

**IN THE MATTER OF
LAWRENCE EKANEY, P.D.
LICENSE NO. 12095**

*** BEFORE THE
* MARYLAND STATE
* BOARD OF PHARMACY**

Respondent

* * * * *

FINAL DECISION AND ORDER

Background

This case arose out of allegations that Lawrence Ekane, P.D. (the "Respondent") failed to adhere to the standards of practice in the production of a total parenteral nutrition ("TPN") intravenous ("IV") solution and failed to comply with the conditions of a Consent Order dated January 16, 2002. Specifically, the Respondent was charged with failing to check pump volumes and failing to discard unused syringes in the TPN production process. In addition, the Respondent failed to notify his employer that he was under a Consent Order, as mandated by the terms of the Consent Order. Based upon its investigation, on March 29, 2005, the Board of Pharmacy (the "Board") issued Charges against the Respondent.

A contested case hearing was held under the Administrative Procedure Act, Md. Code Ann., State Gov't §10-201 *et seq.*, before a quorum of the Board on August 25, 2005. A preliminary motion to recuse Board member David Chason was made by Respondent based on Mr. Chason's disclosure that two of the Respondent's witnesses were contractual employees at MedStar Health Systems, where Mr. Chason serves as the Corporate Vice President for Pharmacy Services. The Board granted the Respondent's motion and Mr. Chason was immediately recused from the proceeding. The Respondent

also made a motion for reconsideration of the Board's Pre-Hearing Order in which it excluded the Respondent's expert witness based on the Respondent's failure to adhere to the Board's discovery regulations. The Board denied the Respondent's motion for reconsideration.

After the conclusion of the hearing on the same date, August 25, 2005, the same quorum of the Board convened to deliberate and voted to affirm the charges against the Respondent and to impose the sanctions contained in this Final Decision and Order.

SUMMARY OF THE EVIDENCE

A. Documents.

The following documents were admitted into evidence.

- State's Exhibit No. 1 - December 17, 2003 letter to Office of Health Care Quality from President, Johns Hopkins Home Care Group
- State's Exhibit No. 2 - February 6, 2004 letter to Chief, Division of Drug Control from Vice President, Home Health Care Group Services with attachments
- State's Exhibit No. 3 - December 1, 2003 Pharmaquip Daily Routing Slip
- State's Exhibit No. 4 - May 13, 2004 Board of Pharmacy Investigatory Memorandum
- State's Exhibit No. 5 - Agency Medication Profile, December 1, 2003 Physician Prescription, CADD-PRISM...TPN Delivery Mode, Compounding Sheets and Labels
- State's Exhibit No. 6 - Patient A Lab Results
- State's Exhibit No. 7 - January 26, 2004 letter to OHCQ from President, Johns Hopkins Home Care Group and attachments; Root Cause Analysis report
- State's Exhibit No. 8 - February 18, 2004 Statement of Deficiencies

- State's Exhibit No. 9 - Transcript – Lopa Patel, investigatory interview
- State's Exhibit No. 10 - Transcript – Lawrence Ekaney, investigatory interview
- State's Exhibit No. 11 - Health Care Resources of America – Ekaney personnel file
- State's Exhibit No. 12 - Johns Hopkins Home Care Group – Job Description for Staff Pharmacist
- State's Exhibit No. 13 - Johns Hopkins Home Care Group – Job Description for Clinical Staff Pharmacist
- State's Exhibit No. 14 - National Advisory Group on Standards and Practice Guidelines for Parenteral Nutrition (“ASPEN”) Special Report: Safe Practices for Parenteral Nutrition Formulations
- State's Exhibit No. 15 - Johns Hopkins Home Care Group Pharmacy Policy: TPN Compounding
- State's Exhibit No. 16 - Code Md. Regs. tit. 34, § 34.10, *et seq.* – Pharmacist Code of Conduct
- State's Exhibit No. 17 - November 30, 2004 – Jill A. Morgan, Pharm.D., BCRS – Report regarding Lawrence Ekaney
- State's Exhibit No. 18 - Jill A. Morgan Curriculum Vitae
- State's Exhibit No. 19 - Board of Pharmacy Final Consent Order, *In the Matter of Lawrence Ekaney*
- State's Exhibit No. 20 - Violation of Consent Order and Charges Under the Maryland Pharmacy Act, *In the Matter of Lawrence Ekaney*

