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Kansas State Board of Pharmacy

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New Executive Director Named

Debra Billingsley was appointed executive director of the Kansas State Board of Pharmacy effective September 15, 2003. Debra has a bachelor of science degree from Southwest Missouri State University and a juris doctor from Washburn University. Debra was an assistant attorney general for the past several years and has had extensive experience in administrative agency law. She has also previously worked for the Kansas Board of Healing Arts.

Board Welcomes New Compliance Officer

The Kansas State Board of Pharmacy is pleased to announce that Melissa Martin has been selected to join the Board staff as a compliance officer. Melissa has a bachelor of business administration in management degree from Ft Hays University. She was a pharmacy technician II and district trainer with Wal-Mart Pharmacy prior to coming to work for the Board.

Board Meeting Dates

The next Kansas State Board of Pharmacy meeting has been scheduled for March 9-10, 2004, at the AmeriSuites in Topeka, KS. We encourage you to join us. Other meeting dates are scheduled for June 8-9, 2004, and September 21-22, 2004.

FluMist Vaccine

One of the questions that has arisen recently is whether or not a pharmacist can administer the FluMist™ vaccine. The Board reviewed this question at its September meeting and it was determined that a pharmacist could administer FluMist pursuant to K.S.A. 65-1635a. This statute provides that a pharmacist may administer a vaccine if he or she has successfully completed a course of study and training approved by the American Council on Pharmaceutical Education or the Board in vaccination storage, protocols, injection technique, emergency procedures, and record keeping. A pharmacist who successfully completes such a course of study and training shall maintain proof of completion and, upon request, provide a copy of such proof to the Board.

Name Tags

In April 2003 the regulation requiring name tags was amended so that each pharmacist, pharmacy student, intern, and pharmacy technician must wear a visible name tag while performing pharmacy functions. The name tag is to include the person's name and designation. A question arose as to whether or not the last name of the individual had to appear on the name tag in order to be in compliance with this regulation. The Board determined that the individual must have his or her first name and either a last name or last name initial on the name tag. The designation of whether the person is a pharmacist, a pharmacy student, etc, shall be on each name tag. **Note:** This regulation does not replace K.S.A. 65-1663. You still must post the technician names in a conspicuous location.

HIPAA – Disclosures Made to the Board of Pharmacy

Section 164.510(f) and 164.512(d) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits pharmacists to disclose protected information to the Board of Pharmacy inspectors without individual authorization. Section 164.512(d) specifically permits pharmacists and pharmacies to release protected health information to the Board of Pharmacy for oversight activities that include audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; or activities necessary for the oversight of the health care system. Law enforcement officials, such as Board of Pharmacy inspectors, need protected health information for their investigations. HIPAA also permits pharmacists to make certain disclosures to Board of Pharmacy inspectors on their own initiative if the information disclosed constitutes evidence of criminal conduct that arises out of and is directly related to (a) the receipt of health care or payment for health care or (b) qualification for receipt of benefits, payments, or services based on a fraudulent statement or material misrepresentation of the health of a patient. Similarly, the law permits and expects pharmacists, on their own initiative, to disclose to Board of Pharmacy officials protected health information that the pharmacist believes in good faith constitutes evidence of criminal conduct that either occurred at the pharmacy or was witnessed by an employee (or other workforce member) of the pharmacy.

All of the information currently requested and provided to the Board of Pharmacy inspectors as part of routine inspections and investigations is permitted under HIPAA. The rule does not expand current law enforcement access to protected health information. In fact, the Privacy Rule does not interfere with the present requirements of federal and state laws for reporting information to Board of Pharmacy officials. The rule sets a national floor of legal protections; it is not a set of "best practices."

Medication Errors/Consumer Complaints

The mission of the Kansas State Board of Pharmacy is to protect the public health, safety, and welfare. Thus, the Board responds to all consumer complaints. The number of consumer complaints involving medication errors in pharmacies is increasing. The increasing number of complaints is probably due to more public awareness concerning its prescriptions than an actual increase of errors. The Kansas State Board of Pharmacy is aware that a large majority of prescriptions are dispensed correctly and occasionally a pharmacist will commit a dispensing error. Most known prescription errors are resolved between the pharmacy and the consumer. Notification of the error by the pharmacy to the Board office is not required. However, K.A.R. 68-7-12b (Incident Reports) states that as soon as possible after discovery of the incident, the pharmacist shall prepare a report. The preparation of an incident report shall meet the requirements of the regulation and shall be the responsibility of each pharmacist involved in the incident and the pharmacist-in-charge. One of the most important requirements of the incident report is to set out the steps taken to prevent a recurrence.

When a consumer telephones or returns to your pharmacy questioning a possible prescription error, the pharmacist should verify that the prescription was filled correctly. Try to handle the complaint yourself. Recent complaint investigations have discovered that store managers and technicians are giving out misinformation when a consumer questions the accuracy of his or her prescription. The misinformation creates confusion and generally results in the consumer filing a complaint. The following are some of the reasons that consumers give when they file a complaint:

1. After inquiring about their prescription, the pharmacist never returned their call.
2. The pharmacist stated that this error is no big deal, errors happen all the time.
3. The pharmacist did not care or was not sincere when discussing the complaint.
4. The pharmacist was too busy to listen to the complaint.
5. If only the pharmacist would have apologized.

Some consumer complaints are without merit, but if you would take the time to listen to each complaint, it may save you a great deal of aggravation in the future.

Prevention of Errors and Scan Verification

Workload and working conditions are commonly cited in several studies as the leading occupational risk in causing dispensing errors. Errors are more frequent by the pharmacist who works more than a 12-hour shift and goes without breaks during the workday. Several studies have indicated that approximately 90% of medication errors that reached the patient after a final check by the dispensing pharmacist could have been discovered if the patient had been properly counseled. K.A.R. 68-2-20 states that in Kansas, the pharmacist shall personally offer to counsel each patient with each new prescription dispensed and once yearly on all maintenance medications. Other simple procedures to help avoid errors are: keep the prescription and the label together during the fill process, always question bad handwriting, double- or triple-check your work, keep common look- and sound-alike drugs stored in different areas of the pharmacy, and visually check the product in the bottle.

In a large percentage of the complaints the Board receives, the patient was dispensed the wrong drug in a correctly labeled prescription container. At the Board meeting in September 2003, the Board discussed the need for pharmacies to start implementing some type of manual or electronic National Drug Code (NDC) scan verification checks on filled prescriptions. The Board **strongly recommends** (not a law) that pharmacies start using a manual or electronic NDC check to help decrease the number of errors. Since counseling is not required on refilled prescriptions, this check would be valuable in ensuring the accuracy of refilled prescriptions. Commercial scan verifiers are now available at a reasonable cost. The scanner will verify that the patient bottle is being filled with the correct medication. You scan the bar code on the patient prescription label and the bar code on the manufacturer's bottle, and the scanner matches them to determine whether or not they represent the same medication. This eliminates laborious manual matching of the name and strength of the prescribed medication to the manufacturer's bottle.

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