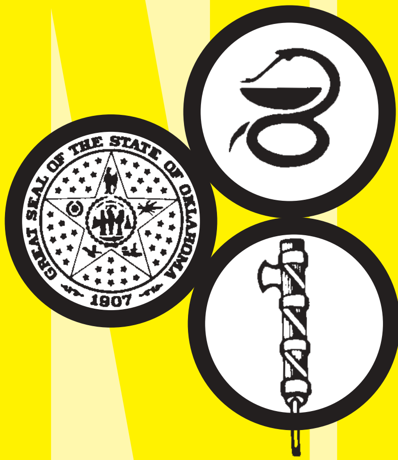
October 2003



Oklahoma State Board of Pharmacy

Published to promote voluntary compliance of pharmacy and drug law.

4545 N Lincoln Blvd, Suite 112, Oklahoma City, OK 73105-3488

Board Meeting – July 9, 2003

Reorganization of the Board

Jerry Allen has been elected president and James Spoon vice president of the Oklahoma State Board of Pharmacy for 2003-2004.

Disciplinary Action

Kelly Williams, DPh, #10657 – Case 679: Received Letter of Reprimand; must view "Error Correction Video" and complete the accompanying course within 90 days. *Charge:* received two or more warning notices within a 12-month period.

The Board also took action in three (3) impaired cases: **Case 677 – DPh, #12842,** was suspended for ten (10) years with the suspension stayed and placed on probation. She must enter into and abide by an Oklahoma Pharmacists Helping Pharmacists contract and may request that the suspension be lifted after five (5) years; **Case 598 – DPh, #10013,** appeared to request probation. His license was placed on probation after agreeing to continue with Board requirements in the original order. He will work with another pharmacist for the first six (6) months and has agreed to not become an owner of a pharmacy; **Case 590 – DPh, #11238,** appeared to request probation. His license was placed on probation providing he correct the dilute drug screens and continue with Board requirements in the original order. He will notify each employer of his Board action and agreed not to work in relief-type situations where he had to travel and work at different stores on a regular basis.

Board Meeting – August 14, 2003

Disciplinary Action

Ronald Terry, DPh, #8265, and Family Discount Pharmacy, #6-4377 – Case 678: License suspended for five (5) years to be placed on probation effective February 1, 2004. $20,500 Fine. Must attend Law Seminar in 2003, 2004, and 2005. Must complete live required continuing education in 2004 and 2005. Agreed not to own another pharmacy in Oklahoma. *Charge:* Failure to keep proper record keeping system for the purchase, sale, delivery, possession, storage, and safekeeping of drugs; processing prescriptions for brand name but dispensing generic instead; submitting fraudulent billing or reports to a third party payor of prescription drugs; forging or increasing the quantity of drug in a prescription, or presenting a prescription bearing forged, fictitious, or altered information; failure to conduct business as a pharmacist in conformity with all federal, state, and municipal laws; failure to conduct himself at all times in a manner that entitles him to the respect and confidence of the community in which he practices.

Stephen Layne Summers, DPh, #10608 – Case 668: License suspended with probation for one (1) year. $2,000 Fine. Must attend Law Seminar in 2003. *Charge:* Failure to establish and maintain effective controls against diversion of prescription drugs; failure to file and keep all prescriptions for a period of not less than five (5) years; failure to include the name of the prescriber on a prescription label; committing an act that violates federal, state, or local laws and rules governing pharmacists or pharmacies; increasing the quantity of a drug in a prescription.

Vicky Nott, Tech #6713 – Case 681: Permit revoked. *Charge:* Possession of a controlled dangerous substance without a valid prescription; theft of merchandise.

From the Inspectors:

- **Controlled Dangerous Substances (CDS) Invoices:** A pharmacy must keep invoices for all CDS. Each invoice must be confirmed as accurate and the date the drugs were received must be recorded on the invoice. **Drug Enforcement Administration (DEA) suggests that the person checking in the order should sign or initial the invoice.** CDS invoices must be maintained in two readily retrievable files. Schedule II invoices must be separated from Schedule III, IV, and V invoices. **A DEA 222 Form is required to be completed when Schedule II drugs are received.**
- **Physician Assistant (PA) – Schedule II Drugs:** PAs may write an order for Schedule II drugs for immediate or ongoing administration "on site" pursuant to a written protocol and the PA formulary. "On site" is defined as "hospital in-patients, emergency rooms, licensed surgicenters, medical clinics or offices in an emergency." This will not allow a PA to write a prescription for an ambulatory patient to have filled in a pharmacy. Their authority is for orders for immediate or ongoing administration.