- Respondent's Ex. No. 1 - HCRA Employment Documents
- Respondent's Ex. No. 2 - HCRA Orientation Documents
- Respondent's Ex. No. 3 - HCRA Training Documents

- Respondent's Ex. No. 4 - HCRA Training Documents
- Respondent's Ex. No. 5 - HCRA Training Documents
- Respondent's Ex. No. 6 - HCRA Additional Training Materials
- Respondent's Ex. No. 7 - HCRA Additional Training Materials
- Respondent's Ex. No. 8 - Employment Advertisement for Infusion Clinical Pharmacist at Johns Hopkins, dated 3/10/04

B. Summary of Pertinent Witness Testimony.

Jill Morgan, Pharm.D., a licensed pharmacist, was admitted as an expert in total parenteral nutrition. Dr. Morgan is currently an assistant professor at the University of Maryland School of Pharmacy as well as the Associate Dean of Student Affairs. Her current pharmacy practice focuses on pediatric care in which she assists physicians in writing and monitoring TPN's. She has completed two residencies, one of which focused on pediatric pharmacy practice. Dr. Morgan also practiced in both hospital and home infusion settings in which she developed, monitored and produced TPN's.¹ [T. 25, 34]

Dr. Morgan testified that she reviewed all of the State's Exhibits and relied upon her experience and training in forming her expert opinion. Dr. Morgan testified about the standard of care in TPN production as well as the policies and procedures for TPN production instituted at Johns Hopkins Home Care Group ("JHHCG" or "Pharmaquip"), where the Respondent was employed through a staffing agency at the time of the alleged violations. (State's Ex. 15) Specifically, Dr. Morgan stated that the standard of care and JHHCG's policy required that the production pharmacist, in performing the check of the

¹ TPN, or total parenteral nutrition, is a complex intravenous nutritional admixture containing amino acids, dextrose, lipids, water, electrolytes, trace elements and vitamins. TPN's are generally administered to patients, including pediatric patients, in severely compromised medical conditions.

technician's pool of electrolytes, discard syringes containing electrolytes that would not be used in the TPN to insure that the technician compounded the TPN using the correct syringes with the correct amounts of electrolytes.² Furthermore, Dr. Morgan testified that the standard of care, as well as JHHCG's own policy, required a pharmacist to check the compounding pump volumes as part of the supervision of the technician.

Dr. Morgan further testified regarding the standard of practice set forth by the American Society for Parenteral and Enteral Nutrition ("ASPEN")³ with respect to TPN production. ASPEN standards state that "the responsibility of the dispensing pharmacist is to ensure that the PN is prepared, labeled, controlled, stored, dispensed, and distributed properly." (State's Ex. 14) Dr. Morgan stated that in order to insure the accuracy of a TPN, the standard of care requires that a pharmacist, at minimum, discard unused syringes and check pump volumes as part of the supervision of the technician. [T. 59, 61] In Dr. Morgan's review of the transcript of the Respondent's investigative interview, she stated that it does not appear that the Respondent did either. (State's Ex. 10) [T. 57-58, 60]

With respect to the adequacy of the Respondent's training and experience in TPN production, Dr. Morgan testified that the Respondent did not receive adequate training with respect to compounding pediatric TPN's, which were compounded manually due to the small amounts of electrolytes used in the admixture. In addition, Dr. Morgan testified

² Because the amount of electrolytes needed for a pediatric TPN is less than what is required to be able to use automation, which is weight-driven, Pharmaquip instituted a process in which an unlicensed technician manually drew up the individual electrolyte quantities in syringes to later be mixed into the TPN. If more than one TPN bag was needed for an individual patient, the individual would pool the electrolytes, which refers to the practice of drawing up the total amount of individual electrolytes needed at one time and then evenly parsing the individual electrolyte solutions into each TPN bag.

