Mrs. Donna S. Thompson, RN, BSN
Churchville, Maryland 21028

Maryland General Assembly Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

RE: UNFAV Bill SB 18

Dear Chair Beidle, Vice Chair Klausmeier, and Members of the Finance Committee:

My name is Donna S. Thompson. I have been a nurse for 26 years, many of which were spent in a critical care setting. I am writing in opposition to Bill SB18.

Changes in nursing are making it more difficult to remain at the bedside. Due to increased nurse-patient ratios as well as an overwhelming amount of required documentation, many nurses and I have verbalized safety concerns. These concerns include patient safety, the inability to answer call lights promptly, ***and safe medication administration***. Errors in healthcare not only endanger the lives of the patients but also subject healthcare workers to criminal and civil liability and losing one's license.

Similar concerns are now being voiced in the pharmacy industry. The demands placed on pharmacists are becoming known among many of us in the healthcare industry. It only stands to reason, that the more one is stretched when trying to perform their duties, the more likely one is to make a mistake.

While working at an in-patient facility for children with behavioral and psychiatric problems, one child was ordered **hydroxyzine**. This medication is **given for its calming effect**. Inside the box was a month's supply of individually wrapped pills. I noticed the medication in the box was **hydralazine, a medication used for treating high blood pressure**. The box was labeled correctly; the contents were wrong.

While working on the Oncology Floor, one of my co-workers was preparing to administer chemotherapy to a cancer patient. Before its administration, the patient was to be premedicated with **Decadron**. The generic name for that is **dexamethasone**. In the hospital setting, there are many safety checks in place. The medication is withdrawn from the Diebold or Pyxis dispensing machine. These medications are entered into the patient's profile and dispensed accordingly. However, the premedication this patient was to receive came in a premixed IV bag from the pharmacy.

The patient's wristband and the bag containing the IV fluid were scanned. Shortly after the drip was started, the patient was noted to be more lethargic and was becoming difficult to arouse. When the patient became unresponsive the nurse immediately stopped the IV drip and called a Code Blue.

The results of the investigation revealed a major pharmacy error. The pharmacy tech withdrew **dexmedetomidine, also known as Precedex, from the vial and injected it into the IV solution**. This **medication is used for conscious sedation**. Fortunately, the patient survived due to the exceptional competence of the seasoned nurse at the bedside. A flaw in the system revealed the pharmacy tech was not required to scan the medication before drawing it up and adding it to the IV fluid bag. Other sound-alike medications such as Zosyn and Zofran are other examples of how mistakes can be made.

Because of my experience, I routinely check the contents of pill bottles we receive from retail pharmacies. On one occasion I found my mother's blood pressure medication bottle contained the wrong medication. This was reported to the pharmacy.

There is a distinct parallel between these two professions, nursing, and pharmacy. We are all human, and no one is immune from making a mistake. The common thread is increased demands and responsibilities, being pulled in too many directions, and the inability to focus on a task without being constantly interrupted.

One retail pharmacist recently shared his thoughts. "I am leaving my retail pharmacy job because of the ridiculous workload. We're expected to work 12-hour shifts, fill thousands of prescriptions, answer phones, test for Covid, and give immunizations to adults. Now they're talking about having us work in a clinic doing vitals and helping with patient care. That was the last straw for me." We must do all of this with extremely short staffing. He went on to say, "Retail pharmacy is on the brink of collapse."

One of the medical assistants in my pediatrician's office drew up the wrong vaccine and administered it to a child. We all know errors occur. I cannot imagine how adding more responsibilities, i.e., administering immunizations to children to already short-staffed pharmacy personnel is safe.

I encourage everyone to verify the contents of any pill bottles they receive from retail pharmacies. This can be done online using a pill identifier application. Healthcare dollars are being stretched. One cost-saving strategy is to put more responsibilities on staff, stretching them too thin. **The dispensing of medication is something that requires concentration**. **I believe this is a public health and patient safety issue. The passage of this bill is a recipe with disastrous consequences**.

Thank you for your time and attention to this matter.

Sincerely,

Donna S. Thompson, RN, BSN
Churchville, Maryland