

Worksheet for the 2022-2023 ISMP Targeted Medication Safety Best Practices for Hospitals



This tool was developed to assist hospitals in analyzing their current status with implementing the **2022-2023 ISMP Targeted Medication Safety Best Practices for Hospitals**. Please refer to the [Targeted Medication Safety Best Practices for Hospitals](#) document for related references, as well as the rationale and significance for focusing on each of these **Best Practices**. Additional resources, including [Frequently Asked Questions](#), are also available.

Each of the **Best Practices** are listed in the first column of the table below (**PLEASE NOTE:** Archived Best Practices appear at the end of this Worksheet. **Best Practice 12**, which was incorporated into **Best Practice 15**, is not listed in this Worksheet). The second column, titled “Hospital Assessment,” allows hospitals to evaluate their implementation status with each **Best Practice**. For this column, select an answer (“Fully Implemented,” “In Progress,” “Not Implemented,” or “Not Applicable”) under the “Implementation Status” dropdown menu (or handwrite your answer next to it). Below your answer, provide a more descriptive analysis of your current status and rationale for your selected answer. In the last column (“Action Required/Assignment”), hospitals can detail their action plan for fully implementing each of the **Best Practices**, as well as to assign individuals or teams/committees certain related tasks.

The purpose of the **Targeted Medication Safety Best Practices for Hospitals** is to identify, inspire, and mobilize widespread 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. ISMP encourages hospitals to focus their medication safety efforts on these **Best Practices**, and this worksheet may help hospitals to identify gaps in their safety practices and to develop their action plan for implementation.

2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 1			
	Dispense vinCRistine and other vinca alkaloids in a minibag of a compatible solution and <i>not</i> in a syringe.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 2			
a	Use a weekly dosage regimen default for oral methotrexate in electronic systems when medication orders are entered.	Implementation Status	
b	Require a hard stop verification of an appropriate oncologic indication for all daily oral methotrexate orders. ➤ For manual systems and electronic order entry systems that cannot provide a hard stop, clarify all daily orders for methotrexate if the patient does not have a documented appropriate oncologic diagnosis. ➤ Hospitals need to work with their software vendors and information technology departments to ensure that this hard stop is available.	Implementation Status	
c	Provide specific patient and/or family education for all oral methotrexate discharge orders.	Implementation Status	

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BEST PRACTICE 2 continued			
	➤ Double-check all printed medication lists and discharge instructions to ensure that they indicate the correct dosage regimen for oral methotrexate prior to providing them to the patient.	Implementation Status	
	➤ Ensure that the process for providing discharge instructions for oral methotrexate includes clear written instructions AND clear verbal instructions that specifically review the dosing schedule, emphasize the danger with taking extra doses, and specify that the medication should not be taken “as needed” for symptom control.	Implementation Status	
	➤ Require the patient to repeat back the instructions to validate that the patient understands the dosing schedule and toxicities of the medication if taken more frequently than prescribed.	Implementation Status	
	➤ Provide all patients with a copy of the free ISMP high-alert medication consumer leaflet on oral methotrexate (found at: www.ismp.org/ext/221).	Implementation Status	

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BEST PRACTICE 3			
a	Weigh each patient as soon as possible on admission and during each appropriate* outpatient or emergency department encounter. Avoid the use of a stated, estimated, or historical weight. <i>* Appropriate encounters include all encounters where the patient is being seen by a licensed independent practitioner, excluding life-threatening situations where the delay involved in weighing the patient could lead to serious harm (e.g., major trauma). Encounters that involve laboratory and other services where medications are not prescribed or administered would be considered an exclusion to this definition.</i>	Implementation Status	
	➤ Have metric scales available in all areas where patients are admitted or encountered. Ensure the metric weight is documented in the medical record.	Implementation Status	
	➤ Do not rely on a patient's stated weight, a healthcare provider's estimated weight, or a documented weight from a previous encounter.	Implementation Status	

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BEST PRACTICE 3 continued			
b	Measure and document patient weights in metric units only.	Implementation Status	
	➤ If scales can measure in both pounds/ounces and kilograms/grams, modify the scale to lock out the ability to weigh in pounds/ounces.	Implementation Status	
	➤ If purchasing or replacing scales, buy new scales that measure in, or can be locked to measure in, metric units only.	Implementation Status	

