

**BOARD OF REGISTRATION IN PHARMACY
PHARMACY BOARD MEETING MINUTES
TUESDAY, MAY 18, 2004
239 CAUSEWAY STREET, ROOM 204
BOSTON, MASSACHUSETTS 02114**

Board members present: James T. DeVita, R.Ph., President, Karen Ryle, R.Ph., M.S., Secretary (arrived at 11:30 a.m.), Dan Sullivan, R.Ph. (exited at 1:30 p.m.), Marilyn Barron, LSW, Public Member.

Board staff present: Charles R. Young, R.Ph., Exec. Dir., James D. Coffey, R.Ph., Assoc. Dir., Susan Manning, J.D., Counsel, Carolyn L. Reid, Admin. Asst., Leslie Doyle, R.Ph., Healthcare Supervisor, and James Emery, Healthcare Investigator.

1. 9:30 a.m. Call to Order –Pres. DeVita
Investigative Conference & Business Meeting

2. 9:30 a.m. to 11:30 a.m.
Investigative Conference: DS-04-011 & PH-04-020, 021, 022 & 023
In the matter of **Boston Medical Center (BMC)**, 818 Harrison Street, Boston, Massachusetts, 02118, (CS Permit 339) and **Mary L. Young**, R.Ph., License No. 15530, **Laurence G. Shah**, R.Ph., License No. 25587, **Michael J. Gonyeau**, R.Ph., License No. 24721, and Patricia Hughes, Risk Manager. **Linda L. Loeffler**, R.Ph., License No. 22008 – not present.

The purpose of the conference was to discuss a June 07, 2003 Sentinel Event occurring at BMC on 3 involving a TPN solution error (ten-fold increase in Potassium Chloride) administered to a child death resulting).

Present:

Kathleen Murray, R.Ph.
Alexandra B. Harvey, Esq., BMC Counsel
Martin Foster, Esq., Counsel for Shah, Gonyeau and Loeffler
Mary Young, R.Ph., Director
Michael Gonyeau, R.Ph.
Laurence Shah, R.Ph.

CEs: Compliant

General discussion of the event with statements by all parties and questions from board members.

Filling pharmacist Shah acknowledged the error in part resulted from her lack of training and experience with pediatric TPN versus adult TPN computer template use, resulting in her multiple inquiries to dietitian regarding repeat concentration warnings. Shah had initially inquired of dietitian as to appropriateness of adult v. pediatric solution. Shah and dietitian concluded warnings were a computer error – not a solution error – resulting in override of warnings. The order was filled by the Baxter Automated Dispensing System in response to second and third checks performed at the East Newton Pharmacy, not the Harrison Avenue Pharmacy. Shah did not consult with another pharmacist.

Gonyeau, the per diem pharmacist at East Newton BMC facility, was responsible for verifying the orders against the labels. He was not trained in TPN.

Pharmacy Director Young stated the computer system had built in error messages to flag/alert users. At the time of the event, BMC had no written policy that pharmacists could not override error messages without certain protocols or requiring pharmacists to consult a physician in the event of high or low concentration level warnings. Director Young stated that when a pharmacist encounters an override message, the policy is “not to dispense until a call is made to physician”.

Atty. Harvey described the root cause analysis performed by BMC immediately following the error and death to identify causes and institute necessary policies and procedures and operational changes. The corrective action plan includes: pharmacists must be properly trained and retrained for specific processes; error warnings cannot be override by any pharmacists unless manager is on-site for approval; physician orders can be changed by physician only; revised TPN forms created; checking and verification procedures revised; no per diem pharmacists will be hired; various staff responsibilities clarified; on-going training for nurses; updated TPN template utilized; on-site nutritionist attending and on-site dietician added.

Matter taken under advisement by Board.

3. 11:00 a.m.-11:45 a.m.

Pharmacist Reinstatement Conference – In the Matter of PH-88-046:
Robert Wisgirda, R.Ph. (Lic. No. 15035 /Consent Agreement – license suspended April 10, 1990, with conditions for reinstatement).

