

ISMP®



2017

**ISMP Medication Safety
Self Assessment® for
Community/Ambulatory Pharmacy**

Frequently Asked Questions (FAQs)

I. PATIENT INFORMATION

Core Characteristic #1

Item #2.

What steps can a pharmacy take to avoid having multiple profiles for one person?

Be cognizant of name suffixes (Jr.), first/last name interchanges, and incorrect assignment of first and last names (e.g., James John vs. John James; Ikembe Fintumbo vs. Fintumbo Ikembe). If applicable, utilize the patient's driver's license name or the name on their insurance card.

II. DRUG INFORMATION

Core Characteristic #2

Item #30.

When would data not be available during a safety screening?

A "no data available" situation may occur for one of several reasons such as 1) a new drug has not yet appeared in the pharmacy system; 2) the community pharmacy elects to receive the drug file data (NDCs, pricing, packaging, ingredients, etc.) weekly but only updates their clinical screening data monthly; 3) a drug, such as one from a regional repackager, is unknown to the drug database provider; 4) the clinical database cannot support screening (such as the "dose" for a topical cream).

II. DRUG INFORMATION

Core Characteristic #3

Item #33.

Who should be able to add newly created MNEMONICS, sig codes, or speed codes to the pharmacy computer system and why?

MNEMONICS, sig codes, and speed codes should only be added to the pharmacy computer system by administrative personnel using a standardized process. These codes should not be created or added at the store level because codes could have different meanings in different stores, which may result in errors.

III. COMMUNICATION OF DRUG ORDERS AND OTHER DRUG INFORMATION

Core Characteristic #4

Item #40.

What is meant by "scanned image accurately represents the original prescription"?

Scanning converts a three dimensional object (the original prescription order) to a two dimensional image. During this conversion, important information can be lost or changed. For example, a faint decimal point that is clearly evident upon visual inspection of the original prescription order can be lost entirely on the scanned image. The pharmacy should have a process to ensure that scanned prescription images accurately represent the original prescription orders.

Item #46.

Besides the prescription, patient’s name, and prescriber information, what other pieces of information should be communicated and “READ BACK” to the prescriber or agent?

The **READ BACK** should include the patient’s date of birth and the indication for the medication being prescribed to ensure the correct patient and medication.

IV. DRUG LABELING, PACKAGING, AND NOMENCLATURE

Core Characteristic #6

Item #57.

Are there guidelines that we can follow for how to format pharmacy prescription labels?

Guidelines containing recommendations for pharmacy prescription labels are available through ISMP and the United States Pharmacopeial Convention (USP):

ISMP Principles of Designing a Medication Label for Community and Mail Order Pharmacy Prescription Packages
<http://www.ismp.org/tools/guidelines/labelFormats/comments/default.asp>.

USP General Chapter <17> Prescription Container Labeling in USP 36–NF 31 <http://www.usp.org/usp-nf/key-issues/usp-nf-general-chapter-prescription-container-labeling>.

Item #58.

What is meant by Universal Medication Schedule (UMS)?

The UMS standardizes directions for use by utilizing explicit times to describe when to take medicine (morning, noon, evening, bedtime).

Item #62.

Where can we find more information about prescription container label guidelines for the visually impaired?

Guidance is available from the US Access Board on how to make prescription drug container labels accessible to people with vision impairments or who are elderly.

V. DRUG STANDARDIZATION, STORAGE, AND DISTRIBUTION

Core Characteristic #8

Item #73.

What is the rationale for keeping two-component vaccines together and for keeping manufacturer-supplied diluents with their corresponding vaccines?