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BEST PRACTICE 3 continued			
	➤ Have charts that convert from kilograms (or grams for pediatrics) to pounds available near all scales, so that patients/caregivers/parents can be told the weight in pounds, if requested.	Implementation Status	
	➤ Ensure that electronic health record screen views, medication device screens (e.g., infusion pumps), printed patient information documents, and printed order and/or communication forms, list or prompt for the patient's weight in metric units only.	Implementation Status	
	➤ Document the patient's weight in metric units only in all electronic and written formats.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 7			
	Segregate, sequester, and differentiate all neuromuscular blocking agents (NMBs) from other medications, wherever they are stored in the organization.	Implementation Status	
	➤ Eliminate the storage of NMBs in areas of the hospital where they are not routinely needed.	Implementation Status	
	➤ In patient care areas where they are needed (e.g., intensive care unit), place NMBs in a sealed box or, preferably, in a rapid sequence intubation (RSI) kit.	Implementation Status	
	➤ Limit availability in automated dispensing cabinets (ADCs) to perioperative, labor and delivery, critical care, and emergency department (ED) settings; in these areas, store NMBs in rapid sequence intubation (RSI) kit, or lock-lidded ADC pockets/drawers.	Implementation Status	

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BEST PRACTICE 7 continued			
	➤ Segregate NMBs from all other medications in the pharmacy by placing them in separate lidded containers in the refrigerator or other secure, isolated storage area.	Implementation Status	
	➤ Place auxiliary labels on all storage bins and/or ADC pockets and drawers that contain NMBs as well as all final medication containers of NMBs (e.g., syringes, IV bags) that state: “WARNING: CAUSES RESPIRATORY ARREST – PATIENT MUST BE VENTILATED” or “WARNING: PARALYZING AGENT – CAUSES RESPIRATORY ARREST” or “WARNING: CAUSES RESPIRATORY PARALYSIS – PATIENT MUST BE VENTILATED” to clearly communicate that respiratory paralysis will occur and ventilation is required.* <i>Exception: The auxiliary label practice excludes anesthesia-prepared syringes of NMBs.</i> <i>* Other acceptable alternatives to labeling storage bins and/or ADC pockets are to affix an auxiliary warning label (in addition to the manufacturer's warning on the caps and ferrules) directly on all vials and/or other containers stocked in storage locations, or by displaying a warning on the ADC screen (e.g., “Patient must be intubated to receive this medication”) that interrupts all attempts to remove a neuromuscular blocker via a patient's profile or on override. The warning should require the user to enter or select the purpose of the medication removal (“other” should not be a choice) and verify that the patient is (or will be) manually or mechanically ventilated.</i>	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 8			
a	Administer medication infusions via a programmable infusion pump utilizing dose error-reduction systems.* <i>This Best Practice applies to all hospital settings, both inpatient and outpatient (e.g., magnetic resonance imaging [MRI] department, emergency department, outpatient infusion clinics), and to all situations in which medications are infused by the IV or epidural route, including anesthesia use and patient-controlled analgesia (PCA). The only exception is for small volume vesicant infusions (i.e., chemotherapy vesicants) which, when administered via the peripheral route, should only be infused by gravity and NOT by an infusion/syringe pump.</i> <i>* Dose error-reduction systems: Refers to the integral computer software in smart infusion pumps intended to aid in prevention of infusion programming-related errors and warn users of potential over- or under-delivery of a medication or fluid by checking programmed doses/rates against facility configurable preset limits specific to a medication, fluid, and to a clinical application (e.g., epidural administration) and/or location (e.g., neonatal intensive care unit, medical/surgical unit).</i>	Implementation Status	
b	Maintain a 95% or greater compliance rate for the use of dose error-reduction systems.	Implementation Status	

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BEST PRACTICE 8 continued			
c	Monitor compliance with use of smart pump dose error-reduction systems on a monthly basis.	Implementation Status	
d	If your organization allows for the administration of an IV bolus or a loading dose from a continuous medication infusion, use a smart pump that allows programming of the bolus (or loading dose) and continuous infusion rate with separate limits for each.	Implementation Status	
	➤ Allocate resources for ongoing maintenance, updating, and testing of the software and drug library for all smart infusion pumps.	Implementation Status	

