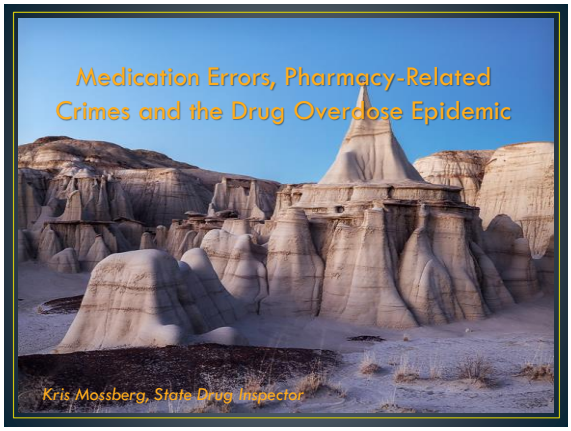

1

MEDICATION ERROR REPORTING

- **Critical in preventing future medication errors**
- **Most Boards of Pharmacy require hospitals & medical facilities (including pharmacies) to report med errors**
- **NMBOP requires reporting of significant adverse drug events**
- **"Significant Adverse Drug Event"** a drug related incident that results in harm to the patient.

2

16.19.25 ADVERSE DRUG EVENT

- **Incident** - a drug that is dispensed in error, that is administered and results in harm, injury or death
- **Harm** - temporary or permanent impairment requiring intervention

The Pharmacist in Charge shall:

A. Develop and implement written **error prevention procedures** as part of the Policy and Procedures Manual.

B. **Report incidents**, including relevant status updates, to the Board on Board approved forms within **fifteen (15) days** of discovery.

- "Significant Adverse Drug Event Reporting Form"

The Board shall:

A. Maintain **confidentiality** of information relating to the reporter and the patient identifiers.

B. Compile and publish, in the newsletter and on the Board web site, report information and **prevention** recommendations.

C. Assure reports are used in a constructive and non-punitive manner.

3

MEDICATION ERRORS

- **BOP receives sworn Complaints Alleging Misfilled Prescriptions.**
- **Not generated from Adverse Drug Event Reports.**
- **Most of these would not have occurred if the pharmacist complied with BOP requirements for:**
  - **Prospective Drug Review**
  - **Counseling**

4

Prospective drug review

(1) Prior to dispensing any prescription, a **pharmacist** shall review the patient profile for the purpose of identifying:

- **(a)** clinical abuse/misuse;
- **(b)** therapeutic duplication;
- **(c)** drug-disease contraindications;
- **(d)** drug-drug interactions;
- **(e)** incorrect drug dosage;
- **(f)** incorrect duration of drug treatment;
- **(g)** drug-allergy interactions;
- **(h)** appropriate medication indication.

Source: NMAC 16.19.4.16 (D)

5

ONLY THE RPh CAN COUNSEL

All clerks and technicians are taught that if there is a question regarding a prescription, the RPh (or intern) must take the question.

6

MEDICATION ERROR REDUCTION: PATIENT COUNSELING

Patients need to know:

- The name of the medication
- How to take it
- What it's for
- If the medication looks different, talk to the pharmacist

http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm096403.htm accessed 6/3/16

7

PATIENT COUNSELING

- **Estimate: half of medication-related deaths could have been prevented by appropriate and timely counseling .***
- **Show the patient the drug while asking:**

1) Tell me what you take this drug for?
2) Tell me how you take the medication?
   -how often, and
   -directions for taking the medication

http://www.uspharmacist.com/continuing_education/ceviewtest/lessonid/105916

*Abood RR. Errors in pharmacy practice. *US Pharm.* 1996;21(3):122-130.

8

REMEMBER THE PATIENT

- **Patients provide a major safety check**
  - Counseling – not a "veiled offer"
  - Wrong patient errors: Not opening the bag at the point of sale
  - Risk of dispensing a correctly filled Rx to the wrong patient at POS – about 6 per month per (community) pharmacy

https://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=91 10/9/2014, accessed 6/3/2016

9

"To Err is Human" Building a Safer Health System

- **the majority of medical errors are caused by faulty systems, processes, and conditions that:**
  - **lead people to make mistakes**
  - **fail to prevent mistakes**

When an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

10

When an error occurs

- Be compassionate
  - ISMP persistent safety gaffe #4 respond with empathy and concern
- Evaluate and address medication use system issues
  - Root cause analysis

https://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=91

11

Root cause analysis (RCA):

- **Process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or risk of occurrence of a sentinel event.**
- **Focus is on systems and processes, not individual performance**
- **Identifying root causes illuminates significant, underlying, fundamental conditions that increase the risk of adverse consequences.**
- **RCA facilitates system evaluation, analysis of need for corrective action, tracking and trending**

12

Table 1. Basic Questions to Answer During RCA
1. What happened?
2. What normally happens?
3. What do policies/procedures require?
4. Why did it happen?
5. How was the organization managing the risk before the event?

