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Minnesota Board of Pharmacy News

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Disciplinary Activity

The Minnesota Board of Pharmacy took the following disciplinary actions concerning **pharmacists** between the dates of September 19, 2012 and April 10, 2013.

Gibson, Brian T., License #116035. Mr Gibson was the pharmacist responsible for the dispensing of a prescription that resulted in a 10-fold overdose of potassium. The patient was the resident of a nursing home. Mr Gibson contacted a nurse at the nursing home, rather than the prescriber, to verify the accuracy of the dose. In addition, he permitted a technician to accept the return call from the nurse, which is not a task that a technician is allowed to perform. Consequently, the Board adopted a stipulation and consent order at its October 31, 2012 meeting, which reprimanded Mr Gibson, required him to pay a civil penalty in the amount of $2,500, and required him to take and pass the Pharmacist Assessment for Remediation Evaluation℠ (PARE℠) that is administered by the National Association of Boards of Pharmacy®. Information about the PARE can be found at *www.nabp.net/programs/assessment/pare.*

Haugerud, Sigrun, License #119035. Dr Haugerud incorrectly certified two prescriptions for controlled substances (CS). In one case, a prescription was written for two fentanyl patches, but two boxes of patches were dispensed. In the other case, the prescription was clearly written for 14 tablets of MS Contin®, but 28 tablets were dispensed. In addition, the patients received no counseling for these prescriptions, which may have helped prevent the errors from occurring. Consequently, the Board issued a stipulation and consent order at its October 31, 2012 meeting that reprimanded Dr Haugerud and assessed a $500 civil penalty.

Klus, Erika A., License #117562. Dr Klus engaged in a pattern of conduct demonstrating an inability to practice pharmacy with reasonable skill and safety, which includes the regular use of an illicit CS. Consequently, the Board adopted an order at its September 19, 2012 meeting that revoked her license.

Lundstad, Lance J., License #119193. Mr Lundstad petitioned the Board for an unconditional license. The Board had placed conditions and limitations on his license in 2007 due to the fact that his Wisconsin license was under restriction in that state due to the diversion of CS. Since he had met all of the conditions of his previous order, the Board granted Mr Lundstad's petition and issued an order of unconditional licensure at its January 30, 2013 meeting.

Schliemann, Nichole B., License #119500. Dr Schliemann agreed that a disciplinary order could be issued by the Board based on the following facts: she had been arrested twice for stealing merchandise from department stores; and a harassment restraining order had been issued against her based upon threatening phone calls she had made to a former pharmacy supervisor. Consequently, at its January 30, 2013 meeting, the Board issued a stipulation and consent order suspending Dr Schliemann's license. The suspension was stayed on condition that she successfully complete the Health Professionals Services Program and abstain from the use of mood-altering chemicals except those expressly prescribed for her.

The Board took the following disciplinary action concerning a **pharmacist-intern** between the dates of September 19, 2012 and April 10, 2013.

Van Beusekum, Valerie A., Registration #808942. Ms Van Beusekum admitted that she attempted to fill forged prescriptions for Lortab® and Methylin™. As a result, she pleaded guilty to felony fifth-degree procurement/possession of a CS by fraud or deceit. Consequently, the Board adopted a stipulation and consent order at its January 30, 2013 meeting, which conditions Ms Van Beusekum's continuing registration as an intern upon her participation in, and successful completion of, the Health Professionals Services Program.

Governor Dayton Makes Appointments to Board

On February 12, 2013, Governor Mark Dayton announced the appointments of Rabih Nahas and Justin Barnes to the Board. Mr Nahas is appointed to a four-year term that expires January 3, 2017. Dr Barnes is appointed to fill out the remaining term that was vacated by Ikram-Ul-Huq. His term expires January 2014.

Mr Nahas, of Orono, MN, is a licensed pharmacist with over 23 years of experience in hospital pharmacy. He is currently

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FDA Issues New Guidelines for Sleep Aids Containing Zolpidem

Food and Drug Administration (FDA) has issued new dosing recommendations for sleep aids containing zolpidem. The new recommendations are based upon new data that shows that when taken at night, blood levels of zolpidem remain high enough in the morning to impair activities that require alertness, such as driving. The new guidelines halve the dosage for women because the new data showed that their bodies take longer to eliminate the drug.

