

FIELD PHARMACIES
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Role of the Pharmacist

The role of the pharmacist as part of a field disaster team has evolved over the years. The initial role of the pharmacist was to dispense medications and supplies to those in the disaster situation in need of prescription refills on a short-term basis. This role became extended to fill orders for medications and supplies in trauma situations. These duties involve not only the initial distribution of supplies but also the requirement to ensure a resupply of medications when initial supplies are exhausted. Most recently, the field disaster team pharmacist has become a critical member of “outreach” teams sent into the community to respond to medical needs outside the central staging facility. In all cases, the number and type of pharmacy personnel and the medications and supplies utilized in a disaster depend on the specific needs of the mission in the specific disaster area. The role of the pharmacist is not static: it related directly to the disaster situation, with an evolving mode of operation. Thus, the pharmacist must be prepared for change while maintaining and following rules and protocols that ensure the objectives and goal of the mission are met.

Areas of primary concern to the pharmacist include drug need assessment, establishment of the ergonomic and physical setup of the field pharmacy, development of drug distribution mechanisms, drug recording procedures, and development of provisions for safeguards and security (i.e., logistics). Pharmacists also must develop working

relationships with other professionals—clinical personnel, administrative personnel, support personnel in a military setting, and medical staff (for drug information consultation). In addition, pharmacists may be called upon to develop relationships with others in collaborative roles in logistics, operations, communications, transportation, and training.

Before being sent to the field, the pharmacist must acquire the training and experience needed for deployment. Experience in logistics, administration, incident command management, and military protocol in a disaster situation can be obtained through different methods, such as serving as a member of a DMAT, serving on a local or state emergency response team (e.g., fire rescue squad), working in a hospital emergency department, and being part of a medical team serving populations in austere environments. Training also can be obtained in those situations as well as in formal programs such as first responder, cardiopulmonary resuscitation (CPR), emergency medical technician (EMT) certification, and basic trauma life support (BTLS) courses.

Other professional qualifications include those required to practice pharmacy. NDMS team members, including pharmacists, are granted temporary permission to practice across state and territorial lines, allowing them to function at disaster sites. Personal physical and hygiene qualifications are imperative for pharmacists to practice at a disaster site while ensuring their own as well as others' safety.

Preparing for Deployment

The following lists will serve as a guide when preparing for deployment:

Personal preparation: uniforms, gear, money, ID cards, credit cards, passport, vaccinations, medications, credentials, medical records, materials for e-mail access.

Family and job preparation: obtain job clearances, pay family bills, complete a will, arrange care for children, arrange care for pets, collect emergency telephone contacts for team members, establish call back times so family members can be reached by members in the field.

Legal Issues and Requirements

Pharmacists are required to have, as a minimum, a bachelor's degree from an accredited school of pharmacy. In addition, they must maintain a valid and unrestricted state license to practice pharmacy. Pharmacy technicians are required to be certified from an accredited training program in the United States.

Setting up a Memorandum of Understanding

The following text is an example of a "memorandum of understanding" that can be used to arrange availability of pharmaceuticals prior to a disaster. The text may be modified to meet a team's particular needs.

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is between (Name of Medical Assistance Team) and (Name of Supplier).

(Name of Supplier) agrees to provide (Name of Team) with designated pharmaceutical products and medical supplies (which may include pediatric formula, pediatric oral re-hydration fluid, as well as IV fluids and irrigation fluids) when requested for a deployment.

The inventory of these items will be kept by the supplier (in a designated area) and reviewed on a regular basis. All parties understand that, if these supplies are requested and taken out of the custody of (Name of Supplier), it will be done under the following conditions and in the presence of a designated pharmacy member of (Name of Team):

- All supplies will be placed in storage containers.
- Each container will be numbered.
- Documentation sheets will be provided to allow recording of the supplies placed in each container.
- A numbered seal or lock will be placed on each container. The seal or lock numbers will be documented on the sheets mentioned above.
- If the supplies are deployed to the field, they may be returned only if the same numbered seals or locks that were placed on the containers prior to removal are still in place and intact. Any supplies in containers with seals or locks that are missing, damaged, or altered or that have a different number from that recorded will not be returned.

