

# THE SENIOR CARE PHARMACIST

## AUTHOR INSTRUCTIONS

### ABOUT

*The Senior Care Pharmacist*® is the official peer-reviewed journal of the American Society of Consultant Pharmacists (ASCP). It is the only journal dedicated to the medication therapy needs of older adults. ASCP members receive *The Senior Care Pharmacist*® as a member benefit. All articles (2004 to present) are free online for members.

### WHAT WE PUBLISH

*The Senior Care Pharmacist*®, published monthly and exclusively online, welcomes submission of original manuscripts relevant to the safe and effective use of medicines for older people, as well as contributions addressing the practice of pharmacy as it relates to the care of older people. These contributions can include pharmacy practice reports, research, opinion, matters related to pharmacy education, or interdisciplinary cooperation.

### GENERAL PEER REVIEW PROCEDURES

On receipt of a manuscript, the editor screens the paper for quality control, ensuring that all instructions are followed, and all necessary parts are included and that the paper falls within the scope of the journal. Authors will be sent notification of the receipt of manuscripts and editorial decisions via email. Receipt of manuscripts is acknowledged immediately, and a final decision is reached on unsolicited manuscripts within three months.

If, based upon comments by peer reviewers, the manuscript is accepted for publication, comments by peer reviewers will be compiled and returned to the corresponding author to be addressed.

During the review process, authors can check the status of their submitted manuscript via the online manuscript submission and review system at [tcp.msubmit.net](http://tcp.msubmit.net). Please wait six weeks for the "Under Review" process to proceed before inquiring with the editorial office ([esmith@ascp.com](mailto:esmith@ascp.com)).

### MANUSCRIPT REQUIREMENTS

The journal follows the style from [The American Medical Association](http://www.ascp.org).

All manuscripts must be original work to the authors and not under consideration elsewhere. Additionally, manuscripts must be typed in 12-point font, double-spaced, and free from tracked changes. Continuous line numbers must be included.



Complete submissions will contain the following:

1. Cover Letter
2. Title Page
3. IRB Approval / Exemption Number
4. Corresponding author phone, email, and mailing address.
5. Manuscript adhering to its specific category requirements (see below) and all general requirements including using continuous line numbers.
6. Figures, and appendices uploaded in separate files (.tiff, .jpg, PDF, EPS, or .ppt) and not embedded in the manuscript.
7. Tables may be included in the manuscript AFTER references or attached separately.
8. Copies of any permissions to reproduce published material must be included.

Manuscripts should be consistent with the "[Uniform Requirements for Manuscripts Submitted to Biomedical Journals](http://www.ascp.org)" established by the International Committee of Medical Journal Editors.

Suggested word counts (see categories below) are provided for guidance. If a contribution varies by > 20% from the suggested length, then please contact the editor to discuss. ([editors@ascp.com](mailto:editors@ascp.com))

To submit: [tcp.msubmit.net](http://tcp.msubmit.net)

### COVER LETTER

For the most successful cover letter, explain the topic of the paper, why it is important research for the field of senior care pharmacy, and what is significant about this topic and your findings. Additionally, explain why this research is appropriate and essential for the readership of the journal.

In the case of any research or investigation involving humans, the authors must state the name of the Institutional Review Board (IRB) that approved the research protocol and the **approval number** or provide information from the IRB about why the research was considered exempt from a requirement for ethical approval and include the IRB **exemption number**. For those investigators who do not have access to formal ethics review committees, the principles outlined in the "Declaration of Helsinki" (JAMA 1997;277:925-6) should be followed.

Certify that the manuscript is not under consideration by any other journal and that it is not a duplicate publication.

For all authors, include a statement that confirms that there are no undisclosed conflicts of interest (financial or otherwise). Where a possible conflict of interest exists, include a summary of this disclosure. Please visit [www.icmje.org](http://www.icmje.org) to review the disclosure form that all authors will need to sign and upload during the submission process.

Certify that the manuscript has been read and approved by all the authors, and that all authors have

made a material contribution per the requirements for responsible authorship [see "Who is an Author?"](#) from the International Committee of Medical Journal Editors. Declarations of any use of Artificial Intelligence (AI) must be made at this time as well.

