Name of Program: __Stellar Hospital__
City, State, Zip Code: __
Chief of Pharmacy: __William Fairfax__
Telephone Number: __
E-mail Address: ____
Program Director: __Benjamin Franklin__
Telephone Number: ____
Date Submitted: __March 1, 2013__
E-mail Address: ____

**Principle 1: Qualifications of the Resident**

1.1a Residency applicant qualifications are evaluated by the residency program director (RPD) through an established, formal procedure that includes an assessment of the applicant’s ability to achieve the educational goals and objectives selected for the program. __X__

1.1b Criteria used to evaluate applicants are documented and understood by all involved in the evaluation and ranking process. __X__

1.2 Residents are graduates of an Accreditation Council for Pharmacy Education (ACPE)-accredited Doctor of Pharmacy degree program. __X__

1.3 Applicants are licensed, or are eligible for licensure in the state or jurisdiction in which the residency program is conducted. Consequences of failure to obtain appropriate licensure are addressed in policy of the organization. __X__

1.4 Residents have participated in and adhered to the rules of the Resident Matching Program process. __X__

Comments: 

**Principle 2: Obligations of the Program to the Resident**

2.1 Program is a minimum of twelve months and is a full-time practice commitment or equivalent. __X__

2.2a RPD assures that the educational outcomes of the program, the welfare of the resident, and the welfare of patients are not compromised by excessive reliance on residents to fulfill service obligations. __X__
2.2b RPD assures residency complies with the current duty hour standards of the Accreditation Council for Graduate Medical Education (ACGME).

2.3 Program adheres to the rules of the Resident Matching Program process.

2.4a RPD provides residents who are accepted into the program with a letter outlining their acceptance to the program.

2.4b RPD provides information on the terms and conditions of the appointment and information is consistent with that provided to pharmacists within the organization.

2.4c Acceptance by residents of these terms and conditions is documented prior to beginning of the residency.

2.5 Program provides sufficient professional and technical pharmacy staff complement to ensure appropriate supervision and preceptor guidance to all residents.

2.6 Program provides residents with an area in which to work, access to appropriate technology, access to extramural educational opportunities, and sufficient financial support to fulfill the responsibilities of the program.

2.7 Policies concerning professional, family, and sick leaves and the effect such leaves would have on the resident’s ability to complete the residency program are documented.

2.8 RPD awards a certificate of residency only to those who complete the program’s requirements. Certificate states program is accredited by ASHP and, if appropriate, its corresponding partner; is issued in accordance with the provisions of the ASHP Regulations on Accreditation of Pharmacy Residencies; and is signed by the RPD and the CEO of the organization.

2.9 Program is compliant with the provisions of the current version of the ASHP Regulations on Accreditation of Pharmacy Residencies.

Comments: 2.8 The program is in its first year thus a certificate of residency only to those who complete the program’s requirements first iteration is planned for end of June 2013. A proposed certificate is available for review on site that is in compliance the provisions of the ASHP Regulations on Accreditation of Pharmacy Residencies; and is signed by the RPD and the CEO of the organization.

 Principle 3: Obligations of the Resident to the Program

3.1 Residents’ primary professional commitment is to the residency program.

3.2 Residents adhere to the values and mission of the training organization.

3.3 Residents complete the educational goals and objectives established for the program.

3.4 Residents ask for verbal and written feedback from preceptors.

3.5 Residents make active use of constructive feedback from preceptors.

Comments: 3.3: RTP has not graduated or had any residents complete our program at this time. 3.4: The RPD has coached, modeled and instructed Residents to ask for verbal and written feedback from
preceptors with good results but not grade as 100% FC. The RPD innovated our custom evaluation in ResiTrak for this purpose. 3.5: The RPD has coached, modeled and instructed Residents to make active use of constructive feedback from preceptors with good results but not 100% FC, in fact I have no example to base this other than handful of observations. An example would be the resident’s and our preceptor’s (CF and AE) frustration after the feedback on medical grand rounds presentation in fall 2012. Application of preceptor feedback was partially observed but needed close attention and repeating in subsequent. Recently the RPD coached the resident AE with hour case presentation on “MRSA and Cellulitis” resident AE has successfully applied said skills in the subsequent opportunity. RPD has worked with preceptor’s who stated the residents’ “should just do it” or “they should know this coming into the program” at the level of the Clinical Pharmacy Supervisor and in preceptor training meetings.

