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Fatigue and Your Practice

We have all been there. You have just struggled through the last couple of hours of your third 10- or 12-hour shift behind the counter and on your feet, and you just want to get home, get something to eat, and get some rest before facing your next shift. You are exhausted; you hope and pray that your work was accurate those past few hours, and you nearly fall asleep driving home. You are not intoxicated and you are not under the influence of drugs, yet your cognitive recognition and physical abilities are all impaired. You are fatigued – that internal human factor that crosses both our emotional state and physical abilities; that overwhelming sense of tiredness, lack of energy, and feeling of exhaustion. You are impaired.

Ten- to 12-hour shifts are popular, offering that three-day weekend, but they can easily lead to fatigue if you do not take precautions. Consider the following suggestions:

- When creating your schedule, keep fatigue in mind.
- Limit your work to 48 hours in a seven-day period.
- Get seven to eight hours of sleep per 24-hour period.
- Do not work more than three 12-hour shifts without a day off.
- Take at least 10-12 hours off between shifts (do not "double back").
- Take a nap prior to a night shift.

Do not work or drive while impaired by fatigue. You owe it to your patients and to the driving public.

Roseman University Opens Medicare Call Lab in Partnership With the Nevada State Health Insurance Assistance Program

By Truong Nguyen and Glen Lee, PharmD Candidates, Roseman University

Have you ever had a patient ask you about Medicare? Have you ever struggled to counsel patients on what their Medicare plan entails or how they can sign up for their benefits once they are eligible? Did you know many patients may qualify for state-funded extra assistance programs when they are in the "donut hole" and cannot afford their medications? The statutes and regulations of Medicare can be rocky waters for both pharmacists and beneficiaries to navigate. With varying rules on enrollment periods, income, and formulary coverage, among other items, beneficiaries may find it difficult to understand how their Medicare plan works or what plan may be the most cost-effective based on their needs. Fortunately, there is the Nevada State Health Insurance Assistance Program (SHIP), a federally funded program that offers free, personalized, and unbiased assistance to Medicare beneficiaries and their families to help smooth the rough seas of Medicare.

SHIP offers assistance in the form of determining plan eligibility, filing claim appeals, and identifying income-based subsidies, as well as selecting an optimal drug plan that is conducive to the patient's medication needs and lifestyle. Roseman University of Health Sciences College of Pharmacy in Henderson, NV, has entered a partnership with SHIP to train student pharmacists to assist the more than 445,000 Medicare beneficiaries in Nevada. These students volunteer to complete a robust 16-hour didactic Medicare training program, in addition to hands-on counseling sessions under the guidance of SHIP trainers. At the completion of this training, the students are SHIP-certified to counsel patients regarding Medicare and extra assistance programs.

Operating out of a call lab on Roseman University's Henderson campus, SHIP-certified student counselors return messages left by beneficiaries seeking assistance. Last year SHIP fielded over 18,000 calls from beneficiaries statewide. Those who are in need of assistance or know someone who may benefit from a free, unbiased consultation are encouraged to call the Roseman University Medicare Call Lab directly at 702/968-6615. Patients may also be referred to the toll-free, statewide SHIP counseling number 1-800/307-4444 or can visit *www.roseman.edu/medicarecalllab.*

Gentle Reminder for New Electronic Prescriptions

A practitioner shall not transmit a prescription electronically to a pharmacy unless the practitioner is the only person who will have access to the prescription until it is received by the pharmacy (Nevada Administrative Code (NAC) 639.7105(2)). In other words, you may not fill new electronic prescriptions transmitted by anyone other than the prescriber himself or herself.

National Vaccine Safety Surveillance Program Available for Reporting Adverse Events

The Vaccine Adverse Event Reporting System (VAERS) eSubmitter program, a national vaccine safety surveillance program cosponsored by the Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA), is available for the reporting of any clinically significant adverse event that occurs after the administration of any vaccine licensed in the United States. VAERS information is analyzed by CDC and FDA to identify new safety concerns. VAERS reports can be filed by anyone, including health care providers, manufacturers, state immunization programs, and vaccine recipients. Vaccine recipients are encouraged to seek help from their health care provider when filling out the VAERS form. Health care providers can find information about submitting a report on the VAERS website at *https://vaers.hhs.gov/professionals/index*.

Improper and Unsafe Vaccine Storage

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.*

Few issues are more important than proper storage and handling of vaccines, because their ability to prevent disease is dependent on these factors. To maintain stability, most vaccines must be stored in a refrigerator or freezer, and many also require protection from light. Excessive heat or cold – even a single exposure in some instances – can reduce vaccine potency. These temperature excursions are often due to improper refrigeration or freezer units, inadequate thermostat controls, and refrigeration/freezer units with inadequate space to allow good air circulation and even temperatures.