## TITLE PAGE

The title page should include the following information:

- Manuscript title
- Author(s) name(s) in order
- Author credentials
- Title(s) (e.g., Professor, PharmD Candidate [2020])
- Institution, department, city and state
- Corresponding author with mailing address, email, and phone number
- Disclose any financial conflicts of interest (if none, specify none)
- **Keywords** (minimum of 3 and no more than 5)
- Total word count (not including title page, references, or tables)
- Total number each of tables, figures, and appendices

## SUBMISSION CATEGORIES & REQUIREMENTS

Each category requires a structured abstract, which the body of the paper must follow. (Further details on this topic can be obtained from Haynes RB et al. More informative abstracts revisited. *Ann Intern Med.* 1990;113:71-9)

### Research & Reports

(Estimated length: 3,000–6,000 words)  
Manuscripts describing original research concerning the prognosis, etiology, diagnosis, treatment, prevention, or economic analysis of a clinical disorder or an intervention to improve the quality of health care. The manuscript should include a structured abstract of no longer than 250 words; it should include the headings background, objective, methods, results, and conclusion. It should contain as many of the key words (cited below) as possible. The manuscript should contain the following headings and information:

**BACKGROUND:** Provide background and rationale for the research.

**OBJECTIVE:** State the main question or objective of the study and the major hypothesis tested, if any.

**DESIGN:** Describe the design of the study indicating, as appropriate, use of randomization, blinding, criterion standards for diagnostic tests, temporal direction (retrospective or prospective), etc.

**SETTING:** Indicate the study setting, including the level of clinical care (for example, primary or tertiary; private practice or institutional).

**PATIENTS, PARTICIPANTS:** State selection procedures, entry criteria, and numbers of participants entering and finishing the study.

**INTERVENTIONS:** Describe the essential features of any interventions, including method and duration of administration.

**RESULTS:** Describe measurements that are not evident from the nature of the main results and indicate any blinding. If possible, the results should be accompanied by confidence intervals (CI)—most often the 95% interval—and the exact level of statistical significance. For comparative studies, CIs should relate to the differences between groups. Absolute values should be indicated when risk changes or effect sizes are given.

**DISCUSSION:** Discuss the key results of the study that are directly supported by data and explain their clinical application (avoiding overgeneralization) or whether additional study is required before the information should be used in usual clinical settings. Equal emphasis must be given to positive and negative findings of equal scientific merit.

**CONCLUSION:** This section states the conclusions of the study.

### Reviews

(Estimated length: 2,500–5,000 words)  
Reviews offer an in-depth report based on a literature review concerning the prognosis, etiology, diagnosis, treatment, prevention, or economic analysis of a clinical disorder or an intervention. Abstract = 250 words

**BACKGROUND:** Provide background and rationale for the clinical review.

**OBJECTIVE:** State the primary objective of the review article.

**DATA SOURCES:** Describe the data sources that were searched, including dates, terms, and constraints.

**DATA SYNTHESIS:** State the main results of the review and the methods used to obtain these results.

**DISCUSSION:** Discuss the primary results of the review their clinical applications, avoiding overgeneralization. Suggest areas for additional research if needed. Equal emphasis must be given to positive and negative findings of equal scientific merit.

**CONCLUSION:** This section states the main conclusions of the review.

### Case Reports

(Estimated length: 2,000–2,500 words)  
Case Reports are manuscripts that provide factual accounts of clinical cases of significance. These can include previously undescribed adverse drug reactions, drug interactions or other clinical experiences related to drug therapy. The manuscript should address a structured description of the case and a discussion that addresses the significant findings. Abstracts of no more than 250 words and the manuscript should contain the following headings:

**BACKGROUND:** Provide background and rationale for the case report.

**OBJECTIVE:** The abstract should begin with a clear statement of purpose describing the particular practice or innovation that is the main point of the paper.

**SETTING:** The type of pharmacy, facility, or other institution should be described in this section, such as community or nursing facility pharmacy, a small independently owned for profit nursing facility, or independent consultant pharmacy practice. Details about the setting should be included under Practice Description.

