2017

ISMP Medication Safety Self Assessment® for Community/Ambulatory Pharmacy

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

Dear Pharmacist, Pharmacy Technician, Manager, Owner, Executive:

The Institute for Safe Medication Practices (ISMP) is pleased to provide the nation's community pharmacies with a newly updated version of the ISMP Medication Safety Self Assessment® for Community/Ambulatory Pharmacy. This 2017 tool is designed to help organizations assess the safety of current medication practices and proactively identify opportunities for improvement.

In preparation for the release of this assessment tool, we selected and updated many items from the 2001 self assessment and added additional items as well. These changes represent new practices and processes that have evolved over the last 15 years that are known to impact medication safety, including new research findings about error prevention, as well as new technologies not widely adopted in 2001 when the previous self assessment was published. To incorporate these new items into the 2017 assessment, while keeping the assessment a manageable size, we have eliminated several items from the 2001 assessment that the majority of pharmacies previously indicated had been fully implemented either in some or all areas of their organization.

We encourage you to complete this self assessment as part of your ongoing quality improvement activities. Because medication use is a complex, multidisciplinary process, many characteristics of your pharmacy system are best assessed from the perspective of varying practitioners. Therefore, to accurately evaluate your system and maximize the value of the self assessment, we strongly encourage you to follow the process outlined on page 6.

We welcome the opportunity to work with you as you assess medication safety in your organization. While there is still much work to do, we are confident of success as we continue to work together to make America's community pharmacies even safer and more efficient.

Warm regards,

Michael R. Cohen, RPh, MS, ScD (hon.), DPS (hon.), FASHP
President
Institute for Safe Medication Practices

About the Institute for Safe Medication Practices (ISMP)

The Institute for Safe Medication Practices (ISMP) is the nation's only nonprofit, charitable organization devoted entirely to medication error prevention and safe medication use. ISMP is known and respected worldwide as the leading resource for independent and effective medication safety recommendations.

The Institute's recommended strategies for error prevention and risk identification are based on up-to-the minute information gained from analysis of reports to the voluntary ISMP National Medication Errors Reporting Program, onsite visits to individual healthcare organizations, and advice from outside advisory experts.

ISMP's initiatives, which are built upon system-based solutions, include: five medication safety newsletters for healthcare professionals and consumers that reach more than three million total readers; educational programs, including conferences on medication use issues; confidential consultation services to healthcare systems to proactively evaluate medication systems or analyze medication related sentinel events; advocacy for the adoption of safe medication standards by accrediting bodies, manufacturers, policy makers, and regulatory agencies; independent research to identify and describe evidence-based safe medication practices; and a consumer website (www.consumermedsafety.org) that provides patients with access to free medication safety information and alerts.

ISMP works with healthcare practitioners and institutions, regulatory and accrediting agencies, consumers, professional organizations, the pharmaceutical industry, and others to accomplish its mission. It is a federally certified patient safety organization (PSO), providing legal protection and confidentiality for patient safety data and error reports it receives.

As an independent nonprofit organization, ISMP receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its lifesaving work. For more information that will make a difference to patient safety, please visit ISMP online at: www.ismp.org.

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES
www.ismp.org

Acknowledgements

Funding Source

ISMP would like to gratefully acknowledge the Cardinal Health Foundation for its continued support of our efforts to improve medication safety in America's pharmacies.

Advisory Panel

ISMP would like to thank the following members of our volunteer Advisory Panel, who helped inform the content of the 2017 ISMP Medication Safety Self Assessment® for Community/Ambulatory Pharmacy.

Alex J. Adams, PharmD, IOM
Vice President of Pharmacy Programs
National Association of Chain Drug Stores
Arlington, VA

Ronna B. Hauser, PharmD
Vice President of Pharmacy Affairs
National Community Pharmacists Association (NCPA)
Alexandria, VA

Coleen Kayden, RPh
Medication Information Services
Division of Williams Apothecary, Inc.
Lancaster, PA

Winnie Landis, RPh, CDE, FAPhA

Stephanie McAntee, CPhT
Former Wyoming State Board of Pharmacy member
Topeka, KS

Jaime McDermott, RPh, CDE
Manager, Pharmacy Safety & DEA Compliance
The Kroger Company
Cincinnati, OH

Randy P. McDonough, PharmD, MS, CGP, BCPS, FAPhA
Co-Owner and Director of Clinical Services
Towncrest, Towncrest Compounding, and Solon Towncrest Pharmacies
Iowa City, IA

Brandan Mehaffie, RPh
Director Pharmacy Asset Protection
Rite Aid Corporation
Camp Hill, PA

James A. Owen, BS Pharm, PharmD, BCPS
Vice President, Practice and Science Affairs
American Pharmacists Association
Washington, DC

Carmen Petruzzelli, RPh
Director of Pharmacy Services
Ganse Apothecary, Ganse Apothecary LTC
Lancaster, PA

Tasha Polster
Senior Director, Pharmaceutical Integrity and Pharmacovigilance
Walgreens Co.
Deerfield, IL

Michael T. Rupp, PhD, FAPhA
Professor of Pharmacy Administration
Midwestern University - Glendale
Glendale, AZ

Roger G. Watts, MAHRD, BSOE, CPhT
Retired

Timothy Wright, PharmD, BCACP
President & CEO
Wagner Pharmacy Co.
Clinton, IA

ISMP Staff

We would also like to acknowledge the ISMP staff and fellows whose tireless efforts supported the completion of this assessment tool.

ISMP Medication Safety Self Assessment® for Community/Ambulatory Pharmacy

The 2017 ISMP Medication Safety Self Assessment® for Community/Ambulatory Pharmacy is designed to heighten awareness of the distinguishing characteristics of safe pharmacy systems.

The self assessment is divided into ten key elements that most significantly influence safe medication use. Each element is defined by one or more core characteristics of a safe pharmacy system that further define a safe medication use system. Each core characteristic contains individual self-assessment items to help you evaluate your success with achieving each core characteristic.

ISMP is not a regulatory or standards setting organization. As such, the self-assessment characteristics represent ideal practices and are not purported to represent a minimum standard of practice. Some of the self-assessment criteria represent innovative practices and system enhancements that are not widely available in pharmacies today. However, the value of these practices in reducing errors is grounded in expert analysis of medication errors, scientific research, or strong evidence of their ability to reduce errors.

Instructions for Conducting the Self Assessment

1. **Establish a team.** Establish a team of owners/managers, staff pharmacists, pharmacy technicians, and pharmacy students to collaboratively assess your pharmacy system by thoroughly investigating the level of implementation for each self-assessment item.

   Because medication use is a complex, interdisciplinary process, the value and accuracy of the self assessment is reduced if a single person involved in medication use completes the assessment.

   IMPORTANT! The self assessment should be completed in its entirety by staff and managers who work within the pharmacy, not by off-site managers on behalf of the pharmacy.

2. **Read and review the self assessment in its entirety before beginning the assessment process.** The team leader should provide each team member with either a hardcopy or electronic version of the self assessment (including the definitions) and the Frequently Asked Questions (FAQs), which can be accessed at: http://www.ismp.org/selfassessments/Community/2017. Staff should be encouraged to read the assessment prior to the first meeting.

   If a self-assessment item has an FAQ associated with it, "FAQ" will be noted next to the item. Defined terms are designated throughout the text in **BOLD, CAPITAL LETTERS** and can be found on pages 34-35.

3. **Convene the team.** Ensure that each team member can view either a hardcopy or electronic version of the self assessment during the evaluation process. There are two options for completing the assessment.

