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New Mexico Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

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Important Notifications

- This is a reminder that annual inventory was due for most licensed locations on May 1, 2016. The actual taking of the inventory may vary not more than four days before or after the annual inventory date. If you have a Drug Enforcement Administration controlled substance (CS) registration, you are required to have an inventory on file, even if you have no CS in stock.
- The August 25-26, 2016 New Mexico Board of Pharmacy meeting was scheduled to be held in Ruidoso, NM. This August meeting has been rescheduled for Albuquerque, NM. The meeting will be held at the Board office. Please update your calendar.
- The Board reminds pharmacists that the Centers for Disease Control and Prevention (CDC) has published new guidelines regarding opiates. The Board encourages pharmacists to review these guidelines. The CDC guidelines may be found at *www.cdc.gov/drugoverdose/prescribing/guideline.html.*
- The Board is in the process of revising committees. If you are interested in participating in a committee, please contact the Board office. Licensees may obtain 0.1 CEU (one contact hour) per year, in the subject area of pharmacy law, by serving on a Board-approved committee.
- New Mexico Prescription Monitoring Program (PMP) – Now accepting reports in American Society for Automation in Pharmacy 4.2 format. Please contact the Board for an updated Data Reporting Manual.

Monitored Treatment Program

The Monitored Treatment Program (MTP) was established to confidentially assist health professionals who have problems that can cause or contribute to impairment, including substance-related disorders, psychiatric problems, behavioral problems, physical disabilities, and others. Participation in MTP can be mandatory as ordered by the Board. Participation in MTP can also be voluntary. If any person knows or suspects that a licensee is impaired, that person shall report any relevant information either to the Impaired Pharmacist Program, which is administered by MTP, or to the Board. Utilization of an unauthorized treatment facility is not allowed because a licensee can seek treatment, then quit the program, and not be reported to the Board, thus allowing for an impaired licensee to continue practicing.

New Mexico PMP – NAR$_X$CHECK

NAR$_X$CHECK, owned by Appriss, Inc, is a patented engine that analyzes CS data from PMPs and provides easy-to-use insights into a patient's CS use. Authorized prescribers and dispensers can easily access PMP data and NAR$_X$CHECK analytics right within their workflow and feel confident that they are utilizing objective insights to improve patient safety and identify and address potential drug misuse or abuse.

An interactive tour on how to use NAR$_X$CHECK is available at *www.appriss.com/HostedDocuments/NARxCHECK/story.html.*

Legislative Update 2016

During the 2016 legislative session, the following bills were signed by Governor Susana Martinez.

Senate Bill (SB) 263 will require practitioners to utilize the PMP when initially prescribing an opiate for greater than a four-day supply. The practitioner will need to check the PMP every three months for patients on chronic opiates.

House Bill 277 will allow for the possession and administration of naloxone with reduced liability. Pharmacists will be allowed to fill naloxone for a patient based on a standing order issued by a practitioner with the New Mexico Department of Health.

SB 78 amended the section regarding licensing of osteopathic physicians. This amended section will allow for the New Mexico Board of Osteopathic Medical Examiners to adopt regulations for osteopathic physicians to supervise pharmacist clinicians.

FDA Approves Naloxone Nasal Spray to Prevent Opioid Overdose Deaths

Food and Drug Administration (FDA) has approved Narcan® Nasal Spray (also known as naloxone), a life-saving medication that can stop or reverse the effects of an opioid overdose. Prior to this approval, naloxone was only approved in injectable forms, most commonly delivered by syringe or auto-injector, explains FDA in a news release.

Narcan Nasal Spray does not require assembly and delivers a consistent, measured dose when used as directed. This prescription product can be used on adults or children and is easily administered by anyone, even those without medical training. The drug is sprayed into one nostril while the patient is lying on his or her back, which can be repeated if necessary. However, it is important to note that it is not a substitute for immediate medical care, and the person administering Narcan Nasal Spray should seek further immediate medical attention on the patient's behalf. The use of Narcan Nasal Spray in patients who are opioid dependent may result in severe opioid withdrawal characterized by body aches, diarrhea, increased heart rate (tachycardia), fever, runny nose, sneezing, goose bumps (piloerection), sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. Narcan Nasal Spray is distributed by Adapt Pharma, Inc, of Radnor, PA. The FDA news release is available at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm473505.htm.*

Selected Medication Safety Risks to Manage in 2016

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 Errors Reporting Program Report online at* www.ismp.org. *Email: ismpinfo@ismp.org.*

It is a nearly impossible task to list all the risks associated with medication use that could lead to harmful medication errors. So where do health care professionals start to improve medication safety? Most people frequently resort to playing "whack-a-mole," addressing risks only after they pop up and become visible after an adverse event.

