A new Joint Commission on Accreditation of Healthcare Organizations National Patient Safety Goal (NPSG) for 2005 is related to look-alike/sound-alike medications. This article reviews this new goal and what actions home care and hospice organizations need to undertake to meet the intent of this new requirement and provides insightful home care and hospice adaptations to the NPSG’s general goals. Even if an agency is not Joint Commission–accredited, this information should be integrated into policies, procedures, and clinician education to avoid dangerous and costly medication errors.

Review Joint Commission’s List of Medication Combinations

To develop this list for your organization, the Joint Commission has published three tables (i.e., Tables 1–3) of look-alike/sound-alike medica-
Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)

<table>
<thead>
<tr>
<th>Potential Problematic Drug</th>
<th>Potential Errors and Consequences</th>
<th>Home Care and Hospice Safety Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 PLATINOL</strong> (cisplatin): Used to treat cancer</td>
<td>Similarity in names can lead to confusion between these two medications. Doses appropriate for carboplatin usually exceed the maximum safe dose of cisplatin. Severe toxicity and death have been associated with accidental cisplatin overdose.</td>
<td>Refer to general home care safety strategies in Table 4.</td>
</tr>
<tr>
<td><strong>PARAPLATIN</strong> (carboplatin): Used to treat cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> Concentrated liquid morphine products versus conventional liquid morphine concentrations</td>
<td>Cross-reference Table 2, medication combination number five.</td>
<td>Cross-reference Table 2, medication combination number five.</td>
</tr>
<tr>
<td><strong>3 ADRENALIN</strong> (epinephrine): Used as a bronchodilator and injection used in the emergency treatment of allergic reactions. Ephedrine: Used as a bronchodilator</td>
<td>These medication names look similar and are available in similar packaging (1-mL amber ampules and vials).</td>
<td>Refer to general home care safety strategies in Table 4.</td>
</tr>
<tr>
<td><strong>4 DILAUDID</strong> (hydromorphone) injection: Used to relieve pain</td>
<td>Cross-reference Table 2, medication combination number six.</td>
<td>Cross-reference Table 2, medication combination number six.</td>
</tr>
<tr>
<td><strong>ASTRAMORPH, DURAMORPH, INFUMORPH</strong> (morphine) injection: Used to relieve pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5</strong> Insulin products</td>
<td>Cross-reference Table 2, medication combination number seven.</td>
<td>Cross-reference Table 2, medication combination number seven.</td>
</tr>
<tr>
<td><strong>6</strong> Lipid-based versus conventional forms of daunorubicin and doxorubicin products</td>
<td>Many drugs now come in liposomal formulations indicated for special patient populations. Name similarity may cause confusion between the liposomal and the conventional formulation. Lipid-based formulation dosing guidelines differ significantly from conventional dosing. Doses of liposomal daunorubicin are typically repeated every 2 weeks, whereas doses of conventional daunorubicin may be administered more frequently. Accidental administration of the liposomal form instead of the conventional form has resulted in severe side effects and death.</td>
<td>Educate staff responsible for administering or monitoring daunorubicin and doxorubicin products on: 1. The differences between conventional and lipid-based formulations. 2. Similarity in names resulting in confusion between the liposomal and the conventional formulation. 3. Products are not interchangeable. 4. Referring to the lipid-based products by their brand names and generic names, verbally and in clinical documentation. 5. Verifying that the correct drug is being administered if anyone notices a change in the solution’s appearance from previous infusions.</td>
</tr>
<tr>
<td>Lipid-based: <strong>DAUNOXOME</strong> (daunorubicin citrate liposomal): Used to treat AIDS-associated Kaposi’s sarcoma <strong>DOXIL</strong> (doxorubicin liposomal): Used to treat cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional forms of daunorubicin and doxorubicin: <strong>CERUBIDINE</strong> (daunorubicin, conventional): Used to treat cancer <strong>ADRIAMYCIN, RUBEX</strong> (doxorubicin, conventional): Used to treat cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1.
Problematic Combination Drug Names for Critical Access Hospital, Hospital, and Office-based Surgery Adapted for Home Care

