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

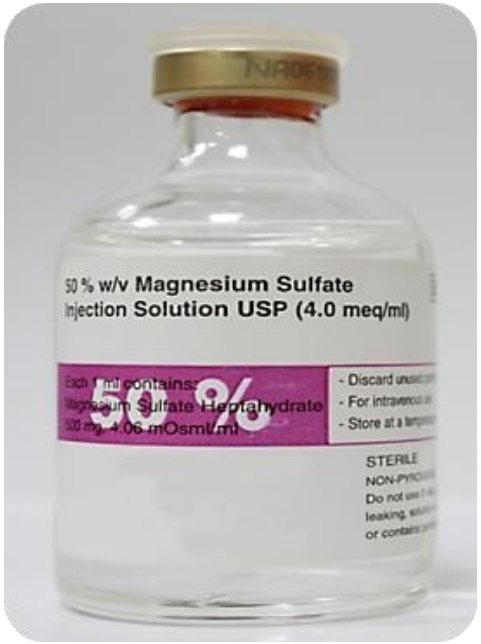
Saudi Medication Safety Center
المركز السعودي لسلامة الأدوية

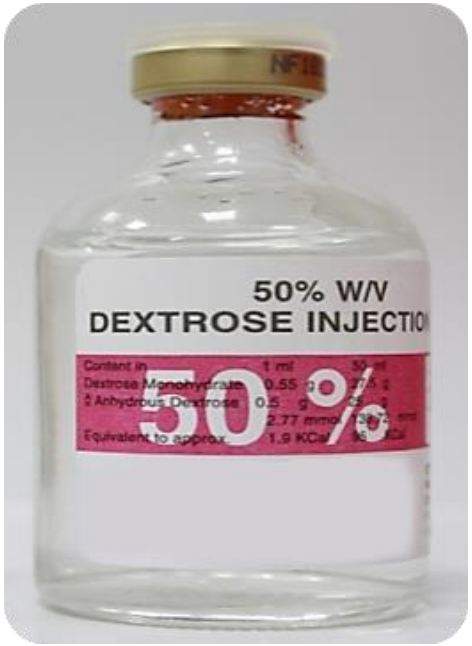
Learning Objectives

- 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

Prescribed	Given	ADE
LOSEC (omeprazole)	LASIX (furosemide)	Death
Morphine	HYDROmorphone	Respiratory Arrest, Death
ChlorproMAZINE	ChlorproPAMIDE	Anoxic Brain damage from sustained hypoglycemia

Similar Packaging / Poor Design

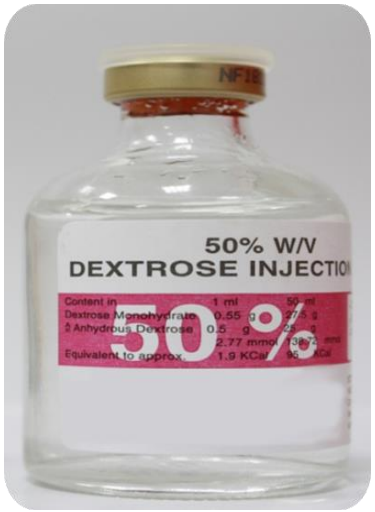
Strategies to Minimize Risks

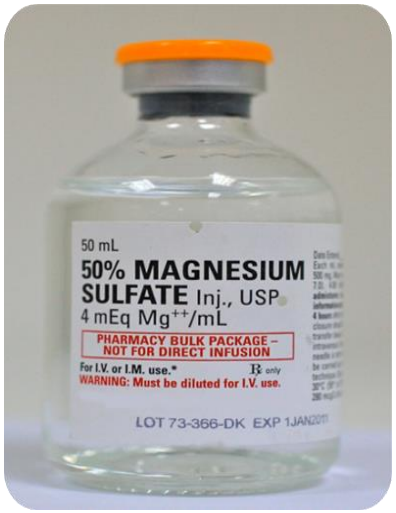
- Awareness of LASA drug names (APP 1429-02)
- Complete prescription (dose, strength, etc.)
- Prescriber documents indication for medication
- Computerized Prescriber Order Entry (CPOE)
- Verbal & Telephonic orders permitted only in emergent or urgent situations
- Use of generic names
- Medication segregation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

