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59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
44-115

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PHARMACY AND 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, and Automated Medical/Dental Record System is available at: **http://dpclo.defense.gov/Privacy/SORNs.aspx**. 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 created as a result of processes prescribed in this publication are maintained IAW AFI 33-322, *Records Management and Information Governance Program*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS). 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

This publication has been revised. This version of 59 MDWI 44-115 updates and clarifies pharmacy policies and procedures, and has been edited for clarity.

1. Responsibilities.

1.1. Chief of the Medical Staff (SGH).

1.2. The Chief of the Medical Staff (SGH) or an SGH appointed physician will chair the Pharmacy and Therapeutics Committee and establish accountability for clinic compliance with this instruction.

1.3. Pharmacy Flight Commanders.

1.3.1. The Pharmacy Flight Commanders will ensure pharmacy compliance with all regulatory requirements to include Drug Enforcement Agency, Food and Drug Administration (FDA), Air Force Instructions, and accrediting agencies.

1.4. Clinical Staff.

1.4.1. Clinical Staff will ensure that all directed policies and procedures are followed and ensure accountability of all medications utilized within the Medical Treatment Facility (MTF).

1.5. Pharmacy Staff.

1.5.1. Pharmacy staff will adhere to all directed policies and procedures and ensure accountability for medications utilized within the MTF.

1.6. Nutritional Medicine Staff.

1.6.1. Collaborates with pharmacy and medical staff annually to determine nutrient-drug interactions and develops patient education materials for nutrient-drug interactions.

1.6.2. Provides Medical Nutrition Therapy in accordance with 59 MDWI 41-103, *Ambulatory Nutrition Screening* and AFMAN 44-144, *Nutritional Medicine*.

1.6.3. Accepts and manages outpatient referrals for patients needing additional nutrient-drug teaching. Patients do not need an electronic consultation in the Electronic Medical Record (EMR) to schedule an appointment for nutrient-drug teaching.

2. Operational Requirements.

2.1. After-hours dispensing and dispensing outside of pharmacy will be accomplished under the supervision of providers whose license allows dispensing directly to patients. The dispensing provider will ensure the accuracy of the medication order prior to dispensing to the patient. Providers must adhere to the same procedures and standards of practice as apply to dispensing from a pharmacy to ensure a single standard of care. Pharmacy will retrospectively review dispensing completed outside of the pharmacy.

2.1.1. Licensed independent providers and "deployed" Independent Duty Medical Technicians (IDMTs) assigned to support the basic training mission dispense drugs pre-packaged by the pharmacy. Pre-packaged medications are labeled to identify the drug, strength, quantity, pre-pack lot number and expiration date with needed auxiliary labels. Blanks on the labels must be filled in with patient and provider names and dosage instructions. Dispensing is always done by a privileged provider or IDMT, and includes patient counseling. The provider or IDMT will use the EMR to document prescribing and profile review before dispensing each medication issued to a patient.

2.1.2. The IDMT drug formulary, like all clinic drug formularies, is subject to 59 MDW Pharmacy and Therapeutics (P&T) approval. Dispensary hours are managed by the 559th Medical Group.

2.2. Order/Prescription Review. Medication Orders/Prescriptions will be reviewed by a pharmacist either prospectively or retrospectively depending on the clinical situation.

2.2.1. All medication orders/prescriptions are reviewed for patient allergies and sensitivities, existing or potential drug interactions, appropriateness, dose, frequency, route, current or potential impact on lab values, therapeutic duplication, and any contraindications.

2.2.2. Concerns, issues, or questions are clarified with the individual prescriber prior to dispensing to the patient. 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.

2.2.3. To expedite the process, medical staff may contact the Clinic Support Pharmacy when immediate administration of the medication is required. However, the product requested will not be released from the pharmacy until an order is received or reviewed as posted in the EMR. Pharmacy personnel will take all necessary actions to support personnel in caring for emergent cases.

2.3. To ensure eligibility for care, pharmacy personnel will require the patient's Uniformed Services photo identification card. IAW DODI 1000.13, *Identification (ID) Cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals*, a paper or digital copy will be acceptable. In the absence of a Uniformed Services ID card, pharmacy staff may opt to verify eligibility with the Defense Enrollment Eligibility

Reporting System, or through another authorizing document. Continuity of care will be considered.

2.3.1. Patients may authorize an adult third party to pick up prescriptions on their behalf IAW DHA-PI 6025.31, *Healthcare Operations Pharmacy*, section 7e. Two patient identifiers will always be used to confirm the identity of the patient.

2.4. Accessible Information. The following information about the patient is accessible to licensed independent practitioners and staff who participate in the management of the patient's medications via the EMR which includes, but is not limited to: Armed Forces Health Longitudinal Technology Application (AHLTA), Composite Health Care System (CHCS), MHS Genesis, Innovian® and Essentris® computer programs:

2.4.1. Age; sex; diagnoses; allergies; sensitivities; current medications; height and weight (when necessary); pregnancy and lactation information (when necessary); laboratory results (when necessary); any additional information required by the organization.

2.5. Outpatient Pharmacy Services.

2.5.1. Hours of Operation vary based on location and are available at **http://www.jbsa.mil/Resources/Medical/JBSA-Pharmacies/**.

2.6. Joint Base San Antonio (JBSA) Provider Prescriptions. New prescriptions for medication and vaccines from providers will be entered electronically via the EMR . The Clinic Support Pharmacy also accepts medication orders annotated on AF Form 781, *Multiple Item Prescription*, Standard Form (SF) 600, *Chronological Record of Medical Care*, or AF Form 3066, *Doctor's Orders*. At a minimum the drug order should contain: patient name, drug, dose, route, directions for use, quantity, refills, and frequency of administration. The pharmacy will fill these prescriptions according to the labels generated by the EMR (no paper prescription required). Medication selection will be limited to formulary drugs as approved by the JBSA Joint P&T Function. When ordering medications for children under 12 years of age the patient's weight should be included in the prescription sent to the pharmacy. For IV admixtures the patient's height as well as the weight and any other pertinent information should be included.

2.6.1. During computer outages, or due to other circumstances, new prescriptions from providers may also be written on an AF Form 781 using ink or indelible pencil. The complete patient information - including the patient name, Department of Defense (DoD) identification, phone number, and date of birth should be completed by the provider prior to giving the prescription to the patient. The prescriber 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. The pharmacy may decline to fill such a prescription, if the prescription is incomplete, illegible, or poses an unsafe condition. The prescriber should also separate Schedule II, Schedule III-V, and legend medications on separate AF Form 781.

2.6.2. Outpatient Substitution. The pharmacy is permitted to change the instructions and prescribed quantities of JBSA prescriptions without contacting the prescriber if:

2.6.2.1. The administration dosage schedule is not altered.

2.6.2.2. 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.

2.6.2.3. Substitution protocols may be published in P & T Quick Summary periodically and at least reviewed annual.

2.7. Order Requirements.

2.7.1. Verbal orders are discouraged; however, using professional judgment a pharmacist is authorized to take a verbal order with a read back from the provider in order to avoid a significant delay in patient care. Verbal orders may only be exchanged between a provider and a pharmacist. Orders for controlled substances will be followed by a signed written order from the provider.

2.7.2. The following medication orders require an "indication" included in the order.

2.7.2.1. All as needed (PRN) orders should be qualified with indication of use (i.e.; "PRN cough", "PRN pain").

2.7.2.2. Unfractionated heparin or low molecular weight heparins must specify whether it is indicated for prophylaxis or treatment (i.e. for DVT prophylaxis, for unstable angina, etc.).

2.7.3. Summary orders are prohibited to resume previous medications. Automatic stop orders are used when patients are transferred. All orders must be reviewed for appropriateness and completely rewritten.

2.7.4. 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 pain" or "morphine sulfate 2-4 mg IM every 4 hours PRN 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. However, a greater dose/short interval may be used if the nurse's assessment shows the need.

2.7.5. Titrating and taper orders must specify specific parameters for dosing and specific timeframe the dose should be given based on defined criteria.

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

2.7.7. 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.

2.7.7.1. Investigational medication orders are addressed later in this instruction.

2.7.8. Like other prescriptions, air evacuation prescriptions are signed by privileged providers and dispensed by pharmacy as outpatient prescriptions. Clinic stock drugs are not used for these purposes.

2.7.9. Medications brought into the facility by same-day surgery patients are not usually administered. When this happens, the family/escorts are informed that this practice is not allowed. The medications are given to the patient's family to take home. Nurses are not permitted to maintain or store these items. An exception is allowed when a patient is admitted with a needed non-formulary drug in hand. 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 if prescribed by the provider.