Listed below are two serious medication safety risks that might fall off the radar screen unless an adverse event happens to draw attention to them. Additional serious risks will be published in future issues of the National Association of Boards of Pharmacy® *National Pharmacy Compliance News.*

Patient Information – Placing Orders on the Wrong Patient's Electronic Health Record

A potentially hidden vulnerability that can lead to serious errors is placing orders on the wrong patient's electronic health record. A recent study published in the *Journal of the American Medical Informatics Association* identified and quantified close calls that would have resulted in wrong-patient errors. According to this study, about 14 wrong-patient electronic orders are placed every day in a large hospital system with approximately 1,500 beds, or about 68 wrong-patient errors per 100,000 medication orders. By this measure, one in 37 hospitalized patients will have an order placed for them that was intended for another patient.[1]

These errors are sometimes due to juxtaposition but more often caused by interruptions and having more than one patient's electronic health record open.

Multiple studies have demonstrated ways to reduce these events. Requiring verification of the patient's identity has reduced errors by 16% to 30%, and requiring re-entry of the patient's identification has reduced errors by 41%.[1,2] Prompting clinicians for an indication when certain medications are ordered without an indication on the patient's problem list has intercepted errors at a rate of 0.25 per 1,000 alerts.[3] In one study, most emergency department (ED) staff (81%) felt a room number watermark on the patient's electronic health record would eliminate most wrong-patient orders in the ED.[4]

Communication About Drug Therapy – Confusing the Available Concentration as the Patient's Dose on Electronic Records

Another risk deals with how home medications appear on computer screens. For example, a physician accidentally ordered 100 units of Lantus® (insulin glargine) instead of the correct dose of six units because the list of medications used at home displayed the concentration right next to the drug name on the first line, and the patient's dose below it on the second line: "Insulin glargine (Lantus) 100 units/mL," followed on the next line with "6 units subcutaneous daily every evening."

Now that insulin is available in 100 units/mL, 200 units/mL, 300 units/mL, and 500 units/mL concentrations, the risk

of receiving an overdose of insulin is high if the presentation of the order lists the product's concentration before the patient's dose. ISMP's recommendation is to list the drug name, patient-specific dose, and directions for use on the first line of the electronic medication administration record and patient medication lists, and the available concentration and any directions on how to measure the patient's dose below it.

References

1. Adelman JS, Kalkut GE, Schechter CB, et al. Understanding and preventing wrong-patient electronic orders: a randomized controlled trial. *J Am Med Inform Assoc*. 2013; 20(2):305-310.
2. Green RA, Hripcsak G, Salmasian H, et al. Intercepting wrong-patient orders in computerized provider order entry system. *Ann Emerg Med*. 2015; 65(6):679-686.
3. Galanter W, Falck S, Burns M, Laragh M, Lambert BL. Indication-based prescribing prevents wrong-patient medication errors in computerized provider order entry (CPOE). *J Am Med Inform Assoc*. 2013; 20(3):477-481.
4. Yamamoto LG. Reducing emergency department charting and ordering errors with a room number watermark on the electronic medical record display. *Hawaii J Med Public Health*. 2014; 73(10):322-328.

FDA Provides Training Videos on MedWatch Resources and Breakthrough Therapy

FDA Drug Info Rounds, a series of online videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better decisions. In the January 2016 Drug Info Rounds video, "MedWatch Tips and Tools," pharmacists discuss reporting adverse events to FDA's MedWatch Safety Information and Adverse Event Reporting Program and the resources available for health care professionals to report safety information. In the December 2015 Drug Info Rounds video, "Breakthrough Therapy," pharmacists discuss the breakthrough therapy designation program, which is intended to expedite the development and review of drugs for serious or life-threatening conditions. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research (CDER), Office of Communications, Division of Drug Information. All Drug Info Rounds videos can be viewed on the FDA website at *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm.*

Reading Medicine Labels Helps Reduce Acetaminophen Overdoses

The Acetaminophen Awareness Coalition (AAC) reminds pharmacists and other health care providers to encourage patients to properly read medicine labels to avoid unintentional acetaminophen overdoses. The coalition also encourages pharmacists and other health care providers to talk to their patients about medicine safety and acetaminophen use.

AAC's "Know Your Dose" campaign reminds patients to take these four steps to avoid acetaminophen overdose:

(1) Always read and follow the medicine label.
(2) Know if their medicines contain acetaminophen.
(3) Take only one medicine at a time that contains acetaminophen.
(4) Ask their health care provider about any questions.

