



High-Alert Medicines — Double-Check Before You Give

The medicines most likely to cause serious harm when used in error. Independent double check, every time

HIGH-ALERT MEDICINES

Two people. Independent check. Every time.

Class	Examples	What goes wrong
Anticoagulants	Heparin, enoxaparin, warfarin, DOACs	Wrong dose or duplicate → bleeding
Insulin	All insulins; U-100 vs U-500	Units misread as ml; wrong type → hypoglycaemia
Opioids	Morphine, fentanyl, oxycodone, methadone	Tenfold errors; wrong route; respiratory arrest
Concentrated electrolytes	Potassium chloride, magnesium sulphate, hypertonic saline	Given undiluted → cardiac arrest. Never stored on wards.
Sedatives and neuromuscular blockers	Midazolam, propofol, vecuronium, rocuronium	Look-alike vials; paralysis without ventilation
Chemotherapy	All cytotoxics; methotrexate (weekly, not daily)	Frequency errors; wrong route (intrathecal vincristine)
Hypoglycaemics (oral)	Sulfonylureas	Confused names; hypoglycaemia in the elderly

The independent double check

1. Second person checks the order, the patient, the drug, the dose calculation, the route and the pump setting — without being told the answer first.
2. Both sign the chart. A verbal "yes, fine" is not a check.
3. Concentrated electrolytes are stored only in pharmacy and ICU, in a separate locked place, labelled "MUST BE DILUTED".

ASF standards: Standard 4 — medication safety criteria (high-alert list displayed; double-check documented; concentrated electrolytes removed from wards)