

# PHARMACY PRACTICE NEWS

**In this bimonthly column for *Pharmacy Practice News*, DeeAnn Wedemeyer Oleson, PharmD details the rewards and challenges of providing pharmacy services in small and rural hospitals. Dr. Wedemeyer Oleson is Director of Pharmacy at Guthrie County Hospital in Guthrie Center, Iowa. She welcomes your feedback at [dawopharmd@yahoo.com](mailto:dawopharmd@yahoo.com)**

## **Make a Difference—No Matter Your Hospital's Size**

Because this is my inaugural column, I'd like to tell you about my background—or at least, a portion of it that hopefully will explain why I feel so passionately about the benefits of practicing in a rural hospital pharmacy.

I grew up in Adair, a town of 750 people in rural western Iowa. I attended pharmacy school at Drake University in Des Moines and received my PharmD in 1999. After graduation, I completed an ASHP-accredited specialty residency in geriatric pharmacy practice in another state. I was then faced with the same key decision that every resident grapples with: what to do when your year of residency training is finished.

I considered several options, but more than anything, I wanted to return home and contribute to the healthcare of my family, friends and neighbors. Guthrie County Hospital in Guthrie Center, Iowa, located about 25 miles from my hometown, was at the top of my list of potential practice sites. But this would not be easy.

Pharmacy services at Guthrie County were minimal, to say the least. Pharmacists at the local community pharmacy worked at the hospital as consultants, putting in 30 to 60 minutes each morning (excluding weekends) before opening their own drugstore. Pharmacy services included placing an order for drugs and setting out controlled substances for floor stock. There was no unit dose system; the nurses administered medications from stock bottles. There was no pharmacy software system. There was a vertical laminar airflow hood that was never used; all intravenous (I.V.) admixtures were prepared by nurses on a countertop. There were no pharmacy policies and procedures. Medication orders were not reviewed by a pharmacist. The Pharmacy & Therapeutics Committee was nonfunctional. There was not even a physical pharmacy—just shelves where drugs were stored behind the nurse's station. In short, even the most basic aspects of hospital pharmacy practice simply did not exist at Guthrie County. Yet I was still determined to make a go of it and start my career at the hospital.

Unfortunately, my residency preceptor didn't share my enthusiasm about my post-residency plans. She bluntly told me that if I was going back to practice in some small hospital in the middle of nowhere, my residency had been a waste of my time and her time. She thought that I should pursue academia or perhaps a geriatrics clinical position in a large hospital.

I suppose there are some people who would agree with her. But I felt, and still feel, that she was terribly wrong. My specialty residency in geriatrics had prepared me to provide clinical pharmacy services to the aging population. Where better to begin practicing than in a rural county in Iowa, where we have one of the largest populations of elderly, both over the age of 65 and the very old over the age of 85? Aren't these patients just as deserving of a safe medication use system as patients in large and urban facilities?

I certainly thought so, and wanted the opportunity to make it happen. So, towards the end of my residency, I let the Guthrie County Hospital administrators know that I wanted to return to the area to practice. I began as the Director of Pharmacy in July 2000, working 20 hours a week—an amount the hospital CEO believed was sufficient for the delivery of pharmacy services at the 25-bed hospital. I was disappointed with the number of hours, but I felt that if I could prove the value of a pharmacist, my hours would increase. I was confident that I would be able to make a positive difference in this small hospital.

### **Overcoming Barriers**

But the task was not easy. I had a “to do” list a mile long and a resistant medical and nursing staff that felt my presence was unnecessary and unwanted. The general feeling among the physicians and nurses was that the hospital had done just fine without a pharmacist for 50 years and didn’t see the need for one now. I discovered that many Board of Pharmacy rules and controlled substances laws were being blatantly disregarded. I expected that we would work to come into full compliance with these regulations, which, of course, only made me more unpopular. The nursing staff was adamantly opposed to implementing a unit dose system because they “didn’t have a medication error problem.” They were furious when I told them that I would be preparing I.V. admixtures in the hood whenever I was at the hospital.

Moreover, nurses routinely dispensed medications to emergency room and discharge patients without any oversight by a physician. The physicians either didn’t understand basic controlled substances laws or simply didn’t care and they were not at all accustomed to having a pharmacist review their medication orders and make recommendations.

Without going into unpleasant details, let’s just say that my first two years were rough. I felt completely unappreciated and I was tempted to leave more times than I can count. Why did I stay? Because I was confident that having a pharmacist improved the safety and effectiveness of the medication use system at Guthrie County Hospital.

This July will mark my five-year anniversary serving as the Director of Pharmacy at Guthrie County Hospital. My hours have steadily increased, and I have been full-time for two years now. The pharmacy department has made great strides during that time:

- We’ve expanded to include a second full-time, residency-trained clinical staff pharmacist and a full-time certified pharmacy technician.
- We are currently in the planning stages of building a new pharmacy, including a new clean room that will be compliant with United States Pharmacopeia (USP) Chapter 797 rules on compounding sterile preparations.
- Our inpatient clinical services include an admission medication history program, discharge medication education program and dosing service.
- We are involved in the hospital’s cardiac rehabilitation and diabetes education programs.
- The clinical staff pharmacist and I can frequently be seen providing patient care in the three hospital-owned clinics, as the pharmacists are key team members in the diabetes management, geriatric and anticoagulation clinics.

As you can see, we have come a long way, and yet my “to do” list still seems long!

### **The Rewards for Pharmacists**

My story is not unique. There are pharmacists across the country practicing in small and rural hospitals with similar stories to tell. My guess is that they would tell you the same thing I will: Small and rural hospitals are some of the most rewarding and professionally fulfilling settings in which to practice pharmacy. My residency preceptor was wrong. It doesn't matter where you practice pharmacy. What matters is that you make a positive difference wherever your corner of the world is. I strongly believe that it is the very smallest corners of the healthcare system that need the expertise of a pharmacist the most.

I feel fortunate to have been offered the opportunity to write this bimonthly column for *Pharmacy Practice News*. I am looking forward to hearing your stories, sharing ideas from your practices, and raising awareness of the importance of pharmacy services in small and rural hospitals. I hope this column will serve as a mechanism to improve the standard of pharmacy practice in small and rural hospitals. Please feel free to contact me at [dawopharmd@yahoo.com](mailto:dawopharmd@yahoo.com) with your thoughts and ideas for future columns.