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| FOR IMMEDIATE RELEASE | CONTACT |
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## ISMP Survey Shows Medication Error Reduction Plans Benefit Patient Safety

## *Respondents indicated MERP helped reduce risk, increase reporting, justify MSO positions*

**Plymouth Meeting, Pa.** – The Institute for Safe Medication Practices (ISMP) has recommended that healthcare organizations use California’s Medication Error Reduction Plan (MERP) as a model, and results from a recent survey reinforce the impact this type of comprehensive strategic framework can have on prevention efforts. The survey findings also revealed that even respondents from states without a MERP regulatory requirement could see its value.

The survey, which was conducted with the help of the California Society of Health-System Pharmacists, received 226 responses, 81% of which were from pharmacists. More than half of the respondents work in states that do not require a MERP, and the remaining work in California (47%) or Arkansas (1%), which do require one through their Department of Public Health and State Board of Pharmacy, respectively. Key findings include:

* Overwhelmingly, 84% of respondents from states requiring a MERP use external medication-error related error alerts to help identify systems and processes that need to be modified, something that ISMP has long recommended.
* Nearly three-quarters of respondents from California or Arkansas reported that they believe patients in their organization were safer in part due to enforcement of the MERP’s legal requirements.
* The majority of respondents (78%) that did have a MERP felt that it has reduced harmful medication events.
* More than half of respondents from California or Arkansas have a designated Medication Safety Officer (MSO) or similar position responsible for leading the coordination of their organization’s MERP, and two out of three indicated there was no MSO or similar position prior to the MERP requirement.
* Most survey participants from California or Arkansas (84%) reported that they use a Just Culture process when evaluating and discussing medication errors.
* The majority (68%) of respondents from 30 states that do not require a MERP were in favor of their state adopting a regulatory requirement.

ISMP believes that California’s MERP initiative advances many key error-reduction strategies and urges healthcare organizations to complete a gap analysis using the MERP structure as well as develop their own impactful program that focuses on high-leverage systems and technologies. ISMP recommends that plans include a proactive approach to risk analysis, effective and timely use of measurable assessments, and an annual review to assess the program’s effectiveness.

For a copy of the May 4, 2023, *ISMP Medication Safety Alert!® Acute Care* newsletter article with an analysis of survey results, visit: <https://www.ismp.org/resources/survey-results-show-implementing-medication-error-reduction-plan-merp-improves-safety>

The MERP initiative calls for learning from external medication safety events--healthcare organizations can refer to ISMP’s action agendas ([Action Agendas | Institute For Safe Medication Practices (ismp.org)](https://www.ismp.org/action-agendas)), which identify prominent safety problems and provide actionable recommendations for review by internal safety or quality improvement committees to prevent medication errors.

ISMP also publishes *Targeted Medication Safety Best Practices for Hospitals* to inspire widespread, national adoption of consensus-based best practices for specific medication safety issues that continue to cause fatal and harmful errors in patients, despite repeated warnings in ISMP publications:

[Targeted Medication Safety Best Practices for Hospitals | Institute For Safe Medication Practices (ismp.org)](https://www.ismp.org/guidelines/best-practices-hospitals)

**About the Institute for Safe Medication Practices**

The Institute for Safe Medication Practices (ISMP) is the nation’s first 501c (3) nonprofit organization devoted entirely to preventing medication errors. ISMP is known and respected for its 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 to create one of the largest healthcare quality and safety entities in the world, and ECRI and the ISMP PSO is a federally certified patient safety organization by the U.S. Department of Health and Human Services. 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. Visit [www.ismp.org](http://www.ismp.org) and follow @ismp\_org to learn more.