BOARD OF REGISTRATION IN PHARMACY
PHARMACY BOARD MEETING MINUTES
TUESDAY, FEBRUARY 24, 2004
239 CAUSEWAY STREET, ROOM 206
BOSTON, MASSACHUSETTS 02114

The meeting was called to order by President James T. DeVita at 9:30 a.m.

The following Board members were present: James T. DeVita, R.Ph., President (excused at 12:30 p.m.), Karen M. Ryle, R.Ph., MS, Secretary, Marilyn M. Barron, MSW, Public Member.
Absent: Harold B. Sparr, R.Ph., M.S., Donna Horn, R.Ph. and Dan Sullivan, R.Ph.

The following Board staff were present: Charles R. Young, R.Ph., Exec. Dir., James D. Coffey, R.Ph., Assoc. Dir., Arthur J. Chaput, R.Ph., Pharm.D., Susan Manning, J.D., Counsel, Carolyn L. Reid, Adm. Asst.

AGENDA ITEMS

1. 9:30 a.m. Call to Order

2. Investigative Conference & Business Meeting

3. 9:30 a.m. to 10:10 a.m. Investigative Conference: DS-03-080 & PH-04-009 In the matter of Brooks Pharmacy #565, 653 Squire Road, Revere, MA 02151 (Permit 3136) and Registrant, Alexander F. Przybylski, R.Ph. (License #15763).

   The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about April 18, 2003, Registrant dispensed Lisinopril 10mg instead of Lisinopril 5mg as prescribed while employed at Brooks Pharmacy #565, 653 Squire Road, Revere, MA.

   Present
   Registrant: Alexander Przybylski
   Brooks Pharmacy representatives: Robert Bryant

   CEs: Registrant/compliant.

Registrant (no longer employed by Brooks Pharmacy) admitted to dispensing Lisinopril 10mg instead of the prescribed medication Lisinopril 5mg, stating error was caused by technician data entry. Technician was counseled and retrained. Registrant acknowledged final verification might have been skipped. Registrant said the complainant came to the pharmacy to inform them of the error, due to a misunderstanding with the technician, the complainant left the pharmacy before speaking to the pharmacist. Registrant called the complainant's house to apologize for the error, and he also tried to call the doctor. Registrant authorized the technician to deliver the correct medication to the complainant's house.

Brooks Pharmacy Representative stated basket method was used at time of error and that Brooks updated the computer system to include new features.

The Board suggested that new prescriptions be reviewed prior to scanning, imaging and barcode against labels and bottles, and to perform a final verification check on new prescriptions.

Board Decision
Pharmacist: Motion/Ryle to issue an Advisory Letter with completion of 2 hours of CE's in Medication Error Reduction and a USP Medication Error Report Form. Second/DeVita. Motion carried.
Drug Store: Motion/DeVita to issue an Advisory Letter to Brooks Pharmacy. Second/Ryle. Motion carried.

4. 10:10 a.m. to 10:50 a.m. Investigative Conference: DS-04-019 & PH-04-038. In the matter of Brooks Pharmacy #623, 201 Market Street, Rockland, MA, 02370 (Permit 3091) and Registrant, Leroy K. Ullrich, R.Ph., (License #18967).

The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about May 27, 2003, Registrant dispensed Advair Diskus 500/50 instead of Advair Diskus 100/50 as prescribed while employed at Brooks Pharmacy #623, 201 Market Street, Rockland, MA.

Present
Complainant and son
Registrant: LeRoy Ullrich
Manager of Record: Brian ODonnell
Brooks Pharmacy representatives: Steven Horn

CEs: Registrant / Manager of Record compliant.

The complainant stated he received a call from his physician advising him the wrong medication (Advair 500/50) was dispensed to his son, who had ingested the wrong medication for 30 days. Complainant is concerned about the long-term adverse effects/complications of the wrong medication.

Registrant admitted to dispensing Advair 500/50 in error. The prescription was written as Advair 50/100 when actual strength should have been written as 100/50. Registrant apologized to the complainant for the medication error. Registrant stated that since the strength was written backwards on the prescription, the prescription was read incorrectly by Registrant and technician. At the time of the incident, Brooks Pharmacy was in the process of implementing a new computer system that included a new basket system.

The Pharmacy Manager stated the error was discovered when the patient called in for the first refill of the medication. He immediately contacted the physician to inform her of the incident and the physician said that she would speak to the patient.

The Board suggested that the prescription be looked at first and then the label.

Board Decision
Pharmacist & Drug Store: Motion/Ryle to take the matters under advisement. Second/DeVita. Motion carried.
Pharmacist: Motion/DeVita to issue an Advisory Letter with completion of 2 hours of CE's in Medication Error Reduction and a USP Medication Error Report Form. Second/Barron. Motion carried.

Drugstore: Motion/DeVita to dismiss based on fact that at the time of incident, the pharmacy had adequate written policy and procedure in place to decrease medication errors and to improve medication outcomes. Letters to be sent to Brooks Pharmacy and manufacturer of Advair. Second/Ryle. Motion carried.

5. 11:00 a.m. to 11:40 a.m. Investigative Conference: DS-03-059 & PH-04-005. In the matter of Spring Street Drug, 121 Spring Street, Springfield, MA 02148 (Permit 13508) and Registrant, Richard R. Lavallee, R.Ph., (License #13616). --CANCELLED

   The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about March 21, 2003, Registrant dispensed Topamax 100mg instead of Lamictal 100mg as prescribed while employed at Spring Street Drug, 121 Spring Street, Springfield, MA.

   Investigator: James C. Emery

6. 11:40 a.m. to 12:20 p.m. Investigative Conference: DS-03-072 & PH-04-003.
   In the matter of Brooks Pharmacy #250, 237 Broadway Street, Taunton, MA, 02780 (Permit 2447) and Registrant, Ramson M. Gutierrez, R.Ph., (License #22796).

