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| **Originating Unit** | [ ] Administration [ ] Alice! [ ] CPS [ ] Disability Services<br>[ ] Patient Services [X] Medical Services [ ] SVR | |
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## SUBJECT: High Alert and Confusing (Look-Alike Sound-Alike) Medications

**SCOPE**
Applies to all clinicians in Medical Services (MS).

**POLICY**
Medical Services maintains a small medicine cabinet, which is managed by the Assistant Nursing Manager under the supervision of the Associate Director, Nursing, and the Executive Director of Medical Services. Our goal is to maintain a supply that provides appropriate, inexpensive and safe medication for the convenience of the students whom we serve. Medications are only prescribed and administered by those who are licensed to do so according to their scope of practice. This procedure and process is to prevent errors that could be encountered when prescribing and administering confusing medications with look-alike or sound-alike names as well as medications that have high risk for causing significant harm when they are used in error.

The list will be approved by the Executive Director, Medical Services and SVP and reviewed by the Governing Body annually.

**PROTOCOL**:

1. The Pharmacy Committee will make changes to the high-alert and medications lists, when appropriate, based on internal medication error reports and national lists available through the Institute for Safe Medication Practice and by recommendation of contracted pharmacist.
    a. High Alert Medications
        i. High alert medications have a higher risk of causing harm when administered in error.
            1. High-Alert Medications should only be stored in individual containers (such as bins) with only one type of container per bin (i.e. vials, pills, liquids)
            2. Label storage container with both the generic and brand name suing TALLMAN lettering for sound alike/read alike medications
            3. Label High-Alert medications with a HIGH ALERT label
            4. Physically separate look alike medications
            5. All medications to be ordered by authorized prescriber via EMR and verified by the RN prior to administration. (No verbal orders)

6. Routinely audit medication errors to re-evaluate safety measures and adjust/ retrain as indicated

b. – Confusing (Look-Alike and/or Sound-Alike) Medications
   i. -Confusing (Sound-Alike and Look-Alike or Read-Alike) medications can cause confusion and errors between prescribed/intended medication and what is administered. Name pairs of medications that have been involved in medication errors published in the ISMP List of Confused Drug Names has been reviewed and cross-checked with medications that are administered-administered at MS and an appropriate list has been created, reviewed and posted.
      2. A list of generic and brand name items is also posted in close proximity to the dispensing area using TALLMAN lettering.
      3. When possible  Confusing medications will not be stored on the same shelf
      4. -Confusing medications will have ALERT stickers affixed.
      5. New staff will be oriented to the medication cabinet and the medications that are stored.
      6. Staff will demonstrate a familiarity with the lists and where medications are located.

**REFERENCES**

Institute for Safe Medication Practices High-Alert Medications in Acute Care Settings
Institute for Safe Medication Practices High-Alert Medications in Ambulatory Settings Institute for Safe Medication Practices List of Confused Drug Names

**RELATED POLICIES:**
**PCMS-PRF PRAC 8, FORM 1**

**APPROVALS**

| Approver | Date | Approver | Date |
|---|---|---|---|
| [x] Senior Vice President | 11/11/21 | [x] Executive Director, Medical Services | 11/11/21 |
| [x] Executive Director, Counseling and Psychological Services | 11/11/21 | [x] Executive Director, Disability Services | 11/11/21 |
| [x] Executive Director, Alice! Health Promotion | 11/11/21 | [x] Executive Director, Sexual Violence Response | 11/11/21 |
| [x] Chief of Administration | 11/11/21 | | |