


1-DAY REGIONAL MEETINGS

Preventing Errors:


Look- and Sound-Alike Medications



Presented in partnership with the ICHHP Annual Meeting

Faculty

Matthew Grissinger, RPh, FISMP, FASCP
 Director, Error Reporting Programs
 Institute for Safe Medication Practices

Disclosure

Matthew Grissinger, RPh, FISMP, FASCP: Spouse's Employer—Johnson and Johnson

Learning Objectives

- Identify the types of medication errors that are the result of look-alike and sound-alike names
- Describe strategies for health-system pharmacists for reducing errors due to similarity in drug names

Audience Polling Question

What is the most common pairs of medication names that are involved in wrong drug errors?

- HydrALAZINE and hydrOXYzine
- Tramadol and trazodone
- Morphine and HYDROmorphone
- GlipiZIDE and glyBURIDE

FDA Name Differentiation Project

Established Name	Recommended Name	Established Name	Recommended Name
Acetofenamide	AcetoHEXAMIDE	Hydralazine	HydrALAZINE
Acetalsamide	AcetaZOLAMIDE	Hydromorphone	HYDRORmorphone
Bupropion	BuPROPion	Hydroxyzine	HydrOXYzine
Buprone	BuPROPone	Medroxyprogesterone	MedroxyPROGESTERone
Chlorpromazine	ChlorpROMAZINE	Methylprednisolone	MethylPREDNISolone
Chlorpropamide	ChlorpPRAMIDE	Methyltestosterone	MethylTESTOSTERone
Clomiphene	ClomIFENE	Minoxantrone	MiNOXANTRone
Clompramine	ClomPRAMINE	Nicardipine	NIcARDipine
Cyclosporine	CycloSPORINE	Nifedipine	NIfeDipine
Cytosentine	CytoSERINE	Prednisone	PREDNISone
Doxorubicin	DOXORuBicin	Prednisolone	PREDNISOLone
Doxorubicin	DOXORuBicin	Risperidone	risPERIDone
Dimethyldimale	DimethylDIMATE	Ropinirole	ropINIrole
Diphenhydramine	DiphenyDRAMINE	Sulfadiazine	SulfADIAZINE
Dobutamine	DOBUtamine	Sulfisoxazole	SulfISOXAZOLE
Dopamine	DOFamine	Tolazamide	TOLAZamide
Glipizide	GLipiZIDE	Tolbutamide	TOLBUtamide
Glyburide	GlyBURIDE		

US Food and Drug Administration. www.fda.gov/Drugs/DrugSafety/MedicationErrors/ucm164587.htm. Accessed on February 16, 2016.

Where Are Names Confused?

- Medication Orders
 - Handwritten Orders
 - Order forms, preprinted orders
 - CISPlatin/CARBOPlatin
 - vinCRIStine/vinBLAStine
 - DOPamine/DOBUtamine
- Order Entry Screens

Handwritten Look-Alike Names

Cisplatin 4 mg po qd
Regimone 400mg PO qd

Handwritten Look-Alike Names (continued)

Doxil 150mg bid
Tigec 210mg qd
Myzant 1 qd
Zyrufta 10.180mg qd

Electronic Order Entry

Code	Description	Dose	Route	Schedule	Pause
ACTO15	ACTOS 15MG TABLET	15 MG	PO	DAILY	Y 5
ACTO30	ACTOS 30MG TABLET	30 MG	PO	DAILY	Y 5
ACTO30 02	ACTONEL 30MG TABLET	30 MG	PO	Q28W	Y 5
ACTO35	ACTONEL 30MG TABLET	25 MG	PO	Q7DAYS6	Y 5
ACTO45	ACTOS 45MG TABLET	45 MG	PO	DAILY	Y 5
ACTOS 02	ACTONEL 9MG TABLET	5MG	PO	Q28W	Y 5

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Electronic Order Entry (continued)

Type: All Rx Search: Starts With

find: insulin Real Time SI

bl Insulin Aspart

Insulin Aspart Prot & Aspart

Insulin Detemir

Insulin Glargine

Insulin Glulisine

Insulin Isophane & Regular

Insulin Isophane Human

Insulin Lispro & Lispro Prot

Insulin Lispro (Human)

