RIVERSIDE MEDICAL CENTER, INC.

DR. PABLO O. TORRE MEMORIAL HOSPITAL

METRO PACIFIC HEALTH
THE HEART OF FILIPINO HEALTHCARE

DEPARTMENT: Pharmacy Division		**POLICY NUMBER:** DPOTMH-MPP-PHAR-P018(01)	
TITLE/DESCRIPTION: **MANAGING HIGH ALERT MEDICATION**			
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PURPOSE:

To establish safe medication practices for High Alert Medications to maximize the safety of the medication processes associated with these medications.

DEFINITIONS:

Medication Management (MM) - a partnership of the pharmacist, the patient or their caregiver, and other health professionals that promotes the safe and effective use of medications and helps patients achieves the targeted outcomes from medication therapy. MM includes the analytical, consultative, educational and monitoring services provided by pharmacists to help consumers get the best results from medications through enhancing consumer understanding of medication therapy, increasing consumer adherence to medications, controlling costs, and preventing drug complications, conflicts, and interactions.

High-Alert Medications - are medications that have 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 drugs, the consequences of an error are clearly more devastating to patients. High Alert meds such as concentrated electrolytes have a higher risk of causing injury, either as a result of a narrow therapeutic range or due to a high incidence of reported serious error.

Universal Protocol for Time-out - immediately before starting administration/procedure, Time-out must be conducted in the location where the procedure/medication will be done / administered.

RESPONSIBILITY:

All Physicians, Nurses, Pharmacists and other Healthcare Professionals of Riverside Medical Center Incorporated

POLICY:

1. It is the policy of the Riverside Medical Center, Inc. (RMCI) to maintain a list of high alert medications that require specific safeguards and strategies to reduce the risk of errors related to ordering and prescribing, location, transcribing, labeling, identification, preparation, storage, dispensing and administration.

2. High alert medications are drugs that have an increased risk of causing significant harm to a patient when used in error. Because the consequences of an error associated with use of these medications can result in significant patient injury, special precautions shall be employed with their management throughout the process.

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3. All identified high alert medications shall be labeled with a striking neon orange or red sticker bearing the words "HAM". See sample below:

4. It is the policy of RMCI to adopt, maintain, and enforce a truly closed-loop medication management system that supports patient safety and allow for future improvements and changes in the quality of care.

5. Audits for high alert medications shall be conducted for both pharmacy-stored and wardstock medications at least annually, but if possible during the monthly floorstock inspection (please refer to Floorstock Inspection Policy) using the High Alert Medication Audit Form.

HIGH ALERT MEDICATIONS:

1. **Vinca Alkaloids: vinCRIStine (vinCRIStine ™), vinBLAStine (vinBLAStine ™), vinorelbine (Vinorelbine ™)**

   1.1 **Risk Reduction Strategies**

   1.1.1 All doses of vinCRIStine and vinBLAStine shall be prepared and dispensed in 25mL minibags of 0.9% Sodium Chloride for injection. Vinorelbine shall be prepared and dispensed in a maximum of 50 mL minibags of 0.9% Sodium Chloride for injection.

   1.1.2 The minibag label shall contain the warning, "Fatal if given intrathecally. For IV use only. Do not remove covering until moment of injection."

   1.1.3 The minibag shall be affixed with a HIGH ALERT: DOUBLE CHECK.

   1.1.4 Each minibag shall be placed in an over wrap (e.g., chemo bag) with the same warning listed above. As part of a pause for verification, an independent double check shall be conducted in the pharmacy by two healthcare professionals including an independent double-check.

   1.1.5 The Universal Protocol for "Time-Out" shall be conducted at the bedside immediately prior to the administration of all doses by two qualified healthcare professionals (registered chemotherapy nurse and second chemotherapy-proficient registered nurse or pharmacist or physician), included in this "Time-out" process is the independent double check verifying the correct patient, drug, dose, dose calculation and site of line insertion and scheduled date and time of

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administration upon initiation, bag change, change in dosage and at handoff.

1.1.6 This double-check shall be documented in the nurses notes and patient Medication Administration Record (MAR) by staff performing the "Time-out" process. Order changes involving infusion rates and/or pump settings shall be documented in patient medical record (e.g. flow sheet).