Table continues on opposite page


<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
<th>Potential Errors and Consequences</th>
<th>Home Care and Hospice Safety Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td></td>
<td>6. Appearance of lipid-based products may be cloudy, whereas conventional formulation is clear. 7. Specific method of administration for these products. Facility-based hospice care:  • Do not store lipid-based products in patient care areas and automated dispensing cabinets.</td>
</tr>
</tbody>
</table>
| 7 | Lipid-based amphotericin products versus conventional forms of amphotericin:  
Lipid-based: **AMBISOME** (amphotericin B liposomal): Used to treat fungal and protozoal infections  
Lipid-based: **ABELCET** (amphotericin B lipid complex): Used to treat antifungal infection  
Lipid-based: **AMPHOTEC** (amphotericin B cholesteryl sulfate complex for injection): Used to treat antifungal infection  
Conventional: **AMPHOCIN, Fungizone Intravenous** (amphotericin B desoxycholate): Used to treat fungal and protozoal infection | Lipid-based formulation dosing guidelines differ significantly from conventional dosing.  
If conventional amphotericin B is given at a dose appropriate for a lipid-based product, a severe adverse event is likely.  
Confusion between these products has resulted in respiratory arrest and other dangerous, sometimes fatal outcomes due to potency differences between these drugs. | Educate staff responsible for administering or monitoring amphotericin on: 1. The differences between conventional and lipid-based formulations and dosing. 2. Name similarity resulting in confusion between the liposomal and the conventional formulation. 3. The products are not interchangeable. 4. Referring to the lipid-based products by their brand names and generic names, verbally and in clinical documentation. 5. Verifying that the correct drug is being administered if anyone notices a change in the solution’s appearance from previous infusions. 6. Differences in appearance, because lipid-based products may be cloudy, and conventional formulation is clear. Facility-based hospice care:  • Consider limiting lipid-based amphotericin B products to one specific brand.  • Do not store lipid-based products in patient care areas and automated dispensing cabinets. |
| 8 | **TAXOL** (paclitaxel): Used to treat cancer  
**TAXOTERE** (docetaxel): Used to treat cancer | Confusion between these two drugs can result in serious adverse outcomes. | Educate staff involved in administering or monitoring the effects of these medications on the differences in dosing recommendations. |
Select Home Care Medication Combinations
To meet the intent of this NPSG requirement:

- Review the medications listed in Tables 1 to 3 and select a minimum of 10 medication combinations that are commonly monitored or administered by home care or hospice staff.
- From the selected combinations, at least five of the medication combinations must be from Table 2 for home care.
- The other five medication combinations may be selected from any of the three tables (Joint Commission, 2004b).

For example, the home care organization may select all 10 medication combinations from Table 2 or may select five from Table 2 and five others in combination from Tables 1 and 3.

Implement Safety Strategies
Once the organization-specific list of at least 10 look-alike/sound-alike medication combinations is developed, medication-specific strategies need to be developed to prevent medication errors. In addition to the medication-specific strategies, a list of general, non—drug-specific actions that may be taken by staff is provided in Table 4.

