***ISMP Medication Safety Self Assessment® for Perioperative Settings: How to Obtain the Most Valuable, Accurate, and Useful Results***

| **Question(s)** | **Answer** |
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| **Applicable Perioperative Settings** | |
| Is the labor and delivery setting separated or is it included in with the general operating room setting? Would you recommend that procedural areas (e.g., cath lab, interventional radiology) within the same facility be included in the assessment? | If the labor and delivery and/or procedural areas within a facility conduct medical and/or surgical procedures that require moderate sedation, deep sedation, monitored anesthesia care (MAC), regional anesthesia, and/or general anesthesia, they should be included in the assessment. The level of implementation with each applicable best practice should be evaluated for the labor and delivery and/or procedural areas, along with all other perioperative areas where medical and/or surgical procedures that require moderate sedation, deep sedation, monitored anesthesia care (MAC), regional anesthesia, and/or general anesthesia are performed. |
| **Conducting the Assessment** | |
| I see The Joint Commission (TJC) has endorsed the assessment. Does this mean that TJC requires organizations to conduct a self-assessment and/or achieve a certain level of implementation for the assessment or individual best practices? Can you further explain if this assessment is mandatory to complete for acute care hospitals or if it is a beneficial safety review? | Completion of this assessment or particular score attainment is not mandatory or required by TJC or any other accreditation organization for either hospitals or ambulatory surgery centers; however, using an assessment tool like this one to evaluate organizational practices, identify opportunities for improvement, and demonstrate actions around identified safety gaps is often viewed by accreditation agencies as an example of your commitment to organizational quality and performance improvement and a commitment to care excellence.  Importantly, completion of the assessment allows perioperative teams to pinpoint how currently designed systems, staff practices, and emerging challenges may impact perioperative medication safety. The assessment will allow organizations to identify and prioritize opportunities for improvement; create organization-specific, safety-focused initiatives; compare their experiences with the aggregate experiences of demographically similar organizations; and track their experiences over time. |
| For organizations that are part of a larger health system, would you recommend each hospital/facility complete the assessment individually? Or should we complete the assessment as a system and select the score corresponding to the lowest value possible? Since we have two hospitals within our health system, is the expectation that we would submit two separate assessments? | It is important for each facility in a health system to complete the assessment individually and submit its information separately. The items in the assessment evaluate practices more often than policies and procedures, and although standardization across a health system is desirable, practices often differ. For an accurate assessment, the tool requires information that can only be provided by practitioners who work in the facility. Each facility will truly benefit from completing the assessment individually and obtaining its own individual set of scores to focus on vulnerabilities that may vary from facility to facility. Corporate-level assessment invalidates the tool’s effectiveness and usefulness. |
| If our ambulatory surgery center is connected to our hospital via a covered walkway, would that be considered a separate facility for this assessment? | It would benefit the hospital and ambulatory surgery center to conduct the assessment separately if operation of the two facilities and practitioner practices differ. That way, each perioperative setting can clearly evaluate its level of implementation of the best practices presented in the assessment and work to improve vulnerabilities specific to their settings. |
| What I am hearing is that there should be an interdisciplinary team and not two different teams (e.g., OR and pharmacy) conducting the same assessment? | The assessment should be conducted by an interdisciplinary team representative of all perioperative settings in the facility, not individually by teams based on the perioperative setting or departments. Because medication use is a complex, interdisciplinary process, the value and accuracy of the assessment is significantly reduced if it is completed individually by separate perioperative settings, departments, or a single discipline. |
| Perioperative departments are quite stretched currently as we work through back log secondary to COVID as well as staff vacancies; there is some concern of resources required to complete this assessment. Can you speak generally to required time/resource to complete? | During pilot testing of the assessment, ambulatory surgery centers (ASCs) typically created teams comprising three practitioners or more, and hospitals typically created teams comprising three to eight practitioners (largely dependent on the size of the facility). Approximately three 1.5 hour meetings for ASCs and four 1.5 hour meetings for hospitals were required to complete the assessment, after the Demographics questions have been answered. |
