October 2001

North Carolina Board of Pharmacy

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Item 1130 – July Disciplinary Actions

The North Carolina Board of Pharmacy has secured many comments from pharmacists on the number and extent of the disciplinary actions listed in the July *Newsletter*. It needs to be pointed out that every one of these disciplinary actions on dispensing errors was initiated by a consumer complaint. The Board cannot ignore consumer complaints that reveal violations of a statute or a rule that are a danger to the public health and safety.

This new and more extensive format was used at the suggestion of one Board member who had received a complaint about what appeared to be a severe disciplinary action when only one minor violation was listed. Cases can vary, but in any situation there are multiple offenses. Staff has returned to the more concise method of describing disciplinary actions for the October issue.

Some clarifications need to be made on at least two entries in the July issue. In one case it appeared that 20 ml of Zithromax was dispensed when only 15 ml had been authorized. A more complete description of the problem is that there was a reconstitution error on the part of the pharmacist when 20 ml of a more diluted product was dispensed instead of 15 ml of the correct concentration. The evidence also reflected that the prescription was dispensed by a pharmacy technician without a pharmacist review prior to delivery to the patient.

In another case, atenolol 25 mg was dispensed on an order for atenolol 50 mg. A more correct description was that the pharmacist changed the dosage units and strengths producing a different regimen and a different dosage level than what was authorized by the prescriber. In another case, Roxicet 500/5 was dispensed on an order for Percocet, which, absent any specification on strength, would be designated as 325/5. In this case, capsules were also dispensed for tablets contrary to a specific provision in the product selection law.

Item 1131 – Disciplinary Actions

Full Hearings

April

Vivian M. Belton (DOB September 1, 1962), High Point. Dispensing a compounded product with no label affixed to the medication vial. Warned regarding the dispensing error.

June

Charles T. Bynum (DOB September 26, 1952), Greensboro. Dispensed Zoloft® on a prescription written for metronidazole; no patient counseling offered; the patient ingested the wrong medication for a period of four days before the error was discovered. Official Board Warning.

Frye Regional Medical Center, Hickory, and **Paul R. Troiano** (DOB April 24, 1957), Hickory. Operating pharmacy during third shift without a pharmacist being present. Pharmacy Reprimanded with conditions. License of Troiano suspended seven days, stayed three years with specific conditions.

Prehearing Conferences

April

Jane Hinnant (DOB September 12, 1945), Aiken, South Carolina. Heard by Board Member Crocker. Filled an order for Dilantin® suspension with incorrect directions for administration on the vial resulting in the patient being hospitalized for approximately eight days. Recommendation: License suspended seven days, stayed two years with active three-day suspension of the license and other conditions. Accepted by: Ms Hinnant March 19, 2001; the Board April 17, 2001.

Denise L. Huggins (DOB May 28, 1964), Hope Mills. Heard by Board Member Watts. Dispensed Histinex® DM Syrup to a patient with incorrect directions on the vial. Recommendation: Letter of Concern. Accepted by: Ms Huggins March 13, 2001; the Board April 17, 2001.

Richard Rains (DOB July 27, 1946), Elm City. Heard by Board Member Nelson. Dispensed Synthroid on a prescription for Maxzide® with the patient ingesting the wrong medication for approximately seven days before the error was discovered. Recommendation: License suspended five days, stayed three years with active suspension of one day and other conditions. Accepted by: Rains April 10, 2001; the Board April 17, 2001.

Indian Trail Pharmacy, 106 Indian Trail, Indian Trail. Heard by Board Member Overman. A pharmacist working

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at that facility dispensed Dilantin® liquid with incorrect directions on the bottle with the patient receiving nine administrations of the product before the error was discovered. Recommendation: Permit suspended one day, stayed two years with conditions. Accepted by: Charles Stine on behalf of Indian Trail Pharmacy March 20, 2001; by the Board April 17, 2001.

Eckerd Drugs, 945 N Harrison Ave, Cary. Heard by Board Member Crocker. Pharmacist employed dispensed Zyrtec® 10 mg with both Zyrtec and Lipitor® 10 mg dispensed in same vial. The error resulted from Zyrtec and Lipitor being placed in a "Baker Cell" without the knowledge of the pharmacist. The patient ingested at least four dosage units of Lipitor as a result of the error. Recommendation: Letter of Warning with the pharmacy to implement an effective Policy and Procedure for automatic devices used in the dispensing of prescription drugs. Accepted by: James M. Coleman on behalf of Eckerd Drugs March 27, 2001; by the Board April 17, 2001.

