

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT HUACHUCA, ARIZONA 85613

MEDDAC MEMORANDUM
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Medical Services
MEDICATION MANAGEMENT

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*This memorandum supersedes MEDDAC Memo 40-53 dtd 22 February 2005 and
MEDDAC Memo 40-157 dtd 1 February 2005

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1. HISTORY: This issue publishes a revision of this publication

2. PURPOSE: To summarize regulatory guidelines and set forth local Pharmacy and Therapeutics Committee (P&T) approved policies and procedures for the operation of the Pharmacy Service. Contained herein are P&T approved policies and procedures governing the ordering, storing, prescribing, preparation, dispensing, and administration of pharmaceuticals throughout the U.S. Army Medical Department Activity (USA MEDDAC) and U.S. Army Dental Activity (USA DENTAC) Fort Huachuca.

3. SCOPE: This memorandum applies to all MEDDAC, DENTAC, and VETCOM, Fort Huachuca personnel involved in ordering, storing, prescribing, preparation, dispensing, or administration - or who are in anyway responsible for pharmaceuticals or pharmaceutical services.

4. REFERENCES:

4.1 AR 40-3, Medical, Dental and Veterinary Care

4.2 AR 40-7, Use of Investigational Drugs and Devices in Humans and the Use of Schedule I Controlled Drug Substances

4.3 AR 40-61, Medical Logistics Policies and Procedures.

4.4 AR 40-66, Medical Record Administration and Health Care Documentation.

4.5 AR 40-68, Clinical Quality Management

4.6 AR 190-51, Security of Unclassified Army Property (Sensitive and Nonsensitive)

4.7 Controlled Substances Act of 1970

4.8 MEDDAC Memo 15-1, Committees and Minutes

4.9 MEDDAC Memo 40-24, Emergency Response Protocol, Resuscitative Equipment and Supplies Management.

4.10 MEDDAC Memo 40-131, Management of Regulated Medical Waste (RMW)

4.11 MEDDAC Memo 40-166, Unacceptable Abbreviation and Symbol List.

4.12 MEDDAC MEMO 385-2, HAZCOM Program

4.13 Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission), Standards for Ambulatory Care manual, 2008, Medication Management (MM) chapter.

5. RESPONSIBILITIES:

5.1 The Chief, Pharmacy Service will:

5.1.1 Ensure that MEDDAC Pharmacy Service operates as described herein.

5.1.2 Conduct appropriate oversight in areas outside the pharmacy where medications are stored, reconstituted, administered, or dispensed.

5.1.3 Serve as the proponent of this policy and/or any other policies or standard operating procedures related to medication management.

5.2 The Deputy Commander for Health Services (DCHS) and Deputy Commander for Clinical Services (DCCS) will ensure that personnel assigned to their patient care areas order, store, and manage pharmaceuticals as described herein.

5.3 The Clinical Department Chiefs will ensure:

5.3.1 Appropriate health care personnel assigned to patient care areas, order, store and manage pharmaceuticals as described herein.

5.3.2 Plan, develop and implement Clinic Standard Operating Procedures (SOPs) addressing medication administration, procurement, storage and management are current and include the following:

5.3.2.1 Appropriate personnel administering medications ensure they are labeled with the following: drug name, strength, and amount and expiration date.

5.3.2.2 Guidelines are in place for prescriber notification in the event of an adverse drug reaction or medication error.

5.3.3 Appropriate health care professional and non physician healthcare providers are trained and competent to administer drugs, and before administering a medication do the following:

5.3.3.1 That medication is stable, based upon visual examination for particulates or discoloration and that the medication has not expired.

5.3.3.2 That there is no contraindication for administering the medication.

5.3.3.3 That the medication is being administered at the proper time, in the prescribed dose, and by the correct route.

5.3.3.4 That patients are advised or, if appropriate, the patient's family is advised about any potential clinically significant adverse reactions regarding a new medication.

5.3.4 That policies address monitoring of each patient's response to his or her medication according to the clinical needs of the patient and the patient's response to the prescribed medication and actual or potential medication-related problems while the patient is under the direct care of the organization.

5.3.5 The clinic has a process to respond to actual or potential adverse drug events or medication errors and that the physician or care provider that is responsible for the patient is notified and appropriate action is taken when an actual or potential adverse drug event is identified.

5.3.6 Proper storage of controlled, non-controlled, high-risk/high-alert, look-alike/sound-alike, and emergency medications

5.3.7 Red Cross Volunteers may perform duties commensurate with their individual licensing/certification and/or training.

6. CONTINUITY OF PATIENT SPECIFIC INFORMATION:

6.1 Patient Specific Information (PSI): A minimal set of patient specific information will be available each time a medication is prescribed, administered, or dispensed:

6.1.1 Age.

6.1.2 Sex.

6.1.3 Current medications.

6.1.4 Significant diagnoses and co-morbidities

6.1.5 Laboratory values that are relevant

6.1.6 Allergies and past sensitivities

6.1.7 Lactation status, pregnancy status, weight/height or any other information as applicable

6.2 Valid sources of patient specific information:

6.2.1 Where the electronic or hard copy medical record is available, clinical staff involved in a given medication action will review the summary list and clinic note for the visit at each site of prescription, administration, or dispensing, as required. The documentation of prescriptions in the patient's medical/dental record will be accomplished IAW AR 40-66. Medications prescribed for outpatients will be reflected in the patient's current medication list as displayed on the EMR (AHLTA) note (See Health History, Med Rx Tab in AHLTA or automatic medication list display on active electronic SF 600-clinic note).

6.2.2 CHCS/AHLTA generally contain most pertinent patient specific information and may be consulted as a cross-reference for Patient Specific Information (PSI) See appendix M for a complete reference of lists for PSI.

6.3 Transmission of pertinent clinical information to the pharmacist:

6.3.1 The hard copy medical record does not generally accompany the patient to the dispensing window of the main or refill pharmacies. Therefore, whenever possible for significant diagnoses or for diagnoses where a given medication can be used for more than one indication, the LIP will place the diagnosis or symptom for which a given medication is prescribed in the CHCS/AHLTA sig or comment field for medications.

6.3.2 When additional clinical information is required by a pharmacist to ensure further understanding, a copy of the summary list and/or clinic note may be handed to the patient to be given to the pharmacist.

6.3.3 The pharmacist will ask the patient at the dispensing window details that are not clear from the aforementioned sources.

7. SELECTION AND PROCUREMENT:

7.1 The Pharmacy and Therapeutics Committee (P&T), determines the criteria for what medications are selected, listed, and procured IAW AR 40-3, Medical, Dental and Veterinary Care. The charter for this committee is located in MEDDAC Memo 15-1, Committees and Minutes. This committee will review medication lists on an annual basis.

7.2 The criteria used for selection and procurement include indication for use, effectiveness, costs, and risks, including propensity for medication errors, abuse potential, and sentinel events.

7.2.1 Requests for the addition of a drug to the formulary will be submitted on DD Form 2081, New Drug Request, through the department chief, to the Chief, Pharmacy Service for review by the Pharmacy and Therapeutics (P&T) Committee.

7.2.2 Each new drug request will be submitted with the following supporting data: medication use evaluation (MUE) criteria; a recommended deletion(s) from the formulary to cover the estimated cost of the requested drug or show institutional cost savings resulting from the addition of the requested drug (decreased drug use, decreased laboratory and/or radiological studies, or other decreased consumption of MTF resources; documentation (i.e. published clinical studies) supporting significant medical benefit of the new agent over current formulary agents.

7.2.3 The P&T Committee will review each new drug request and determine if it is warranted. If the supporting requirements are not correct, the request will be returned to the submitting prescriber for completion without consideration.

7.2.4 The physician or his/her representative requesting the new drug may be present at the P&T Committee meeting to discuss the rationale for the new drug request, if possible.

7.2.5 Drugs recommended for deletion will be presented to the P&T Committee. These drugs will remain on the formulary until the next P&T Committee meeting. Representatives will be responsible for soliciting input from his/her service/department to evaluate the suggested deletion. The P&T Committee will consider the service/department response(s) in making its recommendation to delete, as planned, or retain on the formulary. In the absence of arguments for retaining the drug as a formulary item, the drug will be deleted.

7.3 MTF Formulary: The formulary, which provides current list of medications, is available through a link on the RWBAHC intranet.

7.4 The Medication Use and Evaluation Committee (MUE) is the organization's vehicle for conducting an annual medication class review to check for emerging safety and efficacy information. The charter for this committee is located in MEDDAC Memo 15-1, Committees Management.

7.5 Non-formulary medication: LIPs in the organization use a special drug request, RWBAHC Form 474, to obtain medications that are not on the formulary. Non-formulary drugs requiring Medical Necessity/Prior Authorization will be accompanied by the appropriate DoD MN/PA form. A MTF Prescriber requesting a drug as a purchase for a specific patient will submit the request on RWBAHC Form 474 to the Chief, Pharmacy Service for review. The Chief, Pharmacy Service may approve the purchase at that level if deemed appropriate or send to the Clinic Chief or to the DCCS. The DCCS may approve the request at this level or he may send to the MEDDAC Commander for approval/disapproval. The purchase of non-formulary drugs will be limited to medical necessities for MTF patients for which no suitable formulary substitute exists. The MTF LIP must justify the reason(s) why a formulary drug with similar therapeutic qualities will

not be appropriate for the patient. As a minimum, the requesting physician will address therapeutic efficacy, side effect profile, and cost of the non-formulary drug compared to formulary drugs. Total usage of special drugs will be forwarded to the P&T Committee for final review.

7.6 Medication shortages and outages. Notification to LIPs and staff occurs from the Chief of Pharmacy or his/her designated representative via e-mail and the *Pharmacy OneSource* link. In the event of a long term shortage, protocols designed by an ad-hoc Pharmacy & Therapeutics Committee will be implemented and communicated to LIPs and appropriate clinical staff via e-mail and the *Pharmacy OneSource* link. In the event of a disaster, obtaining medications happens via coordination with allied medical treatment facilities and is rehearsed annually IAW with the organization's Emergency Management Plan (EMP).

7.7 Emergency Procurement of Drugs: When it is necessary to procure a drug on an emergency basis that is otherwise unavailable from standard sources, procurement will be attempted in the following order: (1) Prime Vendor/Alternate Prime Vendor/Manufacturer emergency order; (2) Local hospitals/Pharmacies; (3) U.S. Army or U.S. Air Force (USAF) clinics in the immediate area; and (4) DPSC Depot on 03 priority supply requests.

7.8 Use of Medication Samples: Distribution and/or storage of medication samples at MEDDAC facilities is prohibited and samples will not be used to treat MEDDAC patients.

8. STORAGE AND SECURITY:

8.1 Inspection and oversight of areas where medications are stored: Individual clinic personnel are responsible for daily oversight of medication storage areas, including stock levels and expiration dates. Pharmacy personnel will perform periodic physical inspection of all drug storage areas; Logistics Division drug storage areas, where medications are stored prior to administration or dispensing, are not included. All clinics will maintain medications IAW their clinic stockage lists. A record of all medication related inspections is maintained in the Pharmacy. Records of the inspections are maintained by the Pharmacy NCOIC. Discrepancies will be reported to the Chief, Pharmacy and Clinic Department NCO responsible for the correction. The Chief of Pharmacy reports the discrepancy(s) to the Deputy Commander for Health Services for the MEDDAC or to the Commander of the USA DENTAC, as appropriate.