- *Source: NM Board of Pharmacy newsletter March 2013*

13

Case Study:

- **Patient experienced sudden shortness of breath, chest pain (breathing worsened pain), dizziness, lightheadedness, anxiety and heart palpitations**
- **Patient went to ER, treated for a submassive pulmonary embolism.**
- **Admitted and Discharged after 5 days with prescriptions for atorvastatin 80 mg, Toprol XL 25 mg, lisinopril 5 mg and apixaban (Eliquis) 5 mg**
- **Hospital sent Rxs electronically to pharmacy**

14

- **Case Study continued:**
- **Pharmacist dispensed medications and counseled patient.**
- **Patient received an automated message that a prescription was ready 5 days later.**
- **Went to pharmacy and received apixaban prescription. Claimed not aware of apixaban Rx.**
- **Physician upset and contacted pharmacy about delay. RPh said did not dispense apixaban because did not have full quantity to fill Rx and patient said he would wait.**

15

- **Case Study continued:**
- **Pharmacist's actions appropriate? Was this a misfilled prescription?**
- **Does patient have enough knowledge of medications to know which are critical? What does the pharmacist have?**
- **Pharmacist's other options.**
- **- Partial fill…what else?**

16

FDA Guidance – Insanitary Conditions

- Putting on gowning apparel in a way that may cause the gowning apparel to become contaminated
- Leaving the cleanroom and re-entering from a non-classified area without first replacing gowning apparel
- Performing aseptic manipulations outside of a certified ISO 5 area
- Failing to disinfect containers of sterile drug components or supplies immediately prior to opening
- Lack of adequate routine environmental monitoring - nonviable airborne particulate sampling; viable airborne sampling; and surface sampling, including but not limited to equipment, work surfaces, and room surfaces

17

Insanitary Conditions - Continued

- Lack of adequate personnel sampling (including glove fingertip sampling)
- Lack of routine certification of the ISO 5 area, including smoke studies performed under dynamic conditions
- Lack of HEPA-filtered air, or inadequate HEPA filter coverage or airflow, over the critical area
- Buffer room or ISO 5 areas that contain overhangs or ledges capable of collecting dust (pipes and window sills)
- Failing to appropriately and regularly clean and disinfect (or sterilize) equipment located in the ISO 5 area
- Lack of disinfection of equipment and/or supplies at each transition from areas of lower quality air to areas of higher quality

18

Serious conditions - FDA recommendation includes immediate recall and cease sterile operations

- Vermin (e.g., insects, rodents) or other animals (e.g., dogs) in ISO 5 areas or areas immediately accessible to production
- Visible microbial growth (e.g., bacteria, mold) in the ISO 5 area or in immediately adjacent areas
- Sources of non-microbial contamination in the ISO 5 area (e.g., rust, glass shavings, hairs, paint chips)
- Performing aseptic manipulations outside of a certified ISO 5 area
- Personnel aseptic practices that are a contamination hazard to an exposed sterile drug product or its constituent sterile components
- Exposing sterile drugs and materials to lower than ISO 5 quality air for any length of time. (i.e. exposing partially stoppered drug products or stock solutions in a container/closure system that is not fully closed)

19

Serious conditions - FDA recommendation includes immediate recall and cease sterile operations

- Cleanroom areas with unsealed or loose ceiling tiles
- Production of drugs while construction is underway in an adjacent area
- Consistent and frequent pressure reversals from areas of less clean air to areas of higher cleanliness
- Using a filter for the purposes of product sterilization that is not appropriately graded for sterilization, not appropriate for pharmaceutical use, or used in excess of its volume or pressure capacity
- Using parameters for sterilization (e.g., temperature, pressure, time) that are not lethal to resistant microorganisms

20

Pharmacy Crimes

21

Rogue Online Pharmacies

Consumer protection program operated by NABP:

safe.pharmacy

Discovered:

40,000 websites fail to comply with NABP patient safety and pharmacy practice standards or applicable laws

95% of websites offering prescription-only drugs online operate illegally

89% of illegal online pharmacies did not require a prescription

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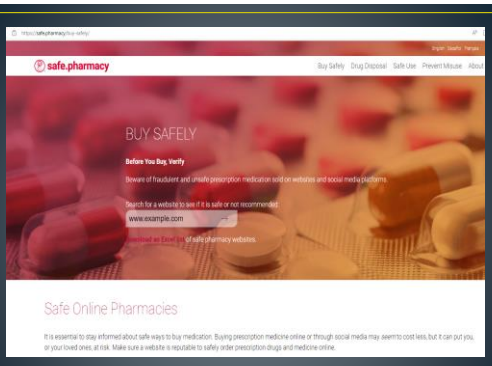


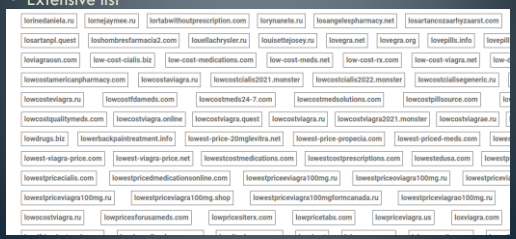
- Search engine for name of website or download an excel list

23

Rogue Online Pharmacies

Also: A List of Not Recommended Sites

- Not Recommended Sites - Safe.Pharmacy
- Extensive list



24

Diversion

- What is diversion?
- Definition: Transfer of a prescription drug from a lawful to an unlawful channel of distribution or use.