May

Renae A. Bausley (DOB August 3, 1962), Charlotte. Heard by Board Member Haywood. Dispensing isosorbide 60 mg on a prescription for isosorbide 30 mg. The patient did not ingest any of the incorrect medication. Recommendation: Reprimand and violate no laws governing the practice of pharmacy or the distribution of drugs. Accepted by: Bausley April 17, 2001; the Board May 15, 2001.

Kent Huffman (DOB July 30, 1939), Oak Ridge. Heard by Board Member Nelson. Dispensing of prescription drugs to his wife without authorization of a physician and creating fraudulent prescriptions to cover for these products dispensed. Recommendation: Reprimand. Accepted by: Huffman April 20, 2001; the Board May 15, 2001.

John Bennett (DOB June 15, 1944), Carolina Beach. Heard by Board Member Nelson. Dispensing of controlled substances and other prescription drugs to a patient without regard to proper drug utilization review. Recommendation: Letter of Concern and pharmacist should evaluate and change conditions that might have led to prescription drugs being dispensed without proper drug utilization review. Accepted by: Bennett April 30, 2001; by the Board May 15, 2001.

Kimberly Sayaseng (DOB January 27, 1968), Raleigh, Heard by Board Member Nelson. Dispensing of hydralazine on a prescription for hydroxyzine 25 mg with the order being refilled several times from the original dispensing date, resulting in the patient ingesting the incorrect product. Recommendation: License suspended five days, stayed three years with active one-day suspension of the license and other conditions. Accepted by: Sayaseng May 2, 2001; the Board May 15, 2001.

Olusola Ojo (DOB August 15, 1966), Gastonia. Heard by Board Member Nelson regarding the dispensing of Fiorinal® on an order calling for Florinef ® with the patient ingesting three dosage units before the error was discovered. Recommendation: License suspended five days, stayed three years with active one day suspension and other specific conditions. Accepted by: Ojo April 23, 2001; the Board May 15, 2001.

Larry Robinson (DOB August 30, 1943), Garner. Heard by Board Member Watts. Dispensing Vibramycin 100 mg on a prescription for vitamins with the patient ingesting the incorrect medication for approximately 34 days before discovery of the error. Recommendation: Warning to exercise greater care in his dispensing practices in the future. Accepted by: Robinson May 10, 2001; the Board May 15, 2001.

June

Henry McLamb (DOB November 6, 1939), Fayetteville. Heard by Board Member Rogers. Dispensing sulfasalazine 500 mg to a patient on a prescription order for sulfadiazine 500 mg. Recommendation: Letter of Warning for his actions in this matter. Accepted by: McLamb May 30, 2001; the Board June 26, 2001.

Melissa Dolman (DOB August 7, 1972), Hillsborough. Heard by Board Member Rogers. Dispensing prednisone 5 mg to a patient who was to receive glipizide. Recommendation: Letter of Warning for her actions in this matter. Accepted by: Dohlman May 30, 2001; the Board June 26, 2001.

Patricia Ellsworth (DOB December 19, 1959), Raleigh. Heard by Board Member Watts. Embezzlement or diversion to her own use Stadol® NS from the pharmacy where she was employed. Recommendation: License suspended indefinitely, stayed five years with specific conditions. Accepted by: Ellsworth June 4, 2001; the Board June 26, 2001.

Terry Lovell (DOB March 7, 1965), Elizabeth City. Heard by Board Member Watts. Dispensing verapamil to a patient on a prescription calling for Zantac® with the patient ingesting two dosage units of the incorrect medication before the error was discovered. Recommendation: Letter of Warning for his actions in this matter. Accepted by: Lovell May 23, 2001; the Board June 26, 2001.

Stuart Hamm (DOB April 7, 1961), Snow Hill. Heard by Board Member Rogers. Dispensing Toradol® 10 mg to a paitent with no label affixed to the vial. Recommendation: Letter of Caution for his actions in this matter. Accepted by: Hamm May 24, 2001; the Board June 26, 2001.