8.2 Approved formulary or special purchase medications destined for outpatient use or clinic stock are stocked as required.

8.3 Medications are safely stored under conditions delineated by the manufacturer recommendations.

8.4 Security.

8.4.1 The Main Pharmacy and PX Refill Pharmacy have an access roster that controls entry into both pharmacies to designated personnel. The door to the main pharmacy is keyed and coded, the door to the PX pharmacy is keyed, and both pharmacies are alarmed. Those not on the access roster must be escorted across this entry point to the areas of medication storage.

8.4.2 Weekend/Holiday Access Clinic (WHAC) stock: The WHAC, located in room J-24 has a key controlled medication room where medications are dispensed, administered, stored, and occasionally reconstituted. Medications are dispensed from the PickPoint automated dispensing machine. Only a designated registered nurse has a key to the room and only pharmacy personnel have a key to the PickPoint machine. Only registered nurses and LIPs may enter the medication storage room. Exceptions are: designated pharmacy personnel for restock and maintenance purposes. Such personnel will be accompanied by a RN during the inspection or inventory process.

8.4.3 Other clinic stock areas: Clinic stocks of secure medications are also located at the Department of Family Care Clinics A and B, Military Medicine Clinic, Military Intelligence Student Clinic (MISC), Immunization Clinic, Optometry Clinic, Internal Medicine Clinic, General Surgery, Physical Therapy, Orthopedic Clinic, the Anesthesia Workroom, and the Post Anesthesia Recovery Room (PACU). Access to locked cabinets is restricted to designated registered nurses, LPNs, LIPs, and designated pharmacy personnel (See Appendix A, Dispensing of Outpatient Medications from the WHAC.)

8.4.4 Clinic medication dispensing machines (Pick Points): Pick Points are double locked and may not be accessed by anyone other than pharmacy personnel. The pharmacy technician who stocks the PickPoints has a key to these machines. The Pharmacy NCOIC is the responsible party for Key Control.

8.5 Storage and security of controlled substances: The organization's procedures regarding the storage of controlled substances are covered in MEDDAC Memo 40-52. This policy defines the necessary safeguards in place to prevent diversion.

8.6 Collection and segregation of contaminated, damaged, and expired medications: Until they can be properly turned in, these medications are to be segregated from other medications in specially-labeled blue bins in the rear of the Pharmacy.

8.7 Segregation of "look alike/sound alike" medications: Medications (for example, Zyrtec and Zantac) that have been identified to be problematic are identified, are marked with a shelf tag and/or identified with a special comment in CHCS under the drug's name. Drugs must be physically segregated from other medications by relocation to a special shelf. Special "look-alike-sound alike" labels are also utilized for additional identification.

8.8 Medications and chemicals used to prepare medications are stored in a designated compounding area. Each container is labeled with its native commercial label, which includes contents, expiration dates, and appropriate warnings. Material Safety Data Sheets (MSDS) are also readily available on site and on the internet.

8.9 Management of medications brought into the organization by patients, their families, or practitioners: The facility does not administer or dispense medications brought into the organization by patients, their families, or practitioners from outside the facility.

9. STANDARDIZATION AND LIMITATION OF NUMBER AND CONCENTRATION OF MEDICATIONS:

9.1 The Pharmacy and patient care areas appropriately limit the number of available medications while ensuring that patient care needs are met. The amount and location of medications maintained as clinic stock requires P&T committee approval.

9.2 Concentrated electrolyte solutions and other high concentration medications: Concentrated electrolytes are not available as clinic stock. The Pharmacy maintains a limited quantity of these for use for Emergency Drug Boxes and the crash cart.

10. EMERGENCY MEDICATIONS:

10.1 Appropriate organizational leaders and health care professionals have defined what emergency medications and supplies are available in which patient care areas.

10.2 All emergency medications are available as ready-to-administer, age-specific, and unit-dose forms where possible (see stocking list for crash carts in MEDDAC Memo, 40-24, Emergency Response And Patient Transfer Protocol).

10.3 The next medication for outdate is listed on the outside of the crash carts, Hypothermic Cart, ANA Kits and emergency response boxes, so that the staff can readily determine that the contents are complete and that they are not expired. Each area will have a contents/list available in a book with a contents list on file.

10.4 After opening a crash cart, the OIC/NCOIC of the patient care area will notify the designated Pharmacy point of contact and CMS, who replaces the used item stock as soon as possible after use.

10.5 Details of the organization's procedures regarding emergency medications are covered in MEDDAC Memorandum 40-24.

11. ORDERING AND TRANSCRIBING:

11.1 The following are means of valid mechanisms for writing a medication order:

11.1.1 CHCS/AHLTA order entry fields – the preferred mechanism

11.1.2 Handwritten prescription pads (DD Form 1289) - as a back-up to CHCS, when non-formulary medications are ordered or from non-MTF LIPs who do not have access to CHCS. Prescription Pads (DD Form 1289) are controlled by pharmacy through the pharmacy narcotic vault technician.

11.1.3 SF 600 clinic encounter - for administration of medications in the clinic only.

11.1.4 Transmission via FAX machine from non-MTF LIPs.

11.1.5 Transmission via FAX or hard copy brought in by patient with an encoded prescriber signature from a Personal Digital Assistant(PDA).

11.1.6 Stamped prescriptions are discouraged but will be accepted if verified via the prescribing office.

11.1.7 Verbal Orders: Medications will not be dispensed to an outpatient without receipt of a properly written and authenticated prescription, unless a true emergency exists. In cases where a true emergency exists, the pharmacist or nurse may take the order over the telephone. The nurse will immediately reduce the verbal order to writing on a prescription blank or SF 600 and repeat the order back to the person originating the order for clarification, demonstration mandatory verbal order read-back in accordance with the National Patient Safety Goal Standards.

11.2 The minimum required elements of a medication order are the same regardless of whether CHCS or handwritten orders are used. The minimum required elements of a medication order are the following:

11.2.1 The first and last name of the patient.

11.2.2 The address and/or telephone number of the patient.

11.2.3 The prescriber's clinic or service.

11.2.4 The date the prescription was written.

11.2.5 The name, strength, quantity, directions for use, and clinical indication for use.

11.2.6 The prescriber's name, signature, name/address of the medical treatment facility where the prescription is written, and, if military, social security number, license type, i.e. DDS, MD, NP, etc., grade and branch of service. For off-site LIPs, a DEA number must be recorded IAW Controlled Substances Act 1970.

11.2.6.1 Authorized Prescriber Verification: Patient drug orders will only be accepted from persons authorized to write prescriptions as specified in AR 40-3 and AR 40-48. A P&T approved prescribing list for all non-physician prescribers (NPPs) will be established. Signature cards of MTF prescribers, with SSNs, will be kept on file in the pharmacy for authentication of prescriptions.

11.2.6.2 Prescriptions from LIPs unknown at this facility will be verified by the following procedures: If a written prescription is received for filling by an unknown prescriber, it is necessary to validate the prescriber information prior to entering it into CHCS. This may be accomplished by one of four procedures: (1) Call the physician's office; (2) Call the credentialing office of the hospital or sponsoring organization of the prescriber; (3) Call the licensing agency in the state where the prescriber practices; or (4) Access a DEA database on the internet.

11.2.7 The indication for use as part of the medication order is used whenever clinical indication for use is required.

11.2.8 RWBAHC clinical staff will ensure the use of a process for comparing a patient's current medications (to include, but not limited to, prescription, over-the-counter, herbs, and vitamins) with those ordered for the patient during a clinic visit/scheduled appointment with a provider. RWBAHC clinical staff will use a standardized Medication Record Card during reconciliation to ensure that patients are directly involved in maintaining an accurate medication list. Although clinic staff (e.g. clerks, medics, nurses) may participate in the medication reconciliation process, ultimate responsibility for ensuring a reconciled list of medications during a patient appointment rests with the LIP. Patients' accurate medication reconciliation list is communicated to the next provider of service through one of two mechanisms. The Electronic Medical Record (EMR) will reflect the patient's current medications, and will be used by future RWBAHC providers to complete subsequent reconciliations.

Additionally, all patients will be provided with a Medication Record Card and encouraged to maintain an accurate list of their medications on it. Patients will also be encouraged to bring this card to all clinic visits (both internal to RWBAHC and external to Tricare Network appointments). For patients who do not have a card on arrival for their appointment, front desk or clinic personnel will ask them to complete a new card. Many patients are referred for civilian network care and do not know which provider/consultant they will see. Thus, RWBAHC providers will use the Medication Record pocket card to ensure an accurate list is provided to the patient to be shared with the consulted network provider. For a schematic example of the Medication Reconciliation Process, see Appendix K.

11.3 Generic Medication Policy: A policy of generic substitution will be in effect for all drug orders written by MEDDAC/DENTAC prescribers. Prescriptions for multi-source drugs from civilian prescribers marked "do not substitute" or Dispense As Written (DAW) may be returned unfilled to the patient. At the discretion of the pharmacist, the prescriber may be contacted to authorize generic substitution. If so, the name of the individual granting authorization will be annotated on the prescription. The P&T Committee may also authorize the substitution of therapeutically equivalent products by the Pharmacy Service without further permission from the U.S. Government employed prescriber.

11.4 Look-alike or sound-alike drugs. For drugs identified as being problematic, pharmacy personnel will insert a comment that shows up automatically when the LIP enters the order entry data fields for all medications listed on the RWBAHC look-alike, sound-alike list. These comments give the LIP a warning that the drug chosen may be confused with another drug. The Pharmacy Service receives notice of look-alike, sound alike drugs from the USP, Facts and Comparisons, and Formulary OneSource as an additional source of information to further eliminate confusion for look-alike sound alike medications. These alerts are sent to the appropriate RWBAHC/Medical Staff via email, through Medical Staff meetings, and are also available on the RWBAHC formulary link on the intranet.

11.5 Actions taken with incomplete, unclear, or illegible orders: If an order is encountered that is incomplete, unclear, or illegible, a pharmacist will contact the ordering LIP by phone, fax, or in person to establish the correctness of the order. Prescriptions with any question of correctness would not be filled until they are clarified with the prescriber.

11.6 Do not use abbreviations: Monthly monitoring of handwritten prescriptions containing Do Not Use Abbreviations is ongoing. Prescriptions containing these unauthorized abbreviations will be filled after clarification. Providers continuing to violate the UA policy will be notified. This applies to prescriptions written within or outside of RWBAHC. A complete list of Unacceptable Abbreviations, Acronyms, and Symbols List may be found at Appendix D.

11.7 As needed orders:

11.7.1 Medication dispensing: If an LIP prescribes an “as needed”, or “PRN”, order, a dose range (e.g 2-4 mg or 1-2 tabs) may be included with the order. Specific instructions for frequency of administration (e.g. give 2 mg po q4 h prn pain) and clinical indication (e.g. pain, headache, fever, etc.) will also be included.

11.7.2 Medication administration: With the exception of the Department of Anesthesia Perioperative Surgery (DAPS) and the endoscopy suite, “PRN” medication orders for administration are not used.

11.8 Standing, hold, automatic stop, resume, titrating, and taper: These orders are not authorized. The DAPS does not utilize preprinted order sheets from the certified registered nurse anesthetist (CRNA). However, the CRNA may write 'range' orders for pain (i.e., morphine 2-4 mg IV for a total of 10 mg, titrated every 5-10 minutes as needed for pain greater than 5/10.)

