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Hamden, CT  
RE: HB 5406  
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Thank you Senator Colapietro and Representative Shapiro. My name is Diana Henderson and I am testifying in support of HB 5406, AN ACT CONCERNING PUBLIC ACCESS TO INFORMATION REGARDING PHARMACY AND PHARMACIST PRESCRIPTION ERRORS.

Last week I submitted related testimony in support of SB 325. I am extremely fortunate, and very grateful, that both Sen. Looney and Rep. Sharkey have introduced legislation on this important topic.

My infant daughter was the victim of not one but two (2) pharmacy errors. In one a medication intended for use in her ear was mislabeled with instructions that it be placed in her eye. In the second she was given a completely wrong medication. Both errors occurred at the same time at the same pharmacy. I contacted the Department of Consumer Protection Drug Control Division and followed through in every way. Since that time I have done everything humanly possible to get information about pharmacy errors and have discovered that the state of Connecticut offers no transparency, accountability or checks and balances. There is no way to make an educated decision about where to have my family's prescriptions filled. There is no way to choose a safe pharmacy even if it is located next door to a dangerous one.

I am asking you to make information about pharmacy errors public so that consumers have the ability to make an informed decision about such an important part of our health care. To be clear - I am not asking the state of Connecticut to break new ground. A simple internet search of pharmacy board minutes around the nation showed that many other states already release identifying information. I am circulating examples of how 9 or 10 states address the issue of pharmacy errors. I have also attached examples from both Arizona and Kansas to my written testimony, as well as sample minutes from the Connecticut Commission of Pharmacy for comparison.

In written testimony against SB 325 a pharmacy lobbyist claimed that keeping this information secret somehow serves to protect the consumer.

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The argument seems to be that secrecy leads pharmacists to be more open about their errors. In fact in her testimony related to SB 325 she indicated that a transparent system, which apparently works well in numerous other states, would be "disastrous" here and lead Connecticut pharmacists to "hide or bury" their errors.

She spoke of pharmacists becoming "scared" or "embarrassed." When weighed against a parent's ability to make an informed decision about having their child's prescription filled safely this seems like a minor consideration. Pharmacists are respected professionals and holding them to an appropriate standard of professional conduct should not translate to fear, embarrassment or refusal to cooperate in appropriately protecting their patients.

Having the pharmacist appear on the record to indicate not only how an error occurred but also what has been done to reduce the likelihood of it being repeated makes me more confident as a consumer that errors are being addressed than having all errors cloaked in secrecy. In the examples attached here errors were addressed by such simple actions as rearranging the placement of medications to reduce the likelihood that the pharmacist would take the wrong one off the shelf. Erroneously giving a prescription to a customer with a similar name was addressed by verifying the patient's street address as well as name. Making these simple actions public should not cause embarrassment but can make consumers safer and allow us to feel more secure that errors are being appropriately addressed.

I did not encounter the cooperative environment that the pharmacy lobbyist tried to present. Instead I experienced a cavalier attitude that seems to come from pharmacy staff knowing that there will be little, if any, consequences for their actions. When we contacted the pharmacy about the first error a pharmacy employee actually laughed and said "Oh that happens all the time. Of course the drops go in her ear." When we contacted them again about the second error the pharmacist indicated that

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she had found my daughter's bottle of medication, labeled with her name, but made no efforts to contact us to warn us about the error.

When I reported my daughter's errors to the pharmacy I was not given instructions about contacting Drug Control. Fortunately I found the contact information on my own. The Drug Control agent I met with indicated that the vast majority of patients who experience errors return the medications to the pharmacy. This makes it extremely difficult to document errors even if reported. In the past week I had 5 prescriptions filled and could not locate the contact information to report any possible error to Drug Control on any of them. In other words hiding or burying errors already occurs.

The idea that if pharmacists are either scared or embarrassed they will be more likely to "hide or bury" errors could easily be addressed by making pharmacists and other pharmacy employees mandated reporters. In the same way that teachers and day care providers are mandated to report suspected child abuse these professionals can be required to report any and all suspected errors. Openness should lead to increased vigilance in preventing errors as well as greater efforts to identify and correct problems which allowed them to occur.

As the system currently exists the Department of Consumer Protection seems to be protecting the pharmacy industry at the expense of protecting the consumer. My daughter was already a victim twice. Please give me the tools to make a better choice about where to fill her prescriptions in the future so that I can minimize the risk of her being the next victim of a pharmacy with a history of preventable errors.

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### **Arizona**

#### **COMPLAINT # 2858**

Pharmacist Tammy Bruno and Pharmacy Supervisor Melanie Malee were present in response to a consumer complaint. Compliance Officer Sandy Sutcliffe gave a brief overview of the complaint.

Ms. Sutcliffe stated that the complainant stated that her prescription for Wellbutrin SR 100mg was incorrectly filled with Wellbutrin SR 150mg. The patient was out-of-town when she discovered the error. The patient missed approximately one or two doses of her medication before she received the correct medication. The patient did not take any of the incorrect medication.

President McCoy asked Ms. Bruno about the complaint. Ms. Bruno stated that the two strengths of Wellbutrin were beside each other on the shelf. Ms. Bruno stated that the bottle was a sealed bottle and she did not catch the error when she verified the prescription. Ms. Bruno stated that when the patient called her that evening she should have been more aggressive in getting the correct medication to the patient.