Oklahoma Board of Nursing

Kim Glazier, executive director of the Oklahoma Board of Nursing, asked the Board to notify pharmacists of the following online information available for reference:

- **Status of the Prescriptive Authority of Advance Practice Nurses:** www.youroklahoma.com/nursing
- **Inclusionary Formulary for Certified Registered Nurse Anesthetists:** www.youroklahoma.com/nursing/prac-crnafrm.pdf
- **Exclusionary Formulary for Advanced Registered Nurse Practitioners, Certified Nurse-Midwives, and Certified Nurse Specialists:** www.youroklahoma.com/nursing/prac-exclusfrm.pdf

Board to Look at Possible Rules on Staffing of a Pharmacy

The Board has requested that a committee be formed to look at the possibility of adding a requirement for pharmacies to have support staff on duty under certain conditions. Concern for the protection of public health was raised when it appeared that there is often inadequate staff in large-volume pharmacies. Current laws and rules require a phar-

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macist to be present for the pharmacy to be open; and most pharmacies have a system by which they are able to replace a pharmacist quickly. This is not the case in replacing a technician and often the pharmacist and the public are placed in an unsafe position by inadequate staffing. The Board is currently selecting the committee and welcomes volunteers. The committee will meet this fall and next spring. Please write the Board office if you would like to volunteer.

Medication Errors Continue to Be an Issue

Medication errors continue to be an issue in Oklahoma as they are nationwide. The Nevada State Board of Pharmacy addressed this issue in their April 2003 Newsletter. *Since the scenarios described in the Nevada article are similar to what Oklahoma has faced, we thought it would be appropriate to run the Nevada article.*

In February 2003, the Nevada State Board of Pharmacy faxed a broadcast alert notice resulting from two consumer complaints by the survivors of patients in which morphine sulfate solution (20 mg/ml) was allegedly mislabeled by the pharmacy.

Whether the subsequent overdoses caused or were contributory to the patients' deaths is under investigation. Most important to this agency, and hopefully to every practicing pharmacist, is the question: How does a concentrated morphine solution leave the pharmacy labeled incorrectly?

Here are some rhetorical questions you might consider in your practice:

- Are the speed codes for sigs easily confused between directions for milliliters and teaspoonfuls?
- Does your computer system have a high-dose alert that cannot be overridden by a clerk or technician's single keystroke?
- Does a high-dose alert cause a computer to do a hard stop?
- When a manufacturer's recommended dosage is in milliliters, will your computer create a stop requiring a pharmacist override if a teaspoonful or a larger quantity dose is typed into the sig?
- Does your pharmacy acknowledge and address the most common drugs causing death or injury to patients? For example, Nevada's top two are morphine and Coumadin. Are the products placed in special storage for special handling and review? Could they have a caution sleeve covering or be in a box to alert special consideration?
- Are pharmacists too comfortable with their clerk's or technician's work and are, thus, not checking their work as diligently as they should?
- Has your double-, triple-, or quadruple-check system emphasized the product contents and not the directions?

During a quality assurance discussion in your pharmacy, you might consider these or other systems to prevent medication errors. Pharmacists have repeatedly expressed their chagrin for allowing an uncomplicated medication error. Nobody – not the patient, the physician, the pharmacist, or the Board – wants even one more medication error, so please examine your pharmacy to determine what might be done to prevent the next error from being in your pharmacy.

OPhA Law Seminar – December 7, 2003

As part of the Oklahoma Pharmacists Association 2003 law seminar there will be a section on the new **Hospital Drug Room rules.** If you are a consultant pharmacist for a hospital drug room, you should plan to attend this meeting.

Oklahoma Pharmacists Helping Pharmacists

If you or a pharmacist you care about is suffering from chemical dependency, there is a solution. Oklahoma Pharmacists Helping Pharmacists (OPHP) is readily available for help. Pharmacists in Oklahoma, Texas, and Louisiana may call the OPHP Help-Line at 1-800/260-7574 ext 5. All others may call OPHP at 405/528-3338. All calls are confidential.

Board Web site: www.pharmacy.state.ok.us
Board e-mail: pharmacy@oklaosf.state.ok.us

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