11.9 Compounded drugs and drug mixtures not commercially available: If the Pharmacy stocks the ingredients, they will compound whenever possible.

11.10 Medication-related devices: Except for aerochambers with or without masks, pill splitters, and insulin administration devices, the organization does not dispense medication related devices or use these devices in patient care areas for medication administration.

11.11 Use of investigational drugs: At this time the organization does not dispense or administer investigational medications. If a need arises for such use, AR 40-7 will be followed and Pharmacy Service will be the custodian of such investigational drugs.

11.12 Herbal products: At this time the organization does not stock, dispense, or administer herbal products. Patients are to be asked if they are taking any herbal or natural products and if so, they will be added to the patient’s CHCS profile for reference, even though they are not dispensed at this facility.

11.13 “Orders” for medications from the Department of Anesthesia Perioperative Service (DAPS). All such medications are dispensed using the same procedures employed for the dispensing of medications from other patient care areas. All medications and solutions will be labeled on and off the surgical field to include all bottles, syringes, aseptos, and basins. Medications names will be written out completely ensuring the use of a leading zero for those medications that are less than 1 percent of a solution. For example, 0.5% Marcaine with Epinephrine (1:200,000). (See Appendix L)

11.14 Blanket reinstatement of previously-written orders: The organization does not allow the blanket reinstatement of previously-written orders. Orders for all medications must be re-written if the patient is transferred from one patient care area to another.

12. PREPARATION AND DISPENSING

12.1 Review of the order:

12.1.1 Responsibility for review: A pharmacist and/or LIP reviews all prescriptions orders prior to dispensing. At the Weekend and Holiday Access Clinic, the PICK POINT machines, and in clinical areas where medications are administered, an LIP controls the preparation, administration, and dispensing of medications, when on-site pharmacy support is not provided.

12.2.1 Content of a review: When a prescription is written, a pharmacist or LIP reviews all orders for appropriateness of the drug, its dose, its frequency, its route of administration; contraindications with a patient's medical profile or co-morbid conditions; variation from the organizational criteria for use; and other relevant medication-related issues and concerns. IVP contrast agents are considered medications and orders for contrast agents are reviewed and authorized by a pharmacist prior to schedule of procedure. Pharmacists complete the medication reconciliation process for patients who are scheduled to have IV Contrast procedures performed. This is communicated directly to the Radiology staff and documented on the IV Contrast Administration Consent Form. The radiologist reviews this form and makes final decision on appropriateness of use of IV contrast prior to the procedure.

12.2.2 The pharmacist or LIP reviews all prescription orders by automatically applying a real-time scan against the PDTS database that integrates all Tricare approved pharmacies, which includes all MTF, network, and the national Tricare Mail Order Pharmacy (TMOP). This database provides real time information about therapeutic duplications; real or potential interactions between the prescription and other medications; and real or potential allergies and sensitivities and also assist LIPs in reconciliation of medications obtained from network pharmacies.

12.2.3 The pharmacist or LIP also reviews the orders for real or potential interactions with food and laboratory values. A pharmacist, in the role of patient educator, will counsel the patient using patient education monographs or RWBAHC Handout 330 (Appendix M) and provide the patient with one of these Drug-Food Interaction Handouts.

12.2.4 Patient concerns, issues, or questions are clarified and resolved with the dispenser before medications are dispensed.

12.3 Safe preparation of medications:

12.3.1 At the main health center during standard operating hours, qualified pharmacists and pharmacy staff prepare all medications in the Main Pharmacy. Parenteral orders which require the addition of one or more drugs to the basic solution will be compounded in the intravenous (IV) room under the supervision of a Pharmacist for all clinical areas.

12.3.2 In the Weekend/Holiday Access Clinic or out side the main health center, registered nurses under the direct supervision of LIPs are allowed to prepare commonly dispensed oral medication such as pediatric antibiotics, injectable steroids, and certain IV solution additives IAW Appendix E, Preparation of Parental Admixtures by Nurses. Whenever concerns arise, Pharmacy personnel may be contacted after hours and from outside the main health center by contacting the AOD, who will contact the “on-call” Pharmacy personnel.

12.3.3 Preparation of hazardous medications. Preparation of hazardous meds for injecting is not currently done. The facility maintains a hazardous drug list and has specific procedures in place to address their storage and use.

12.3.4 Preparation accuracy in the Main Pharmacy: For reconstituted oral antibiotics, the pharmacy uses a bar code driven reconstituting device to automatically and accurately prepare.

12.3.5 Aseptic techniques for preparation in the main pharmacy: Details concerning the standard procedures for aseptic medication preparation will be added in detail in each clinic’s medication SOP. (See Appendix F, SOP for the Preparation of Medications in the Sterile Products Area (IV Room.) How these procedures meet the intent of regulatory standards is covered below.

12.3.6 Training: A designated pharmacy staff instructs other pharmacy staff in aseptic technique and manipulation of items used in the preparation of IV admixtures and other prepared medication.

12.3.7 Where aseptic medication preparation occurs: The designated area, currently in room 102-22, for product preparation is clean, uncluttered, and functionally separate to minimize the possibility of contamination.

12.3.8 Use of a laminar flow hood: A barrier isolator is used while preparing any intravenous admixture, any sterile product made from nonsterile ingredients, or any sterile product that will not be used within 24 hours.

12.3.9 The preparer, dispenser, or administrator of prepared medications conduct a visual inspection of these products for integrity prior to dispensing or administration.

12.4. Labeling of medication

12.4.1 Standardization: The organization uses as standardized labeling criteria and procedures using CHCS.

12.4.2 Medications prepared prior to administration or dispensing: The main pharmacy pre-packs oral medications prior to dispensing to service the main pharmacy, the Pick Point machines, and the Weekend and Holiday Access Clinic. The pre-packs are appropriately labeled as defined in 12.4.3. Items dispensed as over-the-counter products will bear no label other than that of the manufacturer unless the prescriber changes the directions.

12.4.3 Label content: Dispensing: Medications dispensed throughout the organization are labeled to identify patient name, medication name, strength, quantity, and expiration date when not dispensed within 24 hours of the order.

12.4.3.1 Administration: Medications are administered as soon as possible after their preparation. The organization does occasionally administer medications later than 24 hours, but not to exceed 48 hours, or whatever the stability is according to the manufacturer and/or sterile products compounding literature beyond their intended use. Therefore they are labeled with expiration or "beyond use" dates. For IV admixtures the preparation date and diluent are included.

12.4.3.2 The perioperative area is the only location that requires Pharmacy-prepared medications for multiple patients. The labels of these medications, in addition to the information listed above, includes the location of the patient, directions for use (including route and storage information), and applicable cautionary statements.

12.5 Dispensing:

12.5.1 Quantities of dispensed medications do not exceed 90 days for non-controlled substances and 30 days for controlled substances. Exceptions include ADHD medications, 60 days each, and phenobarbital, and clonazepam, which are 90 days each. Soldiers preparing for long deployments may be dispensed up to 180 days of most medications, if reasonable and safe, and ordered by an LIP during the Soldier's predeployment medical evaluation process.

12.5.2 Dispensing procedures adhere to applicable law, regulation, licensure, and professional standards of practice.

12.5.3 Dispensing in a timely fashion:

12.5.3.1 New medications: New medications are filled at the time of dispensing in most cases. Exceptions to this would be if a drug is temporarily out of stock, then it would be filled when the medication arrives.

12.5.3.2 Refill medications: Refill medications are usually filled at the time of request but are dispensed within 48 hours of filling. Medications not dispensed within 7 days of filling are returned to stock, and the order is marked with an asterisk thereby denoting that the medication was not received by the patient. LIPs also receive a notification through CHCS of patient “nonadherence”.

12.5.3.3 Medications are dispensed in the most ready-to-administer form available. Some medications are re-packaged by qualified pharmacy staff or a licensed repackager. Some medications may require tablet spitting, in which case patients are provided with a tablet spitting device, and are given specific one-on-one education on dosage and on how to split tablets with written assistance available. This guidance is also on our website as a formulary link.

13. ACCESS TO MEDICATIONS WHEN THE PHARMACY IS CLOSED. The Weekend and Holiday Access Clinic (WHAC), the Military Medicine Clinic, and the Military Intelligence Student Clinic (MISC) have the capability to dispense medications to patients when the main pharmacy is closed. The pharmacy is opened Monday-Friday, 0730-1700 (except Thursday 0800-1700). Medications not stocked at these locations are available from local network pharmacies or in special circumstances from the main pharmacy, which can be opened by the pharmacist staff member who can be accessed via the Pharmacy Call Roster through the NCOIC/pharmacy schedule.

14. RECALL OR DISCONTINUATION PROCEDURES: Drug Recall Procedures are outlined in Appendix C, Drug Recall & Defective Medical Materiel Reporting Procedures.

15. MANAGEMENT OF RETURNED MEDICATIONS

15.1 Medications nearing expiration or medications that have expired: Clinic stocks will be rotated to minimize loss through expiration. Efforts will be made to return near-dated items to the Pharmacy Service soon enough so that they may be utilized in other areas. In general, medications within 30 days of expiration are returned to the Pharmacy, accounted for, and held by segregating them in the appropriately named blue container by dosage form, until they can be processed by RWBAHC Pharmacy personnel to be forwarded and processed by the reverse distributor. When a medication is turned in, a pharmacist in the Main Pharmacy has the option to dispense the medication to be used up to the date of expiration.

15.2 Unused medications: Only the Main Pharmacy will accept unused medications. These medications are held in a designated container that is segregated from the medications in the Pharmacy, until it is disposed of using the same procedures as other hazardous waste IAW MEDDAC Memo 385-2, HAZCOM Program. The bottle with the patient specific information on the label is disposed of in a HIPAA compliant manner.

15.3 Turn-in of Controlled Substances: Procedure can be found in the Controlled Substances Policy, MEDDAC Memo 40-52.

15.3.1. The Pharmacy Service and Materials Branch are the only activities authorized to accomplish destruction of controlled substances stocks IAW AR 40-61 and AR 40-3. The Chief, Material Branch may destroy controlled substances when authorized by supply messages directing such action. Destruction must be done IAW AR 40-61 and documented.

15.3.2 Outdated, deteriorated, or excess stocks of controlled substances will be turned-in to the Pharmacy Service on DD Form 1289. This form will be prepared in duplicate by the activity returning controlled substances. The Pharmacy Service will acknowledge receipt of the turn-in by issuing a document number obtained from the Pharmacy Inventory Specialist and by logging the quantity received into the appropriate CHCS controlled drug file. One copy of the turn-in document, with assigned document number, will be returned to the activity and be retained with the controlled substances register as evidence of the turn-in. Activities accounting for controlled substances on DA Form 3349-1 will also have this form annotated by the Pharmacy Service evidencing the turn-in. A copy will be maintained with other receiving documents in the vault records.

15.3.3 The Pharmacy Service will log returned patient prescriptions in the appropriate CHCS controlled drug file. The prescription number on the returned vial and the patient name will be included in the entry.

15.3.4 Return of controlled substances to Material Branch may be done only by units authorized to do business with Material Branch IAW AR 40-61.

