



Oregon

Kate Brown, 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

2016 CORRECTIONAL FACILITY INSPECTION REPORT

Date: _____ Registration Number: _____

Correctional Facility: _____

Address: _____

E-Mail Address of Consultant Pharmacist: _____

OAR 855-043-0620 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 855-041-1130(1)(k)

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

OAR 855-043-0630 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 non-routine 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 Reconciled 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: _____