25

PMP

- A RPh Shall request and review a PMP report if (at least 1 year time period):
  - PERSON EXHIBITS POTENTIAL ABUSE/MISUSE OF OPIATES
    - OVER-UTILIZATION
    - EARLY REFILLS
    - MULTIPLE PRESCRIBERS
    - SEDATED/INTOXICATED
    - UNFAMILIAR PATIENT
    - PAYING CASH INSTEAD OF INSURANCE

26

PMP

- A RPh Shall request and review a PMP report if (at least 1 year time period):
  - OPIATE Rx FROM UNFAMILIAR PRACTITIONER
    - OUT OF STATE OR USUAL GEOGRAPHIC AREA
  - OPIATE Rx FROM UNFAMILIAR PATIENT
    - OUTSIDE USUAL PHARMACY GEOGRAPHIC PATIENT POPULATION AREA

27

PMP

- A RPh Shall request and review a PMP report if (at least 1 year time period):
  - INITIAL RX FOR ANY LONG-ACTING OPIOID FORMULATION
    - INCLUDES ORAL AND TRANSDERMAL DOSAGE FORMS
  - BECOME AWARE PATIENT IS RECEIVING AN OPIOID CONCURRENTLY WITH A BENZODIAZEPINE OR CARISOPRODOL.
  - PMP reports shall be reviewed a minimum of once every three months during the continuous use of opioids for each established patient

28

Pharmacy Robberies Albuquerque

- **April 29, 2015 - Six Albuquerque Residents Indicted on Federal Robbery, Firearms, and Prescription Drug Trafficking Crimes Arising Out of Pharmacy Robberies –FBI.gov**
- **3 fugitives at time of indictment**
- **Last suspect (Blake Gallardo) was arrested June 11, 2015**
- **Stole over 68,000 tablets of oxycodone**

29

Pharmacy Safety

30

Scam Phone Calls – BOP, DEA, FBI or other LE

- Callers identifying themselves as Board of Pharmacy Investigators, Inspectors or Agents
- Callers "spoofing" the Board of Pharmacy phone number
- Told licensees they are under investigation and their license may be suspended or arrest warrant was issued and they demand money. Also, inquired about their wholesale distributors.
- NMBOP will never contact licensees by telephone to demand money or payment of any form.

31

Scam Phone Calls

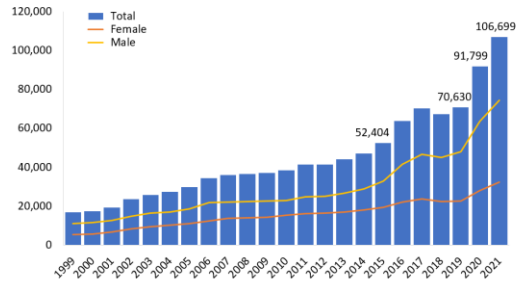
- Do not give them money!
- Do not give them any information!
- Contact an inspector or e-mail pharmacy.board@rld.nm.gov to inquire if there is an official investigation being conducted
- If the caller is stating they are from the DEA, you can report the scam using the DEA Extortion Scam Online Reporting Form
- If the caller is stating they are from the FBI, you can report the scam using the FBI Internet Crime Complaint Reporting Form
- If the phone number of the caller appears to be a New Mexico Board of Pharmacy telephone number, you can report the scam using the Federal Communications Commission Consumer Complaint Form

32

United States Drug Overdose Epidemic

33

Figure 1. National Drug-Involved Overdose Deaths*, Number Among All Ages, by Gender, 1999-2021



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

34

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2021

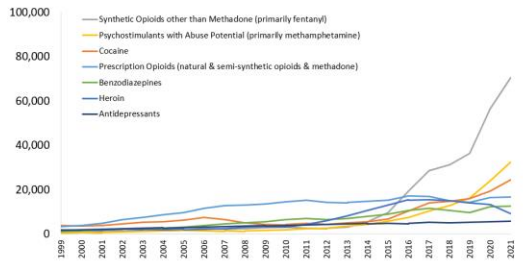


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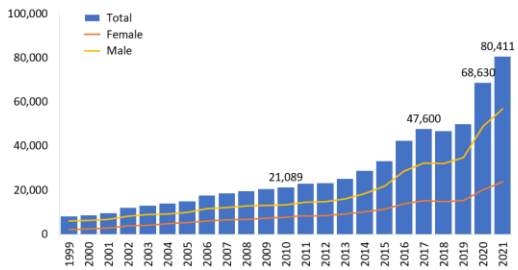
Figure 3. National Overdose Deaths Involving Any Opioid*, Number Among All Ages, by Gender, 1999-2021



*Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

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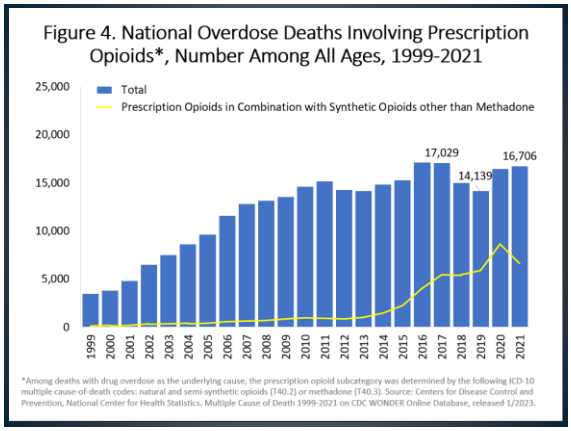