15.3.5 Controlled substances that are provided for use by patients being air evacuated must be ordered and accounted for in the same manner as controls that are issued at the clinics. Upon reaching destination, the accountable person will turn-in excess controlled substances to the receiving facility and obtain proper receipt forms (DD Form 1150 or DA Form 3161--both are Request for Issue or Turn-In). Alternatively, the person may keep the controlled substance and DA Form 3949-1 and return these to the Pharmacy Service upon their return to the MEDDAC. All documents obtained from a turn-in at another facility will be turned over to the Pharmacy Service upon return of the accountable person.

15.3.6 Return of Controlled Substances: Controlled substances on hand at the Pharmacy Service that are expired, contaminated or have deteriorated to a point where they are unsuitable for use, will be turned-in to DoD contract return company for possible credit. A copy of the DA Form 3161, Request for Issue or Turn-In, will be appropriately signed, witnessed as required by AR 40-61, assigned a document number, appropriate information entered into the proper CHCS controlled drug file, and the copy will be retained with vault records as evidence of the turn-in.

15.4 Reverse Distributor Involvement and Oversight: One specific reverse distributorship is selected for the return of all expired/returned medications. This contract is reviewed annually each fiscal year and either renewed or an alternate vendor is selected. In addition, designated pharmacy personnel periodically audit the returned stock for accuracy and to prevent diversion, as well as maintain records of the quantities turned in to the current reverse distributor vendor.

16. ADMINISTRATION :

16.1. Who may administer: Only LIPs with specific privileges to do so or RNs, LVNs, LPNs, who have demonstrated the competence to do so, may administer medications. The initial and annual competency based orientation, which is located in each staff member's Competency Assessment Folder, is the mechanism the organization uses to demonstrate competence.

16.2 Administration:

16.2.1 Procedures that occur before administration: The nurse will verify the following: first verify the right patient using the full name and date of birth, then verify that the medication selected for administration is correct based upon the written medication order and product label; that the medication is stable based on visual examination for particulates or discoloration and that the medication is not expired; that there is no contraindication to administration; that the medication is being administered at the proper time, in the correct dose, and by the appropriate route. The nurse will advise the patient, or if appropriate, the patient's family about any potential clinically significant adverse reaction or other concerns about administering a new medication. The nurse will discuss any unresolved significant concerns about the medication with the physician or prescriber, if different from the physician, or relevant staff involved with the patient's care, treatment, or services.

16.2.2 Special considerations for administration in the Internal Medicine Clinic, the Occupational Medicine Clinic, and in Diagnostic Imaging, where medications or contrast agents are sometimes administered in conjunction with diagnostic tests, the LIP who has clinical oversight of that particular section must review the patient's medical condition and medication regimen to ensure that they can be safely administered (e.g. administration of IVP contrast during an IVP or albuterol during a PFT). This same LIP is also responsible for responding promptly to any acute adverse events associated with the administration of these medications.

17. MONITORING:

17.1 Administration: All patients who have received medications administered in a patient care area are observed for at least 20 minutes for clinical response or adverse drug reaction. A reassessment is done at 20 minutes by the LIP, LVN/LPN, or RN nurse who documents patient's perception about side effects or efficacy, relevant laboratory results, clinical response, or medication profile in the medical record. Patients with no evidence of an adverse drug reaction e.g redness, rash, or shortness of breath are released. If there is evidence of an adverse drug reaction, the clinical support staff will notify the prescriber immediately. Patients who experience an acute drug reaction at home will notify the prescriber through the usual access procedures. If the patient notifies a pharmacist rather than the prescriber, then the pharmacist will contact the LIP so that appropriate follow-up may be arranged.

17.2 Dispensing: RWBAHC is responsible for monitoring the first dose of medications dispensed within the organization. To monitor the effects of dispensed medication, including first-dose, the LIP's treatment plan will include patient and family education to follow-up for evidence of efficacy, as well as any evidence of an adverse drug reaction (ADR). In select cases the pharmacist will personally monitor patients for efficacy and side effects. This is done via personal and/or phone interview.

17.3 Adverse Drug Reactions (ADRs):

17.3.1 When a pharmacist or physician receives information indicative of a potential or real ADR, then a DA 4106 is generated by clinic that receives the information and submitted to the Risk Manager directly or via Pharmacy. They are then given to the ADR pharmacist, who aggregates them into MedMarx.

17.3.2 Aggregated data regarding ADRs are presented in a variety of forums, including the Risk Management Committee, the Executive Committee of the Professional Staff (ECOPS), the Medical Staff Committee, and the MUE Committee.

17.3.3 In order to increase the rate of reporting, the pharmacist reviews a representative sample of records from various services, looking for evidence of ADRs. These reviews provide an opportunity to educate LIPs about ADR reporting procedures and add to the quality of collected ADR data.

17.3.4 The MUE Committee monitors selected drugs for utilization, cost, efficacy, and safety. Typically high-risk, high-cost, high-volume medications are selected for focused monitoring.

17.3.5 External reporting of ADRs: The organization reports all potential or real ADRs to the appropriate agencies.

17.4 Medication errors, including prescribing, administration, and dispensing errors: Effective 1 Mar 04, the governing body (MEDCOM) directed our organization to use a contracted commercial database, the MedMarx error reporting database.

18. HIGH RISK/ HIGH ALERT (HR/HA) MEDICATIONS:

18.1 The organization uses the Institution for Safe Medication Practices (ISMP) list of high alert medications as a guideline for our facility's list. Using internal ADR, medication error, and sentinel event data, certain additional medications may be added to generate an MTF specific list, which is approved by the MUE Committee and reported to the P&T Committee. This list is updated when necessary. The current MTF specific list is available on the Formulary One Source database. The web site for the ISMP list is www.ismp.org.MSAarticles/highalert.htm (see also Appendix G-High Alert Medications

18.2 As appropriate to the services provided, the organization develops processes for procuring, storing, ordering, transcribing, preparing, dispensing, administering, and/or monitoring HR/HA medications.

18.2.1 Procuring: This organization procures HR/HA medications according to manufacturer or legal specifications or requirements.

18.2.2 Storing: All HR/HA medications are identified with a high risk label.

18.3.3 Ordering: The pharmacist or pharmacy technician puts special comment lines in CHCS to notify an LIP that the medication being ordered is HR/HA.

18.3.4 Transcribing: The organization does not transcribe HR/HA orders.

18.3.5 Preparing: HR/HA medications are prepared separately when indicated by the manufacturer or regulatory guidance.

18.3.6 Dispensing: HR/HA medications are dispensed separately when indicated e.g. narcotics.

18.3.7 Administration: HR/HA medications are administered in accordance with manufacturer guidance.

18.3.8 Monitoring: Select high risk medications are monitored by the MUE Committee or special programs e.g. Sole Provider Program when warranted.

18.4 The organization does not procure, stock, prescribe, dispense, or administer investigational drugs at this time.

19. EVALUATION:

19.1 The organization's evaluating body for medication management is the MUE Committee.

19.2 The evaluation process focuses on potential patient safety risk points, messages from the governing body and/or local literature sources. The Committee aggregates this data and recommends interventions to optimize safe medication management practices. The reporting format for MUE is the minutes of the P&T Committee.

The proponent of this memorandum is the Pharmacy Service. Users are invited to send comments on DA Form 2028(Recommended Changes to Publications and Blank Forms) directly to the Commander, USA MEDDAC, ATTN: MCXJ-RX, Fort Huachuca, AZ 85613-7079.

FOR THE COMMANDER:

OFFICIAL:

GREGORY A. SWANSON
Deputy Commander
for Administration

Robert D. Lake
Information Management Officer

DISTRIBUTION: E

APPENDIX A
**DISPENSING OF OUTPATIENT MEDICATIONS
FROM THE Weekend/Holiday After Hours Clinic (WHAC)**

1. **PURPOSE:** To establish guidelines for the dispensing of outpatient medications from MEDDAC Clinics.
2. **SCOPE:** This appendix applies to all personnel assigned to or working in MEDDAC clinics dispensing from the Medical Officer Drug (MOD) Cabinet.
3. **REFERENCE:** AR 40-3, Medical, Dental, and Veterinary Care.
4. **POLICIES:**
 - a. **General:**
 - (1) Only authorized prescribers may dispense medication from the clinics. The prescriber will check the medication and label and provide the patient with all required counseling. By Federal Law and Army Regulation 40-3, these dispensing functions cannot be delegated/relegated to a non-prescriber
 - (2) Only those drugs recommended by the Pharmacy and Therapeutics Committee (P&T) and approved by the Commander, USA MEDDAC, will be dispensed from the clinics.
 - (3) Drugs will be dispensed only to those patients evaluated by an authorized MEDDAC prescriber in the clinic or by the Dentist on-call.
 - (4) The Pharmacy Service has personnel on-call to procure medications not stocked in the clinic for necessary patient treatment.
 - b. **Authorization to Dispense:** In the clinics, the completed Standard Form 600 is the authorization to dispense all medications, except controlled substances. A written prescription (DA Form 1289) or CHCS entry must be prepared by an authorized prescriber in order to dispense controlled substances and other legend items on formulary.

c. Quantities of Medications Authorized for Issue: Medications dispensed will be limited to prepackaged quantities designated by the P&T Committee or Chief, Pharmacy Service.

d. Supply and Control of Medications.

(1) Medications intended for dispensing from the clinic will be maintained separately from drug stocks intended for in-house use. These medications will be secured in locked cabinets or carts. Medications will not be dispensed from the clinic during hours of pharmacy operation.

(2) Pharmacy personnel will inventory the WHAC cabinet each day and replenish stocks as required. A one-week operating level, as determined by usage history, will be maintained.

(3) Supplies of controlled drugs must be ordered on DD Form 1289 signed by an authorized prescriber or an RN. Controlled substances may be received only by RNs and authorized prescribers assigned to the area ordering the substances. A DA Form 3949 (Controlled Substance Record) will be maintained for each controlled substance ordered. The DA Form 3949 will indicate receipts from the Pharmacy Service and issues to patients.

**APPENDIX B
PROCEDURES FOR OBTAINING, STORING, AND DISPENSING DRUGS
FROM CLINICS**

1. **PURPOSE:** To establish written procedures and policies for the operation of Pharmacy Service activities in connection with units and clinics for the purpose of ensuring that drugs are obtained, stored, and dispensed effectively, and in a manner consistent with federal laws, and Army regulations.

2. **SCOPE:** This appendix applies to all personnel assigned to or working in Clinics under the control of USA MEDDAC/DENTAC Fort Huachuca.

3. **REFERENCES:**

- a. AR 40-3, Medical, Dental and Veterinary Care
- b. AR 40-68, Clinical Quality Management.
- c. AR 40-61, Medical Logistics Policies and Procedures.

4. **GENERAL.** Medication usage within the MEDDAC is based on a formulary recommended by the Pharmacy and Therapeutics Committee (P&T) and approved by the MEDDAC Commander. The MEDDAC Pharmacy Service serves as the primary source of Federal Supply Class 6505 items (drugs), intended for issue to patients, for all MEDDAC Clinics. Medications from other origins will not be dispensed from clinics. The Pharmacy Service also exercises direct technical supervision over the Unit/Clinic/DC drug storage areas and all Pharmacy Service related procedures conducted therein. Pharmacy personnel on a monthly basis will inspect drug storage areas. Training support will be given to Unit/Clinic/DC personnel, when required, either by presentation of class's on-site or individual instruction by on-the-job training at the Pharmacy Service. A record of inspections/liaison visits will be maintained in the Pharmacy. A copy of the inspection results will be provided to the responsible Charge Nurse/OIC/NCO for correction. Noteworthy and repeat discrepancies will be reported to the PI Committee of the servicing health clinic, Deputy Commander Nursing, and to the DCCS, or DENTAC Commander, as required. Telephonic communication with the supporting pharmacy is encouraged should any medication related problem arise.