2.7.10. Medication Orders in the Procedural Setting:

2.7.10.1. Medications administered in-clinic will be documented in the EMR. Orders will be entered to the Wilford Hall Ambulatory Surgical Center (WHASC) IN-CLINIC USE site for ADL medications stored in outpatient clinics or ADCs. Non-ADL medications be ordered from Pharmacy via the EMR or on an AF Form 781.

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

2.7.10.1.2. Write the order into the clinical documentation.

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

2.7.10.1.4. Only after writing the order, reading the order back to the LIP, and receiving confirmation of the accuracy of the read back will the medication be administered.

2.8. Non-Formulary Requests.

2.8.1. All non-formulary prescription requests for JBSA enrolled beneficiaries are reviewed using non-formulary process.

2.8.2. DHA-PI 6025.31, section 1b, requires all providers practicing at an MTF to preferentially use medications listed on the MTF formulary. An MTF provider may request the purchase of non-formulary item(s) when formulary medications do not or cannot reasonably meet the needs of an individual patient. Certain non-formulary medications have specific "medical necessity" or "prior authorization" paperwork requirement as directed by the Defense Health Agency Pharmacy and Therapeutics Committee or TRICARE Management Activity. The TRICARE Formulary and authorization forms can be found at **http://www.tricare.mil/CoveredServices/Pharmacy**.

2.8.3. Requests can be completed by sending a Non-Formulary Medication request, along with medication prior authorization, medical necessity, and/or brand medical

necessary forms as applicable to organization's non-formulary email. Providers must include: Drug, Strength, Dose, Directions, Quantity, Refills, patient contact information and any additional comments such as indication, expected length of therapy.

2.8.4. Non-formulary/special purchase order procedures may also be used to request a restricted formulary drug for a use not covered by the restriction or for quantities greater than allowed by established policy. Non-formulary or non-stocked medications may take up to 7 business days to source. Over-the-counter medications will normally not be filled using this process.

2.8.5. Non-formulary medications (DoD Tier 3) medications from non-MTF providers will not be filled unless the patient has been referred to that provider by the MTF. Patients not empaneled to the MTF may use the Home Delivery Pharmacy instead of Retail Pharmacies for obtaining non-formulary medications.

2.9. Brand Name Only Requests. As per Defense Health Agency rules, pharmacy cannot fill brand name only requests if a generic is available. If patient has a documented allergy or adverse reaction to an excipient, a non-formulary request should be initiated. This exclusion does not apply to P&T approved brand name requests for specific medications with narrow therapeutic windows.

2.10. Herbal medications and nutritional supplements are not stocked or dispensed within the ambulatory surgery center and will not be special ordered for outpatients (IAW DHA-PI 6025.31 section Enclosure 3, 1b7. "Pharmacies procure, dispense, recommend or use only drugs approved by the FDA").

2.11. Prescription Quantities and Refills.

2.11.1. Telephone Refill Service and Tricare Online Refill Service. These automated refill services optimize service and are highly encouraged for all refills. For telephone refills, local patients call (210) 292-9995 and long distance patients call 1-800-469-7170. For online refills, the website is: **www.tricareonline.com**. Walk-in refill requests are discouraged, as they lead to increased wait times for all pharmacy patients. When a patient does not have a current refill, they will be directed to their primary care manager (PCM) or the clinic that prescribed the medication and not the Urgent Care Center.

2.11.2. Per DoD guidelines, the maximum quantity pharmacy may dispense is a 90-day supply with refill authorization up to one year. Quantities exceeding a 90-day supply will be reduced by the pharmacy staff and refills will be adjusted accordingly.

2.11.3. The following specific policies apply:

2.11.3.1. Methylphenidate and Amphetamines (Schedule II): up to a 3-month supply when prescribed for narcolepsy or attention deficit disorder.

2.11.3.2. All other controlled medications are limited to a 30-day supply, excluding some hormone replacement therapies and other therapies approved by the Joint P&T Function.

2.11.3.3. Schedule II medications may not be refilled. Schedule III-V medications may not be refilled beyond 180 days.

2.11.4. Deploying personnel on chronic medications may receive enough medication to cover up to 180 days plus one month (for recovery period or if the return to home station is delayed). Patients will be asked to present their orders for deployment verification. A pharmacist will be consulted if the orders are unavailable. Patients deploying for greater than 180 days to bases with Army Post Office or Fleet Post Office capability may utilize the TRICARE Mail Order Pharmacy Deployment Prescription Program (DPP) for resupply. Pharmacy staff will brief patients on this option.

2.11.4.1. Deploying personnel on controlled medications will be limited to a 180-day supply for Schedule III-V medications and a 90-day supply for Schedule II medications. Patients will utilize the DPP for resupply.

2.12. Veterans Administration (VA) Prescriptions. VA prescription forms identified as "to be filled at VA facility only" are accepted from DoD eligible patients.

2.13. Prescription Transfers. Prescriptions may be transferred in accordance with the guidelines in DHA-PI 6025.31 and applicable federal and state laws. Patients should be informed transfers may take up to 72 hours to complete and the prescription will be cancelled at the location from which it was transferred. Schedule III-IV controlled substance prescriptions may be transferred once before the expiration of the prescription. Pharmacy personnel will use 59 MDW Form 22 *Pharmacy Transfer* for verbal prescription transfers.

2.14. Veterinary Prescriptions. Limited to the care of military animals and live patient models in the 59 MDW.

2.15. Preprinted Prescriptions. Preprinted prescription pads from outside sources are not authorized for use by MTF providers. Locally generated preprinted prescription pads must be approved by the 59 MDW P&T Committee.

2.16. Special Controlled or Restricted Drug Policies.

2.16.1. Military providers are not authorized to prescribe controlled substances to patients who are not under their direct care. In addition to the information normally required, prescriptions written for controlled drugs must include the patient's physical address (no post office boxes).

2.16.2. Pharmacy will comply with medication restricted access and/or risk evaluation and mitigation procedures as required by the FDA or manufacturer.

2.16.3. Providers may not prescribe medications for themselves except in emergencies or isolated situations when no other provider is available.

2.16.4. Providers may not prescribe medications listed on the controlled substances list for themselves or for their family members.

2.16.5. Providers who prescribe medications not on the controlled substances list for their family members must ensure that the treatment is within their scope of privileges, an evaluation is completed, and documentation of that evaluation is placed in the family member's health record.

2.17. Emergency Dispensing.

2.17.1. In cases where the pharmacist is not able to obtain refill authorization, he or she may dispense a limited amount of drug to the patient to supply the patient until the

prescriber can be contacted. This should be limited to situations where it is in the best interest of the patient's health to dispense an emergency supply of the medication.

2.17.2. The quantity dispensed is limited to enough medication to last until the patient's provider has normal office hours or is available to renew the prescription for the patient.

2.17.3. Controlled substances are not authorized for emergency dispensing.

2.18. Emergency Contraception.

2.18.1. FDA–approved emergency contraception will be provided to patients 17 years of age and older. Pharmacists will screen eligibility for walk-up patients using the emergency contraception pharmacy questionnaire. Eligible patients will have prescriptions entered via standing order. The screening questionnaire and standing order will be updated annually at P&T. Procedures will be IAW DHA-PI 6025.31.

2.18.2. Patients under 17 years of age must request a prescription for emergency contraceptive medication through their provider care team.

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

2.18.4. Pharmacy staff shall refer beneficiaries who request emergency contraception more than 2 times in 6 months to a provider for family planning counseling.

2.18.5. Medical personnel who, for moral or 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.

2.19. Naloxone nasal spray will be provided to eligible patients or caregivers upon request. Pharmacists shall screen patients using the 59 MDW Outpatient Pharmacy Naloxone Evaluation and Prescription form criteria. Prescriptions will be entered via standing order. Pharmacists will counsel the patient/caregiver in opioid overdose prevention, recognition, response, and naloxone administration. The screening questionnaire and standing order will be reviewed annually at P&T.

2.20. Compounded Products. Clinic Support pharmacy will compound products that have a valid recipe/formulation complete with stability and, if required, sterility data. Aseptic technique will be utilized, depending on the product, and the accuracy of the product will be ensured by the pharmacy staff, including a visual inspection of the medication's integrity. Providers are encouraged to coordinate with the Clinic Support Pharmacy in order to provide timely service for delivery to the patient as it may require several duty days to prepare. If a commercially available product exists, that product is preferred.

2.21. Treatment of Minors. The MTF commander 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.

2.22. Injectable Medications. Injectable medications that require special preparation prior to administering, have questionable stability after opening, require special education/training in order to administer or pose considerable danger to the patient if self-administered, will not normally be dispensed directly to patients. Notably, some patients are very well versed in administration (i.e., hemophiliac patients) of special products. The decision to dispense is at the discretion of the pharmacist in charge.