   - ***Option 1:*** Print a hard copy of the self assessment, fill in your choice (A through E, or Not Applicable) for each self-assessment item, and enter your responses into the online self-assessment form. (See ***Step 5*** for how to access the online form.)
   - ***Option 2:*** Use the online self-assessment form to view at team meetings and enter your choice (A through E, or Not Applicable) for each self-assessment item, while saving your entered information between meetings. (See ***Step 5*** for how to access the online form.)

     NOTE: By entering your pharmacy's responses into the online self-assessment form, you will receive a score for each Key Element and Core Characteristic and for the entire self assessment.

   Teams should be provided with sufficient time to complete the self assessment and be charged with the responsibility to evaluate, accurately and honestly, the current status of practices in your pharmacy.

   Based on participant feedback from our prior self assessments, we anticipate that it may take three team meetings of approximately 1 to 2 hours each to complete this self assessment. The purpose of the initial meeting is to allow discussion of the self-assessment items and identification of items that require some further research or input. The purpose of the subsequent meetings is to allow the team to reconvene to complete the assessment.

4. **Discuss each Core Characteristic and evaluate the pharmacy's current success with implementing the self-assessment items within that Core.** As necessary, investigate and verify the level of implementation with others. When a consensus on the level of implementation for each self-assessment item has been reached, select the appropriate column using a 5-point letter scale with:

   A. There has been no activity to implement this item in the pharmacy for any patient, prescription, drug, or staff.
   B. This item has been discussed for possible implementation in the pharmacy, but is not implemented at this time.
   C. This item has been partially implemented in the pharmacy for some or all patients, prescriptions, drugs, or staff.
   D. This item has been fully implemented in the pharmacy for some patients, prescriptions, drugs, or staff.
   E. This item has been fully implemented in the pharmacy for all patients, prescriptions, drugs, or staff.

For self-assessment items with multiple components, full implementation is evidenced only if all components are present.

A few self-assessment items may require evaluation using only column A (no activity) or column E (fully implemented), as partial implementation is not applicable.

Some of the self-assessment items offer the option of "Not Applicable." For these items, "Not Applicable" can only be selected if your pharmacy meets the listed scoring guideline. For example, if your pharmacy does not provide immunization services, then you can answer "Not Applicable" to item number 17.

Pharmacies may want to consider assigning an individual to record any discussion generated around each self-assessment item and the rationale behind the selected choice. This information, meant for internal use only, can assist the team when reviewing their responses to individual items or reassessing their pharmacy at a later date. This will provide insight into why the choice selected for each self-assessment item had been chosen at that point in time.

5. **Enter your responses in the online self-assessment form.** This step will be done simultaneously with ***Step 4*** if ***Option 2*** is used by the team to complete the assessment. To access the online form, go to: https://surveys.ismp.org/s3/Community-Self-Assessment. ***PLEASE NOTE: ISMP will not be collecting or aggregating data received through the online form.***

   - **If you do NOT enter all of your responses during the same session** and need to return to your entered information at a later time: Immediately prior to closing out of your session, save your entered information by clicking the "Save and continue later" link (located on the red bar at the top of each webpage), entering your email address, and pressing "Save." An email (from SurveyGizmo) will then be sent to the provided email address with a link that can be used to return to your saved information. If you do not receive an email, please check your spam, junk, or clutter email folder or quarantined messages.

     IMPORTANT! Only save your information once per session. This should be done immediately prior to exiting out of the online assessment. Your entered information is only saved when you are prompted to enter your email address and to press "Save."

   - **If you DO enter all of your pharmacy's responses during the same session**, but want the ability to return to your pharmacy's results at a later time: Prior to completing Key Element X (Quality Processes and Risk Management), click on the "Save and continue later" link (located on the red bar at the top of the webpage), enter your email address, and press "Save." An email (from SurveyGizmo) will then be sent to the provided email address with a link that can be used to view your pharmacy's results. If you do not receive an email, please check your spam, junk, or clutter email folder or quarantined messages.

     IMPORTANT! This must occur prior to clicking "Next" on the Key Element Ten (X) webpage.

6. **Obtain your pharmacy's results.** To receive your results, click "Next" on the Key Element Ten (X) webpage if you have finished answering all of the assessment items. You will then be prompted to print two reports. The first report is how your pharmacy answered each self-assessment item. The second report contains your pharmacy's score, the maximum score, and your pharmacy's score as a percentage of the maximum score for each Key Element and Core Characteristic and for the entire self assessment.

   IMPORTANT! If you did not save your pharmacy's assessment by providing an email address as described in ***Step 5***, this will be your last opportunity to print these two reports. If you did save your pharmacy's assessment by providing an email address, you can use the link that was emailed to the provided address at any point to retrieve your pharmacy's reports.

IF YOU HAVE QUESTIONS, please refer to the FAQs available on our website: **http://www.ismp.org/selfassessments/Community/2017**. Contact ISMP at **selfassess@ismp.org** or call **(215) 947-7797** during usual business hours (Eastern Time) if you need additional assistance.

Identifying and Prioritizing Opportunities for Improvement

1. **Identify areas of weakness.** Identify the Key Elements and Core Characteristics with the greatest opportunities for improvement (those with the lowest scores as a percentage of the maximum score), as well as the individual self-assessment items with a response of A-D.

2. **Prioritize your work.** Prioritize the above identified opportunities for improvement.

   - Start with items that you know you can achieve without considerable delay. Including these types of items at the top of your prioritized list can help ensure early success and establish momentum for ongoing improvements.
   - An item that scored C or D suggests that the risk-reduction strategy has been implemented in part with some success or in full in the pharmacy for some patients, prescriptions, drugs, or staff. Building upon these early successes is a natural progression of effort.
   - Do not hesitate to include a resource-intensive strategy high on your priority list. Items that require extensive time and financial outlays to implement also require extensive planning. Making a resource-intensive strategy a priority helps to ensure that the planning work begins immediately, even if implementation is a year or more away.
   - Successful change begins with acquiring staffs' buy-in to the change process. Strategies that incite enthusiasm strengthen the commitment to achieving a shared goal.

3. **Develop an action plan.** Develop your medication safety action plan with the goal of obtaining an E (full implementation) for each of your identified priorities.

4. **Monitor progress.** Monitor your pharmacy's progress with implementing the self-assessment items and continue to work toward the goals that your pharmacy outlined in its action plan. Plan to perform the self assessment again at a later date to track your pharmacy's improvement in medication safety.

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

I. PATIENT INFORMATION

Core Characteristic #1

Essential patient information is obtained, readily available in useful form, and considered when dispensing, administering, and monitoring the effects of medications.

