BOARD OF REGISTRATION IN PHARMACY
PHARMACY BOARD MEETING MINUTES
TUESDAY, MARCH 25, 2003
239 CAUSEWAY STREET, ROOM 206
BOSTON, MASSACHUSETTS 02114

The meeting was called to order by President Donna Horn at 9:30 a.m.

The following Board members were present: Donna Horn, R.Ph., President, Dr. Robert P. Paone, R.Ph., Pharm.D., Secretary, Harold B. Sparr, R.Ph., MS, Karen M. Ryle, R.Ph., MS, and James T. DeVita, R.Ph.
Absent: Marilyn Barron, MSW, Public Member, Dan Sullivan, R.Ph. and James T. DeVita, R.Ph.

The following Board staff were present: Charles R. Young, R.Ph., Executive Director, Susan Manning, J.D., Administrative Board Counsel, James D. Coffey, R.Ph., Associate Director, James C. Emery, C.Ph.T., Healthcare Investigator, and Leslie S. Doyle, R.Ph., Healthcare Supervisor and Investigator and Alan Van Tassel, Healthcare Investigator.

AGENDA ITEMS

1. **9:30 a.m. Call to Order**
   Investigative Conference Meeting

2. **9:30 a.m. to 10:10 a.m.**
   Investigative Conference: DS-03-024 & PH-03-054
   In the matter of CVS Pharmacy #281, 80 Market St., Rockland, MA 02370 (Permit #2727) and Registrant, Deanne Wigley, R.Ph., (License # 21778)

   The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about September 23, 2002, the Registrant dispensed Amoxicillin labeled incorrectly, instructing to take 2 tsp., instead of the prescribed 2mls while employed at CVS, 80 Market St., Rockland, MA.

   Present for discussion:
   Complainant: Not present
   Registrant: Deanna Wigley
   Manager of Record: Lisa A. Cordeiro
   CVS representatives: Nataniel Sides
   Investigator: Alan Van Tassel

   CEs: Registrant and Manager of Record compliant.

Investigator Van Tassel reviewed his report of investigation with the Board.

The Registrant stated that the investigator's report was accurate. The Registrant said she was interrupted twice during the filling process but acknowledged responsibility for the medication error. The Registrant was aware that the patient was pediatric.

The Manager of Record stated that current policy requires pharmacists to counsel pediatric patients and to issue oral dosage syringes to care givers. The Manager stated that medications are also double verified.

Nathaniel Sides stated that the pharmacy agreed to take part in a CQI survey with the Board on April 15, 2003.

Board Decision:
Motion/Sparr to take the matter under advisement until the report of the Rockland CVS CQI survey is reviewed by the Board. Second/Ryle. The motion carried.
Drug Store: Motion/Sparr to take the matter under advisement until the report of the Rockland CVS CQI survey is reviewed by the Board. Second/Ryle. The motion carried.

3. **10:10 a.m. to 10:50 a.m.**
Investigative Conference: DS-03-022 & PH-03-056
In the matter of T&T Hospital Pharmacy, 331 Main St., Southbridge, MA 01550 (Permit #1623) and Registrant, Richard F. Trumbull, R.Ph., (License #12702)

The purpose of the conference was to discuss a complaint filed with the Board alleging failure to fill a prescription properly. The complaint alleged that on or about September 6, 2002 the Registrant dispensed Paxil 20mg tablets instead of Paxil 10mg as labeled as prescribed while employed at T&T Hospital Pharmacy, 331 Main St., Southbridge, MA.

Present for discussion:
Complainant: Present
Registrant: Richard Trumbell
Manager of Record: Richard Trumbell
T & T Hospital Pharmacy representatives: Richard Trumbell
Investigator: Alan Van Tassel

CEs: Registrant compliant.

Investigator Van Tassel reviewed his report of investigation with the Board.

Complainant and Registrant stated that the investigator's report was accurate.

