MEDICINES INFORMATION & ADVICE ALERT

ISSUE 3 UPDATED JULY 2025

SPOTLIGHT
Learning from Practice

Reducing the risk of getting the drug name wrong

Background

- MI incident reports have regularly highlighted errors resulting from drug names being misheard or misread.
- Mishearing the drug name at the start of the conversation can lead to time spent researching the wrong drug.
- Misreading the drug name when researching can result in giving out the wrong information for the wrong drug.
- Drug names are not the only information prone to misinterpretation. Numbers and administration routes are also easily misheard.

Why do we think it happened?

- Interpreting speech is inherently problematic because of different accents, dialects, and pronunciations.
- If drug names or other terms are similar, they can be misheard.
- If callers are in a rush, you may not have time to reiterate the drug names.
- Not actively listening to the caller to extract the information relating to the drugs which can help understand which drugs are being talked about.
- Making illegible handwritten notes can result in the wrong drug name being transcribed.
- Abbreviations may be used which are misheard as a drug name.
- Communicating multiple medications also increases the opportunity for error.
- Background noise, fatigue, interruptions, and unfamiliar drug names and terminology often compound the problem.
- Transcribing a verbal enquiry can add unavoidable complexity and risk to the enquiry process.
- Unless there is an option to record all telephone conversations, then the only memory of the verbal communication is with those involved.

Actions for safer practice

- Written communication reduces the need for verbal communication of non-urgent enquiries (though additional verbal communication may be required to gather missing information needed before the enquiry can be progressed).
- For a long list of drugs consider written communication.
- Repeat pertinent points about the drug in communications, e.g. drug name, dosing, indication, strength, formulation. Use non-abbreviated terms, e.g. 'intravenous' instead of 'IV'.
- Spell or repeat unfamiliar drug names using a recognised phonetic alphabet, e.g. https://www.callcentrehelper.com/the-uk-phonetic-alphabet-208583.htm
- Repeat numerical digits separately, e.g. say 'one six' instead of sixteen which can be heard as 'sixty'.
- If calls are recorded, listen to the recording to clarify the details of the conversation.
- Get the current contact number of the enquirer to call back on in the event of any confusion with the enquiry.
- Record the enquiry directly into a version of MiDatabank (where available) which has a drug names spell checker. Auto keyword will also assist in identifying errors in drug names (assuming they are correctly entered in the database).
- Take time to re-read written answers under less pressure – write it, take a break, come back, re-read it. Or ask a colleague to re-read where available.
- Raise awareness of problematic drug names locally (e.g. Medicines Safety Officers) and through UKMi ALERT. E.g. "Lookalike-Soundalike" drug name lists; national lists can be used as a basis, to be edited for local use: https://www.npa.co.uk/information-and-guidance/look-alike-sound-alike-lasa-items/ .
- Tallman lettering is the practice of using uppercase letters to highlight differences in look-alike drug names, such as hydrOXYzine and hydrALAzine, to help prevent medication errors (*July 2025 update*).

Real examples from MI services:

- Misheard Twinrix (for hepatitis) as Shingrix (for herpes zoster/shingles).
- Misheard rifaximin (for diarrhoea/hepatic encephalopathy) as refluxamine (herbal reflux supplement).
- Misheard valaciclovir as famciclovir.
- Misheard statins and sulfasalazine interaction as simvastatin and sulfasalazine interaction.
- Misheard alendronic acid as ibandronic acid.
- Misheard trandolapril (ACEI) as tadalapril (non-existent drug).
- Misheard levofloxacin as linezolid.
- Third party caller misheard fluoxetine in breast feeding as sertraline (transferred mistake to MI).
- Assumed caller was asking about cladribine tablets when they were asking about intravenous cladribine.
- Wrote medroxyprogesterone safety in pregnancy in question field but researched and answered on methylprednisolone.
- Wrote esomeprazole in question field but researched and answered on escitalopram.
- Wrote losartan in question field correctly. Start written answer with losartan but changed to loratadine mid answer.

When something does go wrong

- Follow your in-house procedure for errors or near misses
- Submit an anonymous report through a UKMi ALERT
- Learn as a team

For further details, resources and supporting materials see https://www.ukmi.nhs.uk/.
For any enquiries about this alert, email QRMG.ukmi@nhs.net