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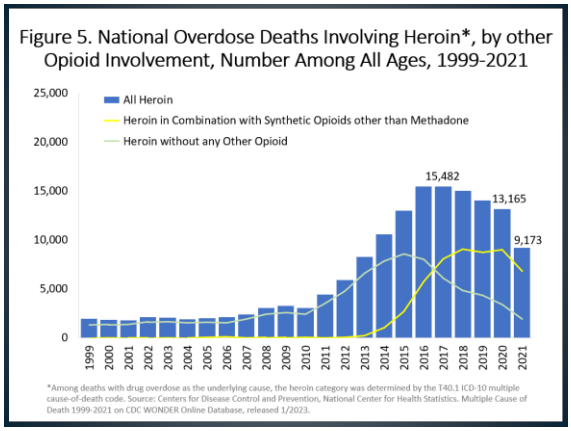

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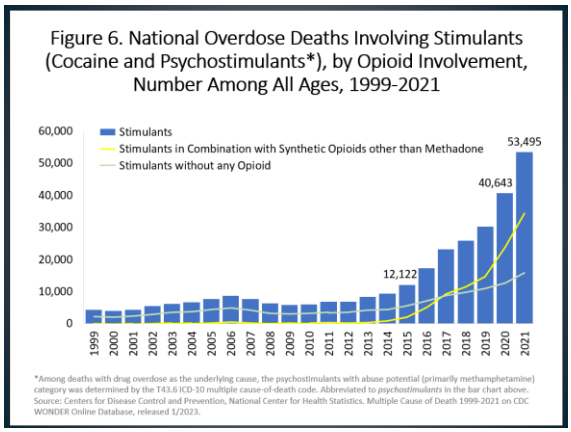

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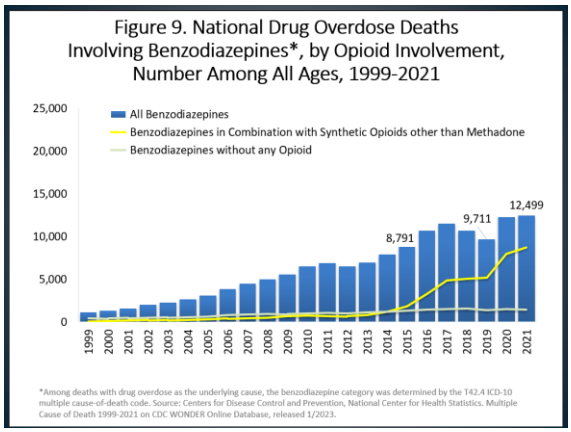

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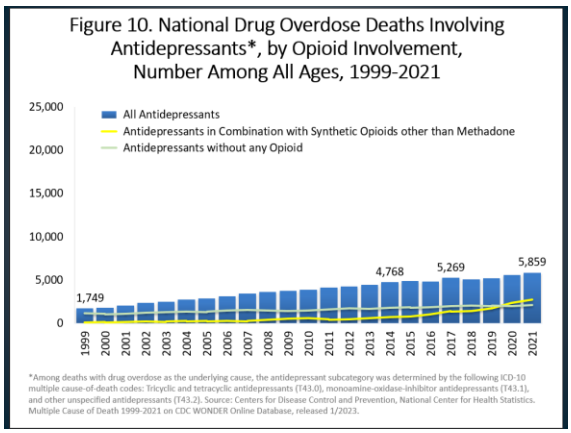

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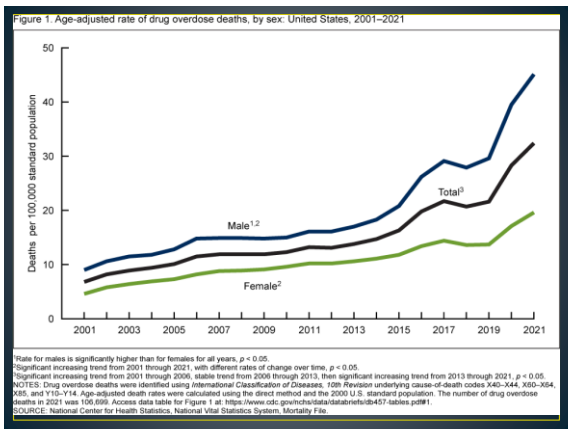

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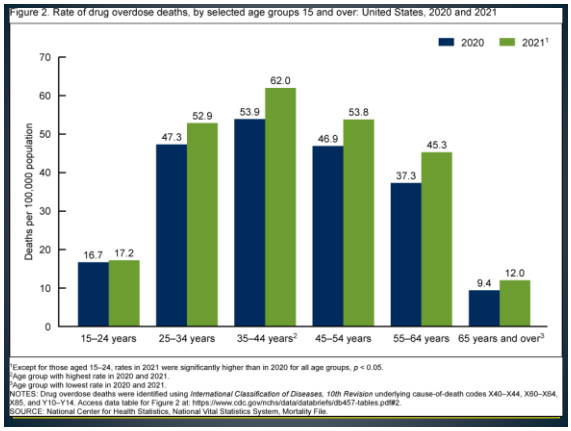

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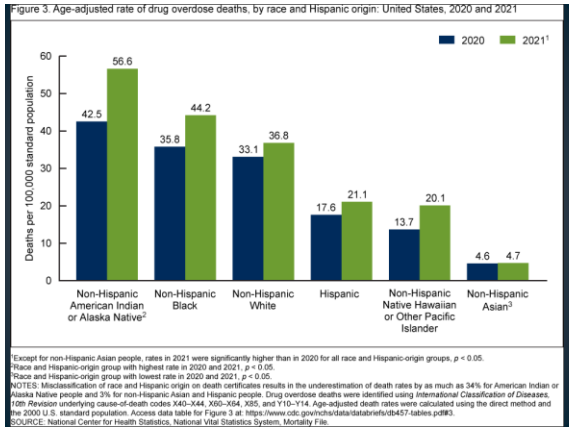

