Meet *ISMP Guidelines*

for Safe Medication Use in Perioperative and Procedural Settings **by 2025** with
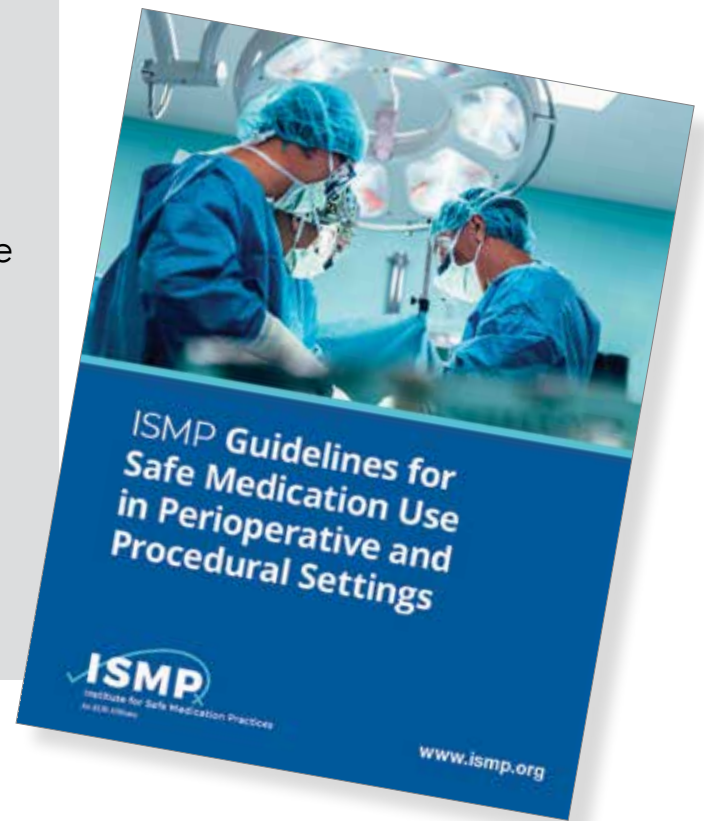
SAFE Label System®

propofol
10 mg/mL

Harmful medication errors are a significant public health problem, *causing at least 1 death every day and injuring 1.3 million people annually.*[1]

In the perioperative setting, medication errors occur frequently in all phases of perioperative care and are a common cause of morbidity and mortality.[2-4]

Overall, medication errors are estimated to occur in at least **1 in every 133** doses administered during anesthesia alone.[5-6]

Codonics Safe Label System addresses these risks and introduces consistent Best Practices that create standardization and bring barcode medication administration (BCMA) and long overdue electronic safety checks that improve patient care while improving the anesthesia workflow. It's helping to meet these new ISMP guidelines[7], several of which are targeted for implementation **by 2025**.

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To help improve medication safety, ISMP worked with clinical experts, professional organizations and industry leaders on best practice guidelines across all phases of perioperative care. These **2022 Guidelines** have been made available to hospitals, ambulatory surgery centers and other procedural locations to address identified national gaps in perioperative and procedural medication safety and provide a stepping stone and support for further implementation to reduce harmful patient events.

ISMP **Guidelines for Safe Medication Use in Perioperative and Procedural Settings**

ISMP Institute for Safe Medication Practices

www.ismp.org

The need to improve medication safety in the OR has received increasing attention in recent years from American Society of Health-System Pharmacists (ASHP), the Anesthesia Patient Safety Foundation (APSF), the Association of periOperative Registered Nurses (AORN) and the Institute for Safe Medication Practices (ISMP). The Joint Commission (TJC) continues to include perioperative medication safety practices as part of its National Patient Safety Goals (NPSG).

"Bar code medication administration has been the standard of care in the majority of hospital locations for nearly two decades. Finally, the Institute for Safe Medication Practices has recently advocated for bringing that same standard of care to our anesthesia practice."

--- Joyce A. Wahr, MD, FAHA
Vice Chair, Quality and Safety, Department of Anesthesiology, University of Minnesota
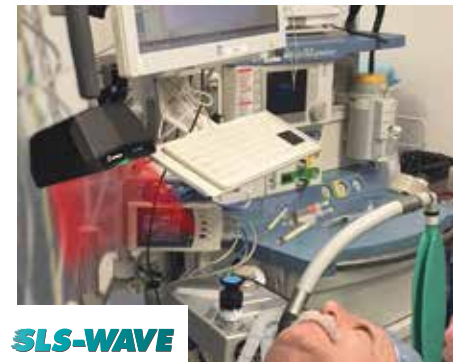
AT PREPARATION

ISMP Guideline 4.3	Eliminate the use of handwritten labels in perioperative/procedural areas **by 2025.**	✓
ISMP Guideline 4.4	Include a machine-readable code (e.g. barcode, radio frequency identification [RFID]) on all syringe and infusion labels, including those that are **PRACTITIONER-PREPARED, by 2025.**	✓
ISMP Guideline 4.5	Label **PRACTITIONER-PREPARED** syringes of medications with, at the minimum, the full name, concentration/dose of the drug, name or initials of the preparing practitioner, as well as an expiration date (when not used in 24 hours) and time (if expiration occurs in less than 24 hours). Application of an anesthesia color-coded drug class label alone is not sufficient.	✓