5. PROCEDURES FOR OBTAINING DRUGS.

a. Preparation and use of CHCS generated stock lists

(1) Non controlled medications will be ordered on a clinic stock list. The Pharmacy Service will honor only orders for medications appearing on the Pharmacy and Therapeutic (P&T) Committee approved Clinic/DC stockage list, and which bear an authorized signature as it appears on a valid DA Form 577 (Signature Card) maintained in the pharmacy.

(2) Clinic Stock List will be prepared by the requesting activity and presented to the pharmacy for filling.

(3) When filling the valid order, Pharmacy Service personnel will indicate the number of units provided and any additional information required to positively identify the items dispensed. If the item ordered is not authorized for issue, "NA" will be listed, or if the item is out of stock "TOS" will be entered by the pharmacy on the CHCS issue sheet. Any item marked with a TOS should be re-ordered at a later date. The pharmacy will provide a new clinic restock sheet, the original order and the issue sheet to the requester upon delivery of order.

b. Use of computer generated bulk drug order sheets.

(1) Orders for bulk drugs may be ordered on a CHCS generated list provided by the Pharmacy Service. An authorized representative must sign the form.

(2) When filling in the computer generated form, the pharmacy personnel will enter this information into CHCS.

(3) The original form will be returned with the filled order.

6. DISPENSING MEDICATIONS.

a. Dispensing is defined as providing the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription prior to the delivery of the prescription to the patient or the patient's representative.

b. Only an authorized prescriber may dispense medication. Prescribers assigned to Clinics, or Dental Clinics may issue any drug on the stockage list that he/she is authorized to write, directly to the patient. Proper annotation must be made in the patient's medical record.

c. When the prescriber dispenses a medication, he/she will check and label the medication and provide the patient with all required counseling. He/ she will ensure that the patient understands how to take the medication, is aware of significant side effects, and any precautions associated with the drug. By Federal Law and Army Regulation 40-3, these dispensing functions cannot be delegated/relegated to a non-prescriber.

d. Once this has been completed, the prescribed medication may be delivered by the appropriate clinic personnel (e.g. nursing staff) to the patient. To assure accurate identification of patients, at the time they receive prescribed medication, full name and date of birth will be verified

7. CLINIC/DENTAL CLINIC STOCKAGE LIST: The Clinics/Dental Clinics are authorized by the MEDDAC/DENTAC Commander to stock a variety of drugs. Alterations to the stockage list can be accomplished through the P&T Committee. The Clinic/DC authorized stockage list will be kept current and posted in each Clinic/DC drug room. The Clinics/DCs and their supporting Pharmacy share the responsibility for maintaining stockage levels at no more than a 15-day supply. If non-authorized or excess quantities of drugs are found in the Clinics/DCs, they will be transferred to the Pharmacy.

8. STORING DRUGS:

a. Physical Security: The Physical security of pharmaceuticals and related devices at the Clinics/DCs requires close attention due to the large number of patients transiting the facility.

(1) Limited Access Area: The Clinics/DC drug rooms are considered as storage areas to which access is limited to staff members involved in patient care or medically related logistical operations and will not be readily accessible to patients or other personnel. A sign stating "Limited Access Area" will be posted at the entrance, accompanied by a list of personnel authorized to be in the area unescorted. The drug room will be secured with appropriate locks at all times when not staffed by authorized personnel.

(2) Patient Areas: All drugs stored in patient areas (prescriber's offices, treatment rooms, etc.) will be secured in locked cabinets during the absence of authorized clinic personnel. Keys to the cabinet containing prescription drugs must either be maintained in the designated nurse or LIP's possession or in an approved key box.

(3) External drugs and chemicals will be stored separately from internal and injectable drugs.

(4) Drugs will be stored under proper conditions of sanitation, light, temperature, moisture, ventilation, segregation, and security.

(5) Adequate refrigeration will be available in areas maintaining drugs, which require refrigeration and a refrigeration temperature log will be posted. These refrigerators will be alarmed and the alarm will be activated when the temperature goes out of range. Refrigeration units storing large quantities or monetarily significant amounts of drugs will be supplied with emergency power, have a 24 hour alarm system, or be monitored IAW MEDDAC Infection Control SOP. In situations in which drugs requiring refrigeration are exposed to temperatures outside the recommended range and there is a question of usability, call the pharmacy service for instructions. If there is any question as to whether the product is usable or not, assume that it is not until advised otherwise by a Pharmacist.

(6) Multiple-dose vials, which have been entered or reconstituted will be used for 28 days after opening. The multi-dose vial will be time, dated and initials to reflect date of opening and expiration date. Oral medications will be considered to be expired upon reaching the manufacturer's labeled expiration date, unless there are signs of visible contamination. Single dose vials or ampules may only be opened and used once.

(7) Outdated or otherwise unusable drugs, i.e. unclear labels, items stored under improper climatic conditions etc, will be isolated and returned to the pharmacy as soon as possible.

(8) Only items approved for stockage by the P&T Committee will be stored in clinics.

b. Disposition of Unusable Drugs: All drugs identified as unusable for any reason must be immediately separated from the remaining drug stock and placed in an area designated for such use. A sign reading "Unusable Drugs" will identify this area. Drugs identified for recall or suspension from use will be handled in a likewise manner. These drugs will be turned-in to the servicing pharmacy as soon as feasible.

c. Drug Recall Procedure: In the event of a drug recall, the servicing pharmacy will notify their respective Clinics/DCs by telephone, followed by a hard copy of the recall message. Recalled drugs will be considered unusable drugs and will be disposed of IAW the above instructions unless informed otherwise. See Appendix D.

d. Reporting of Drug Defects/Complaints: When the appearance of any drug shows signs of undergoing a chemical or physical change (i.e. aspirin tablets with an acetic acid odor, tablets or capsules sticking together, becoming discolored or cracked, particulate matter in injectable preparations, etc.), the drug will be considered unusable and will be removed from stock immediately. The responsible individual (OIC/NCOIC) will telephone the pharmacy and describe the problem. The drugs will be turned-in to the Pharmacy as soon as possible. Pharmacy Service personnel will determine the necessity to report or not report the situation to FDA and DMSC IAW AR 40-61.

9. PACKAGING AND LABELING OF PHARMACEUTICALS: Clinics are not authorized to repackage, transfer from one container to another any legend drug item intended for dispensing to a patient. Pharmacy Service personnel will do all drug repackaging. Prescribers may affix Pharmacy generated labels to Over the Counter Items (OTCs) if the drug is to be used differently than stated by the manufacturer's label.

APPENDIX C
DRUG RECALL/DEFECTIVE MEDICAL MATERIAL REPORTING PROCEDURES

1. **PURPOSE:** To establish comprehensive procedures for drug recalls and for reporting defective medical material.
2. **SCOPE:** These guidelines are applicable to all USAMEDDAC Pharmacy Service personnel. It encompasses all drug storage areas wherein drugs obtained from the Pharmacy Services are stored or dispensed from.
3. **RESPONSIBILITY:**
 - a. The Pharmacy Inventory Specialist (PIS) is responsible for implementing this policy.
 - b. During other than normal duty hours, the Chief, Pharmacy Service, Pharmacist-in-charge, or PIS is responsible for implementing the drug recall procedures set forth in this memorandum.
 - c. The PIS is responsible for obtaining and maintaining USAMMA MMQC messages, follow-up and documentation of actions taken on recalls, and disposition as provided for in this memorandum.
 - d. Public media may be used in Type I Drug Recalls. The decision to recall drugs dispensed to outpatients will be made by the Chief, Pharmacy Service in coordination with the Deputy Commander for Clinical Services and/or the Commander, USA MEDDAC Fort Huachuca. Discretion will be used during public drug recalls.
4. **DEFINITIONS:**
 - a. **Class I Drug Recall:** A situation in which there is reasonable probability that the use of, or exposure to, a violative product will cause serious, adverse health consequences or death. In the event of a Class I Drug Recall, notify the Chief, Pharmacy Service and the Pharmacist on duty ASAP.
 - b. **Class II Drug Recall:** A situation in which the use of, or exposure to a violative product may cause temporary or medically reversible adverse health consequences or when the probability of serious adverse health consequences is remote.

c. Class III Drug Recall: A situation in which the use of, or exposure to, a violative product is not likely to cause adverse health consequences.

d. Pharmacist in charge: The pharmacist responsible for supervising the operation of the pharmacy section. In the absence of a specifically appointed pharmacist in charge, the pharmacist present with the most time in federal service automatically becomes the pharmacist in charge.

e. Technician in Charge: The pharmacy technician so designated or in his/her absence, the senior pharmacy technician present by rank or grade, then by years of federal pharmacy service.

f. Medication Storage Area: Any area, including clinics where pharmaceuticals obtained from the Pharmacy Service are maintained or utilized.

5. POLICIES: SGMMA MMQC messages and SB 8-75 series Supply Bulletins will be maintained on file in the Pharmacy Service IAW AR 40-61. Drug recalls may be initiated from these sources or through information received from U.S. Government agencies or drug manufacturers. The pharmacy Prime Vendor database allows for identification of a specific product's, manufacturer, at any past point in time. The pharmacy service-dispensing database can identify all patients who received the product at that point in time. Patient phone numbers/addresses from the pharmacy database or from patient records enable recall down to the patient level when required (Type I Recall). Type I Drug Recall actions and specifics will be reported at the MEDDAC Safety meetings and will be included in the minutes thereof. Immediately upon notification of a drug recall, by SGMMA MMQC message, MEDCOM, manufacturer, or the FDA, the following procedures will be implemented:

a. The individual receiving the notification will inform the Chief, Pharmacy Service, PIS, NCOIC, or Pharmacist on duty, one of which will verify the information.

b. For Class I Drug Recalls, steps shall be taken in the following order: (Notify Chief, Pharmacy Service ASAP in all cases of Type I Recall regardless of the hour.)

(1) Using Prime Vendor Data Base, ascertain whether or not the pharmacy purchased any of the manufacturer's brand that is being recalled during the time frame covered by the recall. If the answer is no, abort the procedure.

(2) If the answer is yes, inform the Deputy Commander for Clinical Services of the existence of the problem and continue. Run a DUR report from the pharmacy database on the drug being recalled. Make the dates inclusive of the time period covered by the recall. Inform the Deputy Commander for Clinical Services of the number of patients listed on the report and that the Drug recall is being initiated by telephone. Use the Drug Recall Checklist to ensure that all information is transmitted to outpatients.

(3) The Chief, Pharmacy Service will coordinate a message via public media with the Public Affairs Officer (PAO) announcing the details of the recall.

(4) Divide the list among available personnel and begin the telephoning process, checking off the names of patients contacted as you proceed. Those not contacted will be called at various times throughout the following 72 hours until they are reached. If not reached within 24 hours, letters will be mailed to the patient's listed address.

