2011 ISMP Medication Safety Self Assessment® for Hospitals

Frequently Asked Questions (FAQs)

GENERAL QUESTIONS

1. What are the benefits of completing the assessment and submitting it to the Institute for Safe Medication Practices (ISMP)?

The following benefits to healthcare consumers and hospitals can only be achieved if we have the ability to collect and aggregate data on a national level:

- Aggregate results from a large pool of respondents will provide US hospitals with important information about the current status of the medication use system, which can be compared to results obtained in 2000 and 2004, and will create a new baseline in 2011 of hospital efforts to enhance medication safety. Such data will be useful in advising hospitals about ongoing medication system improvements.

- The project will be of great value in gaining consumer confidence, as the public will be able to see that hospitals are being proactive in identifying safe practices and will be able to track aggregate progress over time.

- This assessment will be of significant assistance to hospital managers who seek to identify areas of weakness related to medication use in their organization so that top leadership support can be sought for improvements in these critical areas.

- ISMP, the American Hospital Association (AHA), the Health Research and Educational Trust (HRET), and others will be able to focus additional educational efforts and design useful programs to help hospitals implement high-leverage strategies that can positively impact patient safety.

2. What if a specific self-assessment item does not apply to the services provided in my hospital?

A few of the self-assessment items offer the option of "Not Applicable." For these items, "Not Applicable" can only be selected if your hospital meets the listed scoring guideline. For example, if in your organization, chemotherapy (including oral agents) is never prescribed, you can answer "Not Applicable" to item number 69.

3. **We are a psychiatric hospital that doesn't administer IV solutions or medications in any form (e.g., infusions, IV push). How should we answer items that relate to IV drug administration?**

   If your hospital does not administer any IV solutions then you can answer those items that pertain to IV administration with an E.

4. **Our health system consists of three hospitals, which all share many of the same corporate functions (e.g., Pharmacy and Therapeutics [P&T] Committee, Risk Management, Information Technology, policies and procedures). Should we complete just one assessment for all three hospitals?**

   It is important that each hospital in a multihospital system complete the assessment individually and submit their information separately. The items in the assessment ask questions well beyond governance and policies and procedures that are in place. Each hospital will truly benefit if they complete the assessment individually and obtain their own individual set of scores.

5. **We are a behavioral health/ambulatory care organization. Is the ISMP assessment appropriate for our organization?**

   Many of the items contained in the assessment may not be applicable to your organization, but we would encourage you to organize an interdisciplinary team, review those items that are appropriate for your organization, and use the results internally. If you have further questions, please contact: selfassess@ismp.org.

DEMOGRAPHICS

1. **Must I answer all of the questions in the demographics section?**

   All questions in the demographics section must be completed with the exception of question #17.

2. **Are there specific guidelines available for which choice to select for certain questions in the demographics section?**

   Hospital administration should be contacted for the correct responses when completing the demographic questions. Answers to questions such as number of staffed inpatient beds (#1), type of organization (#2), type of service (#3), healthcare system with shared ownership and/or governance (#8), and location (#10), should be consistent with the responses your organization submits to state and federal agencies for licensure, Medicare participation, and on accreditation surveys and applications.

3. How do I answer question #12 if my hospital is located outside of the United States?

When entering your information into the online self-assessment form, you can select either "US Military Foreign" or "Non-US Country" from the drop-down list. If you answered demographic question #2 as "Military," please select "US Military Foreign" as your response to this question. If you are a non-military hospital located outside of the United States completing this assessment, please select "Non-US Country."

4. My hospital is part of a collaborative that plans to aggregate the results of its hospital members. How do I obtain my code for question #17?

If you are part of a participating collaborative that plans to share its aggregate data internally, within the collaborative group, please enter your assigned collaborative-specific code into the box (or boxes, if you have multiple collaborative codes) provided in question #17. If you do not know your collaborative-specific code, please contact your collaborative leader before submitting your information. If you are not part of a collaborative that will be aggregating its results, please leave this question blank.

SELF-ASSESSMENT ITEMS

I. PATIENT INFORMATION
Core Characteristic #1

Item #14
For electronic systems (e.g., electronic medication administration record [eMAR], automated dispensing cabinets [ADCs], COMPUTER ORDER ENTRY SYSTEMS), do all of the patient's known allergies need to be visible?

For electronic systems (eMAR, ADCs, **COMPUTER ORDER ENTRY SYSTEMS**), at a minimum, the patient's allergy status (e.g., "No Known Allergies," "Allergies") should be present on all screens. If limited by space; however, if the patient has several allergies, all of the patient's allergies do not need to be listed on the screen. The user, though, should either be able to easily access a full list of the patient's allergies through a link present on the screen or should be directed to another source (e.g., the patient's chart) for a complete list of allergies.