³ ASPEN is an organization of health care professionals representing the fields of medicine, nursing, pharmacy and dietetics. Specific practice guidelines are based on a consensus of ASPEN's National Advisory Group.

that the Respondent did not receive sufficient training in checking pools of electrolytes, nor was the Respondent ever trained in actually compounding a TPN. (State's Ex. 11) [T. 64-67]

Dr. Morgan clarified that the flow chart contained in State's Exhibit 7 was part of the root cause analysis that was performed by JHHCG in investigating the medication error occurring on December 1, 2003. Dr. Morgan testified that the flow chart demonstrates the actual practice at that time of the error, and does not set forth the standard of practice expected by JHHCG in its policies and procedures. [T. 81]

Joseph Parsons, a certified pharmacist technician, testified on behalf of the Respondent.⁴ Mr. Parsons has been a pharmacist technician for approximately 18 years, seven of which he worked at JHCCG. [T. 136] Mr. Parsons testified that he compounded the TPN for Patient A, which subsequently caused the Board's investigation of the Respondent. [T. 138] Mr. Parsons initially testified that he could not recall who the production pharmacist was on December 1, 2003, because "they've had different pharmacists in and out of the pharmacy." [T. 138] Mr. Parsons later recalled the Respondent being "there" on December 1, 2003. Mr. Parsons also testified that the Respondent checked the electrolyte pool for Patient A's TPN although he could not identify the Respondent's initials in the "checked by" box on the compounding sheet. [T. 144, 152]

Mr. Parsons testified that the Respondent pushed the unused syringes to the side, but did not discard them. Mr. Parsons also testified that he would program the pump

⁴ The Board does not license or certify pharmacy technicians. However a technician may choose to become "certified" by a private certifying body. In Mr. Parsons' case, he was certified by the National Pharmacy Technician Certification Board ("PTCB"). [T. 135] The PTCB certification process consists of a written examination regarding pharmacy practice in general, and not specifically focused on IV pharmacy practice.

volume himself based on the calculations of another technician, but the Respondent did not check the pump volume. Mr. Parsons stated that he would actually start compounding the base solutions in the pump before the pharmacist entered the clean room to check the TPN. [T. 141] Mr. Parsons stated that the pharmacists at Pharmaquip generally did not discard the unused syringes or check the pump volumes. [T. 146-47]

Lopa Patel, a licensed pharmacist, testified on behalf of the Respondent. Ms. Patel is the owner of Healthcare Resources of America (“HCRA”) which is a temporary staffing agency for pharmacists to be placed in primarily hospital and home infusion pharmacies. [T. 169] Ms. Patel employed and provided training to the Respondent on IV production. Ms. Patel testified that she believed that TPN production pharmacists only require the ability to do a final check of the ingredients and do not need to have actual knowledge of how to compound a TPN. Thus, Ms. Patel testified that she did not train the Respondent on how to make a TPN. [T. 221] In addition, Ms. Patel stated that she herself did not know how to make a TPN because “there’s always technicians that would be making it.” [T. 217] Ms. Patel testified that she provided on-site general IV training in home infusion and hospital settings. Ms. Patel testified that most of the Respondent’s experiential training focused on checking automated IV’s, and not TPN’s that utilized the manual electrolyte pooling method. [T. 200]

Ms. Patel further testified that she was not aware of JHHCG’s requirement that production pharmacists have 2 years of experience and that the Respondent was not privy to the contract terms between HCRA and JHHCG. [T. 189] Ms. Patel does not follow ASPEN or its standards. [T. 216] Ms. Patel testified that the Respondent did not advise her about his January 16, 2002, Consent Order, either verbally or in writing, at the time of

his hiring. Ms. Patel stated that the Respondent advised her of his probationary status after the error was discovered with respect to Patient A's TPN. [T. 215]

Shirish Patel, licensed pharmacist, testified on behalf of the Respondent. Mr. Patel, no relation to Lopa Patel, is the pharmacy manager at UMMS Shock Trauma. Mr. Patel was the pharmacy manager at Shock Trauma in 2002 when the Respondent served as a temporary pharmacist for UMMS. Mr. Patel recalls that he "may have supervised his [the Respondent's] work on one or two occasions" although he does not recall what areas of pharmacy practice he supervised. [T. 230-31]

