

Answer Key

- A = There has been no activity to implement this characteristic
- B = This characteristic has been discussed for possible implementation but not implemented
- C = This characteristic has been partially implemented in some or all areas of the organization
- D = This characteristic is fully implemented in some areas of the organization
- E = This characteristic is fully implemented throughout the organization
- F = Not applicable

Key Element I: Patient Information

Core distinguishing characteristic 1 : *Essential patient information is obtained, readily available in useful form, and considered when prescribing, dispensing, and administering medications.*

		A	B	C	D	E	F
1	Prescribers and nurses can easily and electronically access inpatient laboratory values while working in their respective inpatient locations.						
2	Pharmacists can easily and electronically access inpatient laboratory values while working in their respective inpatient locations.						
3	Prescribers and nurses can easily and electronically access outpatient laboratory values while working in their respective outpatient locations.						
4	Pharmacists can easily and electronically access outpatient laboratory values while working in their respective outpatient locations.						
5	Prescribers and nurses can easily and electronically access both inpatient and outpatient laboratory values while working in their respective inpatient and outpatient locations.						
6	Pharmacists can easily and electronically access both inpatient and outpatient laboratory values while working in their respective inpatient and outpatient locations.						
7	A pharmacist or prescriber routinely adjusts doses of medications that may be toxic in patients with renal or liver impairment.						
8	A nurse, pharmacist, or prescriber verifies that any patient allergy information entered into the computer system is clinically accurate, and that the names of allergens are spelled correctly and properly coded to allow for pharmacy computer screening.						
9	Orders cannot be entered into the pharmacy computer system until the patient's allergies have been properly entered and coded (patient allergies is a required field).						
10	The pharmacy computer system automatically screens and detects drugs to which patients may be allergic (including cross allergies) and provides a clear warning to staff during order entry.						

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PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

11a	In hospitals WITHOUT computerized prescriber order entry (CPOE) systems: Distinctive and visible prompts that list patient allergies are included on all pages of hard-copy order forms as a visible reminder to those prescribing drugs. (Prescribers initially list the allergies on order forms and patient care unit staff consistently transfer the information to subsequent order forms when replenishing charts with blank copies of order forms.)								
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OR

11b	In hospitals WITH computerized prescriber order entry (CPOE) systems: Prescribers are provided with an electronic alert if a drug is entered to which a patient is allergic.								
12	Allergies are listed and clearly visible on all pages (or screens) of medication administration records (MARs), including those for new admissions, as a reminder during drug administration.								
13	Patients who receive MODERATE SEDATION, patient-controlled analgesia (PCA), or other IV infusions to treat pain are monitored for signs of oversedation at least every 4 hours by evaluating the patient's level of alertness and vital signs (including rate and quality of respirations).								
14	MACHINE-READABLE CODING (e.g., bar coding) that utilizes at least two identifiers of the patient (e.g., name and birth date, name and medical record number) is used to verify patient identity during drug administration.								
15	Basic information (e.g., patient name, hospital unit location, birth date, physician) is clear and easily visible on orders transmitted to the pharmacy via addressograph imprints, stickers on hard copy or facsimile, or is sent electronically.								
16	Information about the patient's comorbid and/or chronic conditions (e.g., hypertension, diabetes, renal or liver impairment, pregnancy, lactation) is obtained, communicated to pharmacists, and available in the pharmacy computer system for reference.								
17	The computer system used for medication order entry is directly INTERFACED with the laboratory system to automatically alert practitioners to the need for potential drug therapy changes.								
18	Medication orders cannot be entered into the pharmacy computer system until the patient's weight has been entered (weight is a required field).								
19	Patient selection criteria have been established for using PCA, which exclude patients who will not be able to deliver the medication themselves due to their level of consciousness, physiological condition, or limited intellectual capacity. Scoring guideline: Choose NOT APPLICABLE (N/A) if you do not offer PCA in your hospital.								
20	Enhanced monitoring (e.g., capnography, apnea alarms) is required for patients who receive PCA or other IV infusions to treat pain whenever risk factors such as obesity or low body weight, concomitant use of medications that potentiate opiates, or preexisting conditions such as asthma or sleep apnea exist, and/or when NURSE-CONTROLLED ANALGESIA is employed.								

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21	Only trained healthcare workers (not parents or other care providers) administer oral sedatives (e.g., midazolam, chloral hydrate) to children in preparation for a procedure (e.g., MRI), after the child has arrived at the facility to ensure proper monitoring of neurologic and respiratory status, and availability of resuscitation equipment in the event of respiratory depression. Scoring guideline: Choose NOT APPLICABLE (N/A) if care is not provided to pediatric patients, even in the emergency department, outpatient surgery, or outpatient diagnostics.						
22	Archived allergy information from a prior admission is readily available for pharmacists to review (e.g., pop-up screens during entry of the first set of orders) when a patient is readmitted, but the information does not automatically populate the allergy field before practitioner verification.						
23	Allergies are prominently visible on each patient-specific screen for all electronically displayed medication systems and records (e.g., CPOE screens, pharmacy computer screens accessed during order entry, automated dispensing cabinet screens, electronic MARs).						

Key Element II: Drug Information

Core distinguishing characteristic 2: *Essential drug information is readily available in useful form and considered when ordering, dispensing, and administering medications.*

		A	B	C	D	E	F
24	A complete drug history, including prescription and over-the-counter medications, vitamins, herbal products, and illicit drugs is obtained on every inpatient and outpatient upon admission or initial encounter (including during the pre-admission process).						
25	All patient care areas where medications are administered are supplied with updated drug reference texts, which includes information on herbal and alternative medicines, annually and all outdated texts are removed from use. (Texts are outdated after one year of publication or whenever the next edition is available.)						
26	Pharmacists and pharmacy technicians have easy access (e.g., on each computer terminal) to user-friendly, up-to-date, computerized drug information systems (e.g., MicroMedex, Facts and Comparisons), which include information on herbal and alternative medicines, in the pharmacies.						
27	Prescribers and other non-pharmacy practitioners have easy access (e.g., on each computer terminal, palm devices) to user-friendly, up-to-date, computerized drug information systems (e.g., MicroMedex, Facts and Comparisons), which include information on herbal and alternative medicines, in all patient care areas.						
28	Current protocols, guidelines, dosing scales, and/or checklists for high-alert drugs (e.g., chemotherapy, anticoagulants, opiates, insulin, electrolyte replenishment with potassium, magnesium, sodium, and phosphate) are readily accessible to prescribers, pharmacists, and nurses, and used when high-alert drugs are prescribed, dispensed, and administered.						
29	MAXIMUM DOSES for high-alert drugs such as chemotherapy, electrolytes, and opiates have been established and posted, disseminated, and/or included on preprinted order forms as reference for prescribers, pharmacists, pharmacy technicians, and nurses.						