		A	B	C	D	E
1	Patient information (patient's full name [including suffix], address, home telephone number, alternate means of contact [e.g., email address or cell phone number], gender, date of birth, and allergies) is obtained and entered into the pharmacy computer system before dispensing prescriptions, and is updated at each encounter.					
FAQ 2	The pharmacy has implemented policies and procedures and system enhancements to ensure that only one profile per person exists in its system.					
3	The pharmacy assesses and documents patients' preferred language for communication, health literacy, cultural influences relevant to medication therapy, and any hearing and/or visual impairments that may affect compliance with medication therapy.					
4	A current medication list, including prescription and over-the-counter (OTC) medications (with dose, frequency, and route) and immunizations (with vaccination dates), is obtained, entered into the pharmacy computer system, and updated at each encounter.					
5	A list of vitamins, herbal products, dietary supplements, homeopathic medications, and alternative medicines currently used by the patient is obtained, entered into the pharmacy computer system, and updated at each encounter.					
6	Basic information about comorbid and/or chronic conditions (e.g., diabetes, hypertension, renal or liver impairment, pregnancy, lactation) is obtained, entered into the pharmacy computer system, and updated at each encounter.					
7	The pharmacy takes steps to obtain patient weight when dispensing weight-based drugs, such as those used in chemotherapy treatment or pediatrics.					
8	When taking orders over the telephone, the prescriber (or authorized agent) is specifically queried about comorbid conditions, allergies, date of birth, patient weight (if applicable), and indication.					
9	Recent clinical data such as blood glucose levels, liver enzymes, renal function, blood pressure, and cholesterol levels are available to pharmacists to support clinical drug monitoring of patient-specific drug regimens.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

I. PATIENT INFORMATION (continued)

		A	B	C	D	E
10	Pharmacists verify any critical clinical information about the patient that is necessary to confirm the appropriateness of the medication and dose (e.g., allergies and reactions, weight, opioid tolerance, laboratory values, indication for drug).					
11	Prescription orders cannot be entered into the pharmacy computer system until the patient's allergies (or "no known allergies") have been properly entered and coded (patient allergies is a required field).					
12	Allergy information (including reaction information) is clearly visible on pharmacy computer system screens and accessible during order entry.					
13	There is a defined process that specifies how to modify patient allergies and reactions in the pharmacy computer system and who is permitted to make such changes.					
14	The pharmacy system incorporates special prompts for selected **HIGH-ALERT MEDICATIONS** to obtain or verify critical information about the patient (e.g., past opioid use for patients receiving transdermal fenta**NYL** patches, concentrated morphine solutions, long-acting opioids) necessary to confirm the appropriateness of the prescribed medication, dose, dosage form, and directions for use.					
15	Pharmacists consider the need for dose adjustments for medications based upon specific recent clinical data available (e.g., patient with renal impairment is identified when prescribed a potentially toxic drug that is excreted by the kidney).					
16	At the point of sale, pharmacy staff ask the patient (or person picking up the prescription) to state the patient's name and date of birth, and these two identifiers are verified against the patient's profile to help ensure that medications are being dispensed for the proper patient.					
17	All administered vaccines are fully documented in the patient's profile including: vaccine name, dose, national drug code (NDC) number, date of administration, vaccine manufacturer, vaccine lot number, the name and title of the person who administered the vaccine, and the address of the facility where the permanent record will reside. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				
18	Vaccine registries are checked before vaccines are administered to avoid duplication. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

II. DRUG INFORMATION

Core Characteristic #2

Essential drug information is readily available in useful form and considered when dispensing, administering, and monitoring the effects of medications.

		A	B	C	D	E
19	Online drug information references are easily accessible in all dispensing areas and include user-friendly, up-to-date information on prescription, OTC, herbal, and alternative medicines.					
20	Online or other current veterinary references are easily accessible and used as needed when dispensing to nonhumans.					
21	The pharmacy computer system is periodically evaluated for clinically insignificant and false positive alerts, and action is taken to minimize alert fatigue.					
22	The pharmacy computer system performs dose range checks and warns pharmacy staff about overdoses and under-doses for narrow therapeutic index and **HIGH-ALERT MEDICATIONS**.					
23	The pharmacy computer system is tested and updated at least twice annually to ensure that critical alerts are present for narrow therapeutic index and **HIGH-ALERT MEDICATIONS**.					
24	The pharmacy computer system requires pharmacists to document rationale when overriding a serious alert (e.g., exceeding a **MAXIMUM DOSE**, a serious drug interaction).					
25	The pharmacy computer system defaults to a weekly dosage regimen for oral methotrexate, and if overridden to daily dosing, a **HARD STOP** verification of an appropriate oncologic indication is required.					
26	The pharmacy computer system automatically screens and detects medications to which patients may be allergic (including cross allergies), provides a clear warning to staff during order entry, and requires pharmacists to enter an explanation to override the warning.					
27	Pharmacists review all clinically significant pharmacy computer system warnings, even when a pharmacy technician initially enters prescriptions into the pharmacy computer system.					
28	The pharmacist ascertains the clinical purpose of each prescription before the medication is dispensed to ensure that the prescribed therapy is appropriate for the patient's condition.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

II. DRUG INFORMATION (continued)

		A	B	C	D	E
29	At least weekly, an updated interactive database, supplied by a drug database provider for the pharmacy computer system, is loaded into the system.					
FAQ 30	The pharmacy computer system alerts staff when safety screening does not occur due to data not being available.					
31	A designated pharmacist routinely reviews, for quality improvement purposes, reports of the documented rationale for selected pharmacy computer system warnings (e.g., **MAXIMUM DOSE** alerts, serious drug interactions, allergy alerts) that have been overridden to ensure justification and appropriateness.					

Core Characteristic #3

Medications added to the inventory are reviewed for their error potential, and strategies are undertaken to minimize the possibility of errors.

32	If sig codes are used by pharmacy staff during order entry, the codes are standardized within the pharmacy (and throughout a chain with multiple stores) and reviewed regularly to evaluate error potential.					
FAQ 33	A defined process exists for **PHARMACY LEADERSHIP** to create standardized **MNEMONICS**, sig codes, and speed codes.					
34	When a new item is added to the pharmacy inventory, the potential for error with that medication (e.g., sound-alike names, look-alike packaging, complex instructions for patients, confusing dosing parameters, clinical monitoring requirements) is evaluated.					
35	Before a new product is added to the pharmacy inventory, an evaluation assessing the potential for error includes a review of the literature for published errors related to that product.					
36	When new medications with heightened error potential are identified, the pharmacy establishes safety enhancement(s) (e.g., check systems, alert labels, reminders, limitations on use, sequestered storage and location) before initial use.					
37	After a medication has been on the market for several months, a staff or corporate level pharmacist is assigned responsibility to determine if medication errors or adverse reactions have been reported internally or externally since product launch, and safety enhancements are established in the pharmacy as necessary.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

III. COMMUNICATION OF DRUG ORDERS AND OTHER DRUG INFORMATION

Core Characteristic #4

Methods of communicating prescription orders and other drug information are standardized and automated to minimize the risk for error.

		A	B	C	D	E
38	The pharmacy computer system is able to receive electronic prescriptions with minimal data entry/transcription required.					
39	If the prescription is received on paper, prescription scanning is used to show an image of the original prescription on the pharmacy computer screen.					
FAQ 40	A process is in place to verify that the scanned image accurately represents the original prescription. *Scoring guideline: Choose NOT APPLICABLE if scanning is not utilized at the pharmacy.*					
		NOT APPLICABLE				
41	A list of **ERROR-PRONE ABBREVIATIONS** (e.g., "U" for units) and dose designations (e.g., using trailing zeros for whole number doses, lack of using a leading zero for doses less than one) is established and used for internal communication and documentation of drug information on prescription orders, pharmacy labels, and in pharmacy computer systems.					
42	Feedback is provided to prescribers about quality and/or safety issues of electronic prescriptions generated by their prescribing systems (e.g., missing or mismatched quantities [1 for 10 mL insulin vial], mismatches between drug dosage form ordered and dosage units ordered [solution ordered, dose indicated in tablets], wrong drug selected, sig field contradicts instructions in the notes field).					
43	The pharmacy does not accept telephone orders for chemotherapeutic agents.					
44	Telephone or voice mail prescription orders received by a pharmacist, pharmacy intern, or certified technician (where allowed by regulation) are written down immediately on a pharmacy prescription blank.					
45	For telephone prescription orders, the pharmacy uses prescription pads that prompt the receiver to ask the caller for indication, allergies, date of birth, and, if needed, comorbid conditions and patient weight.					
FAQ 46	When telephone orders must be taken, the order is **READ BACK** to the prescriber or authorized agent for confirmation.					
47	The pharmacy uses an integrated voice response (IVR) system that includes prompts that require the prescriber or agent to stop and spell all names (prescriber, patient, and drug) and sound out numbers (e.g., 60 is emphasized as "six zero," 15 as "one five") when leaving a spoken prescription order.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

