Look-alike, Sound-alike (LASA) & Error-prone Abbreviations

Basic Medication Safety (BMS) Certification Course
King Saud bin Abdulaziz University for Health Sciences, Ministry of National Guard – Health Affairs
Learning Objectives

- Define LASA Drugs
- Improve Awareness of LASA Drugs
- Share our experiences
- Identify Error-prone abbreviations
- Identify strategies to minimize risks
- Identify strategies to improve
Look-Alike Medications

Drugs with similar names or packaging that can add to confusion and lead to errors.
Sound-Alike

Refers to drug names which due to their pronunciation, may sound similar to other drugs

<table>
<thead>
<tr>
<th>Prescribed</th>
<th>Given</th>
<th>ADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOSEC (omeprazole)</td>
<td>LASIX (furosemide)</td>
<td>Death</td>
</tr>
<tr>
<td>Morphine</td>
<td>HYDROMorphone</td>
<td>Respiratory Arrest, Death</td>
</tr>
<tr>
<td>ChlorproMAZONE</td>
<td>ChlorproPAMIDE</td>
<td>Anoxic Brain damage from sustained hypoglycemia</td>
</tr>
</tbody>
</table>
Similar Packaging / Poor Design

Proprietary Name
Generic Name

10 mg

Proprietary Name
Generic Name

100 mg
Strategies to Minimize Risks

- Awareness of LASA drug names (APP 1429-02)
- Complete prescription (dose, strength, etc.)
- Prescriber documents indication for medication
- Computerized Prescriber Order Entry (CPOE)
- Verbal & Telephonic orders permitted only in emergent or urgent situations
- Use of generic names
- Medication segregation
- Use of TALL man lettering
Preventative Strategies

Purchasing From different companies

Use Axillary Label
Improve Readability

Proprietary Name
Generic Name 10mg
contains 0mg ingredient and ingredient

Each tablet contains ingredient equivalent to 0mg of ingredient and 0mg ingredient.

28 Tablets
Distributed by Company Pharmaceuticals
123 Any Road
Any town
Any postcode
Products licence holder
123 Any Road
Any town
Any postcode
Code 00/00/00/00/00/00/00/00
00/00/00/00/00/00/00/00

Proprietary Name
Generic Name
Capsules

10 mg
28 Capsules
Color Differentiation
Re-designed Packaging

Critical Information in the Same Field of Vision on at least Three Non-opposing Faces
Trademark Suffixes

- **Suffixes** are placed after the stem of a word. It may be a letter, number or combination of letters and / or numbers (e.g., SR, LA, CR, ER, XL).
- Example: **NIFEdipine** 10mg and **NIFEdipine** 30mg LA
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CZOL1KR</td>
<td>CeFAZolin Injection (LASA)</td>
<td>32218</td>
<td>CeFAZolin 1 gram injection LASA</td>
</tr>
<tr>
<td>CPRZSR</td>
<td>Cefprozil (250mg/5mL) Suspension</td>
<td>111591</td>
<td>Cefprozil 250 mg / 5 mL suspension</td>
</tr>
<tr>
<td>CTRX1R</td>
<td>CefTRIAXone Injection (LASA)</td>
<td>32271</td>
<td>CefTRIAXone 1 gram injection LASA</td>
</tr>
</tbody>
</table>
Error-Prone Abbreviations, Symbols, and Dose Designations

I DON'T UNDERSTAND A WORD YOUNG PEOPLE SAY THESE DAYS.

CU - I'LL TXT U LBR ::)
APP 1427-16 Error-Prone Abbreviations, Symbols, and Dose Designations

- Refers to abbreviations, symbols, or dose designations that have been shown to cause errors and compromises patient safety.

- Orders that are illegible or contain Error-Prone abbreviations will NOT be carried out.
### APP 1427-16 Error-Prone Abbreviations, Symbols, and Dose Designations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Reason abbreviation NOT to be used</th>
<th>Acceptable Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>µg</td>
<td>Mistaken as “mg” (milligram), which can result in a thousand-fold dosing overdose</td>
<td>Use “mcg”</td>
</tr>
<tr>
<td>cc</td>
<td>Mistaken as “units” when cc can look like a “u” or “0”</td>
<td>Use “mL”</td>
</tr>
<tr>
<td>D/C, d/c</td>
<td>Can be interchanged to mean discontinue or discharge</td>
<td>Use “discontinue” or “discharge” as appropriate</td>
</tr>
<tr>
<td>HS, hs</td>
<td>Mistaken as bedtime, at bedtime or hours of sleep</td>
<td>Use “half-strength” or “bedtime”</td>
</tr>
<tr>
<td>IU**</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Use “units”</td>
</tr>
<tr>
<td>o.d or OD</td>
<td>Mistaken as “right eye”</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>q.d. or QD</td>
<td>Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “I”</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>qhs</td>
<td>Mistaken as “qhr” or “every hour”</td>
<td>Use “nightly”</td>
</tr>
<tr>
<td>q.o.d or QOD</td>
<td>Mistaken as “q.d.” (daily) or “q.i.d.” (four times daily) if the “o” is poorly written</td>
<td>Use “every other day”</td>
</tr>
</tbody>
</table>
| SC, SQ, Sub q| SC mistaken for SL (sublingual)  
SQ mistaken as “5 every”;  
The “q” in “Sub q” can be mistaken as “every” | Use “subcut” or “subcutaneously” |
| U or u       | Mistaken as the number 0 or 4, causing a 10-fold overdose or greater, e.g., 4U seen as ‘40’ or 4u seen as “44”; mistaken as “cc” so dose given in volume instead of units, e.g., 4u seen as 4cc | Use “unit” |
Medication Names Must Not be Abbreviated

Using Abbreviations May Save Minutes,

**PROHIBITING**

Abbreviations May Save Lives

**AZT**

Zidovudine
Mistaken as Azathioprine or Aztreonam

“Nitro” drip

Nitroglycerin infusion
Mistaken as Sodium Nitroprusside infusion
Safe Patient Care Is Our Goal