GENERAL STATEMENT OF PURPOSE

- Look-Alike / Sound-Alike (LASA) medications refer to names of different drugs that have orthographic similarities and/or similar phonetics (i.e. similar when written or spoken). These similarities increase the risk of an error occurring in the medication administration process to include such areas as: ordering, transcription, dispensing, and/or the administration phase.
- The Joint Commission (TJC) Medication Management (MM) standards require institutions to address the safe use of LASA medications by developing a list of such medications and taking proactive steps to prevent errors involving the interchange of these agents.

POLICY

Identify and review a list of LASA drugs specific to the North Shore University Hospital. This list will be used to ensure that safeguards are put in place to prevent medication errors and protect the patient.

SCOPE

This policy applies to all members of the North Shore University workforce including, but not limited to, employees, business associates, medical staff, volunteers, students, physician office staff, and other persons performing work for or at North Shore University Hospital.

GUIDELINES

- Requests to add or remove agents from this list will be directed to the System P&T Committee.
- The ultimate decision to modify this policy shall lie with the System P&T Committee membership.
- Safety Strategies include
  - Pharmacy Department Storage
    - Segregated storage to prevent mix-up
    - Storage bins labeled as “Sound-alike/Look-alike medications”
  - Automated Dispensing Cabinets
    - “Look-Alike / Sound-Alike” alert appears when loading and removing LASA medications from the cabinet
    - TALLman lettering utilized
  - Formulary Management
    - LASA names and similar labeling of generic products considered when determining the Formulary determination of products
  - Education
    - LASA lists disseminated to all patient care areas

REFERENCES:

TJC: CAMH - MM.01.02.01, EP1
<table>
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<tr>
<th>CONFUSED DRUG NAMES</th>
<th>POTENTIAL ERRORS</th>
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| **CISplatin (Platinol®)**                              | • Similarity in medication names can lead to confusion between these two agents.  
| **CARBOplatin (Paraplatin®)**                          | • Doses appropriate for CARBOplatin usually exceed the maximum safe dose of CISplatin.  
|                                                         | • Severe toxicity and death has been associated with accidental CISplatin overdoses.  
| **PACLitaxel (Taxol®)**                               | • Confusion between these two agents can result in serious adverse outcomes since they have different dosing recommendations and use in various types of cancer.  
| **DOCEtaxel (Taxotere®)**                             |                                                                                                                                                                            |
| **VinBLAStine (Velban®)**                             | • Due to name similarity, fatal errors have occurred when patients were erroneously given vinCRISTINE intravenously, but at the higher vinBLASTINE dose.  
| **VinCRIStine (Oncovin®)**                            |                                                                                                                                                                            |
| **HYDROmorphone Injection (Dilaudid®)**                | • Some providers have mistakenly assumed that HYDROmorphone is the generic equivalent of morphine.  
| **morphine Injection (Astramorph®, Duramorph®, Infumorph®)** | • These products are NOT interchangeable. Fatal errors have occurred when HYDROmorphone was confused with morphine. Based on equianalgesic dose conversion, this may represent a significant overdose, thus leading to serious adverse events. |
| **hydrALAZINE (Apresoline®)**                          | • Patients affected by a mix-up between these agents may experience serious adverse events.  
| **hydrOXYzine (Atarax®, Vistaril®)**                   |                                                                                                                                                                            |
| **CeleXA® (Citalopram)**                              | • Similar spelling of these brand name drugs can lead to confusion, which in turn can lead to error.  
| **CeleBREX® (Celecoxib)**                             | • Patients affected by a mix-up between these three drugs may experience a decline in mental status, lack of pain or seizure control, or other serious adverse events.  
| **CereBYX® (Fosphenytoin)**                           |                                                                                                                                                                            |
| **HumuLIN® R U-100 (Regular insulin human)**          | • Similar names, strengths and concentration ratios have been shown to contribute to medication errors. This confusion can be especially problematic with illegible handwriting.  
| **HumuLIN® R U-500 (Regular insulin human)**          |                                                                                                                                                                            |
| **HumuLIN® N NPH (human insulin isophane)**           |                                                                                                                                                                            |
| **HumuLIN® 70/30 (70% human insulin isophane, 30% human insulin)** |                                                                                                                                                                            |
| **HumaLOG® (Insulin lispro)**                         |                                                                                                                                                                            |
| **HumaLOG® Mix 75/25 (75% insulin lispro protamine, 25% insulin lispro)** |                                                                                                                                                                            |
| **HumaLOG® Mix 50/50 (50% insulin lispro protamine, 50% insulin lispro)** |                                                                                                                                                                            |
| **cloNIDine (Catapres®, KlonopIN® (Clonazepam))**     | • The generic name for clonidine has been confused as the trade or generic name for clonazepam.  
| **Concentrated Morphine Sulfate Oral Solution [20 mg / mL] (Roxanol®)** | • Concentrated forms of oral morphine solution (20 mg / mL) have often been confused with the standard concentration (listed as 10 mg / 5 mL or 20mg / 5 mL), leading to serious errors.  
| **Conventional Morphine Sulfate Oral Solution [10 mg / mL, 20 mg / mL]** | • Accidental selection of the wrong concentration, and prescribing / labeling the product by volume, not milligrams, contributes to these errors, some of which have been fatal.  
| **OxyCODONE (Roxicodone®)**                           | • Name similarity has resulted in frequent medication mix-ups.                                                                                                           |
| **OxyCONTIN® (Oxycodone ER)**                         |                                                                                                                                                                            |