(5) Contact all medication storage areas under pharmacy service jurisdiction, by telephone or in person. Determine if the recalled item is on hand. Negative responses are required. Recalled items will be turned in to the Pharmacy Service on a Bulk Drug Order. Immediately move all on hand stocks of the item being recalled, to include bulk storage, prepackaged items, unit dose items, and automatic prescription counting cell stocks, into the area designated for unusable drugs.

c. If the drug recall is a Class II or III, implement the following steps:

(1) Using Prime Vendor Data Base, ascertain whether or not the pharmacy purchased any of the manufacturer's brand that is being recalled during the time frame covered by the recall. If the answer is no, abort the procedure, if Yes, proceed to the next step.

(2) Notify all drug storage area supervisors to remove all lots of the item in question from their shelves and place them in the unusable drug area. It will be returned ASAP to the servicing pharmacy in a container clearly marked to indicate that the contents are Unusable Drugs.

(3) Recalled drugs will be isolated in a designated area in the Pharmacy Service pending disposition instructions from logistics personnel or in accordance with instructions in the recall message.

(4) A Memorandum for Record (MFR) of actions taken during a drug recall will be prepared and kept on file and reported during the next scheduled MEDDAC Safety meeting. All drug recalls will be documented, even if a negative report is rendered, indicating that none of the item was supplied through the Pharmacy Service.

6. DOCUMENTATION:

a. All SGMMA-MMQC messages will be filed and a logbook will be used to record each message number, the topic of the message, and the actions taken. All messages will be available. Any gaps in the log will be investigated immediately and any missing messages will be obtained from the Logistics Division. Drug recalls received from other sources will be filed in this log in the same manner.

b. The completed Recall Notification Checklist (included) will be attached to this Message and filed with it.

7. MEDICAL DEFECT REPORTING:

a. Procedures: Medical Material Complaints may be submitted on any drug or medical device, regardless of source of supply. Any medical item suspected of being ineffective or unsafe to the patient or staff will be reported on FDA Form 3500.

b. Medical Reports of Deficiency (RODs) on the above will be submitted on Forms SF-361's, SF-364's, and SF-380's as appropriate. RODs will be sent to DPSC-MAMC, 2800 S. 20th Street, Philadelphia, PA.

c. All such actions and outcomes will be reported to the Pharmacy and Therapeutics Committee.

DRUG RECALL NOTIFICATION CHECKLIST

DATE AND NUMBER OF MESSAGE:

DATE AND TIME MESSAGE WAS RECEIVED:

RECEIVED BY:

TYPE OF DRUG RECALL:

(I, II, etc>)

ITEM RECALLED:

Drug:

Manufacturer:

Lot Number:

Expiration Date:

NOTIFICATION OF SUPERVISORY PERSONNEL:

Name:

Date and Time:

ACTION DIRECTED BY MESSAGE:

VERIFICATION THAT THE ITEM HAS BEEN ISSUED BY THE PHARMACY SERVICE:

Date item received:

Quantity received:

**NOTIFICATION OF USA MEDDAC DRUG STORAGE AREAS OF RECALL AND
COMMUNICATION OF DISPOSITION INSTRUCTIONS:**

**OTHER MEASURES TAKEN (e.g. Data base screen of outpatient records - Class I Recall
only.)**

RESULTS OF DRUG RECALL:

(Product being recalled on hand Y/N)

Qty turned-in to log

REVIEWED BY AND DATE:

APPENDIX D
Unacceptable Abbreviation and Symbol List
Do NOT use any of the following when ordering or prescribing:

Do Not Use	Potential Problem	Use Instead
Trailing or terminal zero after decimal point	Can be mistakenly read as multitudes of the intended amount without notice of the decimal point	Do not use trailing or terminal zeros—write doses as whole numbers
Decimal point preceding dose without preceding zero	Can be mistakenly read as multitudes of the intended amount without notice of the decimal	Include the preceding zero (0) before a decimal point when the dose is less than a whole unit
Using shorthand or code to refer to duration of doses or days	Unclear as to reference to doses or days	Write out
Using shorthand or code to that contains dosage interval	Can be confused for one another	Write out the word “daily”, and “every other day”
U (for unit)	Mistaken as zero, four or cc	Write “unit”
IU (for international Unit)	Mistaken as IV or 10	Write “international unit”
MS	May be mistaken for Morphine Sulfate or Magnesium Sulfate	Write ‘morphine sulfate’ Write ‘magnesium sulfate’
MSO4 and MgSO4	Confused for one another	Write out the complete drug name

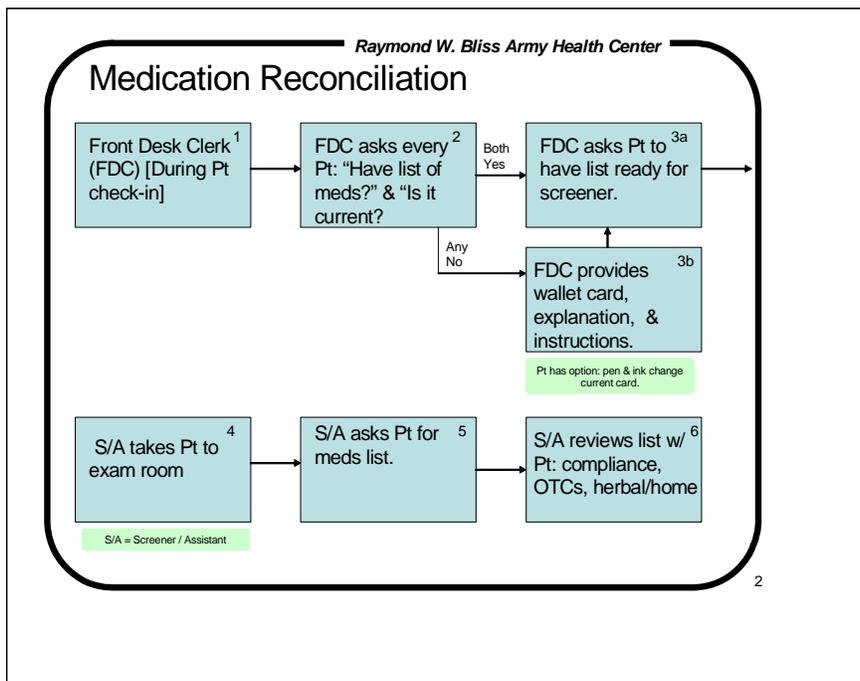
APPENDIX E
STANDARD OPERATING PROCEDURES (SOP) FOR THE PREPARATION OF
MEDICATIONS IN THE STERILE PRODUCTS AREA

1. Hand washing with a suitable approved antibacterial skin cleanser must be accomplished prior to the preparation of parenteral medications IAW RWBAHC Infection Control Policy.
2. Avoid coughing, sneezing, and talking while preparing a product for parenteral administration.
3. Examine the LIP's order and select the size and quantity of additive, diluent, syringes, needles, etc.
4. Carefully examine the condition of packaged items, labels, and expiration dates for any sign of unsuitability.
5. Inspect the contents of containers, ampules, vials, etc. for particulate matter, discoloration or other abnormalities. Examine glass containers for cracks.
6. If math procedures are involved, obtain a double check from a pharmacist on all calculations prior to mixing.
7. Refer to the pharmacy resources, package insert or other guidelines (ex. Trissel's Handbook on Injectable Drugs) for the correct reconstitution diluent, carrying solution, quantities of diluent and carrying solution, and compatibility of multiple additives.
8. Referring to IsoTech Barrier Isolator Use Instructions kept in IsoTech's antechamber wipe down inside of the IsoTech barrier isolator antechamber, work chamber and orange or brown gloves/yellow sleeves (which are inside work chamber) with decontamination solution (Cavicide is recommended by manufacturer). When opening work chamber place orange or brown gloves/yellow sleeves in sleeve "hole"-do not let gloves drag on the floor.
9. Place needed supplies & medication(s) in antechamber through antechamber door NOT the work chamber door. Have IV bag label ready to be placed on IV bag.
10. Ampules and vials are cleaned with 70% isopropyl alcohol pads. Close sliding plastic doors between antechamber and work chamber. Close antechamber and work chamber doors. Turn on pressure fan for at least 30 minutes
11. After 30 minutes of pressure fan on and ready to mix medications wash hands with a suitable antibacterial skin cleanser IAW RWBAHC Infection Control Policy. Put on white cotton gloves and orange/brown work gloves/yellow sleeves. Open sliding plastic doors between antechamber and work chamber. Move medications and equipment into work chamber. Close sliding doors and proceed with medication mixing.
12. Disinfect the additive port of the carrying solution bag and rubber closures of vials with 70% isopropyl alcohol pads. Do not touch contaminate needles, ports, or vial stoppers.
13. A five micron straw filter needle is to be used to withdraw contents from glass ampules. Discard straw filter needle and select a 20 gauge needle or smaller prior to injecting into piggyback back, or patient.

14. Ensure that the vial is free of undissolved drug particles, stopper cores, or precipitates prior to drawing into a syringe for injection into the carrying fluid.

15. Inject the drug additive aseptically and invert the bag or bottle 3 times to mix the additive. With ports in the up position, squeeze injection ports to discharge any drug additive that might be inside. Remember to invert the bag or bottle at least 3 times to ensure proper mixing of the additive and the carrying fluid.

16. When mixing is finished dispose of sharps into "sharps" receptacle and other waste in "trash" receptacle inside work chamber. From the inside open sliding plastic doors into antechamber. Place the prepared medication and other non-disposed of material into antechamber. Close the sliding plastic doors. Remove upper extremities from orange or brown gloves/yellow sleeves and cotton gloves. Open outside antechamber door to remove material/medications. If appropriate put IVA Seal III over rubber stopper on IV bag used to inject medication. Label IV bag IMMEDIATELY!



Appendix F**Raymond W. Bliss Army Health Center High Alert Medication List:**

**Epinephrine
Norepinephrine
Propranolol(IV)
Metoprolol(IV)
Labetalol(IV)
Propofol
Ketamine
Lidocaine(IV)
Amiodarone(IV)
Warfarin
Heparin
Enoxeparin
Glyburide
Glipizide
Avandia
Metformin
Digoxin(IV)
Midazolam
Chloral Hydrate
All Narcotics/vault items, including Levitra
Isoview 300
All Insulins
Potassium Chloride(injection)
Potassium Phosphate(injection)
Promethazine(IV)
Dextrose, hypertonic, over 20%
Sterile Water for Injection, Inhalation, and Irrigation(excluding pour bottle) in
containers of 100ml or more
Succinylcholine
Rocuronium
Anastrozole
Azathioprine
Cyclophosphamide
Exemestane
Hydroxyurea
Letrozole
Megestrol tablets and suspension
Methotrexate injection and tablets
Mycophenolate mofetil
Tamoxifen**

APPENDIX G
RAYMOND W. BLISS ARMY HEALTH CENTER MEDICATION
MANAGEMENT RISK ASSESSMENT

RISK POINT	RISK LEVEL	DESCRIPTION	ACTION TAKEN	RESULTS	STATUS
Selection/Procurement-Formulary Decisions/dissemination of information	High	Much of formulary management is controlled at the DoD level; maximum communication needed to Medical and Pharmacy staff and patients regarding formulary decisions	Medical staff are informed via email and Medical Staff Meetings; Pharmacy staff via email/staff meetings; Pharmacy Newsletter proposed 1/08, draft status 12/07; Post pertinent information on intranet/formulary page	Assess results through survey to medical staff	Open
Storage and Security-Access to medication storage areas	High	A. Insure all areas with medication storage have limited access	Access rosters posted; access rosters recommended for shared access areas, radiology, FCCA	Assess compliance during periodic clinic inspections	Open
Storage and Security-Transportation of medication from Main Pharmacy to PX/Outlying clinics	Medium	B. PX medication delivery/Outside clinics was undefined and unpredictable	Vehicle obtained specifically for pharmacy deliveries; pharmacy technicians have met driver's training requirements	Medication delivery is scheduled and coordinated through pharmacy	Procedure modified 12/07-monitor for change
Storage and Security-Key control awareness to limit access to medication areas and prevent diversion	Low	C. Insure keys to medication storage areas do not leave the facility	Enforce Key Control; keep keys in secure area with access by authorized personnel only	Spot checks for compliance and 4106 review to identify possible events	Open