**PRACTICE DESCRIPTION:** Relevant characteristics of the practice or facility should be included here. These might include such facts as pharmacy volume, type of patients served, numbers of pharmacists and technicians employed, and types of nursing facility residents involved.

**PRACTICE INNOVATION:** The types of unique activities and other advances in practice that are the primary subjects of the manuscript should be summarized here. These could include new techniques for in-service education; better ways of distributing or handling medications; or management innovations in purchasing, scheduling, marketing, or personnel relations.

**RESULTS:** The actual outcomes of the practice innovation are summarized in this section. All relevant types of results described in the paper should be stated briefly.

**DISCUSSION:** This section discussed the clinical context of the illustrated case. If appropriate, applications to other practice settings should be stated.

**CONCLUSION:** This section states the main conclusions of the case report.

### **The Geriatric Pharmacotherapy Case Series**

(Estimated length: 2,000 to 3,000 words)

[View a sample of a Geriatric Pharmacotherapy Case Series.](#)

This category is used to present case studies that illustrate an important issue or principle that is mainly focused on issues relevant to the safe and effective use of medications for older people. The Geriatric Pharmacotherapy Case Series (GPCS) aims to address topics that are specific to geriatric pharmacotherapy.

While all topics are not exclusively for geriatric patients, the main focus would often address issues not commonly, specifically, related to drug safety and pharmacotherapy in younger patient groups.

This format aims to address education, geriatric pharmacotherapy themes, resources and assessment tools that will be encountered in the context of geriatric pharmacotherapy. Cases should focus on the underpinnings of geriatric pharmacotherapy principles: these are not often articulated in educational curricula and can be overlooked in randomized controlled trials due to exclusion of geriatric participants. Examples could include frailty assessment and how that may impact interpretation of guidelines, the impact of altered pharmacodynamics or pharmacokinetics in real world scenarios, or other principles not evident when applying disease management guidelines that may have been developed for use with younger people.

The format encourages the inclusion of learning resources such as illustrations, and demonstration of assessment tools, such as the Naranjo scale, or Medication Appropriateness Index.

To adequately develop discussion of the GPCS issue or principle addressed, we recommend focusing on one issue in-depth, rather than several issues concurrently.

The cases may be based on the actual circumstances of an individual patient, or they can be developed to optimally illustrate the issues under consideration. The manuscript should be constructed in a standardized format and authors seeking to contribute in this category should read the free sample in the hyperlink above.

#### **Abstract**

**Background:** Includes a brief description of the case including, but not limited to the patient's past medical history and the context or practice setting in which the patient was encountered (illness, medical and social history?)

**ASSESSMENT:** Include a discussion of the approach to the patient's presentation, including all aspects such as psycho-social determinants, treatment course, and other assessment logic supported by presenting data.

**OUTCOME:** Describe the case outcome, in simple terms.

**CONCLUSION:** Summarize the clinical pearls that can be applied to future patients of this kind.

#### **Geriatric Pharmacotherapy Case Series Manuscript Organization**

**CASE TITLE:** The title could be straight forward such as "Overactive Bladder" or could allude to the take home lesson in the case presentation itself.

**INTRODUCTION:** Introduce the patient and include clues to the psycho-social determinants of health that may impact the case. Authors may include living situation, support system, personal preferences, and other background information.

**HISTORY OF PRESENT ILLNESS:** Please describe the chief complaint and how this problem presents.

**PAST MEDICAL HISTORY:** A simple listing of diagnosis and problems is sufficient.

**SOCIAL HISTORY:** Classic Social History. May present atypical social history characteristics with elaboration, keeping in mind that this is an educational case series. Remember to relate back to atypical social history data later.

**MEDICATIONS:** Medication list with dose and dosing interval.

**LABORATORY VALUES:** Provide any laboratory values relevant to the case. Authors do not have to include comprehensive data, nor irrelevant data to the case. Include the level of "distractor" data that is relevant to make the case engaging.

