|  |  |
| --- | --- |
| FOR IMMEDIATE RELEASE | CONTACT |
| February 22, 2024 | Renee Brehio, ISMP Public and Media Relations |
|  | rbrehio@ismp.org • 614-376-0212 |

## ISMP Announces Three Additions to 2024-2025 Targeted Medication Safety Best Practices for Hospitals

*New Items Focus on Tranexamic Acid, Transitions in Care, and Vaccines*

**Plymouth Meeting, Pa.**–Healthcare organizations deciding on where to focus their medication safety efforts over the next two years now have updated recommendations from the Institute for Safe Medication Practices (ISMP). ISMP has released its *2024-2025* *Targeted Medication Safety Best Practices for Hospitals* to identify recurring problems that continue to cause fatal and harmful errors despite repeated warnings and mobilize widespread national action to prevent them.

This year’s list includes new *Best Practices* on preventing wrong-route errors with tranexamic acid, errors at transitions in care, and mistakes with vaccines in inpatient and outpatient settings. “ISMP encourages hospitals and health systems to review this latest set of *Best Practices* and make implementation a priority,” says Christina Michalek, BS, RPh, FASHP, Director of Membership and Patient Safety Organization (PSO). “Our focus is on key areas of concern where there are practical, achievable prevention strategies available to address risk.”

The new *Best Practices* that have been added for 2024-2025 call for practitioners to:

**Safeguard against Wrong-Route Errors with Tranexamic Acid**

Tranexamic acid is an antifibrinolytic used perioperatively or off-label for a variety of hemorrhagic conditions to control bleeding, including postpartum hemorrhage. When accidentally administered intrathecally, it is a potent neurotoxin with a high mortality rate and is almost always harmful to the patient. ISMP has published several safety alerts related to wrong route errors with tranexamic acid. While label colors and vial sizes have been changed for tranexamic acid to help avoid mix-ups with local anesthetics in similar packaging, mistakes related to cap color can still happen when the vials are stored upright near each other. Tranexamic acid and local anesthetics are also available in ampules outside the United States, which contain labels on clear glass that are difficult to read and can be mistaken. In addition, these drugs are often found in areas where barcode scanning may not have been implemented or is not routinely utilized (e.g., perioperative areas, labor and delivery, emergency department), so practitioners are less likely to detect mix-ups.

**Implement Strategies to Prevent Medication Errors at Transitions in the Continuum of Care**

Discrepancies in medication histories and incomplete or inaccurate medication reconciliation are common causes of errors during transitions in the continuum of patient care, which have included drug omissions, wrong doses, wrong drugs, additional drugs, and drugs inappropriate for the patient’s current care level or setting. Establishing expectations for conducting medication history collection, verification, and reconciliation, as well as designating the specific and appropriate individuals who should complete each process step are key to improving safe care handoffs for patients. The new best practice strategies are intended to prevent errors by facilitating collection of the best possible, most complete medication list at the patient’s entry to the care setting, ensuring the medication and doses are correct for that patient given their current state of health, and by having a provider reconcile the medication history list to prescribed therapy documenting modifications and resolving any discrepancies.

**Safeguard against Errors with Vaccines in the Inpatient and Associated Outpatient Settings.**

Immunizations prevent diseases in children and adults; however, errors with vaccines can result in unintended and unrecognized vulnerability, leaving patients unprotected against serious diseases. Analysis of reports submitted to ISMP National Vaccine Errors Reporting Programshow that there are opportunities to reduce the risk of vaccine-related mistakes based on commonly identified contributing factors, such as errors with age-specific formulations, wrong patient errors due to confusion between siblings, invalid doses (given too soon) or missed opportunities to vaccinate, wrong route errors caused by unfamiliarity with the vaccine, errors with combination vaccines or vaccines with diluents, wrong vaccines related to vaccine nomenclature, wrong vaccine and dose errors related to labeling and packaging, errors related to unsafe vaccine storage, administration of expired vaccines, and failure to involve the patient in the verification process.

ISMP began issuing *Best Practices* in 2014. The 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 Directors. They are designed to set realistic goals, which have already been adopted by numerous organizations.

For a copy of the 2024-2025 ISMP *Targeted Medication Safety Best Practices for Hospitals* document, which contains specific, actionable error prevention suggestions, visit: [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 30 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.