



# State of New Hampshire – Board of Pharmacy

7 Eagle Square, Concord, NH 03301

Email: [pharmacy.compliance@oplcnh.gov](mailto:pharmacy.compliance@oplcnh.gov)



## Institutional Pharmacy / Pharmacist-In-Charge – Self-Inspection Report

*Copy of Completed Form Must Be Kept on File & Readily Retrievable/Presented to Board Inspectors During Your Next Regular Board of Pharmacy Inspection.*

**Date of last inspection:** \_\_\_\_\_

<b>Reason for Self-Inspection:</b>	<input type="checkbox"/> Annual <input type="checkbox"/> Biennial <input type="checkbox"/> PIC Change <input type="checkbox"/> Audit <input type="checkbox"/> Other – list →:
<b>Date Completed</b>	
<b>Name of Pharmacy</b>	
<b>Address of Pharmacy</b>	
<b>Pharmacy License #</b>	
<b>DEA Registration #</b> <b>Expiration Date:</b>	
<b>Phone #</b>	
<b>Fax #</b>	
<b>Pharmacy Email Address:</b>	
<b>Pharmacist-In-Charge (Name, License #, Personal Email)</b>	
<b>Date you became PIC of this pharmacy?</b>	
<b>Has there been a PIC Change in last 12 months?</b>	<input type="checkbox"/> Yes* – Date of PIC Change: _____ <input type="checkbox"/> No * If Yes, the date a controlled substance inventory was completed as part of PIC change? _____

# 1. Pharmacy Personnel Information

Pharmacists				
Full Name	Licensed As		License #	Registered with NH Prescription Drug Monitoring Program?
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Regular Pharmacy Staff	<input type="checkbox"/> Floater		<input type="checkbox"/> Yes <input type="checkbox"/> No

Pharmacy Interns			
Full Name	License #	Name of Pharmacy School	Anticipated Graduation (Month/Year)

\* Attach additional copies of this page if necessary to include all pharmacist & pharmacy intern staff.

<b>Certified Pharmacy Technicians (CPhT's)</b>			
<b>Full Name</b>	<b>Registration #</b>		

<b>Registered Pharmacy Technicians</b>						
<b>Full Name</b>	<b>License #</b>	<b>Data Entry Training Completed (Month/Year)</b>		<b>Full Name</b>	<b>License #</b>	<b>Data Entry Training Completed (Month/Year)</b>

**Any new hires since last inspection?** \_\_\_\_\_

**CPhT's performing sterile compounding?** \_\_\_\_\_

**Have they completed USP training prior to sterile compounding?** \_\_\_\_\_

*\* Attach additional copies of this page if necessary to include all pharmacy technician staff.*

## 2. Refrigeration / Freezers

Item	Answer
Number of <b>refrigerators</b> in pharmacy/licensed area?	
Number of <b>refrigerators</b> in / on each floor of hospital/facility?	
How is the <b>refrigerator</b> temperature monitored/logged?	<input type="checkbox"/> Automated <input type="checkbox"/> Manually <input type="checkbox"/> Both
Has there been a loss of power to the pharmacy, or has the <b>refrigerator</b> alarm been otherwise activated, in the past 12 months?	<input type="checkbox"/> Yes – Date(s) of Incident(s): _____ <input type="checkbox"/> No
How many days have there been temp. excursions in the past 30 days?	
How many <b>freezers</b> containing medications are located in the hospital?	
How is the <b>freezer</b> temperature monitored/logged?	<input type="checkbox"/> Automated <input type="checkbox"/> Manually <input type="checkbox"/> Both
Has there been a loss of power to the pharmacy, or has the <b>freezer</b> alarm been otherwise activated, in the past 12 months?	<input type="checkbox"/> Yes – Date(s) of Incident(s): _____ <input type="checkbox"/> No
Is the ambient temperature of the pharmacy maintained / monitored (per Ph 702.02, 1002.01)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 3. Patient Owned Meds

Item	Answer
Medications admitted with patient are properly stored and secured according to the hospital's / facility's policies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often are policies & procedures reviewed regarding patients admitted with their own meds?	

## 4. Pharmacist Remote Order Entry

Item	Answer
Pharmacist remote order entry?	<input type="checkbox"/> Yes * <input type="checkbox"/> No
* If yes to above, company used, along with list of pharmacists, their NH licenses numbers	

## 5. EMS Medications

Item	Answer
A. Does pharmacy provide EMS medications?	<input type="checkbox"/> Yes * <input type="checkbox"/> No
B.* If Yes, to whom do you provide EMS medications?	<input type="checkbox"/> Ambulance Service <input type="checkbox"/> ALS (Advanced Life Support) Personnel <input type="checkbox"/> Other – please specify:
C.* If Yes, type of EMS medications provided?	<input type="checkbox"/> "Kit" Exchange <input type="checkbox"/> ADM <input type="checkbox"/> Other – please specify:
Are proof-of-use forms utilized to adequately account for controlled substances used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is controlled substance stock "sealed"?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Upon delivery to ALS/EMT?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Upon return from ALS/EMT?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does pharmacy use an ADM for non-controlled drugs for EMS?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 6. Emergency Room

