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**Survey Shares Pharmacist, Technician Perspectives
on Compounded Sterile Product Management**

Horsham, Pa--- The national outbreak last year of fungal meningitis from contaminated steroid injections dispensed from a compounding pharmacy issued a wake-up call to the healthcare community—results from a survey recently released by The Institute for Safe Medication Practices (ISMP) provide new insights into how hospitals are managing the preparation and/or purchase of compounded sterile products (CSPs).

ISMP's survey was fielded in November and December of 2012, and had 412 pharmacist and pharmacy technician respondents. The survey focused primarily on management of high-risk CSPs, defined as those where non-sterile ingredients or a non-sterile device is involved in the preparation and terminal sterilization is required before use (not simple mixtures of sterile ingredients).

Results from the survey were published in the January 24, 2013 issue of the *ISMP Medication Safety Alert!*[®] newsletter. Below are highlights of the findings.

Disclosure to prescribers. About a quarter (23%) of respondents do not believe pharmacists need to disclose to prescribers the *source* of high-risk CSPs. Two-thirds (67%) believe disclosure to prescribers is warranted—more so when the high-risk CSP has been prepared by an external compounding pharmacy (75%) rather than by the hospital pharmacy (60%).

Disclosure to patients. About half (54%) of respondents did not think prescribers need to disclose to patients the *source* of high-risk CSPs. More felt that disclosure to patients was warranted when high-risk CSPs were prepared by an external compounding pharmacy (59%) than when prepared by the hospital pharmacy (48%). However, less than half (45%) felt that written, informed consent should be required before drug administration.

Responsibility to investigate, approve, and monitor. For sterile compounding in hospital pharmacies, most respondents felt that the pharmacy (72%) and accrediting agencies (80%) were responsible for monitoring compliance with USP <797>. The majority of survey participants said responsibility for investigating an external compounding pharmacy and its ability to prepare high-risk CSPs for the hospital still falls squarely on the purchasing hospital pharmacy (79%). However, accrediting agencies and prescribers were considered to have greater responsibility when external compounding pharmacies were used rather than hospital pharmacies.

Technician training. Eighty-one percent of respondents believe the state pharmacy boards should require technicians who work in sterile compounding to be certified or licensed after successful demonstration of proficiencies in sterile compounding. No significant differences were seen when comparing responses from technicians with responses from pharmacists.

Contamination . About 13% of respondents reported that contamination of high-risk CSPs had happened in their facility during the past year. However, significant differences were noted between the percent of pharmacists—11%—and the percent of pharmacy technicians—29%—who reported actual contamination. Differences were also apparent among the percent of frontline staff (16%), managers (11%), and directors (6%) who reported contamination of a high-risk CSP in the past year. Only half (50%) of all staff pharmacists and 38% of pharmacy technicians were confident that contamination had not occurred.

For a copy of the full ISMP newsletter cover article, which provides more details and data from the survey, go to: <http://www.ismp.org/Newsletters/acutecare/showarticle.asp?id=40>

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 35 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org