The Registrant said the pharmacy does not pre-fill the blister packages but rather blister packs are prepared pursuant to a prescription. A pharmacist pulls the medication off the shelf and the technician fills the blister packages without a final check by a pharmacist. The Registrant said at the time of the incident the pharmacist did not conduct a final check of the blister pack and the technician bagged the blister package for related delivery or pick up.

The Registrant outlined the corrective actions implemented after the incident- hiring of a new pharmacy technician; the Registrant obtained new eye glasses; pharmacists conduct a final check of blister packages prior to bagging; and only one medication on the counter at a time for filling purposes. The Registrant no longer provides ½ tablets to patients.

Board Decision:
Motion/Paone to issue an Advisory Letter to the Registrant to include the completion of USP Medication Error Report and a 2- hour medication error reduction CE program. Second/Sparr. The motion carried.
Motion/Paone to issue an Advisory Letter to T&T Hospital Pharmacy. Second/Sparr. The motion carried.

4. **11 a.m. to 11:40 a.m.**
In the matter of Registrant, Louis, G. Attzberger, R.Ph., (License #15831 / Status: Voluntary Surrender effective 12/14/1993) applicant for Pharmacy Technician Registration

The purpose of the conference was to the merits of an application for Pharmacy Technician Registration. The applicant did not attend the conference.

Board Decision: Motion/Sparr to send the applicant a second notice to appear before the Board on April 08, 2003 to discuss the application. Second/Ryle. The motion carried.

5. **11:40 a.m. to 12:20 p.m.**
Investigative Conference: DS-03-025 & PH-03-038
In the matter of CVS Pharmacy #938, 8 Washington Street, N. Attleboro, MA 02760 (Permit 1505) and Registrant, Deven Shah, R.Ph. (License #24316)

The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about September 30, 2002 the Registrant dispensed Zyrtec rather than Zantac as prescribed while employed at CVS Pharmacy #938, 8 Washington Street, N. Attleboro, MA.

Present for discussion:
Complainant: Not present
Registrant: Deven Shaw
Manager of Record: Tom Eisenmann
CVS Pharmacy representatives: Bruce Kaplan
Investigator: Leslie S. Doyle

CEs: Registrant and Manager of Record compliant.

Investigator Doyle reviewed her report of investigation with the Board.

The Registrant stated that the investigator's report was accurate. The Registrant stated that in mid-October 2002, the pharmacy implemented a new policy requiring the date of the birth to be evident on the prescription. The Registrant acknowledged responsibility for the medication error.

The Manager of Record stated that the pharmacy uses the EPIC software system and as an additional safeguard both the hardcopy prescription and stock medication flow to the verification pharmacy using the basket method. The Manager noted that the "prescription fast movers" are dispensed by an automated baker cell with out a stock bottle being forwarded to the verification pharmacist therefore, the pharmacist must rely upon the screen tablet image for accuracy.

Board Decision:
Motion/Paone to issue an Advisory Letter to the Registrant to include the completion of USP medication Error Report and a 2- hour medication error and or pediatric dosing CE program. Second/Sparr. The motion carried.
Motion/Paone to issue an Advisory Letter to CVS Pharmacy. Second/Sparr. The motion carried.

6. **12:20 p.m. to 1:20 p.m. Lunch**

7. **1:20 p.m. to 2 p.m. Investigative Conference: DS-03-027 & PH-03-045 In the matter of CVS Pharmacy #736, 199 Great Rd., Bedford, MA 01730 (Permit 1039) and Registrant, Lorri Cresta, R.Ph. (License #23252)**

The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to fill a prescription properly and failure to adhere to standards of practice. The complaint alleged that on or about October 24, 2002 the Registrant dispensed Ketoconazole 200mg rather than Ketoprofen 200mg as prescribed while employed at CVS Pharmacy #736, 199 Great Rd., Bedford, MA.

Present for discussion:
Complainant: Present.
Registrant: Lorri Cresta
Manager of Record: Lorri Cresta
CVS Pharmacy representatives: Dick Sharp
Investigator: James C. Emery

CEs: Registrant compliant.