Edward Smith (DOB September 29, 1938), Advance. Heard by Board Member Rogers. Dispensing of the narrow therapeutic index drug levothyroxine sodium to a patient without the physician's approval for the substituted medication. Recommendation: Letter of Caution for his actions in this matter. Accepted by: Smith May 30, 2001; the Board June 26, 2001.

William Frostick (DOB March 2, 1932), Laurinburg. Heard by Board Member Watts. Embezzlement or otherwise diversion to his own use of approximately 900 dosage units of hydrocodone; during the first six months of the year 2000 committing seven errors in the dispensing of prescription drugs to patients; history of alcohol and controlled substance abuse for approximately 25 years. Recommendation: License suspended indefinitely, stayed five years with specific conditions. Accepted by: Frostick May 15, 2001; the Board June 26, 2001.

Debbie McClain Perkins (DOB August 29, 1959), Greenville. Heard by Board Member Watts. Dispensing propylthiouracil to a two-year-old patient on a prescription calling for Purinethol® with the patient ingesting the wrong medication from January 10 until June 20, 2000, when the

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error was discovered. Recommendation: License suspended 30 days, stayed three years with an active suspension of seven days to begin no later than June 30, 2001, and other conditions. Accepted by McClain May 17, 2001; the Board June 26, 2001.

April Anderson (DOB September 29, 1969), Durham. Heard by Board Member Watts. Dispensing morphine 15 mg on a prescription calling for Roxicodone™ 5 mg with the patient ingesting 81 morphine 15 mg dosage units before the error was discovered. Recommendation: Letter of Warning for her actions in this matter. Accepted by: Anderson May 17, 2001; the Board June 26, 2001.

Kmart of NC LLP, 2455 Lewisville-Clemmons Road, Clemmons. Heard by Board Member Rogers. Dispensing of the narrow therapeutic index drug levothyroxine sodium to a patient without the approval of the physician for the substituted medication. Recommendation: Letter of Warning with respondent pharmacy submitting in writing to the Board's office its policy on narrow therapeutic index drugs and its policy on patient counseling by June 15, 2001. Accepted by: Edward Smith, pharmacist-manager June 11, 2001; the Board June 26, 2001.

Gary R. Glisson (DOB August 15, 1955), Nashville, and Ward Drug Company, 117 W Church St, Nashville. Heard by Board Member Overman. Dispensing of prescription drug refills to a patient on 58 occasions without authorization of the prescriber from September 1998 until May 2001. Recommendation: Pharmacist Glisson be issued a Reprimand for his actions in this matter and Ward Drug Company be issued a Reprimand for the actions of respondent pharmacist. Accepted by: Glisson June 11, 2001; accepted by Glisson on behalf of Ward Drug Company June 11, 2001; the Board June 26, 2001.

William P. Horton (DOB October 3, 1926), Wilson. Heard by the Durable Medical Equipment Subcommittee. Allowing prescription drugs to be held for sale and sold without the site holding a pharmacy permit; allowing persons not licensed as pharmacists to dispense prescription drugs from the site without the supervision of a pharmacist; falsifying records; misbranding; failure to maintain prescription drug orders in a safe and lawful manner. Recommendation: License suspended 30 days, stayed two years with active 15 consecutive business days and other conditions. Accepted by Horton June 5, 2001; the Board June 26, 2001.

Paul Hetrick (DOB March 16, 1974), Apex. Heard by Board Member Overman. Dispensing of doxepin 10 mg to a patient on an order calling for doxepin 100 mg. Recommendation: Warning to exercise greater care in his dispensing practices. Accepted by: Hetrick June 15, 2001; the Board June 26, 2001.

Item 1132 Runoff Election Results

The ballots for the runoff election for District II were counted the afternoon of July 16 in the offices of the Board in Carrboro. The results are below.

Betty Dennis	1,482
William "Bill" Post	1,183

Dr Betty Dennis was declared the winner for District II representing the north central part of the state. She will assume this position on the Board in spring 2002.

Item 1133 – Playground Drugs

Norman Tarter in Conover reported an actual scenario that he encountered and that should give us all pause to reflect on drug use in schools. A mother brought a drug into Mr Tarter's pharmacy that her 12-year-old daughter had obtained in school. The number "5" printed on the tablet was presumed to be hydrocodone by the seller and purchaser. However, the drug checked out to be generic warfarin 5 mg, which would cause any pharmacist's, physician's, or nurse's heart to jump.

