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New Mexico Board of Pharmacy News

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Fifty-Year Pharmacists

The New Mexico Board of Pharmacy wishes to honor pharmacists who have been registered in New Mexico for 50 or more years. To honor them, the Board will publish their names in the *Newsletter* regularly. Interestingly, the first person on the list in alphabetical order, Joseph Abeyta, has been registered the longest. Joseph was registered March 12, 1951. At the other end is Donald Welborn. Donald, the newcomer, has only been registered since July 8, 1964. Of the 33 names on the list, all but four still reside in New Mexico. Congratulations to all, and thank you for your service to the profession of pharmacy.

Joseph Abeyta	Robert McClelland
Jack Churchill	Joseph Mengoni
Durward Colbert	Lewis Muir
Kenneth Corazza	Lonnie Nunley
George Downs	Edward Osborne
Lawrence Etherton	Philip Parkhurst
Arturo Figueroa	Dennis Pena
Kenneth Fourcher	Tony Pesavento
John (Chris) Gallegos	Walter Peyton
Robert Ghattas	Ramon Rede
Richard Gomez	James Reed
Laurence Guggino	Robert Shmaeff
John Heaton	Raymond Sierks
John Huffmyer	Larry Sparks
Dillard Irby	Johnny Volpato
Lowell Irby	Donald Wellborn
William Long	

Disciplinary Actions

Bobby Arther – ECO Medical Supply – License WD-10370. ECO Medical Supply is registered with the Board as a wholesale drug distributor. As a wholesale drug distributor, ECO Medical Supply can receive, store, handle, and distribute prescription drugs. Regulations passed by the Board specifically mandate that a wholesale drug distributor cannot operate from a place of residence. ECO Medical Supply did not meet the requirements stated in the regulations. After being cited during an inspection, respondent did not correct violations listed. The Board suspended registration. Respondent may reapply for licensure after becoming certified from the National Association of Boards of Pharmacy® as a Verified-Accredited Wholesale Distributor®. Must pay costs totaling $1,261.

John Ashcraft, PA – License CS-17837. Practitioner's controlled substances (CS) registration was revoked by default.

Gregory Chavez, PT – License PT-7587. On November 13, 2013, the Board was alerted that respondent had obtained and filled CS prescriptions using the credentials of a certified nurse practitioner (CNP) who worked where respondent had been employed. Respondent was positively identified by the CNP using surveillance video from the pharmacy. The Board issued a Notice of Contemplated Action (NCA). The NCA was returned to Board as "Attempted - Not Known." Respondent did not request a hearing. Respondent's pharmacy technician registration was revoked by default for a period of at least 36 months. Respondent must pay $400 fine.

Geneva Cisneros, PT – License PT-8639. Respondent was suspected, by her employer, of the attempted theft of 10 tablets of morphine sulfate 30 mg ER from the pharmacy at which she was employed. Respondent was sent an NCA by certified mail. The NCA was returned as unclaimed. Respondent did not request a hearing. Respondent's pharmacy technician registration was revoked by default. The Board may consider reinstating respondent's registration after a period of 36 months. Respondent must pay a fine of $1,650.

Anthony Fliss, PT – License PT-8039. The Board was notified that respondent was behind in child support payments. This is a violation of the New Mexico Parental Responsibility Act. Also, respondent failed to notify the Board of his change of address, a regulatory requirement. The Board requested an NCA. Respondent did not request a hearing in the required period. The Board revoked respondent's registration as a pharmacy technician. Upon verification that respondent is in compliance with the New Mexico Parental Responsibility Act, respondent may reapply. Must pay costs of investigation in amount of $100.

Harriet James, CNP – License CS-207595. Respondent had her nurse practitioner certification suspended by the New Mexico State Board of Nursing. This certification is required for a nurse practitioner seeking a CS registration from the Board. Respondent had reapplied for a CS registration. This request was withdrawn by respondent prior to a hearing by the Board.

Jennifer Kobyljanec-Rodgers, RPh – License RP-6539. Respondent voluntarily surrendered her registration to practice pharmacy.

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National Pharmacy

(Applicability of the contents of articles in the National Pharmacy Comp
and can only be ascertained by examini

New Educational Video for Pharmacists Addresses Prescription Drug Abuse

The National Association of Boards of Pharmacy® (NABP®) and the Anti-Diversion Industry Working Group (ADIWG), a consortium of pharmaceutical manufacturers and distributors of controlled substances (CS), have released an educational video for pharmacists to help them identify the warning signs of prescription drug abuse and diversion when dispensing CS prescriptions. The video, entitled "Red Flags," encourages pharmacists to help combat this national problem by exercising their professional judgment to ensure that the prescriptions they dispense were written for a legitimate medical purpose, and to act upon any unusual behavior they observe.