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30	All internally developed drug information tools (e.g., pocket references, drug information cards, preprinted order forms, protocols or checklists, patient drug education materials, compounding recipes) undergo a formal approval process before use, which includes at a minimum, review by a pharmacist and those who will be using the tool.						
31	Pharmacists regularly (e.g., one 8-hour shift per 24 hours) work directly in inpatient care units performing clinical activities such as reviewing patient records and drug orders, attending interdisciplinary rounds, providing input into the selection and administration of drugs, and monitoring the effects of medications on patients.						
32	Pharmacists regularly (e.g., one 8-hour shift per 24 hours) work directly in outpatient care units (e.g., ED, ambulatory surgery, clinics) performing clinical activities such as reviewing patient records and drug orders, attending interdisciplinary rounds, providing input into the selection and administration of drugs, and monitoring the effects of medications on patients.						
33	The pharmacy computer system performs dose range checks and warns practitioners about overdoses and underdoses for all high-alert drugs and for most other medications.						
34	Pharmacy staff routinely tests the computer system to assure that MAXIMUM DOSE alerts are present for high-alert drugs and builds alerts for those that are not present.						
35	A designated pharmacist routinely reviews, for quality improvement purposes, reports of selected computer warnings (e.g., MAXIMUM DOSE alerts, serious drug interactions, allergy alerts) that are overridden.						
36	Drug information updates for medication order entry systems (e.g., pharmacy system, CPOE system) are received from a database vendor and loaded at least quarterly. Scoring guideline: Do not choose level D or E if updates are received or loaded less frequently than quarterly.						
37	Except in emergent lifesaving situations, all inpatient drug orders are entered into a computer and screened electronically against the patient's current clinical profile for contraindications, interactions, and appropriateness of doses before drugs are administered.						
38	The information technology system maintains (for at least five years) ongoing patient profiles with basic demographic information (including allergies) and drug therapy records for each episode of care, which are readily accessible to pharmacists when a patient is readmitted. Scoring guideline: Do not choose level D or E if information is purged more frequently than every five years.						
39	Inpatient and outpatient pharmacy computer systems are linked so that comprehensive patient and drug information is available to practitioners wherever (inpatient or outpatient) the patient receives care in the hospital system. Scoring guideline: Choose NOT APPLICABLE (N/A) if your hospital pharmacy does not prepare any outpatient prescriptions and your hospital does not have an outpatient pharmacy.						
40	The pharmacy computer system (and prescriber order entry system if in use) requires practitioners to enter an explanation upon overriding a serious alert (e.g., exceeding a MAXIMUM DOSE for a high-alert drug, a serious drug interaction, an allergy).						
41	Practitioners have confidence in the process used to verify (reconcile) the medications that the patient had been taking at home before admission and compare them to the medications prescribed upon admission and discharge.						

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42	Pharmacy interventions in response to a potentially harmful medication order are immediately communicated to the nurses who provide care to the patient to reduce frustrations with delays and halt the potential administration of the medication from floor stock while awaiting clarification of the order.					
43	Minimum and MAXIMUM DOSE limits have been established for parenteral medications titrated to effect (e.g. insulin infusions, dopamine, dobutamine), which when approached (fall below minimum doses or exceed MAXIMUM DOSES), require notification of the prescriber for further instructions regarding the dose or possible discontinuation of the medication.					
44	Patients that require contrast media (e.g., radiology procedures) are specifically asked about allergies to iodine (including shellfish); and if an allergy exists, a standardized pre-procedure protocol (e.g., prescriber notification, pre-medications, use of alternative contrast media) is implemented before the procedure if performed.					
45	High-alert drugs used within the organization have been defined, identified, and communicated to all practitioners who prescribe, dispense, and administer the products.					

Core distinguishing characteristic 3: *A closed drug formulary system is established to limit choice to essential drugs, minimize the number of drugs with which practitioners must be familiar, and provide adequate time for designing safe*

		A	B	C	D	E	F
46	The hospital formulary contains almost no duplication of generic equivalents.						
47	The hospital formulary contains minimal duplication of therapeutically equivalent products.						
48	Before a decision is made to add a drug to the formulary, the potential for error with that drug is investigated in the literature, documented in the drug monograph submitted to the PHARMACY AND THERAPEUTICS COMMITTEE (or a similar voting body), and addressed.						
49	When drugs with heightened error potential are identified during the formulary addition process, safety enhancements such as standardized order forms, prescribing guidelines, check systems, reminders, and/or limitations on use, administration, and storage of drugs are established before initial use.						
50	After formulary approval of drugs on the market less than one year, a pharmacist is assigned responsibility to search the literature for at least a six-month period to identify published errors or adverse drug reactions that may have been reported since product launch, and safety enhancements are established as necessary or the drug is removed from the formulary.						
51	A Drug Use Evaluation (DUE) is initiated immediately after introducing a drug for hospital use, that has been identified as having heightened error potential to monitor compliance and success with established safeguards.						
52	Non-formulary products are used only when therapeutically necessary and appropriate (e.g., potential adverse effects if the medication is changed during hospitalization, during a drug shortage).						
53	The hospital's ability to adequately monitor and manage the anticipated adverse effects of a medication is investigated, documented, considered by the PHARMACY AND THERAPEUTICS COMMITTEE (or other interdisciplinary team), and addressed before adding the medication to the formulary.						
54	The pharmacy computer is tested after adding a new drug to verify that important clinical warnings (e.g., serious drug interactions, allergies, cross allergy alerts, MAXIMUM DOSE limits) are functional; and if a serious alert is not yet functional through the drug information system vendor, a temporary free text alert is added so that it appears on the screen during order entry.						

Key Element III: Communication of Drug Orders and Other Drug Information

Core distinguishing characteristic 4 : *Methods of communicating drug orders and other drug information are standardized and automated to minimize the risk for error.*

		A	B	C	D	E	F
55	Prescribers enter medication orders into a computer system that is directly INTERFACED with the pharmacy computer system. Scoring guideline: Do not choose D or E if prescribers enter orders into a computer system that is not directly INTERFACED with the pharmacy computer system.						

PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

56a	In hospitals WITH computerized prescriber order entry (CPOE) systems: The system warns prescribers about unsafe orders (e.g., allergies, MAXIMUM DOSES, interactions) during input and guides the use of formulary drugs and established protocols/clinical pathways.						
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OR

56b	In hospitals WITHOUT computerized prescriber order entry (CPOE) systems: Preprinted order forms are used to guide prescribing of routine medications for preoperative and postoperative patients, for inpatient critical care admissions, and for oncology patients.						
57	A list of prohibited, ERROR-PRONE ABBREVIATIONS (e.g., u, qd, MSO4, chemotherapy regimen acronyms) and unacceptable methods of expressing doses (by volume or number of tablets instead of weight; using trailing zeros for whole number doses; not using a leading zero for doses less than one) is established for all communication of drug information or orders (including in handwritten or preprinted orders and MARs, and in electronic formats such as computer screens).						
58	Compliance with safe methods of communicating the drug name, dose, route, and frequency (e.g., on handwritten and preprinted orders, order entry screens, computer-generated drug labels, drug storage bin labels) is monitored through quality improvement efforts.						
59	Upon admission to the hospital or transfer to a different level of care within the hospital, prescribers write (or electronically enter) complete orders for all drug therapy. Orders to “resume the same medications” or to “take medications from home” are not accepted.						
60	Verbal or telephone orders from prescribers that are onsite in the hospital are used only in emergencies or during sterile procedures where ungloving would be impractical.						
61	Verbal or telephone orders are never accepted for oral or parenteral chemotherapy (including chemotherapeutic agents used for non-oncologic indications). Scoring guideline: Score NOT APPLICABLE (N/A) if you do not offer chemotherapy (including oral agents) to patients.						
62	When verbal or telephone orders must be taken, the nurse or pharmacist receiving the order immediately writes it down and reads it back to the prescriber for verification.						
63	Computer-generated or electronic MARs that share a common database with the pharmacy system are used to guide and document medication administration.						
64	MARs are taken to the patient’s bedside for reference during drug administration.						
65	Nurses and pharmacists have a clear and effective process to follow to resolve conflicts when prescribers and/or supervisors do not agree with their expressed concerns about the safety of an order.						

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66	In non-urgent situations, medications being considered for uncommon uses or in atypical doses are approved through a formal review process (e.g., PHARMACY AND THERAPEUTICS COMMITTEE) before prescribers order the drug.						
67	In urgent situations, a timely informal process is in place to review medications being considered for uncommon uses or in atypical doses before pharmacists dispense and/or nurses administer the drug.						
68	Upon inpatient admission to the hospital, all medications administered in the emergency department or other outpatient settings (e.g., cardiac catheterization lab, radiology) are immediately communicated to the pharmacy and entered (or already available) in the pharmacy computer system in a manner that facilitates an automated alert for duplicate therapy or a drug interaction when medications prescribed upon admission are profiled.						
69	Prescribers have easy access to an electronic or computer-generated medication profile for each patient (which lists all current and recently discontinued medications), and they review this profile on a daily basis to verify the accuracy of order interpretation and as a reference when planning the patient's discharge medications.						

Key Element IV: Drug Labeling, Packaging, and Nomenclature

Core distinguishing characteristic 5: *Strategies are undertaken to minimize the possibility of errors with drug products that have similar or confusing manufacturer labeling/packaging and/or drug names that look and sound alike.*

		A	B	C	D	E	F
70	The ISMP Medication Safety Alert!® and/or other current literature is regularly reviewed to identify drug labeling, packaging, and nomenclature problems and action is taken to prevent errors with these drugs.						
71	The package and label of new drugs that are being considered for formulary addition are examined to identify any potential for confusion.						
72	Products with look-alike drug names and packaging that are known by the hospital staff to be problematic are stored separately and not alphabetically.						
73	Computer MNEMONICS are arranged to prevent look-alike drug names from appearing on the same computer screen; or look-alike drug names are clearly distinguished in a way that differentiates them (e.g., use of TALL-MAN LETTERS) if they appear sequentially on the same computer screen.						
74	Different manufacturers are sought for products with labeling/packaging that look like other products to help differentiate the labels/packages.						
75	Alerts are built into the computer software to remind practitioners about problematic drug names (including drugs with multiple suffixes such as XL, SR, ER, CD, LA), packaging, or labeling.						
76	Auxiliary warnings or other label enhancements (e.g., TALL-MAN LETTERS to accentuate differences in look-alike drug name pairs) are used on packages and storage bins of drugs with problematic names, packages, and labels.						
77	Prescribers include the clinical indication for all ambulatory patient drug prescriptions and inpatient "prn" drug orders to help distinguish those with look-alike names.						

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Core distinguishing characteristic 6: *Readable labels that clearly identify drugs are on all drug containers, and drugs remain labeled up to the actual drug administration.*

		A	B	C	D	E	F
78	Pharmacy computer systems produce clear and distinctive labels free of ERROR-PRONE ABBREVIATIONS and nonessential information (e.g., computer MNEMONICS and other pharmacy codes).						
79	At a minimum, all drug containers taken to the bedside (including syringes of line flushes and other medication prepared from vials and ampuls on patient care units outside of the patient's room) are labeled with at least the drug name, strength, and dose.						
80	The containers of drugs dispensed from the pharmacy for specific patients are labeled with the drug's name, strength, dose, as well as the route of administration, patient name, and location. Exception: Small, UNIT-DOSE containers of PATIENT-SPECIFIC MEDICATIONS. However, these should be dispensed in an outer container, such as an envelope or drug bin/drawer, that is labeled with the patient's name and location.						
81	Labels affixed to commercially available IV infusion containers are correctly positioned to allow observation of the manufacturer's label, which identifies the base solution and the total amount and concentration of any additives.						
82	Labels affixed to pharmacy-prepared IV admixture containers identify the total volume of solution in the container, the base solution, and the concentration or total amount of each drug additive in the container.						
83	All medications are dispensed to patient care units (including neonatal, pediatric, and critical care units) in labeled, ready-to-use UNIT-DOSES, or in labeled, UNIT-OF-USE containers (excluding topical preparations and antacids).						
84	UNIT-DOSE oral medications remain in the manufacturer's (or pharmacy's) packaging up to the point of actual drug administration at the bedside so a final check of the drug against the MAR can be accomplished.						
85	Sterile markers and labels, or preprinted labels, are opened onto the sterile field during all clinical/surgical procedures and all containers (including syringes, basins, or other vessels used to store drugs) are labeled even when just one product/solution is present.						
86	Medications brought into the health facility by a patient or family member are not administered to the patient until an authorized prescriber has approved their use and a pharmacist (or other qualified practitioner when a pharmacist is unavailable) has visually inspected the medications and containers to verify the drugs' identity and proper labeling and packaging to guide safe drug administration.						
87	Syringes of medications prepared for use during anesthesia are labeled with the drug name, strength/concentration, and date or time of expiration.						
88	Doses that require less than or more than a full tablet (e.g. ½ or ¼ tablet, 2 tablets) are repackaged by the pharmacy into unit-dose packages.						
89	Nurses can match the drug name (e.g., generic and/or brand names) on the labels of PATIENT-SPECIFIC MEDICATIONS dispensed from the pharmacy with the corresponding drug name on the MAR, even when therapeutic substitutions are dispensed (e.g., the MAR and label reflect the therapeutic substitution; or the label on the therapeutic substitution lists the product for which it is being substituted).						