Survey Process
During the survey, the organization’s list of look-alike/sound-alike medications will, at a minimum, be reviewed by the surveyor. During individual patient tracer activities, the surveyor may review...
<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> <strong>AMARYL</strong> (glimepiride): Used to treat type II diabetes  <strong>REMINYL</strong> (galantamine hydrobromide): Used to treat symptoms of Alzheimer’s disease</td>
<td>Handwritten orders for Amaryl and Reminyl can look similar. Patients receiving Amaryl in error would not be provided with blood glucose monitoring, which could lead to a serious error.</td>
<td>Refer to the general home care safety strategies in Table 4.</td>
</tr>
<tr>
<td><strong>2</strong> <strong>AVANDIA</strong> (rosiglitazone): Used to treat type II diabetes  <strong>COUMADIN</strong> (warfarin): Used to prevent blood clot formation</td>
<td>Poorly handwritten orders for Avandia have been misread as Coumadin, leading to potentially serious adverse events. Originally the error was caused by a lack of familiarity with Avandia and was read as the more familiar Coumadin; however, mix-ups continue to occur. Neither medication is safe without specific drug monitoring.</td>
<td>Refer to the general home care safety strategies in Table 4.</td>
</tr>
<tr>
<td><strong>3</strong> <strong>CELEXA</strong> (citalopram hydrobromide): Used to treat depression  <strong>CEREBYX</strong> (fosphenytoin): Used to treat seizures</td>
<td>Patients with seizure disorders who receive Celexa instead of Cerebyx would be inadequately treated and could experience serious consequences from lack of seizure control. Conversely, patients erroneously receiving any of the wrong medication may experience a decline in mental status, lack of pain, or other serious adverse events.</td>
<td>Refer to the general home care safety strategies in Table 4.</td>
</tr>
<tr>
<td><strong>4</strong> <strong>CATAPRES</strong> (clonidine): Used to treat hypertension  <strong>KLONOPIN</strong> (clonazepam): Used to treat seizures</td>
<td>The generic name of clonidine can be confused as the brand or generic name for clonazepam.</td>
<td>Refer to the general home care safety strategies in Table 4.</td>
</tr>
</tbody>
</table>
### Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)

<table>
<thead>
<tr>
<th></th>
<th>Potential Problematic Drug Names</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Concentrated liquid morphine products: <strong>ROXANOL, MSIR</strong>: Used to treat pain</td>
<td>Concentrated forms of oral morphine solution (20 mg/mL) have often been confused with the standard concentration (10 mg/5 mL or 20 mg/5 mL), leading to serious errors. Accidental selection of the wrong concentration, and prescribing/labeling the product by volume, not mg, has contributed to these errors, some of which were fatal. For example, “10 mg” has been confused with “10 mL.” If a concentrated liquid morphine product is administered, this amount represents a 20-fold overdose.</td>
<td>Verify that patients and caregivers understand how to measure the proper dose for self-administration. Store concentrated liquid morphine solution in another area in the home if other concentrated medications are present. Hospice: Require the pharmacy to dispense concentrated liquid morphine solutions in dropper bottles to prevent dose measurement errors and differentiate the concentrated product from the conventional products. Facility-based hospice care: • Dispense concentrated liquid morphine solutions in unit-doses for specific patient order. • Do not store concentrated oral morphine solutions as unit/floor stock.</td>
</tr>
<tr>
<td></td>
<td>Conventional liquid morphine concentrations</td>
<td>Based on equianalgesic dose conversion, this may represent significant overdose, leading to serious adverse events. Storage of the two medications in close proximity to one another and in similar concentrations may contribute to errors. Medication errors may result in episodes of respiratory arrest due to potency differences between these drugs.</td>
<td>Educate staff that: 1. Hydromorphone and morphine are not interchangeable; 2. Hydromorphone is not the generic equivalent of morphine; 3. If both hydromorphone and morphine are present in the home, store them in separate areas.</td>
</tr>
<tr>
<td>6</td>
<td>DILAUDID (hydromorphone) injection: Used to relieve pain</td>
<td><strong>ASTRAMORPH, DURAMORPH, INFUMORPH</strong> (morphine) injection: Used to relieve pain</td>
<td></td>
</tr>
</tbody>
</table>