2.23. Discharge Controlled Prescriptions. Nurses/providers are authorized to pick up discharge medications from the dispensing pharmacy as a representative for the patient. If a patient no longer needs a controlled medication that has been dispensed to them, the patient shall be directed to the medication disposal bin in the lobby.

2.24. Force Health Protection Prescription Products (FHPPP). Dispensing of FHPPP is coordinated between Medical Logistics, Pharmacy, and Deployment Medicine Personnel. When Air Force Component theater reporting instructions include FHPPP requests, Deployment Health will note which specific FHPPP is required on the DD Form 2795, *Pre-Deployment Health Assessment* and the medical provider screening the deploying member will place the appropriate prescription in the medical system. The deploying member will then report to the pharmacy and be issued the appropriate FHPPP. The member will maintain the FHPPP until deployed. Bulk issue will be coordinated through Medical Logistics. The EMR of all patients issued FHPPP will be populated with complete documentation of dispensing.

2.25. Medication Reconciliation.

2.25.1. The 59 MDW will record and pass along correct information about a patient's medications. Medications the patient is confirmed to be taking shall be compared to new medications given to the patient. Patients should be informed of any potential clinically significant adverse drug reactions or other concerns. The 59 MDW will ascertain that patients know which medications to take at home and advise patients to bring their up-to-date list of medications every time they visit a doctor.

2.25.2. Medication reconciliation will be accomplished when medications are ordered, prescribed, changed, discontinued or used during the visit. Medication reconciliation is not required when appointments are with non-prescribing providers or for appointments that do not involve discussion of medications.

2.25.3. Screening for specific medication contraindications instead of asking about all medications is acceptable in settings such as the Immunization Clinic or Radiology prior to contrast administration.

2.25.4. For outpatient clinics where medication reconciliation is indicated, staff will query the EMR and print out a medication reconciliation list (MRL). With patient (or designee) input, the staff member will take a complete medication history to obtain and/or update medications the patient is currently taking including prescriptions filled off base. An attempt will be made to obtain the name, dose, route, frequency, and purpose of all newly identified medications. The MRL will be updated to indicate which

medications the patient is taking. A circle around "yes" or "no" will indicate if the patient reports using the medication. 59 MDW clinicians will compare the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolve any discrepancies within their scope of practice.

2.25.5. The patient care team will compare the MRL to new medications provided to the patient and update the EMR within their scope of practice by either discontinuing inactive medications or referring the patient to the prescribing clinic.

2.25.6. 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.

2.26. Sterile Products/Multi-Dose Vials.

2.26.1. Pharmacy will compound sterile products except in emergencies or when not feasible (for example, when product stability is short). Aseptic technique will be utilized and the accuracy of the product will be ensured by the pharmacy staff, including a visual inspection of the medication's integrity.

2.26.2. Safe Injection Practices for 59 MDW are handled IAW the Centers for Disease Control (CDC) Safe Injection Practice guidelines:

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

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

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

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

2.26.2.5. When preparing reconstituted multiple-dose vials, healthcare personnel must label with the diluent, concentration, beyond use date of 28 days unless otherwise specified by the manufacturer, and their initials. They will be visually inspected prior to each use for contamination or deterioration and will be stored as directed by the manufacturer.

2.26.2.6. Dedicate multi-dose vials to a single patient whenever possible. If multi-dose vials 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 (e.g. operating room, patient room/cubicle).

2.26.3. Sterile products are delivered to the unit by pneumatic tube system when possible. High cost drugs, chemotherapy, blood products, and controlled substances are not delivered by the pneumatic tube system. These must be picked up in the pharmacy by an authorized staff member, and hand-carried to the clinic.

2.26.4. Each compounded sterile product solution is labeled for a specific patient. A sterile product labeled for a patient will not be administered to any other patient; to do so is a reportable medication occurrence. Only pharmacy personnel may recycle or re-label products manufactured by pharmacy.

2.26.5. Sterile product labels state the expiration date and time. Sterile products originating from pharmacy and not administered by the indicated time must be returned to pharmacy with the label marked expired (EXP).

2.27. Labeling Medications Prepared Outside of Pharmacy.

2.27.1. Medications prepared outside of pharmacy are for immediate use only. Areas such as Anesthesia, usually prepare medication for immediate use in surgery cases.

2.27.2. Any time one or more medications is not used immediately or not maintained by the preparer, the medication container (e.g. plastic bag, syringe, bottle, medicine cup, basin, etc.) must be labeled. No more than one medication or solution is labeled at one time. Hanging IV bags should be labeled if the preparer does not remain with the product.

2.27.3. Labeling occurs when any medication or solution is transferred from the original package to another container. At a minimum, all medications prepared in the facility are labeled with the following: drug name, strength, amount, and beyond use date and time.

2.27.4. When preparing individualized medications for multiple specific patients, or when the staff member preparing the individualized medications is not the staff member administering the medication, the label also includes the following: patient name and date of birth (DOB), patient location, directions for use and any applicable cautionary statements either on the label or attached as an accessory label (e.g. “requires refrigeration”, “for IM use only”). 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.

2.27.5. 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.

2.28. Clinic Stock.

2.28.1. The Authorized Drug List (ADL) for each ward or clinic contains the items approved by the P&T Function for stock within each area. These items are for administration in the clinic only and are not for dispensing to the patient unless authorized by the P&T Function. The ADL is updated based on specific clinic requests for additions or deletions submitted to and approved by the P&T Function. All ADLs will be reviewed annually by the P&T Function at a minimum. ADL change request forms are available from the Clinic Support Pharmacy.

2.28.2. Automated dispensing cabinets (ADCs) are the preferred storage location for medications determined safe and appropriate for clinic use by the 59 MDW P&T Committee. ADC outpatient functionality provides medication removal and stock level tracking without an override. Since the cabinets do not maintain patient information, as would be done in an inpatient setting, additional overrides are not required and are not

available for review. Clinics will be required to use the PYXIS® system as determined by the Director of Pharmacy Services based on mission requirements, use of controlled substances, volume of product used, and cost and accountability of medications utilized in the clinic. PYXIS® MedStations will be utilized as stock locations providing control and documentation for controlled substances and unit dose medications. The PYXIS® System is required to be plugged into emergency (red) power.

2.28.3. Automated Dispensing Cabinets/Machines (e.g., PYXIS®) are not, in and of themselves, medication control systems, but rather are tools and part of a sound medication control system. Staff members ensure proper medication control systems (designed to prevent medication related sentinel events) are still in place when these machines are used.

2.28.4. Units without a PYXIS® place orders through tailored ADL spreadsheets maintained by pharmacy. These clinic bulk orders are filled by the pharmacy and ready for unit pick-up within 1 duty day from the date of order.

2.28.5. If a medication is needed by a clinic and is not on the ADL, an AF Form 781 is required. The request will then be filled and labeled as an outpatient prescription. It should only be administered to the patient for whom the AF Form 781 was written.

2.28.6. Only authorized medical personnel assigned to the 59 MDW may pick up medication from the Pharmacy for delivery to the units and clinics. Qualified personnel include: military personnel working as permanent party members or civilian employees and contractors working in direct patient care positions.

2.28.7. Only Licensed Healthcare Professionals may sign for receipt of Schedule II thru V controlled substances. Printed name, rank, and signature are required upon receipt of a controlled medication.

2.28.8. Unless stored in the PYXIS® System, all controlled substance medications will be maintained on an AF Form 579, *Controlled Substance Register* or electronic equivalent. Instructions for the proper maintenance of the AF Form 579 or equivalent are contained later in this instruction.

2.28.9. Every reasonable attempt will be made to fill orders with unit dose packaged medications. Each unit dose packaged medication will be appropriately labeled with the medication name, strength, expiration date, lot number, and manufacturer.

2.29. Shortage, back order and outages medication will be communicated to practitioners utilizing the P & T Quick Summary slides or newsletter and posted on the 59 MDW/MDTS/Pharmacy SharePoint.

3. Drug Administration.

3.1. Responsibilities.

3.1.1. All personnel administering or dispensing medications will use two patient identifiers. (i.e. patient's full name and date of birth). Two patient identifiers will be confirmed either verbally or against the 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.

3.1.2. Providers will list all known allergies and drug sensitivities for their patients in the EMR and on the check-in orders as well as subsequent transfer orders. Allergies are also checked prior to administration of any medication.