When a lyophilized (powdered) vaccine is co-packaged with a second component or manufacturer-supplied diluent, danger exists that only one component or only the diluent will be dispensed and administered by practitioners who mistakenly believe it is the complete vaccine. Also, the diluent container label may emphasize the active vaccine, leading to erroneous administration of the diluent alone. Errors have also occurred when an unintended diluent has been used to reconstitute the lyophilized vaccine instead of the specific diluent provided by the manufacturer. Thus, if storage requirements are the same for both vials, it is recommended to keep two-component vaccines together, and to keep diluents and their corresponding vaccines together. Suggestions for keeping the vials together include using a rubber band or placing them together in a sealable plastic bag with an auxiliary label to remind staff to use both vials.

VII. ENVIRONMENTAL FACTORS, WORKFLOW, AND STAFFING PATTERNS

Core Characteristic #12

Item #103.

What are some specific pharmacy dispensing activities that would be considered nonsterile compounding per USP <795>?

Reconstitution or manipulation of commercial products that may require the addition of one or more ingredients is deemed to be nonsterile compounding per USP <795>.

VIII. STAFF COMPETENCY AND EDUCATION

Core Characteristic #15

Item #141

What is the difference between high-leverage and low-leverage safety strategies?

High-leverage strategies fix the system; low-leverage strategies focus on the individual involved in an error. 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). Since not all safety strategies are created equal, selecting the best strategy to remedy medication errors is not easy. Often, the most effective action is not obvious and the best error-prevention tools to use in each situation are not clear, even when system-based causes have been identified. For more information about selecting strategies, visit: <http://www.ismp.org/Newsletters/acutecare/articles/19990602.asp>.

IX. PATIENT EDUCATION

Core Characteristic #16

Item #152.

What are some safety concerns that pharmacists should discuss with patients/caregivers?

When dispensing medications that have been known to be problematic, pharmacists should discuss the potential for error (e.g., look-alike names, methotrexate inadvertently given daily for arthritis) and provide patients/caregivers with strategies to help prevent such an occurrence. Consumer medication information leaflets for select **HIGH-ALERT MEDICATIONS** that offer important safety tips to discuss with the patient/caregiver can be found at: <http://www.ismp.org/AHRQ/signin.asp?link=ha>.

Item #159.

Why does ISMP recommend metric-only devices for patients to measure oral liquid medications?

The National Council for Prescription Drug Programs (NCPDP) has issued recommendations and guidance for standardizing the dosing designation used on prescription container labels of oral liquid medications dispensed by community pharmacies to metric units in order to reduce dosing errors; therefore, patients and caregivers should have a proper metric measuring device. <http://www.ncpdp.org/NCPDP/media/pdf/wp/DosingDesignations-OralLiquid-MedicationLabels.pdf>.

Please explain what you mean by “teach-back” method.

The teach-back method, also called the “show-me” method, is a communication confirmation method used by healthcare providers to confirm whether a patient (or caregiver) understands what is being explained to them. If a patient understands, they are able to “teach-back” the information accurately. For more information, visit: <http://www.teachbacktraining.org/>.

Item #167.

What is meant by comprehensive appointment-based medication synchronization (ABMS) program?

The ABMS program allows pharmacists to manage patients' needs more proactively. The pharmacist performs a complete medication review and discusses the medication therapy and any changes before dispensing. A patient's medications are synchronized to be dispensed once a month on a single appointment day. Prior to the appointment, the patient receives a reminder call during which any prescription changes are discussed. On the appointed day, the patient visits the pharmacy to pick up the medications.

X. QUALITY PROCESSES AND RISK MANAGEMENT

Core Characteristic #18

Item #189

What are some examples of positive incentives?

Leadership recognizes staff and presents an award certificate for a "good catch" or for bringing attention to a hazardous situation.

Award recipients are featured in the organization's newsletter.

X. QUALITY PROCESSES AND RISK MANAGEMENT

Core Characteristic #20

Item #211

What is meant by "INDEPENDENTLY DOUBLE CHECKED by a pharmacist" in regards to this item?

At the point of sale, pharmacists verify that medication requiring reconstitution/mixing has been properly prepared, prior to dispensing it to the patient/caregiver.