1.1.7 In every few specific cases where the health and safety of a young child, without central line access, could be compromised, the vinca alkaloid shall be diluted in 10mL of 0.9% Sodium Chloride for injection and dispensed in a 20mL syringe and packaged and labeled. Attending oncologist shall establish criteria for determining which patients may fall under this exception.

1.1.8 Vinca alkaloids that are delivered via 20mL syringe for specific pediatric patients (young children) shall be delivered directly from the pharmacist who prepared/checked the product to the qualified healthcare professional who shall administer the dose. This may occur at the nursing unit or pharmacy location.

2. **Continuous Intravenous Infusion of Heparin Risk**

2.1 **Risk Reduction Strategies**

2.1.1 The abbreviation "u" shall not be accepted in the medication order.

2.1.2 A standard concentration of 100 units/mL shall be used for all continuous heparin infusions.

2.1.3 Preprinted orders shall be used always for prescribing continuous infusions of heparin.

2.1.4 All infusion bags, vials and ampules of heparin products shall be affixed with the High Alert Auxiliary label.

2.1.5 Use of infusion pumps is compulsory to all heparin continuous infusion procedures.

2.1.6 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division, using the method. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g. IV compounding profile, and or patient's EMR) by both performing professionals.

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2.1.7 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion bag of heparin is initiated, upon any change in dosage, at bag change and at handoff.

2.1.8 Double-checks shall be documented on the patient's MAR in the medical record by both performing professionals. Order changes involving infusion rates and/or pump settings and double checks involving bag change or at handoff may be documented via current practices (e.g. flow sheet).

2.1.9 Therapeutic heparin infusion bags may be stored as stock in critical care areas (e.g. CathLab, Hemodialysis) where it is not feasible for direct pharmacy supply for urgent cases.

2.1.10 Infusion pump is utilized for heparin infusions.

2.1.11 An audit of heparin products stored as wardstock and at the pharmacy is conducted at least annually, but preferably during floorstock inspection.

2.1.12 No restricted heparin is stored as wardstock.

3. **Insulin IV and Subcutaneous**

3.1 **Risk Reduction Strategies**

3.1.1 The abbreviation "u" shall not be accepted in the medication order.

3.1.2 A standard insulin concentration of 1 unit/mL shall be used for all continuous insulin infusions.

3.1.3 All infusion bags shall be affixed with the High Alert Auxiliary label. Use of infusion pumps is compulsory to all Insulin continuous infusions procedures.

3.1.4 All insulin product shall be affixed with the High Alert Auxiliary label.

3.1.5 Store heparin and insulin separately.

3.1.6 Do not use slash marks to separate NPH and regular insulin doses (e.g., NPH 10/12 regular has been confused with 10 NPH and 112 regular because the slash mark was read as the numeral one).

3.1.7 After dispensing /using insulin do not return to the box it came in- this increases the risk that a vial might be placed in the wrong box and next person may automatically select the wrong product.

3.1.8 Nurses shall inform the patient that they are to receive insulin-patients not expecting this shall immediately question the need.

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3.1.9 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.i., IV compounding profile, and record or patient's EMR) by both performing professionals.

3.1.10 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion bag of insulin is initiated, upon any change in dosage, at bag change and at handoff.

3.1.11 Independent double-checks shall be documented on the patient's MAR in the medical record by both performing professionals. Order changes involving infusion rates and/or pump settings and double checks involving bag change or at handoff may be documented via current practices (e.g. flow sheet).

4. **Intravenous, Intraperitoneal and Intrathecal Cytotoxic Chemotherapy Agents**

4.1 **Risk Reduction Strategies**

4.1.1 Verbal/telephone orders shall not be accepted when prescribing intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents with the exception of date or time changes clarifications.

4.1.2 Whenever feasible, preprinted orders shall be used for prescribing intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents.

4.1.3 When prescribing intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents, orders shall be written for individual doses, not the total amount of drug for the entire course of therapy.

4.1.4 Complete orders for intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents should include:

4.1.4.1 Patient name and medical record number; date and time the order is written.

4.1.4.2 State whether this is a new order or a change to an existing order.

4.1.4.3 All elements used to calculate the dose of a chemotherapy agent should be included on the order or prescription (e.g., height, weight, and/or BSA if

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applicable).

