**Error Prevention and Resolution Process**

**Section:** Pharmacy Operations

**Compliance:** URAC Specialty Pharmacy 2.1

**URAC Standards:** PHARM-OP 2, 14

**ACHC Standards:** DRX11-L

**Policy ID:** 7.9

**Approved by:**

**POLICY**

Pharmacy dispensing errors may be serious and have significant adverse effects on treatment outcomes and overall health. In rare cases, some pharmacies have even had documented cases of death occurring as a result of their errors. **[PHARM-OP 14 (a)]**

**PROCEDURE**

In order to minimize the risk of dispensing errors and address the rare occurrence of an actual error, <insert practice name> employees must adhere to the following procedures. **[PHARM-OP 2 (c)]**

1. Patient Identification **[PHARM-OP 2(b)] [PHARM-OP 14 (a-i, ii)]**

When speaking with patients, <insert practice name> personnel will attempt to use two means by which to verify the patient's identity.

* The first will always be patient name, calling the patient by name to verify identify.
* The second may be some other demographic or prescription-related information.
* During the identification process, do not “give” information to the person in the conversation. The ensure compliance with privacy guidelines, ask for another piece of identifying information, such as:
* “Mrs. Smith, can you please give me your current shipping address or date of birth for proper identification?”
* “Mrs. Smith, to follow verification procedures, please provide me with the name of the last medication ordered.”

2. New Prescriptions **[PHARM-OP 14 (a-i, ii)]**

New prescription orders may be taken by a pharmacist, pharmacy student, or designated pharmacy technician. Verbal orders will be immediately reduced to writing and reviewed for accuracy before they are entered into pharmacy software. Written or faxed orders must be reviewed by a pharmacist before they are entered into pharmacy software. The pharmacist and or technician entering the order will ensure that their initials are entered on the electronic record. The pharmacist or technician dispensing the drug will ensure that their initials are entered on the written order form. A pharmacist will review all of this information to ensure its accuracy and place their initials on the written order form to indicate that they have done so.

Should the pharmacist detect an error, the prescription process will stop. The order will be immediately reprocessed and the pharmacist will assign the highest level of priority to ensuring that the order is once again reviewed for accuracy.

3. Refill Prescriptions **[PHARM-OP 14 (a-i, ii)]**

The pharmacist and or technician entering the order will ensure that their initials are entered on the electronic record. A pharmacist will review all of this information to ensure its accuracy. Signature of daily prescription record by pharmacist and technician will indicate their role in filling prescriptions that day.

Should the pharmacist detect an error, the prescription process will stop. The order will be immediately reprocessed and the pharmacist will assign the highest level of priority to ensuring that the order is once again reviewed for accuracy.

4. Reported and/or Detected Errors **[PHARM-OP 14 (b-i, ii, iii)]**

Should a patient report an error or an employee detect an error, this issue will receive the highest priority level until resolved. The pharmacist will immediately take steps to determine why and how this error occurred and whether or not other errors may have resulted as well. Errors that are essentially clerical (such as number of tablets dispensed, etc.) may be resolved quickly and usually without further incident. Errors in which the wrong drug or dosage have been dispensed should be given the highest level of priority and investigated by the pharmacist. Employees should be notified of their error and if necessary, the event should be documented in their personnel record. The pharmacist must immediately evaluate whether or not the patient has been placed at risk and is responsible for mitigating, addressing or rectifying any damages that may have occurred. This may include notifying the prescriber of the event and/or recommending that the patient seek medical attention.

<insert practice name> Pharmacy Manager is made aware of dispensing errors immediately upon detection and will work with pharmacist and technicians to revise practices that might allow further errors to occur.

Summary report of errors and analysis with appropriate follow-up (corrective action if indicated) will be submitted to the Quality Management Committee on a quarterly basis **[PHARM-OP 14 (c)]**

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