Key Element V: Drug standardization, Storage, and Distribution

Core distinguishing characteristic 7: IV solutions, drug concentrations, doses, and administration times are standardized whenever possible.

		A	B	C	D	E	F
90	Concentrations for infusions of high-alert drugs such as morphine, heparin, insulin, and vasopressors used for adult patients are standardized to a single concentration that is used in at least 90% of the cases.						
91	Concentrations for infusions of high-alert drugs such as morphine, heparin, insulin, and vasopressors used for pediatric patients are standardized to a single concentration that is used in at least 90% of the cases. Scoring guideline: Choose A or B if you use the RULE OF 6 to prepare and administer pediatric solutions that contain high-alert drugs, since varying concentrations result when using this method. Score NOT APPLICABLE (N/A) if you do not treat any pediatric patients (including in the emergency department).						
92	Commercially prepared, premixed IV solutions are used whenever they are available on the market.						
93	Manufacturer's prefilled syringes, rather than vials or ampuls, are used for at least 90% of the injectable products (including saline and heparin flushes) that are commercially available in such packaging.						
94	Standard times for scheduled drug administration have been established and are consistently used on each unit throughout the organization. Exception: Selected medications prescribed for infants and young children.						
95	Parameters (e.g., dosing windows) have been established, disseminated, and enforced to help nurses safely administer most medications at established standard times even if the initial dose was administered at a nonstandard time.						

PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

96a	Sliding scale regular insulin is not used to treat elevated blood glucose levels in diabetic patients.						
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OR

96b	A standardized sliding scale protocol is used to treat elevated blood glucose levels in diabetic patients. Exception: The protocol may allow for several choices depending on specific patient conditions such as diagnosis/weight/total amount of daily insulin, but the choices are standardized among different prescribers. Scoring guideline: Choose C if a standard protocol exists, but prescribers do not use it consistently. Choose A or B if variations between sliding scales exist for different prescribers, depending on personal preference.						
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Core distinguishing characteristic 8: Medications are delivered to patient care units in a safe and secure manner and available for administration within a time frame that meets essential patient needs.

		A	B	C	D	E	F
97	The system used to physically deliver medications from the pharmacy to patient care units is directly controlled by the pharmacy using trained staff and/or automated delivery.						
98	Nurses are notified whenever medications are delivered to the unit.						

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99	Discontinued PATIENT-SPECIFIC MEDICATIONS are removed from patient supplies in a timely manner (e.g., upon the patient's discharge, discontinuation of the drug, or within 8-hours during the next scheduled pharmacy rounds to patient care units) to prevent accidental administration.						
100	An appropriately secured area in medication rooms has been established for placing discontinued medications (and medications from discharged patients, or removed from automated dispensing cabinets but not used) until pharmacy pick-up, and borrowing these doses for other patients is prohibited.						
101	Realistic criteria and safe time frames for dispensing emergent (stat), urgent (now), and routine medications have been established and agreed upon by all participants in the medication use process.						
102	TURNAROUND TIMES for drug delivery from the pharmacy is consistent with the time frames established by the hospital for emergent (stat), urgent (now), and routine medications.						
103	Prescribers consistently comply with established criteria for ordering drugs on an emergent (stat), urgent (now), and routine basis. Scoring guideline: Choose D or E only if prescribers do not typically order a stat or urgent dose of medications to compensate for slow delivery of routine medications.						
104	Antidotes for MODERATE SEDATION and PCA/other IV infusion to treat pain, and accompanying guidelines for emergency use, are readily available near the point of use.						
105	Guidelines for alerting practitioners to drug shortages, selecting and using alternative products and doses, and educating practitioners about their safe use (including warnings about potential adverse events) have been established and implemented.						
106	A list of antidotes and other medicines, typical doses, and directions for preparation and administration have been established in anticipation of potential disasters with mass trauma, and a reliable plan for obtaining these products and associated supplies has been established and tested at least annually.						

Core distinguishing characteristic 9 : Unit-based floor stock is restricted.

		A	B	C	D	E	F
107	At least 90% of all IV push medications used in inpatient units are dispensed in UNIT-DOSE form to patient care units.						
108	IV solutions that are unavailable commercially are prepared in the pharmacy unless needed in emergent lifesaving situations.						
109	Drugs stocked in patient care units are carefully selected for each unit by considering the needs of each patient care unit, staff expertise and familiarity with specific drugs, the risk of error with each drug, and the age and diagnoses of typical patients being treated on the units.						
110	Drugs stocked in patient care units are available in the least number of doses, concentrations, and forms that will meet essential patient needs between replenishment (not to exceed 72 hours).						
111	Drugs (including emergency medications) stocked in patient care units are in age-specific, ready-to-administer, UNIT-DOSE forms (no bulk supplies). Exceptions: Topical products and antacids.						
112	First doses of high-alert drugs are not removed from floor stock and/or automated dispensing cabinets before a pharmacist reviews the specific patient order and screens the order for safety. Exceptions: Emergent lifesaving situations and periods when a pharmacist is not on the premises.						
113	Pharmaceutical vendors and prescribers are prohibited from distributing drug samples in inpatient areas and the use of samples is prohibited for inpatients.						