   The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about April 15, 2003, Registrant dispensed Paxil 20mg instead of Lipitor 20mg as prescribed while employed at Brooks Pharmacy #250, 237 Broadway Street, Taunton, MA.

   <u>Present</u>
   Registrant: Ramson Gutierrez
   Manager of Record: James Doolittle
   Brooks Pharmacy representatives: Steven Horn

   Registrant said the Manager of Record apologized to the complainant for the error. Registrant stated he did not open the vial and that he placed the label on the vial. There was adequate staffing on day of

incident (two pharmacists-one day and one night, two cert. techs and three techs). Brooks has since implemented a new computer system with updated features including basket system and prescription imaging.

Manager of Record stated the complainant's wife picked-up the corrected medication and initially declined to give him the bottle. Since the incident, it is a priority for the pharmacists to open vials, count medications, label products and perform final verification.

Board Decision
Pharmacist & Drug Store: Motion/ DeVita to take matters under advisement. Second/Ryle. Motion carried.
Pharmacist: Motion/DeVita to issue Advisory Letter with completion of 2 hours. of CE's in Medication Error Reduction and a USP Medication Error Report Form. Second/Ryle. Motion carried.
Drug Store: Motion/DeVita to take the matter under advisement. Second/Barron. Motion carried.

7. 12:20 p.m. to 1:20 p.m. Lunch

8. 1:20 p.m. to 2 p.m. Investigative Conference: PH-PT-04-027.
In the matter of Registrant, Nataria K. English, Pharmacy Technician, (License #1917).
CANCELLED

   The purpose of the conference is to discuss a complaint filed with the Board alleging controlled substance violations while the Registrant was employed at Stop & Shop Pharmacy #787, 228 King Street – Kingsgate Plaza, Northampton, MA 01060.

   Investigator: Leslie S. Doyle

9. 2:00 p.m. to 2:40 p.m. Investigative Conference: DS-04-0007 & PH-04-039.
In the matter of CVS Pharmacy #1199, VFW Parkway – Village Chest Nut Hill, West Roxbury, MA 02132 (Permit 1981) and Registrant, Catherine A. Rosch, R.Ph., (License #24988).

   The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about June 26, 2003, Registrant dispensed

Clomipramine 50mg instead of Clomid 50mg as prescribed while employed at CVS Pharmacy #1199, VFW Parkway – Village Chest Nut Hill, West Roxbury, MA.

Present
Complainant: Catherine Kasparian
Registrant: Catherine Rosch
Manager of Record: Sherri Borodz
CVS Pharmacy representatives: Tara Thomas

Complainant stated after she ingested four capsules of the wrong medication, she became ill. She contacted a 24 hour CVS Pharmacy and was told by a pharmacist not to worry about taking the wrong medication. She continued to feel ill and saw her physician.

Registrant admitted to dispensing Clomipramine 50mg instead of Clomid 50mg as prescribed. Registrant didn't recall who performed data entry (initials not always entered) but stated she performed the final verification and gave the wrong medication to the complainant. Registrant apologized to the complainant. Registrant was the only pharmacist on duty when the incident occurred (250 prescriptions filled that day).

Board Decision
Pharmacist & Drug Store: Motion/Ryle to take the matters under advisement. Second/Barron. Motion carried.

10. 2:40 p.m. to 3:00 p.m. Investigative Conference: DS-03-061 & PH-03-071. In the matter of CVS Pharmacy #972, 555 Washington Street, South Easton, MA, 02375 (Permit 2728) and Registrant, Daniel F. Torre, R.Ph., (License #15930).

The purpose of the conference is to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about February 15, 2003, Registrant dispensed Proscar 5mg instead of Singulair 5mg as prescribed while employed at CVS Pharmacy #972, 555 Washington St., South Easton, MA.

Present
Complainant: Genina Salvio
Registrant: Daniel Torre
Manager of Record: Sean McClory
CVS Pharmacy representatives: Mike Lesard

Complainant stated pharmacy dispensed Proscar instead of prescribed Singulair. She noticed that the refilled medication looked different. Her son complained about the bitter taste of the medication and became ill. She then read the "Proscar" label on the bottle; called the pediatrician; and went to CVS to make them aware of the error. The complainant said the pharmacists were professional and helpful and that Torre apologized to her about the error.

Registrant (no longer employed at CVS Pharmacy) admitted to dispensing Proscar instead of the prescribed Singulair. Registrant said he received a call from his supervisor informing him of the incident and the Registrant immediately called the complainant at home to apologize for the medication error. Registrant said error could had been prevented if he had opened the manufacturer's bottle to check the contents and placed the medication in the regular brown bottle.

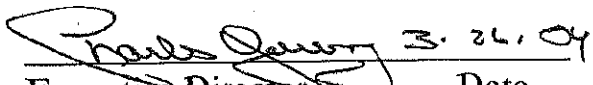
Manager of Record said that Merck manufacture Proscar and Singulair products with similar labeling, however, the product has NDC numbers printed on them. To prevent similar occurrences, they have separate shelf dividers for the two drugs.

Ryle noted Singulair and Proscar bottles are similar and suggested the pharmacists/pharmacies write manufacturer and USP stating the need to change the package of the two products.

Board Decision
Pharmacist & Drug Store: Motion/Ryle to take the matters under advisement. Second/Barron. The motion carried.

11. 3:00 p.m. Motion/Ryle to adjourn meeting. Second/Barron. Meeting adjourned.

Respectfully submitted by:



Executive Director Date

Reviewed by counsel: February 27, 2004
Draft approved: March 2, 2004
Board adopted: March 2, 2004