Present: Robert Wisgirda

CEs History

2004 - 7
2003 - 15
2002 - 18
2001 - 14
2000 - 13
1999 - 6
1998 - 6
1997 - 10
1996 - 5.5

Wisgirda has not practiced pharmacy since date of license suspension (approx. fourteen (14) years). He did not provide documentation of CE requirements for the period that his license has been suspended in 1990. The Board advised Wisgirda to complete the Connecticut Pharmacists retraining modules program and to complete 1500 internship hours.

Motion/DeVita require Wisgirda to complete the Connecticut module Part 1 and after completion of Part 1; may commence 1500 internship hours while completing Part 2 module; and must complete NAPLEX and MPJE exams. Motion/Ryle. Motion carried. Vote: Unanimous in favor.

4. 11:45 a.m.-12:30 p.m.
File Review

5. 12:30 p.m.-1:45p.m. - LUNCH

Motion/Sullivan to adjourn for lunch. Second/DeVita. Motion carried

6. 1:45 p.m.-2:30 p.m.

Investigative Conference: PH-04-049 and DS 04-041
In the matter of **Chad M. Wojnar**, R.Ph., License No. 25605

(Registrant) and **Brooks Pharmacy # 573**, of 710 East Broadway, South Boston, Permit No. 3145.

The purpose of the conference was to discuss a consumer complaint alleging failure to dispense a prescription properly on or about October 20, 2003, when allegedly Registrant dispensed Zyrtec in place of Zantac Syrup to an eleven week old child, resulting in ingestion.

Present: Rick Gainey, R.Ph., District Manager
Chad Wojnar, R.Ph.
George Kareh, Manager of Record

CEs: Compliant

Registrant admitted to dispensing Zyrtec instead of prescribed Zantac Syrup. Registrant said he checked the dispensing drug against the incorrect label instead of the prescription file. He did not follow the verification process for checking medication from beginning to end.

Manager of Record Kareh stated he contacted the physician to make him aware of the incident and sent a letter to the consumer's home apology for the error. Kareh stated when he became aware of the incident, he immediately pulled the hard copy of the prescription; corrected the misfill in the system and redispensed the prescription with Zantac, as prescribed. Brooks now using yellow labels to flag/alert them for sound alike drugs. Zantac and Zyrtec have also been separated on the shelf.

Pharmacist: Motion/Ryle - Advisory Letter, with 2 CEs in Medical Error Prevention and USP. Second/Barron. Vote: Unanimous in favor.
Drugstore: Motion/Ryle - Advisory Letter. Second/DeVita.
Vote: Unanimous in favor.

7. 2:30 p.m.-3:15 p.m.

Investigative Conference: PH-03-034

In the matter of **Andrew Akladiss**, Registered Intern No. 2913.

The purpose of the conference was to discuss a complaint filed with the Board alleging controlled substance violations.

Recused: James DeVita (exited room)

Present:

Andrew Akladiss, Pharmacy Intern

Paul Borosavage, CVS Loss Prevention Manager

Registrant stated that he never took any medications from pharmacy and he never admitted to anyone that he took any drugs from the pharmacy. Registrant stated he was interviewed by the CVS Loss Prevention Manager who requested Registrant to sign a statement that he had taken drugs from the pharmacy. Registrant refused to sign the statement. Registrant said that on his first day of work, he took a lab coat from the rack and he discovered some loose pills in the pockets. He put the pills back in the pocket, took off the coat and put it back on the rack, without looking at the pills.

Loss Prevention Manager stated Registrant made admissions to taking valium and hydrocodone during interview and that Manager was present at interview session (manager statement included in complaint).

Registrant plans to apply for licensure in Maine when he receives his degree (classes have been completed). Registrant declined to complete a urine screen per proposal of MPRS coordinator.

8. Motion/Ryle to adjourn meeting. Second/ Barron. Meeting adjourned.

Respectfully submitted by:


Executive Director Date

Reviewed by counsel: June 18, 2004

Draft approved: June 18, 2004

Board approved: June 22, 2004