Drug Enforcement Administration and various state pharmacy boards have described "red flags" as circumstances surrounding the presentation of a CS prescription that should raise reasonable suspicion about the validity of that prescription. The video highlights a number of these potential warning signs, some of which are not easy to spot, by weaving personal narratives with interactions between pharmacists and customers.

The video is available in the Pharmacists section of the AWAR$_X$E® Prescription Drug Safety website at *www.AWARERX.ORG/pharmacists*.

Root Causes: A Roadmap to Action

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization 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 provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the ISMP National Medication Error Reporting Program Report online at* www.ismp.org. *E-mail: ismpinfo@ismp.org.*

Errors are almost never caused by the failure of a **single** element in the system. More often, there are **multiple** underlying system failures that lead to an error, many of which can be identified when the involved health care providers take the time to uncover them.

Consider the following error: A doctor sent a hand-written order for car**bam**azepine 400 mg twice daily for an adult patient with a history of seizures.

The pharmacist entered the medication into the profile of a four-year-old child with the same last name as the adult patient for whom the medication had been prescribed.

The pharmacist failed to notice that the patient was a child, as age was not in a prominent location on the order entry screen. The nurse failed to recognize that the dose was too high and administered 400 mg of car**bam**azepine to the child. She also never thought to question why the pharmacy would send oral tablets for a four-year-old child, considering that the drug is available in chewable tablets and as a liquid suspension.

The nurse **assumed** that the child was receiving the medication because he had a history of seizures. However, the nurse did not check the patient's medical record. In fact, the child did **not** have a history of seizures.

The parents had a very limited understanding of English, so they were unable to intervene to correct the erroneous seizure history.

The error was finally detected after the child became lethargic and developed nausea and vomiting. At the time of discovery, the child's car**bam**azepine level was 18 mcg/mL; levels greater than 12 in pediatric patients are supratherapeutic.[i]

It may be discouraging to see how many things go wrong when a medication error reaches a patient. However, a thorough root cause analysis (RCA) can uncover the latent failures and produce an action plan to avoid future errors.

ISMP, through a generous grant from the National Association of Boards of Pharmacy Foundation™, has developed the *Root Cause Analysis Workbook for Community/Ambulatory Pharmacy.* The workbook is designed to assist community pharmacy personnel in completing RCA for a sentinel event that may have occurred in their pharmacy. The RCA workbook uses a specific set of steps and associated tools to identify the primary causes of the **sentinel event.**

The goal of the RCA is to create an action plan framework, including risk-reduction strategies, communication and implementation strategies, and measurement of effectiveness.

RCA for **sentinel events** is required in the Center for Pharmacy Practice Accreditation's standards developed by NABP, American Pharmacists Association, and American Society of Health-System Pharmacists Association, as well as by several boards of pharmacy in conjunction with their continuous quality improvement regulations.

This ISMP RCA workbook is suitable for use in community pharmacy, mail-order pharmacy, or other ambulatory pharmacy practice settings that need to investigate a **sentinel event.** For more information and to access the **free** workbook, visit *www.ismp.org/tools/rca/.*

[i] *http://pediatrics.aappublications.org/content/113/2/406.abstract*

FDA Withdraws Approval of Some High Dose Acetaminophen Products

Food and Drug Administration (FDA) is withdrawing approval of 108 abbreviated new drug applications (ANDAs) for prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit. For the 108 ANDAs, the manufacturers asked to withdraw their applications, as announced in the March 27, 2014 *Federal Register* notice. A second *Federal Register* notice addresses the applications of six manufacturers who have discontinued marketing their products, but who have not withdrawn their applications. The notice also announces FDA's intention to begin the process of withdrawing approval of those applications.

In light of these announcements, and to protect patients from inadvertent acetaminophen overdose, NABP advises that pharmacies no longer dispense combination drugs containing more than 325 mg of acetaminophen per dosage unit. NABP also advises that pharmacists consult with prescribers to discuss alternative products with lower acetaminophen doses.

FDA asked manufacturers to voluntarily withdraw these products from the market to reduce the risk of severe liver injury from inadvertent acetaminophen overdose. In January 2014, FDA recommended that providers consider prescribing acetaminophen products containing 325 mg or less per dose. The original announcement may be found in the Drug Safety and Availability section of FDA's website at *www.fda.gov/Drugs/DrugSafety*.

