

# The pharmacy technician's role in medication error prevention

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*Error Alert*



Pharmacy technicians play a major role in modern pharmacy practice. The pharmacist relies on the technician to provide an extra layer of safety. It is important for technicians to follow system-based processes and inform the pharmacist whenever they have questions or concerns or believe that processes do not work or are unmanageable.

## Key safety checks

**Prescription drop-off.** If technicians are stationed at prescription drop-off, consider creating a checklist of critical patient information the technician should obtain from each patient. The date of birth should be written on every hard copy prescription so the pharmacist

has a second identifier readily available during verification. Allergy and medical condition (e.g., pregnancy) information should be updated in the patient's profile at each patient encounter and communicated to the verification pharmacist. Knowing a person's medical conditions can help the pharmacist determine if prescriptions are written incorrectly or for the wrong drug.

**Order entry.** Medication safety is enhanced when technicians know medical/pharmacy terminology and drug names, especially if they enter prescriptions. New drugs are a risk because technicians, and pharmacists, may not be aware of them early on and may instead see and select something else.

Pharmacists and technicians should work together to determine the best method of distributing information on availability of new drugs. It is important that the technician understands the safety features of the computer system and does not create workarounds to improve efficiency at the risk of decreasing accuracy and safety. Drug alerts can be numerous, and the technician may be inclined to override an alert and not "bother" the pharmacist. All alerts that involve medication interactions, allergies, duplications, and other clinical warnings should be relayed to the pharmacist. Pharmacists should inform corporate or commercial software designers of unnecessary or superfluous alerts and discuss the possibility of turning off those alerts.

**Filling/dispensing.** Many mix-ups during this production phase occur due to incorrectly reading a label. The problem is aggravated by confirmation bias, whereby one selects what is familiar or expected on the label rather than what is actually there.

For example, a technician may choose a medication container based on a mental picture of the item, whether it is a characteristic of the drug label; the shape, size, or color of the container; or the location of the item on a shelf. Consequently, the technician may pick the wrong product. Physically separating drugs with lookalike labels and packaging can help reduce these types of errors. The use of bar code technology, viewing scanned images of products and prescriptions by pharmacists, and other technology for verification in the production process will help catch errors in this step.

**Point of sale.** Errors also may occur with a correctly filled prescription if it is dispensed to a patient for whom it was not intended. This error can be avoided by consistent use of a second identifier at the point of sale. The person picking up the prescription should be asked to provide the patient's address or, in the case of similar names, the date of birth, and check this against the information on the prescription receipt and vial. Reviewing each prescription medication with the patient or caregiver at the point of sale provides the best final check.

Implement a process for technicians to refer dispensing of high-alert medications to pharmacists at the point of sale. Use notations on bags for patients that may be new, have had major changes in medications or dosages, and other established internal protocols to direct technicians to refer the patient to the pharmacist for counseling.

## Stay informed

Internal errors should be discussed among pharmacists, technicians, and clerks. To foster proactive learning, it is important to share errors occurring at other pharmacies. This includes errors and prevention strategies reported nationally, such as those published in the ISMP Medication Safety Alert! Community/Ambulatory Care Edition.

**Institute for Safe Medication Practices**, Horsham, PA

Have you experienced a medication error or close call? Report such incidents in confidence to ISMP's National Medication Errors Reporting Program (MERP) at [www.ismp.org](http://www.ismp.org), [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org), or 800-324-5723 to activate an alert system that reaches manufacturers, the medical community, and FDA. Your information may also be published anonymously to alert your professional colleagues.

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