition to the unit dose cards, the Cart is designed to accomodate traditionally dispensed containers i.e. bottles, in one of the narrow drawers. Large bottles of liquid medicines have a seperate section and there is also a double locked drawer in which Controlled Drugs are stored. This piece of equipment is the main storage item for medicines within the nursing home. A measure of the sucess of this type of distribution system was seen in the large number of exhibiting manufacturers at the A.S.C.P. Conference.

Prior to the introduction of modified unit dose systems into L.T.C.F. the traditional method of administration involved the preparation of medicines in pots which were then carried to each patient's room on a tray. Details of the drug(s) dosage and patients name were recorded on a card which was placed in a slot on the tray. The potential for error in this system is higher than with a unit dose system. It is probably still in use in some facilities though I did not see any.

2.7. EMERGENCY DRUGS.

I was surprised to learn that federal law requires that a patient shall receive prescribed medicine no later than 4 hours after that medicine is prescribed. To put this legislation in context I should add that nursing homes are often large distances from their supplying pharmacies. (In one case I know of, the distance is 150 miles). This poses a practical problem and the remedy has been to place a box of Emergency Supplies within the facilities.

These boxes carry a variety of medicines; oral and parenteral antibiotics, drugs to treat allergic reactions, respiratory spasms, cardiac arrest and Controlled Drugs. The box is sealed rather than locked. When the seal has been broken the entire kit is replaced. The consultant pharmacist is required to supply and monitor the use of emergency drugs and to check that all of the contents are within the expiry date on each visit.

Facilities do not pay for this service. The supplier normally reduces the physician's order by the number of doses removed from the emergency box. It is a vital service to the nursing home. Failure to administer a dose of prescribed medicine within the specified 4 hours would attract the state surveyors attention. Supplying pharmacies are sometimes driven to make sub-contracts with other pharmacists to ensure that emergency supply is covered.

I was concerned by the problems of drug abuse that this system seems to encourage. Loss of controlled drugs within facilities is a regular occurrence and particularly from the emergency box. When the box is received back in the pharmacy the record indicates what the box was opened for (Appendix VI (iii) a) Emergency Kit Log Record). It often happens that controlled substances are missing although not recorded as used for patients.

2.8. STAFF TRAINING.

The training of Nursing staff in the safe and effective handling of medicines is considered to be an integral part of the pharmaceutical service to the nursing home. The educational programmes are organised for varying purposes:

(i) The induction of new staff
(ii) The introduction of new legislation
(iii) An update on new drug therapies
(iv) Re-training where there is a deficiency in performance (ref. paragraph 2.5.)

The educational programme is part of the marketing strategy. While most training will be given on site there are occasions when corporate meetings are organised. The Instacare group have commisioned a conference room in their new San Antonio premises and hold regular meetings for Administrators and Directors of Nursing from the facilities they service. Such meetings attract sponsorship from pharmaceutical companies.

The American Society of Consultant Pharmacists has produced video recordings for training sessions on specific drug groups e.g. anti-convulsants.

2.9. DRUG INFORMATION.

The process of providing drug information can be described as pro-active or re-active. Pharmacy consultants are expected to undertake both. Information relating to new products is closely linked with the process of training dealt with in 2.8. but the consultant must be available to answer drug enquiries from medical, nursing and administrative staff at any time and not only when he is on the premises. This cover may be arranged through an 'on-call' system utilising the total pharmacist resource of a company rather than the specific consultant being constantly called. It should be apparrant that these requirements are substantial for the consultant working independently. The larger companies have invested considerable resource in the provision of drug information (see Appendix V (vi), & VI (viii). A monthly edition of a newsletter requires expertise and committment and this may not be available to the independent consultant.

2.10. DRUG REGIMEN REVIEW (D.R.R.).

The regulations for L.T.C.F. to participate in the Medicaid and Medicare programmes were ammended with effect from October 1990 to state the following:

> ' The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician or the director of nursing, or both, and these reports must be acted upon.'

The objectives of a drug regimen review are to ensure that therapy is

conducted properly and that drug-related problems are identified and either prevented or resolved. The review should correlate all the relevant medical information of diagnosis and laboratory test results and on the basis of this data make recommendations concerning drug therapy.

The process of monitoring should provide assurance in the following four categories:

(i) Medication is contributing to the patient's optimum quality of life - treatment, cure, re-habilitation.
(ii) Adverse drug reactions are prevented or reduced by avoiding duplication, drug interactions, contra-indications over-dosage or inadequate dosage, hypersensitivities.
(iii) Medications are reduced to the least number required.
(iv) Cost effective prescribing.

2.10.1. STAGE 1. EVALUATION of DRUG THERAPY.

The first stage of review is for the consultant to ensure that the medication ordered represents optimum therapy for the patient. Each medication order must be supported by an accurate written diagnosis or its need identified by a laboratory test. When a drug is ordered 'as required' it must have specific indications for use. A.S.C.P. have summarised this stage as ensuring the eight 'rights' of drug therapy

right drug
right patient
right time
right amount
right dosage form
right route of administration
right (desired) response
right record of administration

Access to patient's medical history and communication with other health care professionals is essential to determine whether the drug therapy is optimal for the individual.

2.10.2. STAGE 2. MONITORING the ADMINISTRATION of MEDICATION.

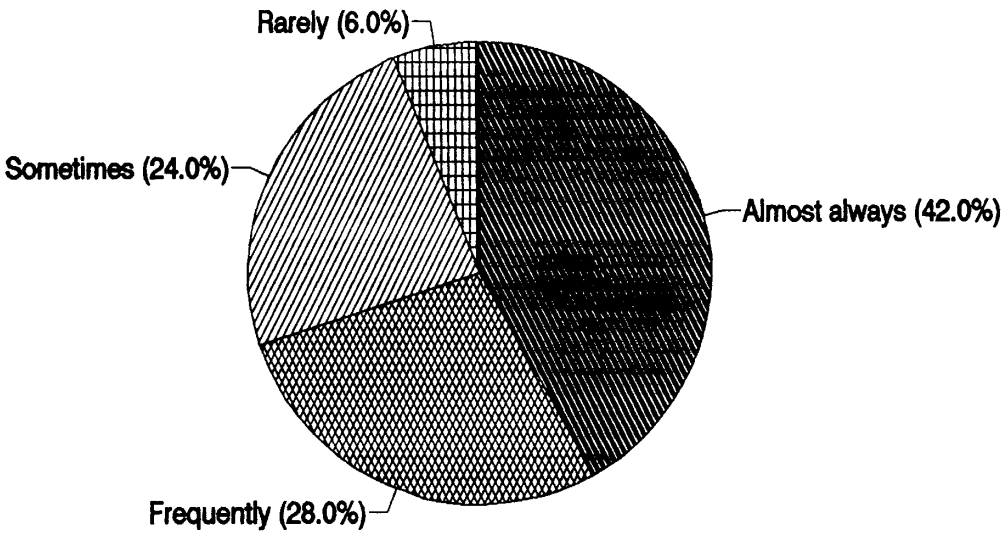
The second stage of review is to monitor whether or not the patient has received the medication as ordered by the physician. This includes inspection of the relevant record charts not only to see if nursing staff have administered the medication but to see if there are any reported refusals by the patient or contra-indications to the therapy on the basis of observations. Part of this stage involves the evaluation of nurse administering techniques as described in 2.5.

2.10.3. STAGE 3. EVALUATION of RESPONSE to DRUG THERAPY.

To arrive at an evaluation of drug therapy the consultant must review laboratory data and nurse assessment of the patient's physical condition and behaviour, with particular reference to side-effects or adverse drug reactions. A decision may be needed on the basis of risk/benefit for the individual patient. If a problem is identified the consultant must make a recommendation regarding the means to correct the problem.

DIAGRAM 2.

USA Prescriber Acceptance of Pharmacist Recommendations



2. 10. 4. STAGE 4. RECOMMENDATIONS.

Once a problem area is identified, the consultant must communicate the observations to the appropriate practitioner with definite recommendations for action. The process of communication is vitally important and must be conducted in such a manner that a positive outcome is achieved without any upset to inter-professional relationships. The consultant's responsibility goes even further than this to verify that a response to the recommendation, whether positive or negative, is received.

Of prime importance is the acceptance by prescribers of the recommendations made by pharmacist consultants. An A.S.C.P. survey shows that 70% of physicians almost always or frequently accept the advice given (Diagram 2, page 34). This would seem to indicate that the physicians and pharmacists agree the fundamental potential problems that warrant attention. The survey also produced information concerning the type of recommendation made and its relative frequency and this information is included in Diagram 3 (page 41).

In all aspects of D.R.R. the consultant must have the full support of the facilities' staff.

2. 10. 5. FEDERAL INDICATORS.

The federal indicators are guidelines which were developed by the Health Care Financing Administation (H.C.F.A.) to provide standardised measures of the effectiveness of D.R.R. The state department resposible for inspection has a pharmacist adviser but many of the surveys will be conducted by non-pharmacists and it was early recognised that such guidance was necessary. They do not constitute a set of rules which must be applied. Rather they indicate a level of activity which should be evident to the surveyor and when viewed overall give an indication of whether or not D.R.R. is being adequately performed.

The indicators are set out in 5 sections. Sections 1 - 4 deal mainly with measurable quantities in a practical sense. Section 5 is devoted to the clinical aspects of D.R.R. listing 33 categories of anticipated intervention in drug therapy. Pharmacists regard these as a minimum standard of clinical services and probably exceed them.

In some states the state requirement is in excess of the federal indicators, and in such cases the state requirements represent the standard.

Although the complete list of federal indicators is printed in Appendix VIII, I have included a brief summary here to emphasise the stringent requirements expected of physicians, nursing staff and consultant pharmacist.

A. Number of reviews compared with bed occupancy.
The number of reviews should mirror the average bed occupancy through the 6 months. A non-compliance finding would be expected if a 100 bed facility consistently provided only 50 D.R.R. per month.

B. Reviews performed within the facility.
The consultant pharmacist should undertake D.R.R. on site where all the necessary data is available. Off site reviews are considered to be a paper exercise.

C. Average prescription utilisation.
The national average number of prescriptions per patient per month is 6.1. If the average within the facility is significantly greater than this, it may be indicative that the D.R.R. is not being adequately performed. When making this assessment the surveyor must take into account the type of patient within the facility.

D. Excessive reviews on the same date.
As previously mentioned, the anticipated average time required to adequately perform D.R.R. is one day for 50 patients. If records indicate significantly more reviews on the same day this may be an indication that the D.R.R. is inadequate.

E. Apparent Irregularities.
These indicate potential drug therapy problems and are the basis for consultant recommendations to physicians and nursing staff. Although there are 33 'drug therapy circumstances' I have grouped them into 6 categories:
a) Un-necessary drugs or excessive dosage e.g. sedatives
b) Excessive duration of drug therapy e.g. antibiotics continued beyond the 'stop' order.
c) Inadequate drug monitoring e.g. anticoagulant therapy without monthly blood clotting test.
d) No documented diagnosis or clinical symptoms to support drug therapy e.g. digoxin used without an appropriate diagnosis.
e) Duplicate therapy e.g. 3 or more analgesics given concurrently
f) Anti-psychotic drug use (refer 2.10.6.)

Consultant pharmacists do not rely upon Federal Indicators but must ensure that the facility complies as far as possible with them.

2.10.6. O.B.R.A. REGULATIONS.

O.B.R.A. 1987 came into effect in October 1990. This piece of legislation has addressed sensitive issues relating to patient's rights and the resulting regulations could be described as a remarkable achievment in relation to drug therapy alone. The rights that are specifically stated include the right of the resident to be fully informed about his/her medical condition and total health status; the right to refuse treatment or participate in clinical research; and the right to self administer drugs if this is deemed appropriate by the physician .

Considerable emphasis is placed upon the provision of quality care with particular reference to the prevention of pressure sores; the provision of a nutritional diet; the use of enteral feeding only when it is unavoidable, and the use of catheterisation only when clinically necessary. However, the statement which relates to drug therapy represents a significant benefit for patients:

> **' The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.'**

Each patient admitted to a L.T.C.F. must now be comprehensively assessed for physical and mental ability and from this assessment a total health care plan is determined. The assessment must include diagnosis of medical conditions (Appendix IX). Before a patient may be prescribed an anti-psychotic drug, his/her medical condition must be diagnosed as within one of the 12 diagnostic groups for which these drugs are indicated. (The list of diagnoses can be found in Appendix X). If the patient's diagnosis is Organic Mental Symdrome it must be further substantiated by observation of behaviour.

There are patients already resident in L.T.C.F. who have been prescribed anti-psychotic drugs inappropriately. The regulations now require that the dosage is reduced until optimal benefit to the patient is achieved and if possible discontinued. The dose reduction must be carefully handled to minimise the effects of withdrawal which characterise these drugs.

In anticipation of these regulations some consultant pharmacists have already begun this activity. One such pharmacist in the San Francisco Bay area produced a poster at the A.S.C.P. conference to show the effects of implementing the regulations over an 18 month period. He detailed anti-psychotic drug usage in a number of facilities with total beds of 3,800. In March 1989 there were a total of 566 patients receiving anti-psychotic drugs i.e. 16.4%. By September 1990 the overall number of patients had decreased to 449 i.e. 11.7%. The results from 3 of the facilities involved are summarised in Table 5.

Table 5. COMPARISON of ANTI-PSYCHOTIC DRUG USAGE in THREE L.T.C.F. in the SAN FRANCISCO BAY AREA.

Facility.	No. of Beds.	Patients receiving Anti-psychotic drugs		
		March 1989	January 1990	September 1990
A.	37	11	7	5
B.	124	23	19	17
C.	48	9	6	2

2.11. DOCUMENTATION.

The use of documentation must address a number of issues: the primary documentation must be aimed at improving patient care by being patient oriented; it should honestly evaluate the performance of the consultant pharmacist by measuring actual achievement in patient care; it must provide a facility with the necessary administrative reports to indicate what level of service is being conducted; and finally it should provide a justification for the service as a whole. The documents that I saw in use fall into one of the following three categories:

2.11.1. NURSING HOME RECORDS.

As in the U.K. a record must be kept of all medicines administered (or not administered) to a patient and these records must be retained by the facility for the specified time according to state law. This is probably even more pertinent in the U.S.A. given the high proportion of legal cases brought against physicians. A description of these charts is included in 2.1.1.

In addition to the regular prescription charting there are at least two other charts in use for specific drug groups:

(i) Antibiotics.
The use of an antibiotic is time limited. A course is usually given for 5 to 7 days and it would not be practicable to ammend the computerised administration chart within this time scale. Thus, an extra chart is provided when the medicine is supplied (Appendix V (ii) c).

(ii) Controlled Drugs (C.D.)
In this case the additional chart is intended to enhance security by providing a continuous check of the remaining balance in addition to the record of administration.
In some instances, a chart is provided for staff to log that the balance of all C.D.s is correct at each duty changeover (Appendix V (ii) d).

In both cases the additional charting procedure raises the awareness of staff to be more vigilant in dealing with these medicines.

2.11.2. CONSULTANT PHARMACIST RECORDS.

All consultant pharmacist activities are fully documented, both to provide a summary of the work undertaken in the facility and as a measure of the effectiveness of the interventions made. It is a process of continuing quality control assessment to satisfy the State Surveyor's requirements and to monitor patient benefits.

Possibly the most important document to the consultant pharmacist is the Drug Assessment Form which is used to detail each patient's medication, diagnosis and clinical tests which indicate the necessity for the medication (Appendix V (iii) a). On admission the relevant data is logged on this form. At each subsequent D.R.R. the consultant ammends the form with details of laboratory tests, observations and indeed any alteration in

the drug therapy. The form also is used to record a summary of the recommendations made by the consultant pharmacist as a result of D.R.R. These forms are kept together in one file, seperate from each patient's file, within the facility as it must be available to the state surveyor. (Similar documents are being developed within the U.K. clinical pharmacy set up).

Effective communication of recommendations is an absolute necessity and may be directed either to nursing staff or physician depending on the nature of the irregularity. Most recommendations are made in writing to ensure that they eventually reach the appropriate practitioner. Both Instacare and Healthcare Network use self-carbonating notes. The original copy is sent to the appropriate practitioner and a carbon copy is retained with the patient's notes. When a response is received, and this may be part of the original communication slip, this is also filed in the patient's notes with the copy. It becomes immediately obvious at the next D.R.R. if a response has not been received. By differing means both companies ensure that the administrator is kept fully informed of all communications and their eventual outcomes.

More sophisticated documents are being compiled to ensure that the O.B.R.A. regulations are implemented as described in 2.10.6. Consultant pharmacists are maintaining seperate profiles for patients receiving psychotropic medicines particularly when their use does not fall into one of the 12 diagnostic groups and a reduction in dose is planned. These documents aim to correlate patient behaviour with dose, thus indicating if the dose should be further reduced, remain the same or be increased. (Examples are included in Appendix V and VI).

2.11.3. QUALITY ASSURANCE DOCUMENTATION.

Some of the documentation determines staff performance e.g. medication administration observation. It is not intended for disciplinary action but as a tool for training where a deficiency is noted.

Storage such as the Drug Cart and the Medication Station are subject to at least quarterly inspection by the pharmacist, and individual patient medication inventory at least monthly by nursing staff. The forms provide a standardised means of inspection and are designed to be completed as speedily as possible. They provide an enormous amount of detail to the facility.

Every quarter, the consultant pharmacist must make a formal report to the Pharmacy and Therapeutics Committee. This report is a summary of all the gathered information (APPENDIX VI (vii)).

I was almost bewildered by the volume of documentation and I do not intend to give a rationale for every form I collected during the visit. On the whole I felt that each of the documents had a designated purpose and was not merely data collection. In addition to quantifying the quality assurance of the service given by the consultant pharmacist, there are possibilities of stating measurable benefits both to individual patients and to L.T.C.F. If the recommendations of the pharmacist result in a reduction of the number of prescriptions per month, this can be expressed

as a dollar saving. Not only is the saving of benefit to the person responsible for paying the drug costs but there is a saving to the facility in the nurse time required to administer drugs. By stipulating an average time required for a nurse to administer one dosage unit, the overall time saving when x patients no longer require y dosage units per day can be converted into an annual saving of nurse time expressed in dollars. The documentation takes on a new perspective when it proves the financial worth of consultant pharmacist activity in the nursing home. The savings achieved by consultant pharmacists in 1987 are shown in Table 6.

Table 6. COST EFFECTIVENESS of DRUG REGIMEN REVIEW by PHARMACISTS.

		Financial Saving.
No. of prescriptions eliminated.	7,490,000	$ 81 million.
No. of hospitalisations prevented.	79,822	$224 million.
Nursing hours saved.	26,500,000	$154 million.

These figures were gathered during one year (1987) for 890,000 nursing home patients.

2.12. OUTCOMES MANAGEMENT.

The varying tasks described throughout this section indicate practical committment to the concept of Outcomes Management. I would therefore like to briefly consider quite what this entails.

The initial stage is for the care team to accept the need for managing outcomes i.e. to specify an achievable health care goal for each patient. There are subsequently three stages in the management of outcomes: Process, Structure and Outcome.

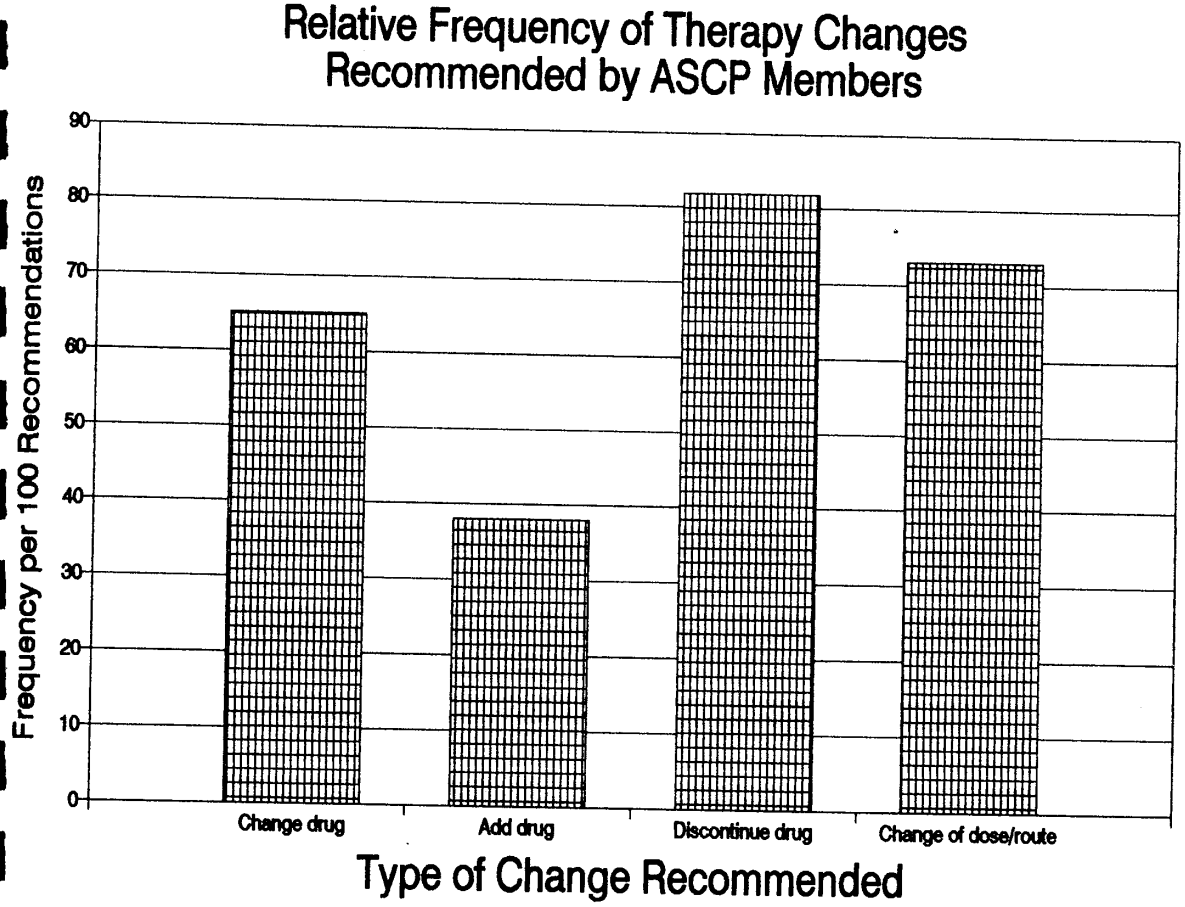
PROCESS is a statement of the work undertaken and details the activities of both carer and patient.

STRUCTURE is a statement of how this activity is carried out e.g. Policy and Procedure documents. To have a good structure requires the use of techniques and 'tools' such as drug formulary, drug utilisation review, discharge counselling of patients, nutritional support. The service must display characteristics of consistency both in terms of time and in relation to individual patients and must be independent of personality. The standard of practice must always be at or above the minimum standard.

The OUTCOME is the effect that the 'work' has upon the health status of the individual patient in terms of physiological and psychological behaviour. Positive patient outcomes may be:

(i) Cure the disease
(ii) Eliminate or reduce symptoms
(iii) Slow down a disease process
(iv) Prevent a disease.

DIAGRAM 3.


Relative Frequency of Therapy Changes Recommended by ASCP Members
Frequency per 100 Recommendations
90
80
70
60
50
40
30
20
10
0
Change drug
Add drug
Discontinue drug
Change of dose/route
Type of Change Recommended

Outcomes cannot be achieved without first establishing a good process and structure within the system but it is also necessary to recognise that the outcome may be death, disease, or disability. (Appendix XI A Paradigm for the Management of Patient Outcomes).

2.12.1. CLINICAL INTERVENTION.

Clinical intervention can been defined as the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. Irrespective of the branch of the profession that a pharmacist opperates within, his main functions are to IDENTIFY potential and actual drug related problems; to RESOLVE actual drug related problems; and to PREVENT potential drug related problems. I have included a list of potential problems:

(i) No prescribed drug for appropriate indication.
(ii) Wrong drug
(iii) Too little of the right drug.
(iv) Too much of the right drug.
(v) Non compliance.
(vi) Adverse drug reaction
(vii) Drug interaction.
(viii) No medically valid reason for patient to receive drug.

2.12.2. OUTCOMES MEASUREMENT.

The criteria that can be employed to measure outcomes may be considered in three categories:

(i) Functional status - the patient's physical and mental ability.
(ii) Health status - the patient's anatomical and biological status.
(iii) Quality of Life - symptoms, emotional status, sleep patterns, energy level, cognitive ability, social interaction.

The documentation relating to these issues must primarily be aimed at what improvement to patient care has been achieved. I was pleased to note that the attitude of consultant pharmacists was very much motivated to this end and the issues of quality care were more important than imposing federal standards.

Following on from this is the important process of evaluating the impact of the care being given. As far as the pharmacist is concerned this measurement may be a reduction in number of prescriptions for inappropriate drugs e.g. psychotropic drugs.

2.13. MARKETING.

Although I asked specific questions regarding marketing stategy I was pleasantly surprised by the relatively low emphasis it received. This may be because the U.S. way of life is so competivitive that my contacts did not consider marketing to be anything other than normal business sense. The session given to this subject at the Conference was poorly attended. The presentation was good and sought to remind pharmacists that marketing of

the 'product' needs special attention principally because pharmacists are seeking to market a Service Profession, not a Product Business!

2.13.1. COMMITMENT to THE COMPANY.

All the healthcare professionals that I met with were totally committed to the company they represented. I have phrased the remark deliberately for each consultant, executive director and individual worker acted as a representative of the company. The Director of Nursing in the Camlu Care Centre firmly believed that they were able to give excellent care and indeed were striving to be thought of as the best nursing home in Texas. They are achieving 95% bed occupancy without advertising but are prepared to give their time to prospective clients and relatives. Likewise, the consultant pharmacists expressed unsolicited praise for the systems introduced by their respective companies.

The company presentation is as important at the worker level as at the top. The attitude of the receptionist or dispensary technician who answers an enquiry can make or break the company's standing in a facility.

There is a lot of media advertising for health care but during my visit I did not see any that related either to consultant pharmacists or to nursing homes.

2.13.2. CLIENT NEEDS.

All marketing must be preceded by a sound knowledge of what service the client requires. In a sense, pharmacists are concerned with educating clients in what a good service comprises and what are it's benefits. Uppermost in the minds of Administrators and D.N.s is the federal requirement to engage the services of a pharmacist. I have highlighted the possibility of 'paper' consultants (and these undoubtably exist) who will undertake to provide D.R.R. without the supporting services I have described in this Section. It will probably be a much less expensive option in the short term and therefore attractive to the less scupulous health care provider. Consultant pharmacists who seek to provide the best service must emphasise the patient care benefits.

The general public expects to find in a pharmacist varying qualities: accuracy of dispensing; prompt service; reliability; relevant information about medicines; the application of professional knowledge and experience. In short a pharmacist must present himself as a person who can be trusted to give expert service. This is very much the image that consultant pharmacists wish to convey.