**Principle 4: Requirements for the Design and Conduct of the Residency Program**

**4.1** RPD and, when applicable, program preceptors collaborate to design the residency program.

a. Program design includes documentation of the program’s:
   - (1) Purpose
   - (2) Outcomes that reflect the program’s purpose
   - (3) Educational goals for each outcome
   - (4) Educational objectives for each goal, the sum of which assure goal achievement

b. Program includes all six outcomes required by the accreditation standard and all of the associated educational goals listed with the required outcomes as follows:
   - (1) Manage and improve the medication-use process.
   - (2) Provide evidence-based, patient-centered medication therapy management with interdisciplinary teams.
   - (3) Exercise leadership and practice management skills.
   - (4) Demonstrate project management skills.
   - (5) Provide medication and practice-related education/training.
   - (6) Utilize medical informatics.

c. The design of program structure has the following characteristics:
   - (1) Facilitates achievement of the program’s educational goals and objectives.
   - (2) Allows resident experience in diverse patient populations, a variety of disease states, and a range of complexity of patient problems as characterized by a generalist’s practice.
   - (3) No more than four months of the program deals with a specific patient population or practice area.
   - (4) Program’s educational goals and objectives, including those for the project, are assigned to a single learning experience or a sequence of learning experiences that allows sufficient practice for their achievement.

d. Preceptors have a description of their learning experience and a list of activities to be performed by residents. Learning activities demonstrate adequate opportunity to learn the educational goals and objectives assigned to the learning experience.

e. Program design for competency-based evaluation includes the following
requirements:

1. Regarding preceptor evaluation of resident performance:
   (a) Each preceptor conducts and documents a criteria-based, summative assessment of each resident’s performance of each of the respective program-selected educational goals and objectives assigned to the learning experience.
   (b) Preceptor summative resident evaluations are conducted at the conclusion of the learning experience (or at least quarterly for longitudinal learning experiences) and reflect the resident’s performance at that time.
   (c) Each resident evaluation is discussed by the preceptor with the resident and RPD, and the reviews are documented by each.

2. Regarding resident self-evaluations:
   (a) Each preceptor provides periodic opportunities for the resident to practice and document criteria-based, formative self-evaluation of aspects of their routine performance.
   (b) Each preceptor provides an opportunity for the resident to document a criteria-based, summative self-assessment of achievement of the educational goals and objectives assigned to the learning experience, completed on the same schedule as required of the preceptor by the assessment strategy.
   (c) Residents complete end-of-the-year self-assessments.

3. Residents complete an evaluation of the preceptor and of the learning experience at the completion of each learning experience (or at least quarterly in longitudinal learning experiences) and provide their evaluations to the RPD.

4. Documentation of the program’s ongoing attention to fulfillment of both preceptor and resident roles and responsibilities shows that:

   a. Regarding orientation activities:
      (1) Residents are oriented to the program to include its purpose, applicable accreditation regulations and standards, designated learning experiences, and the evaluation strategy.
      (2) RPD orients staff to the residency program (when necessary).
      (3) Preceptors orient their residents to their learning experiences, including reviewing and providing written copies of the learning experience educational goals and objectives, associated learning activities, and evaluation strategies.

   b. Regarding customization of resident training programs:
      (1) The RPD and, when applicable, preceptors customize the training program for the resident based upon an assessment of the resident’s entering knowledge, skills, attitudes, and abilities and the resident’s interests including accounting for discrepancies in assumed entering capabilities.
      (2) Residents’ customized plans maintain consistency with the program’s stated purpose and outcomes.
      (3) Customization of resident’s plans does not interfere with achievement of the program’s educational goals and objectives.
      (4) Customized plans and modifications to them, including the resident schedules, are shared with the resident and all preceptors.

   c. Preceptors provide ongoing, criteria-based verbal and, when needed, written feedback. Written feedback is used if there is limited direct contact with the preceptor or verbal feedback alone is not effective in improving performance.
d. Preceptors complete all aspects of the program’s plan for assessment of:
   (1) Resident performance
   (2) Preceptor performance
   (3) Resident self-evaluation

   e. Regarding monitoring of resident progress:
      (1) RPD and, when applicable, preceptors track residents’ overall progress toward achievement of their educational goals and objectives at least quarterly.
      (2) Any necessary adjustments to residents’ customized plans, including remedial action(s), are documented and implemented.

