**Prescription Filling Process**

**Section:** Pharmacy Operations

**Compliance:** URAC Specialty Pharmacy 2.1

**URAC Standards:** PHARM-OP 2, 4, 14

**ACHC Standard:** DRX11-F

**Policy ID:** 7.20

**Approved by:**

**POLICY**

Quality Assurance in pharmacy services is essential. The pharmacist is often viewed as the “safety net” in the healthcare delivery system, responsible for ensuring that the right patient receives the right drug in the right dose at the right time. While <insert practice name> staff makes every effort to prevent dispensing errors, <insert practice name> recognizes that some small number of such errors may occur from time to time. In order to minimize the risk of orders each new order is viewed by “two sets of eyes” (a pharmacy technician and a pharmacist). Orders completed and ready for shipping are reviewed by a pharmacist and a pharmacy technician. This helps to ensure that orders are complete and accurate. Pharmacy dispensing errors may be serious and have significant adverse effects on treatment outcomes and overall health. **[PHARM-OP 2 (c)] [PHARM-OP 4 (a)] [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:

1. **New Prescriptions [PHARM-OP 2 (a)] [PHARM-OP 4 (a)] [PHARM-OP 14 (a-i, a-ii)]**

According to State law, new prescription orders must be taken by a pharmacist or designated pharmacy technician. Verbal orders are immediately reduced to writing and reviewed for accuracy before being entered into pharmacy operating system software. Written or faxed orders are reviewed before being entered into pharmacy operating system. New oral chemotherapy orders will be matched against the treatment tab in the medical office computer system for additional verification. 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 product verification barcode scan is done to ensure that the product entered on the prescription order matches the product pulled for dispensing. 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 filling 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.

1. **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 product verification barcode scan is done to ensure that the product entered on the prescription order matches the product pulled for dispensing. 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 filling 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.

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

Should a patient report a potential error or an employee detect a potential error, the potential error will receive the highest priority until resolved. The pharmacist will immediately take steps to determine: if an error occurred, why and how it occurred, and whether or not other errors occurred as a consequence. Errors that are essentially clerical (such as number of tablets dispensed, etc.) may be resolved quickly and usually without further incident. Errors where the wrong drug or dosage was dispensed should be given the highest level of priority and investigated by the pharmacist. Employees are counseled about the error and if necessary, the event documented in their personnel record. The pharmacist must immediately evaluate if 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 to prevent future errors from occurring.

Summary report of any errors with analysis and 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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