



IoM Strategy	American Society of Health-System Pharmacists	National Coordinating Council for Medication Error Reporting and Prevention	Institute for Healthcare Improvement	National Patient Safety Partnership	Massachusetts Coalition for the Prevention of Medical Errors
Implement standard processes for medication doses, dose timing, and dose scales in a given patient care unit.			Reduce reliance on memory; simplify; standardize.	Standardize drug packaging, labeling, storage.	
Standardize prescription writing and prescribing rules.		All prescription orders should be written using the metric system except for therapies that use standard units. The term "units" should be spelled out. A leading zero should always precede a decimal expression of less than one.  Prescribers should avoid use of abbreviations.	Differentiate; eliminate look-alikes and sound-alikes.	Avoid abbreviations.	
Limit the number of different kinds of common equipment.					
Implement physician order entry.	Establish processes in which prescribers enter medication orders directly into computer systems.	Prescribers should move to a direct, computerized order entry system.	Decrease multiple entry.	Computerize drug order entry.	Implement computerized prescriber order entry systems when technically and financially feasible in light of a hospital's existing resources and technological development.
Use pharmaceutical software					Encourage pharmacy system software vendors to incorporate an adequate set of checks into computerized hospital pharmacy systems.
Implement unit dosing.	Use unit dose medication distribution and pharmacy-based intravenous medication admixture systems.	The medication order should include drug name, exact metric weight or concentration, and dosage form.		Use "unit dose" drug systems (packaged and labeled in standard patient doses).	Maintain unit-dose distribution systems (either manufacturer prepared or repackaged by pharmacy) for all non-emergency medications.
Central pharmacy should supply high-risk intravenous medications.				Use pharmacy-based IV and drug mixing programs.	Institute pharmacy-based IV admixture systems.
Use special procedure			Use protocols and checklists	Limit access to high hazard	Develop special procedures for

and written protocols for the use of high-risk medications			isely.	drugs and use protocols for high hazard drugs.	high-risk drugs using a multi-disciplinary approach, including written guidelines, checklists, pre-printed orders, double-checks, special packaging, special labeling, and education.
Do not store concentrated solutions of hazardous medications on patient care units					Remove concentrated potassium (KCl) vials from nursing units and patient care areas. stock only diluted premixed IV solutions on units.
Ensure the availability of pharmaceutical decision support.	All medication orders before a first dose should be routinely reviewed by a pharmacist and all staff should seek resolution whenever there is a question of safety.				Have a pharmacist available on-call after hours of pharmacy operation.
Include a pharmacist during rounds of patient care units.	Assign pharmacists to work in patient care areas in direct collaboration with prescribers and those administering medications.				Information on new drugs, infrequently used drugs, and on-formulary drugs should be made easily accessible to clinicians prior to ordering, dispensing, and administering medications.
Made relevant patient information available at the point of patient care.	Evaluate the use of machine-readable coding (e.g., bar coding) in their medication-use processes.	Prescribers should include the age and when appropriate, the weight of the patient, on the prescription or medication order.	Improve access to information.	Put allergies and medications on patient records.  Require machine-readable labeling (bar coding).	Consider the use of machine-readable coding (i.e. bar coding) in the medication administration process.  Encourage the use of computer-generated or electronic medication administration records (MAR).
Adopt a system-oriented approach to medication error reduction.	Approach medication errors as system failures and seek system solutions to preventing them.		Increase feedback; train for teamwork; drive out fear; obtain leadership commitment; improve direct communication.		Adopt a systems-oriented approach to medication error reduction; promote a non-punitive atmosphere for reporting of errors, which values the sharing of information.
Improve patient's knowledge about their treatment.		Prescription orders should include a brief notation of purpose unless considered inappropriate.  Prescribers should not use vague instructions such as "Take as directed" as the sole direction for use.	Improve access to information.	Educate patients.  Patients should tell physicians about all medications they are taking and ask for information in terms they understand before accepting medications.	Educate patients in the hospital, at discharge, and in ambulatory settings about the safe and accurate use of their medications.

	Develop better systems for monitoring and reporting adverse drug events.		Organize the work environment for safety.		
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