SEPTEMBER 2023

NEW MEXICO BOARD OF PHARMACY

newsletter to promote pharmacy and drug law compliance

Significant Adverse Drug Events

1. A four-year-old female patient within a hospital facility was given dexmedetomidine 56 mcg in place of the dexamethasone 5.6 mg that was ordered for her. After receiving one dose intravenously, the patient became pale and somnolent. The pharmacist noted that the administered dose was not scanned by the nurse at bedside. The pharmacist also noted that dexmedetomidine was intermingled with dexamethasone in the pharmacy. Lastly, the pharmacist noted that the nurse may have been in a hurry due to a network outage causing delays and the patient's family being upset about the delays. The pharmacist stated that the hospital unit is in the process of updating software to allow scanning of barcodes when filling orders.

2. A three-year-old male patient in a hospital setting had an order for baclofen 10 mg to be initiated at 14:00 hours. The order was delayed for over three hours, due to unavailability in the Pyxis machine. During this delay in therapy, the patient experienced pain that required treatment with an opioid. The pharmacist-in-charge (PIC) noted that the physician should have chosen a medication available in the Pyxis machine and the pharmacist should have known that only the 20 mg dose was present in the Pyxis so that the order could be changed. The PIC discussed the error with other supervisors and all staff involved in the incident.

3. A 63-year-old male patient prescribed sotalol AF 120 mg was given sotalol 120 mg by the dispensing pharmacy. The error was noticed approximately three months later when the patient's sotalol and sotalol AF were refilled

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through the auto-refill system at the pharmacy. According to the pharmacist, the patient did not report side effects from taking the sotalol. The pharmacist believes the error occurred because the "AF" was missed when manually entering the drug name during prescription entry. The pharmacist recommended manually entering the National Drug Code (NDC) when entering a prescription if the NDC does not auto generate from the eRx.

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

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 A. Baca
- Don W. Boyd
- Larry D. Cato
- Drexel Douglas
- Arturo Figueroa
- Johnny L. Goad
- Louis J. Herrera
- Jack F. Lerner
- Delbert W. Lopez
- Allan W. Ludwik
- Donald Peters
- Larry D. Quintana
- Thomas H. Steel
- Jonathan S. Bartlett
- Nick H. Brown
- Wilfred O. Chavez
- George E. Downs
- Robert Ghattas
- Richard Gomez
- Dale L. Kemper
- William J. Long
- Leo F. Lopez
- Lewis Dale McCleskey
- Allen E. Plymale
- Rudolph T. Shoats
- John R. Stroh

This year, there are five newcomers to this distinguished list. They are Jonathan S. Bartlett, Larry D. Cato, Allen E. Plymale, Rudolph T. Shoats, and Thomas H. Steel. Thank you for all you do.

Ketamine Joint Advisory From New Mexico Boards of Nursing and Medicine – Review by Board of Pharmacy

A joint advisory on the use of ketamine was recently released by the New Mexico Board of Nursing, in conjunction with the Board of Pharmacy and the New Mexico Medical Board. The

advisory discusses off-label use, risk for misuse, abuse, and diversion, as well as providers utilizing the medication outside of the legitimate treatment of medical illnesses. The advisory also highlights education and certification, as well as mandatory reporting to the prescription monitoring program. Below is a short summary of the guidance regarding the use of ketamine by the Board of Nursing.

1. Ketamine must be used for the treatment of a legitimate medically recognized illness. This includes a valid patient-provider relationship.
2. Ketamine must be offered as a treatment only upon a valid scientific basis such as evidence-based standards.
3. Patients must be evaluated and diagnosed by a provider with validated, documented educational expertise in the treatment of a condition requiring the use of ketamine.
4. If utilized, ketamine must be part of an ongoing treatment/safety plan including appropriate concomitant therapy.
5. Ketamine must only be administered by a provider trained in its indications, monitoring, and outcome evaluation. This must occur in a setting with full safety response equipment.
6. Safety measures must be in place for managing side effects, including ongoing follow-up once treatment is concluded.

A link to the full document and all guidance recommendations is available on the Board of Pharmacy website.

DEA Drug Take Back October 2023

The biannual Drug Enforcement Administration (DEA) National Prescription Drug Take Back Day is scheduled for October 28, 2023, between 10 AM to 2 PM MST. This is a nationwide event to assist in the decrease of drug overdoses by offering a method for the safe destruction of unused prescription medications. More information, including participating locations and year-round drug disposal locations, can be found at the following website: *https://www.dea.gov/takebackday*.

Disciplinary Actions

The Board took the following action during the July 2023 meeting:

Lori Gallegos – PT00002049. Revocation. The respondent's technician registration was revoked by default as the respondent did not request a hearing.

Alexa Riccobene – RP00008997. Settlement Agreement. The respondent agreed to the following terms:

- Must complete 12 hours of continuing pharmacy education in the area of ethics within one year.

- Review the Board's rules of professional conduct within 30 days.
- Pay a fine of $1,000.

Lemanuel Allison – PT00010752. Voluntary Surrender. The Board accepted the voluntary surrender of respondent's technician registration. Respondent must also pay for investigative costs in the amount of $250 within 90 days.

Walgreen Co, PH00004501 – CS00225010. Settlement Agreement. The respondent agreed to the following terms:

- implement system-wide preventative measures for facilities located in New Mexico within 30 days; and
- pay a fine of $5,000 within 90 days.

2023 Law Update Schedule

Upcoming Albuquerque Pharmacy Law Lecture Dates:

- October 6, 2023

  Webinar. Registration closes on October 4.

- November 3, 2023

  Webinar. Registration closes on November 1.

- December 1, 2023

  Webinar. Registration closes on November 29.

Upcoming Pharmacy Law Lecture Dates (Outside of Albuquerque):

- September 19, 2023

  Webinar for Clovis, NM update. Registration closes on September 15.

- October 24, 2023

  Webinar for Las Vegas, NM update. Registration closes on October 20.

- November 14, 2023

  Webinar for Hobbs, NM update. Registration closes on November 10.

- December 4, 2023

  Webinar for Las Cruces, NM update. Registration closes on November 30.

- December 5, 2023

  Webinar for Las Cruces update. Registration closes on December 1.

The most up-to-date information on review format and the full list of law updates can be found on the Board website.

Reminder

- Be sure to submit Adverse Drug Event reports to the Board within **15 days of discovery.** This is required by regulation and could potentially result in disciplinary action if not compliant. This report **must** include an appropriate root cause analysis with recommendation(s) for improvement.

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