Improper and unsafe storage can also result in serious errors caused by selecting the wrong vaccines, diluents, and other medications with look-alike names and/or labeling and packaging. Storing vaccines close to each other has led to dispensing and administering the wrong vaccine or wrong form of vaccine (eg, adult versus pediatric). Storing vaccines too close to non-biologic medications in a refrigerator or freezer has also led to serious adverse outcomes, particularly when the mix-up involved a vaccine and a high-alert medication. For example, vials of insulin have frequently been mistaken as influenza vaccine, and various neuromuscular blocking agents have been used to reconstitute vaccines or were mistaken as influenza or hepatitis B vaccines.

Store vaccines in their own dedicated refrigeration and freezer units. Regular temperature monitoring is necessary, and technology is available to assist with alarmed, continuous monitoring devices that can alert staff via email and pager if a unit is out of specified range. Separate vaccine vials and syringes into bins or other containers according to vaccine type and formulation, keeping diluents with the appropr iate vaccines. Never store different vaccines in the same containers. Do not store vaccines with similar labels, names, abbreviations, or overlapping components immediately next to each other or on the same shelf. Separate the storage areas of pediatric and adult formulations of vaccines. Label the specific locations where vaccines are stored to facilitate correct age-specific selection and to remind staff to combine the contents of vials. ISMP's March 26, 2015 newsletter[1] contains additional strategies, as does a Vaccine Storage & Handling Toolkit available from CDC.[2]

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Coalition Reports Impact of Educational Efforts on Safe Acetaminophen Use

The Acetaminophen Awareness Coalition reports that progress has been made to increase consumer awareness about the safe use of acetaminophen. The coalition also notes a decline in unintentional overdoses. The National Poison Data System's 2015 report indicates unintentional acetaminophen exposures, including dosing errors and accidental misuse, have decreased through 2013 after a peak in 2009. In addition, a nationwide survey indicates the number of consumers who understand that exceeding the recommended daily dose of acetaminophen may lead to liver damage has increased to 87% in 2013 from 78% in 2010. The survey also reports the number of consumers who think it is important to check the medicine label for the maximum daily dose increased to 98% in 2013 from 93% in 2010.

Developed in 2011, the Know Your Dose campaign encourages pharmacists and other health care providers to talk to their patients about medicine safety and acetaminophen use. The Know Your Dose campaign offers a list of helpful health tips to share with patients, including the following:

(1) Read and follow the label.

(2) Know which medicines contain acetaminophen.

(3) Take only one medicine at a time that contains acetaminophen.
(4) Ask a health care provider or pharmacist about dosing instructions or medicines that contain acetaminophen.

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

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

FDA's Division of Drug Information in the Center for Drug Evaluation and Research presents a series of CE 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. Previous webinar topics have included an overview of FDA's expanded access program and the pregnancy and lactation labeling rule. The webinars and presentation slides can be accessed on FDA's website at *www.fda.gov/AboutFDA/WorkingatFDA/FellowshipInternshipGraduateFacultyPrograms/PharmacyStudentExperientialProgramCDER/ucm228391.htm*.

Fresenius Kabi Recalls Sensorcaine-MPF (Bupivacaine HCl) Injection, USP

In April 2016, Fresenius Kabi USA recalled a single lot of Sensorcaine®-MPF (bupivacaine HCl) injection, USP, 0.75%, 7.5 mg/mL, 30 mL fill in a 30 mL vial, because of visible particulate matter characterized as glass observed by the company during inspection of reserve samples. The recalled product was shipped in the US to wholesaler and distributor outlets between March 4, 2016, and March 21, 2016, and has an expiration date of September 2019. The recall affects lot number 6111504, product code 470237, and National Drug Code number 63323-472-37. The product is supplied as 0.75% strength in a 30 mL single-dose flint molded vial and is packaged in units of 25. To date, Fresenius Kabi has not received any reports of adverse events regarding this recall, indicates the press release posted to the FDA website.

Health care facilities that have the affected lot are instructed to immediately discontinue distributing, dispensing, or using the lot and return all units to Fresenius Kabi. Distributors are instructed to immediately notify their customers who have been shipped or may have been shipped the recalled product. Adverse reactions or quality problems may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting program at *www.fda.gov/MedWatch*. Additional details are available on FDA's website at *www.fda.gov/Safety/Recalls/ucm497812.htm*.