Item #22
What is meant by "available in the pharmacy computer system for reference" in this item?

A patient's comorbid and/or chronic conditions should be contained in the computer system that pharmacists use to enter or verify medication orders, in order to have easy access to this information as orders are processed. If the information is available in a separate system that must be accessed, then the answer to this item should not exceed level C.

II. DRUG INFORMATION
Core Characteristic #2

Item #34.
What are high-leverage error-reduction strategies?

High-leverage error-reduction strategies are strategies that focus on fixing the system, compared to low-leverage strategies, which rely on the individual. Since people cannot be expected to compensate for weak systems, error prevention tools that are designed to fix the system have a broader, more lasting impact (high-leverage), than those directed at changing human behavior (low-leverage). For more information about selecting error-reduction strategies and examples of both high-leverage and low-leverage strategies, click here.

Items #47. and #48.
What are some examples of medication orders that can be used to test COMPUTER ORDER ENTRY SYSTEMS, in order to verify that the system screens for allergies, contraindications, interactions, and appropriateness, based on the patient's profile?

Examples of medication orders that can be used to test your **COMPUTER ORDER ENTRY SYSTEM** can be found at the end of this document. **Please note:** This is not an exhaustive list of examples.

II. DRUG INFORMATION
Core Characteristic #3

Item #52.
What is meant by the "potential for error is investigated" in this item?

The "potential for error" in this item refers to a review of external publications (e.g., *ISMP Medication Safety Alert!*®, FDA alerts, manufacturer notices) for information on reported errors. Feedback from hospital committee members on any personal experiences using the medication outside of the organization is also obtained, and discussion about errors that may be prone to occur due to characteristics of the medication or drug category is reviewed before adding a drug to the formulary.

Item #53.
What does "adequately monitor and manage" mean in this item?

"Adequately monitor and manage" refers to the ability of the healthcare organization to provide relevant and current laboratory information, up-to-date drug alerts, and appropriate monitoring equipment in order for practitioners to adjust medication therapy, prevent adverse drug effects (including errors) from occurring, or to help mitigate their adverse effects.

Items #58. and #59.
Please explain what is meant by "uncommon uses or atypical doses."

Medications that are prescribed for indications or at doses that are not supported in the drug approved labeling or in the current literature would be considered uncommon uses or atypical doses. A medication being prescribed for a non-FDA indication or recommended dose that is supported in peer-reviewed literature would not be considered an uncommon use or atypical dose.

V. DRUG STANDARDIZATION, STORAGE, AND DISTRIBUTION
Core Characteristic #7

Item #98.
What is meant by "consistent terminology" in this item? What would be an example of a "visual cue" that should be used?

When more than one standardized concentration is required for a high-alert infusion, the terminology used to differentiate the concentrations (e.g., double strength, quadruple strength) is consistently used. For example, whenever the term 'double strength' for a specific high-alert infusion is used, it always refers to the same concentration of that high-alert infusion. Visual cues used to distinguish multiple concentrations of the same high-alert infusion may include: using different colored medication labels; using auxiliary labels on the concentrated infusion; and building order entry alerts for verification of the selected concentration.

VI. DRUG MEDICATION DEVICE ACQUISITION, USE, AND MONITORING
Core Characteristic #11

Item #132.
Can all of the components listed in this item (drug/solution, drug concentration, rate of infusion, patient, channel selection, and line attachment) be independently verified using technology?

No. Currently, the technology does not exist to verify all of these components. A second practitioner would still be required to independently verify some of these components (e.g., verify channel selection, line attachment) depending on the capabilities of the technology available in the hospital.

VII. ENVIRONMENTAL FACTORS, WORKFLOW, AND STAFFING PATTERNS
Core Characteristic #13

Items #164. and #165.
How can my organization measure staff perception of staffing patterns and its effect on their ability to perform adequate and safe care?

In order to gain a true perspective from pharmacists, pharmacy technicians, and nurses, regarding the adequacy of staffing patterns within their respective departments, and to select the most accurate choice for each of these items, your organization may want to consider utilizing data obtained from routine, staff surveys that are conducted within your organization. Several surveys on patient safety culture (e.g., AHRQ Surveys on Patient Safety Culture) are available that include questions regarding staff perception of safe staffing patterns.

X. QUALITY PROCESSES AND RISK MANAGEMENT
Core Characteristic #18

Item #247.
Explain the examples given for "effective means of measuring medication safety."

