



# Institute for Safe Medication Practices



Institute for Safe  
Medication Practices

*a nonprofit organization*

1800 Byberry Road, Suite 810  
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[www.ismp.org](http://www.ismp.org)

*A nonprofit organization  
devoted to safe medication  
use and the prevention  
of medication errors*

The Institute for Safe Medication Practices (ISMP) is the nation's only nonprofit organization devoted entirely to understanding the causes of medication errors and providing valuable error prevention strategies to the healthcare community, policy makers, and the public. The organization is known and respected worldwide for its ability to disseminate impartial, timely, and accurate medication safety information.

ISMP's highly effective efforts, which are built on a non-punitive approach and systems-based solutions, focus on improving the safety of medication use systems and drug naming, packaging, and labeling.

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a SCREEN of this pms  
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*ISMP pursues its mission of ensuring safe medication use by:*

### **Expanding Knowledge**

- One of the nation's most highly regarded sources of unbiased information on medication safety
- Collection and analysis of data on medication safety through confidential practitioner reports and hospital surveys
- Independent review of all incidents reported to the United States Pharmacopeia (USP)-ISMP Medication Errors Reporting Program and collection/analysis of errors through ISMP's global information network
- White papers on key issues, including bar coding of unit-dose drugs and electronic prescribing
- Self-assessment tools to help hospitals and community/ ambulatory pharmacies identify opportunities for improvement in their medication use systems and compare their experience with other care sites.

### **Error Analysis**

- Pioneering use of failure mode and effects analysis (FMEA) to learn where/when errors are most likely to occur and how to prevent them
- Site visits and proactive safety consultations in hospitals, cancer centers, and other patient care settings around the world
- Confidential analysis of root causes after serious errors occur
- Partnership with other organizations to support the Pennsylvania Patient Safety Authority, an independent

state reporting system, in collecting data and analyzing medication errors

- Medical Error Recognition and Revision Strategies (Med-E.R.R.S<sup>®</sup>), a wholly owned subsidiary that works confidentially with pharmaceutical companies to predict potential errors due to proposed drug names, labels, and packaging.

### **Medication Safety Education**

- Targeted educational sessions, symposia, and teleconferences
- Extensive collection of educational resources, including CD-ROMs, posters, books, and videotapes
- Knowledgeable and articulate speakers from varied health disciplines who can provide expert advice and education on patient safety issues
- Meeting planning services for medical symposia, including faculty recruitment, promotion, and onsite coordination
- Twelve-month fellowship program and other onsite educational opportunities for pharmacy, nursing, and medical students.

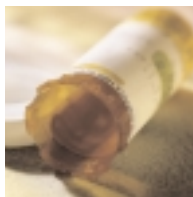
### **Organizational Cooperation**

- Official partnership in the U.S. Food and Drug Administration's MedWatch program to track errors and adverse events
- Collaboration with professional organizations, including the American Hospital Association (AHA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and National Coordinating Council on Medication Error Reporting and Prevention (NCCMERP)
- Highly effective educational efforts with state and federal legislative and regulatory bodies to improve the safety of medication use
- Pathways for Medication Safety ([www.medpathways.info](http://www.medpathways.info)), a set of resource materials designed to improve patient safety, developed with help from AHA and Health Research and Educational Trust, and support from The Commonwealth Fund
- Cooperative regional efforts, such as the Regional Medication Safety Program for Hospitals in the Philadelphia area, a joint effort by ISMP, the Health Care Improvement Foundation, and ECRI, a health services research agency.

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## Broad-based Communication

- *ISMP Medication Safety Alert!*, the nation's only biweekly publication reaching nearly every U.S. hospital with information on medication errors and practical prevention strategies, and three other electronic newsletters that reach nearly one million nurses, community/ambulatory practitioners and consumers
- Special electronic medication hazard warnings on specific issues targeted to healthcare professionals
- Articles and continuing columns in more than 20 journals that reach practitioners in virtually every healthcare field
- Website with timely medication safety information for medical professionals and consumers and a message board that allows individuals from all over the world to discuss medication use problems
- Media relations campaigns that reach millions of medical professionals and the public with messages about safe medication use
- Annual Cheers Awards honoring individuals, organizations and companies setting standards of excellence in the prevention of medication errors.



## Help Us Ensure Safe Medication Use

As an independent organization, ISMP receives no advertising revenues and depends entirely on the assistance of healthcare practitioners, volunteer efforts, educational projects, grants, and donations to pursue its life-saving work.

For more information on medication safety, or to learn how to help support ISMP's mission of error prevention, contact:

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## ISMP Accomplishments

Among its many achievements, the Institute is proud to have:

- Issued repeated warnings about errors from dangerously confusing dose expressions, which significantly influenced manufacturers' decisions to revise package labels
- Published warnings and filed petitions with the United States Adopted Names Council that led to the official renaming of sound alike/look alike generic names
- Led campaign that spurred the Veterans Administration to require removal, and JCAHO to urge nationwide removal, of potassium chloride for injection concentrate from all patient care areas
- Convened a national meeting in the wake of deaths associated with the improper use of lidocaine 1 and 2 gram concentrate prefilled syringes that resulted in the removal of these products from U.S. market
- Helped design special safety labeling for Platinol® (cisplatin), a chemotherapy agent, to prevent confusion on dosing
- Created list of error-prone medication abbreviations, symbols, and dose designations, some of which were added to JCAHO's National Patient Safety Goals
- Influenced decision by the National Coordinating Council for Medication Error Reporting and Prevention to require greater specificity and clarity in doses with decimal points
- Helped develop special hazard warnings and labeling practices for injectable vincristine to prevent repeated incidents of accidental intrathecal injection
- Convinced numerous manufacturers to correct problems with product names, labeling, and packaging that might lead or have led to errors
- Persuaded many pharmaceutical advertisers to eliminate depictions of potentially dangerous prescription-writing practices (such as medical abbreviations and ambiguous handwriting in their ads)