NCPDP Recommends Standardized Metric Measurements on Oral Liquid Medication Labels

The National Council for Prescription Drug Programs (NCPDP) has issued new recommendations and guidance for standardizing the dosing designation used on prescription container labels of oral liquid medications dispensed by community pharmacies in order to reduce dosing errors. NCPDP notes that such errors have been "a source of concern for many years," and that dosing errors involving young children are of particular concern because they may be more susceptible to harm from measurement errors and overdoses. The paper outlines the following recommendations for the dosing designation on prescription container labels for oral liquid medications:

- The millimeter (mL) should be used as a standard unit of measurement.
- Dose amounts should always use leading zeros before decimal points for amounts less than one and should not use trailing zeros after a decimal point.
- Dosing devices with numeric graduations and units corresponding to the container label should be made easily and universally available. For example, a device should be included with each dispensed medication.

The white paper was developed following a meeting with stakeholders representing 27 participants, including NABP. In addition to its general recommendations, the white paper also issued calls to action for relevant stakeholders, including government agencies, standards organizations, pharmacists and pharmacy technicians, pharmacy leadership, and health care associations. The white paper, *NCPDP Recommendations and Guidance for Standardizing the Dosing Designations on Prescription Container Labels of Oral Liquid Medications,* is available for download from the NCPDP website at *http://ncpdp.org/Education/Whitepaper*.

USP Proposes New General Chapter Addressing Compounding of Hazardous Drugs

In an effort to protect health care providers and personnel who handle hazardous drugs, United States Pharmacopeial Convention (USP) has proposed new General Chapter <800> Hazardous Drugs–Handling in Healthcare Settings. The new proposed chapter addresses standards that apply to all personnel who compound hazardous drug preparations and all places where hazardous drugs are prepared, stored, transported, and administered. The new chapter also covers standards for receiving, storing, compounding, dispensing, administering, and disposing of nonsterile and sterile products and preparations. The proposed chapter applies to all personnel who are involved in handling hazardous drugs, including health care providers and staff, occupational health and safety specialists, and human resources. General Chapter <800> was published in the May/June issue of *Pharmacopeial Forum,* and may currently be viewed on the USP website at *www.usp.org/usp-nf*. Comments were accepted until July 31, 2014.

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Gregory Looper, PT – License PT-9094. The Board was notified that respondent was behind in child support payments, and therefore, was in violation of the New Mexico Parental Responsibility Act. The Board requested an NCA. The NCA was returned because respondent did not notify the Board of address change as required. Respondent did not request a hearing in the required period. The Board revoked respondent's registration as a pharmacy technician. Upon verification that respondent is in compliance with the New Mexico Parental Responsibility Act, respondent may reapply. Must pay costs of investigation in amount of $100.

Armin Quedzuweit, RPh – License RP-7774. This matter regarding respondent came before the Board. Respondent had been arrested by local police. Reason for arrest included both battery on a health care professional and battery on a police officer. Arrest report stated that respondent has a "known history of alcoholism." As a result of this possible alcohol abuse, respondent was to be evaluated by the New Mexico Monitored Treatment Program (MTP). Respondent was evaluated by MTP and entered into a contract with MTP. However, respondent was not evaluated in the time period allowed. Respondent was served with an NCA. Respondent requested a hearing. Respondent did not show up for the hearing. The Board revoked respondent's pharmacist registration. Must pay fine and costs totaling $1,850.86. Respondent must complete five-year contract with MTP.

Kenneth Sanchez, PT – License PT-4852. At the January 2011 Board meeting, respondent's pharmacy technician registration was revoked by default. Respondent was ordered to pay $400 at that time. Respondent did not pay. In a letter dated April 4, 2012, the Board requested payment. Instead of paying, respondent appeared before the Board on June 21, 2012, requesting reinstatement of his registration. On July 12, 2012, the Board issued an order to reopen this case. Respondent was still required to pay $400. Board staff again requested payment in a letter dated March 7, 2013. On April 25, 2014, the Board issued an Order to Show Cause to allow respondent an opportunity to present his case. The Order to Show Cause was returned as "Attempted - Not Known." Respondent did not appear at the June 18, 2014 Board meeting. The Board ordered the Default Order of Revocation reinstated. Respondent's pharmacy technician registration is revoked for 10 years, beginning June 18, 2014.

Jason Trimmer, IN – License IN-3108. Respondent appeared to be impaired while working as a pharmacy intern. Respondent then tested positive for Schedule II CS. Respondent was ordered to be assessed by the MTP. Respondent was assessed and it was thought that it is not safe for respondent to work as a pharmacy intern. An NCA was sent by the Board to respondent. Respondent did not request a hearing. Respondent's intern registration was revoked by default. Respondent may be reinstated after a 36-month period. Respondent shall pay a fine of $200.

