BEFORE THE NORTH CAROLINA BOARD OF PHARMACY

In the Matter of:		
Sharon Lawrence (License Number 11523)	)	**FINAL DECISION**

This matter came on for hearing upon a Notice of Hearing issued December 27, 2006 to determine whether or not Sharon Lawrence (Respondent) violated North Carolina General Statute §90-85.38(a)(6), (7), and (9) which provides that the Board may issue a letter of reprimand or suspend, restrict, revoke or refuse to grant or renew a license or require a licensee to complete remedial education if the licensee has:

> "(6) Failed to comply with the laws governing the practice of pharmacy and the distribution of drugs;
>
> (7) Failed to comply with any provision of this Article or rules adopted by the Board; and
>
> (9) Been negligent in the practice of pharmacy."

The Notice set forth specific factual allegations and scheduled a hearing for January 16, 2007. The hearing was conducted at the Board office before Board members Nelson, Dennis, Chesson, Haywood and McLaughlin. At the hearing, counsel for the Board presented evidence in the form of testimony and exhibits; counsel for Respondent presented evidence in the form of testimony and exhibits. Having heard the testimony presented, considered the exhibits offered, and judged the credibility of the testifying witnesses, the Board makes the following:

FINDINGS OF FACT

1. At all relevant times, Respondent was licensed to practice pharmacy by the Board and was the holder of license number 11523. From January 19, 2005 until January 10, 2006, Respondent was employed as a staff pharmacist at an Eckerd Drug in Henderson, N.C.

Currently Respondent is employed as a staff pharmacist at a Kerr Drug in Durham, N.C.

2. On or about April 5, 2005, the Board received a complaint that in March of 2005, the complainant's child received multiple prescriptions from an Eckerd pharmacy that were dispensed in error (Complaint No. 05.142).

3. On or about August 1, 2005, the Board received a complaint that on or about December 17, 2004, Respondent dispensed a NuvaRing on a prescription order for an Estring 2 mg (Complaint No. 05.291).

4. Based upon the information above, Board Investigators Kohler and Wilkins commenced investigations.

Complaint 05.142

5. The investigation produced evidence to show that on March 9, 2005, RPh. James Caviness dispensed a partial fill of Desonide .05% ointment which was the strength prescribed by the patient's physician. Statements provided by Caviness and the complainant indicate that when Respondent dispensed the remaining quantity several days later, she dispensed the incorrect strength of .25% ointment. However, Respondent testified that it was Caviness who dispensed the incorrect strength of .25% ointment.

6. The investigation also produced evidence to show that on March 16, 2005, Respondent dispensed Nystatin and Triamcinolone Acetonide .1% to the same patient when only Nystatin was prescribed.

7. The investigation produced no evidence of side effects or long term harm to the patient.

8. The patient's mother reported that she was not counseled upon receipt of the Desonide. However, pharmacy records reflect that counseling was refused.

9. Investigator Kohler requested incident reports on both Respondent and RPh. Caviness from Eckerd Pharmacy. The reports were provided in a timely manner to the investigator on August 29, 2005.

10. On March 16, 2005, Respondent worked a twelve-hour shift and dispensed a total of 115 prescriptions.

Complaint 05.291

11. The investigation produced evidence to show that on December 17, 2004, Respondent dispensed a NuvaRing (intravaginal contraceptive device) on a prescription refill for an Estring 2mg (intravaginal hormone replacement therapy device).

12. The patient reported to Investigator Wilkins that on or about February 24, 2005, she awoke and noticed that her pajamas were covered with blood. When she reached her gynecologist's office approximately two hours later, she reported to her doctor that she was in severe pain.

13. The patient reported that she returned to the pharmacy several days later to inform pharmacy staff of the severe adverse reaction. The patient also reported that during her return visit to the pharmacy, pharmacy technician Cassandra Hamilton immediately identified that the patient had been dispensed the wrong medication. Ms. Hamilton testified that when the patient returned to the pharmacy, Ms. Hamilton immediately identified the error, as the Estring prescription label had been placed directly on a Nuvaring stock box.

14. During an interview with Investigator Wilkins, Respondent stated that the error occurred because a technician had pulled the wrong medication and Respondent had simply overlooked the error. Respondent also advised Investigator Wilkins that she had been responsible for several additional misfills, but she did not provide him with any specific

information regarding the errors.

15. At the hearing, Respondent testified that she was not present in the pharmacy on the date that the patient returned to the pharmacy. However, Ms. Hamilton testified that Respondent was the pharmacist on duty, and after informing Respondent of the error, Respondent declined to speak to the patient.

16. On or about September 28, 2005, the pharmacy provided incident reports to the Investigator per his request.

17. On December 17, 2004, Respondent worked a twelve-hour shift and dispensed a total of 111 prescriptions.

18. The investigation also produced evidence to show that on or about May 26, 2005, another patient purchased a prescription for Lovenox (blood thinner). When the patient requested counseling, Respondent told the patient that the medication was a pain medicine. The patient questioned whether the medication was for pain and Respondent confirmed that it was one of the best. Several days later, the patient returned to the pharmacy and spoke with another pharmacist, expressing concern about his prior conversation with Respondent.

19. On May 26, 2005, Respondent worked a twelve-hour shift and dispensed a total of 146 prescriptions.

20. During the course of his investigation, Investigator Wilkins also obtained pharmacy incident reports from Kerr Drug where Respondent was currently employed.

21. At the hearing, Respondent produced evidence to show that on or about August 11, 2006, she completed a continuing education course related to error reduction.

22. At the hearing, a representative from Kerr Drug, Respondent's current employer, testified that Respondent had not committed any dispensing error for approximately six months.

CONCLUSION OF LAW

1. The actions of Respondent as described above constitute violations of the following statutes and rules:

   a. G.S. 90-85.38(a)(6), (7) and (9);

   b. G.S. 106-122;

   c. G.S. 106-134.1;

   d. 21 U.S.C. §§331, 352 and 353; and

   e. 21 N.C.A.C. 46 .1805.

IT IS, THEREFORE, ORDERED, that:

1. Respondent Sharon Lawrence's license, number 11523, shall be suspended indefinitely, stayed three (3) years upon the following conditions:

   a. Respondent shall advise the Board promptly in writing of any change of address or change in practice status;

   b. Respondent shall obtain prior approval of all employment as a pharmacist from the Board's Executive Director;

   c. Respondent shall not serve as a pharmacist manager of any pharmacy;

   d. Respondent shall not serve as a preceptor of pharmacy students;

   e. Respondent shall not be employed as a pharmacist more than forty (40) hours per week or eight (8) hours per day, on average;

   f. Respondent shall violate no laws governing the practice of pharmacy or the distribution of drugs;

g. Respondent shall violate no rules and regulations of the Board;

h. Respondent shall promptly provide documentation of any reported errors to the Board's Executive Director within five (5) business days of such error; and

i. Respondent shall continue to participate in the Kerr Drug "watch" program (or an equivalent program if Respondent changes employers) and report to the Board's Executive Director on a quarterly basis regarding her participation and status in such program. Respondent shall also report actions taken by Kerr Drug or her current employer under such program.

2. If Respondent fails to comply with any terms or conditions of this Order, the three-year stay described above shall be lifted and Respondent may be subject to additional disciplinary action by the Board.

This the 16th day of January, 2017.

NORTH CAROLINA BOARD OF PHARMACY

By: _____

Jack W. Campbell, IV
Executive Director