The setting up of companies totally devoted to supplying L.T.C.F. is in itself a marketing feature where they seek to address the whole needs of the facility from documentation to the specialist service of I.V. additives, both of which are designed to meet the needs of the nursing staff by improving accuracy and reducing the work load.

Healthcare Network's summary of marketing features are:

(i) Improving patient care
(ii) Systems which are easy to use and save time
(iii) Support to meet with the regulations.
(iv) Cost effectiveness.

2.13.3. MARKETING TECHNIQUE.

The marketing manager for Instacare has been a pharmacist within the parent company and has merely moved into another sphere of the profession. He spent time with me to explain how he introduces the service to prospective clients and came over as a comfortable person who believed completely in his company but more so in the profession of pharmacy and the contribution it is making to health care. This approach I found wholesome and utterly believable. There is no hard sell technique which might be associated with the U.S.A. and there is good after care to ensure that the company is delivering what has been promised.

Loss leaders are used such as the Medication Cart and Emergency Drug Box. Others are less obvious. The healthcare pharmacy I visited had subcontracted to a community pharmacist to supply emergency items to a facility that was a vast distance away. As Healthcare received a request it faxed a further request to the pharmacist in that locality for a supply to be made to cover 5 days until the next delivery. (Healthcare were then making two deliveries per week to this particular facility). The pharmacist was then reimbursed by Healthcare at a marginally higher level than Healthcare received from the facility. However, the importance to the company of retaining the consultancy contract prompted this relatively insignificant loss of earnings.

The marketing does not seem to be aimed at particular types of facilities. All establishments are targetted and this is now developing into fields where the law dose not require specialist pharmacist services to be available e.g. prisons.

I was aware of some vague references to other consultants working the 'patch'. These companies know their competitors weaknesses and strengths, and they do not underestimate them.

The companies that strive for high quality standards are becoming sucessful mainly because their systems are proving beneficial to patient care and to carer. They are proving that the consultant pharmacist is not only valuable but is in fact an indispensible member of the facility team.

SECTION 3. MARKETING PROFESSIONAL (PHARMACEUTICAL) SERVICES in U.K.

My identified objective when applying for this Travelling Fellowship was to test the feasibilty of marketing a professional service within the U.K. and particularly within the Norwich area. There are 33 private nursing homes/hospitals currently registered with the Norwich Health Authority which represents 1,053 beds. With the exception of one private hospital (74 beds) none of these establishments have pharmaceutical advice on a contracted basis and there is certainly no defined 'clinical' involvement.

Nursing homes are now an essential part of healthcare provision in the U.K. and it is estimated that the beds available amount to 26% of those provided by the N.H.S. for Acute services.

To understand more fully the marketing potential it is important to understand the current situation regarding pharmaceutical services with particular reference to private nursing homes.

3.1. PRIVATE NURSING HOMES in the U.K..

A Nursing Home is defined in the 1984 Registered Homes Act as an establishment that offers 24 hour nursing care. Nursing homes must be registered with the Health Authority (H.A.) in whose district the nursing home is located, and before a nursing home can operate it must be subject to inspection by H.A. officers including a pharmacist. It is the duty of each H.A. to set the level of participation and most authorities adopt the standards recommended by N.A.H.A. Inspections are required twice annually though the recommendation regarding pharmaceutical inspection is quarterly.

3.1.1. PHARMACEUTICAL INSPECTION.

The basis of Guidance regarding medicines is contained in Guidelines supplied to the nursing home when registration is requested. All pharmaceutical inspections of the nursing home monitor the implementation of the guidance given. The Guidelines in use within Norwich Health Authority are included in Appendix XIII. Although the inspection of records includes patient's individual medication charts, time would not permit this to become a therapy monitoring exercise and indeed it could be perceived as unwarranted interference. The role of the inspecting officer is to ensure that systems exist, and are operational, that will ensure each patient receives the medication that has been prescribed in the correct dose and at the correct time. During my discussions with consultant pharmacists in U.S.A. I was constantly referred to as an equivalent of the State Surveyor and this is true to a degree.

3.1.2. SUPPLY of MEDICINES.

Although patients in nursing homes are technically speaking in the 'private sector' nearly all of them receive a supply of medicines through the National Health Service i.e. their prescriptions (F.P.10) are written by General Practitioners and dispensed as though the patients were living in the community. Of those patients receiving medicines by this means, very few if any are subject to prescription charges. Some medicine costs may be

incurred by the nursing home if 'household remedies' such as cough remedies are purchased.

If a patient receives completely 'private' treatment, he/she will become liable for the cost of medicines. Most private care is offered through insurance cover but there are some occasions when a patient obtains medicines with a private prescription and this must be paid for by the patient. In the few instances when the establishment retains its own 'in-house' pharmacy the supply of medicines is from a central stock and a charge is made to the individual patient's account.

3.2. CONTRACTS for PROFESSIONAL PHARMACEUTICAL ADVICE.

In November 1989 the professional advisory role of community pharmacists was recognised and there were two new contracts available with F.H.S.A., namely the provision of pharmaceutical advice to private residential homes and the maintainance of patient's medication records in pharmacies. The most pertinent for consideration in this report is the former.

3.2.1. RESIDENTIAL CARE ESTABLISHMENTS.

At present, a residential home must also be registered but with the Local Authority and not the Health Authority. Inspection is conducted annually by local authority officers who gain advice in professional matters from the appropriate health authority officers. My own experience has been to contribute to the drawing up of Guidelines but not to participate in the inspection process though from time to time I may be called in to a problem area.

3.2.2. NATURE OF THE CONTRACT.

The impetus for this contracted service rests with the pharmacist who is required to approach the owner/manager of a residential home with a request to offer professional advice in addition to the supply service. If the owner/manager agrees and if the pharmacist has undertaken the Royal Pharmaceutical Society's 'learning package', application may be made to the local F.H.S.A. for the contract to be implemented.

At the present time there are no nationally accepted quality standards for this contract. Individual F.H.S.A. set the criteria and monitor the compliance. There are three differing payments: initial visit payment of £50.00; thereafter an annual fee of £200.00 for residences up to 20 beds, and £350.00 for residences larger than 20 beds. At this level of payment very little time can be devoted to individual residences and drug therapy monitoring is unlikely to be carried out on a regular basis. I have roughly estimated that funded time is 40% of that spent per patient in U.S.A. (for a 40 bed residence). Because the funding is flat rated, the larger the establishment, the less time is available per resident and many residential homes are now much larger than 20 beds.

The contract is usually granted to the supplying pharmacist and there is little or no differentiation between the roles of supply and advice.

Consequently the ethical problem also arises in the U.K. that a reduction in prescribing per patient adversely affects business.

3.2.3. EXCEPTIONS to the CONTRACT.

This contract does NOT extend to private nursing homes. I am sure that many nursing homes receive a similar service to that contracted by residential homes although the pharmacist concerned receives no central remuneration. It is certainly a fact that a number of the nursing homes in Norwich Health District are supplied by Dispensing Doctor practices and therefore receive no intervention by a pharmacist other than the inspecting pharmacist from the Health Authority.

Residential establishments do not have to accept professional advice from a pharmacist. This does not mean they are unwilling to accept advice but the point I wish to convey is that the advisory role is not mandatory, nor does the pharmacist have any right to enforce changes in practice. The contract therefore becomes curiously less effective than it might be, because of the funding arrangement to provide it, the limited scope that is possible, and the fact that such activity does not have a basis in law.

3.3. CLINICAL PHARMACY SERVICES within the COMMUNITY.

It is within the scope of all pharmacists to expand their areas of professional activity irrespective of their current position. I am particularly concerned to explore the model of providing a service of professional activity from a H.A. background but this in no way seeks to exclude pharmacists in community pharmacy, industry or academia.

Clinical pharmacy services are developing within the managed service and indeed are considered to be the most effective way forward for hospital pharmaceutical services. The East Anglian Region has for some years provided training in a Clinical Pharmacy Diploma as have most other regions. Consequently a group of clinically experienced pharmacists is growing within the hospital structure and as yet this is not repeated to the same degree by pharmacists in other sectors of the profession. With expertise to hand the H.A. based pharmacists have a stong starting position for the type of professional service that I feel ought to be available to the community.

I would be foolish to think that the marketing of professional services could proceed without problems. Prior to my visit I gave consideration to identified weak spots in the proposed service. I deliberately sought out comparable situations in the U.S.A. to identify how they had been resolved and, to my amazement, did find appropriate models for most of the problem areas.

3.3.1. RELATIONSHIP of CONSULTANT to SUPPLIER.

At the outset I perceived it to be a major drawback that I was purporting to give advice without making the supply. I have indicated that the supply of medicines to facilities in the U.S.A. does not come from one source so that even if a 'supplier' also gives advice there sre still other suppliers to the facility.

All consultants I spoke with made contact with other supplying pharmacists and if problems were encountered with supply or legal matters would raise the issue as appropriate. This did not assure remedial action but the consultant is required by the facility to act on behalf of the patient in all matters concerning medicines.

I have come to the opinion that the patient interest is best served by a system that seperates the role of supplier and advisor either by the use of two agencies or by the supplier employing a pharmacist dedicated only to the role of advice.

I referred in 3.2.2. to the current contract with residential homes. This contract is granted to the supplying pharmacist. In the course of some contracts being granted, pharmacists are losing their supply function to other pharmacist suppliers and there is currently much debate in our profession. In marketing any professional service it will be necessary to emphasise that the employment of an agency consultant will not affect the supply function but rather work in conjunction with it. With careful negotiation, the introduction of agency consultancy should not prove to be unacceptable or threatening either to community pharmacists or dispensing practices. This does not represent a weakspot so much as a sensitive area which should neither be underestimated nor overplayed.

The U.K. set up is in a better position than the U.S.A. due to the existence of Regional Pharmaceutical Advisors who advise F.H.S.A. on necessary pharmaceutical standards, and District Pharmaceutical Officers who at local level are the liason link between the managed pharmacy service and community pharmacy.

3.3.2 NURSING HOME LOCATION.

The second perceived weakness was the distance of nursing homes from the H.A. base. Time taken in travelling to nursing homes accounts for a good proportion of the time involved in inspections and there are benefits when the pharmaceutical advice is literally on the doorstep.

Distance does not feature as a problem in the U.S.A. While for most travel is easy using the Interstate system this is not always the case. Travel to any destination in Los Angeles takes considerable time due to the volume of traffic. Healthcare Pharmacies are not deterred in providing supply and consultancy to nursing homes as far away as 150 miles and the same is true of Instacare in Texas (although the driving admittedly was easier). What they are careful to ensure is that there is sufficient back-up to the nursing home by being available at any time to answer enquiries relating to medicines.

The most distant nursing home within Norwich Health Authority is within one hour's travel by car and would therefore seem to be less of a problem than I had first imagined but any scheme must assure availability of pharmaceutical advice when it is needed.

Closely related to this is the concept of time management and this aspect is closely monitored by both Instacare and Healthcare Network.

3.3.3. ACCEPTANCE by MEDICAL PRACTITIONERS.

The sucessful provision of clinical pharmacy services depends largely upon medical practitioner acceptance of the service. In the U.K. medical practitioners are granted independent clinical judgement without legal restriction and any intervention by a pharmacist to recommend a change in therapy must be with the cooperation of the prescriber. The A.S.C.P. data indicates good acceptance by prescribers when therapy changes are recommended (Diagram 2, page 34). A.S.C.P. have researched factors which influence prescriber acceptance of pharmacist recommendations and these are shown in Table 7.

Table 7. Factors affecting Physician's Evaluation of Pharmacist's Advice.

1 - 6 Point Scale: 0 = not important; 6 = extremely important	
1. Significance of Therapy recommendation.	5.2.
2. Communication method used by Pharmacist.	3.9.
3. Pharmacist's reputation.	3.05.
4. Agreement of Facility Staff with recommendation.	2.6.

In those areas where clinical pharmacy has been introduced in U.K. hospitals there has also been a good response by medical staff.

Good inter-professional working relationships take time to develop and a premature movement into the field of Drug Therapy Monitoring without prior discussion with the relevant practitioners could jeopardise the scheme.

3.3.4. LEGAL REQUIREMENTS.

Probably the most significant weak spot that I could identify was the fact that the law does not stipulate that drug therapy should be regularly reviewed. Achieving acceptence of professional services across the board may be difficult to achieve..

I was constantly reminded by what I heard in U.S.A. that so much of our health care practice is dependent upon 'gentlemens' agreement'. The emphasis in America is upon federal or state law. The clinical freedom already referred to is now coming under close scrutiny in the managed service as we move towards clinical audit, the aim being to reduce expenditure. Probably the largest individual budget a health authority has (excepting staff costs) is for drugs. The introduction at local level of Formulary management is indicative of the changes in attitude and this type of enterprise is reaching the individual practitioner as the era of 'indicative budgets' approaches. It would seem that clinical freedom is almost a past relic or soon will be!

I would suggest that the time is fast approaching when the issues of drug therapy monitoring by qualified pharmacists for patients in private nursing

homes/hospitals, and residents in residential care must be addressed. Recently a question was posed to the Minister for Health in the House of Commons regarding the prescribing of anti-psychotic drugs for residents in private care to ease the burden on overworked staff. I have no proof that such drugs are used generally for 'discipline or convenience' in the private sector but I very much regret that in some instances they probably are. Legislation similar to the O.B.R.A. regulations is as appropriate in the U.K. as in the U.S.A. However it cannot be effectively introduced until the law also requires that all patients/residents have regular drug therapy monitoring.

3.3.5. FUNDING.

Unless Drug therapy monitoring is made mandatory, the issue of funding remains the greatest hurdle of all. How can we obtain the funding for the provision of professional service to an establishment which is not required, either by law or by local registration authority, to purchase the service? This is the one issue that I was unable to find a similar model for.

Expectations of the N.H.S. have become so great that it can no longer fulfil everything that is medically possible. There simply is not sufficient resource. Criticism features prominently in the media relating to high expenditure drugs or technology, and yet it fails to recognise the overwhelming benefits to society that are a daily achievement of the N.H.S. Because the service has appeared to be 'free' it is not always appreciated and in some cases is in danger of being abused. I am not suggesting that the N.H.S. should not be available and free to all but I am suggesting that central funding for all aspects of the N.H.S. may be unhealthy.

A nursing home does not have to pay for patient's medicines since they are supplied by the N.H.S. and hence there is no financial incentive for the nursing home owners to reduce the number of prescriptions per patient. A residential home does not have to pay for pharmaceutical advice because contracted pharmacists are paid from central funds. Again there is no incentive to obtain through the contract a defined standard of service. It is possibly more worrying that although good advice may be offered, there is no responsibility on the part of the owner to act upon the advice.

The aspects of daily life that we each pay for are treated with respect in proportion to the cost! In a similar vein, if individual residences and private nursing homes were resposible for funding pharmaceutical 'advice' the service would probably move into a new dimension.

3.3.6. STAFFING.

The pharmaceutical profession has been faced for a long time with the problem of insufficient practising pharmacists. Partly this is due to the relatively high proportion of female graduates but has been exaserbated by the closure of two schools of pharmacy. A shortfall in the number of pharmacists is not a phenomenon peculiar to the U.K. I have previously been made aware of recruitment difficulties both in Western U.S.A. and in Ontario, Canada.

Added to this scenario is the fact that pharmaceutical staff allocation in the East Anglian Region has been historically low. In Norwich Health District there is no room within current establishment for the clinical service I am postulating to be accommodated. Future developments will require pharmacist resource and whether or not such positions are filled will depend on what potential candidates wish to gain from the experience.

The speciality of Community Service Pharmacists (C.S.P.) is relatively new and hitherto has concentrated on the establishment of good supply lines and policy and procedure development for H.A. activities which are community based. The philosophy of this work differs markedly from the high technological approach of pharmacists in the 'acute' setting and not every pharmacist can relate well to the community situation. Recruitment of suitably qualified, community oriented pharmacists may prove challenging. The Instacare Pharmacy Services in Texas found to their cost that the wrong type of pharmacist can cause problems for the company even though in professional terms the pharmacist is very capable. The role of the consultant demands good communication skills at a level that is understood by both professional and layman.

Before attempting to market any service its continuity must be guaranteed. The American system has taught me that the independent consultant can commit him/herself to an excess of work if not careful. It is important to build safeguards into any plans to cover unexpected crises.

This is certainly an area of activity which would lend itself well to either job-share or part-time work. It should not be regarded as an extension of the current district committment but developed as a seperate entity.

3.4. MARKETING the IDEAL.

Healthcare professionals in the U.K. are not noted for their marketing skills and it is a subject which we will have to address sooner rather than later if we are to become an effective part of the N.H.S. market place. Our services have been provided as a matter of course and little importance has been placed upon quality standards until very recently. I found the A.S.C.P. Conference session on strategic planning to be most helpful yet must admit that most of the logic has not been applied hitherto in providing pharmaceutical services.

3.4.1. PLANNING.

Planning is the essential first stage and should involve consideration of potential customers, existing staff and the competition. Any business must provide a 'product' that is superior to the competition and this is equally true when marketing a 'service'.

The plan must include an accurate assessment of what the current position is and how this can be refined. It will probably state the following:

(i) Strengths and weaknesses.
(ii) The competitive position
(iii) External factors which may have to be considered e.g. legislation.
(iv) What does the customer like and not like.
(v) By consideration of (i) to (iv), what are the options.
(vi) What training is available
(vii) Collect relevant data.

3.4.2. POTENTIAL CUSTOMERS.

Although a major feature of planning is to find out what a customer wants, there is a different emphasis when a new 'product' is marketed. In this case the plan must include ways to convince potential customers of their need and this project seems to be more directed at what the customer really needs but as yet is unaware of. The only way to convince someone that a particular service should be commisioned and paid for is to prove beyond doubt the benefits of the service as it affects the person responsible for payment.

I have earmarked private nursing homes as potential customers of professional pharmaceutical services but must admit that the potential market is as great in this country as in the U.S.A. Many Hospices are independent of the managed health care system; pharmaceutical provision within the prison service is currently under review; some charitable residences are exempt from registration with either health authority or local authority and residential care provision is not yet adequately provided for. All of these present possibilities for the future. I have come to understand that although the establishment is given a particiular title depending on the level of care, the actual residents/patients are not so different in terms of drug therapy.

3.4.3. FURTHER RESEARCH.

In the U.S.A. the benefits to patient care and the financial savings which result from an active intervention system involving the consultant pharmacist are now well understood both by the federal authorities and by individual facilities. It simply cannot be assumed that all the research undertaken by consulant pharmacists in the U.S.A. is automatically relevant to the U.K. A series of studies will be necessary to establish the current status of prescribing within the nursing home sector.

The following studies are proposed as essential precurpsors:

A. Average number of prescriptions per patient within a particular setting e.g. private nursing homes. A number that is higher than the average American norm of 6 may indicate that drug therapy monitoring may be beneficial.

B. Prescribing patterns in the establishment e.g. number of prescriptions for analgesics, psychotropics; whether dosage is regular or when required.

C. Identification of potential drug interactions and their relevant risk.

D. Number of admissions to hospital from nursing homes and particularly if these are drug induced.

Once this information is available, it will pave the way for a possible pilot study in a nursing home to gauge if clinical pharmacy intervention produces similar results to those found in the U.S.A. I do not intend to speculate on the results of future research in this project.

3.5. MODEL for a PROFESSIONAL CLINICAL SERVICE.

If assumptions are made concerning the probable benefits of a clinical service to the private sector and the availability of funding, it is possible to project a model for the marketing of the services I have described in this document.

3.5.1. CONTENT of CONTRACT.

The basic outline of the contract will include:

A. Drug Therapy Monitoring.

This will be characterised by the following items:
a) Undertaken on a regular basis once every calender month.
b) A comittment to communicate with prescriber, supplier and nursing staff as appropriate.
c) Maintainance of records relating to Drug Therapy Monitoring, Recommendations subsequently made and the Outcomes.

B. Participation in the drawing up of Policy and Procedure Documents.

These will be the individual establishment's policies to complement the requirements of the appropriate registration authority.

C. Staff Training Programme.

This to include update in drug therapy and legislation and should comprise at least two sessions per annum.

D. Observation of the Administration of Medicines by nursing staff.

This to be undertaken regularly and at least twice annually.

E. Report to the Nursing Home Quarterly.

3.5.2. LENGTH of CONTRACT.

The contract should be negotiated for a term of ONE year and re-negotiated on an annual basis. Quality standards of service should be incorporated and consultancy terms based on performance.

3.5.3. STAFF.

Taking into consideration the activity proposed, an experienced pharmacist of Grade D level or above is the minimum requirement. The cost of the service should be based on the mid point of scale for this grade of pharmacist PLUS 25% to cover overheads.

The time allotted to each establishment will be dependent upon the number of beds and will be calculated on the basis of 50 beds requiring 6 hours pharmacist time per month to cover all aspects of the contract.

The recruitment of staff will depend upon the number of contracts that can be established. The Health Authority may consider it beneficial to support the scheme as a potential 'income generator' by funding a pharmacist post in advance of contracts being awarded. Any such decisions will depend on documentary evidence concerning the benefits to the District. Hence, the collation of data concerning the admission rate from the private sector is of major importance.

3.5.4. MONITORING the CONTRACT.

Ultimately, the decision concerning the monitoring aspects will depend on the arrangements for funding. The District Pharmaceutical Officer will have an important role in the future setting of pharmaceutical standards within the managed service and as such may be well placed to ensure that any services marketed from the managed service conform to acceptable standards.

SECTION 4. CONCLUSIONS.

4.1. CONSULTANT PHARMACISTS.

The opportunity to observe consultant pharmacists in America has left me with a feeling of frustration. The practice of clinical pharmacy within the U.K. is roughly speaking 20 years behind. I am encouraged, however, to learn that a simiilar situation applied in the U.S.A. at the time when A.S.C.P. was founded 21 years ago. I believe that it will be possible to develop clinical pharmacy practice in this country generally, and particularly in the community set-up of private enterprise. Such development will require much determination from those pharmacists whose concern is focused upon issues of patient care benefits in long term care establishments, whether these are nursing homes or residential care homes.

A principal fore-runner of this activity is training in aspects of clinical activity. This has been recognised by pharmacists in the hospital sector of the profession. If community pharmacists are to further develop their professional role they must similarly become prepared. The clinical role should not become a feature to expand the supply function but develop in its own right as a service to individual patients.

4.2. RESEARCH.

To embark upon the marketing of professional pharmaceutical services within the U.K. at present would not be particularly sucessful, mainly because there is as yet no evidence to suggest the benefits that may be anticipated, no requirement by registration authorities and no legal requirement. Although nursing homes may be pleased to accept the offer of services there is no guarantee of financial security.

There are no shortcuts to success. The American conclusions are a useful guide but the data must be collected within the U.K. situation to be meaningful. This project is merely a springboard to the elements of research outlined in 3.4.3., namely to catalogue the current prescribing of medicines in private establishments and from this to identify whether a need for pharmaceutical intervention exists. The author wishes to pursue such a course at the earliest opportunity

4.3. LEGISLATION.

Many nursing homes patients and residents in residential care homes are supported by D.H.S.S. funding. All attempts to reduce costs for healthcare directly affects the N.H.S. and should be a matter of concern to government. Of equal importance are the issues of patient care and the right of each patient/resident to be provided with the optimum care available. It is important that the results of any research conducted and any documented evidence are lodged with legislating authorities.

I am convinced that the Review of Drug Therapy on a regular basis, by a pharmacist, for each patient/resident of long term care/accomodation, regardless of whether this is within the managed service or the private sector, should become mandatory.

4.4. MARKETING.

It is important to spread the word to a wider audience than the legislators and every effort should be made to raise the awareness within the private sector. Emphasis upon Quality of Life for the patient/resident should feature prominently but the possibility of savings in nurse/carer time will probably attract more attention and should not be ignored. However, since registration authorities insist upon certain staffing levels, I feel it is better to stress the additional tasks that would be possible rather than a financial saving.

4.5. SERVICE PROVIDERS.

There is a distinct need for any pharmacists providing a consultancy to private nursing homes to be distinct from the health authority inspectorate i.e. pharmacists undertaking the role of Inspection must not also act as Consultants. This does not exclude other health authority pharmacists since the role of inspection is undertaken only by specified officers. The role of the consultant should provide the establishment with advice in maintaining a standard of care that is expected by the registration authority rather than compromising the standard.

I now strongly support the seperation of supply and advisory roles in the best interests of patient care, and therefore conclude that clinical services provided from the managed service are feasible.

To emphasise the high level of professional expertise that would be necessary to fulfil the Contract as outlined in 3.5., pharmacists employed for clinical services to private nursing homes should be at least Grade D, and contracts should be costed accordingly. The question of funding remains unanswered.

4.6. EXTENT of PROFESSIONAL SERVICES.

It would benefit individual residents if the provision of professional services were extended beyond the apparrant limitations of the current Contract available to Residential Homes. Contracts should not be undertaken merely to supervise the supply of medicines but rather should relate to Patient Outcomes. Any future schemes should concentrate upon the Monitoring of Drug Therapy on a regular standardised basis with documentation to assure quality standards. .

Although consultant pharmacists would be expected to assist in the drawing up of individual establishment medicine policy documents, these must be within the context of the relevant registration requirements.

Based on the evidence I gathered while visiting the U.S.A., I am confident that it would be beneficial to patient care to market a similar service of professional pharmaceutical advice to the private sector in the U.K., and that it should be the right of all patients/residents in long term care to receive professional pharmaceutical services.

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APPENDICES.

APPENDIX 1.

ITINERARY.

November 1990.

11th		Fly to San Antonio, Texas.
12th	a.m.	Instacare Pharmacy Services. Interview with Store Manager, Senior consultant pharmacist and tour of the premises.
	p.m.	Visit to Camlu Care Centre with Instacare pharmacists. Return to Instacare for interview with marketing manager.
13th		Instacare Pharmacy Services. Further interview with senior consultant pharmacist.

A.S.C.P. CONFERENCE (San Antonio, Texas).

14th	a.m.	Registration
	p.m. 1.	General Session: 'Riverwalk to the Future' Jack H. Llewellyn, Ph.D
	2.	Conference Exhibition.
	3.	Evening reception.
15th	a.m. 1.	Networking Track: 'Focus on Consulting Only' Charlotte L. Luther, R.Ph.
	2.	Management Track: 'Stragegic Planning for Your Business' Thoedore Cohn, Management consultant.
	3.	Management track: 'Assessing the Quality of Long Term Care Pharmacy Services' Susan K. Steinberg, M.S., F.A.S.C.P.
	4.	Networking Track: Poster Session, 1 - 12 (Appendix XII)
	5.	Networking Track: 'Marketing Your Services to Jails and Prisons'.. Edward M. Steres.
	6.	Networking Track: 'I.C.F./M.P.: Practical Aspects' Robert L. Snively, R.Ph., F.A.S.C.P.
16th	a.m. 1.	Networking Track: Poster Session 13 - 27 (Appendix XII).
	2.	General session: 'Update on New Regulations' Samuel W. Kidder, Pharm.D. (H.C.F.A.)