| Regarding the time for completion, the PDF document shows the time commitment was about 26 hours. Why is this so different from the 4 x 1.5 hour meetings? | The time required for small teams to complete this information collection is estimated to be 8.54 hours for ambulatory surgery centers and 25.67 hours for hospitals. This estimate represents an average of the total number of hours, combining all the hours spent by each team member, to complete the assessment during pilot testing. Thus, if an average of 4 to 5 team members in a hospital took four 1.5 hour team meetings to complete the assessment, 24 to 30 hours in total were required to complete the assessment. |
| **Answering the Assessment Items** | |
| What if we think a best practice is Not Applicable (NA) in our facility? | We have anticipated that certain best practices will be NA in certain facilities and have provided an NA answer choice for these items. If there is no NA choice, it typically means all facilities should evaluate their level of implementation to that best practice, as the advisory group and pilot testers felt it was applicable to all—both inpatient and outpatient perioperative settings. However, if you think a best practice item without an NA choice is not applicable in your facility, please contact us and explain why you don’t think that the item is applicable to you. We can help you determine the best answer choice. Also, it would be good for us to know if there is an NA that we missed so that we can make that change in future revisions. Or we can help you understand why the best practice is applicable to your setting. |
| **Submitting and Analyzing Assessment Findings** | |
| What is the best way to submit data to ISMP for a multihospital system with outpatient ambulatory surgery centers? | It is important for each facility in a health system to complete the assessment individually and submit its information separately. |
| How do we obtain a collaborative code or health system code? Can we create a collaborative code for a health-system? Do you know the cost to become part of a cohort of result data? | If you are a health system or collaborative leader who would like to contract with ISMP for a fee to have ISMP aggregate your group’s assessment results, please contact ISMP ([selfassess@ismp.org](mailto:selfassess@ismp.org)) to learn more and receive pricing information.. ISMP will work with each collaborative group to develop the codes that the collaborative then assigns and distributes to each of its facilities (ISMP must approve the codes that are used before distribution). If you are part of a participating health system or collaborative that plans to analyze its aggregate data internally, you can enter your assigned health system- or collaborative-specific code when setting up your account or you can add your code to your account once you have submitted the entire assessment. If you do not know your health system- or collaborative-specific code, please contact your health system or collaborative leader. |
| Within a health system, how do we distinguish results within the same health system? | It is important for each facility in a health system to complete the assessment individually and submit its information separately. So, each facility within a health system should obtain individual scores associated with the assessment. Individual facility assessment scores will be available to each individual facility that submits data to ISMP, even if the data is being aggregated for collaborative analysis and improvement. |
| Can the assessment narrow down the lower scores into different areas inside the facility to finetune implementations to the different areas? | The scores for each self assessment item, core characteristic, and key element represent the cumulative evaluation of the level of implementation of best practices in all perioperative settings in a facility. Keeping notes during the assessment can help you identify specific areas of vulnerability that require improvement. |
| **Miscellaneous** | |
| Could you repeat where to access the Excel spreadsheet? | The Excel spreadsheet can be found at: <https://www.ismp.org/resources/medication-safety-self-assessmentr-perioperative-settings>. Once on that webpage, you will need to be signed into the ISMP website in order to access and download the Excel file. If you don’t have an account for the ISMP website, you can create one for free. If you are signed into your ISMP website account and on the above webpage, you will see a yellow button near the bottom of the page that says, “DOWNLOAD EXCEL.” |
| What is the definition of a "medication error"? | For the purpose of this assessment, a medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. |
| Verbal orders were mentioned. Could you please define when these would be warranted in the OR? | Face-to-face verbal orders from prescribers who are onsite in the facility should never be accepted, except in emergencies or during sterile procedures where ungloving would be impractical. An example of when a verbal order might be appropriate is when a prescriber verbally orders a dose of a moderate sedation agent during a procedure for a registered nurse to administer (if the nurse is allowed to administer certain moderate sedation agents within the scope of their professional practice and under the direct supervision of the physician). |