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

3.1.4. Each new drug administration order will be carefully reviewed by pharmacy and a registered nurse EXCEPT when the resulting delay would harm the patient. Orders written after pharmacy hours will be reviewed by a pharmacist retrospectively within 24 hours and entered into the patient prescription profile. Medication administration by anesthesia personnel will be conducted IAW anesthesia standard of care and CDC guidelines. Pharmacist review verifies proper dosage and screens for drug-drug interactions, therapeutic duplications/overlaps, and drug allergies that may result in unintended effects. Patients will be made aware of any potentially significant adverse reaction or concerns with new medications. Orders are determined to be appropriate based upon medical history, clinical condition, and drug allergies. Clinic medications should be compatible with medications on the patient's MRL and will be checked for compatibility by a pharmacist. The diet compatibility and predictable adverse reactions must also be considered.

3.1.4.1. Prior to administering any drug, the nurse or medical technician will verify that the medication is stable based on a visual examination for integrity, particulates, or discoloration, that the medication has not expired, and that there are no contraindications.

3.1.4.2. Personnel are not required to administer a drug they feel unqualified to administer, believe might be detrimental to the patient, or in situations where patient monitoring cannot be properly accomplished. When concerned about the administration of any drug, consult with a pharmacist, nurse manager, or provider for order clarification. Ethical concerns are addressed in 59 MDWI 44-150, *Advance Directives and End of Life*.

3.1.4.3. Medications requiring specialized/intensive monitoring, or drugs with the potential for causing significant alterations in clinical status are administered only if appropriate monitoring equipment, emergency medications/reversing agents, and qualified nursing support are available and should be closely scrutinized before prescribing.

3.1.4.4. Rate of administration of diluted IV potassium chloride. Maximum concentrations of potassium chloride for peripheral and central lines will be 10 mEq/50mL and 20 mEq/50mL, respectively. The rate of administration for unmonitored, partially monitored, and fully monitored patients will be 10 mEq/hour, 15 mEq/hour, and 20 mEq/hour, respectively. No more than 50 mEq of potassium chloride will be placed in one IV bag. Patients requiring more than 50 mEq of potassium chloride will have the dose split into multiple bags.

3.1.5. Staff members authorized to administer drugs follow the "five rights of medication administration": the right DRUG, at the right DOSE, given at the right TIME, by the right ROUTE, to the right PATIENT.

3.1.6. Pharmacy recommends standardized administration times to facilitate delivery of medications, ensure timely administration, and reduce the potential for errors. Units may adjust actual drug administration times as requirements dictate.

3.1.7. Intravenous push list describes which medications can be administered via IV push and the conditions for doing so. The IV push list will be reviewed at least annually by the P&T Committee.

3.1.8. Outpatient units will document medication administration per their clinical guidelines, and at minimum will enter the order via the EMR for retrospective drug review by a pharmacist. In clinics with authorization to dispense medications directly to patients, documentation will occur via the EMR in the same manner, allowing for retrospective drug review. Any therapeutic effects/side effects or adverse reactions reported by the patient will be documented in the patient EMR.

4. Medication Storage, Security and Inspection.

4.1. Responsibilities.

4.1.1. Flight commanders, flight chiefs, nurse managers, section officers in charge (OIC)s 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 to manufacturer's recommendations.

4.1.2. Checking expiration dates of all clinic stock is a shared responsibility between pharmacy personnel and clinic staff. Pharmacy staff will inspect all medication storage areas located in the clinics on a monthly basis. The original monthly inspection report will be signed by the OIC or NCOIC and they will be given a copy to correct any discrepancies. A copy of each inspection report will be filed for a minimum of one year and then destroyed. Inspection results are briefed at P&T and discrepancies are tracked through the Joint Patient Safety Reporting system.

4.1.2.1. Medication may be used up to the date of expiration. When only a month and year of expiration are provided for a drug, the drug may be used through the end of that month. Any MTF staff member discovering expired or short-dated medications (expiring within 30 days by local policy) must separate that item away from general stock so that it will not be mistakenly given to a patient. If the medication is not a controlled drug, it should be placed in a container (such as a zip-lock bag) that has "EXPIRED MEDICATION" written on it, and returned (hand delivered or via the tube system) to the Pharmacy as soon as possible. If the medication is controlled, then the procedures in **paragraph 4.2.7** must be followed.

4.1.2.2. The Clinic Support Pharmacy will coordinate return or destruction of expired medication with an authorized pharmaceutical returns company.

4.1.3. Inventory of all controlled medication will be completed by authorized staff every duty day.

4.1.4. Persons authorized to access and transport controlled medications (Schedule II, III, IV, and V) include physicians, dentists, nurse practitioners, physician assistants, nurses, pharmacists, pharmacy technicians or other designated personnel. Non-pharmacy personnel will be required to provide printed name, rank, and signature when transporting controlled medications from pharmacy.

4.1.5. Persons authorized to have unsupervised access to non-controlled medications include those listed in 4.1.4., select medical technicians, and other personnel whose job description includes the transportation, dispensing, compounding, or administration of medications.

4.1.6. Persons with supervised access (in the area but not necessarily direct observation) to medications include environmental services personnel, engineering personnel, materials management personnel and other employees so that they may perform their duties. They shall not have unsupervised access to controlled medications, and shall not handle medications to which they have access.

4.2. Procedures.

4.2.1. Biologicals and other thermolabile medications must be stored in a refrigerator. The temperature range should be maintained between 2-8° Centigrade (36-46° Fahrenheit). Thermometers should be placed on a shelf midway between the freezer 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.

4.2.1.1. If the refrigeration temperatures fall outside the recommended range, clinic personnel must contact facility management to correct the refrigeration problem and the pharmacy for information on whether the drugs or biologicals are acceptable for use. Actions taken must be documented on the temperature control log.

4.2.1.2. If the temperature was out of range during the time the clinic was closed clinic personnel are to take the same steps as if they had found an abnormal temperature during their daily checks, as outlined on 59 MDW Form 2942.

4.2.2. Medication storage areas must be secured to prevent diversion and separated from personal belongings. Non-drug items will not be stored in medicine cabinets or in refrigerators where drugs are maintained.

4.2.3. Medication storage areas and PYXIS® MedStations must be properly controlled and secured. Medications must be stored in a manner 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.

4.2.4. Controlled substances not stored in PYXIS® must be kept in a substantially constructed double-locked cabinet. Refrigerated controlled substances not stored in a PYXIS® refrigerator will be stored in the pharmacy. These items will be available to the clinic on an as needed basis.

4.2.5. The Resuscitative Services Working Group with the P&T Committee will determine which emergency medications, to include crash cart meds and antidotes, will be accessible in patient care areas. These medications are secured using a breakable,

numeric lock. 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. The expiration date of the tray is the expiration date of the medication dated to expire first. Before this expiration date is reached, the tray must be returned to pharmacy and exchanged for a tray with a new, later expiration date.

4.2.6. Expired, damaged, contaminated and/or excessive stock of non-controlled drugs in clinics will be picked up by pharmacy personnel or sent to the pharmacy for proper disposal. These medications must be segregated from normal stock and returned to the pharmacy as soon as possible.

4.2.7. Outdated, deteriorated, or excess controlled substances must be turned in to the Pharmacy Vault. These medications must be segregated from normal stock and returned to the pharmacy as soon as possible. Controlled substance turn-ins will be accepted by the pharmacy staff when delivering scheduled drugs to the clinics. Contact the Clinic Support Pharmacy at JBSA-Lackland, and the Clinic Pharmacy at JBSA-Randolph to coordinate return of any controlled medications.

4.2.8. All personnel who work near hazardous materials will report any spills they encounter to the work center supervisor, or other responsible individual in the area, and will comply with the wing spill response procedures to manage hazardous material spills. Safety Data Sheets are located in the Pharmacy.

4.2.9. Pharmaceutical waste is any item such as intravenous bags, tubing sets, vials or needleless syringes that contain traces of unused medications. All pharmaceutical waste with the exception of chemotherapeutic and radioactive agents will be considered medical hazardous waste and disposed of in accordance with the Joint Base San Antonio Hazardous Waste Management Plan. The pharmaceutical waste will be placed in approved non-hazardous containers provided by Civil Engineering. Additionally, specific pharmaceuticals which have been identified as hazardous in the Code of Federal Regulations (40 CFR 261.33, *Discarded Commercial Chemical Products, Off-Specification Species, Container Residues, and Spill Residues Thereof*) are disposed of in the hazardous waste bins. Disposal collection is coordinated by Civil Engineering. It is inappropriate to dispose of hazardous materials through any entrance to the sewer system, to include sinks.

4.3. Controlled Substances and Medication Security.

4.3.1. Pharmacy reviews controlled substance medication use monthly based upon frequency of medication use, number of providers prescribing for the same patient, and quantity of controlled substance prescriptions. Information is provided to the patient's PCM. Concerns regarding medication use are forwarded to the SGH for coordinated action. Pharmacy reports a summary of controlled substance monitoring quarterly at P&T.