Investigator Emery reviewed his report of investigation with the Board.

The complainant presented the prescription label and medication for the Board to review. The complainant said that his daughter had an allergic reaction to the medication.

The Registrant had two prior complaints of record with the Board.

The Registrant stated that the investigator's report seemed accurate. The Registrant said she detected the error during the filling process and set the prescription order aside in order to counsel pharmacy supportive personnel that the wrong drug was selected for order fulfillment. The Registrant noted that the prescription label was typed correctly. The Registrant apologized for the incident.

Corrective measures implemented after the incident include: technicians are not permitted to close the prescription container after filling in order to allow pharmacist to conduct a final check of the prescription container; only pharmacists bag prescriptions; red shelf dividers are used for look-alike/sound-alike medications; and if prescription mistakes are identified at the verification stage the error is corrected immediately and pharmacy staff are counseled at a later period.

Dick Sharp stated that he and the Registrant met with the pharmacy staff to discuss the incident and related corrective actions. Mr. Sharp stated that CVS plans to implement a new customer service remodeling initiative to enable data entry to occur upon prescription drop. The pharmacy master staffing schedule was also reviewed for staffing reallocation.

Board Decision:
Motion/Sparr to take the Registrant matter under advisement. Second/Ryle. The motion carried.
Motion/Sparr to propose a resolution of a Reprimand to the Registrant and require her to complete a USP Medication Error Report and step down as Manager of Record for 3 years. Second/Paone. The motion carried unanimously.

Motion/Sparr to take the pharmacy matter under advisement. Second/Ryle.
The motion carried.
Motion/Sparr to offer CVS Pharmacy a Reprimand or CQI survey.
Second/Paone. The motion carried unanimously.

8. **2 p.m. to 2:40 p.m.**
Investigative Conference: DS-03-002 & PH-03-016
In the matter of Apothecare of Cape Cod, PO Box 292, W. Hyannisport, MA 02601 (Permit #3089) and Registrant, Terrance Brooks, R.Ph., (License #14359)

The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about May 28, 2002 the Registrant (Brooks) dispensed Zyprexa 5mg (medication ordered) as well as Actos 30mg tablets in a blister pack while employed at Apothecare of Cape Cod, PO Box 292, W. Hyannisport, MA.

Present for discussion:
Complainant: Not present
Registrant: Terry Brooks
Manager of Record: James Garvey
Apothecare representatives: James Garvey
Investigator: James C. Emery

CEs: Registrant compliant.

Investigator Emery reviewed his report of investigation with the Board. Mr. Emery stated that the complainant was reluctant to release the MTS blister card with the containing the alleged 2 medications.

The Registrant stated that the investigator's report seemed accurate.

Mr. Garvey said that the alleged MTS blister card medication error was not witnessed by anyone in the pharmacy department.

Board Decision:
Brooks: Motion/Paone to Dismiss due to insufficient evidence. Second/Sparr. The motion carried.
Drug Store: Motion/Paone to Dismiss due to insufficient evidence. Second/Sparr. The motion carried.

9. **2:40 p.m. to 3:20 p.m. Investigative Conference: DS-03-016 & PH-03-034**
In the matter of CVS Pharmacy #769, 216 North Main Street, East Longmeadow, MA 01028 (Permit #2948) and Registrant, Roger Racette, R.Ph., (License #16108)

The purpose of the conference was to discuss a complaint filed with the Board alleging the failure to fill a prescription properly. The complaint alleged that on or about July 11, 2002, the Registrant dispensed Trazadone 100mg rather than Toprol XL 100mg as prescribed while employed at CVS Pharmacy # 769, 216 North Main Street, East Longmeadow, MA.