(Name of Supplier) agrees to provide (Name of Team) access to these supplies 24 hours a day, 7 days a week, with a 1-hour notice. It is understood that, if these supplies are removed from (Name of Supplier) and not returned, a bill may be submitted for said supplies directly to

Department of Health and Human Services
U.S. Public Health Service
Office of Emergency Preparedness
12300 Twinbrook Parkway, Suite 360
Rockville, MD 20857

(Name of Team) is financially responsible for products and supplies requested from and provided by (Name of Supplier) for activities other than a declared federal deployment.

(Team Leader's Signature)

(Supplier's Signature)

Maintaining a Pharmacy Cache at a Storage Facility

Storage areas for the pharmacy cache must be secured in accordance with Drug Enforcement Administration (DEA) regulations and any other applicable laws for drug product storage.

Products must be stored in compliance with temperature requirements stated on the labels. U.S. Pharmacopeia defines storage conditions as follows:

A **refrigerator** is a cold place in which the temperature is maintained between 36° and 46°F (2° and 8°C).

A **freezer** is a cold place in which the temperature is maintained between -4° and 14°F (-20° and -10°C).

Controlled room temperature is a temperature maintained between 59° and 86°F (15° and 30°F).

Access to the pharmacy cache must be restricted to a limited number of personnel, whose names must be specified in a formal document. Each entry to the cache must be documented. Keys, combinations, codes, and other security devices should be changed when personnel leave the team or are reassigned to a different position.

An accurate inventory of the pharmacy cache should be maintained, capturing the product name(s), expiration date, lot number, quantity, and product size. Other helpful information for reordering is the product manufacturer's stock number (MSN), the manufacturer's name, price of the product, the product's unit of issue (UOI), and its National Drug Code (NDC) number. This inventory will allow the team to maintain accurate data on the value of the cache and will be beneficial when rotating stock to prevent products from being stored beyond their expiration date.

Preparing for Deployment

The pharmacy cache should be packed in Rubbermaid totes, which are available with the DMAT basic load. Pharmacy caches shipped directly from wholesalers may be stacked on pallets, banded, and shrink-wrapped to protect the product during shipment.

For shipment of the pharmacy cache, the team can contract with local carriers, FedEx, UPS, or other overnight shippers. All arrangements for shipping must be in place prior to deployment. For shipment of HAZMAT items, refer to the logistic training section.

Field Cache and Dispensing Area Setup

The layout of the field disaster pharmacy will reflect that of regular pharmacies. A field dispensary normally consists of a storage area in the back, from which supplies are brought into the dispensary. Next would be a sorting and pulling area for medications and supplies. Next would be the dispensing area, with a waiting area most forward.

When outside facilities must be used, tents that are properly staked and trenched are essential. All items should be stored off the ground to prevent water damage ; pallets themselves or empty boxed on top of pallets should suffice in most cases. Extra litters can also be used for above-ground storage.

Electricity, usually from a generator source, must be made available to the pharmacy as soon as possible so that adequate lighting is available for safe dispensing operations as well as power for the refrigerator, computer, and any other equipment. To ensure patient safety and confidentiality, the pharmacy should be located away from or at

the end of patient and personnel flow. The end or corner of the tent or facility, in a secure area, is desirable.

Security at the pharmacy must be heightened at all times to limit access to the medical supply areas to pharmacists or to other health professionals in the pharmacist's absence. Locked medical chests (or a safe) are needed for proper security. Manual or electronic logs must be maintained to record dispensing of medications. Changes of shift require a means of recording the passage of responsibility for controlled medications and keys through the use of a log.

