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Baseline Survey Reports on How Hospitals Are Implementing ISMP Targeted Medication Safety Best Practices

Horsham, Pa---The Institute for Safe Medication Practices (ISMP) launched the **2014-2015 Targeted Medication Safety Best Practices for Hospitals** to identify, inspire, and mobilize widespread national adoption of consensus-based best practices on specific medication safety issues that continue to cause fatal and harmful errors in patients. Results of a recent baseline survey of U.S. hospitals reveals that although many are reporting that they are addressing the best practices, a significant number will need time to fully implement the recommendations.

The survey was conducted in the first quarter of 2014; about half (52%) of respondents work in non-academic, non-government, non-profit hospitals. The rest work in hospitals that are: for-profit (9%); government-owned (9%); academic (20%); and critical access (10%). About two-thirds (69%) of the respondents are pharmacists and a quarter (28%) are nurses.

Following are highlights of findings by best practice:

1.Dispense vinCRIStine (and other vinca alkaloids) in a minibag of compatible solution and not in a syringe. About half (53%) of respondents reported full implementation, and about 10% reported partial implementation. A variety of reasons were cited, most frequently believing that other safeguards were sufficient, including a time out process prior to administration of intrathecal medications, dispensing vinca alkaloids in a large syringe, or taking other steps to differentiate the appearance of intrathecal medications.

2a. Use a weekly dosage regimen default for oral methotrexate. If overridden to daily, require a hard stop verification of an appropriate oncologic indication. About a quarter (28%) of respondents reported full implementation. Most who reported partial implementation (19%) indicated that order entry systems defaulted to a weekly dosage regimen, but did not require a hard stop if the regimen was changed to a daily schedule.

2b. Provide patient education by a pharmacist for all weekly oral methotrexate discharge orders. Provide patients with a drug information leaflet that contains clear instructions about weekly dosing, such as the free ISMP consumer leaflet. Only 11% of respondents reported full implementation of this best practice, and 11% reported partial implementation. A few respondents also reported that educational efforts were inconsistent in their hospitals.

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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 (kg, g). If scales can measure in pounds and kilograms/grams (kg/g), modify the scale to lock out the ability to weigh in pounds. Document weights using metric designations only. Use measured weight, not stated, historical, or estimated weight. One-third (33%) of participants reported full implementation. Respondents reporting partial implementation (36%) most often cited inability to lock out or eliminate measurement and documentation of weights in pounds with scales that measure in both kg/g and pounds, or with electronic prompts that allow entry of either measure. They also cited an over-reliance on stated, estimated, or historical weights.

4. Ensure that all oral liquids that are not commercially available as unit dose products are dispensed by the pharmacy in an oral syringe. Use of an auxiliary label, "For oral use only," is preferred if it does not obstruct critical information. Ensure that oral syringes do not connect to parenteral tubing in the hospital. About half (52%) of survey participants reported full implementation. Respondents who reported partial implementation (34%) still dispense bulk bottles or dosing cups for some medications, such as antibiotics and antacids. Four percent of respondents were actively planning implementation.

5. Purchase and use oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale. Approximately 39% of respondents reported full implementation. Respondents reporting partial implementation (17%) noted that hospitals are exhausting the current supply of dosing devices before distributing the new devices. Nine percent are actively planning implementation.

6. Eliminate glacial acetic acid from all areas of the hospital (laboratory excluded if the glacial acetic acid is purchased directly from an external source). Replace glacial acetic acid with vinegar (5% solution) or commercially available acetic acid 0.25% (for irrigation) or 2% (for otic use). Almost three-quarters (74%) of survey participants have fully implemented this best practice. Respondents who reported partial implementation (8%) felt glacial acetic acid was needed in the pharmacy to compound certain products.

ISMP was pleased to learn that many hospitals have accomplished the **2014-2015 Targeted Medication Safety Best Practices** or have them on their to-do list. However, it was disappointing to uncover the extent to which other respondents have not even partially implemented important practices recommended by ISMP and other safety organizations for years. Some do not intend to pursue the best practices at all, most likely because they fail to perceive the immense risk they are taking by not implementing them. For a copy of an ISMP newsletter article that provides full survey results and additional suggestions for implementation, go to: www.ismp.org/Newsletters/acutecare/showarticle.aspx?id=76.

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