



Nevada State Board of Pharmacy

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Darla Zarley Appointed to Board

Darla A. Zarley, PharmD, RPh, was appointed to the Nevada State Board of Pharmacy by Governor Brian Sandoval for a three-year term beginning November 30, 2015. A native of North Dakota, Darla is not only a skilled farm machinery operator, but also an accomplished pharmacist and educator, currently holding the position of director of experiential education/associate professor of pharmacy practice at Roseman University of Health Sciences in Henderson, NV. Being involved with pharmacy academia since 2001, she brings a welcome perspective to the Board. Besides being an avid hiker, Darla has three daughters who keep her busy, one of whom (Kiya) just graduated from pharmacy school. Board staff welcomes Darla to her new appointment, and is eager to work with such a charming personality. Congratulations, Darla!

Does That DEA Number Really Match?

By Yen H Long, Nevada PMP Program Administrator

It is the hustle and bustle of a pharmacy – phones are ringing; the drive-through window is backed up. Patients are dropping off and picking up prescriptions – some are screaming about who knows what. In the midst of this mayhem, a controlled substance (CS) prescription gets filled and a label is affixed naming the wrong prescriber. No one catches the mistake and the medication is dispensed to the patient. Who cares, right?

Contrary to popular belief, selecting the correct prescriber does matter. The law requires that prescription records and labels name the correct prescriber. The name

of the prescriber’s colleague or a staff member, or the name of a practitioner with a very similar name (eg, John Smith versus Jon Smith) is not good enough. The record must be accurate.

Recently, the Board and the Nevada Prescription Monitoring Program (PMP) have received a number of complaints against pharmacies and pharmacists for mislabeling prescriptions with the incorrect prescriber. When the information in the PMP, which is provided by pharmacies, is incorrect, it can lead to prescribers misinterpreting the PMP data and wrongfully accusing patients of “doctor shopping” or writing fraudulent prescriptions. Licensing boards may also wrongfully take disciplinary action on a prescriber for allegedly overprescribing. Such errors, due to the mislabeling of prescriptions with the incorrect prescriber, delay patients from receiving necessary treatment and cause frustrations for prescribers.

When the Board and PMP receive complaints regarding a potential error in the PMP data, they conduct a thorough investigation. The errors they find can generally be ascribed to one or more of the following:

- ◆ The wrong prescriber was selected from a drop-down prescriber list during data entry;
- ◆ The wrong prescriber was selected from a preprinted list of prescribers at the top of the prescription;
- ◆ The dispensing software by design defaults to the last prescriber used on a patient profile;
- ◆ The dispensing software links the prescriber to the wrong Drug Enforcement Administration (DEA) number; and/or
- ◆ Inattention or guessing during the transcribing process.

The dispensing pharmacist is accountable for the information in the pharmacy record. That information must be in accordance with the Nevada Revised Statutes and the Nevada Administrative Code. If these records contain incorrect information and are uploaded into the PMP, then

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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.

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the same erroneous information can be viewed by all health care professionals involved in that patient's care, creating a domino effect in spreading wrong information. When these errors are brought to the attention of the pharmacy or pharmacy manager, the information must be promptly corrected and resubmitted to the PMP database. The Board strongly encourages all pharmacies to implement strategies to prevent these errors. This may mean disabling the default features of the pharmacy's dispensing software program, ensuring the software has the correct DEA number linked to the correct prescriber, removing the prescriber drop-down list, and/or requiring telephonic verification for CS prescriptions with an indiscernible prescriber signature. Pharmacists and technicians must pay closer attention during the transcribing and dispensing process to ensure that the name of the prescriber selected is truly the prescriber who wrote the prescription. They have to verify that the signature matches the DEA number and preprinted prescriber name on the prescription.

The PMP is a powerful tool, but is only as good as the information that pharmacies provide to it. If prescribers and pharmacists are to use the PMP as a tool to provide better patient care and to combat the prescription drug abuse epidemic, it is crucial for the information to be accurate.

Eye-Opening NTSB Analysis

Aviation is the only transportation mode in which fatally injured operators undergo extensive toxicology testing at autopsy. The National Transportation Safety Board (NTSB) recently analyzed toxicology tests from over 6,000 pilots who died in accidents between 1990 and 2012. The trends noted in this study would likely be similar among operators across all modes of transportation, most importantly the operators of cars and trucks on United States highways.

The results of the study revealed a significant increase in the use of a variety of potentially impairing drugs (those with a Food and Drug Administration warning about sedation), CS, and illicit drugs.

Also noteworthy, the study considered "positive" only those drugs that could be qualitatively or quantitatively identified in blood or tissue (not urine).

The study's findings included:

- ◆ Pilots testing positive for at least one drug increased from 10% to 40%.
- ◆ More than 20% of the study pilots from 2008 to 2012 tested positive for a potentially impairing drug, and 6% tested positive for more than one drug.
- ◆ The most common potentially impairing drug was diphenhydramine (eg, Benadryl®, Unisom®).
- ◆ During the most recent five years studied, 8% of the study pilots tested positive for CS (not surprisingly, hydrocodone and diazepam).
- ◆ Positive testing for marijuana rose by about 3% during the study period.

Takeaway for pharmacists: The importance of discussions with your patients (ie, counseling) about the potential risks that their medications can create when operating a vehicle (in any mode of transportation) cannot be overemphasized. Please counsel your patients for the safety of everyone.

The NTSB study, *Drug Use Trends in Aviation: Assessing the Risk of Pilot Impairment*, may be accessed at www.ntsb.gov; click Safety Advocacy at the top of the page, and select "Safety Studies" from the drop-down menu.

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