MARCH 2022

NEW MEXICO BOARD OF PHARMACY

newsletter to promote pharmacy and drug law compliance

Significant Adverse Drug Events

1. A 30-year-old female patient received hydrocodone 10/325 instead of the hydrocodone 5/325 that she was prescribed. The error was discovered by the retail pharmacist when she noticed both strengths mixed together within the automated dispensing robot. Upon investigation, the pharmacist found that the technician did not scan the barcode on the manufacturer bottle when refilling the robot. The pharmacist attributes the error to a break in procedure. The patient reported that she had not taken any doses prior to being notified of the dispensing error. As a result of the error, the pharmacist scheduled a mandatory staff meeting to reinforce policies and procedures.
2. An 11-year-old female patient received the Moderna coronavirus disease 2019 (COVID-19) vaccine at a retail pharmacy even though that particular version of the vaccine was not approved for her age group. The pharmacist identified several factors that may have contributed to the error, including: 1) administering vaccines after normal vaccination hours; 2) administering vaccines to multiple family members simultaneously; and 3) not utilizing the Department of Health portal to screen patients. No adverse effects were reported as a result of receiving the unapproved vaccine. The pharmacist was retrained on policies regarding vaccines and was placed on leave due to the error.
3. Seventy-three total patients within a hospital received bamlanivimab/etesevimab 700/700 instead of the prescribed 700/1,400 strength. The pharmacist stated that because the medication is being used under an emergency use authorization (EUA) for COVID-19, the drug had to be manually entered into the computer system. After receiving the incorrect dose, one patient was hospitalized due to COVID-19 and two patients were admitted to the emergency room, one reporting a headache, and the other shortness of breath. As a result of the error, the hospital procedure for entering EUA products has been updated. All EUA products are entered into the computer system by the director of pharmacy and must be verified by either an ICU specialist or clinic manager.
4. A 68-year-old female patient prescribed mirtazapine 45 mg tablets was instead given pioglitazone 45 mg at a retail pharmacy. The pharmacist stated that the filling technician

labeled a stock bottle without scanning the bottle. The pharmacist also reported that the technician did not write down the National Drug Code as required when it does not match the stock label. The patient did not notice the error until refill and did not report symptoms after taking the incorrect medication. As a result of the error, the pharmacist now requires staff to scan all bottles and labels, even though it is not necessarily required by the filling system.

5. An 89-year-old female patient residing within a nursing home was incorrectly given memantine 10 mg that was intended for her husband with the same last name. The nursing home sent orders to the pharmacy for both husband and wife simultaneously. The pharmacist stapled the orders together and only entered them under the name of the wife. After taking the incorrect medication for a couple of weeks, the patient was hospitalized. The pharmacist-in-charge (PIC) required pharmacists and technicians to attend a meeting related to data entry and company procedures. The pharmacist recommends not stapling prescriptions together and verifying the date of birth on every received prescription, even if they are for the same patient.
6. An 82-year-old female patient was prescribed gabapentin 100 mg; however, she received gabapentin 300 mg from the dispensing retail pharmacy. According to the pharmacist, both strengths of this medication are normally filled via a filling machine. For this fill, the medication was manually overridden and the dispensing label for 100 mg was placed on a 300 mg stock bottle. After taking the incorrect strength for an unspecified amount of time, the patient went to the emergency room due to a fall that caused significant bruising. The pharmacist attributes the error to a fill-in pharmacist who may not have been familiar with how to refill the filling machine when empty. The pharmacist recommends that all staff be trained on the use/refilling of the filling machine.
7. A 46-year-old female patient was prescribed senna 8.6 mg but was provided with simvastatin 40 mg by the dispensing pharmacy. According to the pharmacist, the labels on two dispensing cards were switched by the filling technician after product verification had been completed by the pharmacist. The patient did not report symptoms as a result of taking the medication for an unspecified amount of time. The pharmacist recommends that the filling process be restarted from the beginning if it gets interrupted at any point. The pharmacist also recommends using a checkmark (during the final check) next to the medication description on the label to indicate that the physical description matches what is in the card.

Disclaimer: These suggestions are made by the pharmacist submitting the Significant Adverse Drug Event Report. *Newsletter* publications of recommendations are not an indication of endorsement by the New Mexico Board of Pharmacy.

Regulatory Updates

The Board, during its October 2021 meeting, approved the following rule updates:

- **16.19.4 New Mexico Administrative Code (NMAC) – Pharmacist.** Updated Section 8, defining gross immorality and listing criminal convictions that may result in license suspension or refusal to grant renewal. The Board is not barred from denying an

application or disciplinary action for conduct in violation of the Pharmacy Act; New Mexico Drug, Device and Cosmetic Act (DD&C Act); Controlled Substances Act (CSA); Imitation Controlled Substances Act; Drug Precursor Act; Impaired Health Care Provider Act; or Impaired Pharmacists Act. Added an allowance for custodial care facilities to stock naloxone.

