WYOMING STATE BOARD OF PHARMACY
STATE NEWSLETTER
March 2001

Rule Changes

The rule making order issued by the Board at their October 26 meeting was signed by the Governor and filed with the Secretary of State on December 8th. Brief summaries of the rule changes are as follows:

Chapter 1: *Section 2*--The definition of state board was moved to chapter 2, section 4. *Section 7*--The time requirements for a contestee to file with the Board an answer to a formal complaint was clarified.

Chapter 2: *Section 4*-- "Patient Confidences" is defined as well as those definitions relating to institutional pharmacy practice were deleted and will now appear in Chapter 12 "Institutional Pharmacy Practice Regulations". *Section 5*--Rules for pharmacist licensure by examination were updated. *Section 8*--Controlled Substance inventory requirements with a change in PIC were clarified and a copy of the inventory must now be sent to the Board's office within 15 days of conducting the inventory. Additionally, any change in employment or mailing address for a pharmacist or intern must be reported to the Board's office within 15 days of the change. *Section 9*--The number of hours/wk a pharmacist must work to serve as PIC was established (32 hours/wk or 80% of the time the store is open, if opened less than 40 hours per week) and clarification of what duties a technician may perform when a pharmacist takes a break, but still remains in the building. *Section 11*--Clarified labeling requirements for containers utilized in a traditional dispensing system as well as labeling of unit dose or unit of issue packaging. *Section 19*--Clarified requirements for a prescription to be valid and established that prescriptions received from out of state practitioners are valid only to the extent practitioners licensed in Wyoming may prescribe that medication in Wyoming.

Chapter 4: *Section 2*--Establishes that dispensing a prescription drug without a valid prescription order is considered unprofessional conduct and established that a pharmacist may not work in an unlicensed pharmacy.

Chapter 10: *Section 5*--Eliminated the requirement that a pharmacy must petition the Board for a change in pharmacist/technician ratio and established that a pharmacist may supervise two technicians. *Section 8*--Modified the requirements for licensure as a pharmacy technician, eliminates the Board exam, but now requires an applicant for licensure as a pharmacy technician to be certified by the Pharmacy Technician Certification Board. Applications are now available at the Board's office for individuals seeking licensure as a pharmacy technician.

Chapter 12: Establishes a new chapter for "Institutional Pharmacy Practice Regulations"

This rule making Order issued by the Board (00-1) may be viewed at the Board's web page http://pharmacyboard.state.wy.us. If you have any questions regarding these changes contact the Board's office.

January Board Meeting Highlights

The last Wyoming State Board of Pharmacy meeting was held in Cheyenne on January 17th & 18th. Highlights include the following:

- Bills, which affect the Board of Pharmacy, were discussed and includes SF0083, "Pharmacy Act Amendments"; HF 00103, "Controlled Substance Act registrations"; and HF 0254, "Pharmacy Technician Amendments".
- Dan Grinstead, MD was selected to participate on the Board's Collaborative Practice Advisory Committee. Dr Grinstead is an internist who practices in Casper.
- Board objectives for 2001 were discussed and include: Board's participation in health fairs, implementation of institutional pharmacy practice regulations, increase in secretarial support

for the Board's office, as well as, an increase in duties for Karen Brock, provision of pharmacy law CE at the annual meeting of the Wyoming Pharmacists Association in Sheridan in June, and rule making considerations for 2001 (revising pharmacist renewal regulations, revising pharmacy technician regulations, and developing electronic prescription regulations).

- Discussed obtaining criminal background checks on applicants for licensure as a pharmacist or pharmacy technician. Currently only the Board of Nursing is obtaining this information in Wyoming, but other boards are considering.
- The Board conducted a public hearing on January 18 to hear comments regarding the proposed rule making, which was continued from the October 26 public hearing The Board issued an order dated January 18th adopting the proposed rules. A number of changes were incorporated as a result of public comments given at the October 26 public hearing. No comments were received at the January 18th public hearing. The Governor will have until March 19th to sign the Order. If signed into law, updated chapters will be mailed to all pharmacies licensed with the Board (revisions as a result of Order 00-1 will also be included). A copy of the rule making Order (01-1) issued by the Board may be found on the Board of Pharmacy's web page (http://pharmacyboard.state.wy.us). Please contact the Board's office if you have questions.
- The next Board meeting will be April 17th & 18th in Casper. The agenda should be available on the Board's web page approximately 10 days prior to the meeting.

Advanced Practitioners of Nursing

The following advanced practitioners of nursing have met the Wyoming State Board of Nursing's requirements for prescriptive authority. **Susan Beckwith,** Sheridan, WY; **Jeannie**

Carlton, Bolivar, MO; **William Darryl Faulk**, Rock Springs, WY; **Cynthia Gilmet**, Laramie, WY; **Shona Lenss**, Cheyenne, WY; and **D'Ann Miller**, Casper, WY.

Medication Errors, Matt Stanton, Pharmacy Intern

It seems we can't watch the nightly news these days without seeing evidence that medication errors are on the rise. The ever-expanding volume of prescriptions, as well as, the widening gap in supply and demand of pharmacists, are two of the direct contributors to this situation. Because these circumstances are not likely to improve in the foreseeable future, we must take steps now to prevent a further increase in dispensing errors. To stop filling prescriptions would be the easiest way to eliminate medication errors, but since hoards of sick people and our creditors tell us we can't just go play golf, below are several ways to cut down on these errors:

- A prescription that indicates a dosage increase or drug change shouldn't be accepted blindly. Keep in mind that the patient may not know what's going on, so don't hesitate to ask… "Mrs. Jones, did the doctor discuss changing the dose of your medication with you?" or "Mr. Smith, did the doctor tell you he was changing your blood pressure medication?" Today's patients are much more aware than even five years ago. If the patient isn't certain or doesn't know however, the pharmacist should call the doctor to verify the change.
- Medications with similar names, or brand/generics that are often interchanged might be placed in different sections to avoid taking the wrong drug from the shelf.
- When a prescription is labeled, the pharmacist that filled or checked the prescription should **manually** initial the label, hard copy or both. Even though the label already has the pharmacist's initials printed on it, sometimes the pharmacist that prints the labels is not the pharmacist that fills the prescription. Not only is this a good double check of each other's

work, but it can also eliminate any questions as to who is responsible for filling a prescription, if an error does occur.

- Maintaining a vigilant eye over interns, technicians and technicians-in-training can also eliminate potential problems. A pharmacist is not able to run an entire pharmacy on his/her own, and keeping trained personnel on staff is a sure way to lighten the load on the pharmacist. However, even though good technicians can run many of the pharmacy operations on their own, we must keep in mind that it is not legal for them to give prescriptions to customers until a pharmacist checks the prescription. Also, it is not legal for technicians to counsel patients about their medications. These may seem like unimportant points, but ultimately it is the pharmacist's license that is in jeopardy, if an error were to occur.

Even when we take necessary precautions, it is still possible for errors to occur in the pharmacy that may reach the patient. When this does occur, it is best to handle the error with the utmost attention and respect for the customer; after all, how would you feel if it were your grandfather, mother, or sister that received the wrong medication? Some companies have procedures outlining how to deal with medication errors that reach the patient, however, if your business does not, keep in mind that often, customers are satisfied with a sincere apology and actions to correct the situation.

Special Notice about this Newsletter

The *Wyoming Board of Pharmacy News* has been designated as the official method of notification to pharmacists and pharmacy technicians licensed by the Wyoming Board of Pharmacy. Please read these newsletters and keep them for future reference. These newsletters will be used in hearings as proof of notification.