Brenda Gray, a licensed pharmacist, testified on behalf of the Respondent. Ms. Gray testified that she was placed at Pharmaquip through HCRA from approximately 2000-2003. Ms. Gray testified that when checking the pool of electrolytes done by a technician, she would usually push the unused syringes to the side [T. 247], although she stated that in some cases she may throw them away herself. [T. 249] Ms. Gray further testified that different safeguards need to be in place for pediatric versus adult TPN production because a slight variation could be very significant to a small child. [T. 254]

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at the evidentiary hearing, the Board finds that the following facts are true:

1. The Respondent was at all relevant times licensed to practice pharmacy in the State of Maryland.
2. On January 16, 2002, the Respondent entered into a Consent Order as part of a settlement of allegations that the Respondent filled approximately 77

prescriptions for 21 different patients for which there was not an authorized prescriber, and for which he falsified records by making up the name of the prescriber and a fictitious DEA number. (State's Ex. 19)

3. The January 16, 2002, Consent Order sanctioned the Respondent with a 30-day stayed suspension and indefinite probation, with certain probationary terms. One of the terms of probation required the Respondent to provide written notice to his employer of the existence of the Consent Order. (State's Ex. 19)
4. On July 23, 2003, the Respondent's probation was terminated by the Board. (State's Ex. 11)
5. On June 5, 2002, the Respondent was employed on a part-time basis by Health Care Resources of America, Inc. ("HCRA"). HCRA provides temporary pharmacy staff to various health care facilities, but primarily to hospital and home infusion pharmacies.
6. The HCRA Employment Agreement, which the Respondent signed, states in pertinent part:

In (*sic*) any disciplinary action has occurred that affects your ability to perform as a clinician in good standing or if you have been convicted of a drug-related felony, we must be immediately informed by both telephone and in writing. (State's Ex. 11)
7. The Respondent was on probationary status at the time he was employed by HCRA.
8. The Respondent failed to provide HCRA with a copy of his Consent Order or verbally inform HCRA of his Consent Order notwithstanding the condition in his Consent Order that required him to do so. [T. 215].

9. On December 1, 2003, the Respondent was contracted by HCRA to work as a production pharmacist at Pharmaquip, a division of the Johns Hopkins Health Care Group (“JHHCG”). (Respondent’s Ex. 1) Pharmaquip provides home infusion pharmacy services to patients receiving care by JHHCG, including Pediatrics at Home.
10. The JHHCG job description for a staff infusion pharmacist requires two (2) years experience in hospital/home care pharmacy or equivalent experience. (State’s Ex. 13) The Respondent and HCRA were never informed of this requirement. [T. 189]
11. The Respondent’s professional experience is primarily in the retail pharmacy setting. (State’s Ex. 10, p. 10)
12. Lopa Patel, of HCRA, provided the Respondent with training in checking IV’s. Ms. Patel provided Respondent’s training through on-site experience and reading materials. (Respondent’s Ex. 1-7) [T. 181-84].
13. Ms. Patel did not train the Respondent in how to compound a TPN, although the Respondent was responsible for supervising a technician who compounded TPN’s. (State’s Ex. 11); [T. 221] Ms. Patel, herself, had never made a TPN. [T. 217]
14. The bulk of the Respondent’s training was in checking IV solutions made through automation. The Respondent had minimal training and experience with the manual electrolyte pooling method used in TPN production. (Respondent’s Ex. 1) [T. 200]

15. On December 1, 2003, Pharmaquip did not label syringes containing drawn electrolytes to be injected into the TPN pool. [T. 201]
16. On December 1, 2003, pharmacists at Pharmaquip did not stay in the clean room while a TPN was being compounded. Pharmacists were called in by a technician to do a “check” of the electrolyte pool and would thereafter leave the room again. [T. 159, 246]
17. On December 1, 2003, as the production pharmacist at JHHCG, the Respondent verified the TPN for Patient A, a pediatric patient.⁵ (State’s Ex. 5)
18. In supervising and checking the production of TPN’s, the standard of care requires that a pharmacist discard unused syringes after checking the pool of electrolytes set out by the technician. (State’s Exs. 14, 15) [T. 59]
19. The Respondent failed to discard unused syringes in checking the pool of electrolytes for Patient A’s TPN. (State’s Ex. 10)
20. JHHCG policies and procedures require that unused syringes be discarded after the pharmacist checks the pool of electrolytes. (State’s Ex. 15)
21. A pharmacist must check the volumes of the compounding pump prior to compounding the base solutions (amino acids, lipids, dextrose) and adding them to the pool. (State’s Ex. 15)
22. The Respondent failed to check the volumes programmed into the compounding pump in preparing the TPN for Patient A. (State’s Ex. 10)
23. The TPN prepared by the Respondent for Patient A contained five (5) times the amount of potassium ordered. JHHCG performed a root cause analysis