Item	Answer
Are drugs dispensed from Emergency Room?	<input type="checkbox"/> Yes * <input type="checkbox"/> No
* If Yes, type of ER controlled substance dispensing log?	<input type="checkbox"/> ADM <input type="checkbox"/> Manual <input type="checkbox"/> Other – please specify:
* If Yes, is ER dispensing of Schedule II Controlled Drugs limited to no more than a 2 day supply?	<input type="checkbox"/> Yes <input type="checkbox"/> No
* If Yes, is ER dispensing of Schedule III - V Controlled Drugs limited to no more than a 72-hour supply?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Item	Answer
* If Yes, are labels for ER dispensed meds adequate per RSA 318:47?	<input type="checkbox"/> Yes <input type="checkbox"/> No

* If Yes, ER drugs dispensed verified by?	<input type="checkbox"/> Pharmacist <input type="checkbox"/> Practitioner <input type="checkbox"/> Nurse <input type="checkbox"/> Other – please specify:
* If Yes, Medication counseling offered to patient by?	<input type="checkbox"/> Pharmacist <input type="checkbox"/> Practitioner <input type="checkbox"/> Nurse <input type="checkbox"/> Other – please specify:
Does ER dispense MAT meds? If so, do they upload three days or more to PDMP?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 7. Ancillary Drug Storage Areas / Automated Dispensing Machines

Item	Answer
Types of ancillary drug storage areas / Automated Dispensing Machines (ADM's)?	<input type="checkbox"/> Med Closet <input type="checkbox"/> Med Room <input type="checkbox"/> I.V. Storage <input type="checkbox"/> Other – please specify:
Total number of ADM's in use? If none, enter 0.	
Bedside scanning used (per Ph 807.03)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are using scanning technology, is resupply checked by a certified pharmacy technician?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Is the wasting/disposal of meds done by two licensed personnel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Since your last inspection by the Board, have any <b>hospital</b> employees been terminated due to diversion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Since your last inspection by the Board, have any <b>pharmacy</b> staff been terminated due to diversion?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 8. Compounded Sterile Products (CSP)

Item	Answer
When was the most recent hood certification (enter date)?	
Did all HEPA filters pass inspection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
What type of sterile compounding is performed? (Check all that apply)	<input type="checkbox"/> Immediate Use <input type="checkbox"/> Category I <input type="checkbox"/> Category II <input type="checkbox"/> Hazardous Drugs (HD)
Type of primary engineering control? (Check all that apply)	<input type="checkbox"/> CAI <input type="checkbox"/> LAWf <input type="checkbox"/> CACI * <input type="checkbox"/> BSC **

*If CACI used, vented to outside of the building?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
**If BSC used, vented to outside of the building?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Item	Answer
Since your last Board inspection, were any pathogenic, fungus, yeast or gram negative rods detected in the PEC (Primary Engineering Controls) or buffer room (ISO 5, ISO 7 areas)?	<input type="checkbox"/> Yes * <input type="checkbox"/> No <input type="checkbox"/> Not Applicable *If yes, was remedial action taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Since your last Board inspection, did any surface viable counts in the PEC or buffer room (ISO 5, ISO 7 Areas) exceed actionable levels according to USP 797?	<input type="checkbox"/> Yes * <input type="checkbox"/> No <input type="checkbox"/> Not Applicable *If yes, was remedial action taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Since your last Board inspection, did any air sampling counts in the PEC or buffer room (ISO 5, ISO 7 Areas) exceed actionable levels according to USP 797?	<input type="checkbox"/> Yes * <input type="checkbox"/> No <input type="checkbox"/> Not Applicable *If yes, was remedial action taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Since your last Board inspection, has any PEC Equipment been relocated or has there been a remodel?	<input type="checkbox"/> Yes * <input type="checkbox"/> No <input type="checkbox"/> Not Applicable *If yes, please describe:

## 9. Ante Room

Item	Answer
Is there an Ante Room?	<input type="checkbox"/> Yes * <input type="checkbox"/> No *If yes, the Ante Room is ISO _____ Certified

## 10. Buffer Room

Item	Answer
Is there a classified Buffer Room?	<input type="checkbox"/> Yes* (Answer questions below) <input type="checkbox"/> No (Skip to section 11)
*Buffer Room Air Changes Per Hour (ACHS)?	
* <b>Non-HD</b> Buffer Room is ISO _____ Certified?	Date last Certified:
* <b>HD</b> Buffer Room is ISO _____ Certified?	Date last Certified:
*Primary Engineering Control (PEC) is ISO _____ Certified for <b>Non-HD</b> .	Date last Certified:

*Primary Engineering Control ACPH (Air Changes Per Hour) for <b>Non-HD</b> ?	
*Primary Engineering Control (PEC) is ISO _____ Certified for <b>HD</b> .	Date last Certified:
<b>Item</b>	<b>Answer</b>
*Primary Engineering Control ACPH (Air Changes Per Hour) for <b>HD</b> ?	
*Documentation of uni-directional air flow under dynamic conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
*Are cleaning logs maintained/documented?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
*If any excursions, viable and non-viable, send a copy of environmental monitoring report and copy of corrected action plan. (Compliance will be in contact)	

**11. Certification of Completion by Pharmacist-In-Charge**

I certify that I have performed a self-inspection of:

Name of Pharmacy \_\_\_\_\_ NH Pharmacy Permit #: \_\_\_\_\_

on the following date: \_\_\_\_\_ and affirm that it is an accurate and truthful assessment of the pharmacy as of the date of this self-inspection.

Printed Name of Pharmacist-In-Charge: \_\_\_\_\_

Signature of Pharmacist-In-Charge: \_\_\_\_\_ Date Signed: \_\_\_\_\_

***Entire Form Must Be Kept on File at the Pharmacy & Readily Retrievable / Presented to Board Inspectors During Your Next Regular Board of Pharmacy Inspection.***