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http://www.cdc.gov/drugoverdose/epidemic/riskfactors.html

45

New Mexico Drug Overdose Epidemic

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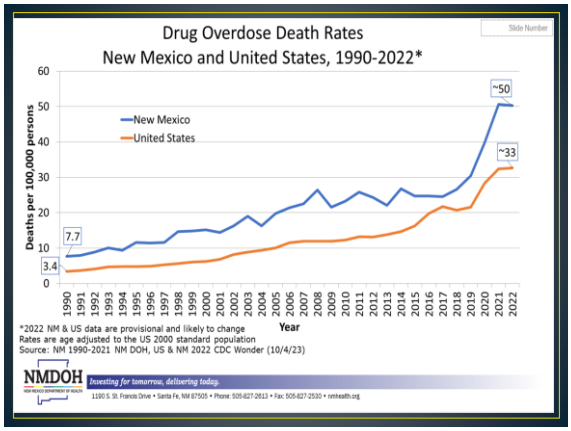

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Drug Overdose Information and Statistics

The State of New Mexico compared to the United States average

- In 2016, New Mexico had the **twelfth** highest drug overdose death rate (25.2 deaths per 100,000 age-adjusted population).
- In 2017, New Mexico had the **seventeenth** highest drug overdose death rate (24.8 deaths per 100,000 age-adjusted population).
- In 2018, New Mexico had the **sixteenth** highest drug overdose death rate (26.7 deaths per 100,000 age-adjusted population).
- In 2019, New Mexico had the **twelfth** highest drug overdose death rate (30.2 deaths per 100,000 age-adjusted population).
- In 2020, New Mexico had the **eleventh** highest drug overdose death rate (39.0 per 100,000) based on current data.
- In 2021, New Mexico had the **sixth** highest drug overdose death rate (based on provisional data)

https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2015.html
https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2019.html
2020 Drug Overdose Death Rates | Drug Overdose | CDC Injury Center

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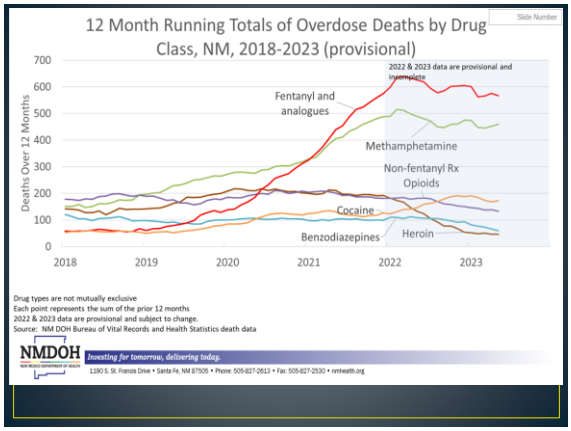

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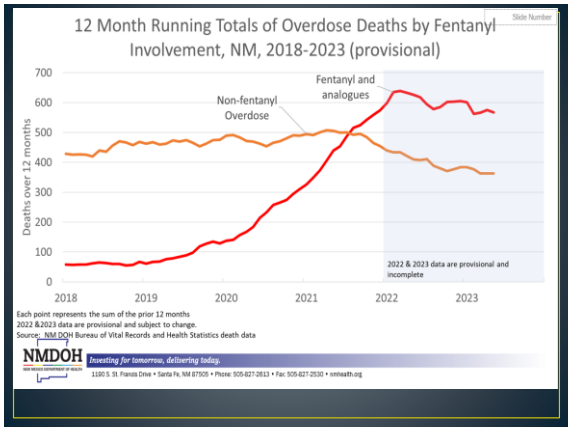

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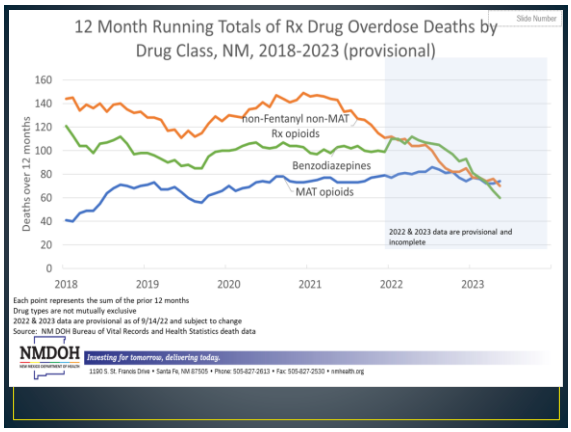

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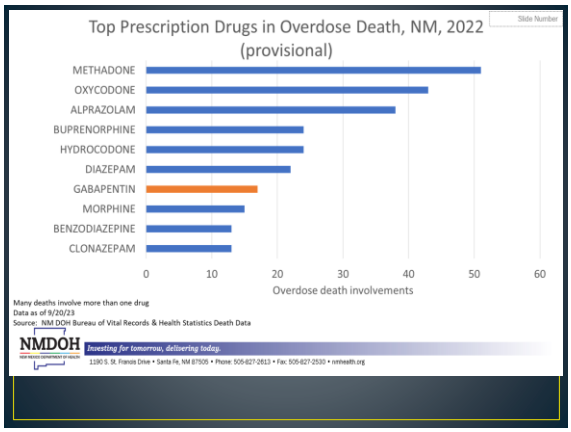