⁵ The identity of Patient A is confidential but was disclosed to the Respondent during the Board’s investigation and discovery process.

and could not replicate the mixture nor deduce the source of the error. (State's Ex. 7)

OPINION

It is undisputed that the Respondent failed to adhere to the terms of his January 2002 Consent Order in not disclosing the Consent Order to his employer. Although the Respondent's counsel submits that this was an unintentional oversight on the Respondent's part, the Board finds difficulty in giving the Respondent any credence on this issue considering the nature of the violations that lead to the Consent Order. In addition, Lopa Patel, who appeared on behalf of the Respondent, testified that the Respondent did not advise her, even verbally, of the existence of his Consent Order. [T. 215] Ms. Patel gave testimony to the same effect during her investigative interview. (State's Ex. 9)

With respect to the Respondent's competency to practice as an IV pharmacist, it is arguable that the Respondent received sufficient training to practice in certain IV settings; that is, the Respondent is probably competent to practice as an IV production pharmacist in pharmacies using total automation. The Respondent practiced under supervision for approximately 90-100 hours in a hospital pharmacy using automated procedures. (Respondent's Ex. 1)

However, at Pharmaquip, the TPN production process was a distinctively different practice that required sound knowledge of manual compounding and pooling of electrolytes. The State's expert testified that different competencies are required for manual versus automated compounding, and that a pharmacist who practiced in a hospital

IV pharmacy was not necessarily competent to practice in a home infusion setting such as JHHCG. [T. 67] Home infusion sites require experience with the pooling process, which is not generally practiced in hospital settings. The Respondent had merely 34 hours of experience in checking manually compounded TPN's using the electrolyte pooling method and was never trained how to actually mix a TPN. Indeed, the Respondent conceded that his professional experience is primarily in retail pharmacy. This is not adequate training to be considered competent in TPN production in a home infusion pharmacy that manually pools electrolytes. TPN's are frequently administered to pediatric patients in compromised medical conditions, and thus, it is imperative that any production pharmacist assuming the supervisory role in the TPN process have independent knowledge and demonstrated experience in manual IV compounding and electrolyte pooling.

The Respondent's assertion that merely having a pharmacist's license allows a pharmacist to practice any pharmacy specialty, regardless of a lack of training or experience, is wholly rejected. The Board's regulations specifically require that a pharmacist practice only within the pharmacist's boundaries of training and education. (State's Ex. 16)

The standard of care for the TPN compounding process was set forth by Dr. Morgan. Dr. Morgan relied on her experience in producing and monitoring TPN's as well as the standards set by ASPEN. Dr. Morgan testified that a TPN production pharmacist in a home infusion pharmacy must discard unused syringes when checking the pool of electrolytes drawn up by the technician. Dr. Morgan stated that this is the only means by which a pharmacist can insure that the technician will mix the TPN using

the correct syringes with the correct amounts of electrolytes. [T. 59-60] To do otherwise would create a risk that the technician could select the incorrect syringe containing the excess electrolytes. Since the syringes were not labeled in this process, this would be a very real possibility. In fact, ASPEN standards state that the manual method “should be carefully undertaken to avoid potentially lethal incompatibilities.” (State’s Ex. 14)

ASPEN standards state that a pharmacist is ultimately responsible for the end product.⁶ While this standard is similarly applied in a retail pharmacy setting, it is of particular importance in the IV pharmacy setting. In IV pharmacies, unlicensed technicians execute a large part of the compounding process. And because it is virtually impossible to visually detect an error in an IV product, including a TPN, a pharmacist must be extra vigilant in his supervision of unlicensed technicians who are participating in the compounding process. It is simply not enough to rely on an experienced technician. The Board does not license technicians, and therefore there are no minimal qualifications to become a technician. The health and welfare of the public requires that a licensed pharmacist, not an unlicensed technician, be responsible for insuring, to the best of the pharmacist’s ability, that every step of the compounding process is accurate. It is only in verifying each step of the process may a pharmacist be able to verify the accuracy of the final product.

