MM.5.1 There is a written multidisciplinary plan for managing high-alert medications and hazardous pharmaceutical chemicals. It includes identification, location, labeling, storage, dispensing, and administration of high-alert medications.

MM.5.2 The hospital identifies an annually updated list of high-alert medications and hazardous pharmaceutical chemicals based on its own data and national and international recognized organizations (e.g., Institute of Safe Medication Practice, World Health Organization). The list contains, but is not limited to, the following:

- MM.5.2.1 Controlled and narcotics medications.
- MM.5.2.2 Neuromuscular blockers.
- MM.5.2.3 Chemotherapeutic agents.
- MM.5.2.4 Concentrated electrolytes (e.g., hypertonic sodium chloride, concentrated potassium salts).
- MM.5.2.5 Antithrombotic medications (e.g., heparin, warfarin).
- MM.5.2.6 Insulins.
- MM.5.2.7 Anesthetic medications (e.g., propofol, ketamine).
- MM.5.2.8 Investigational (research) drugs, as applicable.
- MM.5.2.9 Other medications as identified by the hospital.

MM.5.3 The hospital plan for managing high-alert medications and hazardous pharmaceutical chemicals is implemented. This includes, but is not limited to, the following:

- MM.5.3.1 Improving access to information about high-alert medications.
- MM.5.3.2 Limiting access to high-alert medications.
- MM.5.3.3 Using auxiliary labels or computerized alerts if available.
- MM.5.3.4 Standardizing the ordering, transcribing, preparation, dispensing, administration, and monitoring of high-alert medications.
- MM.5.3.5 Employing independent double checks.

MM.5.4 The hospital develops and implements standard concentrations for all medications administered by intravenous infusion.

**Standard Intent:**

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. Errors may not be more common with these than with other medications, but the consequences of errors may be devastating. Several worldwide organizations had identified a list of High Alert medications such as WHO and ISMP. Hospitals shall have a plan for the safe use of these medications and develop their own annually updated list of high alert medications with the related safety

strategies to minimize errors and harm from these medications and other hazardous pharmaceutical chemicals as much as possible.

**MM.6 The hospital has a system for the safety of look-alike and sound-alike (LASA) medications.**

MM.6.1 There is a multidisciplinary policy and procedure on handling look- alike/sound-alike (LASA) medications.

MM.6.2 The hospital reviews and revises annually its list of confusing drug names, which include LASA medication name pairs that the hospital stores, dispenses, and administers.

MM.6.3 The hospital takes actions to prevent errors involving LASA medications including the following, as applicable:

MM.6.3.1 Providing education on LASA medications to healthcare professionals at orientation and as part of continuing education.

MM.6.3.2 Using both the brand and generic names for prescribing LASA medications.

MM.6.3.3 Writing the diagnosis/ indication of the LASA medication on the prescription.

MM.6.3.4 Changing the appearance of look-alike product package.

MM.6.3.5 Reading carefully the label each time a medication is accessed, and/or prior to administration.

MM.6.3.6 Minimizing the use of verbal and telephone orders.

MM.6.3.7 Checking the purpose/indication of the medication on the prescription prior to dispensing and administering.

MM.6.3.8 Placing LASA medications in locations separate from each other or in non-alphabetical order.

**Standard Intent:**

Medication errors related to look-alike and/or sound-alike medication names and/or packages are common in the healthcare setting throughout the medication use process. Look-alike, Sound-alike medications account for an estimated 25- 30% of medication errors. With tens of thousands of medications currently on the market, the potential for serious error due to confusing medication names is significant. Contributing to this confusion are incomplete knowledge of drug names; newly available products; similar packaging or labeling; similar clinical use; illegible prescriptions or misunderstanding during issuing of verbal orders. Several organizations worldwide such as the WHO and the ISMP had identified, published and periodically updated several lists of look-alike and sound-alike medications. Hospitals shall initiate and then annually update their own list of LASA medication names. They