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114	Pharmaceutical representatives are clearly instructed on the rules governing sample medications; they are required to sign an agreement to abide by the rules; and disciplinary action is taken for intentional rule violations.						
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PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

115a	Pharmaceutical vendors and prescribers are prohibited from distributing drug samples in outpatient areas, including emergency departments, ambulatory surgery/procedure units, and radiology.						
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OR

115b	Orders for drug samples used in outpatient units are screened for safety by a healthcare professional using computer software before administration onsite or dispensing a supply for home use.						
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PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

116a	Neuromuscular blocking agents are not available as floor stock and/or in automated dispensing cabinets (except in operating room/anesthesia stock).						
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OR

116b	If available in critical care units or the ED, neuromuscular blocking agents are sequestered from other floor stock medications (including those stocked in automated dispensing cabinets) and labeled with auxiliary warnings to clearly identify the drugs as respiratory paralyzing agents that require mechanical ventilation when used.						
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PLEASE ANSWER ONLY Part A or Part B or Part C NOT ALL OF THE QUESTIONS BELOW

117a	At least one pharmacist is physically present onsite 24 hours a day, 7 days a week.						
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OR

117b	A night cabinet with a restricted formulary has been established for when the pharmacy is closed, and a pharmacist is on-call for questions and to come into the hospital if needed, and non-pharmacy personnel are prohibited from entering the pharmacy when it is closed.						
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OR

117c	A night cabinet with a restricted formulary has been established for when the pharmacy is closed, but a pharmacist at a remote location is available for questions and to enter and screen medication orders before the drugs are removed from the cabinet. Exceptions: Emergent lifesaving situations.						
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118	A pharmacist or pharmacy technician regularly inspects designated drug storage areas on patient care units to assure that no unapproved medications are stocked, to assure that minimal quantities of approved medications are stocked, and to assure that all stocked medications are in-date (have not expired).						
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119	Vials of concentrated forms of electrolytes (potassium chloride, potassium phosphate, magnesium sulfate, and sodium chloride greater than 0.9%) that require dilution before IV use are not available as floor stock and/or in automated dispensing cabinets on any patient care units (including in operating room/anesthesia stock).						
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Core distinguishing characteristic 10 : *Hazardous chemicals are safely sequestered from patients and not accessible in drug preparation areas.*

		A	B	C	D	E	F
120	Bulk chemicals in the pharmacy (for compounding) are routinely assessed and those that are not regularly used or considered dangerous are eliminated from stock.						
121	Bulk chemicals used in the pharmacy (for compounding) are labeled with contents, the date the product was first opened, and the manufacturer's expiration date (if an expiration date is available from the manufacturer).						
122	Pharmacy does not store or distribute formalin.						
123	Throughout the hospital, all liquid chemicals, including cleaning compounds, are clearly labeled as to their contents.						
124	Containers of guaiac liquid (e.g., Hemoccult, Seroccult) used to test for occult blood are not present in drug storage or preparation areas, patient rooms, or in patient's bathrooms.						
125	All tissue preservatives or fixatives, caustics, and other non-drug substances used in operating rooms and other patient care areas are clearly labeled and stored separate from medications and other patient supplies.						

Key Element VI: Medication Device Acquisition, Use, and Monitoring

Core distinguishing characteristic 11 : *The potential for human error is mitigated through careful procurement, maintenance, use, and standardization of devices used to prepare and deliver medications.*

		A	B	C	D	E	F
126	At a minimum, risk management staff, pharmacists, and nurses are actively involved in all medication device purchasing decisions.						
127	Error potential for all new MEDICATION DEVICES is identified through a literature search and a FAILURE MODE AND EFFECTS ANALYSIS (FMEA); and potentially harmful error potential is documented and addressed before a decision is made to purchase and use the device.						
128	The distal ends of all tubing are clearly and boldly labeled on patients who are receiving multiple solutions via various routes of administration (e.g., labeling of the distal end of bladder installations, IV, central venous, arterial, epidural, and enteral tubing properly identifies relevant access sites).						
129	With each new bag/bottle, or change in the rate of infusion, of selected high-alert drugs and pediatric/neonatal parenteral solutions, one practitioner reads the solution for administration and a second practitioner independently verifies that the correct drug, drug concentration, rate of infusion, patient, channel selection (for multiple channel pumps), and line attachment have been selected before starting the infusion.						
130	Specially designed oral syringes, which cannot be connected to IV tubing, are used for dispensing/administering oral liquid solutions that are not available in commercially prepared UNIT-OF-USE dosing cups.						
131	The types of general-purpose infusion pumps used in the hospital are limited to two or less to maximize competence with their use.						

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132	The types of syringe pumps used in the hospital are limited to two or less to maximize competency with their use. Scoring guideline: Choose NOT APPLICABLE (N/A) if you do not use syringe pumps in your hospital.						
133	The types of PCA pumps used in the hospital are limited to two or less to maximize competence with their use. Scoring guideline: Choose NOT APPLICABLE (N/A) if you do not offer PCA in your hospital.						
134	All electronic infusion control devices undergo inspection and testing at least annually to ensure proper mechanical function.						
135	All solution administration sets used with infusion pumps have integrated free-flow protection to prevent inadvertent free-flow of solutions if the IV tubing and/or the cassette are removed from the pump.						
136	Criteria have been established to determine which patient populations, specific medications, and rates of infusion require delivery of solutions via an infusion control pump.						
137	Practitioners, including agency staff, are educated about MEDICATION DEVICES (e.g., infusion pumps, automated compounding equipment) and associated protocols/guidelines; and competency with their use is verified before they are permitted to operate a device.						
138	General infusion pumps with SMART PUMP TECHNOLOGY are in use with full functionality employed to intercept and prevent wrong dose/wrong infusion rate errors due to misprogramming the pump, miscalculation, or an inaccurately prescribed dose or infusion rate.						

Key Element VII: Environmental Factors, Workflow, and Staffing Patterns

Core distinguishing characteristic 12 : Medications are prescribed, transcribed, prepared, dispensed, and administered in a physical environment that offers adequate space and lighting and allows practitioners to remain focused on medication use without distractions.

		A	B	C	D	E	F
139	Lighting is adequate to clearly read labels and other important drug information in pharmacies, patient unit medication rooms, and at automated dispensing cabinets.						
140	Workspaces where medications are prepared are orderly and free of clutter.						
141	Pharmacies and patient unit medication rooms (or areas) have adequate space for storage of drugs, IV solutions, and drug supplies.						
142	The IV preparation area is isolated to minimize distractions.						
143	All phone calls to the pharmacy are triaged and forwarded to the IV preparation area only when necessary.						
144	Areas where drug orders are transcribed and/or entered into computer systems are isolated and relatively free of distractions and noise.						
145	Medication refrigerators in patient care areas are of sufficient size to allow admixtures that require refrigeration to be stored in an organized manner.						
146	Nurses select medications for administration in medication rooms or other isolated areas that are relatively free of distractions and noise.						
147	Nurses (including nurse anesthetists) and physicians (including anesthesiologists) prepare and/or select one patient's medications at a time, immediately before administering the medication.						