III. COMMUNICATION OF DRUG ORDERS AND OTHER DRUG INFORMATION (continued)

		A	B	C	D	E
48	The pharmacy has a formal policy to assess and clarify any unusual doses or uses of medications before dispensing.					
49	Pharmacists have a written policy to follow, to easily and effectively resolve conflicts when prescribers do not agree with their expressed concerns about the safety of an order.					
50	The pharmacist who clarifies an atypical order documents the problem identified, actions taken, and result or outcome through pharmacy computer systemized notes in the patient's profile or as an annotated note on the scanned prescription.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

IV. DRUG LABELING, PACKAGING, AND NOMENCLATURE

Core Characteristic #5

Strategies are undertaken to minimize the possibility of errors with drug products that have similar or confusing manufacturer labeling/packaging and/or drug names that look and/or sound alike.

		A	B	C	D	E
51	The *ISMP Medication Safety Alert!*® and/or other current literature is regularly reviewed to identify drug labeling, packaging, and nomenclature problems, and action is taken to prevent errors with these drugs.					
52	Different manufacturers are sought for products with labels/packages that look similar to other products to help differentiate the labels/packages.					
53	Alerts are built into the pharmacy computer system to remind practitioners about problematic drug names, including drugs with multiple suffixes such as XL, SR, ER, CD, and LA.					
54	Shelf tags or label enhancements (e.g., **TALL MAN LETTERS**) are used on packages and storage bins of drugs with problematic names, packages, and labels.					
55	Products with look-alike drug names and packaging that are known by the staff to be problematic are segregated and not stored next to one another, and a system clearly redirects staff to where the products have been relocated.					
56	Look-alike drug names do not appear on the same pharmacy computer system screen when selecting a drug during order entry, or look-alike drug names are clearly distinguished in a way that differentiates them (e.g., use of **TALL MAN LETTERS**) if they appear sequentially on the same pharmacy computer system screen.					

Core Characteristic #6

Prescription labels clearly identify the patient, product, directions for use, the dispensing pharmacy, and any other important information that the patient may need to take the medication accurately and safely.

		A	B	C	D	E
FAQ 57	Pharmacy prescription labels are easy for patients to read, have adequate "white" space, have a font size that is legible (i.e., 12-point font for patient name, drug name, strength, directions for use, and indication, if known), and contain the proper information for safe self-administration.					
FAQ 58	When appropriate and within regulatory boundaries, the pharmacy provides directions on the patient's label using the Universal Medication Schedule and simplified language (e.g., "for blood pressure" instead of "for hypertension").					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

IV. DRUG LABELING, PACKAGING, AND NOMENCLATURE (continued)

		A	B	C	D	E
59	The pharmacy computer system produces clear and distinguishable prescription container labels that are free of **ERROR-PRONE ABBREVIATIONS** (e.g., "U" for units) or dose designations.					
60	When dispensing unit-of-use packaging to patients, staff avoid placing the pharmacy label on top of pertinent information on the manufacturer's label (e.g., drug name, strength, NDC).					
61	The pharmacy uses appropriate foreign language labels for patients who need them.					
FAQ 62	Appropriate labels are used for the visually impaired (e.g., larger font, Braille, talking).					
63A	The pharmacy computer system automatically prints appropriate auxiliary labels (e.g., for the ear, for the eye, take with food) when prescription labels are generated.					
OR	**OR** *(Respond to #63A or #63B only)*					
63B	During prescription order entry, the pharmacy computer system suggests appropriate auxiliary labels to be affixed manually prior to dispensing.					
64	If the prescriber provides the purpose of the medication on the prescription, the indication is included on the patient's prescription container label unless inclusion on the label is not desired by the patient.					
65	A description of the product (e.g., shape, imprints, color, scent) appears on the pharmacy label.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

V. DRUG STANDARDIZATION, STORAGE, AND DISTRIBUTION

Core Characteristic #7

Prescribed medications are accessible to patients and dispensed in a safe and secure manner.

		A	B	C	D	E
66	When patients have a legitimate need for prescription medications, but have exhausted their supply while traveling, lost their medications, or there is a statewide emergency, all pharmacists are empowered, as state law permits, to take appropriate action to ensure that critical doses are not missed.					
67	There is an efficient and timely process in place to obtain critically needed medications or notify providers when they are not immediately available (e.g., due to a drug shortage).					
68	A mechanism exists to identify the reasons that prescriptions have not been picked up after being prepared.					
69	A timely and efficient process is in place to identify medications that have been recalled by manufacturers and notify patients as appropriate.					

Core Characteristic #8

Medications and other necessary medication supplies are stored, dispensed, and returned to stock in a manner that reduces the likelihood of an error.

		A	B	C	D	E
70	Electronic systems that document temperature ranges around the clock and provide problem notification are used for refrigerators and freezers that store temperature-sensitive medications, and written procedures regarding how to handle any breach of a safe temperature range have been developed and are followed.					
71	Refrigerators of sufficient size or alternatively, separate refrigerators, are used for stock and prepared prescriptions waiting to be picked up, to ensure refrigerated medications are stored in an organized manner.					
72	The pharmacy has adequate space to safely organize and separate the storage of medications and drug supplies, and utilizes dividers on stock shelves, in narcotic cabinets, and in refrigerators, as needed.					
FAQ 73	There is a process in place to keep two-component (i.e., two vial) vaccines together and to keep diluents and their corresponding vaccines together if storage requirements do not differ. *Scoring guideline: Choose NOT APPLICABLE if vaccines are never stored in the pharmacy.*					**NOT APPLICABLE**
74	The pharmacy separates pediatric and adult vaccine formulations. *Scoring guideline: Choose NOT APPLICABLE if vaccines are never stored in the pharmacy.*					**NOT APPLICABLE**

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

V. DRUG STANDARDIZATION, STORAGE, AND DISTRIBUTION (continued)

		A	B	C	D	E
75	The pharmacy does not stock sound-alike or look-alike drugs in the "fast mover" section (unless automation is employed).					
76	When stocking shelves, staff ensure that stickers (e.g., wholesale price labels) or cross-out lines do not obliterate key information on any part of the stock bottle label.					
77	To verify proper selection, the pharmacy system has implemented tablet/product imaging (or description) on the final verification screen.					
78	If completed prescriptions are not ultimately dispensed to patients, the return-to-stock (RTS) vials are labeled with the medication name, strength, expiration date, and NDC number or barcode (RTS medications are not returned to stock bottles).					

Core Characteristic #9

Hazardous drugs and chemicals are safely sequestered and not accessible in drug preparation areas.