Oral Liquid Docusate Sodium by PharmaTech Recalled Due to Contamination

In July 2016, FDA alerted health care providers that PharmaTech, LLC, of Davie, FL, voluntarily recalled all non-expired lots of Diocto Liquid, a docusate sodium solution distributed by Rugby Laboratories of Livonia, MI. The affected product was distributed nationwide in one-pint (473 mL) bottles with a Rugby label. FDA confirmed the product has been contaminated with *Burkholderia cepacia,* a bacteria linked to an outbreak in five states. The safety alert indicates FDA has received several adverse event reports of *B. cepacia* infections in patients, and some of these reports identify liquid docusate sodium products manufactured by companies other than PharmaTech. FDA and CDC continue to investigate the extent of this issue in order to identify other potentially contaminated liquid docusate sodium products. FDA joins CDC in recommending that clinicians not use any liquid docusate sodium product as a stool softener or for any other medical purpose. Adverse events or side effects may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting Program at *www.fda.gov/MedWatch*. More information may be found in the safety alert on FDA's website at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm511528.htm*.

NABP Seeks Pharmacists From Districts 1, 5, and 7 to Serve as Volunteer Item Writers

The National Association of Boards of Pharmacy® (NABP®) is seeking pharmacists who reside in states in the following districts to serve as volunteer item writers:

- **District 1:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.
- **District 5:** Iowa, Minnesota, Nebraska, North Dakota, and South Dakota.
- **District 7:** Alaska, Idaho, Montana, Oregon, Washington, and Wyoming.

In an effort to secure more individuals representative of these areas of the country, NABP encourages pharmacists in all areas of practice as well as school and college of pharmacy faculty who reside in these states to apply.

NABP uses volunteer item writers to develop questions for the following examination programs: North American Pharmacist Licensure Examination® (NAPLEX®), Multistate Pharmacy Jurisprudence Examination® (MPJE®), Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®), Pharmacy Curriculum Outcomes Assessment® (PCOA®), and Pharmacist Assessment for Remediation Evaluation® (PARE®).

Interested individuals should complete the online interest form available in the Meetings section of the NABP website. Individuals who are selected will receive further information on opportunities to attend and participate in NABP-hosted workshops.

For more information about NABP item writing, visit the Meetings section of the NABP website at *www.nabp.pharmacy*, or contact CompAssess@nabp.pharmacy.

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Auditing Dispensers' PMP Data

By Yenh Long, PharmD, BCACP, Nevada PMP Program Administrator

Prescription monitoring programs (PMPs) are heralded as a useful tool in reducing drug use and overdose. In a White House press release on February 2, 2016, President Barack Obama called upon Congress for **$1.1 billion** in new funding to address the prescription opioid and heroin epidemic and highlighted the utility of PMPs across the nation.[1] But the tool is only as good as the information that is provided to it by dispensers; wrong information in the PMP can have dire consequences.

Nevada's PMP is used primarily by medical professionals (eg, prescribers and pharmacists) to enhance patient care when prescribing and dispensing controlled substances (CS). The PMP allows medical professionals to access and assess the CS prescription histories of their patients to support clinical decisions.[2] Currently, 49 out of 50 states have a CS database. Missouri is the only state without a PMP, but it is committed to passing a PMP bill during the 2016 legislative session. Presently, 23 states require prescribers to enroll in their state's PMP.[3] Twenty-one states require their prescribers to review a patient's PMP report prior to prescribing a CS.[4] Nevada adopted this requirement for its practitioners on October 1, 2015.

With the increased use of PMPs across the nation, **accurate and timely** CS dispensing information to the PMP is absolutely crucial in aiding the prescribers in using the PMP as a tool for prescribing decisions. Common inaccuracies found in PMP data are:

1. Wrong prescriber attributed to prescriptions;
2. Wrong patient attributed to prescriptions;
3. The inactive ingredient of compounds reported rather than the active ingredient.
4. Inaccurate or incomplete patient information reported; and
5. Missing data due to pharmacies and dispensing practitioners not reporting to the PMP.

PMP data quality and timely submission are priorities of the Nevada State Board of Pharmacy. The Board is taking measures to ensure that the PMP is a quality tool for prescribers and dispensers. To that end, Board inspectors will start auditing pharmacies' CS prescriptions to ensure the information provided to the PMP is accurate. You should expect pharmacy inspectors, during your yearly inspection, to request copies of some of the CS prescriptions that your pharmacy has dispensed for auditing. If the inspector finds that the information provided to the PMP is inaccurate based on the CS prescriptions pulled, the pharmacy manager is responsible and will be asked to have the information immediately corrected and resubmitted to the PMP. Failure to comply with the PMP reporting requirements can result in disciplinary action from the Board. To ensure that your pharmacy is reporting accurately to the PMP database, please review NAC 639.926 and the dispenser guide found at *http://bop.nv.gov/links/PMP*.

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The *Nevada State Board of Pharmacy News* is published by the Nevada State 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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