APPENDIX I. ITINERARY (continued).

17th.	a.m.	1. General Session: 'Outcomes Management: An Introduction' Linda M. Strand, Pharm.D., Ph.D. 2. Management Track: 'Documenting Outcomes' Kathleen M. Bungay, Pharm.D. 3. Clinical Track: 'Alternative Treatments for Disruptive Behaviour' Donna rane-Szostak, Ed.D.
	p.m.	1. Management Track: 'Marketing Professionalism' William N. Tindall, Ph.D. 2. Evening reception
18th	a.m.	Conference breakfast Roger Staubach.
	p.m.	Fly to Los Angeles (California).
19th		Healthcare Network. Interviews with the Director of Quality Control, Director of I.V. Nurses and Vice President of Marketing and Development.
20th	a.m.	Unihealth American Interview with Dr. Andre Van Niekerk
	p.m.	Healthcare Network Meeting of Consultant Pharmacists
21st	a.m.	Blue Cross of California Interviews with Director of Pharmacy and vision and the Manager for Special Projects'.
	p.m.	Healthcare Network Visit to Culver City Pharmacy including interview with store manager (formerly a consultant pharmacist).
22nd - 24th		Rest days.
25th		Return to Norwich.

APPENDIX II.

QUESTIONAIRE.

Part 1. STRUCTURE of the ORGANISATION.

1.1. Describe your organisation in general terms with particular reference to its position within the overall system of health care available in U.S.A.
1.2. Would you describe your organisation's relationship to pharmaceutical services as 'purchaser' or 'provider'.

Part 2. PURCHASERS of PHARMACEUTICAL SERVICES.

2.1. Purchased for whom...
2.2. Purchased from which agency (i) hospital, (ii) community pharmacy, (iii) other.
2.3. What services do you require.
2.4. Is the service subject to financial constraint
2.5. What quality of service do you impose and how is the service monitored
2.6. What benefits do you expect from a professional pharmaceutical service.

Part 3. PROVIDERS of PROFESSIONAL SERVICES.

3.1. What services do you supply
3.2. What are the freedoms allowed, and constraints imposed by purchasers.
3.3. What influence do you have upon standards within the nursing home.
3.4. How do you market your professionalism.
3.5. Are you subject to Quality Audit.
3.6. Are you able to recruit staff.

Part 4. Details of Service.

4.1. Frequency of visits.
4.2. Do you supply medicines to the nursing home and if not how does the consultant pharmacist relate to the supplier.
4.3. What records do you keep.
4.4. Do you participate in policy making.
4.5. Do you monitor drug therapy.
4.6. Are interventions made; who is informed; what are the benefits, outcomes.
4.7. Do you undertake training programmes.

Part 5. CLIENT GROUPS.

5.1. What is the age and social status of clients.
5.2. Is treatment restricted to specific illness groups.

Part 6. OVERALL COMMENTS.

APPENDIX III.

A.S.C.P's CODE of ETHICS.

The Code of Ethics of the American Society of Consultant Pharmacists is promulgated to set forth and espouse those high principles of professional conduct and behaviour to which consultant pharmacists shall be expected to conform in the pursuit of their professional practice and their inter-relationships with fellow pharmacy practitioners, other health practitioners, patients and the public.

ARTICLE I.

The consultant pharmacist shall provide a high quality of pharmaceutical care and service which not only meets the minimum standards of existing law and regulation, but surpasses them.

ARTICLE II.

The consultant pharmacist's primary goal and objective shall be the health and safety of the patient, in whose behalf every effort shall be exerted to assure the maximum level of safety and efficacy in the provision of pharmaceutical services.

ARTICLE III.

The consultant pharmacist shall pursue the practice of pharmacy in an ethical manner, and in such a way as to reflect credit on the speciality of consultant pharmacy; and shall be obligated to expose any illegal or unethical conduct or practice among his peers of which he may have knowledge.

ARTICLE IV.

The consultant pharmacist shall agree to practice pharmacy under the terms and conditions which clearly provide for the proper exercise of professional judgement and skill, and which do not tend in any manner whatsoever to subvert the quality of professional services or the ethical conduct of the practice of pharmacy.

ARTICLE V.

The consultant pharmacist shall determine that only those drugs, drug products or medical devices which meet standards of quality required by law and by sound and responsible professional judgement, and which are determined to have therapeutic value for the patient, are dispensed and distributed.

ARTICLE VI.

The consultant pharmacist shall respect the confidentiality of all clinical records, professional notes, memoranda, reports and other records relating to any patient's medical condition or medication therapy; and shall in no case disclose such information without proper legal authorisation.

APPENDIX III cont.

ARTICLE VII.

The consultant pharmacist shall not condone or participate in any transaction with any practitioner of another health profession or any other person whatsoever under which fees are divided, or rebates or kickbacks pais or caused to be paid, or which may result in financial exploitation of patients or their families in connection with the provision of medications and supplies of pharmaceutical services.

ARTICLE VIII.

The consultant pharmacist shall seek continuously to refine and enlarge upon his professional knowledge, abilities and skills, through the pursuit of continuing educational experience in a variety of settings.

ARTICLE IX.

The consultant pharmacist shall, to the best of his ability, associate and affiliate with organisations in so far as they are directged toward the improvement of patient care and safety.

APPENDIX IV. MEDICAID DRUG PLAN by STATE.

STATE.	Prescription limit per month.	Refill limits	Formulary limits.
Alabama	-	5	Yes
Alaska	-	-	-
Arkansas	6	5	Yes
California	-	-	Yes
Colorado	-	-	Yes
Connecticut	-	6	-
Delaware	-	-	-
Dist. of Columbia	-	3	-
Florida	6	-	-
Georgia	6	-	Yes
Hawaii	-	-	Yes
Idaho	-	-	-
Illinois	-	2	Yes
Indiana	-	-	-
Iowa	-	-	-
Kansas	-	-	Yes
Kentucky	-	5	Yes
Louisiana	-	5	-
Maine	-	5	-
Maryland	-	2	-
Massachusetts	-	5	-
Michigan	-	5	Yes
Minnesota	-	-	Yes
Mississippi	5	5	Yes
Missouri	5	-	Yes
Montana	-	-	-
Nebraska	-	-	-
Nevada	5	5	-
New Hampshire	-	-	-
New Jersey	-	-	-
New Mexico	-	-	-
New York	-	5	Yes
North Carolina	6	-	-
North Dakota	-	5	-
Ohio	-	some	Yes
Oklahoma	3	-	Yes
Oregon	-	-	-
Pennsylvania	-	5	-
Rhode Island	-	5	-
South Carolina	4	-	-
South Dakota	-	-	-
Tennessee	7	5	Yes
Texas	3	5	-
Utah	-	-	-
Vermont	-	5	-
Virginia	-	-	-
Washington	-	-	Yes
West Virginia	-	5	Yes
Wisconsin	-	11	-
Wyoming	-	5	-

APPENDIX V. Documentation utilised by INSTACARE PHARMACY SERVICES.

PLI-ABLE SYSTEM
ECKERD Prescription Laboratory, Inc.

PHYSICIAN'S ORDERS

INCLUDE NAME OF DRUG, FORM, STRENGTH, DOSAGE, R.O.A., FREQUENCY (WILL APPEAR ON MEDICATION OR TREATMENT CHARTING RECORD).

○ MEDICATIONS ○ TREATMENTS

SENSITIVITIES

THE FOLLOWING ARE ORDERS FOR THE PERIOD FROM _____ TO _____

Admit to Nursing Home Level of care: _____

May use another brand of legend and non-legend drug product with the same established generic name.

Diagnosis: 1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Diet: _____

NOTATIONS: (These orders will not appear on any charting records.)

May go on therapeutic pass with meds: ☐ Yes ☐ No

May participate in all social activity as tolerated: ☐ Yes ☐ No

Rehabilitative potential of patient: ☐ Good ☐ Fair ☐ Minimal

Discharge plans: ☐ Yes ☐ No If yes, explain:

Whirlpool bath PRN: ☐ Yes ☐ No

☐ Vest ☐ Siderails ☐ Waist ☐ Hand ☐ Ankle ☐ Geri-chair restraints PRN for Personal Safety

Mobility: ☐ Ambulatory ☐ Self ☐ Assist ☐ Walker ☐ Cane ☐ Wheelchair ☐ Bedfast

May check for and remove fecal impaction PRN: ☐ Yes ☐ No

May have alcoholic beverages at social functions: ☐ Yes ☐ No

May crush medications PRN: ☐ Yes ☐ No

S.S. enema PRN: ☐ Yes ☐ No ***** Fleet's enema PRN: ☐ Yes ☐ No

Activity level: ☐ Active ☐ Passive ☐ Bedside

_____

_____

_____

☐ **"I hereby certify that this patient continues to require ICF care for the next 60 days".**

☐ **"I hereby certify that this patient continues to require SNF care for the next 30 days".**

PRINT MD ORDERS ☐ Q 30 Da ☐ Q 60 Da	ADMISSION #
MEDICAID #	MEDICARE #
NAME LAST	FIRST INITIAL

FACILITY NO.	NURSE'S SIGNATURE DATE	PHYSICIAN'S SIGNATURE DATE
STATION	PHYSICIAN ▷	PHONE ▷ ◁
ROOM NO.	ALT. PHYS. ▷	PHONE ▷ ◁

APPENDIX V. DOCUMENTATION utilised by INSTACARE PHARMACY SERVICES.
(i) b.

FORM # EPLI 102 ECKERD Prescription Laboratory, Inc • 5419 Clarewood Dr. • Houston, Texas 77081 • (713) 660-092(

Family Name	First Name	Admission Number	EPLI #	Physician	Room No	Facility No

Date Ordered	ENTER M For order on Med. Charting Record T For order on Treatment Charting Record N For order you do NOT wish to chart	ORDERS

Signature of Nurse Receiving Order | TIME: | Signature of Physician

ORIGINAL COPY — Physician Please Sign and Return Within 48 Hours D 58010

FORM # EPLI 102 ECKERD Prescription Laboratory, Inc • 5419 Clarewood Dr. • Houston, Texas 77081 • (713) 660-092C

Family Name	First Name	Admission Number	EPLI #	Physician	Room No	Facility No

Date Ordered	ENTER M For order on Med. Charting Record T For order on Treatment Charting Record N For order you do NOT wish to chart	ORDERS

Signature of Nurse Receiving Order | TIME: | Signature of Physician

ORIGINAL COPY -- Physician Please Sign and Return Within 48 Hours D 58011

FORM # EPLI 102 ECKERD Prescription Laboratory, Inc • 5419 Clarewood Dr. • Houston, Texas 77081 • (713) 660-092(

Family Name	First Name	Admission Number	EPLI #	Physician	Room No	Facility No

Date Ordered	ENTER M For order on Med. Charting Record T For order on Treatment Charting Record N For order you do NOT wish to chart	ORDERS

Signature of Nurse Receiving Order | TIME | Signature of Physician

ORIGINAL COPY Physician Please Sign and Return Within 48 Hours D 58012

FORM # EPLI-102 - REORDER FROM: ECKERD Prescription Laboratory, Inc • HOUSTON, TEXAS • (713) 660-0920

APPENDIX V. DOCUMENTATION utilised by INSTACARE PHARMACY SERVICES.
(i) c.

PLI·ABLE SYSTEM

PHYSICIANS ORDERS

ECKERD Prescription Laboratory, Inc

LITY:FICTITIOUS MANOR CHECKED BY:
SCONTINUE ALL PREVIOUS ORDERS. DATE PRINTED:01/28/80
ERTIFICATION/RECERTIFICATION: LEVEL OF NURSING CARE REQUIRED:ICF3
FOLLOWING ARE ORDERS FOR THE PERIOD FROM __-_-_-_- TO _____.

DICATIONS:

87	**** SENSITIVITIES ****	PENICILLIN	(Y
0187	MAY CRUSH MEDICATIONS		(Y
0187	DOCUSATE SODIUM 100MG CAPS	1 PO @ AM	(Y
87	TOLBUTAMIDE 500MG TABLETS	1 PO DAILY	(Y
87	DIGOXIN 0.25MG TABLETS	1 PO DAILY ON TUES.THUR,SAT,SUN	(Y
0187	PHENYTOIN 100MG CAPS,EXTND	1 PO TID	(Y
87	DIAZEPAM 5MG TABLETS	1 PO Q4H PRN NERVOUSNESS	(Y
87	MILK OF MAGNESIA SUSP.	30CC PO PRN CONSTIPATION	(Y

MAY USE ANOTHER BRAND OF LEGEND & NON-LEGEND DRUG (N
PRODUCT WITH THE SAME ESTABLISHED GENERIC NAME.

DERS:

DIAGNOSIS: (N
CONGESTIVE HEART FAILURE (N
DIABETES MELLITUS (N
SEIZURE DISORDER (N
ARTERIOSCLEROTIC HEART DISEASE (N

DIET: (N
1500 CALORIE ADA DIET /C HS SNACK (Y

TREATMENTS: (N
MAY KEEP EUCERIN CREAM AT BEDSIDE-USE PRN (Y
CHANGE #18 FOLEY CATH /C 5CC BULB PRN (Y
FASTING BLOOD SUGAR MONTHLY (Y

NOTATIONS: (N
WHIRLPOOL BATH PRN. (N
VEST, SIDERAIL, GERICHAIR RESTRAINTS FOR (N
PERSONAL SAFETY PRN
MOBILITY: WHEELCHAIR (N
CHECK & REMOVE FECAL IMPACTION PRN (N
MAY HAVE S.S. ENEMA PRN CONSTIPATION (N
MAY HAVE FAN IN ROOM (N
PATIENT MAY GO ON THERAPEUTIC PASS WITH MEWS (N
MAY PARTICIPATE IN ALL SOCIAL ACTIVITY AS TOLERATED (N
REHABILITATIVE POTENTIAL OF PATIENT:MINIMAL (N
NO PLANS FOR DISCHARGE (N
"I HEREBY CERTIFY THAT THIS PATIENT-RECIPIENT (N
CONTINUES TO REQUIRE ICF CARE FOR THE NEXT 60 DAYS"

I#: 4 NURS:__-_-_-_-_-_____ DATE:_____
:081987
RM: 2 SIGN:__-_-_-_-_-_____ DATE:_____
D#:4445566661 ST:NORTH PHYS:I.CUREM PH:222-3335
M:OLD. IMA GETTIN' RM:102B ALT.:U.BEICHUM PH:444-5555

APPENDIX V. DOCUMENTATION utilised by INSTACARE PHARMACY SERVICES. (ii) a.

EFFECTIVE DATE 020188

* MEDICATION CHARTING RECORD *

Medication	HOURS	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
**** SENSITIVITIES **** PENICILLIN																																
MAY CRUSH MEDICATIONS																																
DOCUSATE SODIUM 100MG CAPS (COLACE) 1 PO Q AM	9AM																															
TOLBUTAMIDE 500MG TABLETS (ORINASE) 1 PO DAILY	9AM																															
DIGOXIN 0.25MG TABLETS (LANOXIN) 1 PO DAILY ON TUES.THUR,SAT,SUN	9AM	XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX
		XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX
	PUL	XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX
		XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX		XX			XX		XX
PHENYTOIN 100MG CAPS,EXTND (DILANTIN) 1 PO TID	9AM																															
	1PM																															
	5PM																															
DIAZEPAM 5MG TABLETS (VALIUM) 1 PO Q4H PRN NERVOUSNESS	P R N	***RECORD REASON FOR ADMINISTERING MEDICATION***																														
MILK OF MAGNESIA SUSP. 30CC PO PRN CONSTIPATION	P R N	***RECORD REASON FOR ADMINISTERING MEDICATION***																														

FACILITY	FICTITIOUS MANOR	STATION	NORTH	ROOM	1028
FACILITY #	2	EPLI #	4	ADM #	081987
PHYSICIAN	I.CUREM	PHONE	222-3333	PAGE	1
PATIENT	OL IMA TI	PHYS.	.BE UM	PHONE	4-5
EFFECTIVE DATE	02 88				

INJECTION SITES
RA R. ARM
LA L. ARM
RT R. THIGH
LT L. THIGH
RH R. HIP
LH L. HIP

CHARTING CODES
DIET CODE
GOOD 100
FAIR 75
POOR 50
R Refused
S Snack

BM CODE
0 None
1 or more
as occurs

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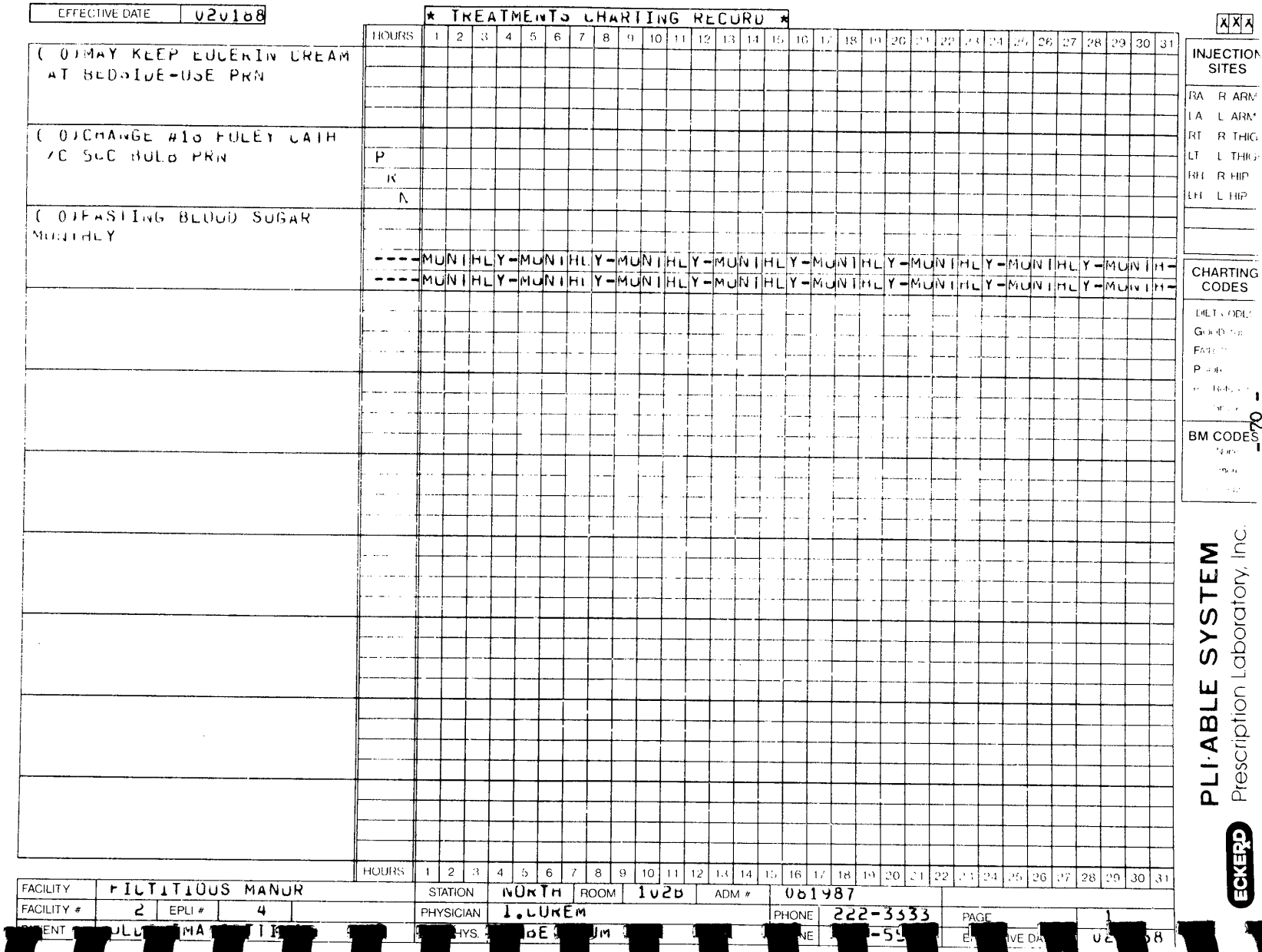
(ii) b.



EFFECTIVE DATE 020188

★ TREATMENTS CHARTING RECORD ★

XXX

HOURS 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

(0)MAY KEEP EUCERIN CREAM AT BEDSIDE-USE PRN

(0)CHANGE #16 FOLEY CATH /C SOC BOLO PRN

P
R
N

(0)FASTING BLOOD SUGAR MONTHLY

----MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTH-
----MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTHLY-MONTH-

HOURS 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

INJECTION SITES

RA R ARM
LA L ARM
RT R THIG
LT L THIG
RH R HIP
LH L HIP

CHARTING CODES

DELTA CODES
GOOD
FAIR
POOR

BM CODES

FACILITY FICTITIOUS MANOR | STATION NORTH | ROOM 1020 | ADM # 061487
FACILITY # 2 | EPLI # 4 | PHYSICIAN I.CUREM | PHONE 222-3333 | PAGE 1
PATIENT [illegible] | PHYS. [illegible] | PHONE [illegible] | EFFECTIVE DATE 02[illegible]88

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XXX

EFFECTIVE DATE 020188

★ DAILY CARE CHARTING RECORD ★

	HOURS	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
(01)1500 CALORIE ADA DIET /C HS SNACK	B																															
	L																															
	S																															
(22)ATE 50% OR LESS, WAS OFFERED SUBSTITUTE A:ACCEPTED R:REFUSED	B																															
	L																															
	S																															
(22)SHOWER BATH 3 TIMES WEEKLY ON MON., WED. AND FRI.	7-3		XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX	
			XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX	
			XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX	
			XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX		XX		XX	XX		XX	
(22)SHAMPOO WEEKLY		XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX	
		XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX	
		XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX	
		XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX	
(22)ADL:DRESS/GROOM/HAIR CARE WITH TOTAL ASSISTANCE																																
(22)ORAL CARE /C ASSIST-DENTURES	7-3																															
	3-11																															
(22)NAIL CARE /C TOTAL ASSISTANCE /C BATH																																
(22)AMBULATION /C ASSIST-UP IN WHEELCHAIR	7-3																															
	3-11																															
(22)SIDERAILS UP WHEN IN BED, MONITOR @ 1 HOUR.	7-3																															
	3-11																															
	11-7																															
(22)RECORD BM'S DAILY EACH SHIFT.	7-3																															
	3-11																															
	11-7																															
	HOURS	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

XXX

INJECTION SITES

RA R ARM
LA L ARM
RT R THIGH
LT L THIGH
RH R HIP
LH L HIP

CHARTING CODES

DIET CODES
GOOD 100%
FAIR 75%
POOR 50%
R Refused
S Snack

BM CODES
0 - None
1 or more - as occurs

FACILITY	FICTITIOUS MANOR		STATION	NORTH	ROOM	102B	ADM # 081987
FACILITY #	2	EPLI # 4	PHYSICIAN	I.CUREM	PHONE	222-3333	PAGE 1
PATIENT	OLD, IMA GETTIN'		ALT. PHYS.	[illegible]	PHONE	[illegible]-55[illegible]	EFFECTIVE DATE 02[illegible]88

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(ii) c.

XXX

EFFECTIVE DATE 020188

★ DAILY CARE CHARTING RECORD ★

XXX

	HOURS	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
(22) VITAL SIGNS WEEKLY AND RECORD.	T	XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
	P	XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
	R	XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
\	B/P	XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
\		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
\		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
\		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX	XX	XX	XX		XX	XX	XX
(22) WEIGHT MONTHLY AND RECORD.																																
(22) RECORD OUTPUT EVERY SHIFT.	7-3																															
\ \ \ \	3-11																															
\ \ \ \	11-7																															
(22) TOTAL OUTPUT	T O T AL																															
	HOURS	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

INJECTION SITES
RA = R. ARM
LA = L. ARM
RT = R THIGH
LT = L THIGH
RH = R HIP
LH = L HIP

CHARTING CODES
DIET CODES
GOOD 100%
FAIR 75%
POOR 50%
R Refused
S Snack

BM CODES
0 None
1 or more as occurs

FACILITY FICTITIOUS MANOR | STATION NORTH | ROOM 102B | ADM # 081987
FACILITY # 2 | EPLI # 4 | PHYSICIAN I. LUREM | PHONE [illegible]
PATIENT [illegible] | ALT. PHYS [illegible] | PHONE [illegible] | EFFECTIVE DATE [illegible]

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ECKERD Prescription Laboratory, Inc.

INDIVIDUAL PATIENT'S NARCOTICS RECORD

PATIENT NAME | PATIENT NUMBER

PHARMACIST'S NAME | AMOUNT RECEIVED

NAME OF PERSON GIVING	DATE	TIME	AMOUNT GIVEN	AMOUNT REMAINING	NAME OF PERSON GIVING	DATE	TIME	AMOUNT GIVEN	AMOUNT REMAINING

DISPOSITION OF UNUSED DRUG

ADMINISTRATOR'S OFFICE ☐ OTHER EXPLAIN _____

HOME WITH PATIENT ☐ _____

FORM #EPLI-106 (Rev. 1-85)
UNITED BUSINESS FORMS INC. HOUSTON, TEXAS 77036 (713) 952-6021

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(ii) e.

Insta-Care Pharmacy Services

INDIVIDUAL PATIENT'S ANTIBIOTIC RECORD

NAME OF PERSON GIVING	DATE	TIME	AMOUNT GIVEN	AMOUNT REMAINING	NAME OF PERSON GIVING	DATE	TIME	AMOUNT GIVEN	AMOUNT REMAINING

UNITED BUSINESS FORMS, INC HOUSTON TEXAS 77036 (713) 952-6031

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(iii) a.

Insta-Care
Pharmacy Services

DRUG ASSESSMENT FORM

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START DATE	MEDICATION	D/C DATE	DIAGNOSIS	INDICATOR	LAB SCHEDULE	*RECOMMENDATIONS/ DATE

PRN MEDS

START DATE	MEDICATION	D/C DATE	INDICATOR	USAGE PATTERN	*RECOMMENDATIONS/ DATE

ALLERGIES	DIET	ADMIT DATE	D.O.B	PATIENT NAME

*Significant recommendations are submitted to the physician and administration as defined in the policy and procedures manual

DO NOT REMOVE THIS PAGE.

DATE	DRUG REGIMEN REVIEWS

LABS	B.S.	Hgb	Hct	MCV	Na	K	BUN	Cr	Dig	Theo	P.T.				B.P	Pulse	Wt.
D																	
A																	
T																	
E																	
S																	

ALLERGIES/COMMENTS	PATIENT NAME

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(iii) b.