Additionally, pharmacists may download or order free educational materials, including posters, flyers, and talking points, to give their patients on the Know Your Dose website at *www.knowyourdose.org.*

Over-the-Counter Children's Medicine Recalled Due to Incorrect Dose Markings

In January 2016, Perrigo Company voluntarily recalled two lots of children's guaifenesin grape liquid cough medicine (100 mg/5 mL) and three lots of children's guaifenesin DM cherry liquid cough medicine (100 mg guaifenesin and 5 mg dextromethorphan HBr/5 mL) sold in 4 oz bottles. The recall was initiated because some packages contain an oral dosing cup with incorrect dose markings. The affected products were sold by distributors nationwide and distributed through retail stores. The recalled lots and store brands are available in the Perrigo press release posted on the company's website, *www.perrigo.com,* under "Investors." To date, the company has not received reports of overdose. Distributors and retailers that have the affected lots should stop distribution and return the product using the information provided in the press release.

Adverse reactions or quality problems may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting Program at *www.fda.gov/MedWatch.*

FDA Offers Webinars on Online Drug Information Resources for Students and Clinicians

FDA's Division of Drug Information, CDER, presents a series of continuing education webinars targeted toward students and health care providers who wish to learn more about FDA and drug regulation. The webinars are presented by FDA staff and allow participants to interact with staff. Past topics have included "Introduction to FDA's MedWatch Adverse Reporting Program" and "An Overview of the FDA's Breakthrough Therapy Designation Program." Upcoming webinars, previous webinars, and presentation slides can be accessed on FDA's website at *www.fda.gov/AboutFDA/WorkingatFDA/FellowshipInternshipGraduateFacultyPrograms/PharmacyStudentExperientialProgramCDER/ucm228391.htm*.

Disciplinary Actions

Gabriella Martinez, PT – License PT-7164. During the April 21-22, 2016 Board meeting, the Board accepted an order accepting voluntary surrender of pharmacy technician registration. Must pay a fine of $325.

Clyde Miller, MD – License CS-212624. During the April 21-22, 2016 Board meeting, the Board accepted an order of voluntary surrender of CS registration. Must pay a fine of $400.

Esperanza Sanchez, PT – License PT-4831. During the April 21-22, 2016 Board meeting, the Board accepted an order accepting voluntary surrender of pharmacy technician registration. Must pay a fine of $100.

Significant Adverse Drug Events

1. A 70-year-old female was prescribed diazepam 2 mg but received clonazepam 2 mg. The patient took one dose and stated she felt different and experienced drowsiness and lethargy lasting the whole day. The pharmacy received the prescription as a fax. The prescription was mistyped and stored in the patient's profile. Two weeks later, the prescription was re-opened and the error was overlooked. The prescription image was blurry, and the pharmacist assumed that it was previously verified correctly, so proper verification was not done. The pharmacist suggests making a copy of the prescription label if verification has not been completed. The filling pharmacist will then know to double-check the prescription with the drug dispensed.
2. A 32-year-old female was prescribed hydroxyzine but received hydralazine 50 mg. The patient had low blood pressure and was hospitalized. The pharmacist reports that the error likely occurred because the drug entered and the drug prescribed look alike, and the same pharmacist did both the data entry and the verification. No recommendations for improvement were provided.
3. A 48-year-old male was prescribed tretinoin 0.01% cream but received tretinoin 0.1% cream. The patient called three weeks later after refilling his tretinoin cream; he complained of redness and irritation on his skin. The wrong drug was pulled and verified incorrectly, possibly due to phone and customer distraction. The pharmacist recommends re-educating all the pharmacists about the verification process of checking the National Drug Code and drug name more closely.
4. A 61-year-old female was prescribed vitamin D 200 units but received a sertraline 25 mg prescription that was for another patient with a similar name. The patient experienced upset stomach and pain. When the patient came to the drive-through to pick up, the employee did not catch that the patient had given a different address than the prescription in the employee's hands. The pharmacist recommends to verify the patient's address more carefully and do not multitask.
5. A 79-year-old male was prescribed risperidone 0.5 mg but received ropinirole 0.5 mg. There was not enough risperidone 0.5 mg in stock so a partial amount was to be given to the patient. The pharmacist checked the stock bottle, which contained risperidone. However, the vial being dispensed to the patient contained ropinirole. The pharmacist only looked at the tablets that were in the stock bottle during product verification. Pharmacist suggests separating each patient's medication and the labels in the basket to prevent mixing up the stock bottles and also opening each vial for verification.
6. A 41-year-old male was prescribed simvastatin 10 mg but received another patient's simvastatin 20 mg. The patient did not experience any adverse drug event. The name on the receipt was crossed with another patient's vial. Counseling was offered, but the patient had refused counseling. The pharmacist recommends that all drug names and the number of receipts should all match and to verify the information prior to bagging the prescription even if counseling was declined.
7. A six-year-old female was prescribed clonazepam 0.5 mg orally disintegrating tablets (ODT) but received clonazepam 0.5 mg tablets. The patient's mother called to say that her child should have received ODT rather than regular tablets because it would be too hard to give her daughter the regular tablets. The in-window technician and the pharmacist did not notice the disintegrating part of the prescription. The pharmacist recommends the doctor underlining or highlighting the disintegrating part.
8. A 40-year-old female was prescribed gabapentin 100 mg but received omeprazole 40 mg. After taking 12 capsules, the patient called the doctor because she was having diarrhea. The robot normally fills and labels the gabapentin 100 mg. However, the robot was not working or broken on the day the incident occurred. The technician had to manually fill the medication and during this process, the technician had placed the wrong label on the medication. The pharmacist must have been too busy to notice the mistake. No recommendation was given.
9. A 68-year-old female was prescribed carbamazepine extended release (ER) 300 mg (one tablet by mouth twice a day) but received both carbamazepine ER 300 mg (one tablet by mouth twice a day) and a de-identified bottle of carbamazepine 200 mg (one tablet by mouth daily). The patient took both carbamazepine ER 300 mg (one tablet by mouth twice a day) and carbamazepine 200 mg (one tablet by mouth daily) on the same day and experienced dizziness. The incorrect carbamazepine was de-identified with a Sharpie. It was possible that this de-identified bottle was