Reminder of PMP Reporting Requirements

Recently, a notice was mailed to all dispenser facilities currently holding a New Mexico CS registration as a reminder of the requirements associated with reporting to the New Mexico Prescription Monitoring Program (PMP).

Regulation NMAC 16.19.29 requires all these dispensers to report CS prescription data to the PMP within seven days of the prescription being filled. **A dispenser who knowingly (1) fails to timely report prescription data, or (2) submits incorrect prescription data violates NMAC 16.19.29.** This includes all dispensing facilities maintaining a New Mexico CS registration: in-state and out-of-state, retail pharmacies, compounding pharmacies, etc.

Dispensers who do not dispense any CS within a seven-day period must still report such through the submission of a "Zero Report." Dispensers maintaining a New Mexico CS registration but not dispensing **any** CS to New Mexico residents may apply for a waiver from reporting.

The Board takes violation of NMAC 16.19.29 affecting reporting to the PMP very seriously. The PMP director now reports all reporting delinquencies during each Board meeting, and a dispenser that is not proactively addressing and resolving its delinquent reporting issues, or a dispenser with repeated delinquencies, will be reported to the Board for its consideration and possible disciplinary action. This disciplinary action could include suspension or revocation of a dispenser's CS registration or licensure, a fine and costs, and/or a formal complaint to the dispenser's licensing authority. Concurrently, a dispenser that does not respond to notices of delinquency shall have its PMP account(s) deactivated.

The Board has seen widespread interest and support for more frequent reporting of data to the PMP (eg, daily reporting). Because of this interest, and the fact that many states already require daily reporting, the Board is expected to consider more frequent reporting in the near future.

More information can be found at *http://nmpmp.org* or by contacting the PMP via e-mail at nm.pmp@state.nm.us.

Employment Opportunities

The Board will be hiring in the near future, and the notice may already be posted. Larry Loring has announced that he will be retiring from the Board effective January 1, 2015. The Board would like to fill this position prior to this date. In this way, the new hire could begin training. The educational requirement is to have a bachelor's or doctor's degree in pharmacy from an accredited college or university. The experience requirement is to have at least eight years of professional-level pharmacy experience. The employment requirement is to have a valid New Mexico driver's license. A pre-employment background investigation is required. You must acquire and maintain active police certification with the New Mexico Law Enforcement Academy, and you must obtain and maintain active pharmacist licensure with the Board.

If you are interested, you must apply online. Interested people should go to the New Mexico State Personnel Office website. An easy way to find the position information on this site is to check the "Regulation & Licensing Dept" box, then click search. You do not have to be a current Board employee to be eligible for this position. If you need help finding the announcement, please contact the Board office for assistance.

If the Board hires one of the current Board state drug inspectors for the executive director/chief drug inspector position, an opening will be created for state drug inspector. Use the same process to apply for this position.

The Board will announce position openings through its e-Alert system. If your pharmacy does not receive these messages, please contact the Board to be added to our list.

Pharmacist Survey

As required by the New Mexico Legislature, the Board has posted a pharmacist survey relating to the workforce in New Mexico. A link to the survey can be found on the Board home page. Please complete this survey as soon as possible. Pharmacists who have not completed the survey by January 1, 2015, will not be allowed to renew their registration until the survey is completed. This is a short five-minute survey. From this point on, you will need to complete a survey each renewal period.

