ISMP Targeted Medication Safety Best Practices for Hospitals Template

(See the ISMP 2024-2025 Targeted Medication Safety Best Practices for Hospitals document for additional detail/description)

	Implemented?		
Targeted Best Practice	**Yes**	**No**	**If "no", what are the barriers to implementation?**
1. Dispense vincristine and other vinca alkaloids in a minibag NOT syringe			
2. Methotrexate a. Weekly PO dosing default b. Hard stop verification on daily PO orders c. Discharge education on PO methotrexate			
3. Weigh patient as soon as possible and document in metric units			
4. Oral liquid medications prepared in the pharmacy dispensed in oral or enteral syringe (archived)			
5. Purchase oral liquid dosing devices that only display metric scale (archived)			
6. Eliminate glacial acetic acid from all areas of the hospital (archived)			
7. Segregated, sequester, and differentiate all neuromuscular blocking agents from other medications wherever they are stored			
8. Smart pumps a. Administer med and hydration infusions via programmable infusion pumps b. Maintain greater than 95% compliance c. Monitor compliance monthly d. If bolus/loading dose from continuous infusion, have separate limits for each			
9. Ensure antidotes, reversal agents, and rescue agents: a. Are readily available b. Have standardized protocols/order sets c. Have directions for use/ administration readily available			
10. Eliminate 1000 mL bags of sterile water from all areas outside of the pharmacy (archived)			
11. When compounding sterile preparations, utilize workflow management systems			
13. Eliminate injectable promethazine from formulary			
14. Gather and use med safety risks and errors from outside your facility			
15. Verify and document opioid status and type of pain before prescribing/dispensing long-acting opioid (Best Practice 12 incorporated into this item)			

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16. Automated dispensing cabinets (ADC) a. Limit variety of medications removable on overrides b. Require an order prior to removing from ADCs c. Monitor overrides from ADCs d. Periodically review appropriateness of medications on override list			
17. Oxytocin safeguards a. Require standard order sets b. Standardize to a single concentration/bag size c. Standardize how doses, concentrations, and rates are expressed d. Provide in ready-to-use form e. Avoid bringing to bedside until prescribed and needed			
18. Maximize barcode verification prior to medication or vaccine administration beyond inpatient care areas, & regularly review compliance and metric data			
19. Layer strategies to improve safety with high-alert medications a. Outline processes for each high-alert medication b. Ensure strategies address vulnerabilities of all stages of the med-use process and apply to all involved (prescribers, pharmacists, nurses, etc.) c. Avoid reliance on low-leverage risk reduction strategies and bundle with mid- and high-leverage strategies d. Limit use of independent double checks to select high-alert medications with the greatest risk of error e. Regularly assess for risk in systems/ practices f. Establish outcome and process measurements for monitoring and data collection			
20. Safeguard against wrong-route errors with tranexamic acid **(NEW in 24-25)** a. Use barcode safety checks in surgical and obstetrical areas b. Use premixed IV bags rather than vials c. Do not store tranexamic acid in anesthesia tray d. Store vials with labels visible e. Review look-like ampules or vials, purchase from different manufacturers if risk of vial-mix up is noted f. Label vial caps with “Contains Tranexamic Acid” label			

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21. Implement strategies to prevent med errors at transitions of care **(NEW in 24-25)** a. Obtain accurate med list on admission b. Ensure meds ordered are correct therapy c. Designate provider to reconcile medications and document modifications at admission, each change in level of care, and at discharge			
22. Safeguard against errors with vaccine administration **(NEW in 24-25)** a. Use standard order sets; require an order prior to admin; use full generic and brand name (if applicable), avoid vaccine abbreviations b. Verify patient's immunization status prior to vaccine admin c. Provide VIS to patients in primary language prior to vaccine admin d. Store vaccines in separate bins based on type & formulation; store two-component vaccines together e. Use prefilled syringes when available; if not available, prepare and label immediately prior to admin f. If multiple adults and children vaccinated at the same time, separate them into distinct treatment areas; bring only one patient's vaccine into treatment area at a time g. Verify patient using two identifiers h. Use barcode scanning technology i. Document vaccine NDC, lot, exp in EHR and local/state vaccine registry prior to admin j. Provide vaccinators ongoing education and competency assessment on vaccines			

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