☐ ADMINISTRATE POLICY & PROCEDURE (APP)	☐ INSTITUTIONAL POLICY & PROCEDURE (IPP) ☐ INTERDEPARTMENTAL ☐ INTERNAL	
TITLE		**POLICY NUMBER/V#**
Management of High Alert & LASA Medications		MMC – MED – 09 (01)
INITIATED DATE	**EFFECTIVE DATE**	**REVISED DATE**
02/08/2025	**01/09/2025**	**01/08/2028**
REPLACES NUMBER		**NO. OF PAGES**
N/A		04
APPLIES TO	**RESPONSIBILITY**	
All Health Care Providers	All physicians, pharmacists, nurses, technician	

1. PURPOSE:

1. To provide specific written procedures for the safe storage and handling of medications that have been designated as High-Alert Medications (HAM) or Look Alike, Sound-Alike.
2. To emphasize high-alert medications awareness so that all health care providers involved in the prescribing, dispensing, storage, and administration of these medications recognize potential risks.

2. DEFINITION:

2.1 High-Alert Medications (HAM): Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error with these medications are clearly more devastating to patients.

2.2 Look-Alike Sound-Alike (LASA) Medications: Medications with generic or proprietary names that look or sound like other medications.

2.3 Medication Segregation: Storing in separate field and are spaced out on shelves (not to follow alphabetical sequence)

2.4 ISMP: Institute for Safe Medication Practices.

2.7 Tall man lettering: is an error -prevention strategy used to reduce the risk of look -alike medicine names errors. Tall Man lettering uses a combination of lower- and upper-case letters to highlight the differences between look -alike medicine names, like fluOXETine and flu VOXAMine, helping to make them more easily distinguishable. The presence of the tall man letters made staff aware of the possibility of an error & reminder that the drug has been confused with another medication a look -alike name to alert them to read it carefully to ensure they have the correct drug.

3. POLICY:

3.1 ISMP High -Alert Medications and CBAHI national hospital standards are the primary reference from which List s of High -Alert Medications & Look -alike/Sound -alike (LASA) Medications are derived.

3.2 implements strategies to improve the safety of High Alert Medication, LASA that include specific storage, prescribing, preparation, administration, and monitoring processes.
3.3 The list of LASA drug names with the tall man letter will be utilized in the medication names.
3.4 Sterile water for injection (100 mL or larger) are not permitted as floor stock in patient care units.
3.5 Any addition, deletion, or changes to the list of HAM, LASA require the approval of the P&T Committee.
3.6 High alert labels are colored red with words “High Alert”.
3.7 LASA labels are colored yellow with word “LASA”.

4. PROCEDURE:

4.1 The list of High Alert Medications and Look -alike and Sound -alike (LASA) Medications are updated on annual basis; or when it is needed
4.2 Updated lists are approved by the Pharmacy in the share folder.
4.3 Medications designated as High alert in this policy shall carry “HIGH ALERT” auxiliary label. This includes original medication box, pre -packed, and/or compounded preparations in a ready -to administer form either parenteral or non -parenteral preparation, medication cassette/shelf will be tagged with High Alert sign as part of the cassette/shelf labels.
4.4 For pharmaceutical storage, it is acceptable to label the medication tray or shelve rather than the original box of insulin vial or pen rather than the original box since patients are usually scared when they see the red “High Alert” auxiliary label. Upon dispensing patients will be counseled accordingly.
4.5 It is the responsibility of the head nurse to double check proper labeling that has been done by the pharmacist as well as checking storage of all high alert medications available.
4.6 Extra High Alert labels will be placed in the medication cassettes to be affixed on the final products prepared by nursing staff for administration.
4.7 Head of pharmacy will monitor compliance with the above mentioned procedure during monthly inspection.
4.8 High -alert medications require a double check procedure prior to transcribing, preparation, dispensing and administration.
4.9 Verbal and telephone orders not acceptable with High Alert medications.
4.10 Verbal orders only allowed during code Blue/life threatening situations (such as RRT).
4.11 For LASA Medication: Caution should be exercised during verbal or telephone orders of Look Alike and Sound Alike (LASA) medications through an independent double check.
4.12 **<u>Strategies to avoid errors involving Look -alike/Sound -alike (LASA) Medications:</u>**

4.12.1 Providing education on LASA medications to healthcare professionals during orientation and as part of continuing education.

4.12.2 Recommendation aimed to minimize name confusion for all new medications by screening for the potential for look -alike/sound -alike errors whenever a new medication is introduced for formulary addition with proper notification to staff by email.

4.12.3 The list of confused drug names is posted on the online formulary, where it is accessible for all healthcare practitioners to serve as a reminder for all health care providers.

4.12.4 Medications that have look -alike/sound -alike names will be separated from each other in different shelves or in no alphabetical order in storage areas & to label each cassette/shelf using Tallman lettering, and to be tagged with LASA sign as part of the medication label. Potential for look -alike/sound -alike errors will be reviewed during floor stock inspections monthly.

4.12.5 Tallman lettering will be used for LASA medication names (e.g., hydrOXYzine, hydrALAzine).

4.12.6 Physicians are requested to clearly specify the dosage form, drug strength, and complete directions on prescriptions, as requested by policy of medication order as these variables may help staff differentiate products.

4.12.7 Nurses are requested to check the purpose/indication of the medication on the prescription & clarify the order if needed prior to processing, dispensing and administering.

4.12.8 On counseling, patients would be alerted to the potential for mix -ups, especially with known problematic drug names, and they would be advised to insist on pharmacy counseling when picking up prescriptions, and to verify that the medication and directions match what the prescriber has told them.

5. RESOURCES:

1. ISMP's List of High Alert Medications.
2. ISMP's List of Confused Drug Names.
3. CBAHI List of High Alert Medications.

6. CROSS REFERENCE:

7. Verbal and Telephone Orders P&P
8. ADR P&P
9. Medication Error Reporting P&P

7. REFERENCES:

1. CBAHI National Standards for Ambulatory Care Centers, Effective Jan,2020.
2. The Joint Commission International (JCI), 7th Edition, Effective Jan 2021.

8. FORMS & ATTACHMENT:

1. list of High Alert Medications with Location.
2. Look alike - Sound alike (LASA) Medications List.

9. Approved

APPROVALS & REVIEWS:			
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