**ASSESSMENT:** Authors may organize assessments with a table or diagram in addition to the written text.

Include a discussion of the approach to the patient's presentation, including all aspects presented such as psycho-social determinants, and other assessment logic supported by presenting data.

**PLAN:** The plan can be simple, and authors may use bullets.

**OUTCOME/FOLLOW UP:** Describe the case outcome, in simple terms.

**DISCUSSION:** Please provide a complete discussion of your approach to this case and how it related to the outcomes. This section can be the "educational" segment where you can include diagrams and other ways to convey the scientific and clinical science framework for your approach and considerations of how the data presented impacted observed problems, plan and outcomes.

**GERIATRIC CLINICAL PEARLS:** In this section, please include a few geriatric clinical pearls or points of geriatric clinical practice wisdom. This is where you can share education for the readers on lessons learned that can help the clinician address the counterintuitive nature of geriatric care. At the end of every case, please invite the reader to think about additional analysis.

**REFERENCES:** Please provide references in standard format. No limit (within reason) as there typically is with a case manuscript. It is occasionally acceptable to use older literature if it represents canonical core geriatric or other clinical concepts and wisdom.

### Practice Innovation

**SQUIRE 2.0:** Revised Standards for Quality Improvement Reporting Excellence<sup>(jSQUIRE 2.0)</sup>

(Estimated length: 3,000–6,000 words)

Manuscripts describing and reporting practice models and quality improvement projects that impact outcomes. Pharmacists are doing critical work to fill unmet needs of facilities, families, patients, and providers. Any interprofessional author is welcome to submit a practice innovation report involving collaborative efforts with pharmacists or practice innovation targeting medication use and outcomes. The settings are not limited to the long-term care setting and are inclusive of any setting serving older adults.

The abstract should be no longer than 250 words and provide adequate information to aid in searching and indexing and summarize key information from sections of the text (background, local problem, methods, interventions, results and conclusions).

The manuscript should adhere to the Squire 2.0 reporting guidelines for quality improvement (<https://www.squire-statement.org/index.cfm?fuseaction=Page.ViewPage&PageID=471>) and contain the following headings and information:

**INTRODUCTION:** *Problem Description:* describe the nature and significance of the local problem (practice models may be generalizable but practice innovation reports discuss local initiatives in local care systems.

Generalizability requires significant reproducibility and is more the domain of research and reports). *Available Knowledge:* Summary of what is currently known about the problem, including previous studies. *Rationale:* Frameworks, models, concepts and/or theories used to explain the problem. Include any reasons or assumptions that were used to develop the intervention(s) and why the intervention(s) are expected to work. *Specific Aims:* The purpose of the project and of this report.

**METHODS:** *Context:* contextual elements important to introducing the intervention(s). The specific practice setting should be described generally rather than naming a particular practice site. *Intervention(s):* description of the intervention(s) in sufficient detail that others could reproduce it, and the specifics of the team involved in the work. *Study of the Intervention(s):* describe the approach chosen for assessing the impact of the intervention(s) and the approach used to establish whether the observed outcomes were due to the intervention(s). *Measures:* describe the measure chosen for study processes and outcomes of the intervention(s), include the rationale for choosing them, definitions, and validity and reliability. Describe the ongoing assessment of elements that contributed to the success, failure, efficacy and costs. Describe the methods used for assessing completeness and accuracy of data. *Analysis:* describe the qualitative and quantitative methods used to draw inferences from the data and methods for understanding variation within the data, including the effects of time as a variable. *Ethics:* describe ethical aspects of implementing and studying the intervention(s) and how they were addressed (including formal ethics review and potential conflicts of interest).

**RESULTS:** Report the details of the process measures and outcome including contextual elements that interacted with the intervention(s). Describe the intervention(s) and their evolution over time (eg, timeline diagram, flow chart, table, graph). Include any observed associations between outcomes, interventions, and relevant contextual information. Also report details about missing data or unintended consequences such as unexpected problems, benefits, failure, or costs associated with the intervention(s).