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FDA Gabapentinoid Warning! - 12/19/2019

- Serious Breathing Difficulties may occur in patients using gabapentin or pregabalin who have respiratory risk factors.
- Risk Factors include:
  - Use of opioid pain medications
  - Use of CNS depressants – anti-anxiety meds, antidepressants, antihistamines
  - COPD or other underlying respiratory disease
  - Elderly patient

FDA advice for HCPs - start gabapentinoids at lowest dose possible and monitor for symptoms of respiratory depression and sedation when co-prescribed with an opioid or other CNS depressant

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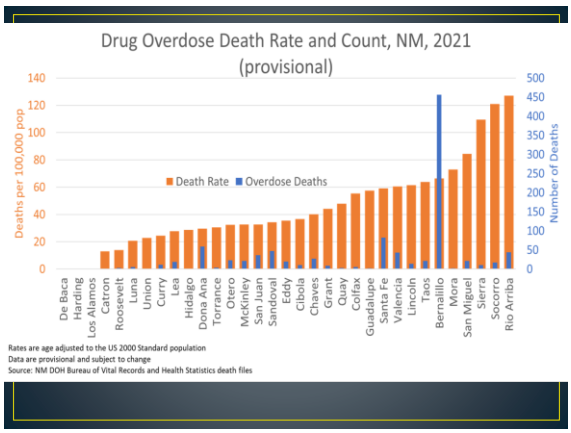

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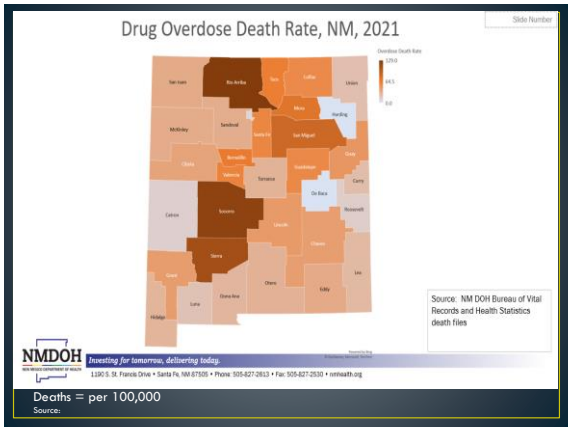

55

High Risk Prescribing Patterns

- Long term use of opioids (≥ 90 days)
- High doses of opioids (≥ 90 MME/day)
- Overlapping prescriptions of opioids from different prescribers
- Multiple Provider Episodes (MPE: Doctor and pharmacy shopping)
- The combination of opioids and sedative-hypnotics
- The combination of opioids, benzodiazepines and muscle relaxants

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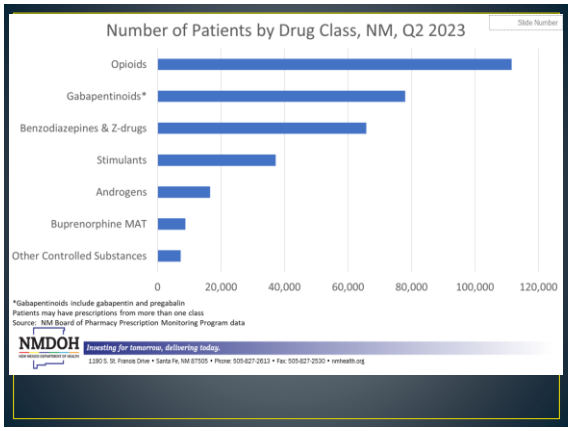

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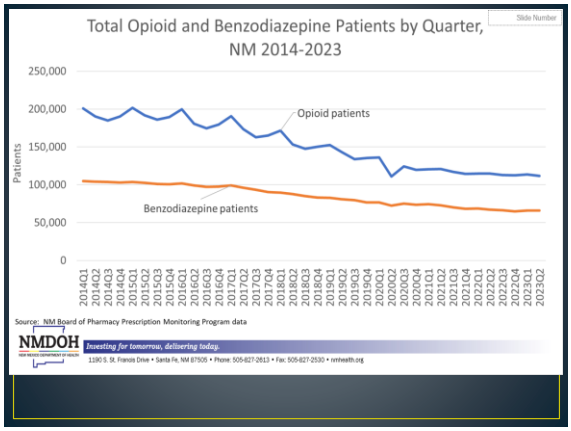

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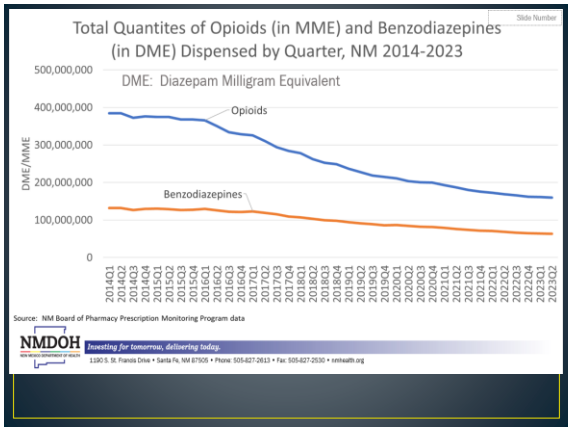