Significant Adverse Drug Events

1. A 56-year-old female with chronic pain was prescribed OxyContin® 30 mg, but was dispensed morphine sulfate 30 mg ER. Patient did not experience any side effects or symptoms. Pharmacist recommends double-checking during input filling and final check, as well as verifying with the patient before dispensing to help reduce such errors.
2. Pharmacy received a faxed prescription for dexamethasone 40 mg, once weekly, but was inputted and dispensed as dexamethasone 40 mg, daily. Patient took the medication daily for three weeks before being hospitalized due to injury to his liver from the overdose. Pharmacist recommends calling prescriber to clarify annotated communication from illegible prescriptions/unusual dosing before dispensing.
3. A 37-year-old female with depression and hypertension was prescribed risperidone 0.5 mg, but was dispensed ropinirole 0.5 mg. Patient questioned different appearance of tablets and the error was discovered. No incorrect medication was consumed. Pharmacist recommends urging all prescription-filling employees to verify drug, strength, quantity, and National Drug Code (NDC) printed on hard copy label against bulk package.
4. A 45-year-old female was prescribed Cortisporin® (neomycin-polymyxin-hydrocortisone) Ophthalmic Suspension, but was dispensed neomycin-polymyxin-hydrocortisone otic suspension. Patient administered one drop into eye, resulting in irritation, but no visual disturbances. Patient discontinued medication. Pharmacist recommends that verifying pharmacist ensure accuracy of dispensed medications.
5. A 73-year-old female with arthritis was prescribed oxaprozin 600 mg, but was dispensed oxcarbazepine 600 mg. Patient read the drug information sheets and knew this drug was not what she needed, so she did not take any of the medication. Pharmacist recommends, instead of alphabetizing the medications by generic name, using brand name to easily distinguish between similarities in name.
6. A 66-year-old male with chronic pain was prescribed Percocet® 10/325 mg, but was dispensed Percocet 5/325 mg. Patient complained of insufficient pain relief after three weeks. Pharmacist recommends double-checking the prescription when verifying.
7. A 45-year-old male was prescribed valacyclovir 1 gm, but was dispensed valacyclovir/atorvastatin 1 gm/80 mg. Patient reported swollen and painful lymph nodes on right side of neck, which is a rare, but not severe side effect of atorvastatin. Pharmacist recommends keeping distractions to a minimum when restocking automated robot and verifying medications to ensure medications being dispensed from the robot are accurate.
8. A 59-year-old male was prescribed citalopram 40 mg, but was dispensed citalopram 20 mg. Patient did not report any symptoms. Pharmacist recommends always double-checking strength/drug in all stages of the pharmacy and taking a little more time during verification to ensure everything is correct.
9. A 46-year-old male was prescribed lisinopril 10 mg, but was dispensed lisinopril 20 mg. Filling pharmacy technician scanned the correct bottle, but used a returned to stock bottle sitting right next to it to fill the prescription. Patient reported feeling lightheaded and out of it. Pharmacist recommends placing return to stock bottles where they belong and making sure technicians are verifying medications before filling.
10. A 72-year-old female with hypertension was prescribed potassium chloride 10mEq, but was dispensed potassium chloride 8mEq. Patient questioned different appearance of tablets, thus discovering the error. No incorrect medication was consumed. Pharmacist recommends urging staff that is filling or checking to verify dose, strength, and NDC printed on hard copy label against bulk package.
11. A 66-year-old female with hypothyroidism was prescribed Cytomel® (liothyronine) 5 mcg, one BID, but was dispensed liothyronine 5 mcg, one every day. Prescription was a return to stock bottle with previous patient's instructions for use and quantity. The return to stock bottle was bagged and verified by pharmacist. Patient's doctor had been trying to get patient levels to a therapeutic level. Due to the misfill, the patient remained sub-therapeutic for an extra month. Pharmacist recommends verifying that the label matches the patient's name and drug before bagging each prescription.
12. A 38-year-old male with asthma was prescribed Symbicort® 160/4.5 mcg, two puffs twice a day, but was dispensed Symbicort 160/4.5 mcg, one puff twice a day. Patient reported feeling fine despite having taken the medication incorrectly for one month. The error was caught on refill. Pharmacist recommends not inputting and checking the same prescription if another staff member is available; if no other option but to do both, then the pharmacist recommends slowing down and triple-checking oneself.
13. Parent called in medication refills for three-year-old son. After receiving medication, it was discovered that a different patient's medication was bagged along with son's medication. Error occurred when parent had touch-toned the wrong prescription number to be filled when calling in the refill. By doing this, a refill for a different individual was requested along with son's prescription. When refills are touch-toned in together, they are batched together by the pharmacy computer. Pharmacist recommends no longer assuming different names/individuals are picking up together or are linked together. So, if patient names do not match, then they will be bagged separately.
14. Six eight- to ten-week-old Australian Shepherd puppies were prescribed sulfadiazine/trimethoprim 250 mg, but sulfamethoxazole/trimethoprim 800/160 mg was dispensed. The owner of the puppies was informed by the pharmacist that this was a high dose and a large tablet. Pharmacist asked if owner was informed how the medication should be given to the puppies. The owner then went back to the veterinarian with the tablets. Veterinarian informed owner to give the medication anyway with no specific instructions. As a result, one puppy died. Pharmacist recommends clarifying medication dosage strength and how to properly administer the medication when any concern arises in regard to the patient's size/weight and/or medication dosage form with the prescriber, so that proper dispensing and counseling may take place.

Disclaimer: The suggestions are made by the pharmacist submitting the Significant Adverse Drug Event Report. The New Mexico Board of Pharmacy may not necessarily agree with these suggestions.

The *New Mexico Board of Pharmacy News* is published by the New Mexico Board of Pharmacy and the National Association of Boards of Pharmacy Foundation™ (NABPF™) to promote compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of NABPF or the Board unless expressly so stated.

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