Storage and Security-PickPoint machines at risk for formulary/default or procedure changes	Medium	D. PickPoint afterhours dispensing machines subject to possible procedural omissions	Routine checks on filling log, safety defaults and formulary compliance during clinic inspections	Periodic spot-checks by Tracer Team, MMFMT, and other SMEs	Pending Review
Storage and Security-Look-Alike/Sound Alike Medications	High	E. LA/SA meds need to be identified and physically separated	Education provided via email, Commander's Call, LA/SA badges, stickers and individual clinic education on what meds they have in clinic and how to safely store and identify them	Tracer Team, MM FMT, Mock Surveys to identify shortfalls	Open
Ordering and Transcribing-Incomplete orders in AHLTA	High	A.Free-text field not consistently used	Education provided to staff, individual champions to instruct	Record review during Tracer meetings	Open
Ordering and Transcribing-Data integrity lapses between AHLTA/CHCS I	Medium	B. Omissions of meds entered in AHLTA to CHCS I; drug name changes	Trouble tickets logged, AHLTA trainer notified, medical staff input requested	Near-misses/4106's monitored to identify recurrence, chart audit	Pending Review
Ordering and Transcribing-Verbal Orders in OR	Medium	C. Inconsistent verbal order read-back	Tracer Team OR visit to observe; records checked to see if re-back was documented	Observation, Chart Audit	Open

RISK POINT	RISK LEVEL	DESCRIPTION	ACTION TAKEN	RESULTS	STATUS
Preparation and Dispensing-Automation	Low	Data integrity problem with NDC verses drug name(clonazepam, oxycodone)	Parata called, IMD technician involved	Periodic spot check to insure integrity	Closed
Preparation and Dispensing-Pharmacy preparation of admixtures	Medium	No transfer of medication transfer to IV bags in clinics	Admixtures mixed in pharmacy	Chart review/pharmacy record review	Pending review
Preparation and Dispensing-Immunizations/Injections	Medium	Insure proper administration of injectable medications in clinic areas	Discussed at MM FMT, Tracer team	Tracer team observation	Pending review
Administration-5 Rights	Medium	Insure 5 rights are being followed	Staff education, competency	Observation, education, documentation	Pending review
Administration-Competency Assessment	High	Need to be able to document proper training to allow personnel to administer medications	Nursing Skills Fair, individual clinic training, competency folders	Audit CAF folders, observation of staff through Peer Review, MM FMT, Tracer Team	Open

**APPENDIX H
RAYMOND W. BLISS ARMY HEALTH CENTER
PLAN B POLICY**

MCXJ-RX

18 June2007

MEMORANDUM OF INSTRUCTION

SUBJECT: Prescribing, Dispensing, and Distributing of Plan B[®] (Levonorgestrel) Emergency Contraceptive

1. References:

a. OTSG/MEDCOM Policy Memo 06-035, Prescribing, Dispensing and Distributing of Plan B[®] (Levonorgestrel).

b. US Food and Drug Administration-Approved Product Labeling and Patient Information, 24 Aug 06, <http://www.fda.gov/cder/foi/label/2006/021045s011lbl.pdf>.

2. Purpose. To establish procedures for the prescribing, dispensing, and distributing of Plan B[®] (levonorgestrel). Plan B[®] is an emergency contraceptive drug approved by the US Food and Drug Administration (FDA) for the prevention of pregnancy after a contraceptive failure or unprotected sex. The drug has been approved by the FDA as both a prescription and an over-the-counter (OTC) product with specific age restrictions: individuals under the age of 18 years of age will require a prescription, while those 18 years of age and older can obtain the drug without a prescription from a pharmacy as an OTC drug product.

3. Scope. These procedures apply to all staff, clinics, and pharmacies at Raymond W. Bliss Army Health Center (RWBAHC).

4. General.

a. The intent of MEDCOM Policy Memo 06-035 is to ensure patient access to Plan B[®] in accordance with the use approved by the FDA.

b. The time interval between unprotected sex and Plan B[®] administration influences the clinical effectiveness of Plan B[®] and should be initiated not later than 72 hours after sexual activity.

c. Department chiefs must have mechanisms in place to guarantee patients' timely access to Plan B[®] while accommodating potentially conflicting moral or ethical beliefs of health care providers and pharmacy personnel.

(1) Department chiefs will ensure that their current and future staff members understand the intentions and procedures detailed in OTSG/MEDCOM Policy Memorandum 06-035 and this memorandum.

(2) Department chiefs will identify and implement department or clinic-level procedures for ensuring timely ordering and/or dispensing of Plan B[®] to a patient in the event that a subordinate health care provider or pharmacist objects to its use.

(3) To avoid potential delays in patient access to Plan B[®], individual health care providers and pharmacists should consider reporting to their clinic or department chief known personal objections to ordering, dispensing, or distributing Plan B[®].

d. Department chiefs must have mechanisms in place to immediately counsel or refer for counseling both males and females that request more than two packs of Plan B[®] within a six month period (from first request). Plan B prescribers will be notified by Chief, Pharmacy service should this occur with one of their patients if the patient reports directly to pharmacy for the request. Health care providers are encouraged to refer any individuals for counseling to RWBAHC Preventive Medicine Service.

5. Procedures.

a. Requisition and storage of Plan B[®]: Bulk supplies of Plan B[®] will be purchased through Pharmacy Service and stored in the main and clinic pharmacies. (RWBAHC, MISC, MMC, and WHAC Pickpoint afterhours dispensing machines).

b. Distribution of Plan B[®]:

(1) Any licensed healthcare provider within his/her scope of practice may order PlanB[®] for eligible beneficiaries in CHCSI/AHLTA medication order module (similar to prescription-only formulary items). Beneficiaries that meet the FDA guidelines and OTSG Policy for OTC Plan B[®] may be sent directly to any Ft. Huachuca Pharmacy except the PX Pharmacy.(No pharmacist is on site)

(a) Providers review the six-month PDTS profile to determine Plan B usage history. (PRI menu option, P profile).

(b) Patients requesting a third (or more) pack within a 6-month period will receive counseling and such counseling will be documented in the health care provider (HCP) comment field for pharmacist review.

(2) Plan B[®] will only be dispensed by a licensed pharmacist or LIP. The licensed pharmacist/LIP dispensing Plan B[®] to the patient or patient's representative will ensure that he/she is provided a manufacturer's patient information handout.

(3) Patient verification.

(a) The pharmacist/LIP will verify the age and beneficiary eligibility status of the female patient by examining the military identification card of the patient.

(b) Patients less than 18 years of age will only receive Plan B[®] pursuant to a non-refillable prescription prescribed by an appropriately licensed individual practitioner (LIP).

(4) Dispensing of PlanB[®]. Pharmacists may dispense Plan B[®] to a patient's representative, in the absence of the patient, provided that all of the following conditions are met:

(a) The patient's representative presents his/her military identification card as well as the military identification card of the female patient. Non-beneficiaries may not request PlanB[®] for military beneficiaries.

(b) The female patient is 18 years of age or older.

(c) The pharmacist enters the distribution into the patient's electronic medical record (as an outpatient medication order).

(d) The pharmacist enters the patient's representative request under the representative's medication profile indicating "request for name/birthdate of the female receiving treatment" in the HCP comment field.

c. Requests for more than two packs within six months. Note that both *male* (representatives) and *female* (patients) requesting more than two packs in greater than six months (from the first request) are included.

(1) Healthcare providers seeing patients or the patient's representative will document counseling and reference such counseling in the HCP comment field (CHCS/AHLTA order med module). Healthcare providers are encouraged to call ahead to the dispensing pharmacy to prevent delay when patient arrives at the pharmacy.

(2) Pharmacists/LIPs that identify patients or representatives requesting more than two packs (OTC or Rx) within a six month period (from first request) will:

(a) Inform the patient or representative that Army policy requires that their PCM be notified regarding the request (not applicable if the PCM has seen the patient and entered an Rx).

(b) Dispense the product to the patient.

(c) Annotate in the pharmacy comment field that a third request was filled on (date).

(d) Email Chief, Pharmacy Service with name and birthdate of patient and/or representative (as applicable).

(e) Chief, Pharmacy service will email PCM directly (RWBAHC providers) or the Contracting Officer's Technical Representative for the TRICARE contract (non-RWBAHC providers).

6. Monitoring. The RWBAHC MUE committee will review utilization and compliance with this policy every 6 months. Results will be reported in the P&T Committee meeting minutes.