4.3 Regarding quality assurance of training program:
   a. RPD evaluates potential preceptors based on their desire to teach and their aptitude for teaching (as differentiated from formal didactic instruction).
   b. RPD provides preceptors with opportunities to enhance their teaching skills.
   c. RPD utilizes a plan for improving the quality of preceptor instruction based on an assessment of residents’ written evaluations of preceptor performance and other sources.
   d. At least annually RPD and when applicable, preceptors, consider overall program changes based on evaluations, observations, and other information.

4.4 RPD evaluates, through employment and other career information of residency graduates, whether the residency produces the type of practitioner described in the program’s purpose statement.

Comments:
4.1 c (2) Patient care units with on-demand services for clinical pharmacy include pediatrics, neonates, and off-site ambulatory care are generally not available or structured into resident training at this time but our treatment population is a diverse and strongly supports pharmacy generalist training services.

4.1 c (3) Infectious Disease core and Family Practice elective may overlap in-patient type with any of the other direct patient care rotations.

4.1 d The DPC Oncology elective was developed by a current resident, with the support of the RPD, RPC and approved by the RAC, as a major practice based project. It represents an focus area where the pharmacy department and RPD desire to expand patient care beyond medication order review and preparation.

Preceptors are co-developing the Pharmacy Practice Management longitudinal experience which has taken on the persona of the prototypical LE “work in progress”. Collaboration and a longer list of T/TEs than other rotations make this a challenging RTP LE.

With the DPC LE’s where R2.6, 2.7.2.9 are T and TE, the partial compliance answer is rooted in a perception that our practice model must have 100% prospective care plan design and implementation where actually we have not achieved this. As a group of pharmacists, we are not clear with the fundamental consensus to achieve prospective review as an overarching change and organizational decision. Pharmacy practice is being molded by the RTP but my view is this will take some time and a large loading dose of leadership.

4.3 a.b.c.d. As a young, new program this is difficult criteria to mark FC as there more plans to conduct said activities than actual outcomes and time dedicated to each task.

4.4: We have yet to complete our first year.
**Principle 5: Qualifications of the Residency Program Director (RPD) and Preceptors**

5.1 RPD is a licensed pharmacist, has completed an ASHP-accredited residency, and has a minimum of three years of pharmacy practice experience. Alternatively, RPD is a licensed pharmacist; has five or more years of practice experience; and has demonstrated mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a residency.

5.2 RPD has documented evidence of his or her ability to teach effectively in the clinical practice environment.

5.3 The program has a single RPD who is a pharmacist from a practice site involved in the program or from a sponsoring organization.

5.4 For multiple site residencies or for a residency offered by a sponsoring organization in cooperation with one or more practice sites:
   a. There is one RPD.
   b. RPD’s responsibilities are defined clearly.
   c. RPD designation is agreed to in writing by responsible representatives of each participating organization.

5.5 RPD has documentation of ability to direct and manage a pharmacy residency.

5.6 RPD has a sustained record of contribution and commitment to pharmacy practice that is characterized by a minimum of four of the following. Please check those that apply:
   - Documented record of improvements in and contributions to pharmacy practice.
   - Appointments to appropriate drug policy and other committees of the organization.
   - Formal recognition by peers as a model practitioner.
   - A sustained record of contributing to the total body of knowledge in pharmacy practice through publications in professional journals and/or presentations at professional meetings.
   - Serving regularly as a reviewer of contributed papers or manuscripts submitted for publication.
   - Demonstrated leadership in advancing the profession of pharmacy through active service in professional organizations at the local, state, and national levels.
   - Demonstrated effectiveness in teaching.

5.7 Preceptors are licensed pharmacists, have completed an ASHP-accredited residency, and have a minimum of one year of pharmacy practice experience. Alternatively, preceptors who are licensed pharmacists but have not completed an ASHP-accredited PGY1 residency are able to demonstrate mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a PGY1 residency and have a minimum of three years of pharmacy practice experience.

5.8 Preceptors have training and experience in the area of pharmacy practice for which they serve as preceptors, maintain continuity-of-practice in that area, and practice in that area at the time residents are being trained.