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AT ADMINISTRATION

ISMP Guideline 10.11	Use machine-readable coding (e.g. **BARCODE SCANNING**, RFID) in **pre**operative/**pre**procedural <u>and</u> **post**operative/**post**procedural settings to verify patients and medications/solutions prior to administration.	✓
ISMP Guideline 10.12	Take steps to implement machine-readable coding (e.g. **BARCODE SCANNING**, RFID) in **intra**operative/**intra**procedural workflows to confirm medication/solution selection prior to administration.	✓
ISMP Guideline 10.13	Take steps to implement and integrate machine-readable coding (e.g. **BARCODE SCANNING**, RFID) to support real-time EHR documentation of medication doses and fluid administration in all preoperative/preprocedural, intraoperative/intraprocedural and postoperative/postprocedural settings.[8] *Future when integrated with BD's Intelliport System	✓

SLS-WAVE

Additionally, AT ADMINISTRATION

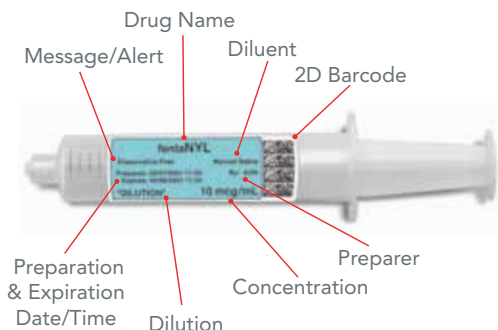|		
Meets ISMP Guideline 6.6	Take steps toward the implementation of bidirectional (i.e. auto-programming and auto-documentation) **SMART INFUSION PUMP** interoperability with the EHR in all preoperative/preprocedural, intraoperative/intraprocedural, and postoperative/postprocedural settings.[9]	✓
ISMP Targeted Medication Safety Best Practices for Hospitals 2022/2023 Best Practice 18	Maximize the use of barcode verification prior to medication and vaccine administration by expanding use beyond inpatient care areas.[10]	✓

Epic

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✓ *Meets ASHP guidelines*
on preventing diversion
of controlled substances[11]

WasteLog™

MEETS
ISMP & ASHP 2022 Guidelines*

Safety & Compliance

- Medication Safety *
- TJC-Compliance *
- COVID-19 Vaccine Labeling *
- Diversion Control *
- Infusion Pump Interoperability in the OR *
- Intelliport™ "FUTURE" *
- AIMS/EHR Integration[12] (Epic Anesthesia, Cerner®) BCMA *
- Anesthesia Cart Integration
- 340B Accuracy

ROI

Syringe label callouts:
- Message/Alert
- Drug Name
- Diluent
- 2D Barcode
- Preparation & Expiration Date/Time
- Dilution
- Concentration
- Preparer

fentaNYL 10 mcg/mL

Safe Label System — SLS550i

Call Codonics today at 800.444.1198 or visit www.codonics.com for more information.

References:
1   World Health Organization. WHO launches global effort to halve medication-related errors in 5 years. Available at: www.ismp.org/ext/279. Published 2017. Accessed July 30, 2018.
2   Beyea SC, Hicks RW, Becker SC. Medication errors in the OR—a secondary analysis of Medmarx. AORN J. 2003;77(1):122,125-9,132-4.
3   Boytim J, Ulrich B. Factors contributing to perioperative medication errors: a systematic literature review. AORN J. 2018; 107(1):91-107.
4   Cooper JB, Newbower RS, Long CD, McPeek B. Preventable anesthesia mishaps: a study of human factors. 1978. Qual Saf Health Care. 2002;11(3):277:82.
5   Gariel C, Cogniat B, Desgranges FP, Chassard D, Bouvet L. Incidence, characteristics, and predictive factors for medication errors in paediatric anaesthesia: a prospective incident monitoring study. Br J Anaesth. 2018;120(3):563-70.
6   Webster CS, Merry AF, Larsson L, McGrath KA, Weller J. The frequency and nature of drug administration error during anaesthesia. Anaesth Intensive Care. 2001;29(5):494-500.
7   https://www.ismp.org/resources/guidelines-safe-medication-use-perioperative-and-procedural-settings
8   Institute for Safe Medication Practices (ISMP.) ISMP Guidelines for Safe Medication Use in Perioperative and Procedural Settings. ISMP; 2022.
9   Institute for Safe Medication Practices (ISMP). Section S. Bi-directional smart infusion pump interoperability with the EHR. In: ISMP Guidelines for Optimizing Safe Implementation and Use of Smart Infusion Pumps. IMSP; 2020. Available at: https://www.ismp.org/guidelines/safe-implementation-and-use-smart-pumps. Accessed June 13, 2022.
10 Institute for Safe Medication Practices (ISMP). Best Practice 18. In: ISMP Targeted Medication Safety Best Practices for Hospitals. ISMP; 2022. Available at: https://www.ismp.org/guidelines/best-practiceshospitals. Accessed June 13, 2022.
11 American Journal of Health-System Pharmacy, Volume 74, Issue 5, 1 March 2017, Pages 325–348, https://doi.org/10.2146/ajhp160919
12 AIMS/EHR integration requires May 2019 or newer (Epic) and September 2019 or newer (Cerner).

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