Present for discussion:
Complainant: Not present
Registrant: Roger Racette
Manager of Record: Michelle Cranston
CVS Pharmacy representatives: Scott Griffin
Investigator: Alan Van Tassel

CEs: Registrant compliant and Manager of Record not compliant (2000; 9 hours of CE / 2001; 5 hours of CE because she moved and can not locate certificates / 2002; 0 hours of CE, Registrant said she completed the 2002, but did not know she was required to bring such today).

Investigator Van Tassel reviewed his report of investigation with the Board stating that the complainant allegedly experienced adverse effects related to medication error.

The Registrant stated that the investigator's report seemed accurate.

The Registrant indicated that the error possible occurred due to the fact that the medications were located side by each in the baker cell. The Registrant said that he did not notice the tablet discrepancy because both tablets were white and similar in shape. The Registrant acknowledged responsibility for the medication error.

Corrective measures implemented in the pharmacy include: utilization of a magnifying glass at the verification stage; utilization of priority colored baskets for efficiency; the stock medication bottle, receipt and prescription label are forwarded to the verification pharmacist for review; and Toprol XL was removed from the baker cell and placed on the dispensing shelf so that the stock bottle flows with the basket to the verification pharmacist.

The Manager of Record outlined additional quality assurance measures to include limiting the number of prescription labels generated by technicians and stated that a staff meeting was held to discuss the incident.

Mr. Griffin stated that CVS is moving away from the baker cell for Innovations (automated dispensing system based in part upon bar coding).

Board Decision:
Motion/ Paone to issue an Advisory Letter to the Registrant to include the completion of USP Medication Error Report and a 2- hour medication error reduction CE program. Second/Sparr. The motion carried.
Motion/Paone to issue an Advisory Letter for CVS Pharmacy to include a statement or response from Mr. Griffin regarding the complainant's request for information specific to pharmacy technician training (Board may forward to consumer upon receipt). Second/Sparr. The motion carried.

Motion/Paone for the Manager of Record (Cranston) to provide the Board with compliant original CEs in 30 days and to step down as Manager of Record until such time that CE situation is resolved. In addition, following the 30 day period, if the Registrant is short 5 or more CEs then she shall be required to pass the MPJE examination in 90 days and step down as Manager of Record until such time that MPJE is passed. Second/Sparr. The motion carried.

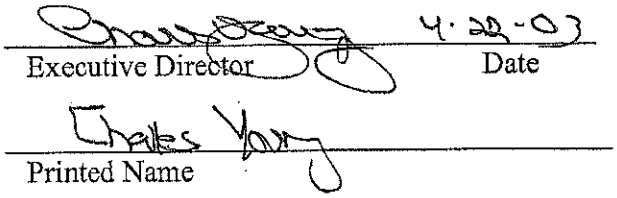
10. **3:20 p.m.**
Review of Continuing Education Programs.
The Board reviewed continuing education programs.

11. **3:45 p.m.**
Administrative Items

a) In the matter of DS-02-115, DS-03-010, DS-03-015 & PH-03-022, PH-03-006, PH-03-026, (Shoppers Drug & Monty Schwartz, R.Ph.); Exec. Dir. Chuck Young advised the Board that a response extension was granted Robert Pavlan, Esq.
b) Graduates of ACPE recognized Canadian Council for Accreditation of Pharmacy Programs (CCAPP) from 1993 through June 30, 2004: The Board determined that TSE is no longer a condition of licensure. The Board advised the Exec. Dir. to develop draft regulations requiring the successful completion of TSE for 2004 graduates of approved colleges of pharmacy.
c) In the matter of PH-00-028, Registrant Charles E. Sliwoski, Jr., R.Ph. (Lic. No. 18064) request for reinstatement. Motion/Sparr to invite the Registrant to a Board Meeting to discuss the merits of reinstatement. Second/Ryle. The motion carried.

12. 4:00
Motion/Sparr to adjourn. Second/Paone. The motion carried. Meeting Adjourned.

Respectfully submitted by:



Executive Director Date

Printed Name

Reviewed by counsel: March 28, 2003
Draft approved: March 28, 2003
Board adopted: April 08, 2003