Table continues on opposite page
### Table 2.
Continued from previous page

<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
<th>Potential Errors and Consequences</th>
<th>Home Care and Hospice Safety Strategies</th>
</tr>
</thead>
</table>
| Insulin products: Used to control blood sugar  
**LANTUS** (insulin glargine)  
**LENTE** (insulin zinc suspension)  
**HUMALOG** (insulin lispro)  
**HUMULIN** (human insulin products)  
**NOVOLOG** (human insulin aspart)  
**NOVOLIN** (human insulin products)  
**HUMULIN** (human insulin products)  
**NOVOLIN** (human insulin products)  
**HUMALOG** (insulin lispro)  
**NOVOLOG** (human insulin aspart)  
**NOVOLIN** 70/30 (70% isophane insulin [NPH] and 30% insulin injection [regular])  
**NOVOLOG MIX** 70/30 (70% insulin aspart protamine suspension and 30% insulin aspart) | Similar names, strengths and concentration ratios of some products (e.g., 70/30) have contributed to medication errors. Errors have also occurred between the 100 U/mL and 500 U/mL insulin concentrations. | Facility-based hospice care:  
- Limit the use of insulin analog 70/30 mixtures to just a single product.  
- Limit the variety of insulin products stored in patient care units.  
- Remove patient-specific insulin vials from stock when no longer needed.  
- Consider auxiliary labels for newer products to differentiate them from the established products.  
- Apply bold labels on atypical insulin concentrations. |
| **LAMISIL** (terbinafine hydrochloride): Used to treat fungal infection.  
**LAMICTAL** (lamotrigine): Used to treat seizures | Patients with seizure disorders who receive Lamisil instead of Lamictal would be inadequately treated and could experience serious consequences. Conversely, patients erroneously receiving Lamictal would be unnecessarily subjected to a risk of potential side effects (including serious rash) and would not receive antifungal therapy. | Refer to the general home care safety strategies in Table 4. |
### Table 2. Continued from previous page

<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
<th>Potential Errors and Consequences</th>
<th>Home Care and Hospice Safety Strategies</th>
</tr>
</thead>
</table>
| 9 **SERZONE** (nefazodone): Used to treat depression  
**SEROQUEL** (quetiapine): Used to treat psychotic disorders | Serzone and Seroquel both:  
• have similar names,  
• are available in 100-mg and 200-mg strengths;  
• have similar instructions and dosage ranges;  
• are used in similar clinical settings.  
Sedation or dizziness has occurred when Seroquel was dispensed instead of Serzone.  
Patients’ mental status have decompensated when Serzone was given instead of Seroquel.  
Serious, sometimes fatal reactions may occur when patients receiving monoamine oxidase inhibitors are given drugs with pharmacologic properties similar to Serzone. | Refer to the general home care safety strategies in Table 4. |
| 10 **ZYPREXA** (olanzapine): Used to treat psychotic disorders  
**ZYRTEC** (cetirizine): Used to relieve or prevent the symptoms of hay fever and other types of allergies | The name similarity between Zyrtec and Zyprexa has resulted in frequent mix-ups.  
Patients who received Zyprexa in error have reported dizziness, sometimes leading to an injury from a fall.  
Patients on Zyprexa to treat a psychiatric disorder have relapsed when given Zyrtec in error. | Refer to the general home care safety strategies in Table 4. |