FORMS PLUS • CAMBRIDGE, MA 02140 • (617) 547-4410

Insta-Care
Pharmacy Services

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Consultant Pharmacist Communication

➔ **To:** ☐ Dr. _____ ☐ Nursing

Resident: _____

_____

_____

_____

_____

_____

Thank You, _____
Consultant Pharmacist

➔ **Your Response** (per OBRA regs):

☐ I agree (please write new orders) No change at this time

☐ Modifications as follows: _____

_____
Response Signature/Date

Insta-Care
Pharmacy Services

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Medication Station Review

Date _____

Facility _____

Station _____

Total Satisfactory _____

Total Comments _____

Satisfactory Rate (%) _____

Code	Criteria	Satisfactory	See Comments Below
	MEDICATION PROCUREMENT		
1.	Order book/record conforms to regulations.		
2.	Medication ordering procedure.		
3.	Medication receiving procedure.		
	MEDICATION ROOM/CABINETS		
4.	Lighting, ventilation and cleanliness.		
5.	External products stored separately from internals.		
6.	Medication nurse controls keys.		
7.	Medication room/cabinet secured.		
8.	Resident medications stored separately.		
9.	No outdated medications.		
10.	No deteriorated medications.		
11.	Outdated/discontinued medications stored separately.		
12.	No storage of non-medication items.		
13.	Proper storage/disposal of syringes.		
14.	No items stored directly on floor.		
15.	Alcoholic beverages appropriately labeled and stored.		
	REFRIGERATOR		
16.	Refrigerator under single lock.		
17.	Refrigerator clean and defrosted.		
18.	Contains only medications and adjunctive foods.		
19.	Adjunctive foods dated.		
20.	No outdated or discontinued medications.		
21.	Temperature is correct. (36°-46° F)		
	CONTROLLED SUBSTANCES		
22.	Count reconciled per required regulation/policy.		
23.	Count book adheres to regulations.		
24.	Countables properly receipted.		
25.	Correct disposition of discontinued/outdated medications.		
26.	Medications stored in separate double locked compartment per required regulation/policy.		

Code	Criteria	Satisfactory	See Comments Below
	MEDICATION CART/TREATMENT CART		
27.	Clean.		
28.	Wheel locks functional.		
29.	Cart locked per required regulation/policy.		
30.	No outdated medications.		
31.	No discontinued medications.		
32.	No deteriorated medications.		
33.	Flashlight available and functional as required.		
34.	Medication nurse controls keys.		
35.	Externals separated from internals.		
36.	Crusher available and clean.		
37.	Handwashing product available, if house policy allows.		
	MEDICATION PACKAGING AND LABELING		
38.	Labels are legible and contain all required information.		
39.	Labels altered only by pharmacist.		
40.	Direction change stickers used appropriately.		
41.	Bulk medications properly labeled.		
42.	Medication containers intact.		
	EMERGENCY MEDICATION SERVICES		
43.	Emergency pharmacy phone numbers posted.		
44.	Content list of EDK posted.		
45.	Kits in conformance with regulations.		
46.	Seals intact.		
47.	Kit contents in date.		
48.	Countable kit properly documented.		
49.	Kits stored under proper security.		
	MISCELLANEOUS		
50.	Proper drug references available.		
51.	Pharmacy Policy and Procedure Manual available.		
52.	Previous recommendations adhered to.		
53.	Bedside medications appropriately stored.		
54.	Other _____		

CODE	COMMENTS/SUGGESTIONS
	Thank you, _____ Reviewer Signature

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(iii) d.

Insta-Care
Pharmacy Services

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Medication Documentation Assurance

Date

Facility

Station

Total Residents Reviewed

Total Requiring Action

Requires Corrective Action

Resident	Charting	PRN Reasons/ Results	BP	Pulse	Sites	Doses Circled With No Explanation	Diet/ Suppl	Antibiotic # of Doses	Allergies	Incomplete Order	Control Drug			Follow-Up Initials
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														
13.														
14.														
15.														
16.														
17.														
18.														
19.														
20.														

Resident	COMMENTS/SUGGESTIONS
	Thank you, _____ Reviewer Signature

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(iv) a.

Insta-Care Pharmacy Services

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Observer's Notes and Reconciliation Worksheet

(HCFA Format - For D.O.N. Only)

Facility ______________________

Date ______________________

Med Pass Time --

Start ______________________

Finish ______________________

Station ______________________

Page ________ of ________ Pages

	Observer's Notes		Reconciliation	
	Description of Doses Observed, Prepared and Administered	Resident	Deviation from Chart Order	Error Type (Codes from Total Med Table)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16.				

Total Medication Administration Errors	
Code	**Number**
A. Medication Omissions	☐
B. Incorrect Route of Administration	☐
C. Wrong Drug	☐
D. Incorrect Dosage Form	☐
E. Incorrect Dose	☐
F. Wrong Time (>60 minutes)	☐
G. Wrong Time (other)	☐
H. Other	☐
Total "Errors"	☐

Total Opportunities for Error	
Doses Observed Administered	☐
+ Medication Omissions	☐
= **Total "Opportunities for Error"**	☐

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(iv) b.

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Pharmacy Services

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Medication Administration Observation

Date
Facility
Station
Med Pass
Observer

RESULTS SUMMARY

	Excellent	Good	Concern
A Observation Summary			
B. Measurement Summary			

A. Observation Summary

Code	Criteria	Satisfactory	See Comments Below
1.	Medication administration is documented in accordance with Facility policy and procedure. Observed: Pour/Chart/Pass ( ) Pour/Pass/Chart ( )		
2.	Information on prescription label is verified with medication administration record.		
3.	Accurate method of resident identification is utilized prior to administration.		
4.	For meds with parameters, vital signs are taken and recorded prior to administration		
5.	Medications are not left on top of the cart or at the resident's bedside.		
6.	Medication cart is locked when not in direct line of sight		
7.	Wheel locks are used when appropriate		
8	PRN medications are administered and documented appropriately.		
9.	Self administered medications are appropriately ordered and documented.		
10	Refusals are documented appropriately		
11.	Controlled substances are either documented or "flagged" for later reference.		

Code	Criteria	Satisfactory	See Comments Below
12	Missed doses are either documented or "flagged" for later reference		
13.	Residents are observed to ensure that all medications are swallowed.		
14	Suspensions are shaken sufficiently		
15	Doses of liquid medication measured accurately		
16	Proper crushing technique is utilized		
17	Only appropriate medications are crushed.		
18	Sanitary technique is maintained during entire med pass		
19.	Proper handwashing technique is utilized.		
20.	Proper ophthalmic medication administration technique is utilized		
21	Proper parenteral administration technique is utilized.		
22	Tube feeding technique a. Tube checked for proper placement b. Tube flushed before/after medication administered c. Proper medication administration d. Proper handwashing observed.		
23	Pitchers of juice or water and applesauce containers are covered, labeled and dated correctly.		
24	[illegible]		

B. Measurement Summary

Total Errors ÷ Total Opportunities for Error = [illegible]

CODE	COMMENTS/SUGGESTIONS
	Thank you. _____ Reviewer Signature

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(v) a.

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Antipsychotic Comprehensive Assessment

Facility

Floor/Room

Date of Assessment

Patient Name	
Drug	Strength
Directions for Use	
Physician	

Please answer these questions to help make certain your facility is in compliance with OBRA. If this document suggests compliance may **not** have been achieved, please bring this to the attention of your Director of Nursing **immediately**!

YES NO

→ ☐ ☐ STEP 1... **Diagnosis**

Is this one of the following appropriate psychiatric condition(s)? Please check all that apply **and** answer "yes". If none apply, answer "no"

- Schizophrenia
- Delusion Disorder
- Acute Psychotic Episodes
- Brief Reactive Psychosis
- Organic Mental Syndromes* (including dementia with associated dangerous and/or agitated features)
- Schizo-affective Disorder
- Schizophreniform Disorder
- Psychotic Mood Disorders (including mania and depression with psychotic features)
- Huntington's Chorea
- Tourette's Disorder

*If Organic Mental Syndrome is checked, complete this section. If not, move on to Step 2.

A. List any specific behaviors (i.e. biting, kicking, scratching)?

Behavior	# of Episodes	Specify day, week or month
_____	_____	per _____
_____	_____	per _____

And...do the specific behaviors listed above cause the resident to? Please check all that apply.
- Present a danger to themselves?
- Present a danger to others (including staff)?
- Interfere with staff's ability to provide care?

B. List any psychotic symptoms (hallucinations, paranoia, delusions) **not** exhibited as specific behaviors (as described above in part A.) **but which cause the patient frightful distress?**

Behavior	# of Episodes	Specify day, week or month
_____	_____	per _____
_____	_____	per _____

YES NO

→ ☐ ☐ STEP 2... **Inappropriate Indications**

If drugs are **solely** used for any of the indications below, answer "no" **and** check the indication(s). If not, answer "yes".

Indifference to surroundings	Poor self care	Fidgeting	Nervousness
Impaired memory	Uncooperativeness	Wandering	Restlessness
Crying out, yelling	Unsociability	Anxiety	Depression
	Insomnia	Simple pacing	

YES NO

→ ___ ___ STEP 3... **Conclusion (Is the use of antipsychotic medication appropriate?)**

If the answer to the questions in Steps 1 and 2 are both "yes", then antipsychotic use is appropriate. If not, answer "no" and continue to Step 4.

YES NO

→ ___ ___ STEP 4... If the resident is using this medication for a short term (7 days or less) or for the symptomatic treatment of indications below (check all that apply) then antipsychotic use is appropriate so answer "yes". If not, answer "no" and continue to Step 5.

Hiccups	Nausea	Vomiting	Pruritis

NO

→ ☐ STEP 5... This therapy may not be in compliance with OBRA regulations. **Answer "no" and bring this document to the attention of your Director of Nursing immediately for review.**

_____
Nurse Reviewer

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(v) b.

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Antipsychotic Drug (APD) Monitoring

Facility

Resident

Drug/Dose

Date (Month/Year) /	Behavior #1			Behavior #2			Behavior #3			Side Effects Observed (Use Key Below)			Milligrams Administered Per Shift		
	Number of Incidences														
	Day	Eve	Night	Day	Eve	Night	Day	Eve	Night	Day	Eve	Night	Day	Eve	Night
Day 1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
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21															
22															
23															
24															
25															
26															
27															
28															
29															
30															
31															
Total															

Side Effects Key

S = Sedation
DM = Dry Mouth
C = Constipation
U = Urinary Retention
SZ = Seizure Activity
J = Jaundice
EPS = Extrapyramidal Symptoms (Describe on reverse)
O = Other (Describe on reverse)
CD = Increased Confusion/ Disorientation
PH = Postural Hypotension

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Psychotropic Drug Summary Report

Facility
Station
Quarter
Date #1/Initials
Date #2/Initials
Date #3/Initials

	Antipsychotic Drug Monitoring									Additional Monitoring (Exceeds OBRA Requirements)					
	OBRA Requirements			Consultant Pharmacist Action											
Resident Name	Single Routine APD	Multiple Routine APD	PRN APD[1]	No Diagnosis[2]	No Dose Reduc.[3]	Noted to MD	MD Response (+)	MD Response (-)		AD	AA	S/H	Li	MDT Date	
	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		1 2 3	1 2 3	1 2 3	1 2 3		

TOTALS

Date	Total Residents	# / %	# / %	# / %						# / %	# / %	# / %	# / %		
1.															
2.															
3.															
Qtr. Avg.															

KEY:

APD = Antipsychotic Drug
AD = Antidepressant Drug
AA = Antianxiety Drug
S/H = Sedative-Hypnotic Drugs
Li = Lithium
MDT = Movement Disorder Test

[1] = Used PRN anti-psychotic drug
[2] = No Diagnosis includes OBS without appropriate target behavior
[3] = No Dose Reduction in past six months where not medically contraindicated

Distribution: White - Administrator's Quarterly Summary; Canary - Month #1 Summary; Pink - Month #2 Summary; Goldenrod - Consultant

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(vi) a.

TIPS

"Reducing Medication Errors"

To Insure Accuracy...
- Always verify information on prescription label with the medication administration record
- Observe residents to ensure that **all** medications are swallowed.
- Shake all suspensions sufficiently.
- Measure doses of liquid medication accurately. Use an oral syringe if necessary.
- If a medication is mixed with applesauce or diluted in liquid, you must observe the resident swallow the **entire** amount.
- Physician's orders should be obtained for the crushing of medication on an individual resident basis.
- Do not crush timed-release preparations or enteric coated tablets.
- Use "double souflé" method for crushing tablets.
- Wait five minutes between each ophthalmic administration if more than one preparation is to be given to a resident at the same time.
- Instruct residents on the proper way to take medications such as inhalers or sublingual tablets.

To Insure Resident Safety...
- Identify the resident (with wristband or current photograph) before administering medications.
- Do not store medications on top of the medication cart during the medication pass.
- If the medication cart is not in your direct line of vision, lock all medication cart drawers and apply the wheel locking devices.
- Do not leave medications at resident's bedside.
- For medications administered according to specific parameters, the appropriate vital signs should be taken **before** pouring the medication.
- Once a medication has been "poured" (taken out of its properly labeled container), do not store that medication in the medication cart.
- Always check for drug allergies when administering a new medication.

To Insure Timeliness...
- Medications should be administered no more than one hour before or after the time the medication is scheduled.
- If the actual administration time differs from the "standard" administration time, the **actual** administration time should be documented in the physician's orders as well as in the MAR. (e.g. If a medication is given twice daily at 9 a.m. and 1 p.m. and "BID" standard times are 9 a.m. and 5 p.m., the physicians orders should state "BID at 9 a.m. and 1 p.m.")
- Medications ordered in relation to meals (AC, PC, with meals) must be administered exactly as ordered.

To Insure Adequate Infection Control...
- Wash hands or use handwashing product (alcohol foam or gel) before and after ophthalmic administration after making resident contact or if you sneeze, cough, etc.
- Do not store treatments or treatment items in the medication cart
- Dispose of used syringes according to your facility policy and procedure
- Avoid routine handling of medications with fingers.
- Keep all containers of water, juice and applesauce covered and date the sides of the containers.

To Insure Proper Documentation...
- Document medication administration in accordance with your facility policy and procedure
- Never "chart" a medication before pouring it.
- Document "PRN" medication administration noting reason and results.
- When initials are circled to indicate either a refused medication or a withheld medication the reason for refusal or withholding the medication should be documented in the MAR.
- Controlled substance administration should be either documented in the Narcotic Book at the time of administration or "flagged" for later entry in the Narcotic Book.
- If a resident takes a partial amount of medication, indicate the percent taken in the MAR

Remember the seven "rights" of effective medication administration
1. the "right" dose of...
2. the "right" medication in...
3. the "right" dosage form given to...
4. the "right" resident at...
5. the "right" time by...
6. the "right" route...
7. will help insure the "right" therapeutic response.

APPENDIX V. DOCUMENTATION utilised by INSTACARE PHARMACY SERVICES. (iv) b.

TIPS

"Eliminating Physical Restraints

eps to Success:

1. **Administrative Commitment**...make certain you have a strong enough philosophical commitment to truly accomplish this goal.

2. **Develop Facility Policy**...which clearly addresses the use of both physical and chemical restraints.

3. **Create Awareness**...tell everybody. Review your policy with all employees, residents families and attending physicians. Be sure to ad safety and liability issues.

4. **Development/Implementation**...select a manageable number of residents whose restraints will be scheduled for removal and deterr the specific reasons for use and action plans to accomplish this goal.

5. **Establish Goals**...develop a care plan of alternatives to restraints for each resident selected. Alternatives must be selected with the n and behaviors of the specific resident in mind.

Alternatives to Restraints:

Reducing Wandering Behavior
- alarm doors and/or fasten bells to allow residents to "wander" without supervision
- "color code" residents rooms, doors and possibly certain personal belongings to reduce confusion
- call lights may be attached to chairs to alert staff when residents are straying from safety
- distract wandering residents rather than confront them
- implement signs that use illustrations or symbols rather than words to denote dining rooms, bathrooms, off limit areas, etc.
- for agenda behavior, determine the residents agenda and create alternatives that will allow the resident to pursue their agenda

Reducing Falls
- use lower chairs or "bean bag" chairs to make falls less likely
- use "Dycem" sheet (creates friction/adherence) under resident
- place "reminder ribbons" across chair (a piece of material attached by velcro to both sides of the chair so the resident may remc
- use sofa-type chairs or recliners because these are more difficult for the resident to leave unaided
- certain types of beds can be positioned so low that a person with very short legs can sit on the edge and still have both feet firmly planted on the ground
- stronger towel racks can be mounted directly into concrete so that they will not come out of the wall if used as grab bars
- residents rooms and bathrooms may be carpeted or padded to cushion falls
- use 4" - 6" wedge cushions to allow residents to sit back in chairs and elevate knees, thus preventing them from standing up quick!
- have physical therapy evaluate previously restrained residents who are acquiring new balance and ambulation skills
- when appropriate, residents may be given exercises to build muscle strength and tone in order to restore mobility

C) **Reducing Agitation**
- identify and reduce, to the greatest extent possible, environmental sources of agitation (loud noises, foul odors, excessive heat or cold, etc.)
- offer activity programs on evening shifts and on weekends
- establish a "drop-in" center for residents
- consider the following activities for demented/confused residents: reminiscence therapy, gardening, baking, music therapy, physical exercise (nature walks, etc.) that promote motor activities
- use non-threatening intervention techniques and approaches that are effective in managing agitation/aggressiveness in nursing home residents (ask for help, distract, "active" listening)

In Summary...keep the "lid" on:

• laugh • ignore • distract

Insta-Care
Pharmacy Services

SEPTEMBER, 1990
VOL. 7 NO. 5

Meds™

Trends in Pharmacy for the Long-Term Health Care Facility

Insomnia in the Elderly

Assessment and Drug Therapy

Arlette B. Moussa, M.S., R.Ph.
Consultant Pharmacist, Northeast Region

Introduction

Insomnia is the chronic inability to obtain the amount of sleep needed for a person to function optimally and feel well. Insomnia is a symptom rather than a disease. The American Psychiatric Association's Diagnostic and Statistical Manual subdivides insomnias into three major groups: (1) insomnias related to another mental disorder, (2) insomnias related to a known organic factor, (3) primary insomnias without objective findings.

Insomnia in the Elderly

Sleeping and waking follow a circadian rhythm of approximately 24 hours. The "internal clock" often accelerates with old age. Hence, older persons fall asleep easily and early in the evening and they often awaken early in the morning. The amount of sleep needed by a person does not change with age. Sleep requirements are dependent more upon physical activity during the day. It is a myth that the elderly require less sleep than the younger population. The aging process must be considered with respect to drug metabolism, however, due to its effect on renal hepatic functions and drug distribution.

Management

Management is often dependent upon the etiologic factors of insomnia. As previously mentioned, psychological stresses, medical disorders or behavioral changes can all attribute to insomnia. It is not good practice to prescribe medication for the symptomatic relief of insomnia before assessing the underlying cause.

A thorough psychiatric evaluation is indicated as the initial step in treating insomnia. Worry or excitement can cause sleep disturbance. Insomnia is frequently a symptom associated with psychosis, mania, major depression or anxiety. Such insomnia is most appropriately alleviated with the use of the specific medications targeted to manage the underlying psychiatric disorder. For example, antidepressant drugs should be used to treat depressed individuals complaining of insomnia.

Various medical causes can interfere with falling asleep. Pain, respiratory ailments, allergies, cerebrovascular or neuromuscular disorders are only a few organic factors that can lead to insomnia. In this case, the medical disease should be treated first to help restore a normal sleep pattern.

Other miscellaneous causes of insomnia include disruption of circadian rhythm, change of environment, stimulant drugs, drug dependence and drug withdrawal. Treating the underlying cause must always be the primary focus with management of insomnia playing a secondary supportive role.

Drug Therapy

Benzodiazepines are the current hypnotic drugs of choice. There is little indication that any one of the benzodiazepines is superior in effectiveness to the others in this class. The choice of a specific drug depends on the drug's onset of action, rate of elimination and degree of side effects.

Benzodiazepines vary in their absorption and rate of elimination. Those drugs with a slower rate of elimination are more apt to produce daytime sedation and to accumulate in the body with chronic use.

The most common side effects associated with benzodiazepines include drowsiness, mild impairment of cognitive function, impairment of motor coordination and mild memory disturbance. Tolerance usually develops and these side effects diminish over time. Other adverse effects reported with the use of benzodiazepines are paradoxical excitement, the possibility of an increase in depression and anterograde amnesia (the inability to recall events occurring after drug administration). When given in large doses, all benzodiazepines have detrimental effects on memory.

Flurazepam (Dalmane®) was the first benzodiazepine marketed as a hypnotic medication. It has a rapid rate of absorption and an elimination half-life of about eight hours. It has an active metabolite with an elimination half-life that ranges from 50 to 300 hours depending on the individual's liver function. The accumulation of this long-acting metabolite could result in impaired daytime functioning in many individuals, especially in the elderly.

Temazepam (Restoril®) has a slower rate of absorption than the other benzodiazepines and an elimination half-life of about eight hours. It has no active metabolites. Due to its slow onset of action, temazepam should be given one half hour before bedtime.

Triazolam (Halcion®) has an intermediate rate of absorption and an elimination half-life of about five hours. It has no active metabolites. It is the least likely of the three drugs to cause morning hangover.

Barbiturates, i.e. phenobarbital, are occasionally prescribed when or if benzodiazepines are ineffective or contraindicated. Barbiturates can be addictive and can interact with other medications prescribed concurrently. Furthermore, these medications are not recommended in the elderly population because of their long duration of action.

Chloral hydrate (Noctec®) is often prescribed in the elderly population. This drug is chemically unrelated to the other classes of hypnotics. Chloral hydrate is considered safe and well tolerated. The more common side effect is gastrointestinal irritation.

Diphenhydramine (Benadryl®), an antihistamine, is prescribed for its sedative side effect. It is considered a mild hypnotic medication, however, the side effects associated with this medication can be more troublesome than the side effects from benzodiazepine therapy. The side effect profile includes constipation, urinary retension, blurred vision, confusion, disorientation, and hallucinations.

All of these hypnotic drugs have been shown to be less effective after 14 to 30 days of consecutive administration. Individuals receiving long-term hypnotic therapy should have a trial of dosage reduction. A suggested tapering procedure includes dosage reduction and a decrease in the frequency of administration. For example, hypnotic medications dosed on an alternating night basis or up to three to four nights per week.

Behavioral and Psychologic Therapies

Relaxation therapy helps most individuals with insomnia to sleep better. Some of the techniques that may be used include abdominal breathing, muscle relaxation, meditation and hypnosis.

Curtailment of sleep can help some individuals with insomnia. After completing a one-week sleep log, the time in bed is then restricted to the amount of time the individual claims to be sleeping. This method may initially cause sleep deprivation, but it is effective in treating insomnia.

Other therapies include "light" therapy and cognitive psychotherapy.

Summary

Hypnotic medication may be used for the short-term management of insomnia. No one drug is ideal for every individual and not all individuals with insomnia should be treated with hypnotic medications. A careful assessment should be completed before prescribing a hypnotic medication.

Elderly individuals are faced with various losses: jobs, physical capabilities, spouses and material belongings. These losses can cause anxiety and depression, that in turn may cause delay in falling asleep. Older people may react more emotionally than younger adults when faced with stressful situations. The increased emotionality can cause alterations in sleep. Organic brain changes are associated with a decrease in total sleep time.

Elderly individuals need to know that some sleep disturbances may be unavoidable and they should be encouraged to go to bed only when sleepy, to get up at the same time each morning, and to shorten or eliminate naps during the day.

Hypnotic Medications

Drug Name	Rate of Absorption	Half-Life (Hours)	Memory Impairment	Usual Maximum Daily Dose Over Age 65
Benzodiazepines				
Short-Acting Triazolam (Halcion®)	Intermediate	2 to 4	4+	0.25 mg
Intermediate Temazepam (Restoril®)	Slow	8 to 20	2+	15mg
Long-Acting Flurazepam (Dalmane®)	Fast	64 to 150	2+	15mg
Non-Benzodiazepines Non-Barbiturates				
Chloral Hydrate (Noctec®)	Fast	4 to 6	1+	750mg
Diphenhydramine (Benadryl®)	Intermediate	4 to 8	2+	50 mg
Barbiturates				
Pentobarbital (Nembutal®)	Fast	15 to 50	-	100mg
Secobarbital (Seconal®)	Fast	15 to 40	-	100mg
Amobarbital (Amytal®)	Intermediate	16 to 40	-	65mg
Phenobarbital	Slow	53 to 118	-	100mg

We would like to dedicate this issue of *MEDS* to the memory of Pierre B. Moussa, M.D.

National Offices

Northeast United States Region HQ

8 Henshaw Street
Woburn, MA 01801
617-935-2273

Southeast United States Region HQ

36 Herring Road
Shenandoah, GA 30265
404-253-9620

2100 Director's Row
Orlando, FL 32809
407-851-4120

Southwest United States Region HQ

1201 West Loop North
Suite 100
Houston, TX 77055
713-680-1325

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Lorrie A. Packer, R.Ph., Co-Editor
Donna L. Goolkasian, Pharm.D., Co-Editor
8 Henshaw Street, Woburn, MA 01801
(617)935-2273

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APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(i) ORDER FORM used by FACILITY.

HealthCare Pharmacies℠
A Division of HealthCare Network

Facility _____ Station _____ Date _____ 223401

	NAME: Last	First	Prescription Number or Peel Off Label	Called In ✓	MEDICATION AND DIRECTIONS	PHYSICIAN	Ordered By	Date Received	Quantity Received	Recei By
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK. (ii).

MEDICATION LOCATOR

PATIENT ______________________ ROOM ________ BED ________

DRUG ______________________

LOCATED:
- ☐ IN REFRIGERATOR
- ☐ WITH SPECIAL DOSE TIME CARDS
- ☐ WITH LIQUIDS
- ☐ WITH VIALS/OUTSIDE PHARMACY MEDS
- ☐ USE HOUSE SUPPLY
- ☐ OTHER ______________

DRUG ______________________

LOCATED:
- ☐ IN REFRIGERATOR
- ☐ WITH SPECIAL DOSE TIME CARDS
- ☐ WITH LIQUIDS
- ☐ WITH VIALS/OUTSIDE PHARMACY MEDS
- ☐ USE HOUSE SUPPLY
- ☐ OTHER ______________

DRUG ______________________

LOCATED:
- ☐ IN REFRIGERATOR
- ☐ WITH SPECIAL DOSE TIME CARDS
- ☐ WITH LIQUIDS
- ☐ WITH VIALS/OUTSIDE PHARMACY MEDS
- ☐ USE HOUSE SUPPLY
- ☐ OTHER ______________

DRUG ______________________

LOCATED:
- ☐ IN REFRIGERATOR
- ☐ WITH SPECIAL DOSE TIME CARDS
- ☐ WITH LIQUIDS
- ☐ WITH VIALS/OUTSIDE PHARMACY MEDS
- ☐ USE HOUSE SUPPLY
- ☐ OTHER ______________

DRUG ______________________

LOCATED:
- ☐ IN REFRIGERATOR
- ☐ WITH SPECIAL DOSE TIME CARDS
- ☐ WITH LIQUIDS
- ☐ WITH VIALS/OUTSIDE PHARMACY MEDS
- ☐ USE HOUSE SUPPLY
- ☐ OTHER ______________

HCP 348

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iii) a.