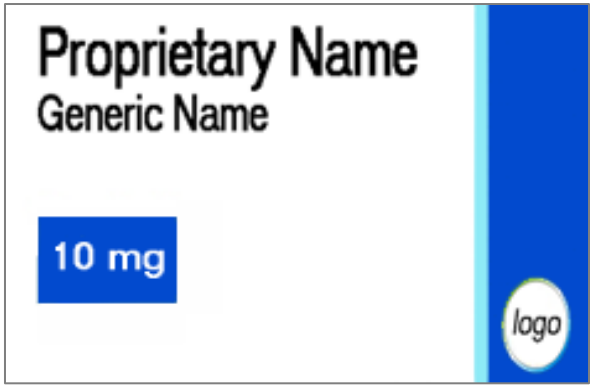
Products license holder
123 Any Road
Any town
Any postcode
Code 00/00000/0000/0000/00
00/00000/0000/0000/00

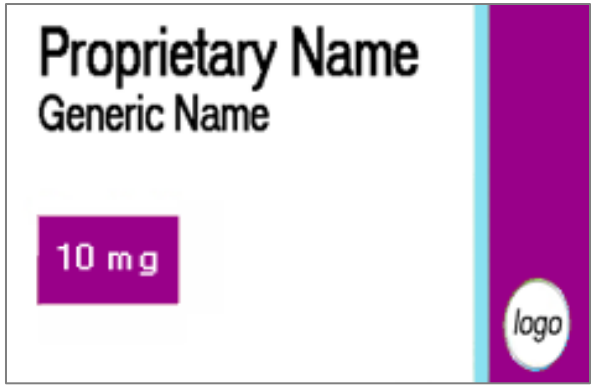
Proprietary Name
Generic Name
Capsules

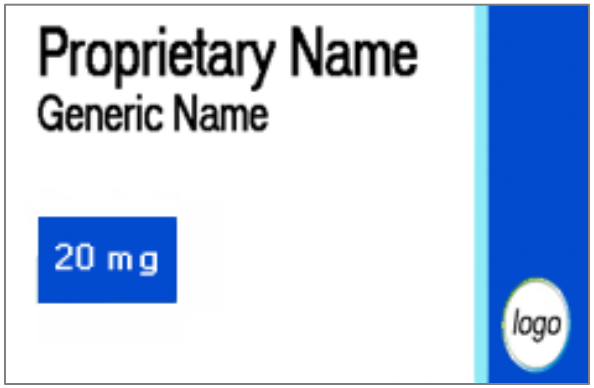
10 mg

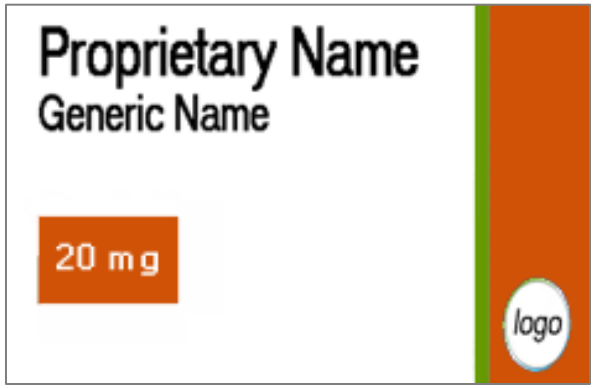
28 Capsules

Color Differentiation









Re-designed Packaging

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

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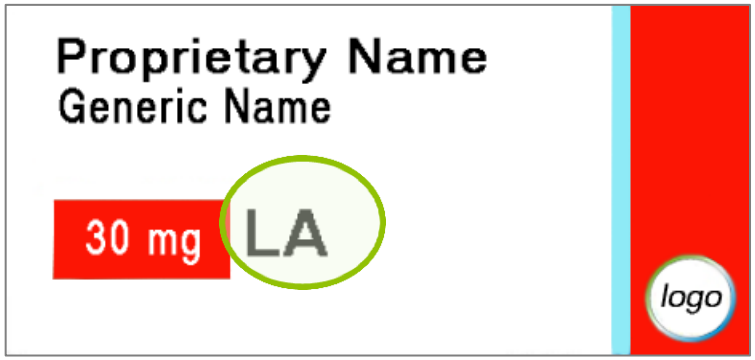
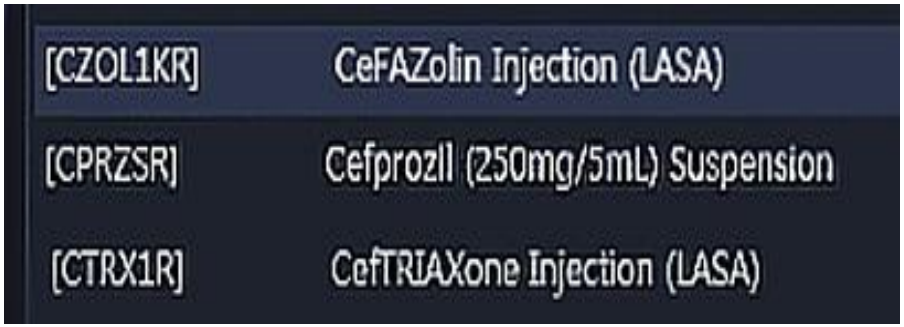
Trademark Suffixes