Insulin Lispro Prot & Lispro

Insulin Admin Supplies

Insulin Cartridge 3ML

Insulin Infusion Pump

Insulin Infusion Pump Suppl

Insulin Pen Needle

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Electronic Order Entry (continued)

Search: ACTO30 Real Time SI

bl Insulin Aspart

Insulin Aspart Prot & Aspart

Insulin Detemir

Insulin Glargine

Insulin Glulisine

Insulin Isophane & Regular

Insulin Isophane Human

Insulin Lispro & Lispro Prot

Insulin Lispro (Human)

Insulin Lispro Prot & Lispro

Insulin Admin Supplies

Insulin Cartridge 3ML

Insulin Infusion Pump

Insulin Infusion Pump Suppl

Insulin Pen Needle

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Which Regular Insulin?

Ln	Drug#	Drug Name	Strength/Volume	Enter	Line #	-----	...
1	13928	INSULIN-HUMULIN L	100U=1ML			DSPN	Pack Sz 10.000
2	46002	INSULIN-NOVOLIN N	100U=1ML			INJ	10.000
3	61501	INSULIN-HUMULIN U	1000U=1ML			INJ	10.000
4	64042	PINK-INSULIN	0.06U=1ML			SYRG	25.000
5	64043	BLUE-INSULIN	0.5U=1ML			SYRG	50.000
6	64044	YELLOW-INSULIN	1U=1ML			SYRG	50.000
7	64038	INSULIN-R DILUTED	0.1U=1ML			VIAL	10.000
8	97012	INSULIN-REG HUMAN	1U=15ML			SYRG	25.000
9	98191	INSULIN-NOVOLIN N	100U=1ML			INJ	10.000
10	98192	INSULIN-REG HUMAN	100U			INJ	100.000
11	98664	INSULIN-REG HUMAN	100U			INJ	1000.000
12	99669	INSULIN-HUMULIN R (FS)	100U			INJ	100.000
13	99818	INSULIN-HUMAN REG	100U			INJ	100.000
14	31421	INSULIN NPH INNOLET	1U			INJ	300.000
15	31321	INSULIN REG INNOLET	1U			INJ	300.000
16	31721	INSULIN 70/30 INNOLET	1U			INJ	300.000
17	22203	INSULIN LANTUS	100U			INJ	10.000
18	30631	INSULIN-NOVOLIN 70/30	100U			INJ	10.000

Enter Line# at top of screen, press ENTER.
 F1=Help F2=Restart F3=Exit F4=Prompt
 F7=Bkwd F8=Fwd F12=Previous F13=Disp Msg F14=Send Msg

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

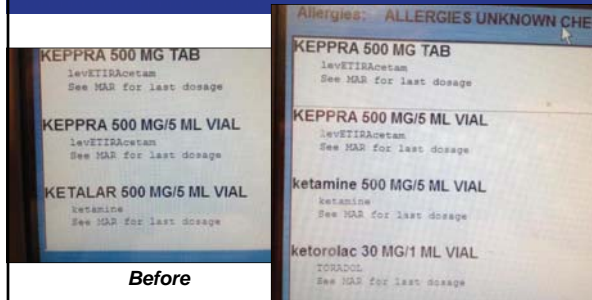
Drug Errors Involving Immediate- and Extended-Release Products

“OxyCONTIN” from CPOE system listed as.....

Medication: OXYCODONE HCL TBCR 10 MG OR
 Qty: 60 Ref: 0 Start: 3/12/
 Route: DAW:
 Sig: 1 TABLET TWICE DAILY

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Medication Devices



Before

After

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Medication Devices (continued)

Test Patient View of MAR

ALL	Scheduled	PRN	Continuous	Pyrexia Orders	Chemo Meds	Adm Times	Phases of Care
Pre-admit from 2012 in PASS							
Discontinued Medications							
Medication 50 mg in 500V 200 mL IV Soln							
Drug CONTINUOUS							
Route intravenous							
Order Dose 0.5 mc/kg/min x 79.4 kg							
Admin Amount 0.397 mg/min							
Ordered Infusion Rate 1.58 mL/hr							
Order Start Time 11 1420							
Order End Time 11 425							
Make Adminmed Information							
Medication 50 mg in 500V 200 mL IV Soln							
Drug CONTINUOUS							
Route intravenous							
Order Dose 0.5 mc/kg/min x 79.4 kg							
Admin Amount 0.397 mg/min							
Ordered Infusion Rate 1.58 mL/hr							
Order Start Time 11 1420							
Order End Time 11 425							
Make Adminmed Information							

Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Where Are Names Confused?