FACILITY EMERGENCY KIT LOG BOOK

DATE	TIME	PATIENT NAME	MEDICATION NAME	DOSE GIVEN	MD. NAME	R.N.- LVN. NAME GIVING DOSE	RE-ORDERED BY:

HCP-EKI

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iii) b.

CONTROLLED DRUG INVENTORY

STATION _____

DATE	TIME	NAME	DISCREPANCY (Patient & Drug)	REPORTED TO DNS BY:	EMERGENCY KITS SEALED (Yes, No)
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				
	7 AM				
	3 PM				
	11 PM				

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iii) c.

DISPOSITION OF UNUSED PORTION OF PRESCRIPTION: AMOUNT________ DESTROYED BY FLUSHING

DATE__________ 1.______________________________, 2.______________________________,
WITNESS WITNESS

Date	Time	No.	Signature	Date	Time	No.	Signature	Date	Time	No.	Signature

Pt. Name/M.D.______________________

Drug/Quant.______________________

Rx #/Date______________________

CO[illegible]OLL[illegible]DRU[illegible]ECOR[illegible]

CER[illegible]/85)

APPENDIX VI. DOCUMENTATION utilized by HEALTHCARE NETWORK. (iii) d.

HealthCare Pharmacies
A Division of Healthcare Network

MEDICATION AND TREATMENT CART AUDIT FORM

Medi Cart _____

Date of Month

Treatment Cart _____

CART AUDIT INSTRUCTIONS:

Check all medications and treatment items against the med and treatment books using the following criteria.

If a discrepancy is found, correct it!

When complete, initial under the appropriate date.

1. Every med/tx ordered is available
2. No meds/tx are in cart which do not have a corresponding order
3. All meds/txs labeled properly
4. Labels match orders exactly
5. "Order Change" labels are properly affixed
6. Expiration dates have not passed
7. "Date Opened" stickers are on all eye meds, nitro-glycerin and multidose vials
8. Cart is clean, including drawers and crusher
9. Flashlight available and working

Return completed form to DON

SHIFT/NURSE ASSIGNED	RM # OR PATIENT	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
D/T	1A M	h																														
	1P	h																														
	1C	h																														
	2 P T		h																													
	2 C		h																													
			h																													
	2A N			h																												
	C			h																												
				h																												

- 94 -

Facility Station: Cart: Month:

MEDICATION AND TREATMENT CART AUDIT FORM

HCP-358 (3/90) SNF FORMS - P.O. Box 4390 ... Grove ... 42 ... 9-1600

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) a.

HealthCare Pharmacies℠
A Division of HealthCare Network

DRUG REGIMEN REVIEWED ON:

DATE	PHARMACIST'S SIGNATURE	NOTE TO: NURSING	NOTE TO: M.D.	COMMENTS

FAMILY NAME   FIRST NAME   ATTENDING PHYSICIAN   ROOM NO.   HOSP. NO.

HCP-302 REV. 12/87

PHARMACIST'S NOTES

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) b.

Consultant Pharmacist Recommendations to Physicians

To: _____

Date: _____

Patient	Recommendations	M.D. Response

Thank you,

Dianne Tobias, Pharm.D
Consultant Pharmacist
HealthCare Pharmacies
(714)544-4403, Ext. 2376

5/90

Please Route to Director of Nurses When Completed

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) c.

HealthCare Pharmacies
A Division of Healthcare Network

DATE: _____

THE FOLLOWING DRUGS BROUGHT WITH THE PATIENT ARE APPROVED FOR USE IN THE FACILITY:

DRUG	STRENGTH	COMMENTS

THE FOLLOWING DRUGS BROUGHT IN WITH THE PATIENT ARE **NOT** APPROVED FOR USE IN THE FACILITY. RETURN TO FAMILY OR DESTROY.

DRUG	STRENGTH	COMMENTS

PHARMACIST'S SIGNATURE: _____

ORIGINAL: Place in Chart, with Medication Sheets YELLOW: Facility, Temporary Receipt, PINK: Pharmacy Copy

LAST NAME	FIRST NAME	ATTENDING PHYSICIAN	ROOM NO.

HCP-331 12/87

MEDICATION VERIFICATION FORM

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) d.

HealthCare Pharmacies
A Division of Healthcare Network

PAGE_____ of _____

CONSULTANT CART AUDIT

☐ Pharmacist
☐ RN

Facility_____ Station_____ Date_____ Consultant_____

Patient	No Problems	Name of Medication	Discrepancy						Other	Action Taken
			direction change sticker needed	no current order	no medication on cart	expired	date opened	quantity problem		

WHITE - Facility YELLOW - Medical Director PINK - Pharmacist

HCP-316 6/87

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) e.

HealthCare Pharmacies
A Division of Health

Page____ of____

CONSULTANT REPORT

☐ Drug Regimen Review

☐ Pharmacist
☐ RN
☐ Dietitian

FACILITY STATION DATE CONSULTANT

Patient	Recommendation/Irregularity	Action Taken

WHITE -Facility YELLOW - Medical Director PINK - Consultant

HCP-317 6/87

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(iv) f.

*HealthCare Pharmacies*SM

PHARMACEUTICAL SERVICES QUALITY CONTROL REPORT

FACILITY _____ DATE _____ CONSULTANT _____

I. DRUG REGIMEN REVIEWS

1. Pharmacist hours spent in the facility _____
2. Dates of visits _____
3. Pages of Review _____
4. Number of notes left to Physicians _____
5. Other Pharmacist activities _____

II. PHARMACY SERVICES

	* C	I	N
1. The schedule of operating hours and deliveries is posted at all nursing stations.	☐	☐	☐
2. The delivery schedule meets the needs of the facility.	☐	☐	☐
3. Pharmacy labels are complete and accurate.	☐	☐	☐
4. Medications from the provider pharmacy are available without interruption or delay.	☐	☐	☐
5. Returnable medications are promptly sent to the pharmacy.	☐	☐	☐
6. Returns to the pharmacy are properly documented.	☐	☐	☐
7. Medications from outside pharmacies are properly labeled.	☐	☐	☐
8. Medications from outside pharmacies are available without interruption or delay.	☐	☐	☐
9. Current drug references are available at all nursing stations and contain monographs of all medications used in the facility.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

III. CHART ORDERS

	C	I	N
1. Medication orders are legally complete.	☐	☐	☐
2. Stop order policies for medications being applied.	☐	☐	☐
3. Telephone orders are properly timed, transcribed and processed.	☐	☐	☐
4. Medication recaps are properly noted.	☐	☐	☐
5. Copies of medication orders are transmitted to pharmacy within 48 hours of signing.	☐	☐	☐
6. New orders for medications are called to the pharmacy.	☐	☐	☐
7. Physician visit and orders are signed in a timely manner.	☐	☐	☐
8. Orders are properly transcribed to medication and treatment sheets.	☐	☐	☐
9. Orders are properly recapped monthly.	☐	☐	☐
10. The system for checking new computer recaps works well.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

IV. ACCOUNTABILITY OF MEDICATIONS

	C	I	N
1. Orders for new medications are properly recorded in the drug order book.	☐	☐	☐
2. Refills are properly recorded in the drug order book.	☐	☐	☐
3. Medications received from the provider pharmacy are properly documented in the drug order book.	☐	☐	☐
4. Medications ordered and received from outside pharamacies are properly documented.	☐	☐	☐
5. Medications brought into the facility on admission are properly handled.	☐	☐	☐
6. Refills of medications are reordered appropriately with no interruption of therapy.	☐	☐	☐
7. Discharge medication orders are properly written.	☐	☐	☐
8. Medications are sent with patients on discharge if appropriate.	☐	☐	☐
9. Documentation of discharge medications is complete.	☐	☐	☐
10. Medications are destroyed on a regular basis, and not kept longer than the required time.	☐	☐	☐
11. Non-controlled medication destruction records contain two signatures, as required.	☐	☐	☐
12. Records of destruction are organized and stored such that information is easily retrievable.	☐	☐	☐
13. Medications sent on pass and returned with the patient are properly documented.	☐	☐	☐
14. Medication quantities are consistent with directions for use.	☐	☐	☐
15. There is not an excessive quantity of medication in overflow storage areas.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

V. ADMINISTRATION OF MEDICATIONS

1. New orders for medications are started timely.	☐	☐	☐
2. Stat orders are administered in a timely manner.	☐	☐	☐
3. Antibiotics, antidiarrheals, anti-nausea, and analgesic etc., medications are administered within time required.	☐	☐	☐
4. Medications not administered as ordered are properly documented.	☐	☐	☐
5. Routine medications are properly documented.	☐	☐	☐
6. PRN medications are properly documented.	☐	☐	☐
7. Appropriate vital signs are monitored for selected drugs.	☐	☐	☐
8. Medications are held as ordered when vital signs are outside specified parameters.	☐	☐	☐
9. The medication administration policy and procedures of this facility are being followed.	☐	☐	☐
10. The treatment administration policy and procedures of this facility are being followed.	☐	☐	☐
11. Proper medication techniques are followed when administering medications.	☐	☐	☐
12. Medications are reviewed for appropriateness of crushing.	☐	☐	☐
13. Medications are crushed with proper technique.	☐	☐	☐
14. Medication administration technique is monitored by the nursing staff.	☐	☐	☐
15. Treatment administration technique is monitored by the nursing staff.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

*CODE: C—Consistent I—Inconsistent N—Never

White Copy—CONSULTANT BINDER Yellow Copy—ADMINISTRATOR Pink Copy—CONSULTANT

HCP-305-1 Rev 4/87

HealthCare Pharmacies℠

PHARMACEUTICAL SERVICES QUALITY CONTROL REPORT

VI MEDICATION STORAGE	* C	I	N
1. Security of medication carts and medication rooms is well maintained.	☐	☐	☐
2. Medication storage areas are neat and organized.	☐	☐	☐
3. There is separation of internal and external preparations in medication storage areas.	☐	☐	☐
4. Refrigerator temperatures range from 36-46 F.	☐	☐	☐
5. Non-refrigerated medications are stored at 59-86 F.	☐	☐	☐
6. Medications not in current use are promptly removed from storage and placed with discontinued and on hold medications.	☐	☐	☐
7. Medications are removed from carts prior to outdating.	☐	☐	☐
8. Medications awaiting destruction or reorder are properly marked.	☐	☐	☐
9. Labels on medications are unsoiled and legible.	☐	☐	☐
10. Facility policies for the labeling of open multidose vials and containers is followed.	☐	☐	☐
11. Proper procedures are utilized for updating medication labels following direction changes.	☐	☐	☐
12. House supply items are properly labeled.	☐	☐	☐
13. An in-house cart audit system is in place.	☐	☐	☐
14. There is an ongoing system in place for medication cart cleaning.	☐	☐	☐
15. Medications stored at the patients bedside are limited to those outlined in policy.	☐	☐	☐
16. Use of bedside medications is properly recorded at least daily.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

VII. EMERGENCY MEDICATIONS			
1. Emergency kit contents are posted at the nursing station.	☐	☐	☐
2. Emergency kits are properly sealed and stored.	☐	☐	☐
3. Use of emergency kits is properly documented in the ER log.	☐	☐	☐
4. Following use, emergency kits are replaced timely.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

VIII. CONTROLLED MEDICATIONS			
1. Controlled medications are properly stored.	☐	☐	☐
2. Controlled medication reconcilliation records are complete.	☐	☐	☐
3. Controlled medications are properly documented when used.	☐	☐	☐
4. Controlled medications awaiting destruction are properly stored.	☐	☐	☐
5. Documentation of destruction of controlled medications is complete; including signatures.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

IX. BEHAVIOR CONTROL MEDICATIONS	* C	I	N
1. Psychotropic medication policy of the facility is being followed.	☐	☐	☐
2. Specific behaviors corollating to psychotropic medications are identified in the patient health records.	☐	☐	☐
3. Proper monitoring of behaviors is being done	☐	☐	☐
4 All psychotropic medications used for behavior are being monitored.	☐	☐	☐
5. Monthly summaries are completed timely according to facility policy.	☐	☐	☐
6. Monthly summaries are complete and correlate with collected data.	☐	☐	☐
7. Side effects are being monitored and documented.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

X. ENTERAL FEEDINGS			
1. The enteral log is complete and updated.	☐	☐	☐
2. Enteral feeding bags are properly labeled.	☐	☐	☐
3. Enteral pumps are set properly.	☐	☐	☐
4. Tubing is changed and labeled properly.	☐	☐	☐
5. Enteral feeding documentation is complete.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

XI. IV THERAPY			
1. IV storage is adequate.	☐	☐	☐
2. Accountability of IV deliveries is complete.	☐	☐	☐
3. Delivery of IVs is timely.	☐	☐	☐
4. Nursing documentation on IV bag is complete.	☐	☐	☐
5. Medication add-on labels are completed when appropriate.	☐	☐	☐
6. IV tubing/bag are changed according to policy.	☐	☐	☐
7. IV medication documentation is complete.	☐	☐	☐
8. IV infusion devices are properly maintained.	☐	☐	☐

COMMENTS/RECOMMENDATIONS: _____

XII. OTHER: _____

XIII. PRIORITIES/TARGET DATES:	DATE

*CODE: C—Consistent I—Inconsistent N—Never

White Copy—CONSULTANT BINDER Yellow Copy—ADMINISTRATOR Pink Copy—CONSULTANT

HealthCare Pharmacies℠
A Division of HealthCare Network

OBSERVATION OF MEDICATION ADMINISTRATION

MEDICATION NURSE: _____ MED PASS TIME: _____

OBSERVER: _____ TIME STARTED: _____

DATE: _____ TIME ENDED: _____

CRITERIA	MET	NOT MET	COMMENTS
Procedure is pour/pass/chart			
Verifies med book/label information			
Maintains sanitary technique with meds			
Identifies patient			
Appropriate vital signs taken before administration			
Observes patient take meds			
Offers sufficient fluid with meds			
Uses/documents PRNs appropriately			
Maintains security of cart during pass			
Documents doses given/not given			
Administers doses accurately			
Uses proper handwashing technique			
SPECIFIC TECHNIQUES Only appropriate meds are crushed			
Proper crushing technique is used			
Uses proper eye med/injection administration technique			
Tube Feeding a. N/G tube checked for placement			
b. Tube flushed before/after meds			
c. Meds administered completely/accurately			
d. [illegible]			

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(v) a.

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(v) b.

HealthCare Pharmacies

[illegible] CA 94577
(415) 351-6666
(510) 273-6665

MEDICATION ADMINISTRATION EVALUATION AND DATA SUMMARY

FACILITY:_____ DATE OF OBSERVATION:_____

WING / UNIT:_____ OBSERVATION PERIOD:_____

EVALUATIVE DEFINITIONS

MEDICATION ERROR- a discrepancy between what the physician has ordered and what is observed during medication administration.

SIGNIFICANT MEDICATION ERROR- one which causes the resident discomfort or jeopardizes his or her health or safety.

INSIGNIFICANT MEDICATION ERROR- all errors observed which are not classified as significant based on the professional judgement of the observer. Areas of consideration include: resident's medical condition, medication category, and frequency of error.

TOTAL OPPORTUNITIES FOR ERROR- all doses observed being administered plus the doses ordered but not administered.

MEDICATION ERROR RATE- percentage error rate calculated per the HCFA formulation.

$$\frac{\text{Number of Errors Observed (both significant and insignificant)}}{\text{Total Opportunities for Error}} \times 100 = \%\ \text{Rate}$$

FACILITY SPECIFIC MEDICATION ERROR RATE:

$$\frac{\text{Total Number of Errors}}{\text{Total Opportunities for Error}} \times 100 = \text{Rate}$$

IDENTIFICATION / CATEGORIZATION OF ERRORS

Medication Administration Errors		Nursing Technique Errors	
Omissions	_____	Pour/Pass/Chart	_____
Unauthorized medication	_____	Medication verification	_____
Wrong medication	_____	Resident verification	_____
Wrong dose	_____	Cart security	_____
Wrong route	_____	Sanitary technique	_____
Wrong dosage form	_____	Other	_____
TOTAL ERRORS	_____	TOTAL ERRORS	_____

Comments / Recommendations:

Completed by_____ Date_____

11/90

HealthCare Pharmacies℠

DRAFT

Antipsychotic Therapy Assessment

Dear Physician:

In an effort to reduce unnecessary drug use, new federal regulations (OBRA) governing long-term care facilities include guidelines regarding antipsychotic drug use (phenothiazines and haloperidol). Under these regulations, antipsychotics must be used to treat "specific condition(s)" and not solely for behavior control. In addition, the guidelines discourage excessive PRN doses without physician review.

This resident is on the following antipsychotic: _____.

I. Please review for appropriateness.

II. Please check the specific condition(s) which apply to the use of the above antipsychotic in this resident. The conditions are reprinted from the federal interpretive guidelines to state surveyors.

___ Organic mental syndrome (including dementia) with psychotic/agitated features as defined by:
- ___ episodes of potential danger to self or others, or interference with care (e.g. biting, kicking and scratching).
- ___ continuous behaviors which cause an impairment in functional capacity (e.g. crying out, screaming, yelling, pacing).
- ___ psychotic symptoms which cause impairment in functional capacity (e.g. hallucinations, paranoia, delusions).

___ schizophrenia
___ schizo-affective disorder
___ delusional disorder
___ psychotic mood disorders (including manic depression)
___ acute psychotic episodes
___ brief reactive psychosis
___ schizophreniform disorder
___ atypical psychosis
___ Tourette's disorder
___ Huntington's chorea

III. ___ If the resident does not have any of the above conditions yet you wish him/her to remain on the drug, please document your reasons in your progress notes.

The federal regulations also recommend gradual dose reduction of these antipsychotic drugs or institution of behavioral programming unless clinically contraindicated.

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Patient Name: _____ Patient #: _____

11/90 FOR A LIST OF ANTIPSYCHOTIC DRUGS, SEE REVERSE OF THIS FORM

Common Antipsychotic Drugs

Brand Name	Generic Name
Haldol	Haloperidol
Thorazine	Chlorpromazine
Mellaril	Thioridazine
Stelazine	Trifluoperazine
Prolixin Deconoate	Fluphenazine Deconoate
Prolixin, Permitil	Fluphenazine
Trilafon	Perphenazine
Navane	Thiothixene
Sparine	Promazine
Vesprin	Trifluprомazine
Serentil	Mesoridazine
Tindal	Acetophenazine
Taractan	Chlorprothixene
Loxitane	Loxapine
Moban	Molindone
Inapsine	Droperidol
Orap	Pimozide
Etrafon/Triavil	Perphenazine (w/ amitriptyline)

APPENDIX VI. DOCUMENTATION utilised by HEALTHCARE NETWORK.
(vi) b.

HEALTHCARE PHARMACY 6195786442 P.03

PSYCHOTROPIC SUMMARY SHEET

BEHAVIOR DATA

MEDICATION: _____ BEHAVIORAL MANIFESTATION: _____

ORDERS: _____

TIME PERIOD	# EPISODES PER SHIFT 7-3	3-11	11-7	# PRN DOSES if appl	ADVERSE REACTIONS see care plan	OBSERVATION COMMENTS	NURSE'S SIGNATURE
-							
-							
-							
-							
-							
-							
-							
-							
-							
-							
-							
-							

DOSAGE CHANGES:

DATE	↑, ↓ OR D/C	NEW DOSE	RATIONALE FOR CHANGE

NAME _____ RESIDENT NO. _____ DR. _____ ROOM NO. _____

HealthCare Pharmacies

PHARMACIST QUARTERLY REPORT - [redacted]

August, 1990 - October, 1990

I. Drug Regimen Review

Drug regimen reviews are performed in the facility on each patient monthly by the consultant pharmacist. Recommendations are made to the attending physicians using a new sheet which asks for M.D. response. "Holding" copies of the form are placed in the consultant binder in the Director of Nurses' office. The success of this form is moderate. Approximately 50 hours were spent on facility related matters in this quarter. Twelve notes were left for physicians during this quarter. This is lower than usual because the pharmacist has not been requesting diagnoses for medications pending institution of the new system for incorporating diagnosis into the body of medication orders. The September inservice on Psychotropic Drugs was not given.

II. Pharmacy Services

Pharmacy services continue to be adequate to meet the needs of the facility and the patients.

III. Chart Orders

There continues to be improvement in the completeness of potassium chloride orders. The letter requesting diagnosis as part of major medication orders was sent to the physician staff from the facility and the program managers have been inserviced as to the system so this program should be implemented in the next quarter. The respiratory staff has been encouraged to transcribe respiratory medication orders to their treatment sheet exactly as written by the physician.

IV. Ordering of Medications and Accountability

There has been improvement in the refill ordering process during this quarter. There also has been improvement in the storage of overflow medication which also indicates improvement in ordering.

V. Administration of Medications

There continues to be improvement in the area of respiratory charting, however omissions and inconsistency in setting up orders still occurs. The new respiratory charting sheet has been a success and it appears that ongoing reinforcement of proper procedures be continued. It is also recommended that a respiratory charting audit be incorporated into the medication charting audit which has been recently revised. The pharmacist will continue to monitor this area and make recommendations when indicated. PRN documentation of medications continues to be somewhat inconsistent. A few instances of late antibiotic administration have been itemized in the last quarter. The staff is reminded of the four-hour rule as we enter the winter season and expect to see more antibiotics used.

VI. Storage

As mentioned above, storage of overflow medications has improved somewhat. The staff is again reminded to mark discontinued medications with d/c tape while awaiting destruction. The new system of the night shift reviewing and destroying medications appears to be working well. The facility policy for labeling multi-dose vials with a date opened sticker is not consistently followed, especially with insulin.

VII. Psychotropics

Psychotropics continued to be monitored inconsistently. Anti-psychotic medications are used very rarely in this facility.

VIII. Goals for Last Quarter

1. Medication reordering system has improved.

2. Respiratory charting has improved.

IX. Goals for Next Quarter

1. Incorporation of diagnosis into medication orders.
2. Psychotropic monitoring.

Dianne Tobias, Pharm. D. November 21, 1990

MEDICATIONS WHICH SHOULD NOT BE CHEWED OR CRUSHED

THIS IS NON INTENDED TO BE A COMPLETE LISTING OF ALL MEDICATIONS WHICH SHOULD NOT BE CHEWED/CRUSHED, BUT RATHER A SUMMARY LIST OF THOSE MEDICATIONS COMMONLY ORDERED IN THE LONG TERM CARE ENVIRONMENT.

* CODES

- **EC** — Enteric coated
- **SR** — Slow release, long acting; designed to release drug over a long period of time – crushing destroys action
- **EFF** — Effervescent
- **CHEW** — Product designed to be chewed; proper action of drug depends on chewing
- **LIQ** — Liquid in capsule form; inaccurate dose if contents emptied
- **SRE** — Slow release, contents may be emptied and mixed with apple sauce or given via NGT but not crushed
- **SL** — Dissolve under tongue; tablets inactive if taken orally

PHENOTHIAZINE DRUGS SUCH AS MELLARIL, THORAZINE, STELAZINE MAY PRODUCE ORAL IRRITATION IF CRUSHED & GIVEN ORALLY OR CHEWED.

MEDICATION	* CODE	LIQUID AVAILABLE	ALTERNATIVES/COMMENTS
BELLERGAL S	SR	NO	Bellergal tab
BISACODYL	EC	NO	Bisacodyl suppository
CALAN SR	EC	NO	Calan, Isoptin
CHLORAL HYDRATE	LIQ	YES	Noctec syrup 500mg/5ml
CHLORPHENIRAMINE MALEATE TD	SR	YES	Chlortrimeton syrup 2mg/5ml, tab
CHLORTRIMETON REPETABS	SR	YES	See Chlorpheniramine Maleate
CHOLEDYL SA	SR	YES	Choledyl elixir 100mg/5ml, tab
COMBID SPANSULES	SRE	NO	
COMPAZINE SPANSULES	SRE	YES	Compazine liquid 5mg/5ml, tab, injectable solution, suppository
DECONAMINE SR	SR	NO	Deconamine tab
DEPAKENE	LIQ	YES	Depakene liquid 250mg/5ml
DEPAKOTE	EC	YES	See Depakene
DES ENSEALS	EC	NO	DES tab, suppository
DIAMOX SEQUELS	SRE	NO	Diamox tab
DIMETANE EXTENTABS	SR	YES	Dimetane elixir 2mg/5ml, tab
DIMETAPP EXTENTABS	SR	YES	Dimetapp elixir
DONNAZYME	SR	NO	Can substitute Donnatol tab and Ilozyme; not exact substitution
DRIXORAL	SR	NO	
DSS	LIQ	YES	DSS liquid 50mg/5ml, pull apart cap
DUCOLAX	EC	NO	See Bisacodyl
ECOTRIN	EC	NO	Plain/buffered ASA tab, suppository
E MYCIN	EC	YES	EES liquid 400mg/5ml (equivalent to 250mg), chewable and regular tabs
ESKALITH CR	SR	YES	See Lithobid
FEOSOL SPANSULES	SRE	YES	Ferrous sulfate elixir 5gr/7ml
FERO-GRAD	SR	YES	Fergon 300mg/5ml, add Vit. C
FERRO-SEQUELS	SRE	YES	Feostat Susp, add DSS 100mg
FEROFOLIC 500	SR	NO	Can substitute ferrous sulfate elixir, folate 1 mg, Vit C, not exact substitution
GAVISCON	CHEW	YES	Gaviscon liquid 15ml
HYDERGINE SL	SL	YES	Hydergine liquid 1mg/ml, tab
IBERET, IBERET 500	SR	YES	Iberet and Iberet 500 liquid
INDERAL SA	SR	NO	Inderal tab
INDOCIN SR	SRE	NO	Indocin cap
ISOPTIN SR			See Calan SR
ISORDIL CHEWABLE, S.L.	CHEW, SL	NO	Isordil tab
ISORDIL TEMBIDS	SR	NO	Isordil tab
K TABS	SR	YES	See Kaon
KLOTRIX	SR	YES	See Kaon
K-LYTE	EFF	YES	See Kaon, may dissolve tabs in water
LITHOBID	SR	YES	Lithium citrate solution Lithium carbonate tab, capsule
MODANE	LIQ	YES	Modane liquid 37.5mg/5ml
MULTICEBRIN	EC	NO	
MICRO K	SRE	YES	See Kaon
MS CONTIN	SR	YES	Morphine sulfate liquid
NALDECON	SR	YES	Naldecon syrup 10ml
NICOBID	SR	YES	Nicotinex 50mg/5ml
NITROGLYCERINE TD	SRE	NO	Nitropaste, Isordil
NOCTEC	LIQ	YES	See Chloral Hydrate
NITROSTAT	SL	NO	
NOVAFED	SR	YES	Novafed or Sudafed syrup 30mg/5ml
NORPACE CR	SR	NO	Norpace cap (can be emptied)
ORNADE SPANSULES	SRE	NO	Ornade tab
PANCREASE	EC	NO	
PAVABID	SR	NO	Papaverine cap
PERITRATE SA	SR	NO	Peritrate, P.E.T.N. tab
PHAZYME	EC	NO	Can substitute Mylicon and Ilozyme; not exact substitution
POLARMINE REPETABS	SR	YES	Polarmine syrup 2mg/5ml
PROCAN SR	SR	NO	Procainamide cap
PROCARDIA	LIQ	NO	
PAPAVERINE HCL TR	SR	NO	See Pavabid
QUINIDEX EXTENTABS	SR	NO	Quinidine sulfate tab, injectable
QUINAGLUTE DURA-TABS	SR	NO	See Quinidex
ROXANOL SR	SR		See MS Contin
SINGLET (NOVAHISTINE)	SR	YES	
SLOBID	SR	YES	Theophylline elixir 80mg/15ml, Accubron 10mg/ml, SloPhyllin
SLOPHYLLIN	SRE	YES	See Slobid
SLOW K	SR	YES	See Kaon
SORBITRATE SA	SR	NO	Sorbitrate tab
SUDAFED SA	SR	YES	Sudafed syrup 5ml, tab
SUSTAIRE	SR	YES	See Slobid
SYMMETREL	LIQ	YES	Symmetrel liquid 50mg/5ml
TELDRIN SPANSULES	SRE	YES	See Chlorpheniramine maleate
THEOBID	SRE	YES	See Slobid
THEODUR	SR	YES	See Slobid
THEODUR SPRINKLES	SRE	YES	See Slobid
THORAZINE SPANSULES	SRE	YES	Thorazine Solution and Concentrate, tab, suppos, injectable
TRENTAL	SR	NO	
TRILAFON REPETABS	SR	YES	Trilafon Concentrate 16mg/5ml
TUSS ORNADE	SRE	YES	Tuss Ornade liquid 10ml
ZARONTIN	LIQ	YES	Zarontin syrup 250mg/5ml

MEDICATIONS WHICH SHOULD NOT BE CHEWED OR CRUSHED

HEALTHCARE NETWORK . . .
A LEADER IN EDUCATIONAL PROGRAMS

HealthCare Network provides extensive continuing education programs developed exclusively for long term care. HealthCare Network is both a BRN and BENHA provider.