79	An appropriately segregated and secured area of the pharmacy has been established to temporarily place returned, outdated, and recalled medications until they are destroyed or removed from the pharmacy.					
80	Active pharmaceutical ingredients and bulk chemicals used in the pharmacy for compounding are assessed at least quarterly, and those that are not regularly used are eliminated from stock.					
81	Active pharmaceutical ingredients and bulk chemicals used in the pharmacy for compounding are clearly labeled with their contents, the date the product was first opened, and the manufacturer's expiration date (if applicable). (If an expiration date is unavailable from the manufacturer, a 1-year expiration date from the date the product was first opened is assigned.)					
82	The pharmacy stores chemicals used in compounding in a separate area according to current USP <795> and <797> standards.					
83	The pharmacy does not store chemical substances (e.g., formalin, methanol) for distribution to a laboratory, doctor's office, or hospital.					
84	All caustic or hazardous chemicals and other non-drug substances are clearly labeled and stored on low shelves separate from all other medications and supplies in the pharmacy's drug inventory.					
85	Pharmacy prescription bottles and labels are not used to re-package non-drug substances (e.g., liquid chemicals, cleaning compounds, insecticides, soaps).					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VI. USE OF DEVICES

Core Characteristic #10

Sanitary practices are followed when using devices and equipment to store and prepare medications.

		A	B	C	D	E
86	Staff members use gloves and proper hand washing when handling individual loose oral solid products.					
87	All pharmacists follow standards for hand washing, wearing gloves, and equipment disposal to minimize the risks of disease transmission during the administration of vaccines. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				
88	Staff members follow appropriate hand washing procedures prior to compounding any prescription product.					
89	Dispensing devices (e.g., counting trays, Fillmaster®) are appropriately cleaned after being used to prepare chemotherapy, penicillin, sulfonamides, opioids, and medications that may leave a residue.					

Core Characteristic #11

The potential for **HUMAN ERROR** is mitigated through careful procurement, maintenance, use, and standardization of devices used to prepare prescription medications.

		A	B	C	D	E
90	The pharmacy performs maintenance, calibration, and cleaning on all counting devices, automated dispensing devices, and compounding equipment according to compendia or manufacturers' standards.					
91	The pharmacy performs manufacturers' suggested maintenance and cleaning schedules for all fax machines, scanners, and printers.					
92	Privileges to make modifications, adjustments, or changes in the bin contents of automated dispensing systems (e.g., robotics) are restricted to staff members who are well-trained in both the theory and the mechanics of the software system.					
93	Barcode scanning or a checklist/sign-off sheet is used to verify the drug name, strength, NDC, lot number, and expiration date of each stock bottle before the contents are added to an automated dispensing system (e.g., robotics).					
94	When adding new products, making changes in strength or dosage form, or when making other modifications to automated dispensing systems (e.g., robotics), two individuals independently verify the change with the use of a checklist/sign-off sheet.					
95	Barcoding is used to verify drug selection.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VII. ENVIRONMENTAL FACTORS, WORKFLOW, AND STAFFING PATTERNS

Core Characteristic #12

Medications are transcribed, prepared, dispensed, and administered within an efficient and safe workflow, and in a physical environment that offers adequate space and lighting and allows pharmacy staff to remain focused on medication use without distractions.

		A	B	C	D	E
96	Lighting is adequate (i.e., illumination levels at least 100 foot-candles) to clearly read labels and other important drug and patient information.					
97	A lighted magnifying lens is in a fixed location and is used to facilitate readability of prescriptions and labels.					
98	The temperature and humidity in the pharmacy conform to drug storage requirements.					
99	The pharmacy has implemented integrated voice response (IVR) systems that are integrated with the pharmacy computer system, to triage incoming calls.					
100	Areas where medication orders are transcribed and/or entered into the pharmacy computer system are isolated and free of distractions and interruptions.					
101	Areas where medication orders are verified are isolated and free of distractions and interruptions.					
102	Areas where point-of-care testing and/or immunization services are provided are private and free of distractions and interruptions. *Scoring guideline: Choose NOT APPLICABLE if point-of-care testing and immunization services are not provided.*					
		NOT APPLICABLE				
FAQ 103	The pharmacy has a dedicated, exclusive area for general, nonsterile compounding that meets current USP <795> standards.					
104	The pharmacy has an area for aseptic compounding of sterile preparations that meets current USP <797> standards. *Scoring guideline: Choose NOT APPLICABLE if sterile compounding is not offered.*					
		NOT APPLICABLE				
105	The pharmacy avoids using storage space that requires staff to reach over their heads or to climb to retrieve products.					
106	Workspaces where medications are prepared are clean, orderly, and free of clutter.					
107	Baskets, bins, or other containers are used during preparation and verification to separate different patients' orders.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VII. ENVIRONMENTAL FACTORS, WORKFLOW, AND STAFFING PATTERNS (continued)

		A	B	C	D	E
108	The pharmacy maintains a prescription pick-up/will-call area that is free from clutter and contains enough space to prevent "spillage" into the next basket or bin.					
109	Plans for new and/or expanded services are well communicated to all affected personnel, and appropriate consideration of resources is addressed prior to implementation.					
110	The pharmacy uses an automated, off-site, centralized dispensing operation to help reduce workload in the pharmacy.					
111	When preparing prescriptions, pharmacy staff work with one drug product at a time and affix the label to the patient's prescription container before working on the next prescription.					
112	All prescription orders (either the hard copy or a scanned image) are displayed at eye level during order entry.					

Core Characteristic #13

The complement of qualified, well-rested pharmacy staff matches the workload without compromising patient safety.

113	An employee assistance program is available, and participation is encouraged to help staff who are experiencing stress or issues that may affect work performance.					
114	Pharmacy staff undergo an annual physical examination, including vision and hearing screenings.					
115	Pharmacy staff work no more than 12 consecutive hours. Exception: isolated situations outside of usual operations.					
116	Pharmacy staff have at least 8 hours of rest between shifts worked. Exception: isolated situations outside of usual operations.					
117	Schedules and workload permit pharmacy staff to take at least one 15-minute break and one 30-minute break (for a meal) per 8 hours of work each day. Exception: isolated situations outside of usual operations.					
118	An effective back-up plan has been established for days when staffing is short due to illness, vacation, educational absences, and fluctuations in workload.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VII. ENVIRONMENTAL FACTORS, WORKFLOW, AND STAFFING PATTERNS (continued)

		A	B	C	D	E
119	Staffing patterns in the pharmacy are adequate to provide safe patient care services, including during times of anticipated higher workload (e.g., beginning of the month, prior to or immediately following holidays).					
120	When temporary agency staff are used, they have been properly oriented and trained in the particular pharmacy environment in which they will be working.					
121	When creating the work schedule, consideration is given to the use of supportive automated dispensing technology, prescription volume, and pharmacist/technician ratios.					
122	Prescription volume data is examined periodically to determine appropriate staffing levels, even during peak times when demand is highest.					
123	Metrics used to ascertain staff productivity and turnaround time are reasonable and do not impede the quality or safety of patient care services.					
124	The pharmacy does not ask pharmacists to meet a specific quota for prescription dispensing, including vaccine administrations if provided.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VIII. STAFF COMPETENCY AND EDUCATION

Core Characteristic #14

Pharmacy staff receive sufficient orientation to medication use and undergo baseline and annual proficiency evaluation of knowledge and skills related to safe medication practices.

