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ISMP Launches Consensus-Based Medication Safety Best Practices

Horsham, Pa---Hospitals and health systems that are deciding what to focus their medication safety efforts on during the next year now have new input from the Institute for Safe Medication Practices (ISMP). Certain medication errors that cause harm or are fatal to patients continue to recur despite repeated warnings. ISMP has launched the 2014-15 Targeted Medication Safety Practices for Hospitals to identify, inspire, and mobilize widespread national action to address these recurring problems.

The 2014-15 best practices target a group of six key safety issues and provide realistic, high-leverage strategies for error prevention; they have been reviewed by an external expert advisory panel and approved by ISMP's Board of Trustees. Each best practice is followed by a list of related articles published in the *ISMP Medication Safety Alert!* newsletter for further reference.

ISMP intends these targeted best practices to be a collaborative effort at hospitals. The Institute will conduct baseline and follow-up surveys to determine how the best practices are being incorporated and collect information on barriers to implementation. A free webinar for practitioners also is being planned for January 30, 2014.

ISMP's **2014-2015 Targeted Medication Safety Best Practices for Hospitals** are:

BEST PRACTICE 1:
Dispense vinCRIStine (and other vinca alkaloids) in a minibag of a compatible solution and not in a syringe.

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BEST PRACTICE 2:

a) **Use a weekly dosage regimen default for oral methotrexate. If overrode to daily, require a hard stop verification of an appropriate oncologic indication.**

b) **Provide patient education by a pharmacist for all weekly oral methotrexate discharge orders.**

BEST PRACTICE 3:

Measure and express patient weights in metric units only. Ensure that scales used for weighing patients are set and measure only in metric units.

BEST PRACTICE 4:

Ensure that all oral liquids that are not commercially available as unit dose are dispensed by the pharmacy in an oral syringe.

BEST PRACTICE 5:

Purchase oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale.

BEST PRACTICE 6:

Eliminate glacial acetic acid from all areas of the hospital.

While ISMP's best practices are targeted for hospitals, some may be applicable to other healthcare settings. For a copy of the best practices document, visit: http://www.ismp.org/tools/bestpractices/.

For more information or to register for the free webinar: http://www.proce.com/bestpractices

About ISMP: The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable 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 nearly 40 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. ISMP is a federally certified patient safety organization (PSO), providing healthcare practitioners and organizations with the highest level of legal protection and confidentiality for patient safety data and error reports they submit to the Institute. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org

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