- **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: **NIFE**dipine 10mg and **NIFE**dipine 30mg LA



LASA: List is Maintained by SMSC



32218
Ce**FAZ**olin 1 gram injection
LASA

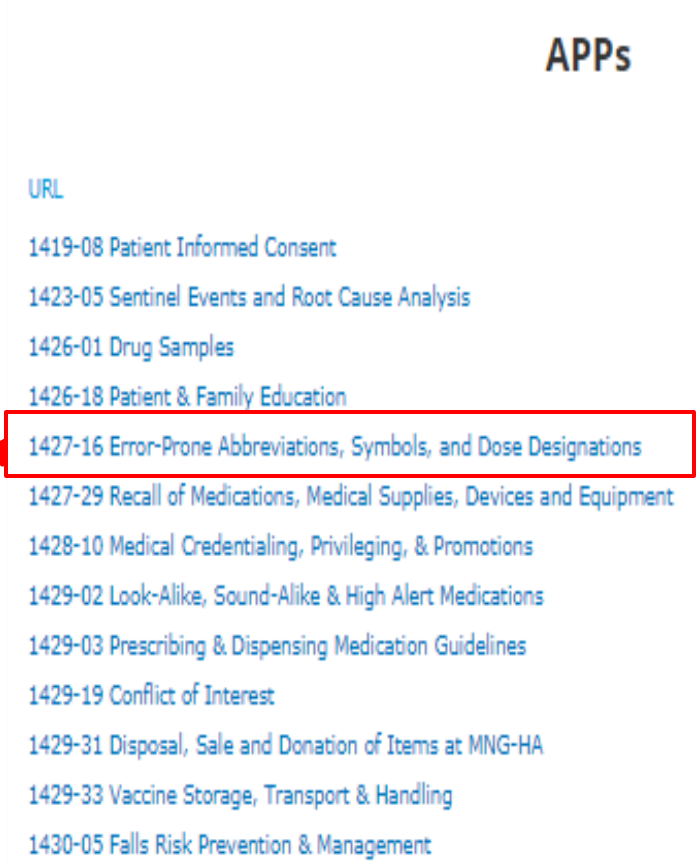
111591
Cefprozil 250 mg / 5 mL suspension

32271
Cef**TRIAX**one 1 gram injection
LASA

Error-Prone Abbreviations, Symbols, and Dose Designations

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



One Stop Resource

APP 1427-16 Error-Prone Abbreviations, Symbols, and Dose Designations

DO NOT USE abbreviations	Reason abbreviation NOT to be used	ACCEPTABLE practice
µg	Mistaken as “mg” (milligram), which can result in a thousand-fold dosing overdose	Use “mcg”
cc	Mistaken as “units” when cc can look like a “u” or “0”	Use “mL”
D/C, d/c	Can be interchanged to mean discontinue or discharge	Use “discontinue” or “discharge” as appropriate
HS, hs	Mistaken as bedtime, at bedtime or hours of sleep	Use “half-strength” or “bedtime”
IU**	Mistaken as IV (intravenous) or 10 (ten)	Use “units”
o.d or OD	Mistaken as “right eye”	Use “daily”’
q.d. or QD	Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “I”	Use “daily”
qhs	Mistaken as “qhr” or “every hour”	Use “nightly”
q.o.d or QOD	Mistaken as “q.d.” (daily) or “q.i.d.” (four times daily) if the “o” is poorly written	Use “every other day”
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

AZT	Zidovudine Mistaken as Azathioprine or Aztreonam
"Nitro" drip	Nitroglycerin infusion Mistaken as Sodium Nitroprusside infusion

Using Abbreviations May Save Minutes,

PROHIBITING

Abbreviations May Save Lives

Safe Patient Care Is Our Goal

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