5.9 Each preceptor has a record of contribution and commitment to pharmacy practice
characterized by a minimum of four of the following. Please check those that apply:

- Record of improvements in and contributions to the respective area of advanced pharmacy practice.
- Appointments to appropriate drug policy and other committees of the department/organization. X
- Formal recognition by peers as a model. X
- A sustained record of contributing to the total body of knowledge in pharmacy practice through publications in professional journals and/or presentations at professional meetings. X
- Serves regularly as a reviewer of contributed papers or manuscripts submitted for publication. X
- Demonstrated leadership in advancing the profession of pharmacy through active participation in professional organizations at the local, state, and national levels. X
- Demonstrated effectiveness in teaching.

5.10 Preceptors demonstrate desire and aptitude for teaching that includes all of the following. Please check those that apply:

- Mastery of the four preceptor roles fulfilled when teaching clinical problem solving (instructing, modeling, coaching, and facilitating).
- The ability to provide criteria-based feedback and evaluation of resident performance.
- Pursuit of continued refinement of their teaching skills.

5.11 If non-pharmacist preceptors are utilized, all of the following conditions are met. Please check those that apply:

X The learning experiences in which they are utilized occur in later stages of the residency when evaluations conducted at the end of previous learning experiences reflect readiness to practice independently, the RPD and preceptors agree that the resident is ready for independent practice, and the main role of the preceptor is to facilitate resident learning experiences.
X A pharmacist works closely with the non-pharmacist preceptor to select the educational goals and objectives and participates actively in the criteria-based evaluation of the resident’s performance.

Comments:

5.4 RTP is not a multiple site residency.

5.8: For Stellar Family Practice Rounding (SFP -direct patient care elective) the preceptors (Dr. Lafayette and Dr. Franklin) have training and experience in the practice area but this learning experience is a stretching of existing practice to include rounding with this medical team for the benefit of the PGY1 residents as well as patients. SFP is seeing about 15 SH inpatients similar to the hospitalist service acting as a PCP to the inpatient. The SFP is essentially a collaboration project justified because SFP conducts a medical residency-training program with 18 medical PGY1,2,3 residents. The SFP DPC rotation is an elective and as such offered late in the final stages when evaluations conducted at the end of previous learning experiences reflect readiness to practice independently. The pharmacist preceptors understand how to maintain the preceptor continuity-of-practice in that area as well as the physician faculty but this is a new endeavor driven by the concept and willingness to explore a different PPMI like model discussed in early stages of our RAC. The RAC and key preceptor Dr. Lafayette agreed to trial and consider changing the Internal Medicine rotation structure in 2013-2014 in order to incorporate team rounding and prospective review by the pharmacist potentially changing practice toward the ASHP PPMI model.

5.9: The program identifies and trains new faculty in order to encourage professional development for satisfaction of PGY1 record of contribution and commitment. The program has a plan for preceptor development aimed at the prototypical “new” preceptor found to be lacking required 4/7 criteria.
A preceptor self-scoring survey has been initiated by the RAC to stimulate interest and concern among our preceptors. Preceptor development training by the RPD and RPC is evidenced by the RTP meetings and feedback by RPD and RPC. This requirement is expected to receive concentrated focus in the years ahead with development tied to the annual performance appraisal process.

**Principle 6: Minimum Requirements of the Site Conducting the Residency Program**

6.1 The residency program is conducted only in practice settings that have sought and accepted outside appraisal of facilities and patient care practice by a recognized organization appropriate to the practice setting.

- a. A health-system (inclusive of all components of the system that provide patient care) that offers or that participates in offering a pharmacy residency is accredited by applicable organizations [e.g., Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), National Committee for Quality Assurance (NCQA)]. Please specify which: _JCAHO_  

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- b. A college of pharmacy that participates in offering a pharmacy residency is accredited by the Accreditation Council for Pharmacy Education (ACPE). Name of college: _Midtown College of Pharmacy and Health Sciences (MCPHS)_

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- c. Other practice settings that offer a pharmacy residency demonstrate substantial compliance with applicable professionally developed and nationally applied standards.

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6.2 The residency program is conducted only in those practice settings where management and professional staff have committed to seek excellence in patient care, have demonstrated substantial compliance with professionally developed and nationally applied practice and operational standards, and have sufficient resources to achieve the educational goals and objectives selected for the residency program.

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6.3 Where two or more practice sites, or a sponsoring organization (e.g., college of pharmacy, health system) and one or more practice sites collaborate to provide a pharmacy residency:

- a. Patient population base and professional practice experience satisfy residency requirements.

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- b. Sponsoring organizations maintain authority and responsibility for the quality of residency training.