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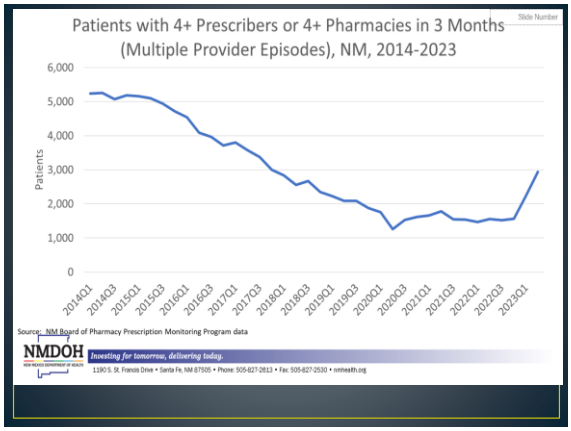

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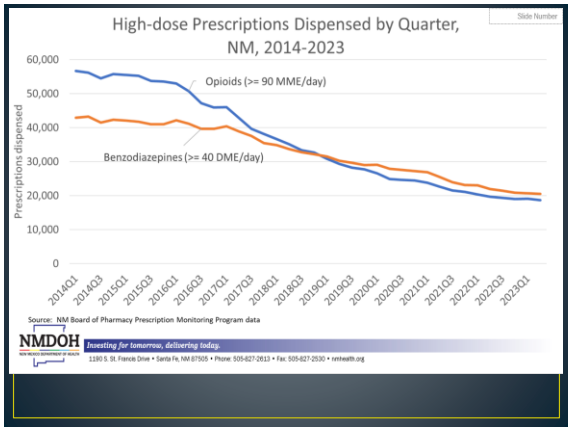

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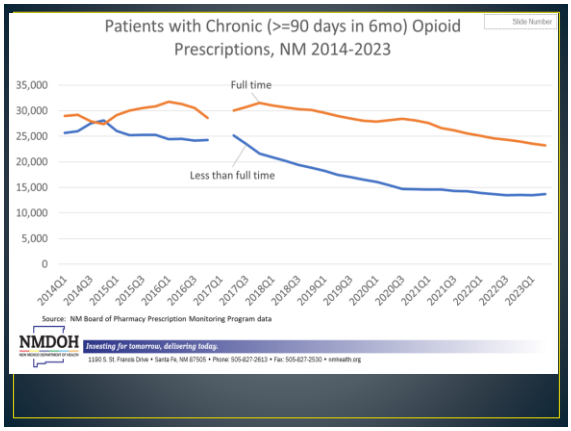

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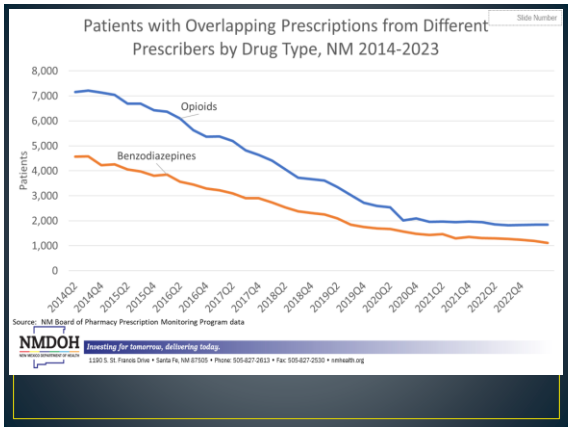

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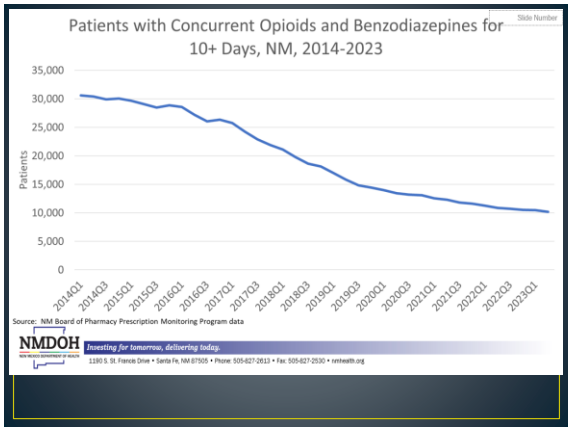

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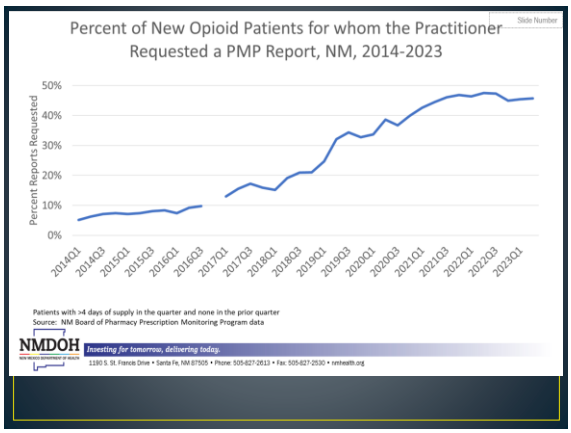