Drug Labeling and Packaging

- Pharmacy
- Manufacturer

Drug Storage

- Pharmacy
- Care Areas
 - ADCs
 - Floor Stock

Pharmacy IV Labels



Manufacturer Bulk Packaging



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Wellbutrin, Zyban, Bupropion.....SR, XL.....



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Manufacturer Unit-Dose Packaging



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Manufacturer Unit-Dose Packaging



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Manufacturer Cartons



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Manufacturer IV Solutions



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Manufacturer Vials



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Pharmacy Labeling



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Look-alike names, Packaging & Storage



Used with permission from the Institute for Safe Medication Practices, Horsham, Pennsylvania.

Identifying the Problem

- **Need to know**
 - Where in the medication use process the pairs of drugs are being confused before you implement risk reduction strategies

Identifying the Problem (continued)

- Identify problematic name pairs in your organization
 - Need to know what drug name pairs are being confused before you take action
 - **Proactive**
 - Observation
 - **Concurrent**
 - Pharmacy checks
 - Cart fills
 - New orders
 - Orders vs label
 - Labels vs drug

Identifying the Problem (continued)

- **Retrospective**
 - Error reports
 - Limited – who does the reporting?
 - Usually wrong meds given to patient or pharmacy dispensing errors caught by nursing
 - Other care areas – OR, ED, radiology
 - Doesn't usually include those that are caught in pharmacy
 - Triggers
 - Opiates – morphine & HYDRomorphone
 - Insulin products

Error Reduction Strategies

- **Failure Mode and Effects Analysis (FMEA)**
 - Med-ERRS (www.med-errs.com)
- **Constraints**
 - Do you really need it on formulary?
 - Limit concentrations/strengths
 - Morphine 2 mg/mL vs HYDROmorphine 1 mg/mL
- **Separation/segregation**

FMEA = Failure Mode and Effects Analysis.

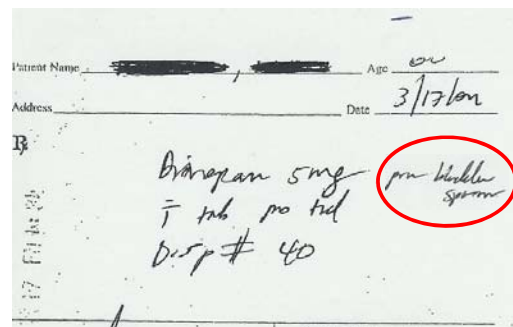
Error Reduction Strategies

- **Redundancies**
 - Independent double checks
- **Differentiation**
 - Tallman lettering
 - Studies with TML
 - www.ismp.org/tools/
 - Include indication for use with orders
 - Highlighting, color (red)
 - Stickers (LAN)

The image shows a document from the Institute of Safe Medication Practices (ISMP) titled "FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters". It includes a table with columns for drug names and recommended tall man letters. The table lists various drugs such as Acetaminophen, Aspirin, and Ibuprofen, along with their corresponding tall man letters (e.g., 'A' for Acetaminophen, 'S' for Aspirin, 'I' for Ibuprofen).

Institute of Safe Medication Practices. www.ismp.org/Tools/tallmanletters.pdf. Accessed on February 16, 2016.

Look-Alike Name Error Due to Lack of Patient Information



Error Reduction Strategies

- **Education**
 - Staff need to know
 - What is being confused?
 - What are you doing about it?
 - What do those stickers mean?
- **Report errors and near-misses**
 - Internally
 - Externally
 - ISMP

The image is a promotional graphic for the Pharmacy Learning Network (PLN) 1-Day Regional Meetings. It features a blue background with a collage of photos showing people in a meeting setting. The text "PLN PHARMACY LEARNING NETWORK" and "1-DAY REGIONAL MEETINGS" is at the top. At the bottom, the word "Questions?" is written in a large, white font.