The following are inservice topics available for presentation:

PHARMACY

Abnormal Movement — EPS
AIDS
Alzheimer's
Antibiotics
Anticoagulants
Anticonvulsants
Antihypertensives I & II
Antispasticity Agents
Anxiolytics, Antidepressants & Antipsychotics
Beta Blocking Agents
Blood Glucose Analysis
Cardiac Drugs
Congestive Heart Failure
Dehydration
Depression in the Elderly
Diabetes
Digoxin
Documenting Patient Care
Drug Allergy
Electrolyte Imbalances
Food/Drug Interactions
Gastrointestinal Drugs
Geriatric Drug Therapy
Inflammatory Bowel Disease-Treatment
Interpretation of Lab Tests
Introduction to Med Issues in Long Term Care
Medication Administration
Pain Assessment
Pediatrics
Pharmacokinetics and Therapeutic Drug Monitoring
Peptic Ulcer Disease
Physical Assessment
Proper Use of Medication Systems
Psychotropic Monitoring
Psychotropic Agents
Psychotropics — Nursing Considerations
Sleep in the Elderly
Tuberculosis
Treatment Administration
Urinary Tract Infections

NUTRITION

Choices in Enteral Formulas and Delivery Systems
Components of Physician's Order
Computerized Nutritional Assessment
Dysphagia
Enteral Feedings
Entrition™
Gravity w/Entrimet™ Bag
Heart Healthy Diets
Newtrition™
Nursing Nutritional Assessment
Nutrition and the Geriatric Patient
Nutrition and Wound Healing
Nutritional Consideration in Medication Administration
Quality Control of Enteral Formulas (Safety)
Reimbursement for Enteral Parenteral Therapy
Role of Enteral Consultant
TPN - Interdisciplinary
TPN - Nursing Management

I.V. THERAPY

Advanced I.V. Technique
Central Lines
I.V. Antibiotics
I.V. Refresher Course
I.V. - Pain Medication Documentation
LVN I.V. Certification
LVN Certification - Blood Withdrawal
Pain Management

FOR MORE INFORMATION PLEASE CONTACT THE PHARMACY MANAGER AT:

HealthCare Pharmacies
A Division of HealthCare Network

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COLTON
(714) 824-0440 (800) 331-0770

SAN DIEGO
(619) 530-0090

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(213) 838-4420 (800) 533-4420

SAN LEANDRO
(415) 351-6666 (800) 922-2767

SALT LAKE CITY
(801) 266-3999 (800) 345-5889

HealthCare Network

[illegible] Dow Avenue
[illegible], CA 92685

[illegible]
(714) 544-4403

HEALTHCARE NETWORK SALES TRAINING

SEPTEMBER 20, 1990

HealthCare Network Overview

Alison Arkin, Vice President of Marketing and Development

```
**************************************
*    Professions Seek Authority;     *
*    Businesses Seek Profit;         *
*    HealthCare Network Seeks Both.  *
**************************************
```

I. HEALTHCARE NETWORK

- History and Philosophy
- Locations
- Product Profile
- Professionals
- Market Shares
- Potential
- Strategic Plan

II. PRODUCTS AND PROGRAMS

- HealthCare Network Program Directors will describe programs with focus on:
  - Benefits to Customers
  - Edge Over Competitors
  - How To Sell!

III. KNOW YOUR CUSTOMER

- What Matters (Random Order)

Long Term Care	Acute Care
. Patient Care	. Patient Care
. Ease of Use (Minimal Work)	. Appeal to Attract Physicians
. Cost Effectiveness	. Opportunity for Grant Funding
. Fit with Regulations	. Learning Opportunities for Interns and Residents
. Marketability to Community	. Ability for Publications or Fame for Medical Staff
	. Marketability to Community

IV. LONG TERM CARE "HOT BUTTONS"

- Patient Care - (Clinical outcomes, such as decreased frequency of diarrhea, accelerated wound healing, elimination of fever, improved breathing, elimination of infection, overall improvement of patient status)

- Ease of Use - Long term care facilities seek providers who will do as much of the work for their staff as possible. Shortage of qualified nursing has lead to this dependence on outside providers. Features of our programs that are attractive to users are: any time savings, ease of ordering, frequency of delivery, teaching support, systems to track use such as sticky label or consignment, professional consultants available.

- Regulations - Long term care is heavily regulated. Consequently, customers are concerned about our support during survey, ability to provide disclaimer letters from manufacturers if surveyors question the use of equipment, and support after survey for action plans.

- Cost Effectiveness - Long term care is under a low margin reimbursement structure. Following are important: when the facility must pay, how frequently they pay, ease of reading bills, how our pricing fits in with reimbursement, what they will have to pay for out of pocket or on their "house account."

V. HEALTHCARE NETWORK'S COMMITMENT TO MARKETING FOR SALES SUPPORT

- Quality Assurance and Ongoing Enhancements of Programs We Sell
- Conventions and Trade Shows
- Educational Seminars
- Brochures
- Sell Sheets and Other Support Materials
- Assistance with Proposals
- Directors to Attend Marketing Calls
- Direct Mailing Promotions
- Promotional Items and Gifts
- Newsletter
- Sales Training!

Welcome to HealthCare Network! We look forward to your involvement with our continued growth and credibility in the health care community!

APPENDIX VII.

AVERAGE PRESCRIPTION REDUCTION EFFECT OF DRUG REGIMEN REVIEW BY PHARMACISTS IN U.S.A.

Pharmacists.	No. patients/beds.	Average reduction per patient.
1. Cheung & Kayne.	517	1.2 (6.8 to 5.6)
2. Rawlings & Frisk	260	1.6 (7.7 to 6.1)
3. Hood, et al	40	0.9 (7.6 to 6.7)
4. Martilla	20	1.6. (7.2 to 5.6)
5. Lofholm	55	2.2 (6.8 to 4.6)
6. Cooper & Bagwell	142	2.4 (7.2 to 4.7)
7. Ellenor & Frisk	475	0.9 (2.4 to 1.5)
8. Underwoods.	160	1.7 (5.6 to 3.9)
9. Young, et al	25	1.8 (6.0 to 3.9)
10. Rush, et al	175	69% decreased cost
11. Strandberg	260	42% decreased use
12. Inoue	400 (ICF)	48.6% dose redn.
13. Wilcher & Cooper	116	2.4 (7.2 to 4.8)
14. Chrymko & Conrad.	21	2.0 (6.5 to 4.5) *
15. Thompson & Ruffalo.	127	2.2 (7.9 to 5.7)
16. Cooper	72	4.1 (8.9 to 4.8)**

* This reduction was achieved by a pharmacy resident during a 2 month rotation. Twelve months later the average had increased to 6.2.

** When this had been achieved the Drug Regimen Review was terminated. Prescriptions rose to an average of 9.6. per patient. When D.R.R. was re-introduced the average was 6.1. per patient.

Data reprinted from 'Pharmaceutical Services in the Long Term Care Facility'.

APPENDIX VIII. FEDERAL INDICATORS for ASSESSING DRUG REGIMEN REVIEW.

A. REVIEWS PERFORMED VERSUS AVERAGE CENSUS.

Compare the number of drug regimen reviews performed to the average census of the facility. If the average census is 100, then the number of reviews that would be performed per month would be about 100. However, this simple indicator cannot be absolute, and tolerances must be allowed. For example, the pharmacist may have reviewed only 50% of the patients in a particular month, but the other 50% are scheduled for review the day after the survey. If the number falls significantly short of patient census over a number of months, a non compliance finding is in order.

B. REVIEWS SHOULD BE PERFORMED IN THE FACILITY.

A pharmacist cannot be required to perform reviews in the facility. The regulations do not state where the reviews must be performed. However, in order to perform acceptable reviews, the facility's reviewer must be examining data sources such as the patient's drug administration record, physician's orders, nursing notes, and laboratory reports. For all practical purposes these data sources are only located in the facility. Thus, to adequately perform reviews, the pharmacist should be conducting them in the facility.

C. AVERAGE PRESCRIPTION UTILISATION.

In 1974 the average prescription utilisation for S.N.F. patients was found to be approximately 6.1. The current average is probably unchanged. As a general rule, one could question the adequacy of drug reviews if the facility's average prescription utilisation were above 6 per patient. There are qualifications to this indicator:

1. The 6.1 average is a national average. Regional and State variations can be significantly different. The average in the State the surveyor serves may be more meaningful. The Medicaid Management Information System, if one is available, can be of assistance in supplying this specific information.

2. The nature of the patient population (e.g. a high number of patients with multiple chronic diseases) may be such that a higher utilisation is appropriate.

3. The assumption that drug regimen reviews reduce utilisation may not always be true. A drug regimen review may result in additional drug utilisation.

4. The pharmacist may be performing good reviews and recommending that drugs be discontinued but the physician may not agree with the recommendations.

APPENDIX VIII cont.

5. Analysis by the surveyor of the trend in prescription utilisation is critical. The pharmacist may be changing attitudes about drug therapy, and a slow improvement may be evolving. Thus, if the average is higher than 6 but the trend is toward reduction, the pharmacist may be adequately performing drug reviews.

6. In an I.C.F./M.R. the drug utilisation is usually significantly lower (approximately 3 per patient per month). I.C.F.'s drug utilisation is usually comparable to S.N.F.

In order to estimate the average prescription utilisation, examine a sufficient sample of charts to establish a pattern. It is not necessary to calculate an exact average. In determining the average, include all legend (the equivalent of Prescription Only Medicines in U.K.) and over-the-counter (O.T.C.) drugs.

Count as one prescription any drug order, including as needed (PRN) orders, if one dose has been administered in the last 30 days. If a drug has been ordered but never administered in the last 30 days, do not count it in the average. Combination drugs (e.g. aspirin and codeine) should be counted as one prescription.

D. EXCESSIVE REVIEWS ON THE SAME DATE.

The ability of the pharmacist to review patient records is finite. Question the adequacy of review if more than 100 patients have been reviewed on the same day by the same reviewer.

E. APPARENT IRREGULARITIES (POTENTIAL DRUG THERAPY PROBLEMS).

The pharmacist should address these apparent irregularities every time they are encountered.

1. RULES FOR APPLYING APPARENT IRREGULARITIES.

   a) The pharmacist conducting reviews is responsible for identifying apparent irregularities and notifying an individual having authority to correct the potential problem.

   b) You (the surveyor) are responsible for determining whether such identification and notification has taken place.

   c) Do not go any further than determining if identification and notification has occurred. It is not necessary to ascertain the disposition of the recommendation made by the pharmacist. Inquiry into the specific treatments or outcome could be construed as Federal interference with the practice of medicine, which is prohibited by Section 1801 of the Social Security Act.

APPENDIX VIII cont.

d) A record of drug regimen reviews must be maintained in the facility in order to demonstrate that such reviews have been performed. This record may or may not be part of the patient's medical record depending on the policy of the facility. In any case each patient must be identified, and documentation of one of the following circumstances must exist:

1. If no potential problems were found by the pharmacist, he or she must have included a signed and dated statement to this effect in the drug regimen review record.
2. If a potential problem was found and the pharmacist deemed it NOT significant, then he or she must have included a signed and dated statement in the drug regimen review record.
3. If a potential problem was found that was considered significant the pharmacist must have included a signed and dated statement in the record describing the situation and indicating that they communicated this information to an individual with authority to correct it, usually the attending physician.
4. The facility's reviewer need not have documented the identification and notification every month even if the apparent irregularity continues, provided:
   - -it has been deemed insignificant by the pharmacist, or
   - -it has been deemed significant, but the recommendation has been rejected by the individual having authority to correct it.

Under these circumstances, the facility's reviewer may document that he or she has identified an apparent irregularity and notified a person having authority to correct the potential problem on an ANNUAL basis. This documentation should appear in whatever record the facility decides to use for documenting drug regimen reviews

2. LIST OF APPARENT IRREGULARITIES.

These drug therapy circumstances may constitute drug irregularities (potential drug therapy problems).

a) Multiple orders of the same drug for the same patient by the same route of administration (e.g. the same chemical entity by different brand names).

b) Drugs administered in disregard of established stop order policies.

c) As needed (PRN) drug orders administered as directed every day for more than 30 days.

d) Patients receiving three or more laxatives concurrently. Sequential use need not be questioned.

e) Use of antipsychotics or antidepressants for less than 3 days.

f) Continuous use of hypnotic drugs for more than 30 days.

APPENDIX VIII cont.

g) Use of 2 or more hypnotic drugs at the same time.

h) Hypnotic drugs administered in excess of the listed maximum doses.

i) Use of 2 or more antipsychotic drugs at the same time.

j) Use of antipsychotic drugs in excess of the listed daily dosage maximums.

k) Use of anxiolytic drugs when their dosages exceed the stated maximums.

l) More than 2 changes of an antidepressant within a 7 day period.

m) Use of antidepressants in excess of the listed daily maximums.

n) Patients who repeatedly lose seizure control while taking anticonvulsants.

o) Patients who are taking thyroid drugs and have not had some assessment of thyroid function.

p) Patients who are taking drugs to reduce Blood Pressure and have not had a blood pressure recorded at least weekly.

q) Patients who are taking anticoagulant therapy and have not had some assessment of blood clotting function at least every month. The most common blood clotting function test is prothrombin time.

r) Patients who are taking cardioactive drugs and have not had a pulse rate recorded daily in the first month of therapy and weekly thereafter or the chart shows a pulse rate consistently below 60 or above 100.

s) Patients who are taking Insulin or oral hypoglycaemics and have not had a urine sugar test at least every 60 days.

t) Patients who are taking iron preparations, folic acid or Vit.B12 and have not had a red blood cell assessment during the first month of therapy.

u) Use of antibiotics in chronic urinary tract infections if an urinanalysis has not been performed at least once every 30 days after therapy was initiated.

v) Patients taking the antibiotics listed under u) who have not had a urine pH determination within 30 days after therapy was initiated, or if therapy is continued when urine pH is continually above 6.

w) Use of Nitrofurantoin for conditions other than treatment or prophylaxis of urinary tract infections, or blood urea nitrogen or serum creatinine levels are not recorded on the chart.

APPENDIX VIII cont.

x) Three or more analgesics used at the same time.

y) Patients taking diuretics who have not had a serum potassium level determination within 30 days after initiation of the therapy.

z) Patients takind diuretics and cardiotonics e.g. Digoxin, who have not had a serum potassium determination within 30 days after the initiation of the cardiotonic therapy and every 6 months thereafter.

aa) Patients who are taking Phenylbutazone continuously and have not had at least one CBC determination 30 days after initiation of the therapy.

bb) The use of cardiotonics e.g. Digoxin, in the absence of one of the following diagnoses: congestive heart failure, atrial fibrillation, paroxysmal superventricular tachycardia, atrial flutter

cc) The use of anticholinergic therapy with antipsychotic drugs in the absence of documented extra pyramidal side effects e.g. tremor, drooling, shuffling gait.

dd) The continuous use of antibiotic steroidal opthalmic preparations for periods exceeding 14 days.

ee) The use of aminoglycocides in the absence of a serum creatinine determination when therapy was initiated.

ff) Order for drugs for which there is a known allergy as documented in the patient's record.

gg) The crushhing of solid dosage forms when the likely result will cause patient discomfort e.g. Dulcolax, or undesired blood levels e.g. Theophylline.

APPENDIX IX.

RESIDENT ASSESSMENT INSTRUMENT FOR LONG TERM CARE FACILITIES

(BACKGROUND INFORMATION/INTAKE AT ADMISSION

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	(First) (Middle Initial) (Last)
2.	DATE OF CURRENT ADMISSION	Month — Day — Year
3.	MEDICARE NO. (SOC. SEC. or Comparable No. if no Medicare No.)	
4.	FACILITY PROVIDER NO.	Federal No.
5.	GENDER	1. Male 2. Female
6.	RACE/ETHNICITY	1. American Indian/Alaska Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
7.	BIRTHDATE	Month — Day — Year
8.	LIFETIME OCCUPATION	
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English 0. No 1. Yes _____ (Specify)
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)* Prior stay at this nursing home a. Other nursing home/residential facility b. MH/psychiatric setting c. MR/DD setting d. *NONE OF ABOVE* e.
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem 0. No 1. Yes
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)* Not applicable — no MR/DD (Skip to item 13) a. MR/DD with Organic Condition Cerebral palsy b. Down's syndrome c. Autism d. Epilepsy e. Other organic condition related to MR/DD f. MR/DD with no organic condition g. Unknown h.
13.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated
14.	ADMITTED FROM	1. Private home or apt. 3. Acute care hospital 2. Nursing home 4. Other
15.	LIVED ALONE	0. No 1. Yes 2. In other facility
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier a. Observation revealed additional information b. Resident unstable at admission c.

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	Month — Day — Year
2.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated
3.	ADMITTED FROM	1. Private home or apt 3. Acute care hospital 2. Nursing home 4. Other
4.	LIVE ALONE	0. No 1. Yes 2. In other facility
5.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier a. Observation revealed additional information b. Resident unstable at admission c.

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1.	CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)	*(Check all that apply. If all information UNKNOWN, check last box only.)* CYCLE OF DAILY EVENTS Stays up late at night (e.g., after 9 pm) a. Naps regularly during day (at lest 1 hour) b. Goes out 1 + days a week c. Stays busy with hobbies, reading, or fixed daily routine d. Spends most time alone or watching TV e. Moves independently indoors (with appliances, if used) f. *NONE OF ABOVE* g. EATING PATTERNS Distinct food preferences h. Eats between meals all or most days i. Use of alcoholic beverage(s) at least weekly j. *NONE OF ABOVE* k. ADL PATTERNS In bedclothes much of day l. Wakens to toilet all or most nights m. Has irregular bowel movement pattern n. Prefers showers for bathing o. *NONE OF ABOVE* p. INVOLVEMENT PATTERNS Daily contact with relatives/close friends q. Usually attends church, temple, synagogue (etc.) r. Finds strength in faith s. Daily animal companion/presence t. Involved in group activities u. *NONE OF ABOVE* v. UNKNOWN — Resident/family unable to provide information w.

Signature of RN Assessment Coordinator _____

Signatures of Others Who Completed Part of the Assessment

_____ _____

_____ _____

● - AUTOMATIC TRIGGER — Go directly to RAP instructions

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Wellbeing
8. Mood State
9. Behavior Problems
10. Activities

▲ - POTENTIAL TRIGGER — Go to RAP instructions for more detailed trigger definitions

11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Used
18. Physical Restraint

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RESIDENT ASSESSMENT INSTRUMENT FOR LONG TERM CARE FACILITIES

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. ASSESSMENT DATE — Month — Day — Year
2. RESIDENT NAME — (First) (Middle Initial) (Last)
3. SOCIAL SECURITY NO.
4. MEDICAID NO. (If applicable)
5. MEDICAL RECORD NO.
6. REASON FOR ASSESSMENT
   1. Initial admission assess.
   2. Hosp/Medicare reassess.
   3. Readmission assessment
   4. Annual assessment
   5. Significant change in status
   6. Other (e.g. UR)
7. CURRENT PAYMENT SOURCE(S) FOR N.H. STAY *(Billing Office to indicate; check all that apply)*
   Medicaid (a.) — VA (d.)
   Medicare (b.) — Self pay/Private insurance (e.)
   CHAMPUS (c.) — Other (f.)
8. RESPONSIBILITY/LEGAL GUARDIAN *(Check all that apply)*
   Legal guardian (a.) — Family member responsible (d.)
   Other legal oversight (b.) — Resident responsible (e.)
   Durable power attrny/ health care proxy (c.) — *NONE OF ABOVE* (f.)
9. ADVANCED DIRECTIVES *(For those items with supporting documentation in the medical record, check all that apply)*
   Living will (a.) — Feeding restrictions (f.)
   Do not resuscitate (b.) — Medication restrictions (g.)
   Do not hospitalize (c.) — Other treatment restrictions (h.)
   Organ donation (d.) — *NONE OF ABOVE* (i.)
   Autopsy request (e.)
10. DISCHARGE PLANNED WITHIN 3 MOS. *(Does not include discharge due to death)*
    0. NO 1. Yes 2. Unknown/uncertain
11. PARTICIPATE IN ASSESSMENT
    a. Resident: 0. No 1. Yes (a.)
    b. Family: 0. No 1. Yes 2. No family (b.)
12. SIGNATURES
    Signature of RN Assessment Coordinator
    Signatures of Others Who Completed Part of the Assessment

SECTION B. COGNITIVE PATTERNS

1. COMATOSE *(Persistent vegetative state/no discernible consciousness)*
   0. No 1. Yes *(Skip to SECTION E)*
2. MEMORY *(Recall of what was learned or know)*
   a. Short-term memory OK — seems/appears to recall after 5 minutes (a.)
   0. Memory OK 1. Memory problem ▲²
   b. Long-term memory OK — seems/appears to recall long past (b.)
   0. Memory OK 1. Memory problem ▲²
3. MEMORY/ RECALL ABILITY *Check all that resident normally able to recall during last 7 days)* (Fewer than 3 ✓ - ▲²)
   Current season (a.)
   Location of own room (b.) — That he/she is in a nursing home (d.)
   Staff names/faces (c.) — *NONE OF ABOVE* are recalled (e.)
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING *(Made decisions regarding tasks of daily life)* (0, 1, 2 - ▲⁴)
   0. Independent— decisions consistent/reasonable
   1. Modified independence — some difficulty in new situations only
   2. Moderately impaired — decisions poor; cues/supervision required
   3. Severely impaired — never/rarely made decisions (1, 2, 3 - ▲²)
5. INDICATORS OF DELIRIOUS — PERIODIC DISORDERED THINKING/ AWARENESS *(Check if condition over last 7 days appears different from usual functioning)*
   Less alert, easily distracted (a.)
   Changing awareness of environment (b)
   Episodes of incoherent speech (c.)
   Periods of motor restlessness or lethargy (d)
   Cognitive ability varies over course of day (e)
   (any ✓●¹ & ▲¹⁴)
   NONE OF ABOVE (f.)
6. CHANGE IN COGNITIVE STATUS — Change in resident's cognitive status, skills, or abilities in last 90 days
   0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING *(With hearing appliance, if used)*
   0. Hears adequately — normal talk, TV, phone
   1. Minimal difficulty when not in quiet setting
   2. Hears in special situations only — speaker has to adjust tonal quality and speak distinctly
   3. Highly impaired/absence of useful hearing
2. COMMUNICATION DEVICES/ TECHNIQUES *(Check all that apply during last 7 days)*
   Hearing aid, present and used (a.)
   Hearing aid, present and not used (b.)
   Other receptive comm. techniques used (e.g., lip read) (c.)
   NONE OF ABOVE (d.)
3. MODES OF EXPRESSION *(Check all used by resident to make needs known)*
   Speech (a.) — Communication board (d.)
   Writing messages to express or clarify needs (b.) — Other (e.)
   Signs/gestures, sounds (c.) — NONE OF ABOVE (f.)
4. MAKING SELF UNDERSTOOD *(Express information content — however able)*
   0. Understood
   1. Usually Understood — difficulty finding words or finishing thoughts
   2. Sometimes Understood — ability is limited to making concrete requests
   3 Rarely/Never Understood (2, 3 - ▲⁴)
5. ABILITY TO UNDERSTAND OTHERS *(Understanding verbal information content — however able)*
   0 Understands
   1 Usually Understands — may miss some part/intent of message
   2 Sometimes Understands — responds adequately to simple, direct communication (1, 2, 3 - ▲³)
   3 Rarely/Never Understands (2, 3 - ▲², 3 - ▲³)
6. CHANGE IN COMMUNICATION HEARING — Resident's ability to express, understand or hear information has changed over last 90 days - ●¹
   0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1. VISION *(Ability to see in adequate light and with glasses if used)*
   0. Adequate — sees fine detail, including regular print in newspapers/books
   1. Impaired — sees large print, but not regular print in newspapers/books
   2. Highly impaired — limited vision; not able to see newspaper headlines; appears to follow objects with eyes
   3. Severely impaired — no vision or appears to see only light, colors, or shapes (1, 2, 3 - ▲³)
2. VISUAL LIMITATIONS/ DIFFICULTIES
   Side vision problems — decreased peripheral vision (e.g. leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) (a.)
   Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes (b.)
   NONE OF ABOVE (a, ✓ - ●³) (c.)
3. VISUAL APPLIANCES — Glasses; contact lenses; lens implant; magnifying glass
   0. No 1. Yes

☐ = Code the appropriate response

☐ = Check all the responses that apply

● = AUTOMATIC TRIGGER — Go directly to RAP instructions

▲ = POTENTIAL TRIGGER — Go to RAP instructions for more detailed trigger definitions

1 Delirium
2 Cognitive Loss/Dementia
3 Visual Function
4 Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Wellbeing
8 Mood State
9. Behavior Problems
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Used
18. Physical Restraint

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SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. *ADL SELF-PERFORMANCE — (Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days — Not including setup)*

0. *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days.

