



Oregon

Theodore R. Kulongoski, Governor

Oregon Board of Pharmacy
800 NE Oregon Street, Suite 150
Portland, OR 97232
Phone: 971 / 673-0001
Fax: 971 / 673-0002

E-mail: pharmacy.board@state.or.us
Web: www.pharmacy.state.or.us

2009
CORRECTIONAL FACILITY INSPECTION REPORT

Date: _____ Registration Number: _____

Correctional Facility: _____

Address: _____

Address: _____

OAR 855-041-0175 Duties of the Pharmacist

1. Do you monitor the facility's compliance with policies and procedures regarding medication management? _____
2. How do you perform and document timely drug utilization reviews?

OAR 855-041-0065(6)(k)

3. Are the patient specific prescriptions properly labeled including the patient identification label?

OAR 855-041-0177 Drug Delivery and Control

(1) The Pharmacist and the practitioner representing the facility shall be responsible for establishing written policies and procedures for medication management including, but not limited to, drug procurement, dispensing, administration, labeling, medication counseling, drug utilization review, medication records, parenterals, emergency and nonroutine dispensing procedures, stop orders, over-the-counter drugs, security, storage and disposal of drugs within the facility. Policies and procedures shall be reviewed and updated annually by the pharmacist and practitioner, maintained in the facility; and be made available to the Board for inspection.

4. When were the policies and procedures reviewed and where are they located?

5. Is consulting pharmacist complying with requirements of OAR 855-019-0240? _____

6. Please complete the follow information and retain the form for three years at the facility site.

Work Area:

- Secure Yes No Other _____
- Well lighted Yes No Other _____
- Interruptions while inspecting Yes No Other _____
- Clean & orderly Yes No Other _____
- Med room license in date and posted Yes No Other _____
- Previous inspections posted Yes No Other _____
- Medication cart (total number) # _____

Comments: _____

Medication:

- Outdates Yes No Other _____
- Expired or DC'd orders Yes No Other _____
- Routes of administration separate Yes No Other _____
- Adequate supply of stock cards Yes No Other _____
- Labels correct & legible Yes No Other _____
- Multi-dose vials dated Yes No Other _____
- Where are medications obtained? _____
- What is the Board registration number of the facility that provides medication? _____

Comments: _____

Documentation:

- MAR's dated, signed & initialed Yes No Other _____
- Current nurse signatures on back of MAR's Yes No Other _____
- Daily delivery reports checked off Yes No Other _____
- Stock count sheets reconcile Yes No Other _____
- Patient signing for "Ok in Cell" meds Yes No Other _____

Comments: _____

Refrigeration:

- Clean & orderly Yes No Other _____
- Outdates Yes No Other _____
- Expired or DC'd orders Yes No Other _____
- Labels correct and legible Yes No Other _____
- Daily temperature log Yes No Other _____
- Current temp (2-8 C or 36-46 F) _____ (C / F)

Comments: _____

Controlled substance:

- Accounts sheets reconcile Yes No Other _____
- Administration documented Yes No Other _____
- Secure storage Yes No Other _____
- DEA 222 Forms Reconcile and Dated Yes No Other _____

Comments: _____

Emergency Kit:

- Locked Yes No Other _____
- Missing medication Yes No Other _____
- Shortest expiration date exp. _____

Comments: _____

Poison Control:

- Phone number posted Yes No Other _____

Comments: _____

Procedure and protocol:

- Written procedures on site Yes No Other _____
- Treatment protocols reviewed & signed Yes No Other _____

Comments: _____

Chart review:

- Orders noted off with initial, date & time Yes No Other _____
- Progress notes correspond to written orders Yes No Other _____
- Protocol orders counter-signed by practitioner Yes No Other _____
- Drug allergies noted Yes No Other _____

Comments: _____

Deficiencies listed on the form must be corrected as soon as possible. This form **must** be posted in plain view and retained for three years for Oregon Board of Pharmacy inspections.

Health service manager/nurse manager: _____

Staff member: _____

Signature & License # of Consultant Pharmacist: _____

Inspector Signature: _____
Date: _____ Deficiency Notice: _____
Comments: _____