### Table 3.
Supplemental List of Other Medications With Look-Alike/Sound-Alike Names Used in Home Care and Hospice

<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
<th>Potential Errors and Consequences</th>
</tr>
</thead>
</table>
| **1** | DYMELOR (acetohexamide): Used to treat type II diabetes  
AK-ZOL; DIAMOX; DIAMOX SEQUELS (acetazolamide): Used to treat glaucoma | Similarity in names can lead to confusion between acetohexamide and acetazolamide. |
| **2** | ADVICOR (Niacin and Lovastatin): Used to lower cholesterol and lipid (fat) levels in the blood.  
ADVAIR (Fluticasone and Salmeterol): Used to control the symptoms of asthma and improve lung function. | Similarity in names can lead to confusion between Advicor and Advair. |
| **3** | AVINZA (morphine sulfate SR): Used to treat pain  
EVISTA (Raloxifene): Used to prevent and treat the thinning of bones | Similarity in names can lead to confusion between Avinza and Evista. |
| **4** | BRETYLOL (Bretyllium Tosylate): Used to treat arrhythmias  
BREVIBLOC (esmolol HCI): Used for temporary control of heart rate and blood pressure. | Similarity in names can lead to confusion between Bretyllium and Brevibloc. |
| **5** | DIABINESE (chlorpropamide): Used to treat type II diabetes  
THORAZINE (chlorpromazine): Used to treat psychotic disorders and symptoms | Similarity in names can lead to confusion between chlorpropamide and chlorpromazine. |
| **6** | DIABETA (glyburide): Used to treat type II diabetes  
ZEBETA (bisoprolol): Used to treat high blood pressure | Similarity in names can lead to confusion between Diabeta and Zebeta. |
| **7** | FOLVITE (folic acid): Used to treat or prevent folic acid deficiency  
WELLCOVORIN (leucovorin calcium) a.k.a. “folinic acid”: Used to prevent or treat the toxicities of medications known as folic acid antagonists | Similarity in names can lead to confusion between folic acid and leucovorin calcium (“folinic acid”). |
| **8** | DAMYCIN (idarubicin): Used to treat acute myelocytic leukemia  
ADRIAMYCIN PFS, ADRIAMYCIN RDF, RUBEX (doxorubicin): Used to treat cancer  
CERUBIDINE (daunorubicin): Used to treat cancer | Similarity in names can lead to confusion between idarubicin, doxorubicin, and daunorubicin. |
| **9** | EPIVIR, EPIVIR-HBV (lamivudine): Used in the treatment of the infection caused by the human immunodeficiency virus (HIV) or hepatitis B virus.  
LAMICTAL (lamotrigine): Used to help control some types of seizures | Similarity in names can lead to confusion between lamivudine and lamotrigine. |
| **10** | LEUKERAN (chlorambucil): Used to treat chronic lymphocytic leukemia; some types of non-Hodgkin’s lymphomas; and advanced Hodgkin’s disease  
WELLCOVIRIN (leucovorin calcium) a.k.a. folinic acid: Used to prevent or treat the toxicities of medications known as folic acid antagonists | Similarity in names can lead to confusion between Leukeran and leucovorin calcium. |

*Table continues on next page*
<table>
<thead>
<tr>
<th>Potential Problematic Drug Names: Brand Name (UPPERCASE) and Generic Name (lowercase)</th>
<th>Potential Errors and Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11</strong></td>
<td>OPIUM TINCTURE (opium preparation): Used to treat severe diarrhea</td>
</tr>
<tr>
<td></td>
<td>PAREGORIC (camphorated tincture of opium): Used to relieve diarrhea</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td>PRILOSEC (omeprazole): Used to prevent ulcers and to treat other conditions in which the stomach produces too much acid</td>
</tr>
<tr>
<td></td>
<td>PROZAC (fluoxetine): Used to treat depression, obsessive-compulsive disorders, and some eating disorders</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>PRIMACOR (Milrinone): Used to treat heart failure</td>
</tr>
<tr>
<td></td>
<td>PRIMAXIN (imipenem and cilastatin): Used to treat infections caused by bacteria</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>RETROVIR (Zidovudine) a.k.a. AZT: Used with other medications to treat the infection caused by HIV</td>
</tr>
<tr>
<td></td>
<td>NORVIR (ritonavir): Used with other medications to treat the infection caused by HIV</td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>ZANAFLEX (tizanidine): Used to relax muscles</td>
</tr>
<tr>
<td></td>
<td>GABITRIL (tiagabine): Used to help control some types of seizures in the treatment of epilepsy</td>
</tr>
<tr>
<td><strong>16</strong></td>
<td>WELLBUTRIN SR (bupropion): Used to treat depression</td>
</tr>
<tr>
<td></td>
<td>WELLBUTRIN XL (bupropion): Used to treat depression</td>
</tr>
<tr>
<td><strong>17</strong></td>
<td>ZANTAC (histamine H₂-receptor antagonists): Used to treat duodenal ulcers and prevent their return</td>
</tr>
<tr>
<td></td>
<td>XANAX (alprazolam): Used to treat anxiety, panic disorders, tremor and insomnia</td>
</tr>
<tr>
<td><strong>18</strong></td>
<td>ZANTAC (histamine H₂-receptor antagonists): Used to treat duodenal ulcers and prevent their return</td>
</tr>
<tr>
<td></td>
<td>ZYRTEC (cetirizine hydrochloride)</td>
</tr>
</tbody>
</table>