4.3.2. Clinic Drug Stocks and Reordering. Clinic controlled drug stocks are stored in PYXIS® units, a double locked cabinet of substantial construction, or a combination safe. Should a PYXIS® become inoperable, clinic staff will first attempt to troubleshoot using the associated guide located on each PYXIS®. If still inoperable, notify pharmacy

personnel for assistance prior to contacting PYXIS® for on-site service. Keys to access the PYXIS® machines are stored in Pharmacy.

4.3.3. All AF Form 579s are reconciled at the beginning of each calendar year. All forms from the previous year are turned in to the pharmacy and new AF Form 579s are issued for the current calendar year.

4.3.3.1. Administrative documentation and inventory of controlled drugs when using AF Form 579s. Clinic personnel administering a controlled drug to a patient will make a corresponding entry on AF Form 579. Entries must be in indelible ink. To correct an error, one line is drawn through the entry, the word "error" is written next to the line, and the person making the change initials and annotates the date and time of the change. A physical inventory of the prescribed drug shall be accomplished before and after administering the drug to the patient.

4.3.4. Waste of controlled drugs is a nursing unit procedure and destruction of controlled drugs is a pharmacy vault procedure. Waste must be documented either on the AF Form 579, on the anesthesia record in the EMR, within the PYXIS® system, or described within a memorandum for record. All waste must be witnessed by another staff member. When clinic stock expires or is suspected of contamination, pharmacy staff will outdate the medication, remove it from the clinic, return it to the vault, and follow return procedures or perform witnessed destruction. (Example: If a nurse has three expired 10mg morphine sulfate tubexes, he/she CANNOT waste all three packaged units. They must be turned into the Pharmacy vault.)

4.3.4.1. When destroying a partial or entire dose of a controlled drug, document the amount wasted along with a brief explanation. 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 documented in PYXIS®. Two licensed clinical staff members must input their access codes documenting the narcotic waste in PYXIS®.

4.3.4.2. When a controlled drug in a tubex or blister pack is removed from the tamper proof packaging, it must be administered to a patient or wasted. An exception is made for pharmacy prepared kits (such as an anesthesia kit) where a pharmacy seal validates the integrity of a returned controlled tubex.

4.3.4.2.1. Waste of a controlled drug dose is accomplished/documented at the source of the drug supply. If the controlled drug was stocked in a clinic, documentation must occur on the corresponding AF Form 579 or PYXIS® system.

4.3.4.2.2. Wasted controlled drugs are always co-signed or initialed by a second person with authorized access to controlled drugs. In some instances, such as for dental technicians, access may be restricted solely for witnessing controlled drug destruction.

4.3.5. Discrepancies. A discrepancy occurs whenever the amount found and entered in the "verify count field" does not match the expected amount stored in PYXIS®. Discrepancies will remain on the PYXIS® 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. The OIC/nurse manager should run a discrepancy report at the end of the shift to verify all discrepancies have been resolved. The pharmacy vault custodian will run a discrepancy report daily to ensure that the controlled drug discrepancies are resolved in a timely manner, ideally within 24 hours. Discrepancy reports from weekends or holidays will be reviewed by the pharmacy vault custodian on the first duty day following the weekend or holiday. All PYXIS® controlled substance reports are reviewed by the pharmacy at least monthly.

4.3.6. Operating Room (OR) Anesthesia Stock.

4.3.6.1. The OR drug inventory is maintained in PYXIS® Anesthesia Carts, which provide nurse anesthetists and anesthesiologists medications, including controlled substances, for administration in OR suites, radiology special procedure rooms and Magnetic Resonance Imaging areas. Any and all waste is documented within the PYXIS® anesthesia cart system.

4.3.6.2. Waste of opened tamper-proof containers or partial units of controlled substances shall be annotated on an AF Form 579. If the controlled drug was removed from PYXIS®, the documentation occurs in that system. Another person certified to administer or destroy controlled drugs witnesses the wastage. Anesthesia personnel will immediately correct any discrepancies and report on AF Form 85, *Controlled Substance Inventory Adjustment Voucher*, then route through the Pharmacy Flight Commander to the MTF Commander or designee for approval.

5. Formulary Management and Medication Lists.

5.1. Medication Use Evaluation Subcommittee. The Medication Use Evaluation (MUE) is a medical staff responsibility and is a subcommittee of the JBSA San Antonio Military Healthcare Systems (SAMHS) P&T Function. The committee shall serve as an advisory committee to the P&T Function on medication use and formulary management. The MUE will evaluate the use of drugs within this facility against pre-approved established criteria. These reviews may be conducted by drug, drug class, department, procedure or diagnosis. Any area of the medication management process may also be evaluated for appropriateness.

5.1.1. Chairperson/Coordinators/Members. The SAMHS MUE Subcommittee is composed of a chairperson, a San Antonio Military Medical Center (SAMMC) coordinator, a 59 MDW coordinator, and medical group/service/department representatives. The chair position rotates between SAMMC and 59 MDW physician prescribers who work together in conducting monthly meetings and approving the minutes of the meeting. Coordinators are pharmacists who are responsible for the administrative aspects of the MUE process to include acting as recorder, report generators and liaisons between the chair/deputy chair and the MUE Subcommittee members. Representative makeup of the subcommittee should balance group dynamics, MTF representation, and task-oriented effectiveness. Consideration is given to medical, surgical, nursing, and pharmacy aspects of medication use. The physician representatives of a group/service/department will represent SAMMC and 59 MDW and coordinate data gathering and information within their group/service/department.

5.1.1.1. Attendance. All MUE members will commit to at least one year of service to the MUE Subcommittee. Members will be present or send a delegate for every

meeting. Any MUE members with a consistent lack of participation and/or lack of appointed delegates in their absence will be asked to resign and a new member will be recommended for selection.

5.1.1.2. Formulary Review. MUE will complete an annual review of the entire combined formulary and recommend additions/deletions to P&T. Formulary review should be coordinated with the Pharmacy Operations Division review schedule in order to prevent medication changes at the local level that are not in alignment with DoD policies. If formulary changes removing item(s) from formulary are approved, the P&T will determine a beneficiary notification plan. MUE will ensure that the combined formulary reflects the recommendations set forth by the DoD PEC to include formulary additions and deletions.

5.2. Logistics/Product Selection/Systems Committee. The Logistics/Product Selection/Systems Committee P&T subcommittee serves as an advisory committee to the P&T and is focused on medication acquisition, Brand to Generic conversion, EMR file/drug table standardization and formulary maintenance and quarterly reports to include National Contract Compliance and the Strategic Sourcing Report.

5.2.1. Composition: One Pharmacist (primary) and an alternate (may be a Pharmacist or Pharmacy Technician) from each MTF.

5.2.2. Meeting frequency will be no less than four times per year.

5.3. P&T Committee is made up of members of the medical staff responsible for all aspects of medication use within the facility to include but not limited to formulary management, vaccines, controlled drug prescribing/use, authorized drug lists, adverse drug reaction review. The membership at the 59 MDW must comply with DHA-PI 6025.31 section 7. All clinics must ensure P&T Function does a review of unit-specific medication policies and procedures prior to implementation. This requirement ensures a comprehensive administrative and clinical review of each drug therapy issue.

5.3.1. Monitor Current Trends in Therapy/Formulary Additions and Selections. As medical therapy changes, the P&T Function will review formulary additions and deletions to provide and ensure that proper indications for use, effectiveness, risk and efficient therapy is available for use.

5.3.2. Requests for 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 the MUE Committee. The MUE recommendations are presented and voted upon at the P&T meetings. New drug requests will not be considered if they are deemed non-formulary by the DoD P&T. 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 at the monthly MUE meeting after which the request will be reviewed and recommendations forwarded to P&T. The

requestor or delegate will also present the request at the following P&T meeting, where it will be voted on for formulary addition. The P&T Function also reviews high volume special purchase drugs for potential formulary addition, again with MUE recommendations.

5.4. Medication Lists.

5.4.1. Pharmacy will maintain the current formulary via the EMR and any additional references available to provider staff. The formulary will be reviewed at least annually based on emerging safety and efficacy information.

5.4.2. Pharmacy will maintain look-alike/sound-alike (LASA), high-risk/high-alert (HRHA), and hazardous medications lists. The medications on these lists will be selected based on ISMP/The Joint Commission recommendations, FDA/DoD guidance, NIOSH guidance, and/or MTF error trends. The current lists are maintained on the Pharmacy SharePoint.

5.4.3. The LASA, HRHA, and Hazardous medication lists will be reviewed and approved annually by the P&T Function. The P&T Function will determine when it is necessary to include indication for use or other precautionary action. Every proposed new formulary addition will be assessed for potential LASA, HRHA, and hazardous medication concerns.