Chests are used to store medications and supplies in the field. A small refrigerator capable of running on grid, solar, or battery power or ice to store items requiring refrigeration is necessary. Additional supplies include reference books, labels, tablet counters, spatulas, bottles, vials, envelopes, log books, stationary, and pens. Desirable items include a lap top computer, a typewriter, shelving, a phone, and a safe. All possible efforts should be made and contacts explored to obtain supplies and equipment.

Dispensing in the Field

Assessment of Medication and Supply Needs. An objective determination of medication and supply needs can be based on the goal and objectives of the mission. Before deployment, the pharmacist must understand the types of medications and supplies needed for initial dispensing, trauma situations, and outreach programs. Although a general formulary may be available, certain drugs specific to the disaster and its location may be required. Certain types of disaster or potential disasters (natural or

man-made) require an assessment of available population statistics and response strategies to determine the types of supplies that will be needed. For example, in certain areas, high blood pressure or diabetes is endemic, so the initial dispensing of medications will be directed toward meeting those specific needs. A specific type of anticipated terrorism would require specific antidotes. And certain types of disasters will demand the treatment of traumatic injuries.

Subjective determinants are driven by doctors, nurses, dentists, and psychologists and more specifically by the medical officer in charge, who will have developed standard operating procedures and protocols to deal with arising medical situations. For instance, the officer in charge could direct the pharmacist to fill prescriptions for a 3-day period even in the absence of a physical original or refill prescription.

Ordering and Distributing Medications and Supplies. Developing a supply formulary or “basic load” provides control over the inventory by preventing duplication of supplies. This list should cover the scope of the mission and meet the majority of expected medical needs.

After local or existing resources, additional suppliers most likely will include active-duty military components or the Veterans Administration (VA) in addition to the U.S. Public Health Service Supply Center. At many disaster scenes, local wholesalers or drug manufacturers will not be accessible. Transportation of drug supplies will not be easy, so strategies for initial supply and resupply must be developed. For ordering and distribution, it may be necessary to work through state and county officials and civilian organizations.

A major area of concern during any disaster is the receipt, management, and distribution of donated medical supplies. In many disasters, it takes more resources to receive and manage these gifts than to actively develop a needs list and procure the needed medications. International groups and others involved with drug donation must follow applicable guidelines to maintain some order and structure in the process so donations can be used effectively.

During federally recognized disasters to which military units are deployed, federal supply resources become available. It is critical for the pharmacist liaison to obtain the name and phone number of the military liaison to the military supplies logistics officer. Arrangements can be made to pull supplies from the military hospital established in the area or from military supply units that support the hospital. In addition, the VA, as a key player in disaster situations, can serve as a source of resupply. It is necessary for the pharmacy liaison to obtain the name and phone number of the VA pharmacy contact.

The Public Health Service Act, Section 42.243(c)(1), indicates that “the Secretary (of HHS) is authorized to develop (and may take such action as may be necessary to implement) a plan under which personnel, equipment, medical supplies, and other resources of the (Public Health) Service and other agencies under the jurisdiction of the Secretary may be effectively used to control epidemics of any disease or condition and to meet other health emergencies and problems.”

Drug distribution will be determined mainly by the goal of the mission and the objectives determined to meet that goal. The pharmacy may be set up as a central unit in one patient care location, established at one location to support outreach teams going out

into the field, or split into multiple patient care locations. The setup also will depend on the number and type of available pharmacy personnel.

If possible, all health care professionals authorized to write pharmaceutical orders should report to the pharmacy with proof of their licensure and should sign the established signature list. The signature list should include the printed name of the individual, his or her signature, and a column documenting that proof of professional licensure was seen (a photocopy of the license should be attached if possible). The list should have an introductory paragraph that specifies the various prescribing authorities for different levels of health care providers.