FDA urges drug manufacturers and health care providers to follow the new dosing instructions, which apply to brand name and generic drugs containing zolpidem:

- Ambien®, Edluar™, and Zolpimist®: 5 mg for women, 5 mg or 10 mg for men
- Ambien CR®: 6.25 mg for women, 6.25 mg or 12.5 mg for men

Additionally, manufacturers of these drugs have been instructed to follow the new guidelines and print new patient information drug labels containing the new recommendations.

The recommended doses of Intermezzo®, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men. Additional details are available in an FDA Drug Safety Communication, available at *www.fda.gov/Drugs/DrugSafety/ucm334033.htm.*

What is the National Medication Error Rate? What Standards Are Available for Benchmarking?

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. *ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

A national or other regional medication error rate does not exist. It is not possible to establish a national medication error rate or set a benchmark for medication error rates. Each pharmacy organization is different. The rates that are tracked are a measure of the number of **reports** at a given organization, not the actual number of **events** or the quality of the care given. Most systems for measuring medication errors rely on voluntary reporting of errors and near-miss events. Studies have shown that even in good systems, voluntary reporting only captures the "tip of the iceberg." For this reason, counting **reported** errors yields limited information about how safe a pharmacy actually is. It is very possible that a pharmacy organization with a good reporting system, and thus what appears to be a high error "rate," may have a safer system.

The National Coordinating Council for Medication Error Reporting and Prevention published a statement refuting the use of medication error rates. The statement, which is posted on the council's Web site (*www.nccmerp.org*), states the "Use of medication error rates to compare health care organizations is of no value." The council has taken this position for the following reasons:

- Differences in **culture** among health care organizations can lead to significant differences in the level of reporting of medication errors.
- Differences in the **definition** of a medication error among health care organizations can lead to significant differences in the reporting and classification of medication errors.
- Differences in the **patient populations** served by various health care organizations can lead to significant differences in the number and severity of medication errors occurring among organizations.
- Differences in the **type(s) of reporting and detection systems** for medication errors among health care organizations can lead to significant differences in the number of medication errors recorded.

According to the statement, the council believes that there are no acceptable incidence rates for medication errors. The goal of every health care organization should be to continually improve systems to prevent harm to patients due to medication errors. Pharmacies should monitor actual and potential medication errors that occur within their organization, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential patient harm. The value of medication error reporting and other data gathering strategies is to provide the information that allows an organization to identify weaknesses in its medication-use system and to apply lessons learned to improve the system. The sheer number of error reports is less important than the quality of the information collected in the reports, the organization's analysis of the information, and its actions to improve the system to prevent harm to patients.

It is more important to create the open environment that encourages the reporting of errors and near errors than to develop less meaningful comparative error rates.

ISMP Launches Program to Track Vaccine Errors

ISMP has launched a National Vaccine Error Reporting Program (VERP) that allows health care providers to confidentially report vaccine administration errors and near misses. Health care providers from all practice settings, including pharmacies and physicians' offices, are encouraged to report all mistakes related to vaccines, regardless of whether any harm resulted from the incident. The program will help ISMP "better quantify the sources of errors and advocate for vaccine name, labeling, device, information, and other needed product changes to ensure patient safety," stated Michael Cohen, ISMP president. The ISMP VERP was designed with the assistance of the California Department of Public Health and with input from experts in the field, indicates ISMP. Reports sent to the ISMP VERP will be shared with FDA and forwarded to the vaccine manufacturer when applicable. ISMP also plans to work with the Centers for Disease Control and Prevention on information received to address vaccine-related safety. VERP can be accessed at *http://verp.ismp.org/.*

Providers Should Ensure Only Diluted Forms of Acetic Acid Are Used, ISMP Warns

ISMP has issued a National Alert Network (NAN) notice advising that health care organizations should take immediate steps to ensure that only diluted acetic acid solutions are used in patient care. ISMP advises that the use and purchase of glacial acetic acid, the most concentrated form of acetic acid available, should be eliminated. Several cases of severe burns, scarring, and other permanent damage to skin or mucous membranes due to the inadvertent application of glacial acetic acid have been reported to the National Medication Errors Reporting Program operated by ISMP. ISMP provides the following steps for preventing further such events:

- Remove glacial acetic acid, which has no use in its current form in clinical medicine, from the pharmacy and replace with vinegar (5% solution) or commercially available diluted acetic acid 0.25% (for irrigation) or 2% (for otic use).
- Restrict purchasing so that pharmacy staff is purchasing acetic acid for all procedural areas.
- Restrict choices for purchasing so that glacial acetic acid is not selected by mistake.
- Ensure the correct strength is ordered.
- Educate staff about the differences between glacial acetic acid and diluted forms of acetic acid.
- Order 5% as "vinegar," which reduces the potential for confusion with glacial acetic acid.
- Verify the product by requiring an independent double-check of acetic acid solutions before dispensing or applying the product.

Information on the cases reported and common reasons for the cases are included in the NAN alert, which is available on the ISMP Web site at *www.ismp.org/NAN/files/20130121.pdf.*

New FDA Training Video

FDA Drug Info Rounds, a series of online training videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better medication decisions. In the latest Drug Info Rounds video, pharmacists discuss how FDA Drug Safety Communications let health care providers, patients, and consumers know about newly observed potential risks of FDA-approved drugs. Drug Info Rounds videos are developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information and are available on the FDA Web site at *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm.*

Progress Made in Implementing Recommendations Intended to Prevent Acetaminophen Overdose

Compelling progress has been made by stakeholders seeking to address the public health issue of acetaminophen overdose, indicates a white paper published by the National Council for Prescription Drug Programs (NCPDP). In 2011, NCPDP made recommendations that the health care industry take actions to support the safe use of acetaminophen, including recommending that pharmacies produce prescription labels with the complete spelling of acetaminophen and eliminating use of abbreviations such as "acet" or "APAP." Previous to that, in July 2010, the National Association of Boards of Pharmacy® (NABP®) recommended that "state boards of pharmacy prohibit the use of the abbreviation 'APAP' on prescription labels, and require that 'acetaminophen' be spelled out to assist in preventing the well-recognized danger of acetaminophen induced hepatotoxicity." The recommendation was based on established policy and a letter, sent by FDA to state boards of pharmacy, regarding the pharmacist's role in educating patients about acetaminophen induced hepatotoxicity caused by unintentional overdose. The recommendation was also consistent with the report of the NABP Task Force on Uniform Prescription Labeling Requirements, which made recommendations to encourage use of prescription labels that are organized in a patient-centered manner. NCPDP reports that pharmacy retailers "estimated to collectively represent more than half of the prescriptions dispensed in 2011, have either implemented or committed to a phased implementation" of the recommendation to use the complete spelling of acetaminophen on prescription labels. "This update to our white paper provides additional guidance for those industry stakeholders who have not yet implemented the new pharmacy labeling practices for acetaminophen-containing medicines," states Lee Ann Stember, president, NCPDP. The updated white paper is accompanied by a bulletin (PDF), available at *www.ncpdp.org/pdf/wp/NCPDPAcetaminophenInfoBulletin_PharmacyStakeholders.pdf,* developed for pharmacists that summarizes some of NCPDP's key recommendations regarding acetaminophen. In addition, the white paper, available for download at *www.ncpdp.org/ind_WP.aspx,* includes a list of resources for pharmacists to use in educating staff and pharmacy staff to use in educating patients (see Appendix D of the white paper). More information is available in an NCPDP news release available at *www.ncpdp.org/press/013113_NCPDP_Acetaminophen%20WP_FINAL.pdf.*

Pharmacists Rated High for Honesty and Ethical Standards in Gallup's 2012 Poll

Pharmacists ranked as the second most trusted profession in the 2012 Gallup Poll that asked consumers to rate 22 professions according to their honesty and ethical standards. Pharmacists were ranked as very high or high in this category by 75% of those surveyed, with nurses ranking first at 85%, and medical doctors third at 70%. Additional information on the results of the 2012 poll is available on the Gallup Web site at *www.gallup.com/poll/159035/congress-retains-low-honesty-rating.aspx*.

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a clinical pharmacist at Abbott Northwestern Hospital in Minneapolis, MN. He earned his bachelor of science degree in pharmacy from Drake University. Mr Nahas is appointed as a pharmacist member and replaces Mr Jim Koppen on the Board.