5.4.4. LASA medications will be identified with "look-alike/sound-alike" stickers on shelf stock and stored away from their often-confused counterpart. LASA medications will be listed in the EMR using TALLman lettering format when possible (i.e. hydrOXYzine). HRHA medications will be identified with "high alert" stickers on shelf stock.

5.4.5. Do Not Use abbreviation list is reviewed annually by the P&T committee and published for review by Patient Safety.

6. Clinical Pharmacy and Clinic Support Services.

6.1. Scope of Services.

6.1.1. Clinic based ambulatory and acute care clinical pharmacy practice includes therapeutic drug monitoring and medication monitoring. Specific services include formulary management, P&T Function support, investigational drug management, drug information services, evaluation and reporting of adverse drug reactions, medication utilization evaluation, medication error reporting, drug defect reporting, and drug recall management. Services also include coordination of DoD pharmacy benefit with SAMMC, and other Air Force facilities in the San Antonio area as well as providing Pharmacy Doctoral program clinical rotations and coordinating an accredited Army-Air Force post-graduate year 1 pharmacy practice residency.

6.1.2. Clinical Pharmacy Practice. Specific programs designed to optimize healthcare outcomes, may include: Lipid/Cardiovascular Health, Diabetes Center of Excellence, Tobacco Cessation clinic, and medication monitoring. Outpatient encounters are documented in EMR as part of the clinic encounter by a credentialed pharmacist.

6.1.3. Poison Information. Contact the National Poison Center Network at (800) 222-1222. This phone number shall be readily available in patient care areas. Lexicomp®

Lexi-Tox is available throughout the facility on the MTF intranet system as a toxicology resource. Additional applications can be downloaded via the Air Force Knowledge Exchange website, under Air Force Medical Service Virtual Library and Overview of Services.

6.1.4. Drug Information. The entire staff of pharmacists will respond to questions from healthcare professionals and patients.

6.2. Investigational Drugs.

6.2.1. All investigational drugs are received, stored, labeled, distributed and dispensed only by the pharmacy. 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. Investigational drugs are ordered via the EMR or on an AF Form 781. These forms must have all pertinent information pre-populated and need only the specific patient information. The request will be documented in the patients' EMR as a prescription order. The prescription will be packaged and labeled IAW federal law and DHA-PI 6025.31.

6.2.2. 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. 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. 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.

6.2.3. Investigational drugs are dispensed to the patient or to the principal or associate investigators IAW DODI3216.02_AFI 40-402, *Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research.*

6.2.4. Self-Medication of Investigational Drug. When a surgical patient is provided treatment under an investigational drug protocol from another facility, the attending physician maintains the patient on the drug, if appropriate. The attending physician is ultimately responsible for contacting the originating facility in a timely manner, to obtain protocol information and materials to educate the pharmacy and nursing staffs. When a patient maintained on an investigational drug checks in for Ambulatory Surgery, the patient must bring the drug to the facility and it may be administered as a self-medication drug. The physician must write an order allowing the self-medication of the investigational agent(s) in the electronic record or on an AF Form 3066 in the patient's chart and follow procedures in section 2.7.9.

6.3. Multidisciplinary Medication Monitoring.

6.3.1. Responsible and efficacious medication prescribing and administration is a collaborative process to include all medical professionals involved in patient care. Input from the patient and all his/her caregivers is used to evaluate, maintain, and improve the patient's drug regimen.

6.3.2. Providers, clinic medical personnel, and pharmacy personnel monitor the therapeutic response to drugs utilizing the patient's own perception about side effects and perceived efficacy, when appropriate, referring to information from the patient's medical record (print or electronic), relevant laboratory results, clinical response, and medication profile.

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

6.4.1. 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). This definition shall include discontinuation of drug, additional treatment such as supportive therapy or antidotes, increased morbidity, death, temporary or permanent disability or increased length of hospitalization. Reactions not reported as ADRs include investigational drugs reactions (reported through the principle investigator), blood transfusion reactions (unless a defect in the anticoagulant substances or equipment), reactions to certain biologicals as monitored by United States Public Health Service, and poisonings. ADR reporting focuses on "unexpected" reactions, even when the reaction is not severe.

6.4.2. It is the responsibility of any and 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 Hotlinks.

6.4.2.1. Prescriber notification must be accomplished for all adverse drug events and significant adverse drug reactions. Notification will occur as soon as practicable after event recognition.

6.4.3. ADRs can also be reported in the AHLTA encounter using the T88.7 non-billable code. Information regarding the reaction will need to be included in the note.

6.4.4. For assistance with any reporting method please contact the outpatient pharmacy team.

6.4.5. Significant ADRs will be reported to the FDA through the Medwatch program. Pharmacy personnel will ensure that Medwatch reports are accomplished for serious or severe reactions IAW FDA guidelines.

6.4.6. 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 **http://www.hrsa.gov/vaccinecompensation/table.htm**. VAERS forms and information can be obtained by accessing the VAERS web site at **http://vaers.hhs.gov/index**.

6.4.7. VAERS Form Distribution.

6.4.7.1. Send the original report form and any appropriate supporting documents to VAERS, P.O. Box 1100, Rockville, MD 20849-1100. If the VAERS form is sent electronically or via fax, then it does not need to be sent by mail.

6.4.7.2. Retain 1 copy for the Patient Safety Program at the reporting medical unit, which will be reported to the P&T Function.

6.4.7.3. 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.

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

6.5.1. Drug recall information is disseminated to the medical staff using e-mail and the P&T Quick.

6.5.2. Recalled items are returned to Pharmacy Logistics for quarantine or destruction. Affected medications are quarantined in the pharmacy return area with the recall notice until disposition.

6.5.3. If required, pharmacy support personnel will remove the affected drug from dispensing stock in all pharmacies; clinics outside the pharmacy that stock the affected drug will be notified and instructed on how to handle the medication. If the drug's use caused or may cause injury or death, prescription and computer profiles must be reviewed and patients directed how to return the suspected drug to the pharmacy. If warranted by the drug recall, patients with current prescriptions on file in the pharmacy computer for the affected drug will be contacted and advised of the drug recall issue.

6.5.4. Depending on the level of recall, pharmacy support personnel will contact each clinic stocking the drug and provide information concerning the recalled product. If manning and inventory permits, the pharmacy staff will conduct an exchange of good stock for the recalled item in each clinic. When the recall notification is after normal duty hours, weekends or holidays, each nursing area will be asked to return the item to the pharmacy.

6.6. Medication Errors. A medication error is a situation when any drug leaves the confines or control of the medical/professional staff bearing a mistake such as the patient, drug, dosage form, dosage strength, or directions that are either labeled, dispensed, administered incorrectly or omitted, regardless of potential outcome.

6.6.1. Each medication error in which the patient ingested medication must be reported to the prescriber. Additionally, each error must be reported using the web-based DoD Patient Safety Reporting application which can be accessed via the 59 MDW SharePoint Hotlinks.

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

6.7. Drug Defect Reporting. Any MTF staff member identifying a defective drug must send or deliver that product to the Clinic Support Pharmacy.

6.7.1. The Clinic Support Pharmacy will complete the appropriate documentation, which will be forwarded to the Medical Logistics Flight.

6.7.2. The Clinic Support Pharmacy will coordinate with the vendor and Medical Logistics Flight for quality problems and adverse medical events. The pharmacy officer in charge or designee will submit a report for product quality issues and/or adverse medical events to MEDWATCH by phone ([800] FDA-1088), fax ([800] FDA-0178), mail (MEDWATCH, FDA, HF-2, 5600 Fishers Lane, Rockville, MD 20857), or online **http://www.accessdata.fda.gov/scripts/medwatch**.

6.8. Pharmaceutical Representatives/Drug Samples. Pharmaceutical representatives should check in at the information desk immediately upon entering the facility

6.8.1. Medication samples are not authorized in the 59 MDW at any time. If a pharmaceutical representative offers a provider medication samples, the provider shall report the representative to the pharmacy. Samples will not be authorized for clinic ADL or stock/use in any clinic.

6.8.2. Any non-authorized medication found during pharmacy clinic inspection, including samples, will be returned to the pharmacy for destruction.

6.9. Pharmaceutical Disposal. Beneficiaries may utilized collection receptacles to safely disposal of controlled and non-controlled prescriptions and over-the-counter medications that are unwanted, unused, expired or returned.

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

6.10. Antimicrobial Stewardship Program (ACP) is joined with Brooke Army Medical Center which develop, implement and monitor activities to promote appropriate antimicrobial medication prescribing practices.