7. The proponent for this policy memorandum is the C, Pharmacy 520-533-9025

**APPENDIX I
SOUND-ALIKE / LOOK-ALIKE DRUGS**

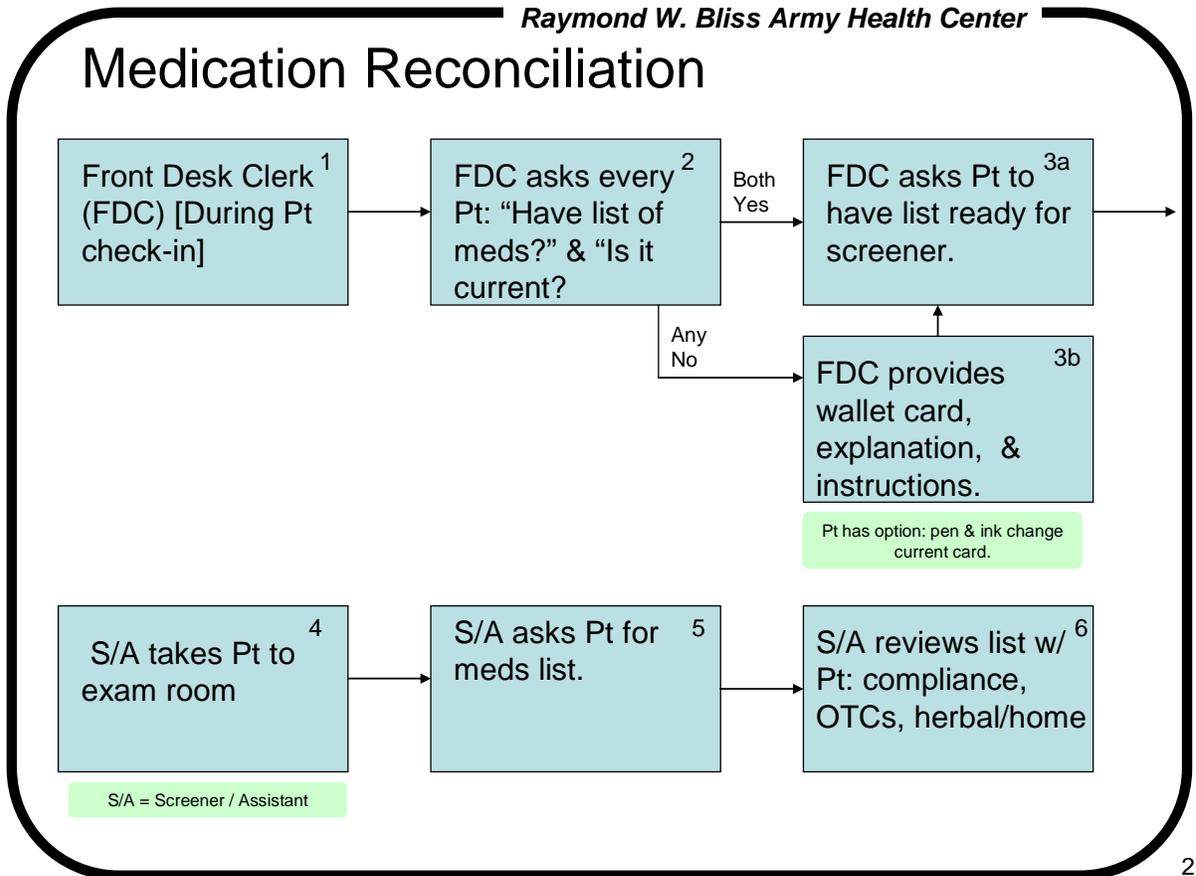
Table I & II

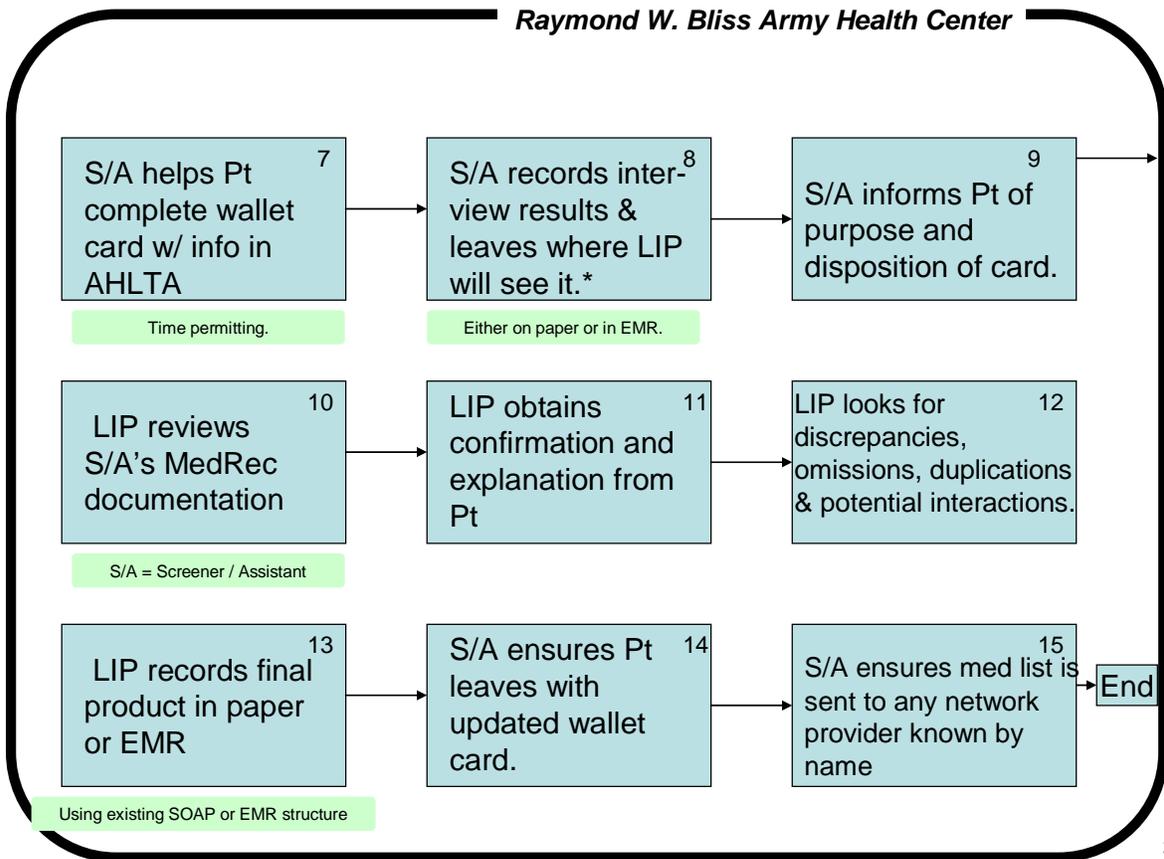
Avandia	Coumadin	
Celebrex	Celexa	Cerebryx
Clonidine	Clonazepam	
Ephedrine	Epinephrine	
Lamisil	Lamictal	
Novolin Mix 70/30	Novolog Mix 70/30	
Novolog	Novolin	
Serzone	Seroquel	
Topamax	Toprol XL	

Table III

Hydrocodone	Oxycodone	
Prilosec	Prozac	
Zantac	Xanax	
Zantac	Zyrtec	

Appendix J:
Example of Medication Reconciliation Process





**APPENDIX K
PERIOPERATIVE MEDICATION MANAGEMENT (SOP)**

1. HISTORY: This issue publishes a revision of this publication.
2. PURPOSE: To provide guidance to the professional OR nursing personnel in inventory, ordering, and maintenance of OR stock drugs and chemical agents.
3. SCOPE: This SOP is applicable to all professional staff OR personnel ordering or administering medications in the OR.
4. RESPONSIBILITIES: The Head Nurse of the OR is responsible for ensuring enforcement and compliance with this policy.
5. REFERENCES:
 - A. Infection Control Manual, MEDDAC Pamphlet 40-160
 - B. Association of PeriOperative Registered Nurses (AORN), Standards and Recommended Practices, Denver, CO., AORN, Inc, 2006.
 - C. 2008 Ambulatory Care Program, National Patient Safety Goal #3D
6. GENERAL. Stock drugs are maintained in the OR for use in surgical procedures. Medications used during surgery will be managed as dictated by this policy. It is important that accurate inventorying, ordering, and maintenance procedures be maintained to ensure availability of these drugs.
7. Procedures for Inventorying, Ordering, and Maintaining OR Stock Medications
 - A. Inventorying and Ordering OR Stock Medications or Bulk Drugs.
 - (1) Medication levels will be inventoried and ordered on a weekly basis or as necessary. Orders will be placed on a Bulk Drug Order (BDO) form located in the Operating Room.
 - (2) Outdates will be checked on a monthly basis. Outdated medications will be returned to Pharmacy for disposal. The medications will be placed in a bag and listed on the BDO clearly labeled as "Expired Medication."
 - B. Procedure for ordering medications
 - (1) Obtain a BDO form from document protector in the OR.

- (2) Order medication levels according to levels posted on the inventory list. Levels listed indicate maximum number for that item which should be kept on hand. Do not order drugs in small amounts, i.e. one or two of a drug.
- (3) Complete the BDO leaving no empty spaces. A line should be drawn through the portion of the BDO on which no medications are ordered. Sign your name, rank, and branch at the bottom of the BDO and forward to Pharmacy.

C. Precautions for maintaining drug integrity.

- (1) All multi-dose vial medications should be prepared in an aseptic manner. A multi-dose vial medication must be discarded 28 days from the day it is opened or if obvious contamination of the vial has occurred within the 28 days. If a multi-dose vial has been previously drawn from, check for obvious contaminants in the vial, clarity, expiration date from day opened and swab off the top with an alcohol swab.
- (2) All medications will be returned to the anesthesia workroom at the end of the day.

D. Medication Administration

(1) The 5 rights will be verified prior to medication administration. Verification of right patient may take place at different times during the patient identification and surgical site verification process.

- a. Right patient
- b. Right medication
- c. Right dosage
- d. Right route
- e. Right time

(2) All medications and solutions will be labeled on and off the surgical field to include all bottles, syringes, aseptos, and basins. Medications names will be written out completely ensuring the use of a leading zero for those medications that are less than 1 percent of a solution. For example, 0.5% Marcaine with Epinephrine (1:200,000).

(3) Prior to preparation of all medications check for outdates, turbidity, discoloration, integrity of the container and rubber seal.

Appendix L

Electronic Record Locations for Prescription Medications

1. CHCSI PRI "A"(Active medications from RWBAHC)
2. CHCSI PRI "B"(Active, Discontinued, and Expired medications from RWBAHC)
3. CHCSI PRI "P"(All medications received by patient through TRICARE Retail, Mail Order or MTFs)
4. AHLTA (EMR) Current Medication List

**M-1
DRUG-FOOD INTERACTION GUIDE**

DRUG-FOOD INTERACTION GUIDE	
<p>This guide does not include all drug/food interactions. If you have any questions concerning this information or need information about other medications, call the Pharmacy Service at 533-2520.</p>	
<input type="checkbox"/>	<p>COUMADIN</p> <p>Too much Vitamin K in the diet, especially the sudden intake of large amounts of Vitamin K can interfere with this medication and reduce its effectiveness. If your diet is already high in these foods, don't change! Consistency is the key, and any drastic changes to your eating habits can affect your health. The following foods contain high amounts of Vitamin K: liver (any type); brussel sprouts; collard greens; kale; soybean oil; broccoli; turnip greens; cabbage; green leafy vegetables; spinach; green tea; chick peas; cauliflower; potatoes; soy products (including tofu); peas; lettuce; fish; vegetable oils; fruits; dairy products; eggs. Also limit caffeine and alcoholic beverages.</p>
<input type="checkbox"/>	<p>LITHIUM</p> <p>Maintain a normal salt intake. A low sodium diet can cause lithium toxicity, while too much sodium in the diet can impact lithium's effectiveness. Avoid highly salted foods such as salty pretzels and chips. Avoid shaking lots of salt on your food. Avoid big changes in your sodium intake without consulting with your doctor. Drink at least 6 to 8 glasses of water or other fluid each day. Avoid alcohol.</p>
<input type="checkbox"/>	<p>FLUOROQUINOLONES (Ciprofloxacin, Gatifloxin, Moxifloxin)</p> <p>Drink plenty of water to prevent crystallization of these drugs in the kidneys. Avoid antacids containing magnesium or aluminum, as well as alkaline foods such as milk, dairy products, peanuts, and sodium bicarbonate within 2 hours of taking these drugs.</p>
<input type="checkbox"/>	<p>TETRACYCLINE</p> <p>Drink a large glass of water with this medication. Avoid alcohol. The absorption of this medication is impaired when taken with foods (and vitamin preparations) containing calcium, magnesium, iron, and zinc. Avoid eating calcium-rich foods within 2 hours of taking a dose. Foods high in calcium include most dairy products such as milk, cheese, yogurt, ice cream, and pudding, as well as many dark green vegetables such as spinach and broccoli.</p>
<input type="checkbox"/>	<p>CALCIUM CHANNEL BLOCKERS (Felodipine, Nifedipine, Verapamil, Amiodarone, Atorvastatin, Buspirone, Carbamazepine, Lovastatin, Midazolam, Sertraline, Simvastatin, Triazolam, Theophylline)</p> <p>Avoid grapefruit and grapefruit juice. These foods will increase the amount of active drug in the body, thereby causing increased side effects such as increased heart rate, blood pressure changes, facial</p>