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Core distinguishing characteristic 13 : *The complement of qualified, well-rested practitioners matches the clinical workload without compromising patient safety.*

		A	B	C	D	E	F
148	Medical students, medical residents, and attending physicians work no more than 24 consecutive hours, with planned rest and naptime available. Exception: Isolated emergency situations outside of usual operations. Scoring guideline: Choose NOT APPLICABLE (N/A) if your hospital does not have medical students, residents, or employed prescribers).						
149	Practitioners involved in medication use (except medical students, medical residents and attending physicians) work no more than 12 consecutive hours. Exception: Isolated emergency situations outside of usual operations.						
150	Practitioners involved in the medication process have at least 10 hours of rest between shifts worked. Exception: Isolated emergency situations outside of usual operations.						
151	Schedules and workload permit practitioners involved in the medication process to take at least one 15-minute break and one 30-minute break (for a meal) per shift of work each day. Exception: Isolated emergency situations outside of usual operations.						
152	An effective back-up plan has been established for days when staffing is short due to illness, vacation, educational absences, and fluctuations in patient acuity and workload.						
153	Staff pharmacists believe that staffing patterns in their department are adequate to provide safe pharmaceutical care on most days.						
154	Staff nurses believe that staffing patterns on their units are adequate to provide safe patient care on most days.						
155	The use of nursing and pharmacy agency staff is minimized. Exception: Long-term agency staff (e.g., traveling nurses) who have been fully oriented to the hospital and medication use processes before working independently.						
156	Hospital or health-system plans for new and/or expanded clinical programs are well communicated to all affected practitioners and appropriate consideration of resources is addressed prior to implementation so that the additional work volume will be met without compromising patient safety.						

Key Element VIII: Staff Competency and Education

Core distinguishing characteristic 14 : *Practitioners receive sufficient orientation to medication use and undergo baseline and annual competency evaluation of knowledge and skills related to safe medication practices.*

		A	B	C	D	E	F
157	All new nurses, including agency staff, undergo baseline competency evaluation before participating independently in the medication use process.						
158	All new pharmacy staff undergo baseline competency evaluation before participating independently in the medication use process.						
159	During orientation, practitioners receive information about the hospital's actual error experiences as well as published errors that have occurred in other facilities; and they are educated about system-based strategies to reduce the risk of such errors.						

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160	During orientation, nurses spend time in the pharmacy (and with clinical pharmacists) to become familiar with the order entry process, drug preparation and dispensing, availability of drug information resources, ways to access these resources, and various medication safety initiatives.						
161	During orientation, pharmacists spend time in patient care units to become familiar with drug prescribing practices, floor stock storage conditions, administration procedures, and patient education processes.						
162	Pharmacists actively participate in the orientation process for new medical staff (including medical students, residents, and attending physicians).						
163	All prescribers, pharmacists, and nurses who work in specialty areas (e.g. critical care, pediatrics, oncology) undergo extensive training and/or obtain certification if available in that specialty before working independently.						
164	Nurses and pharmacists are not pulled from their typically assigned work areas to help in other areas without thorough orientation and ongoing training to maintain their skills and knowledge. Exception: Isolated emergency situations outside of usual operations.						
165	Those who train new staff have a reduced workload to accomplish the goals of orientation safely and thoroughly.						
166	The length of time for orientating new nurses and pharmacists is individualized and based on an ongoing assessment of their needs.						
167	Practitioners' job descriptions, performance evaluations, and the medical staff bylaws include specific accountability standards for patient/medication safety (e.g., willingness to speak up about safety issues, change practices to enhance safety, ask for help when needed, enhance teamwork, follow the safety literature) that do not include the absence of errors or a numeric error threshold; and these standards are supported by the senior leaders and human resources staff.						
168	The hospital information technology department includes personnel with specialty training in clinical informatics (not just general computing support for hardware and software) who are knowledgeable about applications in medication systems, and who are readily available for assistance in the development, application, and troubleshooting of these systems.						

Core distinguishing characteristic 15 : *Practitioners involved in medication use are provided with ongoing education about medication error prevention and the safe use of drugs that have the greatest potential to cause harm if misused.*

		A	B	C	D	E	F
169	Practitioners are educated about new drugs added to the formulary and associated protocols/guidelines and restrictions before the drugs are used in the hospital.						
170	Pharmacists routinely provide nurses with important information about non-formulary drugs before dispensing the products to patient care areas for administration.						
171	Practitioners receive ongoing information about medication errors occurring within the organization, error-prone situations, errors occurring in other healthcare facilities, and strategies to prevent such errors.						
172	Practitioners are provided with the necessary support and time to attend internal and external education programs related to medication use.						
173	Practitioners are trained in the clinical and administrative procedures for responding to a serious medication error.						

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174	When errors occur, educational efforts are widespread among all practitioners who may make a similar error, rather than remedial and directed at only those practitioners who were involved in an error.						
175	Pharmacists present at least four educational programs per year to nurses, pharmacists, and/or prescribers on important drug safety issues.						
176	Simulations of error-prone conditions (e.g., problematic medication packages and labels, mock transcription/order entry of problematic orders) and/or role-playing (e.g., to teach effective communication skills, inquiry skills, conflict resolution) are used as methodologies to orient and educate practitioners and other staff about medication/patient safety.						
177	HUMAN FACTORS and the principles of error reduction (e.g., standardization, use of constraints, redundancy for critical functions) are introduced during practitioner orientation, and used as the foundation for an annual mandatory educational program for all practitioners involved in the medication use process.						