		A	B	C	D	E
125	All new staff, including agency staff, undergo a baseline proficiency evaluation before working independently.					
126	All pharmacy staff, including float and agency staff, are educated about the specific pharmacy equipment available at each site (e.g., barcode scanner, automated dispensing equipment) and associated protocols/guidelines, and competency with equipment use is verified before staff are permitted to operate the equipment.					
127	All pharmacists, including float and agency staff, are educated about the specific patient self-administration and monitoring devices available at each site (e.g., glucose monitors, inhalation devices, pen devices, home diagnostic tests), and competency is verified before staff are permitted to educate a patient about the device.					
128	All compounding personnel receive ongoing education and competency assessment, including knowledge and training on standard operating procedures (SOP) in accordance with current USP <795> and <797> standards.					
129	Staff who administer immunizations are educated about the potential adverse effects of vaccines (e.g., anaphylaxis, syncope) and are prepared to respond appropriately. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				
130	Protocols are available and reviewed with staff on how to treat an emergency during patient care services, emergency supplies are on-hand, and staff know where to find the protocols and supplies.					
131	Those who train new staff have a reduced workload to accomplish the goals of orientation safely and thoroughly.					
132	The length of time for orienting new pharmacists, technicians, and management staff is individualized and based on an ongoing assessment of their needs.					
133	During orientation, pharmacy staff receive information about the pharmacy's actual error experiences, as well as published errors that occurred in other facilities.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VIII. STAFF COMPETENCY AND EDUCATION (continued)

		A	B	C	D	E
134	Pharmacy preceptors review key medication-related policies and procedures, and specific error-prone conditions, at the start of each pharmacy student's rotation. *Scoring guideline: Choose NOT APPLICABLE if your organization does not serve as a site for pharmacy students.*					
		NOT APPLICABLE				
135	Pharmacy staff are educated about system-based strategies to reduce the risk of errors.					
136	Current policies and procedures are readily available, updated on a regular basis, and followed by pharmacy staff.					
137	As part of the overall performance evaluation process, a supervisor assesses each pharmacy staff member's skills and knowledge related to safe medication practices.					

Core Characteristic #15

Pharmacy staff are provided with ongoing education about medication error prevention and the safe use of drugs and devices that have the greatest potential to cause harm if misused.

138	Pharmacy staff are educated about new drugs added to the pharmacy inventory, including OTC medications, and any associated guidelines, restrictions, or special precautions are understood before the medications are dispensed or administered (e.g., vaccines).					
139	Medication errors and ways to avoid them are routinely discussed at staff meetings and in conversations between pharmacists, technicians, and managers.					
140	**HUMAN FACTORS** and the principles of error reduction (e.g., standardization, use of constraints, and redundancy for critical functions) are introduced during staff orientation.					
FAQ 141	Management and frontline staff receive training in identifying risk within the system and in incorporating high-leverage, error-reduction strategies to help eliminate the risk.					
142	Management and frontline staff are trained and skilled in the principles and applications of **CONTINUOUS QUALITY IMPROVEMENT (CQI)**.					
143	At least annually, pharmacy staff must complete an educational program on ways to avoid errors with **HIGH-ALERT MEDICATIONS**, narrow therapeutic index medications, and other error-prone medications or devices.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

VIII. STAFF COMPETENCY AND EDUCATION (continued)

		A	B	C	D	E
144	When errors occur, educational efforts are widespread among all pharmacy staff rather than remedial and directed at only those who were involved in an error.					
145	Pharmacy staff are provided with the necessary support and time to attend internal and external educational programs related to new medications and/or important medication safety issues.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

IX. PATIENT EDUCATION

Core Characteristic #16

Patients are included as active partners in their care through education about their medications and ways to avert errors.

		A	B	C	D	E
146	Pharmacists are allotted time by management for patient education activities.					
147	Confidential areas for patient counseling and medication therapy management (MTM) services are provided and are free of distractions and interruptions.					
148	Patients are encouraged to ask questions about the medications they are receiving.					
149	Patients are offered an opportunity for counseling. The offer includes a clear explanation of what counseling consists of (e.g., how to take and store the medication, possible side effects, interactions with other medications) and how it would benefit them.					
150	Criteria have been established for selected **HIGH-ALERT MEDICATIONS** or high-risk patient populations to trigger required medication counseling, and a system is in place to alert the pharmacist of this need when the patient comes in to pick up the prescription (e.g., bold alert on the bag, pharmacy computer system alert).					
151	Electronic **HARD STOPS** are in place at the point of sale to restrict completion of the sale until patient education has occurred for selected **HIGH-ALERT MEDICATIONS** or high-risk patient populations.					
FAQ 152	The pharmacist discusses important safety concerns (e.g., those found in Medication Guides, ISMP High-Alert Medication Safety Leaflets for consumers) during patient counseling with the patient/caregiver.					
153	The patient's prescription container is opened with the patient/caregiver to verify the medication.					
154	Pharmacists fully investigate all patient/caregiver concerns and questions about a medication (e.g., affordability, inability to swallow, difficulty adhering to directions, change in product appearance) prior to dispensing.					
155	Cultural issues that may affect compliance with prescribed therapy are identified and considered when counseling patients about their medications.					
156	The pharmacy takes steps to effectively communicate with patients who are visually or hearing impaired.					
157	Patients are instructed to call the pharmacy for any concerns or questions about their medication therapy.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

IX. PATIENT EDUCATION (continued)

		A	B	C	D	E
158	Patients are provided with a telephone number at which a pharmacist can be reached 24 hours a day for any concerns or questions about their medication therapy.					
FAQ 159	When dispensing oral liquid medications, a proper metric-only measuring device is provided or suggested (e.g., oral syringe), and patients'/caregivers' ability to correctly measure the dose is verified by using the teach-back method.					
160	The patient or caregiver is asked to verify that the vaccine vial and syringe or the prefilled syringe is what is intended prior to vaccine administration. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				
161	Doses that require splitting tablets are dispensed only to patients who have demonstrated their ability to manipulate the dose properly, and devices for tablet splitting are available from the pharmacy.					
162	Patients are instructed on the proper use and maintenance of any devices dispensed from the pharmacy (e.g., glucose monitors, injectable pens, spacers used with inhalers).					
163	The pharmacy obtains sample devices from manufacturers to be used for patient education/demonstration.					
164	If someone other than the patient or caregiver picks up the prescription, a reasonable effort is made to contact the patient directly to provide medication counseling (e.g., call the patient at home, written suggestion placed in or on the bag for the patient to call the pharmacy for counseling).					
165	Patients are provided with up-to-date, useful, written information in their primary language about the medications that they are receiving, or a trained translator or language line is utilized to provide important oral and/or written information.					
166	The pharmacy provides an updated medication list when therapy changes and reviews it with the patient/caregiver.					
FAQ 167	The pharmacy provides a comprehensive appointment-based medication synchronization (ABMS) program that includes a complete medication review and monthly contact from a pharmacist to the patient, to discuss their medication therapy and any changes before dispensing to optimize medication use.					
168	The pharmacy provides consumers with information about proper disposal of medications and refers them to available community take-back programs.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

IX. PATIENT EDUCATION (continued)

Core Characteristic #17

Pharmacists establish and participate in community-based disease prevention and monitoring programs to promote health and ensure appropriate therapy and outcomes of medication use.

		A	B	C	D	E
169	The pharmacy offers MTM services, delivered by a pharmacist, focused on improving patients' therapeutic outcomes.					
170	The pharmacy provides clinical disease management programs for conditions such as asthma, hypertension, diabetes, or hypercholesterolemia.					
171	In the past year, the pharmacy has provided at least one screening clinic to promote early detection of disease.					
172	The pharmacy develops and conducts at least one annual educational program or other proactive public health effort designed to improve safe use of medications in the community.					
173	The pharmacy transmits patient immunization administration records to the state or local immunization registry. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided or if there is no state or local immunization registry.*					
						NOT APPLICABLE

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

X. QUALITY PROCESSES AND RISK MANAGEMENT

Core Characteristic #18

A safety-supportive **JUST CULTURE** and model of shared accountability for safe **SYSTEM DESIGN** and making safe **BEHAVIORAL CHOICES** is in place and supported by **PHARMACY LEADERSHIP** and immediate supervisors.