The Pharmaceutical Inventory

In addition to any existing drug stocks, pharmaceutical supplies for the dispensing pharmacy must be provided by the federal or state agency requesting disaster assistance. It is logistically impossible to monitor and maintain a complete pharmaceutical inventory of all commercially available agents during a disaster response. Any number of standard formularies, or a new or adapted one, can serve as the beginning pharmaceutical stock.

Fluctuations in the pharmaceutical inventory can be a source of frustration for health care professionals. The pharmacist can alleviate some of this frustration by monitoring the inventory in relation to his or her knowledge of patients' histories, diagnoses, and treatment plans.

The log of all pharmaceutical products dispensed should document the patient's name, an identifying number, the date, the medication dispensed, the quantity dispensed, and the prescriber's name. This log can be extremely helpful not only in managing the

pharmaceutical inventory but also in identifying diagnoses that may need epidemiologic follow-up (e.g., gastrointestinal complaints or infectious disease outbreaks).

Quantities of medications dispensed will depend on arrangements made for re-supply. Whenever possible, medications for acute conditions (e.g., antibiotics for infections) should be dispensed for full-course of therapy (10 days or less). Some balance should be reached between maintaining an inventory and necessitating repeat patient visits (e.g., a 30-supply should not be dispensed to the first 5 patients who arrive, leaving nothing for subsequent patients; however, it would also be unreasonable to give everyone a 1-day supply, making them return every day and thus increasing patient load). This process should be discussed with the medical officer in charge to establish a general policy on this issue.

When possible, prescription vials or bottles, properly labeled (with the patient's name, the date, directions for use, the provider's name, the name of the medication), should be used. Prescription vials and bottles usually can be obtained when medications are being procured. These receptacles usually are sold with child-resistant closures, and they keep medications dry and intact. Medication envelopes are not child resistant, and they are susceptible to moisture and offer little protection against capsules being crushed. However, the size of medication envelopes facilitates their use as labels that can be taped to prescription vials or bottles until self-adhering labels are obtained. Alternatively, small plastic bags with secure closures (i.e., zip-lock bags) or envelopes can be used if no other means of packaging the medication exists. Regardless of the type of container, every attempt should be made to label the dispensed medications. It is the pharmacist's

responsibility to ensure that the field dispensing procedures comply with applicable legal requirements.

Over-the-Counter Products. The pharmacy should be utilized to stock the over-the-counter (OTC) products such as aspirin, acetaminophen, ibuprofen, pseudoephedrine, and diphenhydramine. This allows the pharmacy staff to control the distribution, maintain the inventory, and provide easy access for the medical staff. In a severely affected area, the pharmacy may be the only source of these medications. In many cases, it will be beneficial for the pharmacy to procure and dispense these items, especially if their availability decreases patients' overuse of other medical services.

Intravenous Admixtures. When possible, a central supply source (outside the pharmacy) should be established for ordering large-volume parenterals as well as other supply items. During emergency deployments, the field pharmacy should limit its involvement to preparing intravenous (IV) admixtures for specific therapies (e.g., antibiotics, surgical needs, pediatrics). Due to procurement and environmental constraints, most IV solutions should be prepared immediately prior to use. Daily batching is not recommended in situations where inventory or electrical resources are limited. Pharmacists not experienced with IV admixtures should seek assistance from institutional pharmacists.

Controlled Dangerous Substances/Narcotics. In federally declared emergencies, pharmacists should be briefed on centrally procuring pharmaceuticals (including controlled dangerous substances [CDSs]) through the management support team (MST). Federal regulations must be met, but procurement mechanisms may vary.

- A lockable safe or cabinet not directly visible from patient care areas is needed to store CDSs.
- An inventory and administration log will be needed to record the dispensing and/or administration of CDSs as well as to monitor inventory levels for identifying when re-ordering is needed. This log should also serve as an inventory record from shift-to-shift or daily.
- Security should be established to limit access to the pharmaceutical inventory areas to only the health care professionals responsible for them. If the facility is not operating on a 24-hour schedule, arrangements should be made to secure the CDS, either in a lockable room or vault or by transport of the CDSs in a small lockable box by the person responsible for them.