4.1.4.4 Indication that written informed consent was obtained for investigational drugs used in clinical trials or for non-FDA-approved drugs obtained for compassionate use, if applicable).

4.1.4.5 Chemotherapy agent name, dose, route, date of administration for each drug.

4.1.4.6 Cycle number and/or week number as appropriate to the regimen, if applicable.

4.1.4.7 All doses of intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents shall be independently double checked by two (2) qualified healthcare professionals (e.g. two pharmacists or one pharmacist and one qualified technician) in the Pharmacy before dispensing. When only one (1) pharmacist is present this procedure may include qualified medical or chemo proficient nursing personnel. This check shall include a verification of the correct patient, drug, dose, route of administration, frequency of administration scheduled date and time of administration and label. This check shall be documented in the IV compounding profile/record.

4.1.4.8 Distinctive labeling/packaging shall be used to distinguish intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents from other medications.

4.1.4.9 All doses of intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents shall be affixed with High Alert Auxiliary label as stated above.

4.1.4.10 Missing dose requests for intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents shall be investigated immediately by a pharmacist and a replacement dose shall not be dispensed until the disposition of the first dose is verified.

4.1.4.11 Only nurses with documented competency in chemotherapy administration may administer cytotoxic chemotherapy agents.

4.1.4.12 Two (2) qualified healthcare professionals (one registered chemotherapy nurse plus another registered nurse or pharmacist or physician) shall independently double check all doses of intravenous, intraperitoneal or Intrathecal cytotoxic chemotherapy agents at the bedside before administration or at initiation and upon any change in dosage, at bag change and at handoff.

4.1.4.13 Double-check shall verify the correct patient, drug, dose, dose calculations,

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route of administration, frequency of administration, scheduled date and time of administration, label, infusion pump settings, IV tubing connection and site of line insertion. This check shall be documented in the medical record by both performing professional. Order changes involving infusion rates and/or pump settings may be documented via current practices (e.g. flow sheet).

5. **Concentrated Electrolytes greater than 0.9% Sodium Chloride Injection and equal to 0.4mEq/mL Potassium injection (chloride, acetate, and phosphate)**

5.1 **Risk Reduction Strategies**

5.1.1 Concentrated electrolyte injections shall be stored only in the Pharmacy and in selected critical area.

5.1.2 Concentrated electrolyte shall be affixed with the Caution: concentrated electrolyte auxiliary label.

5.1.3 Concentrated electrolyte shall be affixed with the Caution: concentrated electrolyte auxiliary label.

5.1.3.1 Indications for KCl infusion

5.1.3.2 Maximum allowable concentration

5.1.3.3 Guidelines for when cardiac monitoring is required.

5.1.3.4 KCl infusions shall be given via an infusion pump.

5.1.3.5 Prohibition of multiple simultaneous KCl solutions (e.g. no IV KCl while KCl is being infused in another IV).

5.1.4 Allow only commercially available, standard (e.g., isotonic) concentrations of sodium chloride outside the pharmacy.

5.1.5 Limit option- do not stock the 3% Sodium Chloride injection (only in pharmacy).

5.1.6 In dialysis units, stock a single hypertonic concentration and store in a locked area with limited access and affix high alert auxiliary label.

5.1.7 When infusions of concentrated sodium chloride injection are required for patient use, only commercially prepared products (when possible), with patient-specific affixed a High Alert Auxiliary label.

5.1.8 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the

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Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.i., IV compounding profile, and record or patient's EMR) by both performing professionals.

5.1.9 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion of concentrated sodium or potassium injection is initiated, at dosage changes, at bag changes and at handoff. Double-checks shall be documented on the electronic or paper MAR of the medical record by both parties. Order changes involving bag change or at handoff may be documented via current practices (e.g. flow sheet).