The standard of care with respect to discarding unused syringes is further reflected in JHHCG’s policy and procedure manual for infusion and long term care. The manual, effective March 1, 2000, states that once the pharmacist has checked the pool of electrolytes, syringes or vials to be discarded are removed from the hood. (State’s Ex. 15)

⁶ This standard is derived from the 1995 United States Pharmacopeial Convention on Sterile Drug Products for Home Use.

The Respondent was interviewed in detail during the Board's investigation into this matter and never mentioned that he discarded unused syringes after checking the electrolyte pool. In fact, notwithstanding the standard of care or JHHCG's own policy, Ms. Gray testified that, in general, pharmacists at Pharmaquip did not discard unused syringes but rather "pushed them to the side" although she clarified that she had discarded unused syringes in some cases. It is clear from the testimony, however, that after checking the electrolyte pool, production pharmacists would physically leave the clean room, thereby leaving the technician unsupervised while pooling the electrolytes. Therefore, the production pharmacist never witnessed the technician actually discarding the unused syringes. It is impossible for a pharmacist to verify the accuracy of a final TPN product in good faith without discarding the unused syringes or at least witnessing the technician discard them. While it was asserted that a pharmacist has to "trust her staff", the Board believes that public protection requires more. [T. 249-50]

With respect to the Board's allegation that the Respondent failed to check the compounding pump volume, Dr. Morgan stated that JHHCG's policy required that the production pharmacist check the pump volumes prior to the technician compounding the base solutions. (State's Ex. 15) This standard was echoed by the Respondent's own witnesses, Ms. Patel and Ms. Gray. [T. 184, 245] During the Respondent's investigative interview, he described the TPN process several times and indicated all of his supervisory responsibilities in verifying the accuracy of the TPN. The Respondent never mentioned checking the compounding pump volume. (State's Ex. 10) Although the Respondent's counsel submitted to the Board that the Respondent did, in fact, check the pump volume, the Respondent never testified to this effect.

Mr. Parsons, the technician, gave conflicting testimony on this issue stating that production pharmacists “never” checked the compounding pump, and then later testifying that the Respondent checked the pump volume for Patient A’s TPN. [T. 145-148] In addition, Mr. Parsons gave inconsistent testimony about his recollections of the Respondent as the production pharmacist on December 1, 2003. The Board does not find Mr. Parsons’ testimony credible with respect to his interactions with the Respondent on December 1, 2003.

CONCLUSION

Based upon the foregoing summary of evidence, findings of fact, and opinion, the Board concludes that the Respondent violated the Consent Order, dated January 16, 2002, Md. Code Ann., Health Occ. §12-313(24), and Code Md. Regs. tit. 10, § 34.10.01B(1).

SANCTIONS

It is undisputed that the Respondent violated the terms of his January 16, 2002 Consent Order in failing to notify his employer, either orally or in writing, regarding the existence of the Consent Order. The January 15, 2002 Consent Order demonstrates that the Respondent has a history of professional misconduct before the Board and apparently did not take seriously the terms under which the Board settled the prior offense. In agreeing to the Consent Order, the Respondent acknowledged that the Board could further discipline him in the event that he violated the terms of the Order.

In addition, the Respondent, who is primarily trained as a retail pharmacist, was not competent to check manually compounded IV’s as a production pharmacist.

Although the Respondent received sufficient training with automated IV products, a higher level of competency needs to be established before supervising the production of manually compounded TPN's, or any other manually compounded IV product, particularly in a home infusion pharmacy. In addition, pediatric TPN production, as with the dispensing of any pediatric medication, requires a higher level of vigilance because of the increased risk that even the slightest error may have serious medical consequences.

The Respondent failed to abide by the standard of care and JHHCG's policy regarding discarding unused syringes. This substandard practice, however, appears to have been commonplace at Pharmaquip at the time of the Board's investigation into this matter. Since the Respondent received all of his IV and TPN training through HCRA, which trains its pharmacists pursuant to the practice of the pharmacy to which they are assigned, the Board finds it difficult to sanction the Respondent for merely following the deficient practice of other, much more experienced, pharmacists. While ignorance of the appropriate standards does not excuse the Respondent, the Board will not attribute its sanction to this violation.