Therapeutic Substitution

Therapeutic substitution is the exchange of medications with similar efficacy and toxicity profiles. Because of field or emergency formulary restrictions, pharmacists will be relied upon for advice and consultation regarding therapeutic substitution.

Pharmacists will need to use their best clinical judgment and experience to assess each patient's pharmaceutical needs on a case-by-case basis. When necessary, a pharmacist may have to substitute an alternative medication to replace what was originally prescribed. Therapeutic substitution may be made independent of a primary caregiver. Substitutions should only be made if an equivalent or similar medication cannot be found on the formulary. All substitutions must properly documented.

The precise parameters for therapeutic substitution will be determined upon arrival at a disaster site. Establishment of recommended therapeutic exchanges is a vital function of pharmacists during a disaster response. When possible, pharmacists should review whatever pharmaceutical compendiums are available to determine the most appropriate therapeutic exchange.

By their nature, disasters are not static situations. The confusion and chaos caused by a disaster will undoubtedly result in continuous transition of the formulary. Therefore, pharmacists must be prepared to adapt their therapeutic substitution recommendations frequently. In theory, pharmacists may therapeutically substitute any agent, but in practice the following drug classes may be more amenable to substitution: diuretics, ACE inhibitors, calcium channel blockers, nonsteroidal anti-inflammatory drugs (NSAIDs), sympathomimetic bronchodilators, cough and cold medications, benzodiazepines, tricyclic antidepressants, phenothiazines, H2 antagonists, topicals, and most antibiotics. Pharmacists must carefully review each situation individually. Drug classes (e.g., antiarrhythmics, antiepileptics) should be substituted only in emergencies.

Model Therapeutic Substitution Guidelines. The following procedures may be used as a guide when assessing patient medication requirements in the event of a disaster response:

*Patient History - Review the patient's chart or take a verbal history. If possible, the patient should be asked to provide old prescription vials. The following should be clarified as necessary:

Current medications

- Indication

- Dose
- Route
- Duration patient has received
- Efficacy
- Adverse effects

Concomitant medications/conditions

- Assess the patient for other conditions and use of other medications (legal or illegal)

*Determine if the situation requires therapeutic substitution.

*Review the current formulary and, based on clinical experience, develop appropriate therapeutic substitution actions as warranted and allowed. When possible, consult a pharmaceutical compendium for appropriate exchange.

*Assess the patient's current living conditions. Determine if the patient has access to clean food and water, shelter, refrigeration, transportation, communication, etc.

*Compliance - Assess if the patient will be able to comply with the new instructions.

Consider language barriers, patient cognizance, and medication restrictions (e.g., avoid sunlight, take medication with food).

*Patient Education

- Explain that a substitution is being made and why.
- Clarify the new instructions.
- If applicable, emphasize that the new drug is different in color or shape than the patient's usual medication.
- Detail any potential new or different toxicities or reactions.

- Instruct the patient to return to his or her normal pharmacy as soon as possible to resume the original regimen.
- Do not discharge the patient until both the pharmacist and the patient are comfortable with the new instructions.

*Documentation

- Prescription label - A note similar to the following should be included with the prescription: "As a result of the recent emergency, a therapeutic substitution has been made. When possible, please return to your usual pharmacy to continue with your previously prescribed medication."
- Patient chart/record - Document current medications and what therapeutic substitutions were made (if any). Briefly describe what patient education was undertaken.

Patient Education. Regardless of the setting, good pharmaceutical and professional practice standards dictate that patient education should be given (or at least attempted) whenever medications are dispensed. In a field or austere setting, unique problems or challenges will be present. Among the concerns that should be considered when providing this interface in a field setting are the following:

Environmental Factors - Even in the best of situations, the patient may be overwhelmed with peripheral factors that prevent effective education. In normal patient encounters, very low retention of very small amounts of information has been documented. Under the stresses of an emergency situation and a temporary or new health delivery setting, retention of information becomes extremely problematic.