**DISCUSSION:** Start with a summary of key findings with relevance to the rationale and specific aims and strengths of the project. *Interpretation:* discuss the nature of the association between the intervention(s) and the outcomes. Report comparisons of the results with findings from other publications. Discuss the impact of the project on people and systems, and any reasons for differences between observed and anticipated outcomes, including the influence of context. In this section discussion of costs and strategic trade-offs are appropriate, including opportunity costs. *Limitations:* discuss limits to the generalizability of the work including factors that might have limited internal validity such as confounding, bias,

or imprecision and design, methods, measurement, or analysis. Report any efforts made to minimize and adjust for limitations.

**CONCLUSION:** Identify the usefulness of the work and sustainability. Discuss the potential for the work as it relates to other contexts and implications for practice as well as further study needed. Suggest next steps.

### Consultant Pharmacist Forum

(Estimated length: 1,500–2,000 words)

These articles may include brief reviews of newly approved medications, new uses for medications, or recently observed adverse effects. The column may also comment on recently published research or regulatory issues facing senior care or consultant pharmacists. If the author is a student, he or she must have the involvement of, and oversight by, the faculty mentor. Traditionally, this category was undertaken by students working towards their PharmD degree, in consort with a mentor.

### New Perspectives

(Estimated length: 1,200–1,500 words)

Articles for the column can be commentary or editorials on a contemporary topic of interest to pharmacists caring for older people or a brief description of a unique experience relating to providing this care.

### Letters to the Editor

(Estimated length: 500 words)

Letters should comment on previously published articles. These letters are shared with the corresponding author's article to which the letter refers, and they may submit a response. The letter to the editor and the author's reply will be published together in a subsequent issue.

### REFERENCES

References should be numbered in the order in which they are first mentioned in the text, double-spaced, and included on a separate page.

It is critical that references not appear in the footers of text pages. Do not use automatic footnoting software (e.g., Microsoft Word, Reference Manager, Endnote, others) that embeds references in text.

Examples of reference style (note capitalization and punctuation format) may be found at [The Online Writing Lab at Purdue University](#).

### TABLES FIGURES, & APPENDICES

- The information presented in the table or figure is referenced and cited in the text, but it should not be duplicated.
- All tables and figures should be numbered and carry a descriptive title of approximately 10 words, without abbreviations.
- Tables should be created using Microsoft Word's table feature. Do not use tabs to create tables.
- Tables and figures should include captions that explain all abbreviations used (for example, FDA =

Food and Drug Administration).

- Figures and Appendices must be in a separate file and may not be embedded in the Word document.
- Tables may come at the end of the manuscript after references or be attached separately.
- Titles and detailed explanations should appear in the legends for illustrations, not on the illustrations themselves.
- If materials (e.g., figures and/or tables) are taken from other sources, the author must provide written permission for reproduction from the original publisher and author in the cover letter of their submission. In addition, the source should be cited at the end of the figure legend.
- JPG, TIFF, PDF, or EPS are preferred. PowerPoint files are acceptable.
- Figures with photographic images must be high resolution and at least 300 dpi and no smaller than 4x6 in.

### ABBREVIATIONS

Dosing abbreviations should be spelled out. For example, do not use "bid," use "twice a day;" do not use PO, use "oral;" do not use prn, use "when needed." Formal "Do Not Use" lists are available from the [Institute for Safe Medication Practices and The Joint Commission](#).

### DRUG NAMES

Use generic names whenever drug products are identified. Brand names may be used only when they are important to describe a product (eg, single-source product, generic name not well known); product manufacturers should be identified only when necessary.

### AGE & AGING

Do not use any terminology that would dehumanize or cause exclusion.

- Do not use "elderly."
- Do not use "geriatric" unless it is the official title of something, eg, "Providence Health System Center for Geriatric Medicine."

### STATISTICS

When using *P* for "probability," the *P* is uppercase italics. When using "N" and "n" for "number," include a space before and after (eg, "N = 19)," "n = 3." "N" is the total number studied; "n" is a subset of the total (ie, population vs. the sample).

It can be difficult for authors to determine if  $P = .05$  should be considered significant. The answer depends on the reference statistic. For instance, for type I error usually the  $\alpha = .05$  and thus only a  $P < .05$  should be considered significant.