Key Element IX: Patient Education

Core distinguishing characteristic 16 : *Patients are included as active partners in their care through education about their medications and ways to avert errors.*

		A	B	C	D	E	F
178	Patients are educated routinely upon admission to assist healthcare professionals with proper identification by showing staff their identification bracelet (or other form of identification) and stating their names clearly before medications (and other treatments) are administered.						
179	Physicians and other prescribers routinely educate patients about recommended drug therapy before the patient receives an initial dose.						
180	During drug administration, nurses routinely provide patients and/or families with the brand and generic name of the drug, the general purpose of the drug, the prescribed dose, and important side effects.						
181	Patients are provided with up-to-date, written information at an 8th grade reading level (or lower) about critical drugs that are prescribed at discharge.						
182	Patients are encouraged to ask questions about the medications they are receiving.						
183	Practitioners fully investigate and resolve all patient/family concerns or questions about a medication prior to prescribing, dispensing, and/or administering it.						
184	Criteria have been established (e.g., selected high-risk drugs, high-risk patient populations, or patients discharged on five or more medications) to trigger an automatic consultation with a pharmacist for patient education.						
185	Pharmacists or prescribers design drug administration schedules that consider the patient's lifestyle and minimize the number of times per day that medications must be taken for patients at high-risk for non-compliance with medications prescribed at discharge.						
186	Patients are informed about the potential for error with drugs that have been known to be problematic (e.g., methotrexate prescribed weekly for arthritis, frequently changing warfarin doses) and are provided with strategies to help prevent such an occurrence after discharge.						
187	Patients are instructed on when and whom to call for concerns or questions about their drug therapy after discharge.						

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PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

188a	Written materials for patients about high-alert drugs prescribed at discharge are available in the primary languages spoken in the nearby community and at an 8th grade reading level (or lower).					
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OR

188b	An appropriately trained translator is available before the patient is discharged to write down important information about high-alert drugs for patients for whom written materials are not available in their primary language.					
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Key Element X: Quality Process and Risk Management

Core distinguishing characteristic 17: *A non-punitive, system-based approach to error reduction is in place and supported by management, senior administration and the Board of Trustees/Directors.*

		A	B	C	D	E	F
189	Error prevention strategies focus on system enhancements, not individual practitioners.						
190	Practitioners and other staff report and openly discuss errors without undo embarrassment or fear of reprisal from the hospital/organization. Scoring guideline: If possible, choose score based on staff surveys as noted in item 162.						
191	All medication errors that reach the patient, regardless of the level of harm that results, are honestly disclosed to patients/families in a timely manner.						
192	No disciplinary action is taken against practitioners who make an error in the post-event process. Exceptions: Malicious or illegal behavior that results in an error; drug diversion; chemical dependence; intentional breach of confidentiality; other egregious behavior.						
193	Practitioners do not accumulate demerits or points for making a medication error; and data related to medication errors are not used as a measure of employee competence or vigilance during performance evaluations.						
194	Error rates are not determined or calculated from practitioner error reports and are not used for internal (unit-to-unit) and/or external (hospital-to-hospital) comparison.						
195	Hospital administration and management provide positive incentives for individuals to report errors.						
196	Units with a high error reporting rate are thanked and praised for detecting and reporting errors.						
197	Practitioners are periodically and anonymously surveyed to determine their level of anxiety and fear with making and reporting errors.						
198	Practitioners involved in serious errors that cause patient harm are emotionally supported by their colleagues and provided with psychological counseling (e.g., through an employee assistance program).						
199	The Board of Trustees/Directors actively demonstrates its commitment to patient safety (and safe medication practices) by approving a safety plan, rewarding practitioner error reporting, and approving system enhancements, including technology, that are likely to reduce errors.						
200	Specific medication safety objectives (e.g., reduce the risk of errors with high-alert drugs; improve medication error detection, reporting, and use of the information) are included in the hospital's strategic plans, directly communicated to all staff, and celebrated (acknowledged in a positive manner) when met.						

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201	One or more trained practitioners are employed specifically to enhance detection of medication errors, oversee analysis of their causes, and coordinate an effective error reduction plan (0.5 or 1 full time equivalent qualified practitioner is employed for this purpose alone).						
202	Patient safety is articulated in the organization’s mission and/or vision statements.						
203	Senior leaders (administrative staff, board members when possible) participate in frequent, structured visits (e.g., WALKROUNDS™) to patient care units, the pharmacy, and laboratories to talk to front-line staff about safety and quality issues, learn first-hand about day-to-day challenges that staff face when providing care and services, and show their support for staff-reported errors.						
204	Mid-level managers receive formal training on ways to effectively evaluate practitioner competency and performance, supervise and mentor practitioner’s clinical skills, and handle difficult practitioner behavior without allowing the presence or absence of medical errors to be a factor.						

Core distinguishing characteristic 18 : Practitioners are stimulated to detect and report errors, and interdisciplinary teams regularly analyze errors that have occurred within the organization and in other organizations for the purpose of		A	B	C	D	E	F
205	A clear definition and examples of medication errors and hazardous situations that should be reported have been established and disseminated to practitioners.						
206	Reportable events include both hazardous situations that could lead to an error and actual errors including those that have been detected and corrected before they reach a patient.						
207	Trusted nurse, pharmacist, and physician representatives facilitate periodic, announced, focus groups of front-line practitioners for “off the record” discussions to learn about perceived problems with the medication use system.						
208	The entire medication use process is analyzed at least annually (e.g., using self-assessments such as this tool) to identify potential risk factors for medication errors.						
209	A convened interdisciplinary team, which includes at a minimum, risk management/quality improvement professionals, pharmacists, nurses, physicians, clinical information technology staff, and hospital leadership, reviews medication error reports and other medication safety data to identify the system-based causes of error and facilitate implementation of system enhancements that make it difficult or impossible for practitioners to err.						
210	Practitioners who are directly involved in a serious and potentially serious medication error participate in a ROOT CAUSE ANALYSIS of that error and recommend system enhancements to reduce the potential for future errors.						
211	“Near misses” and hazardous situations that have the potential to cause patient harm (but score low on a patient outcome severity scale) are given the same high priority for analysis and error prevention strategies as errors that actually cause patient harm.						
212	A convened interdisciplinary team routinely analyzes and uses published error experiences from other organizations to proactively target improvements in the medication use process.						
213	In addition to practitioner reporting systems, computer markers or triggers for selected drug orders (such as antidotes) and laboratory tests (such as aPTT greater than 100) are used to enhance detection of potential adverse drug events (both medication errors and adverse drug reactions).						

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214	Prescribing errors that are detected by pharmacists and nurses are recorded, analyzed, and used in conjunction with medical staff quality improvement activities for system redesign (e.g., establishing drug/dosing protocols, standardized ordering, pharmacy dose consultation, prescriber awareness and education).						
215	Prescribers, pharmacists, and nurses are provided with regular feedback about reported errors, hazardous situations, and error reduction strategies that are being implemented.						
216	A convened multidisciplinary team routinely evaluates the literature for new technologies and successful evidence-based practices that have been effective in reducing error in other organizations to determine if it can improve its own medication management system.						
217	Patient representatives from the community are invited to participate in patient safety committees or informal ad-hoc meetings to solicit regular input on medication safety issues and expand the community's awareness of the culture of safety in the organization.						
218	An effective means of measuring medication safety (e.g., random chart review using triggers, tracking risk priority numbers from FAILURE MODE AND EFFECTS ANALYSIS [FMEA], observational methods of error detection, measuring compliance with new medication protocols, drug use evaluations), which does not rely on practitioner-reported data, has been designed and implemented to uncover system-based problems and to demonstrate sustained improvement after implementation of risk reduction strategies.						
219	Hospital leadership actively engages in dialogue about the untoward consequences of intimidation and deals effectively with reported and observed disruptive behaviors of this nature to lessen the hierarchal structures that make it difficult or uncomfortable for people to raise concerns regardless of education, experience, or rank.						