To compensate for these difficulties, the pharmacist can exaggerate the normal components of any patient encounter by asking the patient simple questions about the information just provided: "How many times a day will you take this medicine?" "Are there any problems that you can expect while taking this medicine?"

Written Information -Combining written information coupled with verbal counseling is the best strategy for patient education. In emergency situations, the materials needed for written information may be scarce, but this form of patient education should be provided, if possible.

The pharmacist can emphasize "vital" (as opposed to "needed" or "useful") information by adding another label to the dispensing unit (bottle, bag, or envelope). A word such as "Remember," "Caution," or "Storage" can be used to separate this information from directions for use.

Disease Surveillance

The pharmacist is in a unique position to receive input from a patient about diseases that were overlooked in the triage/treatment area. The "Oh, by the way" phrase often leads to information about other aspects of the individual's condition that were overlooked or simply had a low comparative importance. Examples are borderline hypertension and chronic dizziness. The pharmacist must then determine whether the condition warrants personal intervention to get the patient back into treatment, whether the pharmacist has medications to treat the condition, and if this problem has been addressed in the operating procedures for the clinic. Prudent judgment, good professional intervention, and the reality of the setting must indicate the direction of treatment.

Whatever the outcome, all actions taken must be documented in the record system. If patient records are being used, the problem should be noted on the form. If a “prescription blank” system is in place, the problem should be documented on the form. In whatever record system is used, enough disease/drug information should be provided so that someone who reviews the documentation later will be able to understand the nature of the analysis that occurred, what was considered, and what action was taken. If no real record system exists, the pharmacist must make the best of the situation.

Adverse Drug Event Surveillance

Although good pharmacy practice involves surveillance for adverse drug events, dispensing medications in austere field settings does not allow the usual careful attention to this monitoring. Critical concerns relevant to adverse drug events are listed below:

- *The patient should be advised of any probable adverse effects of drugs being dispensed, especially if the drug is new or a substitution from his or her normal medications.
- *The patient should be advised about the course of action to take if an adverse event occurs, e.g., decrease the medication, decrease activity, tolerate the reaction until it subsides.
- *The patient should be told of possible problems and what to do if they occur, including any possible occurrence that might warrant a return to the clinic.
- *This may be the pharmacist's only encounter with the patient, which will limit surveillance for adverse events. Nonetheless, it is hoped that the normal dispensing system will return quickly.

*Critical instructions, such as “Do not operate motor vehicles,” “Avoid milk and milk products,” “Take this medication with food,” should be given to the patient in writing, if possible.

*The pharmacist should document his or her actions in whatever record system exists.

Field Medical Records

The traditional mechanism for maintaining continuity of care for the patient is the medical record. This roving document becomes the patient's pathway through the entire triage/treatment process. At the end of this process, the record becomes the mechanism for the dispensing of medications. In a field setting, this form, its format, and its content may be considerably different from records used in traditional clinic settings. All pharmaceutical interventions (including medications dispensed, communications with health providers, and modifications in pharmaceutical orders) must be noted clearly in the patient's chart and be signed and dated by the pharmacist.

In addition to being the working file for the patient, allowing transit and care, the medical record is also a legal document that becomes a potential protection or liability to providers—depending on the care with which it has been maintained. Medical records are covered by legal mandates for confidentiality (the Medical Records Confidentiality Act of 1995) and are used to document the effectiveness of care provided by the organization.

Confidentiality is an important factor when patients' records are reviewed before pharmaceuticals are dispersed. Immediately upon arrival at the facility, the pharmacist's desire to provide the best possible level of care must be conveyed to others on the

medical staff. Assurance that the pharmacist's use of patients' records to review medical histories and medications will be professional and meaningful to patients' outcome and to health care management in general must be conveyed.