These are methods often used by hospitals as a more accurate measurement to track risk-reduction strategies. They may include:

- **Triggers -** A list of laboratory values, medications, procedures, and other measures (e.g., INRs or PTTs above a critical value, one time dose of an antidote or reversal agent [e.g., naloxone], emergency returns to the operating room) that may indicate an error has occurred. These may be tracked electronically during order entry or manually via electronic printouts and standardized chart review.

- **Tracking risk priority numbers from FAILURE MODE AND EFFECTS ANALYSIS (FMEA) -** A process of assigning a risk assessment number to a specific **FMEA** for a process, incorporating change strategies into the process, and re-performing the **FMEA** to determine if the risk assessment number has changed.

- **Observational methods of error detection -** A determination of error frequency based on the number of errors detected during direct observation of performance. This measurement is used to obtain a numerator, which is then divided by a volume indicator such as the total number of medication doses that should have been administered, total patient admissions, or number of associated procedures, which becomes the denominator.

X. QUALITY PROCESSES AND RISK MANAGEMENT
Core Characteristic #19

Item #264.
Does this item require a second pharmacist to independently double check every medication order that is entered into the pharmacy computer system?

No. However, medication orders entered into the pharmacy computer system should be double checked for transcription accuracy *either* by a pharmacist or another licensed healthcare practitioner, prior to administration of the first dose. This double check should *ideally* be performed by a practitioner other than the individual who entered the order.

This can be accomplished by using a number of different methods (or a combination of these methods), *for example*:

- The order is entered into the pharmacy computer system and a pharmacist compares either the entered order or the label that is generated to the original order;

- A pharmacist enters the order into the pharmacy computer system and a nurse compares the electronic medication administration record (eMAR) to the original order.

If all medication orders are entered by prescribers into a computerized prescriber order entry (CPOE) system, that is fully integrated or **INTERFACED** with the pharmacy system, an independent double check does not need to occur as no transcription would be required. If the organization's CPOE system; however, is not fully integrated or **INTERFACED** with the pharmacy system, and pharmacists are still required to transcribe some or all medication orders into the pharmacy computer system, then an independent double check of the transcription would still need to occur.

SAMPLE MEDICATION ORDERS FOR COMPUTER TESTING

(The following are examples only. If a medication listed below is not on your hospital's formulary, use a medication that is on your hospital's formulary and that is also applicable to the corresponding test category.)

Test Category	Patient Profile	Drug	Dose	Route	Frequency
Allergies and Cross Allergies	Patient with a penicillin allergy	ticarcillin/clavulanate potassium (TIMENTIN)	3.1 grams	IV	every 4 hours
	Patient with a sulfonamide allergy	sulfamethoxazole 800 mg/ trimethoprim 160 mg	1 tablet	PO	twice a day
Contraindication **Based on: Route**	Adult patient	vin**CRIS**tine	2 mg	intrathecally	now
	Adult patient	cephalexin oral suspension	250 mg	IV	every 6 hours
Contraindication **Based on: Pregnancy/Lactation**	Pregnant patient	simvastatin	20 mg	PO	once daily in the evening
	Pregnant patient	**ISO**tretinoin	40 mg	PO	twice daily
Dose Limit or Contraindication **Based on: Patient Diagnosis**	Adult patient with rheumatoid arthritis	methotrexate	10 mg	PO	daily
Dose Limit or Contraindication **Based on: Laboratory Results**	Adult patient with a creatinine clearance (CrCl) of less than 50 mL/min	levofloxacin	750 mg	IV	every 24 hours
	Adult patient with an INR of 6	warfarin	5 mg	PO	daily
Dose Limit or Contraindication **Based on: Patient Age/Weight**	Pediatric patient with a weight of 8 kg	morphine	8 mg	IV	once
	12 year old patient	**CIS**platin	204 mg	IV	once
	83 year old patient	triazolam	0.5 mg	PO	at bedtime

SAMPLE MEDICATION ORDERS FOR COMPUTER TESTING (continued)

Test Category	Patient Profile	Drug	Dose	Route	Frequency
Single and Cumulative Dose Limits	Adult patient	warfarin	3 mg	PO	every 1 hour
	Adult patient	atenolol	100 mg	PO	three times a day
	Adult patient already receiving: oxy**CODONE** 5mg/ acetaminophen 500 mg, 1 tablet PO every 6 hours	acetaminophen	650 mg	PO	every 4 hours
	Opioid-naïve adult patient	**HYDRO**morphone	4 mg	IV	once
Therapeutic Duplication	Adult patient already receiving: enalapril 5 mg PO daily	lisinopril	10 mg	PO	daily
Ability to build corollary orders into the system	Adult patient without a baseline platelet count	heparin	5,000 units	subcutaneously	every 12 hours
	Adult patient without an ordered INR	warfarin	5 mg	PO	daily