6. **Magnesium Sulfate Infusions (40mg/mL) with Total IV Bag Volume Size Larger than 100mL**

6.1 Risk Reduction Strategies

6.1.1 A standard concentration of 40mg/mL shall be used for all continuous infusions of magnesium sulfate.

6.1.2 All magnesium sulfate infusions in the patient care areas shall be affixed with a High Alert Auxiliary label.

6.1.3 Do not use potentially confusing abbreviations such as "MgSO4" and "MSO4".

6.1.4 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g. IV compounding profile, and record or IV room logbook) by both performing professionals.

6.1.5 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion of magnesium sulfate with a total IV bag size is larger than 100mL is initiated, and upon change in dosage, at bag change and at handoff. Double-checks shall be

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documented on the electronic or paper MAR of the medical record by both parties. Order changes involving bag change or at handoff may be documented via current practices (e.g. flow sheet).

7. **Alteplase (t-PA, Activase ®) Intravenous Infusion**

7.1 Risk Reduction Strategies

7.1.1 All infusions of Alteplase (t-PA) for use in all departments including, but not limited to, the hospital and emergency department shall be prepared by a pharmacist. Administration of Alteplase via IV, Intra-arterial push or instillation for resolving clots in tubing is excluded.

7.1.2 For emergency use, when the pharmacist is verified as not available to prepare the medication, one (1) package dose of Alteplase will be stored in the Emergency Department. When this dose shall be used, appropriate documentation containing patient identification and reason for use shall be transmitted to the pharmacy before a new emergency dose is issued. Use of these emergency doses shall be audited for policy compliance.

7.1.3 All infusions of Alteplase shall be affixed with a High Alert Auxiliary label.

7.1.4 Alteplase shall be supplied from the pharmacy as two (2) patient specific doses as determined by patient weight.

7.1.5 The bolus dose shall be supplied in a syringe with the patient specific dose to be administered (e.g., 10% of total patient specific dose).

7.1.6 The continuous infusion of Alteplase shall be supplied as the patient specific dose for completion of the therapy. There shall be no over-fill. (e.g., 90% of total patient-specific dose).

7.1.7 The label for each Alteplase dose shall include at a minimum, the patient name and MRN, the patient location, the generic and brand name of the drug, the concentration of the drug supplied in mg/mL, the total drug quantity/total volume of solution that is contained in the package, the expiration date and the rate of infusion/administration. Each label (the bolus syringe and the infusion container) shall be patient-specific for that dose to be administered.

7.1.8 The compounding of the medications should be accomplished without interruption and in an area that is sequestered from other activities of disruption.

7.1.9 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division, using the method, at the point of completion of compounding

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sterile dosage forms of alteplase. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g. IV compounding profile, and record or IV room logbook) by both performing professionals.

7.1.10 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever an infusion of Alteplase is initiated and at handoff. Double-checks shall be documented on the electronic or paper MAR of the medical record by both parties. Order changes involving infusion rates and/or pump settings shall be documented via current practices (e.g. flow sheet).

7.1.11 Warning shall be used to differentiate the product from tenecteplase (TNKase) and minimize the possibility of a substitution error.

8. **Tenecteplase (Metalyse [R]) Intravenous Injections**

8.1 **Risk Reduction Strategies**

8.1.1 Two (2) health professionals (e.g., two registered nurses, or one registered nurse and one physician or pharmacist) shall independently double check the correct medication, patient, dose, dose calculations and route of administration and label at the patient's bedside whenever an injection to tenecteplase (Metalyse [R]) is initiated.

9. **Epinephrine, Norepinephrine, Dopamine and Isoproterenol Infusions**

9.1 **Risk Reduction Strategies**

9.1.1 A standard concentration shall be used for all continuous infusions.

9.1.2 Epinephrine: 8 micrograms/mL

9.1.3 Norepinephrine: 16 micrograms/mL

9.1.4 Isoproterenol: 4 micrograms/mL

9.1.5 In clinical situations where more concentrated infusions are required, the syringes/bags shall be affixed with a "Non-standard Concentration" label.

9.1.6 Whenever feasible, all infusion bags of these medications shall be prepared by the pharmacy.

9.1.7 All infusions of these medications shall be affixed with High Alert Auxiliary label.

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9.1.8 Except for use on emergency trays or kits (e.g., Crash Carts), 30mL vials of epinephrine 1:1000 (1mg/ml) vials shall not be store outside the Pharmacy Division.