A zero should be placed before the decimal point in numbers less than 1, unless the number relates to a probability statistic (ie, *P* "probability",  $\alpha$  "alpha", or  $\beta$  "beta") as these values cannot equal 1 without rounding. Therefore, removing the zero may result in considerable space in tables and text.

When considering the number of digits to place after a decimal point, the author should consider the level of specificity required to convey the desired meaning to the reader. It is acceptable to go four or more digits to the right of the decimal point if otherwise the reader might be misled. With that said, when rounding is appropriate, authors should carry no more than four digits to the right of a decimal point. Furthermore, odds ratios, likelihood ratios, confidence intervals, and relative risk should be reported to two digits to the right of the decimal. Lastly, the *P* value should be carried three digits to the right of the decimal point.

Whereas not required, confidence intervals are preferred to *P* values as they convey the same information about significance while allowing for additional exactness. Confidence intervals should include a hyphen separating the two values, unless one of the values is negative and then the word “to” should be used in lieu of a hyphen.

Odds ratio should always clearly be defined as there is not a universal definition. Odds ratio, as it is commonly expressed as a point estimate, should include a confidence interval.

Effect size should be reported when using inferential statistics as significance alone does not indicate the magnitude or importance of the difference between groups. Reporting effect size (eg, Cohen's *d* and Pearson *r* correlation) assists in understanding the practical significance of difference between groups.

Power calculation should be done *a priori*. Power calculations help to ensure the data do not suggest a type II error rather than an actual failure to reject a null hypothesis. It can be argued that with significant results that sufficient power was achieved; however, it is always the preference to report the *a priori* power calculation.

When reporting inferential statistics, the authors should minimally state that there was no violation to statistical assumptions and list the assumption (eg, normality, linearity, equality of variance) assessed prior to the analysis.

Phrases to avoid:

- it was approaching significance
- statistically significant, use clinically significant
- kind of or sort of significant
- always and never
- intensifiers such as very, extremely, really, too

## UNITS

Laboratory values are expressed using conventional units of measure, with relevant Système International (SI) conversion factors expressed secondarily (in parentheses) only at first mention. Articles that contain numerous conversion factors may list them together in a paragraph at the end of the Methods section.

In tables and figures, a conversion factor to SI should be presented in the footnote or legend. The metric system is preferred for the expression of length, area,

mass, volume, and temperature. For more details, see the [Units of Measure conversion table](#) on the website for the AMA Manual of Style.

## COPYRIGHT AND EXCLUSIVE PUBLICATION

Unless otherwise specifically negotiated, manuscripts written for, and published in, *The Senior Care Pharmacist*® become the property of ASCP. Accordingly, the journal requires that authors transfer all copyright ownership to ASCP at the time a manuscript is submitted. These forms will be found in the online submission system.

If materials (eg, figures and/or tables) are taken from other sources, the author must provide written permission for reproduction from the original publisher and author at the time of submission. In addition, the source should be cited at the end of the figure legend.

**Open Access:** Email [esmith@ascp.com](mailto:esmith@ascp.com) for further information.

## STATEMENT OF FINANCIAL INTEREST

Each author is required to acknowledge any [financial interest or affiliation](#) with any company, product, or service that could be considered broadly relevant to the work. This information should be included in the title page and the cover letter for the editor. This information will be recorded on the International Committee of Medical Journal Editors' ICMJE Form of Potential Conflicts of Interests. Forms are available to sign and upload on the submission site.

## FINAL CHECKLIST

- Cover Letter
- Title Page
- Complete manuscript, double-spaced, 12-point font size, continuous line numbers, tables attached separately or after references, and references should be in a format compatible with Microsoft Word.
- Abstracts should follow their category requirements.
- All tables and figures must explain abbreviations used and list the source of the information.
- All figures and appendices must be included as separate files in TIFF or JPG format with a resolution no lower than 300 dpi.

[Submit manuscripts to tcp.msubmit.net](http://tcp.msubmit.net)

**For questions or additional assistance, contact:**

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THE SENIOR CARE  
PHARMACIST

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