LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
- SHREVEPORT

HIGH-RISK MEDICATIONS

Purposes:

To identify high-risk medications and to emphasize high-alert medications so all health care providers involved in the prescribing, dispensing, and administration of these medications recognize potential risk.

To establish and maintain policies which will decrease the potential for medication errors.

Definitions:

- Critical Special Care Areas – All Intensive Care Units (Medical Intensive Care Unit, Surgical Intensive Care Unit, Neurosurgery Intensive Care Unit, Burn Intensive Care Unit, Neonatal Intensive Care Unit, Pediatric Intensive Care Unit, PACU, Renal Unit, Labor Unit) and Emergency Department.
- General Care Areas – All areas not considered Critical Care Areas
- High-Alert Medications – Medications that have a heightened risk of causing significant patient harm when used
- REMS – Risk Evaluation and Mitigation Strategies

Policy:

The P&T Committee will approve a list of high-risk medications and defined protocols/policies to be used when prescribing, dispensing, and administering medications. After approval by the Clinical Board, these policies/procedures will be published in the Pharmacy Newsletter and the Hospital (Pharmacy) website http://myhsc.lsuhscshreveport.edu/pharmacy/ptpolicies.php

The hospital, through the P&T committee and the Pharmacy department, will implement continuous review to ensure policy and procedures are updated as soon as potential problems are identified. This review will include black box warnings, REMS medications, ISMP updates, and Joint Commission Sentinel Events.

The strategies and educational activities that will be ongoing are as follows:

A. Look-Alike/Sound-Alike (LASA) Medications: Confusion with look-alike, sound-alike medications can cause significant harm to a patient. In an effort to decrease the potential for medication errors, the following procedures will be utilized:

1. The hospital, through the P&T Committee, has approved a list of the look-alike/sound-alike medications that have a high potential for causing medication errors. This list will be maintained on the Pharmacy P&T website that can be found at: http://myhsc.lsuhscshreveport.edu/pharmacy/ptpolicies.php.
2. Tallman lettering will be used for LASA medication names displayed in the Electronic Health Record (EHR) and in the automated dispensing machines (ADS), as well as all pharmacy generated labels.

3. Nursing and Pharmacy will monitor the utilization of the electronic Medication Administration Record to ensure that medications are available in a bar-coded form, and scanned in the profile system before administration whenever possible. Nurses will contact the Pharmacy when products are unable to be scanned so that the problem can be corrected.

4. The Pharmacy will work with the Quality Management Department in reviewing all reported medication variances to determine whether a problem with a look-alike/sound-alike contributed to the potential for error. When problems are identified, those medications will be added to the hospital list, and a specific action plan will be developed to decrease the potential for future problems.

5. Medications that have look-alike/sound-alike names will be stored in separate areas, and/or with specific labeling to alert the staff of the potential for errors. Potential for look-alike/sound-alike errors will be reviewed during floor inspections on a quarterly basis.

6. For specific high-risk drugs, a second person verification process may be implemented to decrease the opportunity for an error to occur.

7. The potential for look-alike/sound-alike errors will be considered whenever a new medication is considered for addition to the formulary.

B. Risk Evaluation and Mitigation Strategy (REMS): When concern about a serious risk of a drug or biological product may be related to the pharmacologic class of that product, the FDA may require REMS to ensure that benefits outweigh risks. A class REMS encompasses a particular class or classes of drugs or biological products, whereas a REMS focuses on a specific drug or biological product.

REMS programs are approved by the FDA. Compliance with these programs is required for anyone who purchases, prescribes and dispenses these medications. There are many components to a REMS program. Most contain required information, verbal and written, which must be provided to the patient. Some programs require more extensive procedures, such as requiring hospital to sign an agreement, requiring physicians to register with the manufacturer, requiring specific patient information provided for entry in a registry and on site audits to verify compliance. Drugs affected by REMS and the associated requirements will be maintained on the Pharmacy P&T website at: http://myhsc.lsuhscreveport.edu/pharmacy/ptpolicies.php.

C. Error Avoidance Strategies: The hospital will utilize performance improvement monitoring and staff feedback to identify processes and/or situations that may increase the risk for medication errors. Subsequently the hospital will develop strategies to improve processes and create a medication safety culture.

1. Circumstances Increasing Risk Errors in High Risk Medications
   a. Poorly handwritten medication orders
b. Verbal directions/orders  
c. Similar product packaging  
d. Similar medication name  
e. Improper packaging leading to improper route of administration  
f. Storage of products with similar names in the same location  
g. Similar abbreviations  
h. Improper storage of concentrated electrolytes

2. Strategies to Avoid Errors Involving High Risk Medications

   a. Medication Arrangement  
   b. Avoid storing look-alike, sound-alike drugs next to each other  
   c. Limit/eliminate high-risk drug storage in the diebold  
   d. Maintain awareness of look-alike and sound-alike drug names as published by various safety agencies.  
   e. Clearly specify the dosage form, drug strength, and complete directions on prescriptions. These variables may help staff differentiate products.  
   f. Alert patients to the potential for mix-ups, especially with known problematic drug names. Advise ambulatory care patients to insist on pharmacy counseling when picking up prescriptions, and to verify that the medication and directions match what the prescriber has told them.  
   g. Give verbal or telephone orders only when truly necessary, and never for chemotherapeutics. Include the drug’s intended purpose to ensure clarity.  
   h. Encourage staff to read back all orders, spell the product name, and state its indication.  
   i. Computerize prescribing. Use preprinted orders or prescriptions as appropriate. If possible, print out current medications daily from the pharmacy computer system and have physicians review for accuracy.  
   j. Install and utilize computerized alerts to remind providers about potential problems during prescription processing.  
   k. Configure computer selection screens and automated dispensing cabinet screens to prevent the two confused drugs from appearing consecutively.  
   l. Affix “name alert” stickers to areas where look or sound-alike products are stored (available from pharmacy label manufacturers).  
   m. Store products with look or sound-alike names in different locations in pharmacies, patient care units, and in other settings, including patient homes. When applicable, use a shelf sticker to help locate the product that has been moved.  
   n. Continue to employ independent double checks in the dispensing process (one person interprets and enters the prescription into the computer and another reviews the printed label against the original prescription and the product prior to dispensing).  
   o. Encourage reporting of errors and potentially hazardous conditions with look and sound-alike product names and use the information to establish priorities for error reduction. Also maintain awareness of problematic product names and error prevention recommendations provided by ISMP (www.ismp.org), FDA (www.fda.gov), and USP (www.usp.org).
Hospital Policy Manual
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Administrator

6/19/13
Date

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