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- c. An individual is designated and empowered to direct program and achieve consensus on evaluation and ranking of residency applicants.

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- d. Sponsoring organizations and practice sites contractual arrangement(s) or signed agreement(s) define clearly responsibilities for all program aspects.

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- e. Each practice site providing residency training meets Requirement 6.2 and all of Principle 7 of the standard.

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**Comments:**

6.2 The possible exception to FC is the new Oncology LE. The experience itself was developed as a major practice based project by resident Dr. Knox and preceptor development and overall scope of the LE is under review and finalization by the lead preceptor and by the RAC. In addition we are exploring the potential to attract a qualified MCPHS faculty member to the service for both APPE and Resident training which may be the best idea yet for the endeavor.

6.3e We have an affiliation agreement with MCPHS and have chosen to allow two rotations: Scholarship of
Teaching and Learning (longitudinal) and Ambulatory Care / Rheumatology (elective DPC rotation).
Application of Principle 7 to the MCPHS (college of pharmacy) is an area for investigation with the ASHP survey team however the two faculty members are SH RTP preceptors approved by SH RAC and are listed in the SH RTP roster of preceptors.

**Principle 7: Qualifications of the Pharmacy**

7.1 The pharmacy is led and managed by a professionally competent, legally qualified pharmacist.  

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7.2 The pharmacy is an integral part of the health-care delivery system at the practice site in which the residency program is offered, as evidenced by the following:

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<tr>
<td>a. The scope of patient pharmacy services is based upon assessment of pharmacy functions needed to provide care to all patients served.</td>
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<td>b. Services are of a scope and quality commensurate with identified patient needs.</td>
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<td>c. Pharmacy is involved in the overall planning of patient care services for the practice setting.</td>
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<td>d. Pharmacy services extend to all areas of the practice site in which medications are prescribed, dispensed, administered, and monitored</td>
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<td>e. Pharmacists are responsible around-the-clock for procurement, preparation, distribution, and control of all medications used, including investigational drugs.</td>
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7.3 The chief pharmacist provides effective leadership and management for the achievement of short- and long-term goals of the pharmacy and the organization relating to medication use and medication-use policies by assuring that the following elements associated with a well-managed pharmacy are in place (as appropriate to the practice setting):

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<tr>
<td>a. A pharmacy mission statement.</td>
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<td>b. A written document describing the scope and depth of pharmacy services.</td>
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<td>c. A well-defined pharmacy organizational structure.</td>
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<td>d. A description of pharmacy services provided.</td>
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<td>e. <strong>Documented short- and long-term pharmacy goals.</strong></td>
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<td>f. Current policies and procedures that are readily available to staff participating in service provision.</td>
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<td>g. Position descriptions for all categories of pharmacy personnel.</td>
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<td>h. Systems to document pharmacy:</td>
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<td>(1) Workload</td>
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<td>(2) Financial performance</td>
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<td>(3) Patient care outcomes data</td>
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<tr>
<td>i. Pharmacy involvement with key committees involving medications and patient care.</td>
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<td>j. A quality improvement plan.</td>
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7.4 The pharmacy:

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<td>a. <strong>Complies with all applicable federal, state, and local laws, codes, statutes, and regulations governing pharmacy practice.</strong></td>
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<td>b. Demonstrates substantial compliance with national practice standards and guidelines.</td>
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<td>c. Regularly reviews and develops plans to conform to new practice standards or guidelines.</td>
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<td>d. Has sought and accepted outside appraisals of its facilities and patient care practices.</td>
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7.5 The pharmacy provides a safe and effective drug distribution system for all
medications used within the practice site by including the following components in its drug distribution system/service (as applicable to the practice setting):

a. A unit-dose drug distribution service.  
X
b. An intravenous admixture and sterile product service.  
X
c. An investigational drug service.  
X
d. An extemporaneous compounding service.  
X
e. A system for the safe use of drug samples.  
X
f. A system for the safe use of emergency medications.  
X
g. A controlled substance floor-stock system.  
X
h. A controlled floor-stock system.  
X
i. An outpatient drug distribution service.  

