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Look-Alike/Sound-Alike Drug Names

NURSES CAN become transformational leaders by promoting awareness of patient safety. It is important to understand the basis for causes of medication errors and implement best practices to promote a culture of safety.

M is for Medication Errors. Medication errors can arise during the medication ordering and administration. Confusion arises when the medication name of one drug is misinterpreted as another drug name. This type of error is due to Look-alike/Sound-alike Drug Names (LASA). In evaluating mistakes of this type, the "drug name and confused name" pair is stated. One example involves injectable drugs. Lovenox, a drug used to prevent blood clots, has been confused with a long-acting insulin, Levimir.[1] The first syllable of each drug is similar: LOV- and LEV-. A factor that compounds the potential for error is similar packaging size, colors, and lettering of the drug product or package.

E is for Education. One solution involves educational inservices on drugs commonly used in the practice setting. The Institute for Safe Medication Practices (ISMP), a nationally recognized independent organization, maintains a list of "Confused Drug Names."[1] A strategy to call attention to the drug name is the use of tall man letters, which are a mix of upper and lower case. Amlodipine and amiloride are two cardiovascular drugs with different actions. The tall man lettering for each is amLODIPine and aMILoride. The list of Confused Drug Names should be placed where drugs are stored, dispensed, and administered.[2]

D is for the "dynamic and chaotic patient-care environment" faced by nurses in their practice setting.[3] The workplace setting involves multiple interruptions each day that play a role in medication error frequency. This calls for leadership to promote a culture that implements evidence-based practices to ensure safe medication administration.

Professional development is important for fostering strategies to manage interruptions. Nurses and nursing studies were found to have an average of 6.3 interruptions per hour during medication administration.[3] From observational studies, nurses were found to manage interruptions by taking immediate action to resolve issues during medication administration time. They relied upon alternatives less frequently, such as delegating tasks or postponing action. Advanced training is needed for professional development to acquire skills for prioritization & re-prioritization of managing problems, and strategies for grouping similar tasks or sequences of tasks.[3]

S is for Safety. Medication safety can be addressed by a systemwide approach. Nurses should have easy access to drug information resources and policies on safe medication administration.[2] They should routinely consult with pharmacists at their practice site. Organizations that develop policies and resources on safety are The Joint Commission, ISMP, and the Agency for Health Care Research and Quality.

Nurses can transform their practice setting by leading and engaging others in taking action. Individuals can develop an expertise by signing up for an ISMP newsletter: NurseAdvise-ERR (http://ismp.org/newsletters/nursing/default.aspx). Nurses can participate by reporting medication and vaccine errors to ISMP at www.ismp.org/merp. ■

References

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