Bayne Jones Army Community Hospital

2019 Look-Alike/Sound-Alike Medications

TJC Medication Management Standard: MM.01.02.01

Adderall XR	Adderall
buPROPion	busPIRone
ceFAZolin	cefTRIAXone
CeleBREX	CeleXA
Clonidine	Klonopin
diazePAM	dilTIAZem
DULoxetine	FLUoxetine-PARoxetine
ePHEDrine	EPINEPHrine
glyBURIDE	glipiZIDE
guanFACINE	guaiFENesin
Hespan	heparin
HYDROmorphone	morphine
hydrOXYzine	hydrALAZINE
LaMICtal	LamISIL
levoFLOXacin	levETRIAcetam
LORazepam	ALPRAZolam
metFORMIN	metroNIDAZOLE
oxyCODONE	HYDROcodon-OxyCONTIN oxyMORphone
penicillAMINE	penicillin
rifAMPin	rifAXIMin
TEGretol	TRENtal
traMADol	traZODone
Venlafaxin IR	Venlafaxine XR

Examples of Risk Reduction Strategies: "LEADERS" Preventing Medication Errors

Limit access	• Avoid unit stock of certain concentrations, strength, forms • Dispense the targeted drugs in unit doses • Limit use to a single product/strength
Ensure staff	• Educate staff involved in handling LASA drugs about risks and risk-reduction strategies • Ensure knowledge of differences among LASA drug name pairs (e.g. traMADol vs. traZODone)
Access to Information	• Specify the drug's indication when prescribing medications • Specify the dosage form, drug strength, and complete directions on prescriptions • Consider the possibility of name confusion when adding a new product to the formulary
Differentiate	• Change appearance of LASA names on shelves/bins (bold front/tall man letters/ auxiliary labels)
Empower the Patient	• Advise patients taking LASA drugs about the risk of mix-ups and how to avoid them • Encourage patients to question medications that look different than expected • Investigate patients concern about drug appearance
Redundancy	• Display brand and generic name on label • Employ double check s before dispensing or administering
Separate Storage	• Separate LASA in pharmacy • Separate LASA drugs in patient units • Separate storage of different strengths, forms, releases (Immediate/Extended)

Bayne Jones Army Community Hospital

2019 High-Alert Medications

TJC Medication Management Standard: MM.01.01.03

- **Potassium Chloride 2 mEq/mL (all volumes)***
- **Potassium Phosphate 4.4 mEq/mL (all volumes)***
- **Sodium chloride above 0.9% (all volumes)***
- **Magnesium Sulfate 500 mg/mL (in volume above 2 ml)***
- **Heparin above 5,000 units/mL**
- **All Chemotherapy/antineoplastic agents (methotrexate)***
- **Insulins (See below**)**

* Not stocked in the patient care area, they are stored in the department of Pharmacy

Examples of Risk Reduction Strategies: "LEADERS" Preventing Medication Errors	
Limit access	• Avoid unit stock of certain concentrations, strength, forms • Dispense the targeted drugs in unit doses • Limit use to a single product/strength (EXCEPTION: insulins**)
Ensure staff	• Educate staff involved in handling high-alert drugs about risks and risk-reduction strategies
Access to Information	• Specify the drug's indication when prescribing medications • Specify the dosage form, drug strength, and complete directions on prescriptions • Consider the risk when adding a new product to the formulary
Differentiate	• Change appearance of High-Alert names on shelves/bins (Color/font/size) • Affix "High-Alert" to areas where High-alert medications are stored
Empower the Patient	• Advise patients taking high-alert drugs about the risks and how to avoid them • Encourage patients to report adverse effects • Investigate and document reported adverse effects
Redundancy	• Display brand and generic on label • Employ independent double checks before dispensing or administering
Separate Storage	• Separate High-alert drugs in pharmacy • Separate Storage of different strengths, forms, releases (Immediate/Extended)

Poison Control Help: 1-800-222-1222