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North Carolina Board of Pharmacy News

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Item 2324 – Voting for Board Member Elections for Northern and Western Districts Opens April 14, 2016

As reported in Item 2322 of the January 2016 *Newsletter,* North Carolina Board of Pharmacy member elections for the Northern and Western district seats take place this spring.

The following pharmacists have petitioned to become candidates for the **Northern District,** which consists of Alamance, Caswell, Forsyth, Guilford, Orange, Person, Rockingham, Stokes, Surry, and Yadkin counties:

- Cecil Davis, License #11736 (Forsyth County);
- Haywood Rhodes, License #20380 (Orange County); and
- Keith Vance, License #16411 (Forsyth County).

The following pharmacists have petitioned to become candidates for the **Western District,** which consists of Alexander, Alleghany, Ashe, Avery, Buncombe, Burke, Caldwell, Catawba, Cherokee, Clay, Cleveland, Gaston, Graham, Haywood, Henderson, Jackson, Lincoln, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, Wilkes, and Yancey counties:

- FC "Chip" Etier, License #18061 (Haywood County);
- Tim Gentilcore, License #19256 (Buncombe County);
- Cathy Huie, License #13958 (Wilkes County);
- David Landers, License #11268 (Madison County); and
- Bill Mixon, License #07723 (Catawba County).

Voting will run from April 14 through May 15. **All pharmacists living in North Carolina and actively licensed as of March 15, 2016, are eligible to vote. Voting is not limited to pharmacists who live in the counties that comprise the Northern and Western districts.** Pharmacists are **strongly** encouraged to vote.

As in years past, eligible voters will log in to the Board's secure site using their license number and PIN to cast their vote. The Board's secure website will also contain information about each of the candidates.

Voting closes on May 15 and votes will be tallied immediately following. The Board will convene quickly to review and certify the election results, permitting any necessary run-off(s) to begin immediately.

Please contact Jack W. "Jay" Campbell IV or Kristin Moore at the Board office if you have questions about the election process.

Item 2325 – Board and UNC Eshelman School of Pharmacy Partner to Provide Pharmacists With a No-Cost CE Course on Use of the North Carolina CSRS

The Board and the University of North Carolina (UNC) Eshelman School of Pharmacy have partnered to build a continuing education (CE) program for pharmacists on the North Carolina Controlled Substance Reporting System (CSRS). The online CE module educates pharmacists on the process for activating CSRS access, the menu system for acquiring data in the CSRS, and, perhaps most importantly, provides a series of interactive case scenarios designed to guide pharmacists in the appropriate use of CSRS data in various practice settings. To access the program, **which is available without cost to pharmacists,** please visit *https://learn.pharmacy.unc.edu/csrs/#/csrs_home.*

The Board reminds pharmacists that the CSRS is an important tool to aid pharmacists' exercise of professional judgment in dispensing controlled substances. The Board's statement on CSRS use may be found at *http://www.ncbop.org/PDF/NCBOPStatementConcerningCSRSUseOct2014.pdf.*

More information and resources concerning the CSRS may be found on the Board's website at *http://www.ncbop.org/faqs/Pharmacist/faq_NCCSRS.htm.*

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*.

Item 2326 – Voting for Election Medical Oxygen Supplier Seat on the DME Subcommittee Opens in June

In June 2016, the Board's Durable Medical Equipment (DME) Subcommittee will hold an election for the medical oxygen supplier representative seat. This seat is presently held by DME Subcommittee member David Keesee, who is not running for re-election.

At the time of this writing, the nomination period was open but will close on the date of this *Newsletter's* publication, April 1.

All North Carolina persons-in-charge of a DME permit in the state as of March 15, 2016, are eligible to vote. Voting will be electronic again this year; DME persons-in-charge will log in to their individual Board accounts to cast an electronic ballot. More details, including instructions for requesting a paper ballot, will follow in the coming weeks and will be posted on the Board's website at *www.ncbop.org*.

Item 2327 – NCHRC Produces Guidance for Pharmacists on Naloxone Dispensing by Standing Order and on Nonprescription Sale of Syringes

As pharmacists are aware, North Carolina law permits the dispensing of naloxone pursuant to standing orders. The North Carolina Harm Reduction Coalition (NCHRC) has put together a frequently asked questions (FAQs) document that walks pharmacists through the "Good Samaritan" law's provisions on naloxone dispensing, the use of standing orders, where pharmacists can obtain standing orders, and other highly useful information. Board staff encourages pharmacists to review the NCHRC document, which may be found at *http://www.ncbop.org/faqs/FAQNaloxoneGoodSamaritanNCHRC.pdf*.

Pharmacists often contact Board staff to inquire about the permissibility of nonprescription syringe sales. North Carolina law permits nonprescription syringe sales. Pharmacists, though, often have additional questions about the policy and public health implications of nonprescription syringe sales. To help address these questions, NCHRC has assembled an FAQ document that pharmacists are likely to find helpful and reassuring. NCHRC also offers pharmacists free on-site training on bloodborne pathogens and nonprescription sale of syringes. For more details, please see the NCHRC document, which may be found at *http://www.ncbop.org/faqs/FAQsNonPrescriptionSyringeSalesNC.pdf*.

Item 2328 – United States Pharmacopeia Chapter <800> 'Hazardous Drugs—Handling in Healthcare Settings' Published

On February 1, 2016, the United States Pharmacopeial Convention (USP) published the final version of Chapter <800>, which sets forth standards for handling hazardous drugs in health care settings, including, obviously, pharmacies. Chapter <800>, titled *Hazardous Drugs—Handling in Healthcare Settings,* helps ensure patient safety, worker safety, and environmental protection. These standards apply to health care personnel who handle hazardous drugs and to all entities that store, prepare, transport, or administer hazardous drugs.

The standards become effective on July 1, 2018. After that date, Board staff will be inspecting and enforcing these new standards, which are incorporated by reference into USP Chapters <795> and <797> governing compounding. You can access the USP <800> standards at *http://www.ncbop.org/faqs/USPChapt800HazardousDrugsFeb2016.pdf*.

Item 2329 – North Carolina Medical Board Information on Disciplinary Actions

Pharmacists often call the Board of Pharmacy seeking information about physicians who have been disciplined by the North Carolina Medical Board. Board of Pharmacy staff stand, as always, ready to assist with such inquiries.

However, pharmacists should be aware that the Medical Board maintains a constantly updating website section that details disciplinary actions taken against a physician, physician assistant, or other professional regulated by the Medical Board. That list may be accessed at *http://www.ncmedboard.org/about-the-board/latest-board-activity/recent-board-actions*. Pharmacists may also contact the Medical Board directly at 919/326-1100.

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