9.1.9 Use cardiac monitors on all patients with a central line.

9.1.10 Use labels that differentiate critical parts of the names (e.g. "DOBUtamine" and DOPamine").

9.1.11 Label IV bags and pumps with dosage charts and equivalent delivery rates for these dosages.

9.1.12 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division, using the method, at the point of completion of compounding sterile dosage forms of epinephrine, Norepinephrine, or isoproterenol. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or IV room logbook) by both performing professionals.

9.1.13 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion of one of these medications is initiated and at bag change and at handoff. Double-checks shall be documented on the electronic or paper MAR of the medical record by both parties. Order changes involving infusion rates and/or pump settings shall be documented via current practices (e.g., flow sheet).

10. **Opiate/Narcotic infusions, including Patient Controlled Anesthesia (PCA) therapy**

10.1 **Risk Reduction Strategies**

10.1.1 Whenever feasible, preprinted orders shall be used prescribing opiate/narcotic infusions and PCA therapy.

10.1.2 The following standard concentrations shall be used for PCA therapy: morphine 1mg/mL, meperidine 10mg/mL, hydromorphone 0.2mg/mL.

10.1.3 In clinical situations where more concentrated infusions are required, the syringes/bags/reservoirs shall be affixed with a "Non-Standards Concentration" label.

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10.1.4 All opiate/narcotic infusion syringes/bags shall be affixed with High Alert Auxiliary label. High Alert labels should be affixed to the exterior over packaging on commercially supplied syringes/bags to maintain tamper evidence.

10.1.5 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or IV room logbook) by both performing professionals.

10.1.6 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, route of administration, label, PCA pump settings, label, IV tubing connection and site of line insertion at the bedside whenever an opiate/narcotic infusion bag is initiated, upon any change in dosage or infusion rate, at bag change and at handoff. Double-checks shall be documented on PCA Flow Sheet or the electronic or paper MAR of the medical record by both parties. Order changes involving infusion rates and/or pump settings and double check involving bag change and at hand off may be documented via current practices (e.g., flow sheet). Anesthesia practitioners shall follow the High Alert Medication Policy.

11. Medication Administered via the Intrathecal Route

11.1 Risk Reduction Strategies

11.1.1 When compounding medications for Intrathecal use, compounding personnel shall pause for verification and perform an independent double check in the Pharmacy by two healthcare professionals (e.g., two pharmacists and one technician, one pharmacist and one nurse) after the preparation of the Intrathecal dose to assure it is prepared and labeled correctly. This check shall include a verification of the correct patient, drug, dose, dose calculations, and route of administration. This check shall be documented in the IV compounding records.

11.1.2 The Universal Protocol for "Time-Out", including an independent double check, shall be conducted at the bedside immediately prior to the administration of all doses of Intrathecal medications by two qualified health care professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This

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check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double check shall be documented in the medical record by both parties. Order changes involving rates and/or pump settings should be documented via current practices (i.e., flow sheet). Anesthesia practitioners shall follow the High Alert Medication policy and procedure.

12. **Medications Administered via the Epidural Route**

12.1 **Risk Reduction Strategies**

12.1.1 Whenever feasible, preprinted orders shall be used for prescribing opiate/narcotic epidural infusions.

12.1.2 When appropriate PCA pumps are available, all opiate/narcotic epidural infusions shall be administered using a PCA pump.

12.1.3 All opiate/narcotic epidural infusions shall be affixed with High Alert Auxiliary label.

12.1.4 Whenever feasible, commercially prepared bags of opiates/narcotics shall be used for epidural infusion.

12.1.5 Where feasible, color-coded or labeled tubing without injection ports shall be used for administering opiate/narcotic epidural infusions.

12.1.6 Two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or IV room logbook) by both performing professionals.

12.1.7 Two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, route of administration, label, PCA pump settings, label, IV tubing connection and site of line insertion at the bedside

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whenever an epidural medications is administered, at bag change and at handoff. This check is also required whenever an epidural opiate/narcotic infusion is initiated and upon change in dosage. Double-checks shall be documented the electronic or paper MAR of the medical record by both parties. Order changes involving infusion rates and/or pump settings and double check involving bag change and at hand off may be documented via current practices (e.g., flow sheet). Anesthesia practitioners will follow the High Alert Medication policy and procedure.