Core distinguishing characteristic 19 : *Simple redundancies that support a system of INDEPENDENT DOUBLE CHECKS or an automated verification process are used for vulnerable parts of the medication system to detect and correct serious errors before they reach patients.*

		A	B	C	D	E	F
220	Prescribers include the mg/kg dose for pediatric patients (under 40 kg) along with the PATIENT-SPECIFIC DOSE for drugs that have a published pediatric mg/kg dosing guideline. Scoring guideline: Choose NOT APPLICABLE (N/A) if care is not provided to pediatric patients, even in the emergency department.						
221	Prescribers include the mg/m ² dose (or area under the curve dose) with all chemotherapy drug orders. Scoring guideline: Choose NOT APPLICABLE (N/A) if chemotherapy is never prescribed in the hospital.						
222	If a mg/kg dose is listed in a drug order for a pediatric patient, a pharmacist verifies that it is correct, and documents (e.g., with initials) a double check of the prescriber's calculated dose (or it is performed electronically) before preparing and dispensing the drug. Scoring guideline: Choose NOT APPLICABLE (N/A) if care is not provided to pediatric patients, even in the emergency department.						
223	A pharmacist verifies that the mg/m ² dose, or area under the curve dose, listed with a chemotherapy order is correct, and documents (e.g., with initials) a double check of the prescriber's calculated dose (or it is performed electronically) before preparing and dispensing the drug. Scoring guideline: Choose NOT APPLICABLE (N/A) if chemotherapy is never prescribed in the hospital.						

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224	Nurses permanently document (e.g., with initials) an INDEPENDENT DOUBLE CHECK of the prescriber's calculated dose for pediatric drug orders before administering the drug. Scoring guideline: Choose NOT APPLICABLE (N/A) if care is not provided to pediatric patients, even in the emergency department.						
225	Nurses permanently document (e.g., with initials) an INDEPENDENT DOUBLE CHECK of the prescriber's calculated dose for chemotherapy before administering the drug. Scoring guideline: Choose NOT APPLICABLE (N/A) if chemotherapy is never prescribed in the hospital.						
226	The drugs, actual drug containers, doses, diluents, and volumes added to the diluent for pediatric/neonatal parenteral admixtures are INDEPENDENTLY DOUBLE CHECKED by a pharmacist or a nurse (even if initially prepared by a pharmacist) and documented (e.g., with initials) before dispensing/administering the products. Scoring guideline: Choose NOT APPLICABLE (N/A) if care is not provided to pediatric patients, even in the emergency department.						
227	The drug, actual drug containers, doses, diluents, and volumes added to the diluent for chemotherapy admixtures or compounded oral solutions are INDEPENDENTLY DOUBLE CHECKED by a pharmacist or a nurse (even if initially prepared by a pharmacist) and documented (e.g., with initials) before dispensing/administering the products. Scoring guideline: Choose NOT APPLICABLE (N/A) if chemotherapy is never prescribed in the hospital.						
228	New drug orders are checked and documented (e.g., with initials) by at least a pharmacist and one other person before being dispensed from the pharmacy.						
229	Selected high-alert drugs (as defined by the hospital) that are removed from unit floor stock and/or automated dispensing cabinets are INDEPENDENTLY DOUBLE CHECKED by another practitioner and documented before administration.						

PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

230a	Some form of end product testing (e.g., refractometer, weighing, lab confirmation) of complex intravenous admixtures (e.g., TPNs, cardioplegic solutions) is used to check the contents before the pharmacy dispenses the solution.						
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OR

230b	All complex solutions are outsourced.						
231	MACHINE-READABLE CODING (e.g., bar coding) is used to verify drug selection prior to dispensing drugs (includes robotic dispensing).						

PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

232a	In hospitals WITH automated compounders: MACHINE-READABLE CODING (e.g., bar coding) is used to verify all base solutions and additives attached to automated IV admixture compounders.						
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OR

232b	In hospitals WITHOUT automated compounders OR WITHOUT MACHINE-READABLE CODING for automated compounders: At least a pharmacist and one other person verify and document all base solutions and additives used in compounding all TPNs and/or cardioplegic solutions.						
233	MACHINE-READABLE CODING (e.g., bar coding) is used at the point of care to verify drug selection prior to administering medications.						

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PLEASE ANSWER ONLY Part A or Part B NOT BOTH OF THE QUESTIONS BELOW

234a	In hospitals WITHOUT computerized prescriber order entry (CPOE) systems: Drugs are filled using the order copy and the computer-generated drug label together and a pharmacist compares the label with the original order copy before drugs are dispensed.						
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OR

234b	In hospitals WITH computerized prescriber order entry (CPOE) systems: A pharmacist reviews the order in the computer before generating a label from which the drug order is filled.						
235	The pharmacy computer system (and prescriber order entry system, if used) is periodically evaluated for clinically insignificant and false positive alerts, and action is taken to minimize the appearance of these alerts.						

Core distinguishing characteristic 20 : *Proven infection control practices are followed when storing, preparing, and administering medications.*

236	Standards in the USP General Tests and Assays Chapter 797 (contained in the "Pharmaceutical Compounding-Sterile Preparations," United States Pharmacopeia, 27th Revision, and The National Formulary, 22nd Edition) are followed in all pharmacies where IV admixture occurs.						
237	Pharmacy staff members work in a segregated IV admixture area, utilizing aseptic techniques.						
238	Staff members do not directly handle loose oral solid products.						
239	Staff members use appropriate hand washing procedures prior to preparing any injectable product (e.g., IM, IV push, IV admixture).						
240	In patient care areas, multiple-dose vials are not used for saline or heparin flush solutions, or local anesthetics (as numerous entries into the vial and patient IV lines may occur for a single patient.) Exception: Local anesthetics used in the operating room.						
241	Containers of eye drops are not used for more than one patient.						