Note: Similarity in names can lead to confusion between heparin and Hespan and Diflucan (fluconazole) and Diprivan (propofol); however, these look-alike/sound-alike medication combinations are not applicable because Hespan (used in shock to elevate the blood volume) and Diprivan (propofol, used to produce loss of consciousness) would not be administered or monitored in the home by staff.

the process for managing look-alike/sound-alike medications by:

- reviewing the patient’s medication profile in the clinical record;
- reviewing medications in the home during the home visit;
- asking the patient and caregiver about medication education provided; and
- asking the staff member(s) caring for the patient about staff education received and safety strategies implemented.

If there are no active patients identified taking look-alike/sound-alike medications during the medication management system tracer or individual patient tracer activities, professional staff and management may be interviewed about what education was received and actions that would be taken to prevent medication errors associated with the organization’s selected combination of look-alike/sound-alike medications.

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### Table 4.
Strategies for Eliminating Medication Errors Caused by Look-Alike/Sound-Alike Drugs

<table>
<thead>
<tr>
<th>Actions taken by staff to prevent medication errors may include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documenting the patient’s diagnosis and medication indication on the verbal order form to be mailed to the physician for signature;</td>
</tr>
<tr>
<td>2. Spelling the name of the drug when repeating orders back to the physician and enunciating clearly;</td>
</tr>
<tr>
<td>4. Educating patients and their caregivers to include:</td>
</tr>
<tr>
<td>a. Talking with the physician about the name of any new drug, why it is being prescribed, and how it should be taken when a new medication is being prescribed;</td>
</tr>
<tr>
<td>b. Talking with the pharmacist before leaving the pharmacy, especially if it is a new medication;</td>
</tr>
<tr>
<td>c. Checking the labels on the medication before taking it;</td>
</tr>
<tr>
<td>d. Reporting any changes in the medication’s appearance (e.g., size, color, smell) promptly to the nurse;</td>
</tr>
<tr>
<td>5. Verifying the correct information on the delivery ticket (i.e., name, address, and so forth) when medication is delivered to the patient’s home; and</td>
</tr>
<tr>
<td>6. Storing medications with look-alike or sound-alike names in different locations in the home.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions taken by management may include providing staff education on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New drugs entering the market (both the brand and generic name);</td>
</tr>
<tr>
<td>2. The potential for error and any actual errors that have occurred, and the process for safely administering medication.</td>
</tr>
</tbody>
</table>

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The author of this article has no significant ties, financial or otherwise, to any company that might have an interest in the publication of this educational activity.

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**REFERENCES**


CE Test

Medication Safety: Look-Alike/Sound-Alike Drugs in Home Care

Instructions:
- Read the article on page 243.
- Take the test, recording your answers in the test answers section (Section B) of the CE enrollment form. Each question has only one correct answer.
- Complete registration information (Section A) and course evaluation (Section C).
- Mail completed test with registration fee to: Lippincott Williams & Wilkins, CE Group, 333 7th Avenue, 19th Floor, New York, NY 10001.
- Within 4-6 weeks after your CE enrollment form is received, you will be notified of your test results.
- If you pass, you will receive a certificate of earned contact hours. Within 4-6 weeks after your CE enrollment form is received, you will be notified of your test results.
- A passing score for this test is 10 correct answers.
- A passing score for this test is 10 correct answers.
- Need CE STAT? Visit www.nursingcenter.com for immediate results, other CE activities and your personalized CE planner tool.