12.1.8 Invasive procedures such as epidural insertions require adherence to the Joint Commission's National Patient Safety Goals and use of the Universal Protocol for "Time-Out". The above shall be followed for the procedure but is not required for medication maintenance.

13. **Medications Administered to neonates in the Neonatal Intensive Care Units (NICU)**

13.1 **Risk Reduction Strategies**

13.1.1 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division, at the point of completion of compounding sterile dosage forms of all medications for neonatal patients with the exception of intermittent infusions of short duration (e.g., IV Antibiotics). If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

13.1.2 For all doses of medications, two (2) health care professional (e.g., registered nurse, physician, pharmacist, or respiratory therapist) shall independently double check the correct patient, drug, dose, dose calculations, route of administration, label, IV tubing connection and site of line insertion and any infusion pump settings at the bedside before administration at bag and at handoff. Double-checks shall be documented on the electronic or paper MAR in the medical record by both parties. Order changes involving infusion rates and/or pump settings and double checks involving, bag changes and at handoff may be documented via current practices (e.g., flows heet).

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14. **Medication Administered to Pediatric Patients (Age 0-13)**
    - 14.1 **Risk Reduction Strategies**
        - 14.1.1 Two (2) health care professional (e.g., registered nurse, and physician) shall independently double check the correct patient, drug, dose, dose calculations, route of administration, label, IV tubing connection and site of line insertion and any infusion pump settings at the bedside before administration, with bag changes and at handoff for all medications listed below:
        - 14.1.2 All doses of IV medications in critical care areas including ED
        - 14.1.3 All medications used for procedural sedation except when administered by an anesthesia provider.
        - 14.1.4 Digoxin (all routes)
        - 14.1.5 Chloral hydrate (all routes)
        - 14.1.6 Double checks shall be documented on the electronic or paper MAR in the medical record by both performing professionals. Order changes involving bag changes and at handoff may be documented via current practices (e.g., flows heet).
        - 14.1.7 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shallbe a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

15. **Digoxin Intravenous injection**
    - 15.1 **Risk Reduction Strategies**
        - 15.1.1 Provide patient education by trained staff on the importance of compliance with dosing follow up blood tests and on the warning signs of potential over dosage.
        - 15.1.2 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in

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the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

15.1.3 Clinical units - two (2) qualified healthcare professionals shall independently double check the correct patient, drug, dose calculations, infusion pump settings, label, IV tubing connection and site of line insertion at the bedside whenever a continuous infusion of one of these medications is initiated and at bag change and at handoff. Double-checks shall be documented on the electronic or paper MAR of the medical record by both parties. Order changes involving infusion rates and/or pump settings shall be documented via current practices (e.g., flow sheet).

15.1.4 All digoxin intravenous infusions shall be affixed with High Alert Auxiliary label.

15.1.5 Creatinine clearance information available in order entry system.

16. **Neuromuscular Blocking Agents (Rocuronium, Atracurium, and Cisatracurium)**

16.1 **Risk Reduction Strategies**

16.1.1 Warning: Paralyzing Agent, a High Alert Auxiliary label placed on all storage locations and patient specific doses in all locations.

16.1.2 Standardize ordering: never allow "use as needed for agitation" orders; never refer to Neuromuscular Blocking Agents (NMB) as "relaxants".

16.1.3 Do not store these agents outside of critical care areas.

16.1.4 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.i., IV compounding profile, and record or patient's EMR) by both performing professionals.

16.1.5 The Universal Protocol for "Time-Out", including an independent double-check, shall be conducted at the bedside immediately prior to the administration of all doses of neuromuscular blocking agents by two (2) qualified healthcare

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professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double-check shall be documented in the medical record by both parties. Order changes involving rates and/or pump settings should be documented via current practices (e.g., flowsheet).