2. ADL SUPPORT PROVIDED — *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist

			(1) SELF-PERF.	(2) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions boy while in bed ▲[5]		
b.	TRANSFER	How resident moves between surfaces — to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) ▲[5]		
c.	LOCOMOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair ▲[5]		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis ▲[5]		
e.	EATING	How resident eats and drinks (regardless of skill) ▲[5]		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes ▲[5]		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) ▲[5]		

3. BATHING — How resident takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (EXCLUDE washing of back and hair. *Code for most dependent on self-performance and support.* Bathing Self-Performance codes appear below)

0. Independent — No help provided
1. Supervision — Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence (a - ▲[5])

a. b.

4. BODY CONTROL PROBLEMS — *(Check all that apply during last 7 days)*

- Balance — partial or total loss of ability to balance self while standing — a.
- Bedfast all or most of the time — b.
- Contracture to arms, legs, shoulders, or hands — c.
- Hemiplegia/hemiparesis — d.
- Quadriplegia — e.
- Arm — partial or total loss voluntary movement — f.
- (a, b, d, e, h, j, any ✓ — ▲[11])
- Hand — lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid) — g.
- Leg — partial or total loss of voluntary movement — h.
- Leg — unsteady gait — i.
- Trunk — partial or total loss of ability to position, balance, or turn body — j.
- Amputation — k.
- NONE OF ABOVE — l.

5. MOBILITY APPLIANCES/ DEVICES — *(Check all that apply during last 7 days)*

- Cane/walker — a.
- Brace/protheses — b.
- Wheeled self — c.
- Other person wheeled — d.
- Lifted (manually/mechanically) — e.
- NONE OF ABOVE — f.

6. TASK SEGMENTATION — Resident requires that some or all od ADL activities be broken into a series of subtasks so that resident can perform them

0. No 1. Yes

7. AD FUNCTIONAL REHABILITATION POTENTIAL

- Resident believes he/she capable of increased independence in at least some ADLs — a.
- Direct care staff believe resident capable of increased independence in at least some ADLs — b.
- Resident able to perform tasks/activity but is very slow — c.
- Major difference is ADL Self-Performance or ADL Support in mornings and evenings (at least one category change in Self-Performance or Support in any ADL) — d.
- NONE OF ABOVE (a, b, any ✓ - ▲[5]) — e.

8. CHANGE IN ADL FUNCTION — Change in ADL self-performance in last 90 days

0. No change 1. Improved 2. Deteriorated - ▲[14]

SECTION F. CONTINENCE IN LAST 14 DAYS

1. *CONTINENCE SELF-CONTROL CATEGORIES (Code for resident performance over all shifts)*

0. CONTINENT — Complete control
1. USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL less than weekly
2. OCCASIONALLY INCONTINENT — BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL 2–3 times a week
4. INCONTINENT — Had inadequate control, BLADDER, multiple daily episodes; BOWEL, all (or almost all) or the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

2. INCONTINENCE RELATED TESTING — *(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)*

- Resident has been tested for a urinary tract infection — a.
- Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination — b.
- *NONE OF ABOVE* (2, 3, 4 - ▲[6]) — c.

3. APPLIANCE AND PROGRAMS

- Any scheduled toileting plan — a.
- External (condom) catheter — b.
- Indwelling catheter — c.
- Intermittent catheter — d.
- Did not use toilet room/ commode/urinal — e.
- Pads/briefs used — f.
- Enemas/irrigation — g.
- Ostomy — h.
- NONE OF ABOVE — i.
- (b, c, d, f, any ✓ - ▲[6])

4. CHANGE IN URINARY CONTINENCE — Change in urinary continence/appliances and programs in last 90 days

0. No change 1. Improved 2. Deteriorated

SECTION G. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT

- At ease interacting with others — a.
- At ease doing planned or structural activities — b.
- At ease doing self initiated activities — c.
- Establishes own goals — d.
- Pursues involvement in life of facility (e.g. makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) — e.
- Accepts invitations into most group activities — f.
- *NONE OF ABOVE* — g.

2. UNSETTLED RELATIONSHIPS

- Covert/open conflict with and/or repeated criticism of staff — a.
- Unhappy with roommate — b.
- Unhappy with residents other than roommate — c.
- Openly expresses conflict/anger with family or friends — d.
- Absence of personal contact with family/friends — e.
- Recent loss of close family member/friend — f.
- *NONE OF ABOVE* (a, b, c, d, any ✓ - ●[7]) — g.

3. PAST ROLES

- Strong identification with past roles and life status — a.
- Expresses sadness/anger/empty feeling over lost rolls/status — b.
- *NONE OF ABOVE* b - ●[7] — c.

● = AUTOMATIC TRIGGER — Go directly to RAP instructions

▲ = POTENTIAL TRIGGER — Go to RAP instructions for more detailed trigger definitions

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Wellbeing
8. Mood State
9. Behavior Problems
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Used
18. Physical Restraint

SECTION H. MOOD AND BEHAVIOR PATTERNS

1. SAD OR ANXIOUS MOOD

(Check all that apply during last 30 days)
VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief) — a.
DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS
— Tearfulness, emotional groaning, sighing, breathlessness — b.
— Motor agitation such as pacing, handwringing or picking — c.
— Failure to eat or take medications, withdrawal from self-care or leisure activities — d.
— Pervasive concern with health — e.
— Recurrent thoughts of death e.g., believes he/she about to die, have a heart attack — f.
— Suicidal thoughts/actions — g.
NONE OF ABOVE — h.
(d = ●14) (a-g, any ✓ = ●15)

2. MOOD PERSISTENCE

Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up"
0. No 1. Yes ●8

3. PROBLEM BEHAVIOR

(Code for behavior in last 7 days) (a, b, c, or d, 1, 2 = ●9)
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred less than daily
2. Behavior of this type occurred daily or more frequently

WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) — a.
VERBALLY ABUSIVE (others were threatened, screamed at, cursed at — b.
PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused) — c.
SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummages through others' belongings) — d.

4. RESIDENT RESISTS CARE

(check all types of resistance that occurred in last 7 days)
Resisted taking medications/injection — a.
Resisted ADL assistance — b.
NONE OF ABOVE — c.

5. BEHAVIOR MANAGEMENT PROGRAM

Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve only physical restraints or psychotropic medications in this category)
0. No behavior problem
1. Yes, addressed
2. No, not addressed

6. CHANGE IN MOOD

Change in mood in last 90 days — ▲1
0. No change 1. Improved 2. Deteriorated

7. CHANGE IN PROBLEM BEHAVIOR

Change in problem behavioral sings in last 90 days — ●1
0. No change 1. Improved 2. Deteriorated

SECTION I. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE

(Check appropriate time periods over last 7 days)
Resident awake all or most of time (e.e., naps no more than one hour per time period) in the:
Morning [a.] Evening — c.
Afternoon [b.] *NONE OF ABOVE* — d.

2. AVERAGE TIME INVOLVED IN ACTIVITIES

0. Most — more than 2/3 of time 2. Little — less than 1/3 of time
1. Some — 1/3 to 2/3 of time 3. None (0, 2, 3 = ▲15)

3. PREFERRED ACTIVITY SETTINGS

(Check all settings in which activities are preferred)
Own room [a.] Outside facility — d.
Day/activity room [b.] *NONE OF ABOVE* — e.
Inside NH/off unit [c.]

4. GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)

(Check all PREFERENCES whether or not activity is currently available to resident
Cards/other games [a.] Spintual/religious activities — f.
Crafts/arts [b.] Trips/shopping — g.
Exercise/sports [c.] Walking/wheeling outdoors — h.
Music [d.] Watch TV — i.
Read/Write [e.] *NONE OF ABOVE* — j.

5. PREFERS MORE OR DIFFERENT ACTIVITIES

Resident expresses/indicates preference for other activities/ choices
0. No 1. Yes ●10

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or nsk of death. (Do not list old/inactive diagnoses.)

1. DISEASES

(If none apply, CHECK the NONE OF ABOVE box)

HEART/CIRCULATION
Arteriosclerotic hear disease (ASHD) — a.
Cardiac dysrhythmias — b.
Congestive heart failure — c.
Hypertension — d.
Hypotension — e.
Peripheral vascular disease — f.
Other cardiovascular disease — g.

NEUROLOGICAL
Alzheimer's — h.
Dementia other than Alzheimer's — i.
Aphasia — j.
Cerebrovascular accident (stroke) — k.
Multiple sclerosis — l.
Parkinson's disease — m.

PULMONARY
Emphysema/Asthma/ COPD — n.
Pneumonia — o.

PSYCHIATRIC/MOOD
Anxiety disorder — p.
Depression — q.
Manic depressive (bipolar disease) — r.

SENSORY
Cataracts — s.
Glaucoma — t.

OTHER
Allergies — u.
Anemia — v.
Arthritis — w.
Cancer — x.
Diabetes mellitus — y.
Explicit terminal prognosis — z.
Hypothyroidism — aa.
Osteoporosis — bb.
Seizure disorder — cc.
Septicemia — dd.
Urinary tract infection — in last 30 days — ee.
NONE OF ABOVE — ff.
(ee = ▲14)

2. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

SECTION K. HEALTH CONDITIONS

1. PROBLEM CONDITIONS

(Check all problems that are present in last 7 days unless other time frame indicated)
Constipation [a.] Pain — resident complains or shows evidence of pain daily or almost daily — j.
Diarrhea [b.]
Dizziness/vertigo [c.]
Edema [d.] Recurrent lung aspirations in last 90 days — k.
Fecal impaction [e.]
Fever [f.] Shortness of breath — l.
Hallucinations/delusions [g.] Syncope (fainting) — m.
Internal bleeding [h.] Vomiting — n.
Joint pain [i.] *NONE OF ABOVE* — o.
(b, c, s, h, n, any ✓ = ▲14)

2. ACCIDENTS

Fell in past 30 days [a.] Hip fracture in last 180 days — c.
Fell in past 31-180 days [b.] *NONE OF ABOVE* — d.

3. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, or behavior status unstable — fluctuating, precarious, or deteriorating — a.
Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem — b.
NONE OF ABOVE (a, b, any ✓ = ●11) — c.

● = AUTOMATIC TRIGGER — Go directly to RAP instructions
▲ = POTENTIAL TRIGGER — Go to RAP instructions for more detailed trigger definitions

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Wellbeing
8. Mood State
9. Behavior Problems
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Used
18. Physical Restraint

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.
2.	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice — e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.* HT (in.) a. WT (lb.) b.	
		c. Weight loss (i.e., 5% + in last 30 days; or 10% in last 180 days) 0. No 1. Yes (= ●[12] & ▲[14])	c.
3.	NUTRITIONAL PROBLEMS	Complains about the tasted of many foods a. / Insufficient fluid; dehydrated b. / Did NOT consume all/almost all liquids provided during last 3 days c. — Regular complaint of hunger / Leaves 25% + food uneaten at most meals / *NONE OF ABOVE* (a, c, d, e, any 3 = I12) (b = ●[14]) (c, e = ▲[14])	d. / e. / f.
4.	NUTRITIONAL APPROACHES	Parenteral/IV a. / Feeding tube b. / Mechanically altered diet c. / Syringe (oral feeding) d. / Therapeutic diet e. (b = ●[13]) — Dietary supplement between meals / Plate guard, stabilized built-up utensil, etc / *NONE OF ABOVE* (a, c, d, e, any ✓ = ●[12]) (a, b, any ✓ = ▲[14])	f. / g. / h.

SECTION M. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b.
		Some/all natural teeth lost — does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers or rashes (f not ✓ = ●[15])	e.
		Daily cleaning of teeth/dentures (a, c, d, e, any ✓ = ●[15])	f.
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(Open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers 1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved 2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater 3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues — presents as a deep crater with or without undermining adjacent tissue 4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone (●[12] & ●[16])	
3.	HISTORY OF RESOLVED/CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	
4.	SKIN PROBLEMS/CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		Skin desensitized to pain, pressure, discomfort	b.
		Protective/preventive skin care	c.
		Turning/repositioning program	d.
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e.
		Wound car/treatment (e.g., pressure ulcer care, surgical wound)	f.
		Other skin care/treatment	g.
		NONE OF ABOVE (c, d, e, f, g, none ✓ = ▲[15])	h.

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
2.	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3.	INJECTIONS	(Record the number of days injections of any type received during the last 7 days)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly) Antipsychotics	a.
		Antianxiety/hypnotics (a, b, c = ▲[9], ▲[11], and ▲[17])	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics — otherwise code correct response for last 90 days) Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENT AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE — Check treatments received during the last 14 days	
		Chemotherapy a. / Radiation b. / Dialysis c. / Suctioning d. / Trach. care e. — IV meds / Transfusions / O_2 / Other _____ / NONE OF ABOVE	f. / g. / h. / i. / j.
		THERAPIES — Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days:	
		Speech — language pathology and audiology services	a.
		Occupational therapy	b.
		Physical therapy	c.
		Psychological therapy (any licensed professional)	d.
		Respiratory therapy	e.
2	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days? 0. No 1. Yes 2. No tests performed	
3	DEVISES AND RESTRAINTS	Use the following codes for last 7 days 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	a.
		Trunk restraint	b.
		Limb restraint	c.
		Chair prevents rising (b, c, or d, 1, 2 = ▲[9] & ●[18])	d.

● = AUTOMATIC TRIGGER — Go directly to RAP instructions ▲ = POTENTIAL TRIGGER — Go to RAP instructions for more detailed trigger definitions

1. Delirium
2. Cognitive Loss/Dementia
3. Visual Function
4. Communication
5. ADL Function/Rehabilitation Potential
6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Wellbeing
8. Mood State
9. Behavior Problems
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. Dehydration
15. Dental Care
16. Pressure Ulcers
17. Psychotropic Drug Used
18. Physical Restraint

RESIDENT ASSESSMENT INSTRUMENT FOR LONG TERM CARE FACILITIES

Resident's Name: | Medical Record No.:

Signature of RN Assessment Coordinator:

RESIDENT ASSESSMENT PROTOCOL SUMMARY

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.
2. Document problems, complications, and risk factors: the need for referral to appropriate health professionals; and th reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facilit routinely keeps such information, such as problem sheets or nurses' progress notes.
3. Show location of this information.

RAP Problem Area	Care Planning Decision		Location of Information
	Proceed	Not Proceed	
1. Delirium	☐	☐	
2. Cognitive Loss/Dementia	☐	☐	
3. Visual Function	☐	☐	
4. Communication	☐	☐	
5. ADL Function/ Rehabilitation Potential	☐	☐	
6. Urinary Incontinence and Indwelling Catheter	☐	☐	
7. Psychosocial Well-Being	☐	☐	
8. Mood State	☐	☐	
9. Behavior Problems	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tubes	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcers	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraint	☐	☐	

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APPENDIX X.

SPECIAL BULLETIN

PROVIDED AS A SERVICE BY
AMERICAN SOCIETY OF CONSULTANT PHARMACISTS
2300 9TH STREET, SOUTH ARLINGTON, VA 22204 (703) 920-8492

September 1990

Revisions to the "Indicators" for Surveyor Assessment of the Performance of Drug Regimen Reviews in Long Term Care Facilities.

On October 1, 1990, the Health Care Financing Administration's Medicare and Medicaid Participation Requirements for Long Term Care Facilities will take effect. Included under the rule's drug therapy section are several provisions regarding antipsychotic drugs. This Special Bulletin contains changes to the surveyor "indicators" for pharmaceutical service requirements in long term care facilities and is reflective of the antipsychotic drug requirements included in the new LTCF participation regulations. The sections in brackets are the only new changes and the rest of the surveyor "indicators" remain unchanged from their last release in 1985.

Revised Material	Revised Page	Replaced Page
APPENDIX N	N-7–N-8.2 (4pp.)	N-7–N-8 (2pp.)

Appendix N Surveyor Procedures For Pharmaceutical Service Requirements in Long Term Care Facilities. Provides guidelines to evaluate whether pharmacists have adequately performed drug regimen reviews.

Procedures for Pharmaceutical Services

	Usual Maximum Daily Antipsychotic Dosage for Ages 65 and Over	*Usual Maximum Daily Antipsychotic Dosage*
Chlorpromazine	800 mg.	1600 mg.
Haldol	50 mg.	100 mg.
Loxitane	125 mg.	250 mg.
Mellaril	400 mg.	800 mg.
Moban, Lidone	112 mg.	225 mg.
Navane	30 mg.	60 mg.
Proketazine	200 mg.	400 mg.
Prolixin	20 mg.	40 mg.
Quide	80 mg.	160 mg.
Repoise	80 mg.	160 mg.
Serentil	250 mg.	500 mg.
Stelazine	40 mg.	80 mg.
Taractan	800 mg.	1600 mg.
Thioridazine	400 mg.	800 mg.
Thorazine	800 mg.	1600 mg.
Tindal	150 mg.	300 mg.
Trilafon	32 mg.	64 mg.
Vesprin	100 mg.	200 mg.

- Use of the antipsychotic drugs listed in excess of their listed daily dosage maximums;

- Use of a listed antipsychotic drug unless the clinical record documents that one of the following specific conditions exists:

(1) Schizophrenia
(2) Schizo-affective disorder
(3) Delusional disorder
(4) Psychotic mood disorders (including mania and depression with psychotic features)
(5) Acute psychotic episodes
(6) Brief reactive psychosis
(7) Schizophreniform disorder
(8) Atypical psychosis
(9) Tourette's disorder
(10) Huntington's disease
(11) Organic mental syndromes (including dementia) with associated psychotic and/or agitated features as defined by:

(a) Specific behaviors (e.g. biting, kicking, scratching) which are quantitatively (e.g. number of episodes) documented by the facility and which cause the resident to:
—Present a danger to themselves
—Present a danger to others (including staff) or
—Actually interfere with staff's ability to provide care, or

(b) *Continuous* crying out, screaming, yelling or pacing if these specific behaviors cause an *impairment in functional capacity* and if they are quantitatively (e.g. periods of time) documented by the facility, or

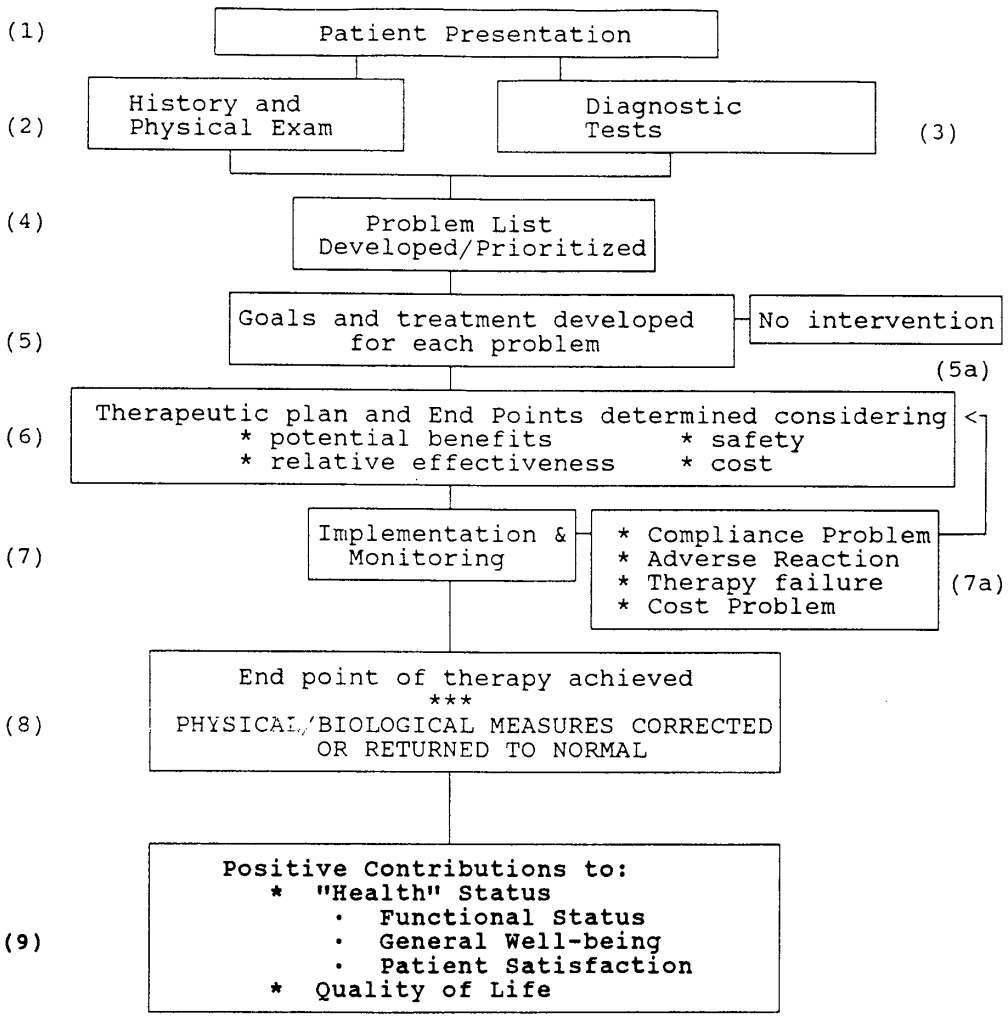
NEW

(c) Psychotic symptoms (hallucinations, paranoia, delusions) not exhibited as specific behaviors listed in "a" and "b" above if these behaviors cause an *impairment in functional capacity*.

(12) Short term (7 days) symptomatic treatment of hiccups, nausea, vomiting or pruritus.

- Use of the antipsychotic drugs in the absence of gradual dose reduction attempted every six months after therapy began. Gradual dose reductions are not necessary if within the last six months the resident has had a gradual dose reduction and the dose has been reduced to the lowest possible dose to control symptoms.
- Use of a listed antipsychotic drug when one or more of the following behaviors is the only indication for use:
  (1) Wandering
  (2) Poor self care
  (3) Restlessness
  (4) Impaired memory
  (5) Anxiety
  (6) Depression
  (7) Insomina
  (8) Unsociability
  (9) Indifference to surroundings
  (10) Fidgeting
  (11) Nervousness
  (12) Uncooperativeness
  (13) Unspecified Agitation
- The use of a P.R.N. antipsychotic drug more than five times in any seven-day period without a review of the residents condition by a physician.

APPENDIX XI. PARADIGM for the MANAGEMENT of PATIENT OUTCOMES.



ASCP Poster Abstracts

1. Alerting the Pharmacist to the Problem of Incontinence in the Elderly Nursing Home Population

Ingrid K. Lewis, PharmD, Charles C. Pulliam, M.S, University of North Carolina at Chapel Hill

During DRR the pharmacist should be alert to medications that may contribute to incontinence. Culprit drugs include any which interfere with alpha, beta, and parasympathetic actions. This study (conducted in four facilities with a total 160 residents age 65 or older) identified patients incontinent of urine, as well as contributing drugs and diseases. At DRR eighty-nine (56%) were incontinent. Fifty-six (63%) had been incontinent on admission. Of the incontinent residents 34% were taking one drug that might contribute to the problem; an additional 17% were taking two or more such drugs. Data reflecting contributing factors such diagnoses, mobility limitations, and physical restraints were also compiled.

2. A Consultant Pharmacist Controlled Dosing Program for Amantadine Prophylaxis in Long Term Care Facilities (LTCF): Variability in Dose Regimens

S.K. Somani, D.R.P. Guay, S.L. Cooper, S. Roberts, J. Degelau, St. Paul-Ramsey Medical Center, St. Paul, Minnesota, and University of Minnesota, Minneapolis, MN

Amantadine 100 mg per day is recommended by the Centers for Disease Control (CDC) for prophylaxis during influenza A outbreaks in institutions housing high risk persons such as the elderly. Data needed to design amantadine dosing regimens were collected by a consultant pharmacist in four LTCFs. Estimated creatinine clearance values revealed a substantial degree of variation and four different regimens for amantadine were recommended. The data collection and medication dispensing process was time consuming and may be impractical for consultant pharmacists serving a large number of LTCFs. It is important, however, to be prepared to dispense appropriate amantadine doses on short notice when influenza outbreaks occur. Alternative ideas for dosing programs will be discussed.

3. Identification of the Type of Communication Physicians Prefer from a Pharmacist

Bobbi J. Meritt, RPh, Bend, OR

Presentation of the results of a survey of 30 local physicians with nursing home patients. They were asked questions concerning their preference to handwritten or typed communication. They were also asked which source materials they professionally respect for references added to a recommendation A list of 20 journals and medical tests were provided for their choices.

4. A Review of Fluoxetine Use in a Skilled Nursing Facility

L.L Jew, G.M. McCart, J. West, University of California Medical Center, San Francisco, CA

The use of fluoxetine was prospectively audited in a 1200-bed skilled nursing facility over six-week period. All patients (13) taking fluoxetine were evaluated according to criteria established by the Pharmacy Committee. Ten patients were being treated for depression, while three patients were being treated for obsessive-compulsive disorders (OCD). Five of the 10 patients treated for depression experienced side effects including constipation, dry mouth, anorexia, urinary retention, and confusion. Two of the three patients with OCD experienced agitation and anorexia. Nine of the 11 patients who started fluoxetine in the institution did so based on a psychiatry consultation. This review concluded that fluoxetine was generally prescribed appropriately but more attention to monitoring documentation by nurses and physicians is necessary.

5. Impact of a Drug Holiday Program on PRN Medication Consumption

Katheryn Russi, RPh, M.P.A., Drake University, Des Moines, IA

Drug holiday programs in long term care facilities are increasingly being utilized as a tool to avoid drug accumulation and to evaluate the necessity of drug therapy in the elderly. Twenty-one ICF/RCF residents were enrolled in a one-day-per-week drug holiday and 14 ICF/RCF residents were enrolled in a two-day-per-week drug holiday. PRN medication requests and administration in the drug holiday groups and a control group of 30 residents were monitored for three months. No significant difference in PRN medication consumption was found between either of the drug holiday groups and the control group.

6. A Review of Antibiotic Utilization in Long Term Care Facilities

M.R. Yakabowich, P.R. Montgomery, L.E. Nicolle, A.J. Kirshen, Manitoba Health Services Commission, Winnipeg, Manitoba

A random sample was taken of all courses of antimicrobials administered in 1986 to residents of Manitoba nursing homes. Retrospective chart reviews were conducted and information on symptoms, cultures and concomitant medications and diseases was collected. Of 979 courses evaluated, 57% were judged appropriate, 34% not appropriate, and 9% inadequate data on the chart to decide. Inappropriateness was more commonly judged where the diagnosis was urinary tract infection, or none-recorded compared to respiratory tract or skin infections. Antibiotics most likely to be deemed inappropriately prescribed were co-trimoxazole, nitrofurantoin, and ophthalmic and otic gentamicin preparations, and most topical antibiotics. These data give direction for further research and education regarding rational use of antimicrobials in nursing homes.