CE TEST QUESTIONS

GENERAL PURPOSE
To provide registered professional nurses with information on one of the new patient safety goals of the Joint Commission on Accreditation of Healthcare Organizations for 2005, the actions home care and hospice organizations must take to meet the new requirements, and insightful home care and hospice adaptations to achieving the new goals.

LEARNING OBJECTIVES
After reading this article and taking this test, you will be able to:
1. Outline the new patient safety goal related to look-alike/sound-alike drugs.
2. List specific examples of drugs that are easily confused and the consequences of administering the look-alike/sound-alike drugs.
3. Make specific recommendations for reducing errors when administering look-alike/sound-alike drugs.

1. To meet the new Joint Commission on Accreditation of Healthcare Organization’s (JCAHO’s) National Patient Safety Goal (NPSG) requirements, home care and hospice organizations must select how many medication combinations that are commonly used in the particular organization?
   a. five
   b. 10
   c. 15
   d. 20

2. Of those medication combinations that a home care organization selects
   a. at least five must be from table 1.
   b. at least five must be from table 2.
   c. all must be from table 1.
   d. all must be from table 3.

3. Once an organization has finalized its selections, their focus must shift to
   a. evaluating their choices.
   b. deciding which medications are problematic.
   c. reviewing the experts’ recommendation.
   d. devising strategies to prevent medication errors.

4. During the JCAHO home care and hospice survey, the surveyor is likely to examine the organization’s process related to their selected list by
   a. reviewing the organization’s medication inventory.
   b. asking patients how they think safety could be improved.
   c. reviewing medications in the home during the home visit.
   d. summarizing their requirements for patients and families.

5. An identified risk in dispensing or administering carboplatin (Paraplatin) is
   a. mistaking it for cisplatin and administering an exceedingly high dose of cisplatin.
   b. giving the liposomal form instead of the conventional form of carboplatin.
   c. inducing a decline in mental status by administering carbopoda instead of carboplatin.
   d. causing seizures by mistaking carboplatin for carbamazepine and administering the wrong drug.

6. A severe adverse event is likely if conventional amphotericin B is given instead of which of the following drugs?
   a. Ambisome
   b. AmBisome
   c. AmBisome
   d. Amicar

7. If patients prescribed Reminyl are given Amaryl instead, they will be at risk for undetected changes in
   a. blood pressure.
   b. serum cholesterol.
   c. heat rate.
   d. blood glucose.

8. When Celexa is mistakenly administered instead of Cerebyx, the patient is at high risk for
   a. seizures.
   b. thrombophlebitis.
   c. incontinence.
   d. tachycardia.

9. When administering various forms of morphine, it is essential to understand that hydromorphone
   a. is equivalent to Astramorph.
   b. is not interchangeable with Dilaudid.
   c. is the generic equivalent of Duramorph.
   d. is not interchangeable with morphine.

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10. When Seroquel is administered instead of Serzone, the patient is at particular risk for
   a. dizziness.
   b. bradycardia.
   c. diarrhea.
   d. hypertension.

11. If a patient is prescribed two look-alike/sound-alike medications, the author recommends
   a. taking them at different times.
   b. storing them in different locations in the home.
   c. asking the physician to prescribe something else.
   d. asking the pharmacist to dispense another form of each drug.

12. The author specifically recommends that drug names
   a. be reviewed daily in the patient’s record.
   b. be written in script then printed in parentheses.
   c. are documented in their generic form only.
   d. never be abbreviated at all.

13. Actions the author specifically suggests for nurses to take to help eliminate medication errors caused by look-alike/sound-alike drugs include adding which of the following to the verbal order form to be mailed to the physician for signature?
   a. the patient’s specific indication for the particular medication
   b. any potential for error that might apply to that patient
   c. a footnote to explain any abbreviation used on the form
   d. the availability of the medication in the organization’s inventory

14. Actions the author specifically suggests for managers to take to help eliminate medication errors caused by look-alike/sound-alike drugs include providing staff education about
   a. adverse effects of medications.
   b. new drugs on the market.
   c. compliance with drug therapy.
   d. contraindications for specific drugs.