16.1.6 Limited product availability in the pharmacy and selected critical areas (e.g., Intensive Care Unit).

17. **IV Esmolol and Propanolol**

17.1 **Risk Reduction Strategies**

17.1.1 Minimize the need for Esmolol by promoting alternative agents.

17.1.2 Standardize order communication- do not allow Esmolol to be ordered by "amp" or "vial".

17.1.3 Store Esmolol only in the Pharmacy and prepare drips and IV syringes only in the pharmacy, except for use in emergency trays or kits (e.g., Crash Carts).

17.1.4 The Universal Protocol for "Time-Out", including an independent double- check, shall be conducted at the bedside immediately prior to the administration of all doses of IV Esmolol and Propanolol by two qualified healthcare professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double-checks shall be documented in the medical record by both parties. Order changes involving rates and/or pump settings shall be documented via current practices (e.g., flow sheet).

17.1.5 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

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18. **Benzodiazepines (Midazolam or versed)**
    - 18.1 **Risk Reduction Strategies**
        - 18.1.1 Provide appropriate monitoring during the use of Midazolam (e.g., use pulse oximetry, have resuscitation equipment in the area).
        - 18.1.2 Restrict access: Do not use Midazolam for pre-op sedation except in Operating Room (OR), since appropriate monitoring equipment may not be available.
        - 18.1.3 Limit packaging option: use only one concentration and use the smallest package size possible.
        - 18.1.4 The Universal Protocol for "Time-Out", including an independent double-check, shall be conducted at the bedside immediately prior to the administration of all doses of benzodiazepines by two (2) qualified healthcare professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double-check shall be documented in the medical record by both parties. Order changes involving rates and/or pump settings shall be documented via current practices (e.g., flow sheet).
        - 18.1.5 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

19. **Anticoagulants (e.g., Warfarin, low molecular weight heparin, IV unfractionated heparin)**
    - 19.1 **Risk Reduction Strategies**
        - 19.1.1 Provide patient education by certified staff in a structured setting.
        - 19.1.2 Increase monitoring (e.g., more frequent clinic visits, or home testing).
        - 19.1.3 The Universal Protocol for "Time-Out", including an independent double-check, shall be conducted at the bedside immediately prior to the administration of all doses of anticoagulants medications by two (2) qualified healthcare professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double-checks shall be documented in the medical

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record by both parties. Order changes involving rates and/or pump settings shall be documented via current practices (e.g., flow sheet).

19.1.4 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

20. **Antiarrhythmics, IV (e.g., Lidocaine)**

20.1 **Risk Reduction Strategies**

20.1.1 Use lidocaine only in single-dose vials. Do not place vials that hold more than 500 mg in patient care areas. Single-dose vials reduce the risk of overdose and eliminate the risk of contamination.

20.1.2 The Universal Protocol for "Time-Out", including an independent double- check, shall be conducted at the bedside immediately prior to the administration of all doses of antiarrhythmics drug by two (2) qualified healthcare professionals (e.g., physicians and registered nurse or pharmacist or two registered nurses). This check shall verify the correct patient, drug, dose, dose calculations, route of administration and label. Double-check shall be documented in the medical record by both parties. Order changes involving rates and/or pump settings should be documented via current practices (e.g., flow sheet).

20.1.3 Pharmacy Services - two (2) qualified pharmacy staff, one of whom shall be a pharmacist, shall independently double check the accuracy of the product in the Pharmacy Division. If two (2) qualified healthcare professionals are not available in the pharmacy, the checks may be accomplished with a pharmacist and a registered nurse or physician at the location of administration using the documentation of the compounding activities. This check shall be documented in the pharmacy records (e.g., IV compounding profile, and record or patient's EMR) by both performing professionals.

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PROCEDURE (SOP): N/A

WORK INSTRUCTION: N/A

WORK FLOW: N/A

FORMS:

1. DPOTMH-PHARM-F007 (01) - High Alert Medications Availability, Concentrations And Responsibilities
2. Dpotmh-Pharm-F008 (01) - HAM Audit Form
3. DPOTMH-PHARM-F009 (01) - Dilution And Dose Range Guidelines For High Alert Medications

EQUIPMENT: N/A

REFERENCES:

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
2. Accreditation Canada Qmentum Standards 2018
3. ISMP Managing High Alert Medications 2021
4. Reducing the Risk of Errors Associated with High-Risk, High Alert Drugs

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