Dr Barnes, of Minneapolis, is a postdoctoral researcher of neurodegenerative diseases at the University of Minnesota Institute for Translational Neuroscience. His research focuses on underlying disease mechanisms of Parkinson's disease. He earned his bachelor of science degree from Michigan State University where he majored in biochemistry and molecular biology, and completed his doctorate in neuroscience at the University of Minnesota in 2011. Dr Barnes is appointed as a public member and replaces Ikram-Ul-Huq on the Board.

Pharmacy Technicians

Continuing Education

A pharmacy technician's registration renewal for calendar year 2014 will not be issued unless the technician has completed 20 hours of approved continuing pharmacy technician education (CPTE) during the two-year period between August 1, 2011 and July 31, 2013. Thereafter no annual pharmacy technician registration renewal will be issued unless the technician presents the Board with satisfactory evidence of completion of 20 hours of approved CPTE per two-year reporting period, with each period ending on July 31, of odd-numbered years. This information was first provided to pharmacy technicians in 2011, with follow-up reminders in 2012. Note that technicians who registered for the first time on or after September 1, 2011, are required to complete a smaller number of CPTE hours, based on the number of months between the date that they registered and the end of the CPTE reporting cycle.

CPTE must focus on competencies related to the duties that technicians are allowed to perform. The Board automatically accepts programs developed **specifically** for technicians by continuing education (CE) providers approved by either the Accreditation Council for Pharmacy Education or by the Board. The Board also automatically accepts programs that are developed by such providers for **both** pharmacists and technicians. The Board does **not** automatically allow technicians to receive CE credit for programs that are developed **exclusively** for pharmacists. A technician may also apply for credit for completion of programs developed by other organizations, provided that the technician completes a CE program approval form, obtainable from the Board's Web site, and submits it to the Board within 90 days after completing the program *(www.pharmacy.state.mn.us/forms/ceatndee.pdf).*

Please note that meeting the CE requirement for certification as a pharmacy technician does NOT necessarily mean that the technician has met the Board's CPTE requirement. CPTE courses that you complete as part of the certification process **can** be used to meet the Board's CE requirement for this reporting period, but **only** if they are completed between August 1, 2011 and July 31, 2013. CE courses completed prior to August 1, 2011, cannot be used for this reporting cycle, even if they did count for certification purposes. This applies whether the certification is obtained through the Pharmacy Technician Certification Board or the National Healthcareer Association.

Technicians must certify that they have completed the required CPTE. This can be done in one of several ways, which are described in detail in a document that can be viewed on the Board's Web site at *www.pharmacy.state.mn.us/forms/cetech.pdf.*

As that document explains, technicians who have not certified the completion of CPTE by August 1, will have their registration status automatically changed to "Owes CE" and will not be allowed to renew their registration until they either mail, fax, or scan to the Board evidence of having completed the required CPTE.

Just as occurs with pharmacists, 10% of technicians who have certified completion of their CE will be audited by the Board. Those technicians will be required to send in proof that they have completed the required CPTE. Failure to certify completion of CPTE, or falsely certifying completion of CPTE, may result in disciplinary action.

If you have had a crisis over the past two years that has affected your ability to complete your CE, please send the Board a letter or e-mail stating why you did not complete the CE requirement, how many hours you still need to complete, and the date when these hours will be completed. These extension requests will be reviewed and you will be notified, in writing, if the approval is granted or not. If it is granted, you will be given a new due date. Generally, extensions are only approved for serious medical conditions or other significant, life altering events, such as a divorce or the death of a close family member.

Questions Concerning Technician Registration Requirements

The Board's office continues to receive many questions concerning the technician registration changes that were adopted by the Board in 2011. Information about those changes has been provided in previous editions of this *Newsletter,* in e-mails sent to licensees and registrants, and in documents posted on the Board's Web site. Individuals who have questions about pharmacy technician registration are strongly encouraged to review the documents posted on the Board's Web site on the following page: *www.pharmacy.state.mn.us/pharmtec.htm.* Questions not answered by the documents found on that Web page may be directed to members of the Board's staff by calling the office during normal business hours or by e-mail. The Board's general e-mail address is Pharmacy.Board@state.mn.us.

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