



Look Alike / Sound Alike (LASA) Medications - September 2019

The Institute of Safe Medical Practices (ISMP) received two reports this year where vials of tranexamic acid were confused with either bupivacaine or ropivacaine because the bottles were similar in look, size, and had blue caps. This confusion led to patients receiving an intraspinal injection of tranexamic acid instead of the intended anesthetic which could result in seizures, permanent neurological injury, or paraplegia. Unfortunately, there have been numerous cases of accidental intraspinal injections of tranexamic acid due to look-alike / sound-alike (LASA) errors over the past few years.

LASA errors can occur when medications are in similar looking packages, have similar generic or brand names, sound the same, or are available in varying strengths or formulations.

The Joint Commission standards encourage health care facilities to address LASA medications by:

- 1) developing a list of LASA medications that the service unit stores, dispenses, or administers,
- 2) updating and reviewing the LASA list annually, and
- 3) taking action to prevent errors involving the

LASA medications.

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To assist in creating and updating a LASA list, the ISMP has developed a list of LASA medications called the "ISMP List of Confused Drug Names." This list is available on their website:
<https://www.ismp.org/recommendations/confused-drug-names-list>

In addition to this list, please find attached is a handout with actions that you can take to reduce the risk of LASA medication errors at your health care facility.

Prevent Look-Alike / Sound-Alike (LASA) Medication Errors



Improve medication identification by providing details. Try to include:

- Diagnosis or Intended Use
- Dose or strength
- Route of administration or formulation

Reduce the risk of medication error in patient care areas.

- Keep rarely used or LASA medications in the pharmacy.
- Label bins or shelves with brand names for LASA medications.
- Keep medication dispensing areas clean and organized.
- Have a double check system in place to help prevent accidental errors.

Store medications so they are easily recognized.

- Store LASA medications in separate locations or non-alphabetically.
- Place medications so the label and medication name is always showing.
- Use Tall Man lettering to emphasize differences in medications with sound-alike names: [metFORMIN](#) and [metoPROLOL](#).
- Add auxiliary labels to storage bins or shelves or provide labels with information such as route of administration or formulation to more easily identify the correct medication.
- Label bins or shelves with brand names for LASA medications.
- Minimize the availability of multiple medication strengths.

Encourage patients to help reduce the risk of medication errors

- Utilize the teach-back method when providing counseling and education.
- Discuss LASA medications and tell patients what to look for when picking up their medications.