6.10.1. The ACP sets at least one annual antimicrobial stewardship goal using evidence-based practice guidelines.

6.10.2. The committee collects, analyzes and reports data pertaining to the antimicrobial stewardship goal to leadership and prescribers. Educational resources pertinent that are related to its antimicrobial stewardship goal and strategies which promote appropriate antimicrobial medication prescribing practices should be provided to all clinical staff and licensed independent practitioners.

DANIEL K. FLOOD, Colonel, USAF, MC
Chief of the Medical Staff

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DODI 3216.02_AFI 40-402, *Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research*, 10 September 2014

AFPD 44-1, *Medical Operation*s, 9 June 2016

AFMAN 41-209, *Medical Logistics Support*, 4 January 2019

AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 30 August 2018

AFI 44-102, *Medical Care Management*, 17 March 2015

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59 MDWI 44-130, *Patient Safety*, 10 January 2017

59 MDWI 44-142, *Code Blue Management*, 13 April 2017

59 MDWI 44-150, *Advance Directives and End of Life*, 17 July 2019

59 MDWI 44-157, *Infection Prevention and Control Program*, 8 May 2020

Guide to Texas and Federal Pharmacy and Drug Law, 10th Edition, 2016

Resource Conservation and Recovery Act, 1976

United States Pharmacopeia 38/National Formulary 27, 2009

40 CFR 261.33, *Discarded Commercial Chemical Products, Off-Specification Species, Container Residues, and Spill Residues Thereof*, 16 January 1981

Prescribed Forms

59 MDW Form 22 *Pharmacy Transfer*

59 MDW Form 23 *Monthly Clinic Inspection Checklist*

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

Adopted Forms

DD Form 2081, *New Drug Request*

DD Form 2795, *Pre-Deployment Health Assessment*

59 MDW Form 2995, *Daily/Monthly Code Cart Checklist*

AF Form 85, *Controlled Substance Inventory Adjustment Voucher*

AF Form 579, *Controlled Substances Register*

AF Form 781, *Multiple Item Prescription*

AF Form 847, *Recommendation for Change of Publication*

AF Form 3066, *Doctor's Orders*

Abbreviations and Acronyms

ADC—Automated Dispensing Cabinets

ADL—Authorized Drug List

ADR—Adverse Drug Reaction

AHLTA—Armed Forces Health Longitudinal Technology Application

CDC—Centers for Disease Control

CHCS—Composite Health Care System

DOB—Date of Birth

DoD—Department of Defense

DPP—Deployment Prescription Program

EMR—Electronic Medical Record

FDA—Food and Drug Administration

FHPPP—Force Health Protection Prescription Products

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

MRL—Medication Reconciliation List

MTF—Medical Treatment Facility

MUE—Medication Use Evaluation

NCOIC—Noncommissioned Officer in Charge

NVIC—National Vaccine Injury Compensation Program

OIC—Officer in Charge

OR—Operating Room

PCM—Primary Care Manager

PRN—As Needed

P&T—Pharmacy and Therapeutics

SAMHS—San Antonio Military Healthcare Systems

SAMMC—San Antonio Military Medical Center

VA—Veterans Administration

VAERS—Vaccine Adverse Events Reporting System

WHASC—Wilford Hall Ambulatory Surgical Center

Terms

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 (DNUA) is updated annually at P & T and available through 59 MDW patient safety.

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. 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 has a medication formulary or list of medications routinely available for ordering/dispensing. 59 MDW providers are required by DHA-PI 6025.31 to prescribe from this list to the maximum extent possible. This formulary is available via CHCS and in an on-line format on the 59 MDW Intranet homepage at **http://online.lexi.com/lco?siteid=59**. The formulary is reviewed at least annually, either in part or in total.

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. Further guidance is provided in 59 MDWI 44-105, *59 MDW Trainee Supervision 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.

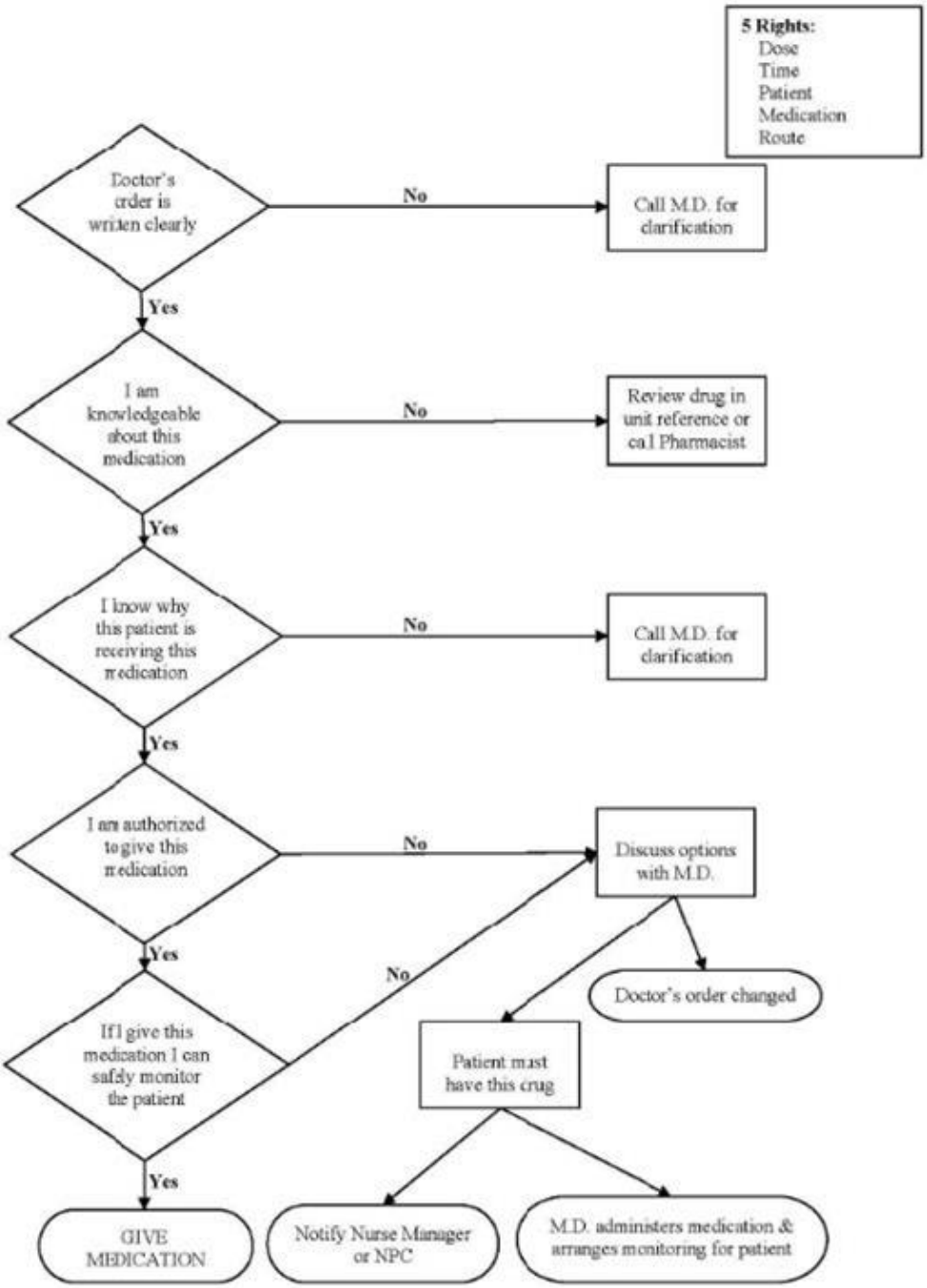
Pharmacist Availabilit—y—59 MDW no longer has on-call pharmacists, pharmacy technician support is available 24/7.

Product Selection—Pharmacy routinely changes drug strength, instructions and quantities of prescriptions without contacting the 59 MDW provider if the same dose strength (e.g., milligrams) is obtained by giving a multiple or divided portion, such as two tablets in place of a single tablet.

Attachment 2

GIVING MEDICATIONS SAFELY

Figure A2.1. Giving Medications Safely.



Attachment 3

LESSON PLAN: STERILE PRODUCT COMPOUNDING OUTSIDE LAMINAR FLOW HOODS (I.E. OUTSIDE OF PHARMACY)

A3.1. General Principles of Sterile Compounding.

A3.1.1. When an on-site, licensed pharmacy is available, only the pharmacy compounds or admixes all sterile medications, intravenous admixtures, or other drugs except in emergencies or when not feasible (for example, when the product's stability is extremely short).

A3.1.2. Staff will use safety materials and equipment while preparing hazardous medications.

A3.1.3. Staff shall use techniques to assure accuracy in medication preparation.

