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Table 1. Compliance with the three new *2024-2025 ISMP Targeted Medication Safety Best Practices for Hospitals*

	Best Practice Statement	Percent Compliance			Common Barriers (B) or Enablers (E)
		None	Partial	Full	
20	Safeguard against wrong-route errors with tranexamic acid				
	Utilize point-of-care barcode-assisted medication safety checks prior to administering medications in surgical and obstetrical areas.	18	47	35	B: Limited by electronic health record (EHR) options, anesthesia staff reluctance
	When appropriate, use premixed intravenous (IV) bags of tranexamic acid, which are less likely to result in mix-ups than the vials of tranexamic acid.	42	18	40	B: Shortages impact the ability to supply premixed bags E: Pharmacy prepares and dispenses premixed bags
	If possible, do not store tranexamic acid in an anesthesia tray.	18	20	62	B: Anesthesia provider resistance
	Separate or sequester tranexamic acid in storage locations (e.g., pharmacy, clinical areas) and avoid storing local anesthetics and tranexamic acid near one another.	12	27	61	B: Limited space E: Tranexamic acid is not stored outside pharmacy
	To prevent misidentifying medications by viewing only the vial caps, avoid storing injectable medication vials in an upright position, especially when stored in a bin or drawer below eye level. Store them in a way that always keeps their labels visible.	18	44	38	B: Human-dependent, users can change vial orientation, space constraints E: Education before and after implementation
	Conduct a review to identify any look-alike ampules or vials (including caps) and determine if the risk of a mix-up will be reduced by purchasing them from different manufacturers. If so, purchase them from different manufacturers.	24	43	33	B: Drug shortages, purchasing based on cost, limited time and resources to conduct a review E: Annual product review by the Medication Safety Officer (MSO)
Consider labeling vial caps with a label that states, "Contains Tranexamic Acid."	74	9	17	B: Label fatigue, labor-intensive	
21	Implement strategies to prevent medication errors at transitions in the continuum of care				
	Obtain the most accurate medication list possible upon admission to the organization before the first dose of medication is administered (except in emergency or urgent situations).	2	52	46	B: Not enough staff, inconsistent process, lack of communication E: Designated technicians, widespread education and training, using a remote medication reconciliation service
	Include asking about allergies and associated reactions, prescription, and over-the-counter medications (including herbals and dietary supplements), and non-enteral medications.	1	36	63	B: Labor, budget, and time constraints E: Implementing a standard checklist and scripting
	List drug name, dose, route, frequency, indication, and time of last dose.	2	45	53	B: Information is not readily available, indication and last dose are not required fields in the EHR E: Built in the EHR
	Consider assigning dedicated practitioners to obtain medication histories.	22	42	36	B: Cost, limited staff E: Robust 24/7 medication reconciliation technician program, using a remote medication reconciliation service
	Ensure the medication and doses collected and subsequently ordered are correct therapy for that patient, given their current state of health.	4	39	57	B: Technicians or nurses not allowed by law to determine appropriateness E: Prescribers or pharmacists evaluate this after the medication history is completed
Designate a provider to compare the prescribed medications to those on the medication history list and resolve any discrepancies. Have providers document reconciliation and modifications made to the current therapy upon admission, with each change in level of care, and at discharge.	13	47	40	B: Cost, resources, and time; physician resistance; compliance is not monitored E: Built in the EHR, collaborative relationships between providers and pharmacy	

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Best Practice Statement	Percent Compliance			Common Barriers (B) or Enablers (E)
	None	Partial	Full	
Safeguard against errors with vaccines administered in the inpatient and associated outpatient settings				
Utilize standard order sets to prescribe vaccines. Require an order prior to administration of any vaccine. Utilize the full generic name and brand name (if applicable) and avoid vaccine abbreviations.	13	35	52	B: Order sets not available for all vaccine orders, abbreviations used in the EHR may be confusing E: Built in the EHR
Verify a patient’s immunization status (in the EHR as well as vaccine registries) prior to providing vaccines.	11	41	48	B: No capability of pulling vaccine registry data into the EHR E: Pulling vaccine data from registries is being addressed by some via an EHR upgrade
Provide patients and/or caregivers with vaccine information (e.g., Vaccine Information Statement [VIS]) in their primary language prior to vaccination.	6	29	65	B: Budget, workforce, availability of interpretation services E: Built in the EHR
Store vaccines in separate bins or containers based on type and formulation. Store two-component vaccines together.	6	22	72	B: Space limitations, inconsistent practices
Use prefilled syringes when available. If not available, prepare each vaccine dose immediately prior to administration and label with the vaccine name, dose, and if appropriate, the indicated age range.	4	27	69	B: Time constraints, lack of staff education, limited space prevents the storage of prefilled syringes E: Evaluate prefilled syringe availability prior to purchasing vaccines
If multiple adults and children are being vaccinated at the same time, separate them into distinct treatment areas; bring only one patient’s vaccines into the treatment area at a time.	10	39	51	B: Human-dependent process, susceptible to high patient volumes and room turnover, one parent may bring two or more children E: Policy and procedure requirement
Verify the patient’s identity using two unique identifiers.	1	10	89	B: Outpatient pharmacies have systems and processes to do this prior to dispensing medication but not vaccine administration, room numbers used rather than unique identifiers E: Analyze and learn from barcode medication administration (BCMA) data
Use barcode scanning technology to verify the correct vaccine and dose are being administered to the correct patient.	13	27	60	B: Clinics do not have this technology, frontline staff do not understand the benefit of BCMA
Document the vaccine’s national drug code (NDC) number, lot number, and expiration date prior to administration; document administration in the EHR; and ensure information is sent to the local or state vaccine registry.	5	19	76	B: EHR does not have this built as a required field E: EHR prompts the clinician to document this as a required field
Provide vaccinators with ongoing education and competency assessment about vaccines and their appropriate storage, selection, administration, and monitoring.	13	38	49	B: Lack of resources to create competency assessments or to educate staff E: Dedicated clinical educator

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