ACCREDITATION

Required Organizational Practice (ROP) of the Month

MANAGING HIGH ALERT MEDICATIONS

- The **Required Organizational Practice (ROP)** for **Managing High Alert Medications** states the organizational leaders implement a mitigation strategy to safely manage high-alert medications.
- **High Alert Medications** are drugs that can cause significant harm to clients if they are administered incorrectly.
- A **risk assessment** is completed to determine the risks vs benefits of stocking the high-alert medication in the care area and identify risks so a mitigation strategy can be put into place (e.g. special labeling, storage conditions, documentation). It considers the type of care/care setting: surgical care, palliative care, acute care, long-term care, or home care; and populations served: newborns, children, youth adults, or older adults.

Examples of High-Alert Medications: anticoagulants, insulins, chemotherapeutic agents, opioids, neuromuscular-blocking agents, and concentrated electrolytes.

AT HEALTH PEI:

- The ***High-Alert Medications Policy*** includes the organization's list of high-alert medications based on the 2024 Institute for Safe Medication Practices (ISMP) Canda High-Alert Medications List. Health PEI's ***High-Alert Medication List*** is posted in medication prep areas.
- Programmable IV pumps with drug libraries that include limits for dosing and/or infusion volume are used for high-alert medication administration.
- A sub-set of high-alert medications require an **Independent Double Check (IDC)** when administered by nursing. See Health PEI ***Independent Double Check for High-Alert Medications*** policy for more information. The list is also available on CIS.
- Stocking of targeted high-alert medications is limited in patient care areas.
- Concentration and volume options for high-alert medications are limited and standardized in pharmacy departments and patient care areas.
- **Audits** of high-alert medications in patient service areas and pharmacy departments are conducted, and results are reviewed, and quality recommendations created by Medication Management Quality Improvement Team.

Questions Surveyors May Ask Staff:

- What are examples of high-alert medications that you administer?
- What safety practices are in place on your unit to minimize the risk of high-alert medication errors?
- What learning activities are available to mitigate risk when working with high-alert medications? Where would you find that?

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