		A	B	C	D	E
174	Error-prevention strategies in the pharmacy target **SYSTEM DESIGN** and the management of safe **BEHAVIORAL CHOICES** of all staff.					
175	Pharmacy staff openly discuss errors without embarrassment or fear of reprisal from **PHARMACY LEADERSHIP** or immediate supervisors.					
176	Pharmacy staff are trained in clinical and administrative procedures for responding to medication errors.					
177	All medication errors that reach the patient, regardless of the level of harm that results, are honestly disclosed to patients/caregivers/families in a timely manner.					
178	If a medication error occurs and the patient takes the medication, regardless of the resulting level of harm, the error is honestly disclosed to the prescriber in a timely manner.					
179	**PHARMACY LEADERSHIP** and immediate supervisors have received formal education on establishing and/or maintaining a fair and just safety culture (e.g., **JUST CULTURE**).					
180	No disciplinary action is taken against pharmacy staff for making a **HUMAN ERROR**.					
181	**PHARMACY LEADERSHIP** and immediate supervisors receive formal training on ways to effectively evaluate pharmacy staff competency and performance, supervise and mentor staff on clinical skills, **COACH AT-RISK BEHAVIORS**, and handle difficult pharmacy staff behavior without allowing the presence or absence of medication errors to be a factor.					
182	Job descriptions and performance evaluations include specific accountability standards related to patient/medication safety (e.g., accountability for **BEHAVIORAL CHOICES** in response to the risks seen; willingness to speak up about safety issues and ask for help when needed; to follow the safety literature) that do not include the absence of errors or a numeric error threshold.					
183	The organization anticipates **AT-RISK BEHAVIORS** and proactively takes steps to encourage safe **BEHAVIORAL CHOICES** and discourage **AT-RISK BEHAVIORS**.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

X. QUALITY PROCESSES AND RISK MANAGEMENT (continued)

		A	B	C	D	E
184	Immediate supervisors **COACH** staff who engage in **AT-RISK BEHAVIORS** involving patient safety, to assist them in making safer **BEHAVIORAL CHOICES** in the future.					
185	Error rates are not determined or calculated from error reports and are not used for internal (pharmacist-to-pharmacist) or external (pharmacy-to-pharmacy) comparisons.					
186	During event investigation (e.g., **ROOT CAUSE ANALYSIS [RCA]**), once risks have been identified, the focus of the initial analysis of the event is widened to analyze the same or similar risks throughout the organization and among other processes, and interventions extend beyond addressing the immediate risks involved in the event.					
187	When an event involves staff who cut corners, breached a policy, and/or did not follow a procedure, the conditions that led to these **AT-RISK BEHAVIORS** are investigated to uncover system-based incentives that encourage the behavior and/or system-based disincentives that discourage safe behaviors.					
188	When an event involves **HUMAN ERROR**, an investigation is undertaken to uncover any preexisting performance shaping factors (e.g., task complexity, workflow, time availability/urgency, experience, training, fatigue, stress) and other environmental conditions, **SYSTEM DESIGN** attributes, **BEHAVIORAL CHOICES**, or equipment design flaws that allowed the error to happen and reach the patient.					
FAQ 189	**PHARMACY LEADERSHIP** and immediate supervisors provide positive incentives for individuals to report errors.					
190	Pharmacy staff are anonymously surveyed at least annually to assess the organization's safety culture.					
191	Pharmacy staff involved in serious errors that cause patient harm are emotionally supported by **PHARMACY LEADERSHIP**, immediate supervisors, and colleagues, and are provided with ongoing support through an employee assistance program or other crisis intervention strategies.					
192	**PHARMACY LEADERSHIP** actively demonstrates its commitment to patient safety (and safe medication practices) by approving a safety plan, encouraging pharmacy staff to report errors, and approving **SYSTEM DESIGN** enhancements, including technology, that are likely to reduce errors.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

X. QUALITY PROCESSES AND RISK MANAGEMENT (continued)

		A	B	C	D	E
193	Specific medication safety objectives (e.g., reduce harm from errors with **HIGH-ALERT MEDICATIONS**; improve medication error detection, reporting, and use of the information) are included in the organization's strategic plans, directly communicated to all staff, and celebrated (acknowledged in a positive manner) when met.					
194	Patient safety is articulated in the organization's mission and/or vision statements.					

Core Characteristic #19

Pharmacy staff are expected to detect and report adverse events, errors (including **CLOSE CALLS**), hazards, and observed **AT-RISK BEHAVIORS**, and to regularly analyze these reports, as well as reports of errors that have occurred in other organizations, to mitigate future risks.

195	A clear definition and examples of medication errors and hazardous situations that should be reported have been established and disseminated to staff.					
196	A formal process has been established to report both hazardous situations that could lead to an error and actual errors, including **CLOSE CALLS**.					
197	One or more pharmacists in an individual pharmacy are assigned the responsibility of enhancing detection of medication errors, overseeing analysis of their causes, and coordinating an effective error-reduction plan (with corporate support as applicable).					
198	The pharmacy staff utilize a tool (e.g., Assess-ERR™) to document and analyze errors.					
199	A trusted pharmacist or manager facilitates periodic, announced focus groups for "off the record" discussions to learn about perceived problems with the dispensing system.					
200	The pharmacy operates a **CONTINUOUS QUALITY IMPROVEMENT (CQI)** program to enhance patient safety.					
201	The pharmacy periodically conducts patient satisfaction surveys regarding patient care services, with the intent of improving services and outcomes of care.					
202	The dispensing process is proactively analyzed at least annually (e.g., using a **PROACTIVE RISK ASSESSMENT** tool) to identify potential risk factors for medication errors.					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

X. QUALITY PROCESSES AND RISK MANAGEMENT (continued)

		A	B	C	D	E
203	Practitioners who have been directly involved in a serious or potentially serious medication error participate in a **RCA** analyzing those failures in the system that allowed the error to happen, and assist with the development of **SYSTEM DESIGN** enhancements to reduce the potential for future errors.					
204	**CLOSE CALLS** and hazardous situations that have the potential to cause patient harm are given the same high priority for analysis and error-prevention strategies as errors that actually cause patient harm.					
205	Management and pharmacy staff routinely read and use published error experiences from other organizations to proactively target improvements in the dispensing process.					
206	Management routinely evaluates the literature for new technologies and successful evidence-based practices that have been effective in reducing errors in other organizations, to determine if the new technology and/or practice should be implemented in their organization.					
207	Pharmacy staff are provided with regular feedback about errors reported in the pharmacy, hazardous situations, and error-reduction strategies that are being implemented.					
208	**PHARMACY LEADERSHIP** and immediate supervisors support practitioner reporting to external error reporting programs such as the ISMP National Medication Errors Reporting Program and the ISMP National Vaccine Errors Reporting Program.					

Core Characteristic #20

Redundancies that support a system of **INDEPENDENT DOUBLE CHECKS** or an automated verification process are used for vulnerable parts of the medication system, to detect and correct serious errors before they reach patients.