As to the Respondent's failure to check the compounding pump volumes, the Board finds that this demonstrates another deficiency in the Respondent's practice. Without first checking pump volumes, it is impossible to insure the technician has compounded the correct amounts of base solutions for the TPN. Because the technicians not only performed mechanical functions but also made calculations for total volumes of base additives [T. 89], it is imperative that a pharmacist check the calculations and the pump to insure that the correct volumes are programmed. A pharmacist may not otherwise verify the accuracy of the final TPN product.

In order to impress upon the Respondent the seriousness of the Respondent's failure to comply with the Consent Order and his violation of the standard of care, as well as to deter future violations of the Board's orders and the Maryland Pharmacy Act, the Board will issue six-month suspension with all but three (3) months stayed. Upon the lifting of the suspension, the Respondent shall be placed on probation for two (2) years during which the Respondent shall provide his employer with a copy of this Final Order. In addition, the Respondent shall not practice manual IV production unless and until he acquires 1,000 hours of supervised experience in manual IV production under the supervision of a board-approved supervisor. The Respondent shall also be fined \$3,000.00.

ORDER

Based on the foregoing Findings of Fact, Opinion, and Conclusion, by a unanimous decision of a quorum of the Board it is hereby:

ORDERED that the Respondent be **SUSPENDED** for six (6) months, with three (3) months **STAYED**. The active suspension period to begin on January 1, 2006; and be it further,

ORDERED that upon termination of the suspension, the Respondent shall be placed on **PROBATION** with the following terms and conditions:

1. The Respondent shall provide a copy of this Final Order to his pharmacy employer(s) prior to commencing employment and shall insure that the attached verification form is completed by the employer and returned to the Board prior to commencing employment; and be it further,

2. The Respondent shall not practice manual IV production unless and until the Respondent acquires 1,000 hours of supervised experience in manual IV production under the supervision of a Board-approved supervisor. The Board-approved supervisor shall submit a report, satisfactory to the Board, detailing the Respondent's experience and competencies; and be it further,

ORDERED that the Respondent may petition the Board for release from probation no earlier than two (2) years from the date probation commences. The Board, in its discretion, shall release the Respondent from probation provided that the Respondent has fully complied with the probationary conditions above; and be it further,

ORDERED that the Respondent shall pay a fine of \$3,000, payable within six (6) months of the date of this Order; and be it further,

ORDERED that should the Respondent violate any of the terms and/or conditions of this Order, the Board, in its discretion, after notice and an opportunity for a hearing, may impose any additional sanctions, including revocation and/or a monetary penalty authorized under the Maryland Pharmacy Act; and be it further,

ORDERED that on or before January 1, 2006, the Respondent shall submit his wall certificate, wallet license, and renewal certificate to practice pharmacy to the Board of Pharmacy to be held by the Board during the active suspension period; and be it further,

ORDERED that this is a final order of the State Board of Pharmacy and as such is a **PUBLIC DOCUMENT** pursuant to Md. Code Ann., State Gov't Art., §§10-611, *et seq.*

11/15/05
Date



John Balch, P.D.
President, Board of Pharmacy

NOTICE OF RIGHT TO APPEAL

Pursuant to Md. Code Ann., Health Occ. Art., §12-316, you have the right to take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your receipt of this Final Decision and Order and shall be made as provided for judicial review of a final decision in the Maryland Administrative Act, Md. Code Ann., State Gov't Art., §§10-201, *et seq.*, and Title 7, Chapter 200 of the Maryland Rules.

PHARMACY EMPLOYER VERIFICATION FORM

[TO BE COMPLETED BY PHARMACY EMPLOYER]

I hereby acknowledge that I am in receipt of a copy of the Final Decision and Order, dated _____, pertaining to the pharmacy license of LAWRENCE EKANEY.

I further acknowledge that I have read and understand the terms and restrictions placed upon Mr. Ekaney's ability to practice pharmacy.

Signature

Printed Name

Title

Name of Pharmacy/Company