ASHP Medication Safety Program Tool

Introduction

Working on improving medication safety in your organization can be an overwhelming venture. In particular, organizations without dedicated medication safety resources may find it difficult to determine where to start and prioritize the number of tasks involved with maintaining a medication safety program. ASHP has developed a list of tasks that should be considered as part of any medication safety program. In addition, this list has been prioritized for organizations with limited resources or a new medication safety program. When considering the use of this tool, it would be important to gather support from your organization's leadership and key stakeholders. The tool is provided in multiple formats for ease of use.

Prioritization

This medication safety program tool lists tasks in order of priority using three measures:

1) Medication safety program priority
2) Medication safety impact
3) Time/resource allocation estimation

Medication Safety Priority

The following ratings are used to define medication safety priority.

High	These tasks are viewed as an essential foundation for a medication safety program.
Medium	These tasks are valuable to implement after the foundation for a medication safety program is established.
Low	These tasks may still be very important to complete within an organization, but they may have been rated low because they are either 1) Not the primary responsibility of the medication safety program; or 2) Viewed as a medication safety program enhancement.

Medication Safety Impact

The following ratings are used to define medication safety impact.

Major	These tasks may decrease risk to patients, employees, or the organization if completed.
Minor	These tasks may be useful to complete but may pose less risk to patients, employees, and the organization if not completed.

Time/Resource Allocation Estimation

For this rating estimation, an assumption was made that the organization does not currently employ this task as part of its existing medication safety program and a new infrastructure would have to be developed. The following ratings are used to define time and resource allocation estimation.

1	Least amount of time and effort estimated to implement/complete the task
2	Moderate amount of time and effort estimated to implement/complete the task
3	Most amount of time and effort estimated to implement/complete the task

Resources

Resources have been provided for certain medication safety tasks where available. These resources will help to provide a foundation for medication safety knowledge. It is important to check with your own state for any policy or legislative requirements for continuous quality improvement or medication safety. In addition, it is important for you to be familiar with the standards set forth by your hospital's accrediting body.

	A	B	C	D	E
1					
2	**Medication Safety Program Tasks**	**Medication Safety Program Priority**	**Medication Safety Impact**	**Time/Resource Allocation Estimation**	**Resources (use bold lettering for search terms)**
3	Monitor adverse drug events and report to national reporting programs as appropriate.	High	Major	Least	Guidelines for monitoring and reporting adverse drug reactions are available through ASHP (**ASHP Guidelines on Adverse Drug Reaction Monitoring and Reporting**). Organizations and websites for reporting include: **FDA Medwatch:** for consumers/patient and health professional, does not include vaccines **Vaccine Adverse Events Reporting System:** Includes all vaccine reports, including reports of ADRs and vaccination errors **ISMP Medication Error Report**: for consumers and healthcare professionals- includes medication errors, ADRs, and preventable adverse reaction with vaccines
4	Develop a process for ISMP newsletter gap analysis review by completing the Quarterly Action Agenda.	High	Major	Least	**ISMP Quarterly Action Agenda** is available through ISMP
5	Implement voluntary medication safety reporting program.	High	Major	Moderate	Guidelines on reporting errors include: **ASHP Statement on Reporting Medication Errors**
6	Develop a process for routine medication safety report review.	High	Major	Moderate	Guidelines for review include: **ASHP Guidelines on Preventing Medication Errors in Hospitals**
7	Form a Medication Safety Committee to review medication safety practices, safety reporting program information, and discuss systems changes.	High	Major	Moderate	**AHRQ Patient Safety Primers:** Guides for key topics in patient safety through context, epidemiology, and relevant AHRQ PSNet content.
8	Review external sources of medication safety FDA alerts, conduct gap analyses and develop action plans	High	Major	Moderate	**FDA Medwatch**: Safety alerts for human products, drug safety labeling changes **FDA Recalls, Market Withdrawals, & Safety Alerts**: provides information gathered from press releases and other public notices about certain recalls of FDA-regulated products
9	Review medication use process for high alert medications (including look-alike/sound-alike medications) and develop policies and procedures to minimize risks with the use of high alert medications.	High	Major	Moderate	**ISMP High Alert Medications:** provides background and recommendations for different health care settings **FDA/ ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters:** resource for look-alike/sound-alike medications
10	Education staff about medication safety principles	High	Major	Moderate	
11	Understand and promote Just Culture in the organization.	High	Major	Most	**ASHP Policy Statement on Just Culture:** includes rationale, recommendations, and definitions
12	Prioritize and review ASHP and ISMP best practice guidelines, conduct gap analyses, and develop action plans.	High	Major	Most	Policy and Guideline Statements: **ASHP Guidelines** **ISMP Guidelines**
13	Review use of medication safety-related automation and technology (e.g. bar-code scanning, infusion pumps, clinical decision support, automated dispensing cabinets).	High	Major	Most	
14	Disseminate the ISMP newsletter to all clinical staff.	High	Minor	Least	
15	Serve as a liaison to other patient safety committees (e.g. Patient Safety Committee, Risk Management, etc.)	High	Minor	Moderate	
16	Review and ensure compliance with medication safety-related National Patient Safety Goals.	Medium	Major	Least	
17	Incorporate medication safety into organization's strategic plan.	Medium	Major	Moderate	Background and guidance for a medication safety strategic plan include: **ISMP pathways for medication safety**
18	Identify and engage a medical staff/provider and nursing champion for medication safety.	Medium	Major	Moderate	
19	Develop a prioritized action plan using gaps identified from the ISMP Medication Safety Self-Assessment.	Medium	Major	Moderate	**ISMP Self-Assessments:** tools will help you assess the medication safety practices in your institution surrounding the use of medication therapy, identify opportunities for improvement, and compare your experience with the aggregate experience of demographically similar organizations.
20	Determine organization's metrics for medication safety	Medium	Minor	Moderate	

	A	B	C	D	E
21	Complete the ISMP Medication Safety Self-Assessment with a multidisciplinary team.	Medium	Minor	Most	
22	Ensure compliance with medication management standards (TJC, NIAHO, state-specific standards, if applicable).	Low	Major	Least	
23	Review and ensure compliance with sterile compounding and outsourcing regulations (i.e., USP chapters).	Low	Major	Least	
24	Ensure compliance with REMS programs.	Low	Major	Least	
25	Oversee medication use process for safe handling hazardous medications.	Low	Major	Moderate	**NIOSH List of Antineoplastic and Other Hazardous Drugs** contains a general approach to handling hazardous drugs, definitions, strategies and reference documents
26	Oversee medication use process for security of controlled medications.	Low	Major	Moderate	
27	Publish an organization-specific medication safety newsletter.	Low	Minor	Moderate	