7. Referral Services Provided by Consulting Pharmacists in Retail Practice

Sheryl L. Szeinbach, Ph.D. and Benjamin F. Banahan III, Ph.D., Department of Health Care Administration and The Research Institute of Pharmaceutical Sciences, School of Pharmacy, University of Mississippi

The purpose of this study was to investigate the role of consultant pharmacists in patient referrals. Consultant pharmacists were defined as pharmacists who spent more than 1% of their time consulting to a long term care facility. Preliminary results from a nationwide study indicated that referral patterns differ between consultant and nonconsultant pharmacists. Results from T-tests show a significant difference for consultant pharmacists with respect to referrals to long term care facilities ($P< 0.001$), mental health agencies ($P<0.07$), and hospitals ($P<0.05$) compared to nonconsultant pharmacists. Additional results include referrals to other health care organizations and outcome measured by an improvement in patient care.

8. Importance of Visually Monitoring/Educating for Correct Administration of Weekly Catapres Patch

David Schack, Pharmacy Corporation of America, Union City, CA

1. Importance for monitoring: Weekly patch is convenient and effective when patch is applied correctly. However, if the patch is applied incorrectly, treatment of high blood pressure will be ineffectual.
2. Data to support necessity of "visual" monitoring: Data will be shown on the observance of error rates during monthly visits by pharmacist consultant for 15 months (4/89 to 6/90).
3. Report of problem and suggestions for labeling and packaging to USP/FDA and manufacturer.
4. Development of specific recommendations for proper administration of patch and importance of the education of nurses.
5. Dissemination of information and education about problem to other consultants locally, regionally, and nationally.

9. Evaluation of Pharmacy Based Digoxin Concentration Monitoring Utilizing the Clinimate TDA in a Nursing Home Setting

Tom Nolin, Charles Pulliam and Mike Miles, University of North Carolina at Chapel Hill

This study evaluated reliability of the Clinimate in determining digoxin concentrations in saliva, and is developing a pharmacy model in which Clinimate TDA can be used to assist therapeutic drug monitoring. Phase one has involved a review of therapeutic drug monitoring practices during a six month period of 1989. Data includes blood chemistries on digitalized patients (dates and outcomes) and the influence on therapeutic decisions (i.e. dosage changes, etc.). In Phase two a pharmacy based digoxin concentration monitoring program using the Clinimate is being compared with data from the six month baseline. This provides a basis for suggesting the potential value of such pharmacy services.

10. Opioid Analgesic Use in Two Hospice Populations

David A. Solomon, PharmD, Jon Bouchard, and Dave Goldwater, Insta-Care Pharmacy Services, Woburn, MA

This poster will present the usage trends of all opioid analgesic prescriptions in two Medicare certified home hospice programs. Data was collected on more than 80 patients with a diagnosis of terminal cancer over a three-month period. Patient demographic information, diagnoses, a detailed summary of analgesic usage, and several comparisons describing drug usage trends and variables will be presented. This poster will provide valuable information for consultants who provide services to hospices or are considering working in the hospice setting.

11. The Usage Patterns and Cost Effectiveness of Ciprofloxacin in Nursing Homes

David A. Solomon, PharmD, Insta-Care Pharmacy Services, Woburn, MA

This presentation will report the findings of a 12-month retrospective antibiotic study in 187 nursing homes. The objectives of the study were to evaluate (1) ciprofloxacin usage ("appropriate/inappropriate"), (2) the potential of providing ciprofloxacin in place of intramuscular antibiotics and (3) the potential of providing ciprofloxacin in the nursing home in place of hospitalizing patients for the treatment of an infection. The preliminary results of this study of 17,580 nursing home residents indicate that ciprofloxacin was usually used appropriately. In addition, there is a great potential for utilizing oral ciprofloxacin as a cost effective alternative to intramuscular antibiotics and hospitalization for the treatment of infections, which would also increase the quality of life of residents.

12. Diuretic Usage and Electrolyte Effects in a Geratric Nursing Home Population

James W. Cooper and Allison E. Cooper, College of Pharmacy, University of Georgia

The patient records of 120 nursing home patients were reviewed at one point in time for diuretic usage. A diuretic treatment group of 42 patients was identified and compared for demographic and serum electrolyte data present in the chart with a control group of 42 patients not taking diuretics. There were no significant age, sex, or race differences groups in this predominantly white female population.

It appears that diuretic usage in geriatric nursing home patients is commonly associated with electrolyte abnormalities, predominantly of serum potassium. One-half of patients had multiple abnormalities of serum electrolytes, and one-fifth of the abnormalities were uncorrected with changes in diet and/or drug electrolyte supplementation.

13. Falls and Fractures in Nursing Home Patients Receiving Psychotropic Drugs

James W. Cooper and Tracy Jordan, College of Pharmacy, University of Georgia

Falls in 44 matched control patients (mean age 87.1) were statistically compared to 38 patients (mean age 85.3) who received scheduled or as needed (prn) single-agent psychotropics over a six-month period. Prospective assessment of psychotropic drug therapy were made on a monthly basis, and data on falls were retrospectively gathered. Both scheduled and prn usage of benzodiazepine (BZ) hypnotics, and scheduled usage of BZ anxiolytics, antipsychotics and antidepressants increased the rate of falls by two-to-greater-than three-fold over the frequency of falls found in the control group (14%). It appears that all psychotropics, except the shorter-acting BZs given on a conservative prn basis, increase the risk of falls in a very-old frail nursing home population.

14. Diabetes Mellitus Prevalence and Treatment Outcomes in a Geriatric Nursing Home Population - A Three Year Study

James W. Cooper, Janet E. Gordon, and Roy C. Parish, College of Pharmacy, University of Georgia

The patient and consultant pharmacists records for a 120-bed nursing home were retrospectively reviewed for the diagnosis and treatment outcomes of diabetes mellitus (DM) over a three-year period.
Diabetic complications and fasting blood sugars (FBS) outside the acceptable FBS treatment range of 100-160 mg/dl were predominantly in the insulin plus diet treatment group. Hyperglycemic episodes were more common (27 of 30 episodes) in the overweight insulin group. Hypoglycemic reactions were most common in the underweight insulin group (17 of 24 episodes).
Hospitalization and death rates were compared for both DM and non-DM patients over the study period. There was significant difference in the rate of hospitalization per DM patient (2.84) vs. non-DM patients (1.82).

15. Anti-Psychotic Medication Review

John F. Aforismo, RPh, R.J. Health Systems, Inc., Wethersfield, CT

To comply with the "OBRA 87" guidelines for the review of nursing home residents who are taking anti-psychotic medications, we have developed the following program:
A. Policy and Procedure: This document lists the review process and the various forms that will be used by the nursing and pharmacy staff for resident review along with the methods of reporting to the various physicians.
B. Poster: Signs of Extrapyramidal Reactions: Poster graphically depicts certain extrapyramidal reactions and lists information on the various anti-psychotic medications.
C. Prescription Labeling: Prescription labels have been developed that describe the various side effects the nursing staff should be watching for.
D. Evaluation Forms: Forms that will be used by nursing and pharmacy staff during the resident review process.

16. Compliance with the New Chemical Restraint Free Environment Regulations in a Chronic Head Injury Rehabilitation Facility

Lisa N. Schatz, PharmD. Schatz Clinical Services, McKees Rocks, PA

The degree of psychotropic intervention and timing of withdrawl presents a challenge to the consultant pharmacist practicing in a chronic head injury rehabilitation facility, because it must be appropriately timed in the cognitive recovery cycle of the patient. A multidisciplinary approach, coordinated by the pharmacist, involves the creation of a patient specific psychotropic intervention plan, including non-drug behavioral interventions. The pharmacist selects patients for a psychotropic drug dosage reduction, accomplished through drug specific dosing weaning protocols. An abnormal behavioral scale profiles the types of targeted behaviors for which intervention is necessary, and serves to objectify assessment both during and after psychotropic therapy. We feel we have developed an effective strategy to deal with this challenge.

17. Laxative Use in an Intermediate Care Facility

Donna M. Lisi, PharmD, Assistant Professor, Anthony Fazio, PharmD, Assistant Professor, Dottie McCain, Director of Nursing, Stacy Elizabeth White, BS Pharmacy, Brent Greer, BS Pharmacy, Northeast Louisiana University, College of Pharmacy, and St. Joseph's Home, Monroe, LA

As a result of physiological and pharmacological changes, a decrease in mobility, and often improper diet and fluid intake, the elderly frequently utilize laxative medications. In the institutional setting, physician education and dietician involvement are important. Before this can be undertaken, a needs assessment in the form of a drug use evaluation must be conducted. This study, which is still in progress, discusses the preliminary finds of a drug use evaluation of laxatives ordered in a 132-bed intermediate care facility.

More than one-half of the 101 nursing residents whose charts were reviewed had a physician order for either a scheduled or as-needed laxative.

18. Clinical Pharmacist Intervention and Analysis of Medication Transfer Orders Between Acute Care Hospital and Extended Care Facility

Colleen P. Ivers, RPh, Robert W. Wetmore, PharmD. Botsford General Hospital, Farmington Hills, MI

Consultant pharmacists are frequently hindered during their assessment and development of drug therapy recommendations for nursing home residents because of incomplete or unavailable medical records from a recent patient hospitalization.

In an effort to provide an optimal continuum of medication use between a hospital and its corporate owned skilled nursing facility, hospital clinical (consultant) pharmacists began routine screening of hospital discharge medication orders for patients being transferred to long term care facilities. A criteria and data collection form was developed in tandem with a departmental policy to aid the clinical pharmacist in detecting areas of possible intervention.

Preliminary data suggests that 45% of all patients being discharged from our acute care hospital and transferred to a skilled nursing facility required changes in medication regimens following clinical pharmacist review.

19. Quality Assurance in Medication Administration

Andrea L. Wall, RPh, FASCP, Assistant Professor of Pharmacy Practice, University of Cincinnati Medical Center, Terri Proud, RPh, FASCP, Consultant, Home Care Pharmacy, Cincinnati, OH

The accuracy of medication administration was assessed in four long term care facilities. Medications were chosen at random. The criteria for these medications was that they could not be prn medications nor could they be refilled by the pharmacy in the designated time period of the study. A baseline was obtained determining the initial inventory of each medication chosen for the study. A second inventory was obtained after the specified time period. Discrepancies, those medications with too few or too many doses, were then identified by comparison of physical counts to the medication administration record.

322 medications in four facilities were surveyed. Twelve different studies were done. The discrepancy rate ranged from 12-73%.

Studies of this type will help identify problems in medication administration and isolate specific trends in administration of medications.

20. A Quality Assurance Program for the Reduction of Psychoactive Medications

Lori A. Packer, RPh, Consultant Pharmacist, Insta-Care Pharmacy Services, Woburn, Massachusetts, Luella Chesley, RN, MEd, Director of Nursing Services, Briarwood Healthcare Nursing Home, Needham, MA

In response to OBRA 1987, HCFA released new requirements for long term care participation in Medicaid and Medicare programs. These regulations refer to the use of unnecessary drugs and the appropriate use of psychotropic medications.

To comply with the OBRA mandates, the 120-bed skilled and intermediate nursing care center developed a program to decrease the use of psychoactive medications to an absolute minimum. A multidisciplinary committee was formed to evaluate psychoactive medication use in the facility. Medications were reduced and/or discontinued where medically appropriate while the resident's physical and psychological health was maintained or improved and their quality of life enhanced.

21. Alternate Antibiotic Protocol for Non-Life Threatening Methicillin-Resistant Staphylococcus Aureus

Joe R. Davis, RPh, FASCP, Consultant Pharmacist, ARA Living Centers, Houston, TX

An alternate to standard intravenous therapy with vancomycin in the form of a combination of oral antibiotic and topical product was tested with very positive results. The oral therapy is a staggered combination of four different oral antibiotics, ciprofloxacin, minocycline, trimethoprim/sulfamethoxazole DS, and rifampin, utilizing two concurrent products. The topical product used was mupirocin 2% ointment when indicated for topical infections.

In summary, the use of oral and topical antibiotics in the treatment of MRSA can be successful when used appropriately. This can be more cost effective than intravenous vancomycin and prevent hospitalization which will maintain the patient in the nursing home with less stress and disruption of daily living. Also, it will remove the stigma that exists with the MRSA patient and remove the barriers of placement in the facility of their choice.

22. I.V. Therapy in the Nursing Home: The Impact of Automated Infusion Pumps

Richard Bulich, PharmD, Central Coast Medical Systems, Inc., Monterey, CA

The demand to provide I.V. therapy in the skilled nursing facility is increasing rapidly. A problem associated with these therapies is the increased demand on nursing time. This report describes our experiences with ambulatory automated infusion pumps on delivering I.V. antibiotics and patient controlled analgesia to sixty-eight patients in four long term facilities.

The logistics of infusion, medications utilized and monitoring flow sheets will be presented. The impact on economics as well as nursing time will be outlined. Examples of each therapy will be presented and the advantages and disadvantages will be detailed. Photographs of various infusion pumps will be included in the poster presentation.

23. Impact of an Adverse Drug Reaction Reporting System in a Geriatric Health Care Setting

Janelle M. Mahoney, PharmD, Assistant Professor of Pharmacy Practice, Saint Louis College of Pharmacy, Susan W. Miller, PharmD, Associate Professor of Pharmacy Practice, Mercer University, Southern School of Pharmacy

The susceptibility of elderly patients to adverse drug reactions (ADRs) coupled with the absence of ADR reports at the Geriatric Health Care Center prompted an investigation into the existing ADR reporting system. A survey was conducted to determine professional staff education, a more aggressive system was implemented utilizing voluntary reporting, altering orders, and laboratory abnormalities as opposed to voluntary reporting only with the previous system. Most reactions were moderated in severity and pharmacologic in nature, suggesting the need for education of prescribers on appropriate use of medications. Costs incurred were lower that expected due to the small population studied and conservative estimates. Follow-up surveys indicated beneficial effects of education on staff knowledge of the ADR reporting system at this Geriatric Health Care Center.

24. A Multi-Disciplinary Team Approach to Monitoring and Assessing Medication Administration in Long Term Care Facilities

Richard Januszewski, MS, FASCP, Director of Pharmacy Services, Sheri Miller, RNC, BA, Director of Nursing Services, Health Care Consultants of Minnesota

A multi-disciplinary team approach to monitoring and assessing medication administration was developed. Using this system over a 12 month period of time, outcomes of the drug distribution systems in 28 long term care facilities were assessed. An overall 9.1% error rate was detected while observing 4352 medication administrations during 75 separate med-pass observations. In addition to detecting med-pass errors, 112 nursing administration technique problems were identified. The impact of focused inservices were evaluated and results suggest a positive impact. This study demonstrates the feasibility and value of a team approach to med-pass monitoring and assessment.

25. The Development of a Qualitative Medication Error Monitoring System

Richard Januszewski, MS, FASCP, Director of Pharmacy Services, Health Care Consultants of Minnesota

The purpose of this study was to develop an objective and qualitative medication error assessment tool. Over a period of six months 1499 reported medication errors were reviewed and points assigned to each using an objective point system. Later, a survey was conducted in 25 LTCFs for the purpose of evaluating the tool's validity. The results of the survey only slightly modified the tool's point system. Using this tool, facilities' Quality Assurance and Assessment Committees now have a means by which to qualitatively evaluated medication errors. This study demonstrated the feasibility and validity of a short med-error assessment tool that can objectively determine the severity of a medication error.

26. The Use of Liquid and Microencapsulated Potassium Chloride Formulations in a Geriatric Long Term Care Facility with Emphasis on Patient Preference and Gastrointestinal Effects

Rosemary Battaglia, PharmD, Clinical Pharmacist, V.A. Medical Center, Brooklyn, New York, Judith L. Beizer, PharmD, Assistant Clinical Professor, Virginia J. Galizia, PhD, Associate Clinical Professor, Peter G.Barber, PharmD, Assistant Clinical Professor, St. John's University, College of Pharmacy and Allied Health Professions

Potassium supplements are routinely prescribed for elderly patients over age 65 to prevent diuretic-induced hypokalemia. The objectives of this study were to ascertain if there was: 1) a significant difference in patient preference between the liquid and microencapsulated potassium chloride formulations and 2) a significant correlation between patient preference and the development of subjective gastrointestinal irritation in the geriatric population. No preferences for either formulation was noted by three of five patients. There was no significant correlation between patient preference and the development of adverse drug reactions with either formulation. There was no significant difference between the two formulations with respect to the development of adverse drug reactions or to the ease of swallowing, taste and aftertaste.

27. Trends in Antipsychotic Utilization in the San Francisco Bay Area

Tim Groves, RPh, Senior Consultant Pharmacist, Vivyanne Owashi, PharmD, Director of Continuing Education, Joel Ransom, Information Systems Manager, CPS Pharmaceutical Services, Mountain View, CA

An approach to providing the consultant with antipsychotic drug experience extracted from existing prescription data and converted to equivalent milligrams of Thorazine has been developed. A selected group of facilities representing approximately 3800 patients is presented with results from March 1989 through September 1990. Significant reductions have occurred in the number of patients receiving antipsychotics, equivalent milligrams of Thorazine dispensed, antipsychotic prescriptions dispensed, equivalent milligrams of Thorazine per bed, and percentage of patients receiving antipsychotics.

APPENDIX XIII.

NORWICH HEALTH AUTHORITY

Guidelines for the Supply, Administration, Storage, Security and Disposal of Medicines and other Pharmaceuticals in Registered Nursing Homes and Private Hospitals

1. INTRODUCTION

1.1. The Norwich Health Authority has drawn up the following guidelines which serve to express the 1984 Registered Homes Act in relation to '... recording, safekeeping, handling and disposal of drugs' (Part 2 Regulation 12(1)(0)).

1.2. Persons registered with the Norwich Health Authority for the purpose of running a private nursing home are required to comply with and implement 'adequate arrangements ...' as interpreted in these guidelines.

1.3. Persons registered are responsible for being familiar with and observing the statutory requirements concerning controlled drugs and other medicines held and administered in the nursing home. Further information on the safe keeping and handling of medicines can be obtained from the Registering Authority's Pharmaceutical Officer.

1.4. The Pharmaceutical Inspection of Private Nursing Homes is undertaken by Health Authority Community Services Pharmacists (C.S.P.) on behalf of the District Pharmaceutical Officer (D.Ph.O.). (See Appendix).

1.5. The registered person, in conjunction with the Authority's Pharmaceutical Officer, is required to establish and maintain clear policies and procedures for the supply, storage and administration of drugs.

2. SUPPLY

2.1. Where a pharmacist is employed by the nursing home or private hospital medicines should be obtained by that pharmacist and stored under his control.

2.2. Where a pharmacist is not employed, supplies should normally be obtained through a retail pharmacy or dispensing doctor, on the authority of a written prescription (FP.10) signed by a doctor or dentist.

2.3. In addition to the written prescription (FP.10) by the G.P., doctors should be encouraged by the appropriate authority to complete a Drug Administration Card or to sign the card prepared by a registered nurse.

2.4. In the case of prescribed medicines, clear typewritten labelling is essential. In addition to the statutory requirements, the label should give:-

(a) Direction for use, as recommended in the British National Formulary. These should be specific, and directions such as 'as before' or 'as directed' should not be used.

(b) Any precautions relating to the product, e.g. 'store in refrigerator'.

(c) The expiry date, if appropriate.

2.5. Tablets and capsules, except those supplied in blister or strip packed form should be supplied in an airtight re-closable container such as a glass or plastic bottle or drum. They must continue to be stored in this container and the labelling must not be changed under any circumstances.

2.6. Some medicines may be brought into the home by the patient on admission. These should be checked with patient's G.P. before use.

3. STORAGE

3.1. All medicines should be stored under the control of a pharmacist or, if there is no pharmaceutical department, under the control of a 1st level registered nurse designated for the purpose by the person in charge of the home. They should be stored in locked cupboards, trolleys or rooms which should be kept locked and used exclusively for the storage of medicines. If medicines are stored in a locked trolley, it should be securely fastened to a wall when not in use.

3.2. All cupboards and trolleys in which medicines are stored should be situated away from sources of heat and moisture.

3.3. Separate locked cupboards should be provided for:-

Medicines for internal use
Medicines for external use
Controlled drugs
Medicines requiring cool storage. * A lockable box stored in a domestic refrigerator may be adequate for the occasional small requirement.
Diagnostic reagents

Where quantities of large volume intravenous infusion fluids are used, they should also be stored in a separate cupboard from other internal use medicines.

3.4. In homes where medicines are obtained on F.P.10 prescriptions, it is recommended that each resident's medication should be stored either in an individually labelled drawer in the medicine trolley, or where the use of a trolley is not practical, in an individually labelled stackable plastic stockbox which is stored in a locked cupboard or stored separately.

3.5. The keys of all cupboards used for the storage of medicines must be in the personal possession of and be the personal responsibility of the 1st level registered nurse in charge of the nursing home at any given time. While duplicate keys may be required for use in emergencies, the number of these should be restricted and in any case held securely.

3.6. Care should be taken to ensure that medicines are removed and disposed of when the treatment is discontinued or when their shelf life has expired. Special care is necessary with eye drops and eye ointments since the activity of these preparations is guaranteed only for a specific period after the date of opening.

3.7. In special circumstances some patients may be permitted to keep their own medicines with the consent of their General Practitioner. Provision must be made for secure keeping of medicines.

3.8. Every place within the nursing home where medicines are stored should be inspected regularly by a pharmacist authorised by the registration authority. Stocks of medicines and records and any relevant document, should be readily available for inspection by the authorised pharmacist.

4. ADMINISTRATION

4.1. Each nursing home is required to draw up a formal system for the Administration of Medicines. This should include the individual home's policy for the recording of the administration of drugs, missed or refused doses and household remedies.

4.2. Medicines, other than domestic remedies, should be administered to a patient only in accordance with the directions of a doctor or dentist.

4.3. Where medicines are received against a prescription for a named patient, they should be administered to that particular patient and under no circumstances must they be used for other patients. When they are no longer required for that patient, the medicine should be disposed of.

4.4. The administration of any medicine must be undertaken by a 1st or 2nd level registered nurse.

4.5. The correct dose should be administered to the patient at the correct time, giving due consideration to any precautions and warnings related to the particular medicine. The procedure for the administration of medicines should include:-

(a) Reading the prescription

(b) Ascertaining that the prescribed dose has not already been administered

(c) Selecting the medicine required

(d) Checking the label with prescription

(e) Preparing the medicine and double checking with the prescription

(f) Checking the identity of the patient

(g) Administering the medicine

(h) Recording the administration as appropriate

Medicines must be tendered to the patient personally and not, for example, be left on a plate in the dining room.

4.6. All medicines should be administered to patients directly from the containers in which they are dispensed. However, if the use of a drug trolley is impractical, an approved daily dosage distribution system may be permitted. Guidance should be sought from the Authority's inspecting Pharmaceutical Officer.

4.7. A small (agreed) stock of 'domestic remedies' (authorised by general practitioner in the form of a written policy stating dose frequency and maximum number of doses) may be kept and administered at the discretion of the 1st level registered nurse in charge. The administration of these medicines must be recorded. They are to be used for immediate relief only. If required for regular use by a resident, a prescription must be obtained from the general practitioner.

4.8. It is recommended that a copy of the B.N.F. should be available for reference by the nursing staff. This will assist in the clarification of drug names, dosage and other relevant details. (See appendix).

5. RECORDS

5.1. To ensure complete accountability for all medicines a record must be kept of receipts, dates and times of administration and dates of disposal of all medicines.

5.2. A medication record should be kept for each patient, the entries signed by the prescriber, and showing:-

(a) The name, house address and age of the patient (and registration number and ward where appropriate)

(b) The name of the medicine

(c) The dose

(d) The route of administration

(e) The frequency and time for administrating each dose

(f) The date of prescribing

(g) In red, any known hypersensitivity

(h) Any special requirements

(i) Records should be kept for 3 years from the date of discharge or death

5.3. All prescribed medicines brought into the home by a resident on admission should be recorded.

5.4. A record of administration of all drugs must also be kept.

(The enclosed Drug Administration Record is suggested as suitable for use in all Nursing Homes in the District).

The person in charge of the home is responsible for the maintenance of records.

6. CONTROLLED DRUGS

6.1. Special Provisions
Special provisions apply to controlled drugs. The guidance given here is brief and further information on controlled drugs should be sought from the Registering Authority's Pharmaceutical Officer.

6.2. Authority to Possess
Only nursing homes which are wholly or mainly maintained by a public authority out of public funds, or by a charity or by voluntary subscriptions, or those possessing a Home Office licence, can hold stocks of controlled drugs. All other homes may only hold controlled drugs that have been prescribed and supplied for individual patients.

6.3. Procurement of Controlled Drugs as Stock
Where a pharmacist is employed, controlled drugs should be obtained from suppliers over the pharmacist's signature. Where no pharmacist

is employed, controlled drugs should be obtained by the person in charge, or as otherwise designated on the licence, or by F.P.10 prescription for individual patients.

6.4. Storage

Controlled drugs must be stored in a suitably locked cabinet which complies with the Misuse of Drugs (Safe Custody) Regulations 1973. Advice is also available from the Pharmaceutical Officer of the Registering Authority, Inspectors of the Home Office, Inspectors of the Pharmaceutical Society and Police Officers.

6.5. Administration

The administration of controlled drugs should be undertaken by a medical practitioner or by a 1st level registered nurse and must be witnessed.

6.6. Records

In the case of controlled drugs, a record must be kept in an appropriate record book reserved specially for recording the receipt and administration of controlled drugs in accordance with the Misuse of Drugs Regulations (1973). (See Appendix).

7. DISPOSAL OF UNWANTED MEDICINES AND DRUGS

7.1. Medicines dispensed for individual patients are their property and should be sent with the patient on discharge or, if that is inappropriate, they should be destroyed in the presence of the patient or a relative or alternatively, returned to the supplier for destruction. They should not be used for other patients.

7.2. The destruction of medicines should take place on the premises by a 1st level registered nurse, be in the presence of an appropriate witness (a doctor, pharmacist or another 1st level registered nurse), recorded and the record signed by both persons concerned.

7.3. Nursing homes authorised to hold stocks of controlled drugs may destroy any such controlled drugs only in the presence of an authorised person, (i.e. a police officer, an Inspector of the Home Office Drugs Branch or an inspector of the Pharmaceutical Society of Great Britain). Controlled drugs prescribed and supplied for individual patients should be disposed of in accordance with paragraphs 1. and 2.

8. INSPECTION

Every place within the nursing home where medicines are stored will be inspected regularly by a pharmacist authorised by the Registering Authority. Stocks of medicines and records and any other relevant document, should be readily available for inspection by the authorised pharmacist.