POLICY NO: 2009

Effective:
05/05

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05/08

SOUND-ALIKE LOOK-ALIKE MEDICATIONS

I. DEFINITION: Medication names that look similar or sound similar have been identified as a potential source of error in health care systems.

II. POLICY: It is the policy of Aurora Health Care that sites will establish and implement policies and procedures to minimize the potential for error resulting from miscommunication due to medication names with similar spelling or pronunciation.

III. PURPOSE: This policy is established to assure that sites, departments, and areas in Aurora Health Care that handle medications for administration to patients have considered the risk of error associated with similar sounding and/or similar looking names, and have incorporated practices to minimize that risk.

IV. PROCEDURE

A. The following list of drugs has been identified from national recommendations and from Aurora Health Care medication event reporting. Following the list of drugs is a list of safety practices that should be applied to minimize errors. More than one practice may be appropriate for each drug.

B. It is expected that areas that use these medications will enact practices from this policy and develop their own site-specific policy supporting those practices.

C. This list of drugs should be considered a minimum standard and additional drugs or interventions may be undertaken based on practice site.

D. Medications that sound-alike or look-alike

- Medications with lipid and non-lipid based formulations. (e.g., daunorubicin, doxorubicin, amphotericin)
- Carboplatin (Paraplatin) and Cisplatin (Platinol)
- Vinblastine (Velban) and Vincristine (Oncovin)
- Morphine (Astramorph, Duramorph, and Infumorph) and Hydromorphone (Dilaudid)
- Insulin Formulations
- Clonidine (Catapress) and Clonazepam (Klonopin)
- Lamivudine (Epivir) and Lamotrigine (Lamictal) and Terbinifine HCI (Lamisil)
- Citalopram (Celexa), Celecoxib (Celebrex), and Fosphenytoin (Cerebyx)
- Nefazodone (Serzone) and Quietapine (Seroquel)
- Buproprion SR and XL (Wellbutrin SR and Wellbutrin XL)
- Tizanidine (Zanaflex) and Tiagabine (Gabitril)
- Hydralazine (Apresoline) and Hyroxyzine (Atarax®, etc.)
- Captopril (Capoten®, etc.) and Carvedilol (Coreg®)

- Norepinephrine and Nicardipine (Cardene)
- Paclitaxel (Taxol, etc.) and Paclitaxel Protein-Bound (Abraxane, etc.)
- Methadone and methylphenidate (Metadate® CD, Metadate® ER)
- Valganciclovir (Valcyte®) and valactoclovir (Valtrex®)
- Infliximab (Remicade®) and rituximab (Rituxan®)
- Rifaximin (Xifaxan®) and rifabutin (Mycobutin®) and rifampin (Rimactane®, Rifadin®)

E. Actions to reduce risk

- Do not store the products in immediate proximity to one another and/or use shelf flags to alert staff.
- Place a cue in the computer system to check the dosage and formulation of the medications
- Staff education on the difference between lipid-based on non-lipid based products
- Use safe handling recommendations and safety stickers when provided by manufacturer
- Place maximum dose warnings on in computer system.
- Use generic names when prescribing and not chemical names or abbreviations
- Require written orders for chemotherapeutic agents
- If possible, use "tall-man" lettering to differentiate the difference in the printed names.
- Do not stock dosage forms with high concentration of these drugs on nursing units
- Limit the brands of comparable products that are stocked in the pharmacy and the patient care areas.
- Place a reminder in computer to double check generic name and indication when ordered by brand name
- Remove patient specific products, such as insulin, from stock upon patient discharge.

V. References

1. The Joint Commission. Comprehensive Accreditation Manual for Hospitals: http://www.jointcommission.org/

2. The Joint Commission. Look-alike/sound-alike drug list: http://www.jointcommission.org/

3. ISMP. What's in a name? Ways to prevent dispensing errors linked to name confusion. *ISMP Medication Safety Alert!* 7(12) June 12, 2002.

4. ISMP. Keeping patients safe from iatrogenic methadone overdoses. *ISMP Medication Safety Alert!* 13 (3) February 14, 2008.