Institute for Safe Medication Practices
200 Lakeside Drive Suite 200, Horsham, PA 19044
www.ismp.org

FOR IMMEDIATE RELEASE
November 7, 2008

CONTACT: Renee Brehio, Media Relations
704-831-8822
rbrehio@ismp.org

ISMP Granted Patient Safety Organization Status

Horsham, Pa.— The Institute for Safe Medication Practices (ISMP) has become one of the first ten Patient Safety Organizations (PSOs) designated by the Secretary of the Department of Health and Human Services (HHS).. The creation of PSOs was initiated by the Patient Safety and Quality Improvement Act of 2005, to identify groups that share the goal of improving the quality of healthcare delivery and can give healthcare providers confidential, expert advice on the analysis of patient safety-related events.

In the past, healthcare providers have sometimes been reluctant to participate in external error reporting programs and quality review activities for fear of legal liability. Since 1975 when its national voluntary error reporting program began, ISMP has never compromised reporter identity. Now, because reporting to a PSO confers both privilege and confidentiality for the information reported, ISMP's PSO status will afford an even higher level of protection when clinicians and organizations submit error data and other patient safety work to the Institute.

Healthcare practitioners should continue to report medication and related device errors to ISMP as they have in the past. In addition, pharmacy and therapeutics, patient safety, and quality committees in hospitals, health systems, community pharmacies, outpatient centers, physician practices, and other healthcare organizations now can work with ISMP under its PSO status to aggregate and analyze their internal information, which will better enable the identification and reduction of the risks associated with medication use in patient care. ISMP also can work with other PSOs to provide expert analysis as part of the services offered to their clients.

-more-

For more than 30 years, ISMP has pursued its mission of ensuring safe medication use by learning from errors shared through a voluntary, confidential national healthcare practitioner error reporting program. Each year, the innovative United States Pharmacopeia (USP)-ISMP Medication Error Reporting Program (MERP) receives hundreds of reports that provide invaluable information about errors, near errors, and hazardous conditions.

ISMP also is contracted for reviewing all medication error reports submitted by healthcare facilities to the Pennsylvania Patient Safety Reporting System, and will be implementing a consumer error reporting program as part of its soon-to-be-launched consumer medication safety website.

The Institute analyzes all error reports it receives through these and other channels and uses the "lessons learned," along with information gathered through hundreds of visits to healthcare organizations across the country, to expand the healthcare community's knowledge of the underlying causes and risks associated with medication errors.

For more information on the PSO designation, visit www.pso.ahrq.gov. For more information on ISMP's services to assist healthcare organizations in preventing errors and reducing risk, visit www.ismp.org/consult.

About ISMP: The Institute for Safe Medication Practices (ISMP) is a 501c(3) nonprofit organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 30 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org.

-end-