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BEST PRACTICE 8 continued			
	➤ Ensure drug library content is consistent with the drug information and nomenclature (e.g., drug name, dosing units, dosing rate) in the electronic health record.	Implementation Status	
	➤ Plan for the implementation of bi-directional (i.e., auto-programming[†] and auto-documentation[‡]) smart infusion pump interoperability with the electronic health record. <i>† Auto-programming: Automatic programming of infusion parameters from the electronic health record system to the smart infusion pump (which are then verified, and the infusion is started manually by the practitioner) after use of the barcode medication administration system to associate the patient, fluid container (e.g., bag, bottle, syringe), and pump channel.</i> <i>‡ Auto-documentation (also known as auto-charting or infusion documentation): Sending infusion information such as intake data, dose/rate changes, and infusion stop time, to the electronic health record system for manual clinician confirmation to enable accurate recording of this information to the patient's record after the infusion is started.</i>	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 9			
	Ensure all appropriate antidotes, reversal agents, and rescue agents are readily available. Have standardized protocols and/or coupled order sets in place that permit the emergency administration of all appropriate antidotes, reversal agents, and rescue agents used in the facility. Have directions for use/administration readily available in all clinical areas where the antidotes, reversal agents, and rescue agents are used.	Implementation Status	
	➤ Identify which antidotes, reversal agents, and rescue agents can be administered immediately in emergency situations to prevent patient harm.	Implementation Status	
	➤ Use this list to develop appropriate protocols or coupled order sets to ensure that the above Best Practice is met.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 11			
	When compounding sterile preparations, perform an independent verification to ensure that the proper ingredients (medications and diluents) are added, including confirmation of the proper amount (volume) of each ingredient prior to its addition to the final container.	Implementation Status	
	➤ Specifically, eliminate the use of proxy methods of verification for compounded sterile preparations of medications (e.g., the “syringe pull-back method,” checking a label rather than the actual ingredients).	Implementation Status	

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BEST PRACTICE 11 continued			
	➤ Except in an emergency, perform this verification in all locations where compounded sterile preparations are made, including patient care units.	Implementation Status	
	➤ Use technology to assist in the verification process (e.g., barcode scanning verification of ingredients, gravimetric verification, robotics, IV workflow software) to augment the manual processes. <i>When technology is in use, it is important that processes are in place to ensure it is maintained, the software is updated, and that the technology is always used in a manner that maximizes the medication safety features of these systems.</i>	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 13			
	Eliminate injectable promethazine from the formulary. <i>This Best Practice includes not using intramuscular administration of promethazine because this can also cause tissue damage if accidentally injected intraarterially.</i>	Implementation Status	
	➤ Remove injectable promethazine from all areas of the organization including the pharmacy.	Implementation Status	
	➤ Classify injectable promethazine as a non-stocked, non-formulary medication.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 13 continued			
	➤ Implement a medical staff-approved automatic therapeutic substitution policy to convert all injectable promethazine orders to another antiemetic.	Implementation Status	
	➤ Remove injectable promethazine from all medication order screens, and from all order sets and protocols.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 14			
	Seek out and use information about medication safety risks and errors that have occurred in other organizations outside of your facility and take action to prevent similar errors.	Implementation Status	
	➤ Appoint a single healthcare professional (preferably a medication safety officer) to be responsible for oversight of this entire activity in the hospital.	Implementation Status	
	➤ Identify reputable resources (e.g., ISMP, The Joint Commission, ECRI Institute, patient safety organizations, state agencies) to learn about risks and errors that have occurred externally.	Implementation Status	

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BEST PRACTICE 14 continued			
	➤ Establish a formal process for monthly review of medication risks and errors reported by external organizations, with a new or existing interdisciplinary team or committee responsible for medication safety. The process should include a review of the hospital's current medication use systems (both manual and automated) and other data such as internal medication safety reports to determine any potential risk points that would allow a similar risk or error to occur within the hospital	Implementation Status	
	➤ Determine appropriate actions to be taken to minimize the risk of these types of errors occurring in the hospital.	Implementation Status	
	➤ Document the decisions reached and gain approval for required resources as necessary.	Implementation Status	

