

> **Best Practices** — continued from page 3**Table 1.** Compliance with three new 2022-2023 **ISMP Targeted Medication Safety Best Practices for Hospitals** (N = 188)

Best Practice*	Percent Compliance			Commonly Reported Barriers (B) and Enablers (E) to Implementation
	None	Partial	Full	
<b>#17. Safeguard against errors with oxytocin use</b>				
Require the use of standard order sets when prescribing	5	12	83	<b>B:</b> Anesthesia staff resistance; allowing prescribers to bypass the order set <b>E:</b> Implement systemwide standard order sets; leadership requiring its use
Standardize to a single concentration for both antepartum and postpartum infusions	7	9	84	<b>B:</b> Anesthesia staff resistance; supply issues <b>E:</b> Provide a single concentration in the electronic prescribing system and infusion pump drug library
Standardize how oxytocin doses, concentration, and rates are expressed	4	16	80	<b>B:</b> Different dose expressions based on the indication <b>E:</b> Standardize dose expressions in order sets and infusion pump drug library
Communicate infusion orders in terms of the dose rate and align with the smart infusion pump dose error-reduction system (DERS)	5	13	82	<b>B:</b> Workflow challenges; oxytocin excluded from infusion pump interoperability <b>E:</b> Review oxytocin dose rates monthly at medication safety meetings
Provide oxytocin in a ready-to-use form	5	9	86	<b>B:</b> May not be available commercially; supply issues <b>E:</b> Pharmacy prepares infusions; purchases infusions from a compounder
Boldly label both sides of the infusion bag to differentiate oxytocin bags from plain hydration and magnesium infusions	49	15	36	<b>B:</b> Infusions purchased from a compounder are only labeled on one side <b>E:</b> None reported
Avoid bringing oxytocin to the bedside until it is prescribed and needed	7	36	57	<b>B:</b> Staffing shortages; nurse preference to have all emergency supplies in room; nurse unable to leave patient alone to get supplies <b>E:</b> None reported
<b>#18. Expand the use of barcode verification prior to medication and vaccine administration beyond inpatient care areas</b>				
Target areas with a short or limited patient stay, such as:				
a. Emergency department	7	28	65	<b>B: Equipment related</b> - Not enough scanning equipment; lack of space for equipment; concerns about sterility or metal objects <b>B: Information technology related</b> - Requires complex rebuilding of the electronic health record; problems with electronic prescribing templates <b>B: Staffing related</b> - Not enough pharmacists to verify orders; training needs, especially with contracted per diem nurses; misperception that scanning is only needed for documentation; perceived increase in time; low compliance <b>B: Workflow related</b> - One-step medication prescribing, administration, documentation (no order entry); verbal orders; medications not prepared and barcoded in the pharmacy; patient's identification band under a sterile drape; lack of barcodes on some drugs such as radiopharmaceuticals; medication/solution (e.g., dialysate) not documented on the medication administration record <b>E:</b> None reported
b. Operating rooms (ORs)	38	55	7	
c. Procedure rooms	24	60	16	
d. Perioperative holding areas	13	24	63	
e. Post-anesthesia care units (PACU)	9	18	73	
f. Radiology	28	41	31	
g. Labor and delivery	5	23	72	
h. Infusion clinics	16	8	76	
i. Dialysis centers	11	22	67	
j. Cardiac catheterization labs	31	46	23	
Regularly review compliance data and other metrics to assess utilization and effectiveness	0	31	69	<b>B:</b> Unable to tell if compliance statistics reflect scanning <i>before</i> (appropriate) or <i>after</i> (inappropriate) drug administration <b>E:</b> None reported
<b>#19. Layer numerous strategies throughout the medication-use process to improve the safety with high-alert medications</b>				
For each high-alert drug on the facility's list, outline a robust set of processes for managing risk, impacting as many steps of the medication-use process as possible	1	35	64	<b>B:</b> Difficult to assess all aspects for each drug; lack of time <b>E:</b> Put guidance in an electronic format; address certain medications that have the highest risks to patients first
Ensure that the strategies address vulnerabilities in each stage of the medication-use process and apply to all involved disciplines	1	36	63	<b>B:</b> Easy to overlook some phases of medication-use process <b>E:</b> Required element in the California (CA) Medication Error Reduction Plan (MERP)
Avoid reliance on low-leverage strategies to prevent errors, and instead bundle these with mid- and high-leverage strategies	0	49	51	<b>B:</b> Cost; technology limitations; high-leverage strategies not a leadership priority; overreliance on high-alert medication stickers <b>E:</b> None reported
Limit the use of independent double checks to select high-alert medications with the greatest risk for error	3	31	66	<b>B:</b> Standardization within health systems; pediatric safety requirements <b>E:</b> Electronically controlling a few key independent double checks
Regularly assess for risk in safety systems and practices by using information from internal and external sources	0	31	69	<b>B:</b> None reported <b>E:</b> Required element in the CA MERP; schedule time to review internal and external information and make the review a standing agenda item
Establish outcome and process measures to monitor safety and routinely collect data to determine the effectiveness of strategies	6	53	41	<b>B:</b> Overreliance on voluntary reporting <b>E:</b> Required element in the CA MERP

\* For a full description and the exact wording of each *Best Practice*, please visit: [www.ismp.org/node/160](http://www.ismp.org/node/160).