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added to the patient's bag because of the technician's inattentiveness. The technician received training just two weeks prior to working. The pharmacist suggests that pictures should be taken of all the bottles being dispensed and there should be no rebagging of prescriptions.

10. A 68-year-old male was prescribed metformin ER 500 mg but received metformin ER 1,000 mg. The patient experienced diarrhea after the first and second dose. The patient followed up with a doctor visit to discuss the side effects of the medication. The doctor called the pharmacy to verify the prescription, and this is when the error was discovered. The pharmacist recommends double-checking at data entry for look-alike/sound-alike medications and that the pharmacist must assist technicians as electronic prescriptions come in.
11. An 18-year-old female was prescribed Amnesteem® 40 mg (one capsule twice a day) but was dispensed Zenatane™ 40 mg (one capsule three times a day). The patient experienced weight loss. No recommendations for improvement were provided.
12. A 15-year-old male experienced elevated blood pressure after receiving lisinopril 5 mg. The doctor had sent the wrong strength on an electronic prescription, and then the pharmacy mislabeled the vial. The pharmacy personnel were handling multiple prescriptions at once. The prescription was supposed to be lisinopril 10 mg. No recommendation for improvement was provided.
13. A new prescription was faxed into the pharmacy for Fioricet®, but Fioricet with codeine was dispensed to the patient. The patient experienced upset stomach. The prescription was typed incorrectly by an inexperienced technician and verified incorrectly by the pharmacist. There are normally three checks before the prescription is sold. No recommendations for improvement were provided.
14. A 13-year-old female was prescribed clonazepam 2 mg but received levothyroxine 50 mcg. The patient experienced rapid heart rate and flu-like symptoms. The pharmacist had placed the wrong drug into the patient's bag. The pharmacist suggests double-checking the patient's name and medication to make sure the product matches.
15. A 70-year-old female was prescribed morphine ER 10 mg but received morphine ER 100 mg. The patient had taken 27 doses of the incorrect dose. The patient experienced chills, sweats, malaise, irregular heartbeat, and trouble breathing. The patient was seen at urgent care and followed up with an emergency room visit. No recommendations for improvement were provided.
16. A 48-year-old male was prescribed alprazolam 0.5 mg but received alprazolam ER 0.5 mg. The patient experienced anxiety, lack of focus, and feeling on edge. The incorrect dosage form was selected and dispensed. Contributing factors to the incident were that the drug names are similar in appearance, improper training, and handling of multiple prescriptions at once. No recommendations for improvement were provided.
17. A 16-year-old female experienced stomach cramps after the wrong drug was dispensed to her. At the filling station, the prescription was filled with the incorrect drug. The pharmacist verified and approved the wrong drug. The error most likely occurred because of the handling of multiple prescriptions at once and improper training and workflow. No recommendations for improvement were provided.

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.

Fifty-Year Pharmacists

The following is the current list of pharmacists who have been licensed by the state of New Mexico for at least 50 years and who also maintain an active license. The Board thanks you for your service and dedication to the profession of pharmacy and the citizens of New Mexico.

Joseph R. Abeyta	Nick H. Brown
Grace Colvin	Kenneth L. Corazza
M.R. Delhotal	George E. Downs
Lawrence N. Etherton	Arturo Figueroa
Kenneth L. Fourcher	John (Chris) C. Gallegos
Robert Ghattas	Richard Gomez
John A. Heaton	John Huffmyer
Lowell M. Irby	William J. Long
Joseph Mengoni	Lonnie R. Nunley
Edward A. Osborne	Philip A. Parkhurst
Dennis S. Pena	Walter F. Peyton
Robert T. Shmaeff	Raymond C. Sierks
Larry W. Sparks	Johnny S. Volpato, Sr

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