The formats of medical records systems vary and, with the advent of institutional computer systems, the physical copy of a medical record may be a thing of the past. However, in an austere field setting, the written document may be all that exists. Its integrity is vital to the proper functioning of the unit.

Critical elements of any record system include the following:

- Patient's name and unique identifier(s)
- Physical parameters (weight, height, etc.)
- History of exposure, familial factors, medical history, and other relevant issues
- Nature of the complaint for the current visit
- Observations of care providers
- Actions taken by the providers to address the complaint
- Any future actions for the patient

A reasonable effort should be made in conjunction with the other components of the field health setting to ensure use of the most reasonable record system that will meet the immediate needs of the patients and staff, but also allow a transfer back to normal community services when the emergency is over. Regardless of the record system in a field setting, a vital element of treatment is determining who can have access to the medical record, who can enter items on the record, who is responsible for maintaining the record after the patient encounter (or ensuring patients take the record with them), and who maintains the supply of blank forms.

In most settings, the pharmacist must ensure that the chart follows the patient throughout the treatment process and that the complete record is the basis for dispensing all medications. Proper background information can provide additional information improving pharmaceutical care. Having only a written prescription may complicate matters and create a problem in dispensing medications. Although most providers now acknowledge this need for background information, the team pharmacist may have to address this issue to ensure optimal patient flow and treatment.

The medical record benefits from simplicity. Only necessary information should be provided. Notations should be brief yet complete. Only generally acknowledged abbreviations or shorthand should be used. No extraneous material should be noted, especially if it may confuse another provider. All information that will be needed by the permanent care provider should be entered.

For pharmaceutical care, the diagnosis should be stated clearly and the dispensing provider should have a clear and proper order. If the medication that is requested is not available, the policy established for therapeutic substitution at the site should be followed and documented in the record. As under normal conditions, specific information about the dispensed medication (name, quantity, etc.) should be documented.

Medical/Medication History

In most cases in the field setting, the pharmacist does not need to collect much medical history—this should have been done in the triage/treatment process. The physical assessment should also have been completed. However, these expectations for the process will not prevent a new minor occurrence from arising during the pharmacist's

encounter with the patient. (“This cut was not enough to bother the doctor, but could I have something for it.”)

The pharmacist should read the patient’s history and determine what information is applicable to his or her interaction with the patient and what additional information is needed for the dispensing of medication. Information about allergies is especially important. If the medication to be dispensed has special storage problems, they should be explained to the patient (e.g., the need for reconstituted antibiotics to be refrigerated). Since the stress of a traumatic situation heightens problems in communication, and the pharmacist is often the patient's last stop before leaving the facility, the pharmacist should make an extra effort to talk with patients and ask if there is anything else they need before leaving. The patient may need clean bandages, instruction about when to come back for follow-up, or a list of the clinic's hours. The pharmacist is encouraged to stretch the limits of pharmaceutical care—he or she may be the most critical element in the patient's time in the clinic.

Finally, in concurrence with whatever procedure has been adopted in the field environment, the pharmacist must ensure the patient’s medical record is managed after the dispensing function. The patient might take it along when he or she leaves, or it might be returned to the triage area.

Re-Deployment Activities at Home

Critical incident stress management (CISM) should be required following every deployment. The pharmacist should inspect and inventory supplies immediately. All items that were used or damaged during deployment should be replaced. Product

integrity and expiration dates should be checked and items replaced as warranted. In addition, the staff should make sure all equipment is in working order. Travel vouchers should be filed promptly. Uniforms and equipment should be cleaned, and repaired if necessary, so everything is ready for the next deployment.

After-Action Issues

Reporting all concerns, observations, problems, corrective suggestions, and positive feedback is very helpful to the Office of Emergency Preparedness in planning for future events or deployments. The following format can be use to report after-action issues:

U.S. Public Health Service/Office of Emergency Preparedness
After-Action Issues

Subject:

Observation:

Discussion:

Recommendation:

Lesson Learned:

Comment:
