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59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
44-115

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MEDICATION MANAGEMENT

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This instruction implements Air Force Policy Directive 44-1, *Medical Operations*. This Medical Wing Instruction (MDWI) contains policies and procedures defining pharmacy, nursing, and medical staff standards for pharmaceutical issues. This instruction applies to all personnel assigned, attached, or on contract to the 59th Medical Wing (MDW). This instruction does not apply to the 959th Medical Group, the Air National Guard or Air Force Reserve. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974, authorized by 10 U.S.C. 55, *Medical and Dental Care*, and E.O. 9397 (SSN). The applicable SORN F044 AF SG D, Automated Medical/Dental Record System, is available at: **https://dpcld.defense.gov/Privacy/SORNs/**. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. Ensure that all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction 33-322, *Records Management and Information Governance Program*, and are disposed of in accordance with (IAW) the Air Force Records Disposition Schedule which is in the Air Force Records Information Management System. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

59 MDWI 44-115 has been revised. Major changes include restructuring content to improve readability, workflow changes driven by Military Health System (MHS) Genesis, revision to 59 MDW Pharmacy and Therapeutics (P&T) Committee's oversight of outpatient and inpatient

formularies, procedures to properly waste narcotics, and numerous changes to ensure compliance with Joint Commission Medication Management Standards.

1. Responsibilities.

1.1. The 59 MDW P&T Committee.

1.1.1. The 59 MDW P&T Committee is a multidisciplinary group made up of members of the medical, nursing, and pharmacy staff responsible for all aspects of medication use within the facility including, but not limited to, the availability, selection, distribution, storage, handling, administration and use of drugs, vaccine, and diagnostic materials. The membership of the 59 MDW P&T Committee must comply with Defense Health Agency-Procedural Instruction (DHA-PI) 6025.31, *Military Medical Treatment Facility Pharmacy Operations* section 7. The 59 MDW P&T Committee voting (required) members include the Chief of the Medical Staff (chair), the Pharmacy Flight Commander (co-chair), the Chief of Nursing staff (SGN), a family practice clinician, and a flight medicine clinician. Attendance by members of other disciplines is encouraged but not required for quorum.

1.2. Chief of the Medical Staff (SGH).

1.2.1. The SGH or an SGH-appointed physician will chair the P&T Committee to establish accountability for clinic compliance with this instruction.

1.3. Pharmacy flight commander.

1.3.1. The pharmacy flight commander or a pharmacy flight commander-appointed pharmacist will co-chair the P&T Committee.

1.3.2. The pharmacy flight commander will ensure pharmacy compliance with all relevant regulatory requirements to include, but not limited to: Defense Health Agency (DHA)

instructions, United States Code, Code of Federal Regulations (CFR), Drug Enforcement Agency (DEA) regulations, Food and Drug Administration (FDA), Occupational Safety and Health Administration, The Joint Commission (TJC), National Patient Safety Goals (NPSG), and United States Pharmacopeia (USP) Chapters 795, 797, and 800.

1.4. Clinical staff. Clinical staff will follow all directed policies and procedures noted in this instruction and will assist in ensuring the safe and effective storage, handling, dispensing, documentation, use, and administration of all medications utilized within the Medical Treatment Facility (MTF).

1.5. Pharmacy staff. Pharmacy staff will adhere to all directed policies and procedures noted in this instruction and will assist in ensuring the safe and effective storage, handling, dispensing, documentation, use, and administration of all medications utilized within the MTF.

2. Planning.

2.1. Accessible patient-specific information. The following information about the patient is accessible to assist licensed independent practitioners and staff who participate in the management of the patient's medications and vaccines via the electronic medical record (EMR) (MHS Genesis and Joint Legacy Viewers computer programs) including, but not limited to: age, sex, diagnoses, medication allergies and sensitivities, current medications, height and weight (when necessary), pregnancy and lactation information (when necessary), laboratory results (when necessary), and any additional information required by the organization.

2.2. Look-Alike/Sound-Alike (LASA), High-Risk/High-Alert (HRHA), and Hazardous medications.

2.2.1. Pharmacy will maintain LASA, HRHA, and Hazardous medications lists. The medications on these lists will be selected based on the Institute for Safe Medical Practices and TJC recommendations, FDA, Department of Defense (DoD), and the National Institute for Occupational Safety and Health guidance, and/or MTF error trends. The current lists are maintained on the pharmacy SharePoint.

2.2.2. The LASA, HRHA, and Hazardous medication lists will be reviewed and approved annually by the 59 MDW P&T Committee.

2.2.3. LASA, HRHA, and Hazardous medication lists will be posted in all medication storage areas, including automated dispensing cabinet (ADC, i.e., PYXIS®) used for medication storage. All clinic stock inventories will be assessed for potential LASA, HRHA, and Hazardous medication concerns.

2.2.4. LASA medications will be identified in such a way as to distinguish them from their often-confused counterpart. LASA medications are listed in the EMR using TALLman lettering format (i.e., hydrOXYzine).

2.2.5. HRHA medications will be identified in a way that distinguishes them from other shelf stock. Hazardous medications are classified as either antineoplastic medication or non-antineoplastic hazardous medications. ADCs will alert clinic staff of the medication's hazardous classification when the medication is removed. Locations without an ADC will have the hazardous medication list posted and hazardous stock will be labeled.

2.2.6. Hazardous medications will be stored separately from other operating stock and will be handled IAW USP 800, *Hazardous Drugs-Handling in Healthcare Settings*, standards.

2.3. Manufacturer samples. Manufacturer samples are not permitted in the MTF in accordance with DHA-PI 6025.31, *Healthcare Operations/Pharmacy*.

3. Selection and Procurement.

3.1. Outpatient formulary management.

3.1.1. The San Antonio Military Health System P&T Committee mirrors the TRICARE Basic Core, Extended Core, and Uniform Formularies across all System MTFs. Providers will adhere to TRICARE formulary guidelines for outpatient prescriptions IAW DHA-PI 6025.31.

3.1.1.1. The TRICARE formulary search tool contains the most up-to-date information on a medication's formulary status. It is a publicly accessible website and may be used to determine formulary status, off-base cost, and coverage rules for each medication.

3.1.1.2. Non-formulary medications and/or uniform formulary medications requiring prior authorization, medical necessity, or brand name request documentation will be filled only after providers and patients meet relevant approval criteria through the MHS Genesis claims adjudication process.

3.1.1.3. Medications listed as "not covered" on the TRICARE formulary will not be filled at the 59 MDW, except as necessary to support the mission (i.e., reactive skin decontamination lotion).

3.2. In-clinic formulary management.

3.2.1. The 59 MDW P&T Committee monitors current trends in therapy to manage in-clinic formulary additions and deletions and evaluates the use of drugs within this facility against pre-approved established criteria, including but not limited to indications for use, effectiveness, and risks.

3.2.1.1. Requests for in clinic formulary additions are made using DD Form 2081, *New Drug Request*. A department chairman must endorse each request. The requesting provider must submit a new drug request packet to P&T Committee. The requested medication should have an advantage over existing formulary medications (indication for use, safer, more effective, less frequent dosing, and/or less expensive) or be a drug in a new pharmacologic class with clinically significant advantages over formulary agents. The pharmacy coordinator or their representative will verify documents are completed and will prepare necessary supplemental information which may include utilization data, pricing, and an economic impact estimate. The request will be presented by the requesting provider or a delegate.

3.2.2. Concentrated electrolytes will be available in patient-care areas only when patient safety necessitates their immediate use and/or as determined clinically appropriate by the 59 MDW P&T Committee. Precautions are taken to prevent inadvertent administration. Concentrated electrolytes are included on the facility HRHA list and are accompanied by notification pop-ups when stored and pulled from ADCs.

3.3. Authorized Drug List (ADL) review.

3.3.1. Medications stocked in ADCs or medication cabinets for access and control by a Licensed Independent and Credentialed Practitioner must be approved by the 59 MDW P&T Committee and documented on an ADL.

3.3.1.1. ADLs for each clinic will be maintained in Item Location Maintenance in MHS Genesis.

3.3.1.2. Pharmacy will maintain the current in-clinic formulary via the EMR.

3.3.1.3. ADLs will be reviewed by the 59 MDW P&T Committee at least annually to evaluate continued necessity and emerging safety and efficacy information.

3.4. Medication shortages and outages.

3.4.1. The pharmacy will communicate medication shortages and outages to staff through the 59 MDW Pharmacy SharePoint page, email and/or facility approved messaging applications (i.e., WhatsApp, Signal).

3.4.2. The pharmacy also provides a report of medication shortages/outages to the San Antonio P&T Committee for review and the report is documented in the meeting minutes.

3.4.3. For in-clinic medications, the requesting clinics may submit an off-cycle ADL change request with an alternative to the unavailable medication to be reviewed by the 59 MDW P&T Committee.

3.5. Medication substitution.

3.5.1. The pharmacy is permitted to change the instructions and prescribed quantities of Joint Base San Antonio (JBSA) prescriptions without contacting the prescriber if:

3.5.1.1. The administration dosage schedule is not altered.

3.5.1.2. The same pharmacological effect can be obtained by giving a multiple or divided dose of the item stocked by the pharmacy, that is, two tablets, one-half tablet, or so forth.

3.5.1.3. A pharmacist may therapeutically substitute a dosage form for a product when in the best interest of the patient.

3.5.2. A substitution protocol authorizing the pharmacy to substitute medications when a provider orders a dosage form that is not stocked in the pharmacy has been approved by the 59 MDW P&T Committee. Substitution protocols may be published in JBSA P&T minutes and are reviewed at least annually.

3.6. Medications from outside sources. Outside Medications brought into the facility by the patients/caregivers/licensed practitioners are not routinely administered. Except as specified below, the family/escorts/patients/licensed practitioners are informed that this practice is not allowed, and the medications are to be removed from the MTF. Nurses are not permitted to maintain or store these items. An exception is allowed when a patient is being treated and requires administration of a non-formulary drug (Tier 4, “not covered”). The provider will document approval to use the patient’s drug supply. The provider will write an order specifying the drug, dosage, route, and frequency in the EMR. Before use or administration of a medication brought into the organization, a nurse, provider, or pharmacist identifies the medication and visually evaluates the medication's integrity. Medications brought into the

facility by En-Route Patient Staging System patients are authorized for in-clinic use by the patient if ordered by the provider.

3.7. Investigational drugs.

3.7.1. All investigational drug therapy initiated at the 59 MDW must follow protocols approved by the Institutional Review Board (IRB) to ensure review, approval, supervision, and monitoring.

3.7.1.1. If the pharmacy is expected to be utilized in the protocol, a pharmacy letter of support must accompany the proposed protocol when it is presented to the IRB. Any letter of support is valid for only 180 days and will require reaffirmation of support.

3.7.1.2. IRB approval will not be obtained prior to the acquisition of a pharmacy letter of support. Pharmacy personnel will follow the IRB approved protocol and will not deviate from it unless there is an IRB approved amendment indicating changes to protocol.

3.7.2. All investigational drugs are received, stored, labeled, distributed, and dispensed only by the pharmacy.

3.7.3. All investigational drugs will be received and inspected by the pharmacist preferentially or by pharmacy technician staff when a pharmacist is not available. This includes handling unused, expired and/or contaminated investigational drugs.

3.7.4. Investigational drugs are ordered via the EMR. The request will be documented in the patients' EMR as a prescription order.

3.7.5. The prescription will be packaged and labeled IAW federal law and DHA-PI 6025.31.

4. Medication storage, security, and inspection.

4.1. Medications will be stored in accordance with manufacturer recommendations.

4.1.1. Refrigerators storing medications shall have thermometers placed on a middle shelf between the ceiling and the floor of the refrigerator. 59 MDW Form 2942, *Refrigerator/Freezer Temperature Chart*, should be used to record daily temperatures if an automatic recording gauge that maintains a 24-hour recallable history is not available.

4.1.1.1. If the refrigeration temperatures fall outside the manufacturer's recommended range, clinic personnel must contact facility management and the pharmacy. Facility management will work to correct the refrigerator failure as soon as possible, and pharmacy staff will determine if medications remain acceptable for use. Document all corrective actions on the temperature control log.

4.1.1.2. Follow the same procedures if the temperature falls out of range during the times of clinic closure.

4.1.2. Medications stored outside of hardened, temperature-controlled facilities will have a mechanism in place to monitor the temperature of the storage area. Generally, room temperature is defined by manufacturers as 68 to 86°F.

4.1.2.1. Each area will have a process in place to protect medication integrity if the storage area exceeds manufacturer recommended storage temperatures. The

monitoring device must be able to store temperature data or alert in real time if the temp goes out of range (per Wing SGH MFR located at P:\Pharmacies\OIs & MDWIs\GSA Remote Medication Storage Process.pdf.

4.2. Non-drug items will not be stored in medicine cabinets or in refrigerators where drugs are maintained.

4.3. ADCs (i.e., PYXIS®) are the preferred storage location for medications approved for clinic use by the 59 MDW P&T Committee and will be utilized as stock locations providing control and documentation for controlled substances and unit dose medications.

4.3.1. Medications removed from the ADC via the basic emergent function will be reviewed monthly to assess for allergic reaction responses and appropriateness of use.

4.3.2. Clinics will be required to use an ADC as determined by the 59 MDW P&T Committee based on mission requirements, use of controlled substances, volume of product used, and cost and accountability of medications utilized in the clinic.

4.3.3. ADCs will be plugged into emergency (red) power in the Emergency Department (ED), same-day surgery, cardiology, and other clinical areas where access to medications must be maintained at all times.

4.4. Medication storage areas must be secured to prevent diversion and separated from personal belongings.

4.4.1. Medication storage areas and ADCs must be housed in a room capable of being locked or with active access control measures when not in-use or actively staffed. Medication storage areas must have measures in place to prevent access by unauthorized individuals. Medication in use outside of a secure storage area must remain in the possession or line of sight of the authorized user.

4.4.2. Persons authorized to have unsupervised access to non-controlled medications include providers, dentists, nurses, pharmacy staff, select medical technicians, select dental technicians and hygienists, and other personnel whose job description includes the transportation, dispensing, compounding, or administration of medications.

4.4.2.1. Personnel must complete appropriate training to be granted access to ADCs.

4.4.2.2. Personnel requiring access to medication storage areas for the performance of job duties, such as environmental services personnel, engineering personnel, materials management personnel, et cetera, must be supervised. They shall not have unsupervised access to controlled medications and shall not handle medications.

4.5. Flight commanders, flight chiefs, nurse managers, section officers in charge (OICs) and noncommissioned officers in charge (NCOICs) assigned to nursing units and clinics are responsible for the proper maintenance, storage, and security of drugs located in their assigned areas in accordance with standards set forth by the FDA, DEA, DHA, TJC, and manufacturer's recommendations.

4.6. Controlled substance storage.

4.6.1. Controlled substances are stored IAW DHA-PI 6025.31 and 21 CFR 1301.

4.6.2. Controlled substances within the pharmacy are stored in a BD PYXIS® CII Safe capable of constant tracking and monitoring of controlled substance inventory and staff access to that inventory.

4.6.3. Controlled substances stored outside the pharmacy are stored in an ADC, a double locked cabinet of substantial construction, or a combination safe. Refrigerated controlled substances not stored in a PYXIS® refrigerator will be stored in the pharmacy and will be available to the clinic on an as needed basis according to the clinic ADL.

4.6.3.1. If controlled substances must be stored outside of an ADC with a tracking function, an AF Form 579, *Controlled Substance Register*, must be issued with each controlled item. The recipient of the issued item is responsible for accurately documenting receipt, inventory, and utilization of each controlled substance. Both the pharmacy staff member issuing the controlled substance and the recipient are required to complete an inventory of each controlled substance at receipt and turn-in.

4.7. Stored medications will bear manufacturers labeling containing information on the contents of the container, expiration date, and any warning from the manufacturer. If medications are removed from manufacturer-labeled containers for repacking (i.e., pre-packed), they must be labeled with the medication name, strength, quantity, expiration date, and any applicable warnings.

4.8. Medication inspections.

4.8.1. All medication storage areas are inspected by pharmacy staff monthly utilizing the 59 MDW Monthly Clinic Inspection Checklist.

4.8.1.1. Originals of the monthly inspection reports for in-house and outlying clinics with medication storage areas will be signed by the OIC or NCOIC, and they will receive a copy of the inspection report to correct any discrepancies. A copy of each inspection report will be filed for a minimum of one year in the pharmacy and then destroyed. Inspection results are briefed to the 59 MDW P&T Committee. The technician responsible for performing the inspection or a clinic support pharmacy team member will report discrepancies in the Joint Patient Safety Reporting (PSR) system to allow tracking.

4.9. Expired medication.

4.9.1. Expired, damaged, and/or contaminated medications in the pharmacy are removed from operating stock and stored separately until they are processed by a medication reverse distributor.

4.9.2. Checking the expiration dates of clinic stock is a shared responsibility between pharmacy personnel and clinic staff. Medications within 30 days of the manufacturer's expiration date will be removed and returned to the pharmacy for reverse distribution or destruction.

4.9.2.1. When in short supply, medications for in-clinic use may be used up to the date of expiration but will be tracked closely. When only a month and year of expiration are provided for a drug, the drug may be used through the end of that month.

4.9.3. Any MTF staff member discovering expired, improperly labeled, opened multidose vials, or short-dated medications (expiring within 30 days by local policy) must segregate

the unusable stock from operating stock or store it in the ADC return bin, as appropriate, and contact clinic support pharmacy staff to coordinate removal of the medication from the clinic. Pharmacy staff will collect the expired medications and return them to pharmacy for disposition by a medication reverse distributor.

4.9.4. Outdated, deteriorated, or excess controlled substances will be moved to the return bin, if stored in an ADC. In the absence of an ADC, unusable controlled substances must be segregated from normal stock but still stored in a substantially constructed, double locked cabinet and annotated on AF Form 579. Contact the Clinic Support Pharmacy at JBSA-Lackland, and the Clinic Pharmacy at JBSA-Randolph as soon as possible to coordinate return of any controlled medications.

4.9.5. Pharmacy will coordinate return or destruction of expired medication with Medical Logistics and an authorized pharmaceutical returns company.

4.10. Pharmaceutical waste.

4.10.1. Any item such as medication packaging, personal protective equipment (PPE), or other supplies that come into contact with a pharmaceutical to include intravenous bags, tubing sets, vials or needleless syringes that contain trace amounts of unused medications. Pharmaceutical waste is divided into two main categories, non-hazardous and hazardous.

4.10.2. Hazardous medications are identified on the 59 MDW Hazardous Drug List as outlined in **paragraph 2.2** of this instruction.

4.10.3. Hazardous medications are disposed of IAW AFI 90-821, *HAZCOM Program*, 59 MDWI 32-1001, *Facilities and Environment*, and USP 800 guidance.

4.10.3.1. Hazardous pharmaceutical waste includes all hazardous medications including chemotherapy. Waste bins are provided and removed by Civil Engineering, reachable at 210-671-3658.

4.10.3.2. Trace chemotherapy waste includes *only* medication packaging, PPE, or other supplies that come into contact with chemotherapy products during usual use and may still contain trace amounts of chemotherapy. These bins are purchased by the unit but removed by housekeeping, reachable at 210-292-5985.

4.10.4. Non-hazardous medications will be considered medical hazardous waste and disposed of in accordance with the Joint Base San Antonio Hazardous Waste Management Plan.

4.10.4.1. Medical hazardous waste will be placed in approved non-hazardous containers provided by Civil Engineering.

4.10.5. Wasting controlled substances.

4.10.5.1. Wasting of controlled substances occurs because of incomplete administration of an entire unit of a controlled substance and occurs either because less than the full dosage unit was ordered or a change in therapy was desired after drawing up the contents of a dosage unit.

4.10.5.2. All waste must be witnessed by another LIP and must be documented either on the AF Form 579, within the PYXIS® system, or described within a memorandum for record (MFR). For clinics using AF Form 579s for narcotics, two sets of initials (of

those authorized to administer narcotics) must be present to document and witness narcotic waste. For clinics with PYXIS®, narcotic waste is routinely documented in PYXIS®. Two licensed clinical staff members must input their access codes documenting the narcotic waste in PYXIS®. Under extenuating circumstance, waste may be documented in the EMR and a MFR routed to pharmacy. The MFR will be signed by the clinical staff member and witness.

4.10.6. Controlled substance discrepancies.

4.10.6.1. A discrepancy occurs whenever the amount of medication physically available in inventory does not match the amount noted on the AF579 as remaining, or for those units with a PYXIS ADC/anesthesia cart, when the amount of medication found and entered in the "verify count field" does not match the expected amount stored in the PYXIS®. Discrepancies will remain with the unit until a resolution is documented. The nurse/provider discovering the discrepancy should make every effort to resolve the discrepancy by the end of the shift. For units with a PYXIS ADC/anesthesia cart, the OIC/nurse manager should run a discrepancy report at the end of the shift to verify all discrepancies have been resolved. Discrepancies should also be described in an MFR and routed to pharmacy.

5. Emergency Medications.

5.1. The Resuscitative Committee together with the 59 MDW P&T Committee, will determine which emergency medications, crash cart medications, and antidotes will be accessible in the patient care areas. These medications are secured using a breakable, numeric lock.

5.1.1. Each emergency medication tray stored within the crash carts is sealed within a plastic, tamper resistant bag with the expiration dates of the tray clearly visible.

5.1.1.1. The stocked medication in the tray will be in unit-dose, age-specific, and ready-to-administer forms. If stored within ADCs, they will be on emergency override.

5.1.2. The expiration date of the tray is the same as the expiration date of the medication with the earliest expiration.

5.2. When emergency medications or supplies are used or expired, the affected clinic areas will coordinate with the Clinic Support Pharmacy to procure replacements as soon as possible in order to maintain a full stock. In case of outage/backorder, the Committees will determine a temporary replacement until normal supplies return.

5.2.1. The Clinic Support Pharmacy will always maintain at least one complete crash cart medication tray to facilitate rapid replacement of used emergency medications.

5.3. The procedure for management of Naloxone dispensing is established and will be reviewed as needed by the San Antonio Military Health System P&T Committee.

5.3.1. Naloxone nasal spray will be provided to eligible patients or caregivers upon request. The patients will be screened using the 59 MDW Outpatient Pharmacy Naloxone Evaluation and Prescription Form. A standing order is available for the pharmacy to dispense Naloxone to patients. The patients or their caregivers will be counseled on opioid overdose prevention, recognition, response, and naloxone administration. The screening questionnaire and standing order will be reviewed annually at P&T.

5.4. Emergency contraception.

5.4.1. The procedure for management of emergency contraception will be IAW DHA-PI 6025.31. Eligible patients will have prescriptions entered via a standing order. The screening questionnaire and standing order will be updated annually at the San Antonio Military Health System P&T Committee.

5.4.2. Emergency contraception will be provided to patients 17 years of age and older without a prescription.

5.4.3. Patients 16 years of age or under must request a prescription for emergency contraceptive medication through their provider care team.

5.4.4. Males requesting emergency contraceptives must present their military identification card along with the military identification card of the female beneficiary who will consume the medication.

5.4.5. Staff shall refer beneficiaries who request emergency contraception more than two times in six months to a provider for family planning counseling.

5.4.6. Medical personnel who, for moral, ethical, religious, or professional grounds, object to providing family planning services need not perform or assist in such procedures but are obligated to facilitate timely identification of a willing provider. Medical personnel should register their objections to the SGH or Department Chairperson on arrival to the MTF. This will allow sufficient time to make alternative arrangements for family planning services prior to the need arising.

6. Operational Requirements.

6.1. In accordance with NPSG 01.01.01, staff will validate patient identity using two DoD-recognized patient identifiers (i.e., patient's name and date of birth) prior to administration of medications, vaccines, blood, or blood products; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.

6.1.1. Providers ordering medications or vaccines in clinics will verify the identity of the patient using two patient identifiers with the patient directly or the patient's representative prior to writing any prescriptions or entering orders for in-clinic administration to ensure the correct medication is ordered for the correct patient.

6.1.2. Medication(s) will only be dispensed to a patient or representative after the identity of the patient has been validated using two patient identifiers.

6.2. Treatment of minors. The MTF Director must comply with local state laws and/or Department of Health and Human Services regulations governing consent for medical treatment of minors, including the state definition of a minor. Treatment for minors, which includes prescription needs, is governed by 59 MDWI 44-121, *Treatment of Minors*. Texas defines a minor as an individual under the age of 18 years. A minor who is permitted to consent to treatment IAW 59 MDWI 44-121 may pick up a prescription related to that treatment. Air Force personnel may disclose a minor's medical information to parents or legal guardians as allowed by 59 MDWI 44-121.

7. Ordering and Transcribing.

7.1. Medication reconciliation.

7.1.1. The 59 MDW will maintain an accurate record of a patient's medications. A patient's current medication list, including over-the-counter medications and medications received from an off-base source, will be reviewed in accordance with NPSG and compared with any new medications given to the patient. Patients should be informed of any potential clinically significant adverse drug reactions or other concerns.

7.1.2. Medication reconciliation will be accomplished when medications are ordered, prescribed, changed, discontinued, or used during the visit or when specific medication contraindications may be encountered during a procedure.

7.1.3. 59 MDW clinicians and/or the patient care team will compare the patient's current medication list to the new medications that are ordered for the patient and resolve any discrepancies within their scope of practice.

7.1.4. Medication reconciliation is not required when appointments are with non-prescribing providers or for appointments that do not involve discussion of medications.

7.1.5. A complete list of the patient's medications will be provided to the patient and available for transfer to the next provider of service when the patient is referred or transferred to another setting, service, practitioner, or level of care.

7.2. Order types.

7.2.1. The following order types are acceptable only as outlined in this paragraph: verbal orders, as needed (PRN) orders, automatic stop orders, titrating and taper orders, range orders, hold orders, and standing orders.

7.2.1.1. Verbal orders are discouraged; however, using professional judgment, a pharmacist is authorized to take a verbal order with a read back from the provider to avoid a significant delay in patient care. Verbal orders may only be exchanged between a provider and a pharmacist. For all verbal orders, the provider must document the order in the EMR.

7.2.1.2. PRN orders are recommended to include an indication for use (i.e., "PRN for cough", "PRN for pain").

7.2.1.3. Automatic stop orders are used when patients are transferred. All orders must be reviewed for appropriateness and rewritten upon arrival at the new location.

7.2.1.4. Titrating and taper orders must specify specific parameters for dosing and a specific timeframe the dose should be given based on defined criteria. The order must include medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide change, if applicable.

7.2.1.5. Range orders will specify an indication, dose, and frequency and only contain one range per order. For example, "morphine sulfate 4 mg intramuscularly (IM) every 4-6 hours PRN for pain" or "morphine sulfate 2-4 mg IM every 4 hours PRN for pain". They will not contain two variables such as "morphine sulfate 2-4 mg IM every 4-6 hours PRN pain". Multiple orders for the same medication may not be used to achieve multiple ranges unless specific directions for administration (i.e., pain scale) are included in the order. If a range order is written, the nurse should start at the lowest

dose or longest interval prescribed and titrated to a greater dose/shorter interval may be used if the nurse's assessment shows the need.

7.2.1.6. Unspecified hold orders will be treated the same as an order to discontinue the medication (i.e., hold all blood pressure medications). Hold orders that specify a certain course of action will be honored (i.e., hold next dose, hold dose if blood pressure > than XX/XX).

7.2.1.7. Standing orders are approved following review by the P&T committee and the Executive Committee of the Medical Staff. After initial approval, annual reviews are required.

7.2.1.8. Orders for unfractionated heparin or low molecular weight heparins must specify if it is indicated for prophylaxis or treatment (i.e., for deep vein thrombosis prophylaxis, for unstable angina, etc.).

7.2.1.9. Orders to resume all previous medications are prohibited.

7.3. Medication orders in the procedural setting.

7.3.1. During procedures, medication orders are given by the Licensed Independent Practitioner (LIP) to the medic administering the medication. The medic administering the medication will:

7.3.1.1. Write the order into the clinical documentation and the patient's Medication Administration Record.

7.3.1.2. Read the order back to the LIP and receive confirmation the read back was correct.

7.3.1.3. Before a medication can be administered, the following steps must be completed: writing the order, reading the order back to the LIP, receiving confirmation of the accuracy of the read back, and verifying the correct medication and dose is pulled.

7.4. Medication order requirements.

7.4.1. New prescriptions and in-clinic medication orders will be entered electronically via the EMR unless unavailable.

7.4.2. All medication orders are reviewed through the EMR for patient allergies and sensitivities, existing or potential drug interactions, clinical appropriateness, to include dose, frequency, route, current or potential impact on lab values, therapeutic duplication, and any contraindications. A pharmacist or provider, as situationally appropriate, must be consulted for severe or contraindicated allergies or drug interactions.

7.4.3. Abbreviations and symbols: To minimize errors, the use of abbreviations is discouraged. Providers are encouraged to write out all medication names. The 59 MDW list of "do not use" abbreviations is reviewed annually at P&T, updated if necessary, and available through 59 MDW patient safety.

7.5. Outpatient dispensing of medications.

7.5.1. Prescription orders will be entered electronically through the EMR.

7.5.1.1. The patient's weight shall be included when prescribing medications for children under 12 years of age or for adults when prescribing for weight-based dosing of medications (i.e., low-molecular weight heparin).

7.5.2. If a MTF provider must hand-write a prescription for outpatient dispensing (i.e., EMR outage), an AF Form 781, *Multiple Item Prescription*, will be utilized.

7.5.2.1. Using ink or indelible, the AF Form 781 must bear the following information:

7.5.2.1.1. The complete patient information – including the patient's name, Department of Defense (DoD) identification number, phone number, and date of birth – should be completed by the provider prior to giving the prescription to the patient.

7.5.2.1.2. Additionally, the prescription should contain the date written, drug, dose, route, directions for use, quantity, refills, and frequency of administration.

7.5.2.1.3. The prescriber's name stamp must be used on all hard-copy prescriptions. If a prescriber name stamp is not available, then the prescriber shall write full name, rank, corps, AFSC, and telephone number.

7.5.2.1.4. The prescriber shall sign all hardcopy prescriptions.

7.5.2.2. The prescriber should separate Schedule II, Schedule III-V, and legend medications on separate AF Form 781.

7.5.2.3. Preprinted prescriptions pads from outside sources are not authorized for use by MTF providers. An electronic version of the AF Form 781 is available for download from the Air Force e-Publishing website. A paper copy will be kept in the pharmacy's continuity of operations plan in the vault and may be copied if a LIP requires it during system downtime.

7.5.3. The pharmacy may decline to fill such a prescription, if the prescription is incomplete, illegible, or poses an unsafe condition.

7.5.4. Concerns, issues, or questions are to be clarified with the individual prescriber prior to dispensing a medication. Actions will be taken to clarify orders that are incomplete, illegible, or unclear. If orders are unable to be clarified, a new order will be written. As applicable, pharmacy personnel will contact the ordering provider, their nursing staff, or the on-call provider for the clinic.

7.5.5. Veterinary prescriptions are limited to the care of military animals and live patient models in the 59 MDW.

7.5.6. All prescriptions dispensed to a patient must be appropriately reviewed as outlined in section 8.1.2. of this instruction.

7.5.7. All outpatient prescriptions must bear a label containing the following information: patient's name and date of birth, medication name and strength, quantity of medication dispensed, directions for use, unique prescription number, applicable refills, ordering provider's name, date of original order (prescription date), date medication was last filled, dispensing location, and any relevant auxiliary labels.

7.5.7.1. If multiple boxes/bottles are required to fulfill an order, each will be labeled.

7.5.8. Controlled substances will be counted by two different individuals and will be sealed with tamper evident tape unless dispensed in an original stock bottle.

7.6. In-clinic medication administration.

7.6.1. The Clinic Support Pharmacy provides operational support for all medications to be administered in-clinic. New orders from providers for medications and vaccines to be utilized within the clinic setting will be entered electronically via the EMR.

7.6.1.1. Orders will be entered to the "Ambulatory – In Office (Meds in Office)" site for ADL medications stored in outpatient clinics or ADCs. **Note:** The ADL for each ward or clinic contains those medications approved by the 59 MDW P&T Committee P&T Committee for stock and use within each area.

7.6.1.2. Non-ADL medications must be ordered from the Clinic Support Pharmacy via the EMR.

7.6.1.3. If the EMR is unable to be utilized, the Clinic Support Pharmacy also accepts medication orders annotated on AF Form 781, *Multiple Item Prescription*, Standard Form (SF) 600-18, *Chronological Record of Medical Care*, or AF Form 3066, *Doctor's Orders*. The same requirements as outlined for outpatient dispensing of medications apply.

7.6.1.4. When immediate administration of a medication is required, medical staff may contact the Clinic Support Pharmacy for assistance in expediting the order. However, the product requested will not be released from the pharmacy until an order is received and reviewed as posted in the EMR. A pharmacist may take a verbal order if a delay in care will result in significant harm.

7.6.1.5. Orders for administration of influenza and pneumococcal vaccines must come from a Doctor of Medicine or Osteopathy or be administered pursuant to organization-specific protocol(s) to meet operational requirements.

8. Preparing and dispensing.

8.1. Review of medication orders.

8.1.1. All new and renewal orders for medications to be dispensed are reviewed for appropriateness by a pharmacist. When a pharmacist is not available, a physician or properly trained, licensed healthcare practitioner will review medication orders.

8.1.1.1. During normal business hours, a pharmacist will review all new and renewal orders before they are dispensed to the patient. After duty hours, a pharmacist will retrospectively review all dispensing orders, such as those dispensed from the ED, as soon as possible.

8.1.1.2. Refills may be verified by a properly trained, Tech-Check-Tech certified pharmacy technician.

8.1.1.3. Medications on DHA Autoverify Formulary will follow the clinical algorithm per MHS Genesis to cross into the ADC for clinic administration if they are stocked in the clinic.

8.1.2. Medication orders are reviewed through the EMR for:

8.1.2.1. Patient allergies or sensitivities.

8.1.2.2. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

8.1.2.3. The appropriateness of the medication, dose, frequency, and route of administration.

8.1.2.4. Current or potential impact as indicated by laboratory values, if necessary and appropriate.

8.1.2.5. Therapeutic duplication.

8.1.2.6. Other contraindications.

8.1.3. Once reviewed, any concerns, issues, or questions regarding the medication order are clarified with the prescriber before dispensing.

8.1.3.1. DHA Autoverify will not automate the verification process if there is a contraindication, out of range dosage/frequency, or incorrect administration route. In such case, the pharmacist must verify the order for validity before the clinic staff is able to obtain the medication from the ADC or Pharmacy.

8.2. Compounded Sterile Product (CSP) preparation.

8.2.1. When an on-site licensed pharmacist is available, a pharmacist, or pharmacy staff under the supervision of a pharmacist, will compound all sterile products. In situations where a delay in treatment could harm the patient, i.e., operating room or emergency room, CSPs can be compounded outside of the pharmacy. CSPs in this category are considered Immediate-Use CSPs under USP 797, *Pharmaceutical Compounding: Sterile Preparations* guidance and the following conditions must be met:

8.2.1.1. Aseptic techniques, processes, and procedures are followed, and written Standard Operating Procedures (SOPs) are in place to minimize the potential for contact with nonsterile surfaces, introduction of particulate matter or biological fluids, and mix-ups with other conventionally manufactured products or CSPs.

8.2.1.2. Personnel are trained and demonstrate competency in aseptic processes as they relate to assigned tasks and the facility's SOPs.

8.2.1.3. The preparation is performed in accordance with evidence-based information for physical and chemical compatibility of the drugs (e.g., approved labeling, stability, and compatibility studies).

8.2.1.4. The preparation involves not more than 3 different sterile products.

8.2.1.5. Any unused starting component from a single-dose container must be discarded after preparation is complete. Single-dose containers must not be used for more than one patient.

8.2.1.6. Administration begins within 4 hours following the start of preparation. If administration has not begun within 4 hours following the start of preparation, it must be promptly, appropriately, and safely discarded.

8.2.1.7. Unless directly administered by the person who prepared it or administration is witnessed by the preparer, the CSP must be labeled with the names and amounts of all active ingredients, the name or initials of the person who prepared the preparation, and the 4-hour time period within which administration must begin.

8.2.1.8. Handling of sterile hazardous drugs must additionally comply with USP 800.

8.2.2. Staff will use clean or sterile techniques in a clean, uncluttered, and functionally separate area to prepare medication products and avoid contamination.

8.2.3. During preparation, staff will visually inspect the medication for particulates, discoloration, or other loss of integrity.

8.2.4. The pharmacy uses a laminar flow hood or other ISO Class 5 environment for preparing intravenous (IV) admixtures or any sterile product that will not be used within 4 hours.

8.2.5. Staff who conduct sterile medication compounding of nonhazardous and hazardous medications are assessed IAW USP 797/800.

8.2.6. Quality assurance of compounded sterile preparations of nonhazardous and hazardous medications is conducted IAW USP 797/800.

8.2.7. Only medications intended for immediate use in a clinic may be prepared outside of the pharmacy.

8.2.7.1. Immediate administration is an authorized staff preparing or obtaining a medication, taking that medication directly to the patient, and administering the medication to that patient without any break in the process.

8.2.7.2. During preparation, staff will also need to visually check the product as mentioned above.

8.3. Safe injection practice guidelines.

8.3.1. Safe injection practices are handled IAW CDC guidance. See the CDC webpage under Safe Injection Practices for Providers, **https://www.cdc.gov/injection-safety/hcp/clinical-guidance/index.html**.

8.3.2. Use aseptic technique to avoid contamination of sterile injection equipment.

8.3.3. Use single-dose vials for parenteral medications whenever possible.

8.3.4. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.

8.3.5. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile each time.

8.3.6. All multi-dose vials, including ready-to-use and those requiring reconstitution, must be labeled at the time of opening or reconstitution with a beyond-use date of 28 days or the beyond-use specified by the manufacturer, if it is more stringent, as well as the initials of the healthcare personnel who opened the vial. All vials must be stored as directed by the manufacturer and visually inspected for contamination and deterioration before each use.

8.3.7. Dedicate multi-dose vials to a single patient whenever possible. If multi-dose vials from the in-clinic stock will be used for more than one patient, they should be restricted to a centralized medication area and should not enter the immediate patient treatment area (i.e., operating room, patient room/cubicle). Multi-dose vials labeled for a single patient will not be used for multiple patients. Any unused medication will be wasted or returned to the pharmacy for destruction, as appropriate.

8.4. Medications are labeled.

8.4.1. Medications containers (i.e., plastic bags, syringes, bottles, medicine cups, basins, etc.) are labeled whenever medications are prepared but not immediately administered, including perioperative and other procedural settings on and off the sterile field.

8.4.1.1. Medications are considered not "immediately administered" if the medication leaves the hand of the staff member who removed the medication from the manufacturer's original container. Laying a medication syringe down on a table in the direct eyesight of the staff member is considered "not immediately administered," thus the medication must be properly labeled.

8.4.2. Multiple doses of a single medication may be drawn up ahead of time and saved for future use. The drawn medication must be segregated and secured from all other medications, and each dose (i.e., each syringe) must be properly labeled.

8.4.3. No more than one medication or solution is labeled at one time.

8.4.4. Hanging IV bags must be labeled.

8.4.5. All medication or solution labels are verified both verbally and visually by two qualified individuals whenever the person preparing the medication or solution is not the person who will be administering it. All original containers from medications or solutions remain available for reference in the peri-operative or procedural area until the conclusion of the procedure. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

8.4.6. At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel. Any medications or solutions found unlabeled are immediately discarded.

8.4.7. All medications prepared are correctly labeled with the following:

8.4.7.1. Medication name, strength, and amount.

8.4.7.2. Expiration date when not used within 24 hours.

8.4.7.3. Expiration date and time when expiration occurs in less than 24 hours.

8.4.7.4. The date prepared and the diluent for all compounded IV admixtures.

8.4.8. When preparing individualized medications for multiple patients, the label also includes the following:

8.4.8.1. The patient's name.

8.4.8.2. The location where the medication is being delivered.

8.4.8.3. Directions for use and applicable accessory and cautionary instructions.

8.4.9. When an individualized medication(s) is prepared by someone other than the person administering the medication, the label contains the following:

8.4.9.1. The patient's name.

8.4.9.2. The location where the medication is being delivered.

8.4.9.3. Directions for use and applicable accessory and cautionary instructions.

8.5. Safe medication dispensing.

8.5.1. The patient or representative should present the patient's government-issued identification (ID) card when picking up a medication. Parents may vouch for children without an ID card until the child reaches the age required by local policy. Exceptions may be made on a case-by-case basis, but the approver must attempt to confirm the patient's identity.

8.5.2. All personnel dispensing medications will use two patient identifiers. (i.e., patient's full name and date of birth). Whenever possible, staff members will confirm the two patient identifiers verbally with the patient or the patient's representative. If verbal confirmation is not possible, verify the two patient identifiers against the patient's identification card, electronic record, or physician order.

8.5.3. The patient or representative should inspect the list of medications ready for pickup and acknowledge receipt by signing or printing unless inappropriate for infection control or another clinical situation. The individual receiving the medication should enter his/her name, and that acknowledgement will be maintained electronically in Nexia or equivalent pharmacy software.

8.6. Dispensing outside of the pharmacy.

8.6.1. Dispensing of medications when the pharmacy is closed is limited to medications pre-approved for the clinic by the 59 MDW P&T Committee.

8.6.2. Medications for dispensing when the pharmacy is closed are stored in an ADC.

8.6.3. After-hours dispensing and dispensing outside of pharmacy will be accomplished under the supervision of trained providers whose license allows dispensing directly to patients. The dispensing provider will ensure the accuracy of the medication prescription.

8.6.4. Licensed independent providers and "deployed" Independent Duty Medical Technicians (IDMTs) assigned to support the basic training mission dispense drugs pre-packaged by the pharmacy.

8.6.5. Providers must adhere to the same procedures and standards of practice as apply to dispensing from a pharmacy such as:

8.6.5.1. Medications dispensed after hours from the approved clinics will only be labeled with a pre-printed label provided by pharmacy which includes medication name, strength, quantity, standard directions, expiration date, dispensing location, and any relevant auxiliary labels.

8.6.5.2. Providers must write in the patient's name, patient's date of birth, ordering provider, and date of dispensing before issuing the medication to the patient.

8.6.5.3. Quality control checking i.e., independent second check by another individual to prevent medication retrieval and dispensing errors.

8.6.5.4. Patient counseling.

8.6.5.5. Documentation in the patient's medical record. The provider or IDMT will use the EMR to document prescribing and profile review before dispensing each medication issued to a patient if possible.

8.6.5.6. Dispensing of the medication to the patient.

8.6.6. If additional medication information is required or if a medication not available from the ADC is needed, after hours providers may contact the Emergency Department Pharmacy at Brooke Army Medical Center.

8.6.7. A pharmacist will retrospectively review dispensing completed outside of the pharmacy.

9. Recalls and returned medications.

9.1. Recalled or discontinued medication management.

9.1.1. Medical Materiel notifies the facility of a medication recall/discontinuation by disseminating a Medical Material Quality Control Message via multiple routes, including pharmacy logistics. Upon receipt of the notice, the pharmacy staff member will obtain the drug's identification to include generic name, trade name, strength, dosage form, size, manufacturer, and affected lot number(s).

9.1.2. Drug recall/discontinuation information is disseminated to the medical staff using e-mail when necessary.

9.1.3. Pharmacy personnel will remove the affected drug from dispensing stock in all pharmacies. Clinics outside the pharmacy that stock the affected drug will be notified by pharmacy and instructed on how to handle the affected medication.

9.1.4. Pharmacy staff will conduct an exchange of non-impacted stock for the recalled item in each clinic if inventory allows.

9.1.5. When a notification occurs after normal duty hours, or on weekends or holidays, each clinical area will be asked to return the item to the pharmacy.

9.1.6. Recalled/discontinued items collected by pharmacy are returned directly to Pharmacy Logistics for quarantine or destruction. Affected medications may be quarantined in the pharmacy return area with the recall notice until disposition.

9.1.7. If warranted by the nature of the safety notification, patients with current prescriptions on file for the affected drug will be contacted and advised of the issue and be directed regarding how to return the medication to the pharmacy.

9.2. Safe medication return management.

9.2.1. Beneficiaries may utilize collection receptacles in the pharmacy lobbies to safely dispose of controlled and non-controlled prescriptions and over-the-counter medications that are unwanted, unused, expired, or returned.

9.2.2. Medications collected in receptacles will be removed from circulation IAW DEA, Federal, State, Local laws and regulations, state and local environmental agencies, and applicable transportation authorities to prevent misuse, diversion, or accidental poisoning.

10. Administration.

10.1. Medications for administration in clinic may only be picked up from the pharmacy by providers, nurses, IDMTs, or properly trained medical or dental technicians.

10.2. Only competency-verified personnel can administer drugs, biologicals, or blood products. Supervisors are responsible for developing and accurately assessing and documenting the competency of subordinate personnel prior to the member administering any medications. Flight commanders ensure competency certification programs are maintained.

10.3. All personnel administering medications will use two patient identifiers (i.e., patient's full name and date of birth) to verify the correct patient is receiving the medication. Two patient identifiers will be confirmed either verbally with the patient or against the patient's wristband and matched to the electronic record or physician order. **Note:** All surgical patients must have identification and allergy bands, as appropriate, placed on the wrist upon arrival to the facility.

10.3.1. When indicated and clinically appropriate, properly trained patients may self-administer medications (i.e., oral dosage forms, autoinjectors).

10.4. Prior to administration, the individual administering the medication will do the following:

10.4.1. Verify that the selected medication matches the medication order and product label.

10.4.2. Visually inspect the medication for particulates, discoloration, or other loss of integrity.

10.4.3. Verify that the medication has not expired.

10.4.4. Verify that no contraindications exist.

10.4.5. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.

10.4.6. Discuss any unresolved concerns about the medication with the patient's physician or other licensed practitioner, prescriber (if different from the physician or other licensed practitioner), and/or staff involved with the patient's care, treatment, or services.

10.5. Before administering a new medication, the patient or patient's representative shall be informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of the new medication.

10.6. Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to be administered is within the prescribed range.

11. Monitoring.

11.1. Prescribers will monitor patients for safety and efficacy of medications prescribed through follow-up appointments, laboratory testing, patient-reported medication intolerances, or another clinically indicated processes.

11.2. Adverse Drug Reactions.

11.2.1. The Adverse Drug Reaction (ADR) program identifies, reports and reviews significant drug reactions to identify opportunities to improve drug use and reduce recurrences.

11.2.1.1. An ADR is any noxious or unintended response to a medication resulting in change of therapy, hospital admission, increased length of stay, or death (including vaccine adverse events).

11.2.1.2. An ADR may require discontinuation of drug, additional treatment such as supportive therapy or antidotes, increased morbidity, death, temporary or permanent disability or increased length of hospitalization.

11.2.1.3. Reactions not reported as ADRs include investigational drug reactions (reported through the principal investigator), blood transfusion reactions (unless there is a defect in the anticoagulant substances or equipment), reactions to certain biologicals as monitored by the United States Public Health Service, and poisonings.

11.2.2. It is the responsibility of all 59 MDW members to report ADRs. Each ADR must be reported using the web-based DoD Patient Safety Reporting application which can be accessed via the 59 MDW SharePoint Site.

11.2.2.1. ADR reporting focuses on "unexpected" reactions, even when the reaction is not severe. Expected side effects of the medication should not be reported as ADRs unless the reaction is excessive.

11.2.3. ADRs should also be reported in the EMR encounter using the T88.7 non-billable code. Information regarding the reaction will need to be included in the note.