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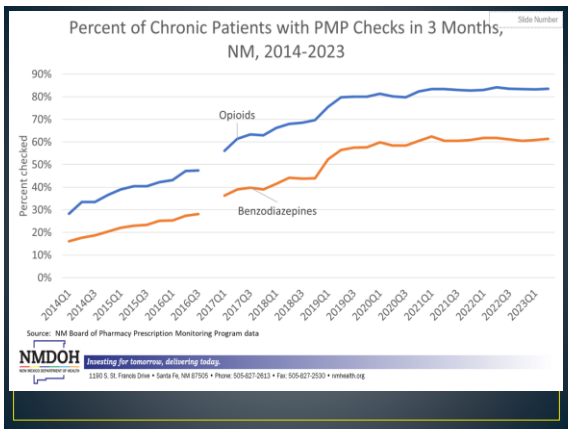

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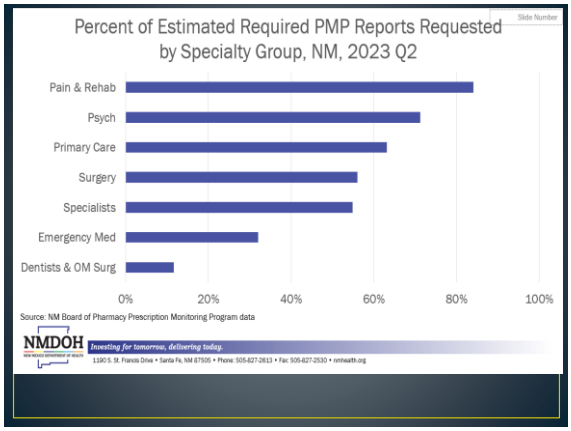

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Program Name	DBA	Street	City	State	Zipcode	Phone	Certification	FullCertification
Albuquerque Health Services	Albuquerque Health Services	112 Monroe St., NE	Albuquerque	NM	87108	(505) 260-9917	Certified	11/1/2003
Recovery Services of New Mexico, LLC	MedMark Treatment Centers Five Points	1528 Five Points Rd. SW	Albuquerque	NM	87105	(505) 242-6919	Certified	9/1/2004
Metro Treatment of New Mexico	Central New Mexico Treatment center	630 Haines NW	Albuquerque	NM	87102	(505) 268-5611	Certified	7/1/2004
Albuquerque Health Services	Albuquerque Health Services_NW Clinic	172 Montano Rd, NW	Albuquerque	NM	87107	(310) 534-5590	Certified	1/26/2011
Recovery Services of NM MDC, LLC	MedMark Treatment Centers NM MDC	100 Deputy Dean Miera Dr. S.W.	Albuquerque	NM	87151	(505) 839-8700	Certified	10/26/2011
Albuquerque Treatment Services, LLC		123 Madiera Street, SE	Albuquerque	NM	87108	(505) 262-1538	Certified	5/10/2007
Duke City Recovery Toolbox, LLC	Duke City Recovery Toolbox	912 First Street NW	Albuquerque	NM	87102	(505) 224-9777	Certified	11/7/2013
Addictions & Substance Abuse Program (ASAP)	Substance Use Disorder program with MAT	2600 Yale Blvd. SE	Albuquerque	NM	87106	(505) 994-7999	Certified	12/18/2003
Courageous Transformations, Inc	Courageous Transformations	3301 Los Arboles NE	Albuquerque	NM	87107	(505) 800-7092	Certified	2/7/2017
Metro Treatment of New Mexico, LP	New Season Albuquerque North	9421 Coors Blvd NW, Suite J&K	Albuquerque	NM	87114	(505) 445-2400	Certified	12/3/2020
State of the Heart Recovery Inc.		203 California St NE	Albuquerque	NM	87108	(505) 308-8296	Certified	3/26/2021
Albuquerque Health Services - South Valley Clinic	Albuquerque Health Services	1209 Isleta Blvd SW	Albuquerque	NM	87105	(505) 873-1973	Certified	1/7/2021
Recovery Services of New Mexico, LLC	MedMark Treatment Centers Belen	2443 Highway 47	Belen	NM	87002	(505) 861-2066	Certified	12/6/2013
Albuquerque Health Services	Espanola Health Services	612 N Paseo de Onate	Espanola	NM	87532	(505) 747-0221	Certified	1/7/2021
New Mexico Treatment Services, LLC	Una Ala Clinic	1227 N Railroad Ave	Espanola	NM	87532	(505) 747-8187	Certified	11/1/2003
New Mexico Treatment Services LLC Farmington		807 E Apache	Farmington	NM	87401	(505) 328-2012	Certified	8/7/2015
ALT Recovery Group	ALT Recovery Group	1141 Mall Drive	Las Cruces	NM	88001	(575) 522-0660	Certified	3/5/2015
ELITE PRIMARY CARE	DBA ELITE METHADONE	530 N Telshor BLVD	Las Cruces	NM	88011	(575)233-3389	Certified	11/20/2023
Rio Rancho Health Services		1558 Stephanie Rd. SE	Rio Rancho	NM	87124	(505) 896-5517	Certified	6/11/2018
Recovery Services of New Mexico, LLC	MedMark Treatment Centers Roswell	1107 South Atkinson	Roswell	NM	88203	(575) 578-4826	Certified	10/7/2015
Santa Fe Health Services		1949 S. St. Francis Drive	Santa Fe	NM	87505	(505) 820-9970	Certified	1/7/2021
New Mexico Treatment Services, LLC	Una Ala Clinic	1264 Rodeo Rd	Santa Fe	NM	87505	(505) 982-2129	Certified	2/4/2008

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