

Institute for Safe Medication Practices
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FOR IMMEDIATE RELEASE
2/27/20

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**ISMP Publishes 2020-2021 Consensus-Based
Medication Safety Best Practices for Hospitals**

Added Items Address Opioids, ADC Overrides

Horsham, Pa. —Hospitals and health systems that are deciding how to focus their medication safety efforts during the next year can now rely on updated recommendations from the Institute for Safe Medication Practices (ISMP). ISMP issued its 2020-2021 Targeted Medication Safety Best Practices for Hospitals to help identify, inspire, and mobilize widespread national action to address recurring problems that continue to cause fatal and harmful errors despite repeated warnings in ISMP publications.

The updated list includes new Best Practices on opioid prescribing and on risks related to the “override” feature with automated dispensing cabinets (ADCs). In addition, five best practices were revised or incorporated into other items. One prior best practice, eliminating glacial acetic acid, was archived because hospitals have shown progress in removing or replacing it with vinegar or commercially available diluted acetic acid to prevent accidental use.

The two Best Practices that have been added for 2020-2021 are:

OPIOID BEST PRACTICE:

- **Verify and document a patient’s opioid status (naïve versus tolerant) and type of pain (acute versus chronic) before prescribing and dispensing extended-release and long-acting opioids.**
- Default order entry systems to the lowest initial starting dose and frequency when initiating orders for extended-release and long-acting opioids.
- Alert practitioners when extended-release and long-acting opioid dose adjustments are required due to age, renal or liver impairment, or when patients are prescribed other sedating medications.
- Eliminate the prescribing of fentaNYL patches for opioid-naïve patients and/or patients with acute pain.
- Eliminate the storage of fentaNYL patches in automated dispensing cabinets (ADCs) or as unit stock in clinical locations where acute pain is primarily treated (e.g., in the emergency department, operating room, postanesthesia care unit, procedural areas).

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ADC BEST PRACTICE:

- Limit the variety of medications that can be removed from an ADC using the override function.
- Require a medication order (e.g., electronic, written, telephone, verbal) prior to removing any medication from an ADC, including those removed using the override function.
- Monitor automated dispensing cabinet overrides to verify appropriateness, transcription of orders, and documentation of administration.
- Periodically review for appropriateness the list of medications available using the override function.
- Restrict medications available using override to those that would be needed emergently (as defined by the organization) such as antidotes, rescue and reversal agents, life-sustaining drugs, and comfort measure medications such as those used to manage acute pain or intractable nausea and vomiting.

ISMP began issuing Targeted Medication Safety Best Practices in 2014. The consensus-based recommendations are based on error reports received through the ISMP National Medication Errors Reporting Program (ISMP MERP) and are reviewed by an external expert advisory panel and approved by the ISMP Board of Trustees.

While targeted for the hospital setting, some Best Practices may be applicable to other areas of healthcare. The Best Practices are designed to set realistic goals, which have already been successfully adopted by numerous organizations.

For a copy of the *2020-2021 ISMP Targeted Medication Safety Best Practices for Hospitals*, visit: <https://www.ismp.org/guidelines/best-practices-hospitals>. Please note that sign-in and/or creation of a free user account may be required for access.

About the Institute for Safe Medication Practices

The Institute for Safe Medication Practices (ISMP) is the only 501c (3) nonprofit organization devoted entirely to preventing medication errors. ISMP is known and respected as the gold standard for medication safety information. For more than 25 years, it also has served as a vital force for progress. ISMP's advocacy work alone has resulted in numerous necessary changes in clinical practice, public policy, and drug labeling and packaging. Among its many initiatives, ISMP runs the only national voluntary practitioner medication error reporting program, publishes newsletters with real-time error information read and trusted throughout the global healthcare community, and offers a wide range of unique educational programs, tools, and guidelines. In 2020, ISMP formally affiliated with ECRI Institute to create one of the largest healthcare quality and safety entities in the world. As an independent watchdog organization, ISMP receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its life-saving work. Learn more at www.ismp.org.