11.2.4. Significant ADRs will be reported to the FDA through the MedWatch program available at **https://www.accessdata.fda.gov/scripts/medwatch/index.cfm**. Pharmacy personnel will ensure that MedWatch reports are accomplished for serious or severe reactions IAW FDA guidelines.

11.2.5. Pharmacy personnel may be contacted for assistance with any reporting method.

11.2.6. Prescriber must be notified for all adverse drug events and significant adverse drug reactions. The pharmacy department will provide notification as soon as is practical after event recognition.

11.3. Adverse vaccine reactions.

11.3.1. The National Vaccine Injury Compensation Program (NVIC) requires health care providers to report adverse events involving vaccines to Vaccine Adverse Events Reporting System (VAERS). Refer to the NVIC Program vaccine injury table for events that require reporting at **https://www.hrsa.gov/vaccine-compensation**. VAERS forms and

information can be obtained by accessing the VAERS web site at **https://vaers.hhs.gov/index.html**.

11.3.2. VAERS reporting form distribution.

11.3.2.1. VAERS may be reported online or by uploading an editable PDF found on the VAERS website. Instructions can be found online at **https://vaers.hhs.gov/reportevent.html**.

11.3.2.2. Retain one copy for the Patient Safety Program at the reporting medical unit, which will be reported to the P&T Committee.

11.3.2.3. File a copy of the VAERS or MedWatch report in the patient's individual health record or annotate the relevant information on the report within the health record.

11.4. Medication errors.

11.4.1. As defined by the National Coordinating Council for Medication Error Reporting and Prevention, a medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

11.4.2. Any medication error in which the patient ingested medication must be reported to the prescriber.

11.4.3. Additionally, each error must be reported using the web-based DoD Patient Safety Reporting application which can be accessed via the 59 MDW SharePoint site.

11.4.4. Medication errors within the facility are tracked and trended by the Patient Safety Function and trends reported to the P&T Committee. If trends are identified, pharmacy will develop an action plan to prevent or reduce the likelihood of the trend continuing.

11.5. Pharmacy staff will engage in process improvement to identify areas of improvement and address recurrent safety concerns as necessary. Performance data is tracked by flight leadership.

12. Antimicrobial Stewardship. Antimicrobial stewardship within the 59 MDW is managed by the Antimicrobial Stewardship Program (ASP) Working Group. The ASP develops, implements, and monitors appropriate prescribing practices and educational resources IAW 59 MDWI 44-157, *Infection Control and Prevention Program*, and DHA Administrative Instruction (DHA-AI) 6025.28, *Defense Health Agency Program for Antimicrobial Stewardship in Support of the National Action Plan for Combating Antibiotic-Resistant Bacteria*.

GWENDOLYN A. FOSTER
Brigadier General, USAF, NC
Commander, 59th Medical Wing

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DHA-PI 6025.31, *Military Medical Treatment Facility Pharmacy Operations,* 20 December 2019

DHA-AI 6025.28, *Defense Health Agency Program for Antimicrobial Stewardship in Support of the National Action Plan for Combating Antibiotic-Resistant Bacteria,* 5 October 2023

59 MDWI 44-121, *Treatment of Minors,* 11 January 2021

59 MDWI 44-142, *Code Blue Management,* 02 May 2022

59 MDWI 44-157, *Infection Prevention and Control Program,* 07 May 2020

Prescribed Forms

59 MDW Form 23 *Monthly Clinic Inspection Checklist*

59 MDW Form 2942, *Refrigerator/Freezer Temperature Chart*

Adopted Forms

AF Form 579, *Controlled Substance Register*

AF Form 781, *Multiple Item Prescription*

AF Form 847, *Recommendation for Change of Publication*

AF Form 3066, *Doctor's Orders*

DD Form 2081, *New Drug Request*

SF 600, *Chronological Record of Medical Care*

Abbreviations and Acronyms

ADC—Automated Dispensing Cabinets (i.e., PYXIS®)

ADL—Authorized Drug List

ADR—Adverse Drug Reaction

AFI—Air Force Instruction

ASP—Antimicrobial Stewardship Program

CFR—Code of Federal Regulations

CSP—Compounded Sterile Product

DEA—Drug Enforcement Agency

DHA—Defense Health Agency

DHA-AI—Defense Health Agency – Administrative Instruction

DHA-PI—Defense Health Agency – Procedural Instruction

DoD—Department of Defense

EMR—Electronic Medical Record

FDA—Food and Drug Administration

ED—Emergency Department

HRHA—High-Risk/High-Alert

IAW—In Accordance With

IDMT—Independent Duty Medical Technicians

IM—Intramuscularly

IRB—Institutional Review Board

IV—Intravenous

JBSA—Joint Base San Antonio

LASA—Look-Alike/Sound-Alike

LIP—Licensed Independent Practitioner

MDW—Medical Wing

MDWI—Medical Wing Instruction

MHS—Military Health System

MTF—Medical Treatment Facility

NCOIC—Noncommissioned Officer in Charge

NPSG—National Patient Safety Goals

NVIC—National Vaccine Injury Compensation Program

OIC—Officer in Charge

PRN—As Needed

P&T—Pharmacy and Therapeutics

SOP—Standard Operating Procedure

TJC—The Joint Commission

USP—United States Pharmacopeia

VAERS—Vaccine Adverse Events Reporting System

Terms

Controlled Pharmacy Areas—The 59 MDW pharmacies are controlled areas with unescorted access limited to pharmacy personnel. Other persons will be escorted at all times unless otherwise indicated on the Entry Authorization List i.e., house-keeping personnel. Pharmacy personnel allowed to deactivate the alarm systems will be identified in writing for each location.

Drug Allergy—Registration of drug allergies is required for all patients. All providers shall document/change allergies through the EMR at every opportunity.

Drugs, Biologicals, and Blood Products—Strict standards govern the control and storage of drugs, biologicals, and blood products within operating rooms, nursing units, clinics, pharmacies and dispensaries.

Formulary—59 MDW outpatient formulary mirrors the Tricare Express Scripts "Uniform Formulary." Tricare Formulary information can be accessed at **https://www.express-scripts.com/frontend/open-enrollment/tricare/fst/**#/. The 59 MDW in-clinic formulary is available through the EMR.

Infection Control—In an effort to minimize the risk of health care-associated infections, all pharmacy staff will comply with current Center for Disease Control and Prevention hand hygiene guidelines. All pharmacy staff will wash hands with an antiseptic approved by the infection control committee IAW 59 MDWI 44-157, *Infection Prevention and Control Program* or as directed by current recognized pharmacy practice standards.

Licensed Independent Practitioner—Licensed Independent Practitioners are defined as any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. When standards reference the term "licensed independent practitioner", this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified healthcare personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

Metric and Apothecary Conversion—The metric system will be used for all medication orders. Charts are available in drug preparation areas on the reverse side of the prescription pads, AF Form 781.

Order (in clinic medications)—A medication order intended to be administered to a patient in the clinic setting by healthcare personnel.

Prescription (outpatient medications)—A prescription is a medication order intended for outpatient dispensing to a patient.