- **16.19.12 NMAC – Fees.** Updated Section 9, waiving registration fees for United States military service members, spouses, dependent children, and veterans applying for pharmacist licensure by reciprocity. Updated Section 12, waiving the initial renewal fees for US military service members, spouses, dependent children, and veterans applying for pharmacist licensure by reciprocity.
- **16.19.22 NMAC – Support Personnel and Pharmacy Technicians.** Added Section 16, allowing for pharmacy technician administration of vaccines (see Technician Administration of Vaccines article below for more information).
- **16.19.27 NMAC – Dishonorable Conduct.** Updated Section 7, listing of criminal convictions that may result in license suspension or refusal to grant renewal. The Board is not barred from denying an application or disciplinary action for conduct in violation of the Pharmacy Act; DD&C Act; CSA; Imitation Controlled Substances Act; Drug Precursor Act; Impaired Health Care Provider Act; or Impaired Pharmacists Act.

The following Board emergency declarations have been updated as follows:

- **Pharmacy Technician COVID-19 Test Administration, October 30, 2020.** Updated January 4, 2022 – removed reference to COVID-19 and childhood vaccine administration, which is allowed pursuant to 16.19.22.16 NMAC.
- **Emergency Dispensing Declaration (pharmacist dispensing of certain drugs from a hospital pharmacy due to COVID-19) December 14, 2020.** Updated January 4, 2022 – additional allowance for a hospital pharmacy not licensed as a retail pharmacy to dispense COVID-19 oral therapeutics consistent with EUA (molnupiravir and Paxlovid™).

Technician Administration of Vaccines

A new subsection was added to Board rule 16.19.22 NMAC, allowing for the administration of vaccines by a technician. The new rule addresses training/education, competency assurance, and oversight requirements. This allowance is for the administration of vaccines prescribed by and under the supervision of a New Mexico-licensed pharmacist with current immunization prescriptive authority. Technicians must be adequately trained, and there is a component of required continuing education (CE). The PIC assumes responsibility for training and oversight of immunizing technicians. While a technician may draw up a vaccine into a syringe, a qualified immunizing pharmacist is still responsible for final product verification prior to administration.

A pharmacist is still responsible for counseling and proper documentation of administration. There are also limits on the number of technicians administering vaccines at any given time that a pharmacist can supervise, depending upon the setting. Please refer to the Board website for all requirements and additional information regarding this new rule.

Disciplinary Actions

William Gardner – CS00019456. Revocation. During the October 2021 Board meeting, the Board revoked the controlled substance (CS) registration of the respondent. The respondent must pay investigative costs in the amount of $270 and the cost of hearing in the amount of $561.49 within 90 days.

Lisa Koselke – RP00007531. Settlement agreement. During the October 2021 Board meeting, the Board approved the following agreement with the respondent: 1) respondent will pay a fine in the amount of $1,000 and the cost of investigation in the amount of $100 within 90 days; and 2) respondent will complete any deficient CE within 90 days.

Kevin Yang – RP00007924. Settlement agreement. During the January 2022 Board meeting, the respondent agreed to the following terms: 1) pay a fine in the amount of $1,000 and the cost of investigation in the amount of $425 within 90 days; 2) accept a 30-day suspension of all Board-issued licenses and certificates; 3) take and pass the Multistate Pharmacy Jurisprudence Examination® within six months; 4) complete 12 hours of CE in ethics; 5) complete a five-year probationary period; and 6) may not work as a PIC for no less than 10 years.

Erin Fenstermacher – CS00218254. Voluntary surrender. During the January 2022 Board meeting, the Board accepted the surrender of respondent's CS registration.

2022 Law Update Schedule

Upcoming Albuquerque Pharmacy Law Lecture Dates:

- March 4, 2022
- April 1, 2022
- May 6, 2022
- June 3, 2022
- July 1, 2022
- August 5, 2022
- September 2, 2022
- October 7, 2022
- November 4, 2022
- December 2, 2022

Upcoming Pharmacy Law Lecture Dates (Outside of Albuquerque):

- **March 29, 2022 –** Presbyterian Española Hospital; Española, NM
- **April 26, 2022 –** Rehoboth McKinley Christian Hospital; Gallup, NM

- **May 10, 2022 –** Miners' Colfax Medical Center; Raton, NM
- **May 24, 2022 –** San Juan College; Farmington, NM
- **June 7, 2022 –** Gerald Champion Regional Medical Center; Alamogordo, NM

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- **August 23, 2022 –** Eastern New Mexico University; Roswell Occupational Technology Center; Roswell, NM
- **November 8, 2022 –** Carlsbad Medical Center; Carlsbad, NM
- **November 28, 2022 –** Memorial Medical Center; Las Cruces, NM
- **November 29, 2022 –** MountainView Regional Medical Center; Las Cruces

Because of COVID-19 restrictions, some of the law update reviews may be held as webinars. The most up-to-date information on review format and the full list of law updates can be found on the Board website.

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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