A3.1.4. Staff members must follow techniques to avoid contamination during medication preparation including, but not limited to the following:

A3.1.4.1. Use clean or sterile techniques.

A3.1.4.2. Maintain clean, uncluttered, and functionally separate areas for product preparation to minimize the possibility of contamination.

A3.1.4.3. Using a laminar airflow hood or other class ISO class 5 environment while preparing any IV admixture in the pharmacy, any sterile product made from nonsterile ingredients, or any sterile product that will not be used within 24 hours.

A3.1.4.4. Visually inspect the integrity of the medications for particulates, discoloration, or other loss of integrity.

A3.1.5. There is proper ventilation, lighting, and temperature control in all pharmaceutical preparation areas.

A3.1.6. When preparing IV admixtures outside the clean-air environment of a Laminar Flow Hood, all personnel will use the following procedures.

A3.1.6.1. Check all ingredients for proper dosage and incompatibilities prior to mixing.

A3.1.6.2. Check with the Ambulatory Surgery Pharmacy for all compatibility questions, especially for IV solutions and drugs given via Volu-Trol or "Y" injection site, prior to mixing or adding anything to IV or parenteral admixtures previously prepared in the pharmacy.

A3.1.6.3. Only use a designated area for IV preparation that is clear of any other items, is clearly marked, and is only used to make IVs.

A3.1.7. To aid in maintaining aseptic technique while admixing IV solutions, take the following steps:

A3.1.7.1. Clean the work area immediately prior to compounding IV in accordance with 59 MDWI 44-157, approved disinfecting agents, and keep the work area clear of patient specimens of any kind at all times.

A3.1.7.2. Wash hands with an antiseptic approved by the Infection Control Committee or in accordance with 59 MDWI 44-157, before each compounding session.

A3.1.7.3. Check all IV containers for cracks, outside moisture and visible particulate matter. Solution bottles must have a vacuum present prior to the initial injection of the drug. IV bags must be checked for leaks by gently applying pressure.

A3.1.7.4. Container drug entry ports, drug vials and ampoules will be swabbed with sterile isopropyl alcohol wipes.

A3.1.7.5. Prepare admixtures as close to their intended administration time as possible. Check prepared solutions immediately for clarity, visible particulate matter, gas release (effervescence) and color change.

A3.1.7.6. Place a "medication added" label on each admixture solution with the name and amount of the drug or drugs added, patient name and DOB, time and date of solution preparation and the initials of the person preparing the admixture. If no pre-existing pharmacy IV label is affixed to the container, label IAW this Instruction, paragraph. 2.25.4.

A3.1.7.7. Magic markers or ink pens must NOT be used to mark plastic IV bags because of the tendency of the ink to bleed through the plastic into the IV solution thereby contaminating it.

A3.1.7.8. Do not hang IV solutions (with or without drugs added) past their beyond-use time or longer than 24 hours, whichever comes first.

A3.1.7.9. Just prior to administration of the admixture, perform a last quality check to verify the physician's order for proper ingredients and amount of each drug. Visually check the solution again for clarity, precipitates, color changes, etc.

Attachment 4

LESSON PLAN: CLINIC MEDICATION MANAGEMENT

A4.1. Drug Security.

A4.1.1. Refrigerators. Check each duty day and record temperature monitoring results; maintain records for one full year. Clinic personnel are instructed to contact the pharmacy if medication refrigerator temperatures fall out of range for any period of time.

A4.1.1.1. Refrigeration for medication is maintained at a temperature between two (2) to eight (8) degrees Celsius (36 to 46 Fahrenheit). If a refrigerator does not have an alarm, then the department must check ALL refrigerators within their section and record results on a temperature control log each business day.

A4.1.1.2. For those areas that are NOT open 24 hours a day, 7 days a week, and store medication in refrigerators in their areas, ALL these refrigerators must have temperature range monitor mechanism if a unit is unable to manually conduct and record a refrigerator check after business hours. The unit must review the monitor's temperature range upon arrival after closure of the clinic (after being closed for nights, weekends, or holidays) as it is the clinic's responsibility to review and document that the temperature from the previous day and during non-duty time periods that the temperature was either in an acceptable range.

A4.1.1.3. If the refrigeration temperatures fall outside the recommended range, clinic personnel must contact facility management to correct the refrigeration problem(s) AND the pharmacy for information on whether the drugs and/or biologicals are acceptable for use. Actions taken must be documented on the temperature control log.

A4.1.1.4. If the temperature was out of range during the time the clinic was closed, they are to take the same steps as if they had found an abnormal temperature during their daily checks (use 59 MDW Form 2942). Actions taken must be documented on the temperature control log.

A4.1.2. Code Carts. Must be secured with tamper tags (breakable lock) and inspected as directed in 59 MDWI 44-142, *Wilford Hall Ambulatory Surgical Center Code Blue Management.*

A4.1.2.1. Log sheets must be identical from clinic to clinic, completely filled out with the numbers listed on the crash cart log sheet corresponding to the number on the breakaway lock.

A4.1.3. Code Cart Kits. Each kit (as discussed in 59 MDWI 44-142) must have a breakable lock with drug expiration dates stated on the outside of the container.

A4.1.3.1. Inspection is documented using the 59 MDW Form 2995, *Daily/Monthly Code Cart Checklist* with documentation, the same as if each kit were a crash cart (date and initials must be annotated on checklist).

A4.1.3.2. Report drug security violations and/or concerns to any pharmacy flight commander.

A4.2. Authorized Drug List.

A4.2.1. Only medications approved for stocking in a particular clinic, as listed on the ADL, are authorized for stock and only in the authorized quantities. All other medications must be returned to pharmacy. Pharmacy and Medical Logistics will not issue any medication that is not listed on a unit's ADL. All controlled medication shall be issued to a clinic by the pharmacy as Medical Logistics is not authorized to issue schedule II-IV medications to anyone other than the pharmacy (AFMAN 41-209, *Medical Logistics Support*) with the exception of war reserve materiel.

A4.2.2. Drug Kits. P&T Function must approve changes in medication stock (this includes the Critical Care Air Transport Team bags.

A4.2.3. Annual review of ADL by P&T Function.

A4.2.4. Pharmacy will send ADL activity list for unit review.

A4.2.5. If rarely requested, a drug should be deleted from the ADL.

A4.2.6. Concentrated KCl was removed from all clinics and will NOT be stocked on any clinic/unit.

A4.2.7. Drug samples from pharmaceutical companies are NOT authorized.

A4.3. Controlled Drug Wastage.

A4.3.1. If a controlled drug is not used, or is only partially used, the nurse or provider must immediately waste the drug and clearly document the quantity wasted (see paragraph. 4.3.4.).

A4.3.2. A second person (authorized to handle controlled drugs) must witness/annotate each destruction immediately, whether it be within an electronic dispensing system (i.e. PYXIS®) or on paper (AF Form 579).

A4.3.3. Document wastage of complete or partial doses of controlled drug.

A4.3.4. If drug was obtained using the PYXIS® system, may document using PYXIS®.

A4.3.5. If PYXIS® is not available, wastage should be documented on AF Form 579.

A4.3.6. Additionally, may document on any approved medication administration record form.

A4.3.7. Must be witnessed by person certified able to administer or destroy controlled drugs.

A4.4. STAT Orders.

A4.4.1. All STAT orders, once scanned or tubed to pharmacy, should immediately be accompanied by a telephone call to the Ambulatory Surgical pharmacy to ensure the order was received

A4.4.2. Ensure legibility. STAT orders are often received with illegible patient name and/or unit identifiers; in such instances pharmacy personnel frequently do not know where to send the medication order, therefore unnecessarily delaying patient care.

A4.5. Multiple Dose Vials.

A4.5.1. Discard multi-dose vials no more than 28 days after the initial puncture or when contamination is suspected. Label with BUD.

A4.5.2. Do not refrigerate unless indicated by manufacturer (always remember to date, time, and initial vials upon initial entry).

A4.5.3. Discard single dose vials (e.g. ampicillin 1 gram vial) after removing the first dose.

A4.6. Medication Inspections.

A4.6.1. For clinics, exam rooms, kits, trays, etc, unit staff members are responsible for regular medication inspections, ensuring items are in date, usable condition and appropriately stored.

A4.6.2. Pharmacy personnel serve as an additional set of eyes. Inspected units are evaluated on overall drug management/security monthly, using 59 MDW Form 23 *Monthly Clinic Inspection Checklist or an electronic program*.

A4.6.3. First failures of any checklist items result in a unit write-up and verbal education.
A4.6.4. Second repeat failures result in a unit write-up and letter to Squadron Commander.
A4.6.5. Third repeat failures result in a unit write-up and letter to Group Commander.