Ms. McCoy asked Ms. Bruno what she has done to change her practice since this error occurred. Ms. Bruno stated that the two medications have been separated in the pharmacy. Ms. Bruno stated that the pharmacy has received the updated scales and the final verification cannot be completed if the filling verification has not been completed by using the scale. Ms. Bruno stated that they have the updated picture of the medication in their system.

Ms. McCoy thanked the respondents for appearing.

#### **Complaint #2868**

Pharmacist Debbie Walton and Pharmacy Technician LaTanya Calamity appeared in response to a consumer complaint. Compliance Officer Ed Hunter gave a brief overview of the complaint. Mr. Hunter stated that a prescription was filled correctly by the pharmacist, but was given to the wrong patient by the pharmacy technician. The technician gave the patient a prescription belonging to another individual with a similar name. The technician's employment was terminated.

President McCoy asked Ms. Walton about the complaint. Ms. Walton stated that when they were made aware of the error they contacted the patient. Ms. Walton stated that the patient told them he would check with his doctor and then come to the pharmacy to pick up the correct medication.

Mr. Dutcher asked Ms. Walton about her new procedure to insure that the correct medication is given to the correct patient. Ms. Walton stated that when the patient signs the log when they pick up their prescription, the technician is to verify that the name matches the name on the prescription.

Ms. McCoy asked Ms. Calamity if she was the technician involved in this incident. Ms. Calamity replied yes. Ms. Calamity stated that she now works at a different pharmacy. Ms. McCoy asked Ms. Calamity if she has changed the way that she verifies that the correct patient is getting the correct medication. Ms. Calamity states that at the pharmacy that she works at now that they must verify the patient's address and she also verifies the patient's first and last name. Ms. Calamity stated that at the pharmacy she works at now there are steps and training provided. Ms. Calamity stated that at the other pharmacy she asked the patient their name and gave them their medicine.

**<http://www.azpharmacy.gov/0405MINUTES.html>**

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## Kansas

**STACI L. SNIDER #13371:** Staci Snider appeared pro se. Assistant Attorney General, Marty Snyder, represented the Board. Ms. Snyder advised the Board that the Respondent was charged with K.S.A. 65-1637 (a)(4) by substituting levothroid on a prescription written for Synthroid. Ms Snyder stated that a consent agreement was sent to the Respondent recommending a \$250 fine and a period of one-year probation. The Board heard both the Respondent and the Complainant. A motion was made and seconded to go into executive session to deliberate until 9:50 a.m. Those present in executive session were Tom Frazier, LaTonyua Rice, Debra Billingsley and Randy Forbes. (Whitchurch/Gilstrap). Motion carried (5-0).

**RECONVENE:** The Board meeting reconvened at 9:50 a.m. with all members present as previously stated.

**MOTION:** A motion was made and seconded to accept the consent agreement as written (Whitchurch/Paul). Motion carried (5-0).

**MICHAEL D. McDANIEL #11364:** Michael McDaniel appeared with his attorney, Gary Peters. Assistant Attorney General, Marty Snyder represented the Board. Ms. Snyder advised the Board that the Respondent was charged with violating K.S.A. 65-1637 (a) in that he had filled a "dispense as written" prescription for Amnesteem with Claravis. The Respondent was also charged with K.A.R. 68-7-12b for failure to file an incident report. Howard Paul recused himself from the hearing and did not participate in any discussion. Ms Snyder stated that a consent agreement was sent to the Respondent recommending a \$500 fine and one-year probation. The Respondent advised that Walgreens had taken aggressive remedial action by requiring the Respondent to take continuing education regarding drug substitution and that he had received an internal reprimand. A motion was made and seconded to go into executive session to deliberate until 10:25 a.m. Those present in executive session were Jim Kinderknecht, Debra Billingsley and Randy Forbes. (Whitchurch/Gilstrap) Motion carried (4-0)

**RECONVENE:** The Board meeting reconvened at 10:25 a.m. with all members present as previously stated.

**MOTION:** A motion was made and seconded to accept the stipulation as written and to accommodate Mr. McDaniel on the language in the newsletter reporting the violation. (Whitchurch/McFarland). Motion carried 4-0.

<http://www.kansas.gov/pharmacy/Minutes/March%202004%20Minutes.pdf>

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**STATE OF CONNECTICUT  
DEPARTMENT OF CONSUMER PROTECTION  
COMMISSION OF PHARMACY**

**Legal Matters**

Attorney Schwane suggested that letters of reprimand be sent for the following dockets:

Docket Number 06-3022  
Docket Number 06-2974  
Docket Number 06-3152

**Commission Action:** Commissioners passed a vote of (6-0) to accept.

Pharmacists Who Have Completed the Continuing Education Course on Prescription Errors  
Attorney Schwane presented the following cases involving pharmacists who have committed prescription errors. These pharmacists have completed a USP Practitioners' Reporting Network error form and taken the continuing education program concerning prescription errors. The Department recommends that the Commission vote to dismiss the following cases.

06-6925 06-3740  
06-9967 06-9190  
06-5424 06-2850  
06-4375

**Commission Action:** Commissioners passed a vote of (6-0) to dismiss the above mentioned pharmacy files.

[http://www.ct.gov/dcp/lib/dcp/pdf/drug\\_control\\_pdf/dc1206minutes.pdf](http://www.ct.gov/dcp/lib/dcp/pdf/drug_control_pdf/dc1206minutes.pdf)