It would be a public service for pharmacists to have cross reference sources available to provide immediate identification in such cases. Letting your patients and customers know of the availability of this service is in the public interest.

Item 1134 – Look-alike/Sound-alike

The United States Pharmacopeia (USP) publishes a list of look-alike and sound-alike drugs in poster form. Individual copies are available from Gail Bormel, USP, 12601 Twinbrook Parkway, Rockville, MD 20852. You may also log on to www.usp.org.

Item 1135 – Top Ten

While reviewing Board records, a compilation of the most frequent surnames of pharmacists include one unexpected entry. The top ten, actually there was a tie for tenth place producing 11 names, are printed below.

Smith	119
Jones	70
Williams	66
Johnson	57
Davis	52
Brown	52
Patel	47
Miller	44
White	43
Moore	42
Taylor	42

The fact that we have 47 pharmacists named Patel, a name originating in India, confirms that we continue to be a nation of immigrants.

Item 1136 – Pharmacy Technicians

The General Assembly adopted legislation, which provides for the Board of Pharmacy to register pharmacy technicians beginning January 1, 2002. A supply of technician applications will be sent with the permit renewals in November, and additional supplies, if necessary, can be obtained at that time.

Technicians who are employed prior to January 1, 2002, may register under a "grandfathering" clause until July 1, 2002. After that time the pharmacist-manager or employer must provide a technician training program and technician status is connected to employment.

The ratio of technicians to pharmacists remains two to one; however, that can be increased if the additional technician is Board certified. The registration fee is $25 annually.

Item 1137 – Reminder: Clinical Pharmacist Practitioners

Clinical Pharmacist Practitioners (CPPs) need to be aware that a total of 35 hours of continuing education is required to renew their CPP status. This can include, of course, the 10 hours specified by Board rule. This new provision will be applied for renewals in 2002.

Applications for CPP status are considered by the Board of Pharmacy in the odd numbered months, and applications need to be in the Board office seven days prior to the Board meeting.

Further information on CPPs can be found on the Board's Web site at www.ncbop.org under Drug Law/Rules/.3100.

Item 1138 – Important Web Sites

As events in health care are changing on a daily basis, it can be useful to keep up with developments by checking appropriate Web sites. Three important ones appear below.

→www.ncbop.org
→www.docboard.org
→www.ncbon.com

Item 1139 – Counterfeit Drugs are Coming to America

According to a recent *US News & World Report* article (June 11, 2001), "Knockoffs on the Pharmacy Shelf, Counterfeit Drugs are Coming to America," the World Health Organization estimates that "more than seven percent of the world's pharmaceuticals are bogus." The report continues that in May 2001, counterfeit vials of Neupogen®, Nutropin AQ®, and Serostim® were shipped by wholesalers to pharmacy shelves in at least eight states. It was reported that some pharmaceutical companies, in an attempt to combat this problem, have put chemical tags into their drugs so that they can verify if the drug is legitimate. Pharmacists are encouraged to continue to be observant of any possible counterfeit drugs and to contact the Food and Drug Administration at 919/856-4474 to report any such activity.

Item 1140 – Changes Pharmacists Can Make to a Schedule II Prescription

The majority of changes to a Schedule II prescription can be made only after the pharmacist contacts the prescribing practitioner. The pharmacist is permitted to make correcting changes in the patient's address, drug strength, drug quantity, drug dosage form, and directions for use. The pharmacist may add information such as the patient's address. The pharmacist is not permitted to make changes to the patient's name, controlled substance prescribed (except to substitute a generic), or the prescriber's signature. After consulting with the prescriber, the pharmacist must document any changes made including the time, date, and signature. Documentation on the prescription is the pharmacist's account of the changes made. These changes should match what appears in the patient's chart at the prescriber's practice site if the dosage form or the directions for use are changed.

Item 1141 – Electronic Renewals

For the first time, the Board of Pharmacy will offer the option for pharmacists to renew their license to practice pharmacy electronically. Look for more information on this important option when you get your 2002 renewal information during the first part of November.

The *North Carolina Board of Pharmacy News* is published by the North Carolina Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote voluntary 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 the Foundation or the Board unless expressly so stated.

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