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News



Kansas State Board of Pharmacy

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Board Unveils New Online Experience

The Kansas State Board of Pharmacy reorganized its website, added new features, and made everything more user-friendly! Visit the Board website at <https://pharmacy.ks.gov> and check out the ongoing improvements. You will find the following items:

- ◆ Announcements on the home page
- ◆ Quick Links
- ◆ Forms – updated, uniform, in one central location, and able to fill/complete electronically
- ◆ Notices – upcoming meetings and agenda, events, public hearings
- ◆ Frequently Asked Questions (FAQs)
- ◆ Proposed Administrative Rules and Regulations
- ◆ Complaint Form – including instructions and processes
- ◆ Instructions and helpful tools for all license, registration, and permit types

Please discard old forms and documents (paper and electronic copies) that may not be up to date. Using the new, fillable forms will be faster and easier and ensure that you have included all required information, fees, and supporting documents. You can identify new versions of forms or documents by checking the “Revised” date in the bottom, right-hand corner of each form.

The Board is also launching a new software called eLicensing that will make applications, renewals, and merely updating your phone or email as simple as logging in and clicking “submit.” You will even be able to upload documents and view your continuing education (CE) credits (linked directly to CPE Monitor[®], a collaborative service from the National Association of Boards of Pharmacy[®] and the Accreditation Council for Pharmacy Education). Get online and create your username/password today!

Taking Steps to Prevent Vaccine Errors

Written by Lainie Linafelter, PharmD Candidate 2017

It may or may not be a surprise to you that the American Pharmacists Association listed vaccine errors as one of the top medication safety issues for 2014. But did you know that the World Health Organization states that adverse effects due to vaccine errors are more likely to occur than adverse effects due to the vaccines themselves? Often it is forgotten that vaccines are prescription drugs and deserve as much attention as the medications pharmacists are dispensing. They must be properly stored and labeled, and steps must be taken to provide health care providers with the information they need to be safely administered.

Unfortunately, a large number of adults and children in the United States remain vulnerable to many vaccine-preventable diseases because of a variety of reasons, including not being offered the vaccination or being denied the vaccination, often as a result of misinformation. The most frightening explanation for some of our population’s vulnerability to disease is due to incorrect vaccination administration and errors, an aspect pharmacists can prevent. In the community pharmacy setting, the vaccines that contributed to the greatest number of error reports were influenza (75%) and zoster (20%).

In order to investigate the cause of the vaccination errors that have been occurring, the Institute for Safe Medication Practices (ISMP) established a National Vaccine Errors Reporting Program (VERP), available at <http://verp.ismp.org>. This program is separate from the Vaccine Adverse Event Reporting System, available at <https://vaers.hhs.gov>, which is the location for patients and practitioners to report adverse events that are suspected to have occurred as the result of a vaccination. After analyzing the VERP reports generated from September 2012 to October 2014, ISMP came up with a list of recommendations to help decrease the number of vaccination errors. Listed below are some of the most

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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.

common factors contributing to vaccine errors, as well as suggestions to prevent future errors.

- ◆ Errors with prescribing, dispensing, and administering age-specific vaccinations.
 - ◇ Verify the patient's age prior to dispensing or administering a vaccination.
 - ◇ Place auxiliary labels on vaccines when first received to differentiate products with different formulations for different age groups.
 - ◇ Consider purchasing different age-specific formulations of the same vaccine from different manufacturers to avoid look-alike errors.
- ◆ Administering invalid doses or missing opportunities to vaccinate.
 - ◇ Always verify the patient's current immunization status first to avoid duplicate doses or administering doses too soon.
 - ◇ Post an up-to-date immunization schedule for staff to double-check for missing immunizations and catch-up schedules.
- ◆ Using the wrong route of administration when giving vaccinations.
 - ◇ Have a reference available for pharmacists to verify the route of administration of vaccines or place auxiliary labels on vaccines to highlight the correct route.
- ◆ Errors with vaccinations that require reconstitution with diluents.
 - ◇ Only use the diluents supplied with the vaccines that require reconstitution.
 - ◇ Establish a process to keep both components of the vaccine together if storage requirements do not differ (dispense in one bag marked with auxiliary sticker).
 - ◇ Establish ongoing education with pharmacists or interns who may dispense or administer these vaccinations.
- ◆ Giving the wrong vaccination because of confusing vaccine nomenclature.
 - ◇ Use caution with look-alike generic names and stick to brand names or current, standard, Centers for Disease Control and Prevention-approved abbreviations for products.
- ◆ Errors related to unsafe and inappropriate vaccine storage.
 - ◇ If possible, store vaccinations in their own refrigerator or in a designated section.
 - ◇ Separate vaccines with similar labels, names, abbreviations, or overlapping components (eg, DTaP, DT, Tdap, Td).
 - ◇ Draw up vaccines only at the time of administration, not in advance.

- ◆ Giving a vaccination that has been expired.
 - ◇ Check for expired vaccinations weekly and remove those expiring from stock.
 - ◇ Label removed vaccines as "expired" and place them away from in-date medications.
 - ◇ Rotate the stock based on the expiration date (place first to expire toward the front).
 - ◇ If an expired vaccine has been administered in error, revaccinate with a valid dose.