7.6 The pharmacy provides the necessary patient care services in a manner consistent with practice site and patient needs.

a. The following patient care services or activities are provided in collaboration with other health-care professionals:

(1) Membership on interdisciplinary teams in the patient care areas associated with the residency program.  
X
(2) Development of treatment protocols, critical pathways, order sets, and other systems approaches involving medications for patients on involved services.  
X
(3) Participation in collaborative practice agreements with other providers and management of patients following collaborative practice agreements, treatment protocols, critical pathways, etc.  
X
(4) Prospective participation in the development of individualized treatment plans for patients of involved services.  
X
(5) Identification of medication-related problems.  
X
(6) Review of appropriateness and safety of medication orders.  
X
(7) Design and implementation of medication-therapy monitoring plans.  
X
(8) Documentation of all significant patient care recommendations and resulting actions, treatment plans, and/or progress notes in the appropriate section of the patient’s medical record or the organization’s clinical information system.  
X
(9) Written and oral consultations regarding medication-therapy selection and management.  
X
(10) Patient disease and/or medication management consistent with laws, regulations, and practice site policy.  
X
(11) Medication administration consistent with laws, regulations, and practice site policy.  
X
(12) Preventive and wellness programs.  
X
(13) A system to ensure and support continuity-of-care.  

b. Drug information activities provided by pharmacy staff and the residents include, but are not limited to, the following (as applicable to the practice setting):

(1) Developing and maintaining a formulary.  
X
(2) Publishing periodic newsletters or bulletins for health-care providers on timely medication-related matters and medication policies.  
X
(3) Preparing medication therapy monographs based on an analytical review of pertinent biomedical literature, including a safety assessment and a comparative therapeutic and economic assessment of each new agent for formulary addition or deletion.  
X
(4) Establishing and maintaining a system for retrieving drug information from
the literature.

(5) Responding to drug information inquiries from health-care providers.
(6) Conducting educational programs about medications, medication therapy, and other medication-related matters for health-care providers.
(7) Participating in the development or modification of policies related to:
   (a) medications
   (b) medication-use evaluation
   (c) adverse drug event prevention, monitoring, and reporting
   (d) appropriate methods to assess ongoing compliance with such policies.

7.7 The pharmacy provides leadership and participates with other health professionals in the following systems (as applicable to the practice setting):

   a. A system to support and actively participate in decision-making concerning the pharmacy and therapeutics function, including the preparation and presentation of drug-therapy monographs.
   b. A system to review medication-use evaluations and to implement new policies or procedures to improve the safe and effective use of medications.
   c. A system to review adverse drug event reports and to implement new policies and procedures to improve medication safety.
   d. A system to evaluate routinely the quality of pharmacy services provided.

7.8 The pharmacy has personnel, facilities, and other resources to carry out a broad scope of pharmacy services (as applicable to the practice setting).

   a. Facilities are constructed, arranged, and equipped to promote safe and efficient work.
   b. Adequate packaging equipment is used to prepare medications for unit-dose dispensing or compliance packaging.
   c. Automated medication systems and software support a safe medication-use system.
   d. Computerized systems support a safe medication-use system.
   e. Professional and technical staff is sufficient in number and of the diversity to ensure that the department can provide the level of service required by all patients served.
   f. Professional staff members seek professional enrichment and demonstrate their interest in continuing competence.
   g. Technical and clerical staff complement is sufficient to handle all functions that can be assigned appropriately to them.

Comments.

7.3 h (3) Patient care outcomes data can always be improved to be more comprehensive and the residency program is one way to achieve the objective to document pharmacist outcomes.

7.6 a (4) We are not always prospective in all practice setting associated with resident training, but we do have reactive coverage with services to requested consults in all patient care areas of the health care facility. This restriction to reactive services in some cases is necessary due to limitations of pharmacist resources and is also complicated by the definition and interpretation of pharmacy services posed by the statement. Progress is reflected in potentially changing the Internal Medicine rotation structure in 2013-2014 in order to incorporate team rounding and prospective review by the pharmacist potentially changing practice toward the ASHP PPMI model.

7.6 a (12) We rarely provide this. One bright spot is we have a 2012 resident project (Dr. J. Adams) aimed at feasibility of smoking cessation services in the inpatient care areas associated with high-level quality improvement target in the SH organization. The PC reflects the exploratory and incomplete stage of the project as well a weak presence in this area of service.
7.6 b (2) The score of PC is based on the lack of a department newsletter but certainly not a lack of publication within other media in the organization. As matter of periodic publication at SH we do not maintain an institutional Pharmacy Department newsletter but choose to contribute to medical staff and staff newsletters on a routine and as needed basis. The pharmacy department participates in medical staff direct mailings and other informational media.