Tech-Check-Tech UnityPoint Health Finley Hospital Pharmacy

Quarterly Update- June 2017

The Iowa Board of Pharmacy approved our Tech-Check-Tech program March 8th 2017. After the approval, our first step was training of our staff. Our pharmacy department has eight pharmacists with one, Greg Brosius, being Director of Pharmacy and the other seven being staff pharmacists. The remainder of our staff includes eleven Certified Pharmacy Technicians and two trainees

All pharmacists and Certified Pharmacy Technicians were provided reading materials covering Chapter 40 of the Iowa Code and our Policies and Procedures. Certified Pharmacy Technicians were provided additional reading material to cover preventing medication errors, look alike/sound alike medications, pharmacy calculations and dosage formulations. After Certified Pharmacy Technicians have the opportunity to study their reading materials, they meet with me for completing what we call Station 1 of our Tech-Check-Tech program. During Station 1 there is an opportunity to ask me any questions they may have about the program and the reading materials. Next, I ask them questions to assess their understanding of the program and reading materials. Finally, I provide an overview of the remainder of the program that must be completed to become a validated Checking Technician for our department.

The next phase of our program is referred to as Station 2 and it involves 50 medications with the Certified Pharmacy Technician being asked to identify if the medications were filled correctly or to identify the error. This Station is designed to simulate the "live" checking environment by having pretend versions of patient labels, cart fill, and Omnicell fill. I have randomly introduced errors in some of the 50 medications in order for Certified Pharmacy Technicians to practice checking in a safe environment whereby the medications involved are for training purposes only and are not for "real" patients.

Station 3 follows next and it provides an opportunity to "shadow" a pharmacist while that pharmacist is checking medications in a "live" environment. Pharmacists share with Certified Pharmacy Technicians their approach to checking and answer any questions.

After completing all three Stations, there is a quiz with a requirement of scoring at least 90% to pass on to the next stage of our program. That next stage is validation and it involves checking 1500 doses with no more than 3 errors. On April 12th 2017 one of our Certified Pharmacy Technicians met all the requirements and became our first Checking Technician. As of this writing, we have six Checking Technicians. Three more Certified Pharmacy Technicians are eligible to complete validation and two Certified Pharmacy Technicians are studying the written materials in order to be ready to begin the Stations and process listed above.

Pharmacists use time saved from the Tech-Check-Tech program in a variety of ways to advance patient care; most notable so far is our Meds to Beds program. This program had its first full week of operation April 2017. By providing medication and pharmacist counseling prior to hospital discharge, there are many benefits to our patients. One such benefit I will point out is that issues with insurance plans/affording medication are addressed prior to discharge. This prevents interruptions in drug therapy when patients transition home. As we continue to validate more of our Certified Pharmacy Technicians to become Checking Technicians, we anticipate

more time saved for pharmacists to advance patient care. We still plan to implement an anticoagulation service as time savings allows.

Continuous quality assurance activities are applied to our department, including the Tech-Check-Tech program. Medication filling and dispensing errors are documented, reviewed and shared with pharmacy staff. As of June 1st 2017 there has only been one error that was identified after dispensing from the pharmacy that was confirmed as being checked by a Checking Technician. Although it was dispensed, it never reached a patient because the pharmacy staff person delivering medications to Omnicell caught the error. The incorrect item was 0.9% Normal Saline 250ml IV bags. It should have been 0.9% Normal Saline 250ml irrigations. The incorrect item was returned to the pharmacy department and the correct item was dispensed. In efforts to avoid an error such as this in the future, I have adjusted two item descriptors in our Omnicell. In fact, as Checking Technicians are checking they inform me as to item descriptors that they find confusing and I have adjusted several item descriptors preemptively to avert problems before they arise. As we look to the future, we have plans to utilize different colored storage bins in our department for different dosage forms of the same drug. For example, enteric coated aspirin would be stored in a different colored bin than chewable aspirin instead of how we currently have both in the same color of bin.

I thank the Iowa Board of Pharmacy for granting us this opportunity to optimize pharmacy operations in ways that will support more pharmacist participation in patient care.

Sincerely, Brenda Foust, RPh