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BEST PRACTICE 14 continued			
	➤ Share the external stories of risk and errors with all staff, along with any changes that will be made in the hospital to minimize their occurrence, and then begin implementation.	Implementation Status	
	➤ Once implemented, periodically monitor the actions selected to ensure they are still being implemented and are effective in achieving the desired risk reduction. Widely share the results and lessons learned within the facility.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 15			
Verify and document a patient's opioid status (naïve versus tolerant*) and type of pain (acute versus chronic) before prescribing and dispensing extended-release and long-acting opioids. <i>FentaML patches are for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.</i> <i>Extended-release formulations are for the management of pain severe enough to require daily, around the clock, long-term opioid treatment and for which alternative treatment options are inadequate.</i> * Opioid-tolerant patient: Opioid tolerance is defined by the following markers: Patients receiving, for 1 week or longer, at least: 60 mg oral morphine/day; 25 mcg transdermal fentaML/hour; 30 mg oral oxyCODONE/day; 8 mg oral HYDROmorphine/day; 25 mg oral oxyMORphone/day; 60 mg oral HYDROcodone/day; or an equianalgesic dose of another opioid, including heroin and/or non-prescribed opioids.		Implementation Status	
➤ Default order entry systems to the lowest initial starting dose and frequency when initiating orders for extended-release and long-acting opioids.		Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 15 continued			
	➤ Alert practitioners when extended-release and long-acting opioid dose adjustments are required due to age, renal or liver impairment, or when patients are prescribed other sedating medications.	Implementation Status	
	➤ Eliminate the prescribing of fentaNYL patches for opioid-naïve patients and/or patients with acute pain.	Implementation Status	
	➤ Eliminate the storage of fentaNYL patches in automated dispensing cabinets or as unit stock in clinical locations where acute pain is primarily treated (e.g., in the emergency department, operating room, postanesthesia care unit, procedural areas).	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 16			
a	Limit the variety of medications that can be removed from an automated dispensing cabinet (ADC) using the override function.	Implementation Status	
b	Require a medication order (e.g., electronic, written, telephone, verbal) prior to removing any medication from an ADC, including those removed using the override function.	Implementation Status	
c	Monitor ADC overrides to verify appropriateness, transcription of orders, and documentation of administration.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 16 continued			
d	Periodically review for appropriateness the list of medications available using the override function.	Implementation Status	
	➤ Restrict medications available using override to those that would be needed emergently (as defined by the organization) such as antidotes, rescue and reversal agents, life-sustaining drugs, and comfort measure medications such as those used to manage acute pain or intractable nausea and vomiting.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 17			
	Safeguard against errors with oxytocin use.	Implementation Status	
a	Require the use of standard order sets for prescribing oxytocin antepartum and/or postpartum that reflect a standardized clinical approach to labor induction/ augmentation and control of postpartum bleeding.	Implementation Status	
b	Standardize to a single concentration/bag size for both antepartum and postpartum oxytocin infusions (e.g. 30 units in 500 mL Lactated Ringers).	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 17 continued			
c	Standardize how oxytocin doses, concentration, and rates are expressed. Communicate orders for oxytocin infusions in terms of the dose rate (e.g., milliunits/minute) and align with the smart infusion pump dose error reduction system.	Implementation Status	
d	Provide oxytocin in a ready-to-use form. Boldly label both sides of the infusion bags to differentiate them from plain hydrating solutions and magnesium infusions.	Implementation Status	
e	Avoid bringing oxytocin infusion bags to the patient's bedside until it is prescribed and needed.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 18			
	Maximize the use of barcode verification prior to medication and vaccine administration by expanding use beyond inpatient care areas.	Implementation Status	
a	Specifically target clinical areas with an increased likelihood of a short or limited patient stay (e.g., emergency department, perioperative areas, infusion clinics, dialysis centers, radiology, labor and delivery areas, catheterization laboratory, outpatient areas).	Implementation Status	
b	Regularly review compliance and other metric data to assess utilization and effectiveness of this safety technology (e.g., scanning compliance rates; bypassed or acknowledged alerts).	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 19			