209	For selected patient groups (e.g., pediatric patients and patients receiving medications dosed according to age or weight), a double check of the prescriber's calculated dose is made before preparing and dispensing the medication.					
210	The original prescription (or image of the original prescription) is used by the pharmacist while conducting data entry verification and when performing medication utilization review.					
FAQ 211	Both the medication base product and the mixing solution/diluent used for reconstituted products are **INDEPENDENTLY DOUBLE CHECKED** by a pharmacist. *Scoring guideline: Pharmacists who work alone should answer A or B.*					

A	No activity to implement
B	Discussed, but not implemented
C	Partially implemented for some or all patients, prescriptions, drugs, or staff
D	Fully implemented for some patients, prescriptions, drugs, or staff
E	Fully implemented for all patients, prescriptions, drugs, or staff

X. QUALITY PROCESSES AND RISK MANAGEMENT (continued)

		A	B	C	D	E
212	A pharmacist verifies the formulation of all OTC insulin with the patient/caregiver before the product is dispensed.					
213	Pharmacists periodically perform quality control checks by reviewing completed prescriptions in the will-call area, examining pharmacy labels, computer entries, and the location of stock bottles replaced in inventory, and conducting other forms of random checks that promote detection of errors.					
214	Medication selection, preparation, and labeling errors identified during routine checking processes are reported and collected for the purpose of identifying **SYSTEM DESIGN** issues and developing error-prevention strategies.					
215	Pharmacists who administer vaccines prepare and/or select one patient's vaccine at a time. *Scoring guideline: Choose NOT APPLICABLE if immunization services are not provided at the pharmacy.*					
		NOT APPLICABLE				
216	The pharmacy has established a process to include an **INDEPENDENT DOUBLE CHECK** of prescriptions for selected **HIGH-ALERT MEDICATIONS** before they are dispensed.					

Definitions *(For purposes of this self assessment)*

Defined terms in this document are designated throughout the text in **BOLD CAPITAL LETTERS**.

AT-RISK BEHAVIOR
A **BEHAVIORAL CHOICE** that increases risk where risk is not recognized or is mistakenly believed to be justified. Examples of common **AT-RISK BEHAVIORS** include: bypassing a duplicate therapy alert during order entry without due consideration; technology work-arounds such as bypassing barcoding during product selection.

BEHAVIORAL CHOICE
Refers to intentional acts that are undertaken by the free exercise of one's judgment. Unlike **HUMAN ERROR**, which is unintentional behavior, **BEHAVIORAL CHOICE** represents the purposeful behavior we intentionally employ while engaging in our day-to-day activities.

CLOSE CALL
An error that took place but was captured before reaching the patient. For example, penicillin was ordered for a patient allergic to the drug; however, the pharmacist was alerted to the allergy during computer order entry, the prescriber was called, and the penicillin was not dispensed to the patient.

COACH
A supportive discussion among staff (peer-to-peer or manager-to-workers) intended to: 1) help staff see the risks associated with their **BEHAVIORAL CHOICES** that were not seen or were misread as being insignificant or justifiable, 2) learn the incentives that encourage these **AT-RISK BEHAVIORS**, and 3) help staff make safer **BEHAVIORAL CHOICES** in the future.

CONTINUOUS QUALITY IMPROVEMENT
A system of standards and procedures to identify and evaluate quality-related events, and to constantly enhance the efficiency and effectiveness of the structures and processes of a pharmacy system that determine the outcomes of medication use. All information, communications, or data maintained as a component of such a system shall be privileged and confidential, and not subject to discovery in civil litigation.

ERROR-PRONE ABBREVIATIONS
Certain medical abbreviations, symbols, and dose designations that are considered "dangerous" and have often contributed to serious medication errors.

A complete list can be found at: www.ismp.org/Tools/errorproneabbreviations.pdf.

HARD STOP
An alert that halts the progress of prescribing, dispensing, or administering a medication that would likely be dangerous to a patient. The alert cannot be overridden until appropriate action occurs.

HIGH-ALERT MEDICATIONS
Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are more devastating to patients. Examples of **HIGH-ALERT MEDICATIONS** include heparin, warfarin, insulin, and opioids. A complete list can be found at: http://www.ismp.org/communityRx/tools/ambulatoryhighalert.asp.

HUMAN ERROR
Inadvertently doing other than what should have been done; a mental slip, lapse, or mistake such as miscalculating a dose, forgetting to add water to an antibiotic powder for suspension, or transposing the labels on two prescription vials during production. **HUMAN ERRORS** are unintentional acts, not a **BEHAVIORAL CHOICE**.

HUMAN FACTORS
The study of the interrelationships between humans, the tools they use, and the environment in which they work and live.

INDEPENDENT DOUBLE CHECK
A procedure in which two individuals separately check each component of the work process. An example would be one person calculating a medication dose for a specific patient and a second individual independently performing the same calculation (not just verifying the calculation) and matching results.

JUST CULTURE
Refers to a safety-supportive model of shared accountability where healthcare institutions are accountable for the systems they design, for supporting the safe behavior choices of patients and staff, and for responding to staff behaviors in a fair and just manner. In turn, staff are accountable for the quality of their **BEHAVIORAL CHOICES (HUMAN ERROR** is not a **BEHAVIORAL CHOICE**) and for reporting their errors and system vulnerabilities.

For more information on **JUST CULTURE**, go to: http://www.ismp.org/NEWSLETTERS/ACUTECARE/articles/20060921.asp

MAXIMUM DOSE
The dose of a medication that represents the upper limit that is normally found in the literature and/or manufacturer recommendations. **MAXIMUM DOSES** may vary according to age, weight, or diagnosis.

MNEMONICS
A limited number of letters and/or numbers that are used typically in electronic systems as a shortcut to represent a specific medication (e.g., AMO250 may represent amoxicillin 250 mg capsules).

PHARMACY LEADERSHIP
Store owners or regional/corporate administrators.

PROACTIVE RISK ASSESSMENT
The process of identifying and systematically analyzing the risk and hazards embedded in the process and structure of care to prevent adverse events from occurring. Knowing the risk and hazards helps to inform the design, planning, and development of appropriate interventions that will eliminate or minimize risk and hazards before patient injury can occur.

READ BACK
A redundant safeguard in which an oral (verbal) prescription is transcribed (e.g., onto a pharmacy prescription pad) and then read back to the prescriber or prescriber's agent to verify accuracy of the prescription, including the patient's date of birth and the indication for the prescribed medication. **READ BACK** differs from repeat back or echoing the prescription from memory.

ROOT CAUSE ANALYSIS (RCA)
A retrospective process for identifying the most basic or causal factor(s) that underlies the occurrence or possible occurrence of an adverse event.

SYSTEM DESIGN
Refers to the design/redesign of processes, procedures, equipment, interfaces, overall structure, and the environment or conditions under which staff work, for the purpose of satisfying specific requirements, such as patient safety. The design of a system dictates how reliable it is in terms of satisfying specific requirements.

TALL MAN LETTERS
Refers to the use of mixed case bolded letters to help draw attention to the dissimilarities of certain look-alike drug name pairs. A list of look-alike drug names with recommended **TALL MAN LETTERS** can be found at: http://www.ismp.org/Tools/tallmanletters.pdf.

Funding Source

ISMP would like to gratefully acknowledge the Cardinal Health Foundation for its continued support of our efforts to improve medication safety in America's pharmacies.

Institute for Safe Medication Practices (ISMP)
200 Lakeside Drive, Suite 200, Horsham, PA 19044
Phone: (215) 947-7797 Fax: (215) 914-1492

www.ismp.org