NEWS RELEASE

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Results of Hospital Medication Safety Self Assessment Includes List of National Priorities

Horsham, Pa. –February 5, 2014 – American hospitals continue to make strides in advancing their medication safety practices, but there are still opportunities to improve, according to recently released data from a survey developed by the Institute for Safe Medication Practices (ISMP). "Assessing the State of Medication Practices Using the ISMP Medication Safety Self Assessment® for Hospitals: 2000 and 2011" has been published in the February 2014 issue of *The Joint Commission Journal on Quality and Patient Safety*.

The self assessment is part of a series conducted by ISMP in cooperation with the Health Research & Educational Trust (HRET) and the American Hospital Association (AHA) through a grant by the Commonwealth Fund. Conducted in 2000, 2004, and 2011, the self assessments have allowed U.S. hospitals to gauge their use of practices that most significantly influence medication use and compare their current systems and practices to similar hospitals nationwide. More than 1,300 hospitals participated in 2011.

The largest percentage improvements in hospital medication safety in 2011 were related to ***communication of drug orders***, ***patient education***, and ***quality processes and risk management***.

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Communication of Drug Orders and Drug Order Information

Although this area was one of the lowest-scoring key elements in the 2000 self assessment, it showed the greatest percentage improvement (57.4%) between 2000 and 2011. Substantial increases were observed for implementation of computerized prescriber order entry (CPOE).

Significant improvements also were observed between 2000 and 2011 in:

- Maintaining a list of prohibited error-prone abbreviations (18% to 91%)
- Using and monitoring safe methods of communicating medication orders (18% to 68%)
- Requiring a complete new set of orders upon admission/transfer (27% to 82%)
- Implementing effective process for resolving conflicts about order safety (46% to 79%)
- Not accepting verbal/telephone orders for oral or parenteral chemotherapy (50% to 75%)

Patient Education

This key element showed the second-highest percent improvement between 2000 and 2011. In hospitals participating in 2011, more prescribers (90%) and nurses (96%) were involved in educating patients about their drug therapy than in 2000 (74% and 77%, respectively). Up from 83% in 2000, 95% of the hospitals in 2011 reported that they provide patients with up-to-date written information about medications prescribed to them at discharge. Hospitals also scored high on a new item added to the assessment in 2011—among the 94% of the hospitals using rapid response teams, 83% empowered patients and family members to activate the team if they have unattended medical concerns.

Significant improvements were observed with:

- Providing customized drug administration schedules to patients at high risk for nonadherence with drug therapy on discharge (31% to 73%)
- Educating patients about the importance of proper patient identification (47% to 93%)
- Teaching patients about the potential for errors with drugs that have been known to be problematic (59% to 81%)

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Quality Processes and Risk Management

Taking a large leap up from 2000 to 2011 was the use of bar-coding technology in pharmacies (10% to 53%) and at the point of care (3% to 58%). However, only about half (54%) of respondents in 2011 who used bar-coding technology at the point of care also consistently reviewed metrics from the system.

Significant increases also were observed with:

- Surveying practitioners periodically to assess the organization's culture (9% to 84%)
- Providing leadership and peer support to all staff involved in serious errors (22% to 64%)
- Including safety objectives in hospital's strategic plan (38% to 82%)
- Disclosing actual medication errors to patients or families (55% to 87%)

Other Data Highlights

In 2011, hospitals scored the lowest in areas related to patient information, staff competency and education, and drug information. Forty percent of the hospitals that responded to the 2011 assessment reporting employing a medication safety officer at least 20 hours per week—those hospitals had higher overall scores in all key elements than hospitals without that position.

National Priorities

On the basis of the results of the 2011 assessment, ISMP compiled a list of national priorities that it believes requires public policy directives; local, state, and national initiatives; and collaborative group efforts to inspire nationwide adoption. These priorities, grouped by topic, are in the article and represent high-impact strategies that hospitals in the United States scored as low implementation:

- Improve order entry systems (vendor and user)
- Expand key technologies
- Better manage alert fatigue
- Update/test technology more frequently
- Use technology data more consistently to improve safety
- Improve care of patients receiving opioids

(more)

- Standardize pediatric postoperative solutions
- Use metric system only
- Expand outpatient and inpatient services
- Increase patient education
- Orient staff more thoroughly
- Teach risk identification/prevention strategies
- Encourage greater leader support for safety and error reporting
- Measure medication safety more effectively
- Be more proactive on medication safety

The full results of the 2011 ISMP Medication Safety Self Assessment for Hospitals® have been published in the February 2014 issue of *The Joint Commission Journal on Quality and Patient Safety*; an abstract and access to the article can be found at: http://www.ingentaconnect.com/content/jcaho/jcjqs/2014/00000040/00000002/art00001

The Institute for Safe Medication Practices (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). For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit www.ismp.org

Health Research & Educational Trust (HRET)
Founded in 1944, the Health Research & Educational Trust (HRET) is the not-for-profit research and educational affiliate of the American Hospital Association (AHA). HRET's mission is to transform health care through research and education. HRET's applied research seeks to create new knowledge, tools and assistance in improving the delivery of health care by providers in the communities they serve. For more information about HRET, visit www.hret.org.

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