	Layer numerous strategies throughout the medication use process to improve safety with high-alert medications.	Implementation Status	
a	For each medication on the facility's high-alert medication list, outline a robust set of processes for managing risk, impacting as many steps of the medication use process as feasible.	Implementation Status	
b	Ensure that the strategies address system vulnerabilities in each stage of the medication use process (i.e., prescribing, dispensing, administering, and monitoring) and apply to prescribers, pharmacists, nurses, and other practitioners involved in the medication use process.	Implementation Status	
c	Avoid reliance on low-leverage risk-reduction (e.g., applying high-alert medication labels on pharmacy storage bins, providing education) to prevent errors, and instead bundle these with mid- and high-leverage strategies.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 19 continued			
d	Limit the use of independent double checks to select high-alert medications with the greater risk for error in the organization (e.g., chemotherapy, opioid infusions, intravenous [IV] insulin, heparin infusions).	Implementation Status	
e	Regularly assess for risk in the systems and practices used to support the safe use of medications by using information from internal and external sources (e.g., The Joint Commission, ISMP).	Implementation Status	
f	Establish outcome and process measures to monitor safety and routinely collect data to determine the effectiveness of risk-reduction strategies.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 4 (archived)			
	Ensure that all oral liquid medications that are not commercially available in unit dose packaging are dispensed by the pharmacy in an oral syringe or an enteral syringe that meets the International Organization for Standardization (ISO) 80369 standard, such as ENFit. <i>Exception: If the pharmacy is employing unit dose packaging automation that does not use oral syringes, unit dose cups/bottles may be provided in place of oral syringes. However, ensure that oral or ISO 80369 compliant syringes (e.g., ENFit) are available on nursing units in case patients cannot drink the medication from the cup or bottle.</i>	Implementation Status	
	➤ Do not stock bulk oral solutions of medications on patient care units.	Implementation Status	
	➤ Use only oral syringes that are distinctly marked "Oral Use Only."	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 4 continued (archived)			
	➤ When ISO 80369 compliant syringes (e.g., ENFit) are used for administration of oral liquid medications, always highlight on the pharmacy label, or affix an auxiliary label, "For Oral Use Only" on the syringe.	Implementation Status	
	➤ Ensure that the oral/enteral syringes used do not connect to any type of parenteral tubing used within the organization.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 5 (archived)			
	Purchase oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale.	Implementation Status	
	➤ In addition, if patients are taking an oral liquid medication after discharge, educate patients to request appropriate oral dosing devices to measure oral liquid volumes in milliliters (mL) only.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 6 (archived)			
	Eliminate glacial acetic acid from all areas of the hospital.[†] <i>† Laboratory use excluded if the laboratory purchases the product directly from an external source.</i>	Implementation Status	
	➤ Remove and safely discard this product from all clinical areas of the hospital (including the pharmacy, clinics, and physician office practices), and replace it with vinegar (5% solution) or commercially available, diluted acetic acid 0.25% (for irrigation) or 2% (for otic use).	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 10 (archived)			
	Eliminate all 1,000 mL bags of sterile water (labeled for “injection,” “irrigation,” or “inhalation”) from all areas outside of the pharmacy.	Implementation Status	
	➤ Use alternatives to avoid the storage and use of 1,000 mL (1 liter) bags of sterile water for injection, irrigation, or inhalation in patient care areas. For example, replace all 1,000 mL (1 liter) bags of sterile water for injection, irrigation, or inhalation with 2,000 mL (2 liter) bags of sterile water for injection, irrigation, or inhalation; bottles of sterile water for irrigation, inhalation, or vials.	Implementation Status	

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2022 – 2023 ISMP Targeted Best Practices		Hospital Assessment	Action Required/Assignment
BEST PRACTICE 10 continued (archived)			
	➤ Establish a policy that 1,000 mL bags of sterile water can only be ordered by the pharmacy.	Implementation Status	
	➤ The pharmacy needs to work with respiratory therapy and other relevant departments of the hospital to establish guidelines regarding the safest way to provide large volumes of sterile water when needed for patient care.	Implementation Status	