

HEADS UP...



TOPIC: *Safe management and use of look-alike/sound-alike and high-alert medications*

SETTING: Ambulatory Health Care (AHC)

Why is this important?

High-alert and hazardous medications can increase the risk of significant patient harm and/or sentinel events when they are used in error (MM.01.01.03 EP 2). Look-alike/sound-alike (LASA) medications are those, either written or spoken, which may lead to potentially harmful errors when confused with each other (MM.01.02.01 EP 2). Inappropriate use and management of these medications continue to cause confusion in the field and can result in findings on survey.

Scope of the Problem:

Time period: January 1, 2018 – May 31, 2019

Number of full surveys performed: **1,065**

Number of high and moderate risk findings related to the safe use of LASA medications: **124 (12%)** and the management of high-alert and hazardous medications: **89 (8%)**

Observations identified within a specific topic area (e.g., medication) may reveal systemic areas for improvement across the organization. These improvement opportunities might be reflected in additional standards/EPs within the medication management chapter and/or other chapters/standards/EPs:

See also EC.02.02.01 EP 8, MM.03.01.01.01 EP 9, MM.01.02.01 EP 1.

Sample survey observations [from surveyor notes] and contributing factors

Observations related to the use of LASA medications:

- Medications were not labeled consistently throughout all areas where medications were stored including crash carts, medication refrigerators, anesthesia carts, and additional carts.
- LASA medications were observed in bulk medication storage areas.
- Multiple vials of lidocaine 1%, lidocaine 1% with epinephrine, lidocaine 2%, and lidocaine 2% with epinephrine were stored in the same bins and without the proper labels.
- Multiple medications that were not on the organization's LASA list were nevertheless labeled "LASA," for example, acetaminophen, clonidine, and ketorolac 60mg/2mL (purple top) to the point that nearly every medication in the cabinet was labeled "Look Alike Sound Alike."

Observations related to management of high-alert medications

- Designated high-alert meds were not labeled in the medication or crash carts, or the medication refrigerator (e.g., Succinylcholine, Rocuronium, Insulin).
- High-alert medications were not identified with stickers per organization policy.
- The high-alert medication list was not available in the patient care area(s).

Potential contributing factors:

- o The high-alert medication list was not available or posted.
- o Staff were not trained on how to label high alert or LASA medications.
- o No consistent process to manage high-alert medications or help staff identify high-alert medications.
- o The high-alert/hazardous medication and LASA lists were not unique to the organization.
- o Inconsistent labeling of high-alert or LASA medications.

How to identify potential problems in your organization

Review your policies and procedures

- ☐ Does the organization have a process or plan for ensuring the safety and management of high-alert and hazardous and LASA medications? Is this process reviewed annually and documented?
- ☐ Has the organization developed its own list of high-alert and hazardous medications based on unique utilization patterns and internal data? This list should be reviewed annually and date-stamped to ensure it is up to date.

Interview staff (clinicians, support staff)

- ☐ Staff are familiar with the high-alert and hazardous and LASA medication lists and where they are located.
- ☐ Staff can discuss the process for ensuring safety and managing high-alert and LASA medications (e.g., segregating medications in different bins or locations, using upper case letters “tall man lettering,” using color-coded or other stickers to identify high-alert or hazardous medications).
- ☐ All staff who administer medications (e.g., physicians, RNs, CRNAs, etc.) can demonstrate knowledge of the high-alert and LASA lists, policies, and strategies to prevent errors associated with use of these medications.

Assess your environment

- ☐ Is there a list of medications approved for dispensing and administering, including a list of high-alert medications and LASA medications? Is this list available/posted where these medications are administered (e.g., in medication rooms and cabinets, crash and anesthesia carts, treatment rooms, narcotic lockers, storage cabinets, etc.)?
- ☐ Where applicable, examine the pre-procedure, procedure, and post-procedure recovery areas (including medication and crash carts) to ensure proper labeling and storage of medication.

Evaluate implementation

- ☐ Conduct spot checks of medication storage areas and carts to ensure high-alert and LASA meds are managed appropriately.
- ☐ Review the high alert and LASA policies and procedures and medication lists annually and ensure that the review and any changes are documented.

What are some resources that can assist in mitigating risks in these areas?

- Joint Commission Ambuzz blog, “Managing High-Alert/Hazardous and Look-Alike-Sound-Alike Medications in Ambulatory settings (blog posting and infographic: https://www.jointcommission.org/ambulatory_buzz/managing_high-alerthazardous_and_look-alike-sound-alike_medications_in_ambulatory_care_settings/)
- ISMP list of high-alert medications for community/ambulatory settings: <https://www.ismp.org/sites/default/files/attachments/2017-11/highAlert-community.pdf>
- Centers for Disease Control and Prevent (CDC)/National Institute for Occupational Safety and Health (NIOSH) List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings: Proposed Additions to the NIOSH Hazardous Drug List 2018 (from Federal Register) <https://www.cdc.gov/niosh/docket/review/docket233b/pdfs/233-BRevisedNIOSHTable42-14-18.pdf>