Overall, an exceptional way to diminish the potential for vaccine errors is to involve the patient in the verification process. This can be done by providing all patients, parents, or guardians with a Vaccine Information Statement in their preferred language prior to administration of the vaccination. Discuss with the patients or parents/guardians the vaccinations to be administered and answer any questions they have. Pharmacists have several opportunities to contribute to decreasing the number of vaccine-related medication errors and similarly decreasing the number of individuals vulnerable to vaccine-preventable diseases.

For additional information, please visit www.ismp.org and reference the December 4, 2014 and March 26, 2015 issues of the *ISMP Medication Safety Alert!* newsletters on Parts 1 and 2 of the ISMP VERP Analysis.

2016 Renewal Notices – New Process, New Timeline

For licenses and registrations expiring June 30, 2016, renewals will be available online and by paper form beginning June 1.

New this year: eLicensing, which is a web-enabled licensing and renewal system that will improve your Board experience, ease of access, and renewal process. First-time users can go to the eLicensing portal on the Board website to generate a username and password, review and update contact information and other required items, answer the disciplinary history questions, and complete the renewal certification. Then use the Board's secure payment processing portal to submit your payment by credit card, debit card, or electronic check. It takes less than 10 minutes!

If you are unable to renew online, please use the appropriate form to complete your renewal, which can be found on the "Forms" page of the Board's website.

Paper renewals must be hand delivered or postmarked no later than June 30, 2016. Electronic renewals must be date/time-stamped on or before 11:59 PM CDT on June 30, 2016. All other renewals will be considered late and will require payment of a late fee; licensees are not authorized to work, practice, or operate a facility until the renewal (and late fee) are submitted to the Board office. **There is no grace period for renewals or CE (pharmacists only).**

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To verify that your renewal has been received and processed, visit the “License Verification” page on the Board’s website and check for the updated expiration date.

If you have any questions regarding the renewal process, please visit the Board’s website and review the renewal instructions for your license/registration type as well as FAQs. If after reviewing this information you are still unable to resolve your issue, please email the Board at pharmacy@ks.gov and a staff member will respond as soon as possible.

Staff Additions

On April 18, the Board welcomed a new staff member. Shelley Rosebrook, RPh, joins the Board as a licensed pharmacy inspector, with over 20 years of experience in the independent retail pharmacy setting. Shelley has lived in central Kansas for almost 30 years and will be based out of Abilene, KS. Please welcome her to your facilities!

Heidi Nelson is a native Topekan with a communications degree from Wheaton College in Illinois. She joined the Board staff part-time in January and recently accepted a full-time administrative specialist position with the Board office. Her main duties include licensing, registration, Kansas Tracking and Reporting of Controlled Substances review, and CE approval requests. Heidi has enjoyed learning all about pharmacies as she helps the Board prepare for exciting new changes.

Ambulance/Emergency Medical Service Registrations

The Board has received an increased number of questions concerning the requirements for ambulance and emergency medical service registrations. To clarify, a Board registration is required for **each** Drug Enforcement Administration (DEA) registration permit, and at least one Board registration is required for each central drug repository. For additional information, please contact the Board office.

Board Adopts New Regulations

At its quarterly meeting on April 20-21, 2016, the Board adopted the Exempt Prescription Products List published by DEA on March 23, 2016. This list is available on the Board’s website under Legal: Reports & Guidance Docs.

In addition, the Board adopted a new collaborative practice regulation, K.A.R. 68-7-22, which sets forth the requirements for collaborative practice agreements for pharmacists in Kansas. A copy of this permanent adopted regulation can be found on the Board’s website

under Legal: Proposed State Reg Changes, along with other proposed regulations currently open for public comment. In the near future, the Board will be developing a page on its website for collaborative practice resources.

Facility Name Changes

The Board requires a facility application and fee for **each** facility name change. If the name change is done in conjunction with a change of ownership and/or location (must be simultaneous and on the same application), only one new application fee is charged. However, if there is a change in ownership and/or location that is followed by a name change some time later (on a separate application), separate fees will be charged due to multiple application processing and registration printing. Please save your dollars and plan ahead – do it all together!

Upcoming Events

July 14, 2016 9 AM

Hearing on Proposed Administrative Regulations
800 SW Jackson, Lower Level, Topeka, KS

July 14-15, 2016

Board of Pharmacy Quarterly Meeting
800 SW Jackson, Lower Level, Topeka

August 5, 2016

Prescription Monitoring Program (PMP) Advisory Committee Meeting
800 SW Jackson, Lower Level, Topeka

October 28, 2016

PMP Advisory Committee Meeting
800 SW Jackson, Lower Level, Topeka

November 3-4, 2016

Board of Pharmacy Quarterly Meeting
Wichita, KS

January 12-13, 2017

Board of Pharmacy Quarterly Meeting
800 SW Jackson, Lower Level, Topeka

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