SUBJECT: Standards for withdrawing medication from rural hospital pharmacies

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Kolkhorst, Naishtat, Coleman, J. Davis, Gonzales, Laubenberg, McReynolds, Truitt, Zerwas

0 nays

2 absent — Hopson, S. King

WITNESSES: For — Don McBeath, Texas Organization of Rural & Community Hospitals; (*Registered, but did not testify:* David Pearson, Texas Organization of Rural & Community Hospitals; Matthew Wall, Texas Hospital Association)

Against — Paul Davis, Texas Society of Health-System Pharmacists; (*Registered, but did not testify:* Brad Shields, Texas Society of Health-System Pharmacists)

On — Gay Dodson, Texas State Board of Pharmacy

BACKGROUND: A Class C pharmacy, also called an institutional pharmacy, operates in a hospital or ambulatory surgical center. A Class C pharmacy that is in an institution with 100 beds or fewer is required to have the services of a pharmacist on a part-time or consulting basis.

When an institutional pharmacy is closed for the day, Texas State Board of Pharmacy rules allow nurses or practitioners in rural hospitals to remove prescription drugs or devices from the pharmacy to fill a drug order for a hospital patient.

Hospitals that use a floor stock method of drug distribution have a limited supply of drugs accessible to health practitioners on the hospital floor.

DIGEST: CSHB 1924 would establish the circumstances under which a nurse or practitioner at a rural hospital could withdraw medications without the aid of a pharmacist and how the withdrawal would be documented.

Rural hospitals. A rural hospital would be defined as a licensed hospital with 100 beds or fewer that was located in a county with a population of 50,000 or less or had been designated as a critical access hospital, rural referral center, or sole community hospital.

Withdrawal for prescription orders. A nurse or practitioner could withdraw a drug or device from a rural hospital pharmacy to fill a prescription order when the pharmacy was closed or the pharmacist was off-duty. The person who withdrew the drug or device either would have to record the following information or substitute a medication order if it contained the following information:

- patient name;
- drug or device name;
- dosage and strength of the drug and the dosage form;
- quantity withdrawn;
- time and date of the withdrawal; and
- signature of the person making the withdrawal.

Withdrawal for floor stock. In a rural hospital that used a floor stock method of drug distribution, a nurse or practitioner could withdraw a prescription drug or device from the institutional pharmacy in the original manufacturer's container or a prepackaged container. The person who withdrew the drug or device would have to record the:

- drug or device name;
- strength of the drug and dosage form;
- quantity withdrawn;
- location of the floor stock;
- time and date of withdrawal; and
- signature of the person making the withdrawal.

Pharmacist review. The hospital pharmacist would have to verify the drug and device withdrawals allowed by this bill and perform a drug regimen review not later than the seventh day after withdrawal.

Board rules. The bill would not restrict or prohibit the Board of Pharmacy from adopting rules governing drug or device withdrawals from an institutional pharmacy not located in a rural hospital.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2009. The provisions of the bill would expire January 1, 2012.

SUPPORTERS SAY:

CSHB 1924 would place in statute Board of Pharmacy rules that safely have governed the withdrawal of drugs by non-pharmacists in rural hospitals since 1981. Despite limited resources and a limited number of health professionals, rural hospitals often are the only health resources for patients. CSHB 1924 would acknowledge that the drug withdrawal processes in rural hospital pharmacies must be more flexible to avoid putting another cost pressure on facilities that already may be struggling to stay in business.

Many rural hospitals are so small that they have a daily census of ten patients or less. Round-the-clock pharmacist staffing is a wasted expense when other health professionals already on the clock could obtain and administer a drug safely.

CSHB 1924 would affirm that rural hospitals, which are vital resources to their communities, could operate in a common-sense manner that would not impose unnecessary costs. No form of ongoing pharmacist supervision, including electronic supervision, has proven cost-effective for rural hospital pharmacies. It would be better to maintain cost-effective, safe drug dispensing options for rural hospitals than to risk imposing the final cost burden that forces a hospital to shut down.

Medical professionals understand how to prescribe medications in proper dosages and drug interactions to avoid. For years, nurses in rural hospitals have filled and administered these drug orders accurately, without complaint. Nurses understand the importance of properly administered medications and follow prescriptions closely. The bill would add the safeguard of detailed documentation by those withdrawing drugs. Pharmacists performing retrospective reviews would make sure proper dispensing and dosing had occurred.

OPPONENTS SAY:

CSHB 1924 would put in statute drug withdrawal procedures that would conflict directly with a task force commissioned by the Board of Pharmacy to make recommendations for Class C pharmacies. At its May 5, 2009, scheduled board meeting, the Board of Pharmacy will consider whether to adopt task force recommendations that would require a pharmacist for a

hospital, regardless of hospital size, to conduct a review of all new orders before they are filled, except those orders requiring urgent or emergency administration. The review could be performed in person, or electronically when an on-site pharmacist was not on duty.

Texas should await the expert Board of Pharmacy's decision on this recommendation before enacting potentially contradictory legislation. The fact that more lenient rules for drug withdrawals in rural hospitals have been in place for many years does not mean they are or ever were safe. CSHB 1924 only would allow for pharmacist review of drug orders up to seven days after they had been made. This would be too late to catch inaccurate dosing and would not permit a trained pharmacist to review the patient's drug history to determine if the prescription could lead to a dangerous drug interaction.

Because CSHB 1924 only would reflect the board's current rules for drug withdrawal by nurses in rural hospitals, there is no need to enact this legislation. If the Board of Pharmacy chooses not to adopt the task force's recommendation, the existing rules would remain in effect, and current practices could continue without legislative action.

NOTES:

HB 1924 as filed would have established a process whereby pharmacy technicians could have been certified to fill medication orders in rural hospitals without electronic or direct supervision by a pharmacist, but subject to documented verification by a licensed nurse.