National Tall Man

Lettering List

Issues register report

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Level 5, 255 Elizabeth Street, Sydney NSW 2000

Phone: (02) 9126 3600  
Fax: (02) 9126 3613

Email: accreditation@safetyandquality.gov.au   
Website: www.safetyandquality.gov.au

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# Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) is responsible for the development and stewardship of the National Tall Man Lettering List.

Implementing relevant action items in the National Safety and Quality Health Service (NSQHS) Standards will assist clinicians to safely store, prescribe, dispense and administer medicines. Health services seeking accreditation under the Australian Health Service Safety and Quality Accreditation scheme are required to:

* Provide evidence of implementation of safety strategies
* Undertake regular assessments of the medication management pathway
* Identify risks and take action to reduce these risks.

The National Tall Man Lettering List is referred to within NSQHS Standard 4: Medication Safety. Health service organisations are encouraged to consider the application of Tall Man lettering to minimise harm associated with look-alike sound-alike (LASA) medicine name pairs,along withother measures such as use of bar code scanners, electronic alerts and separate storage locations.

## National Tall Man Lettering Issues Register

As part of the National Tall Man Lettering Liststewardship, the Commission encourages frontline clinicians to report any adverse incidents or near-misses related to LASA medicine pairs. Issues notified to the Commission are logged in the National Tall Man Lettering Issues Register and are reviewed by the National Tall Man Lettering Expert Advisory Panel (the panel).

The panel is responsible for making recommendations on the medicine name pairs that need to be included in the National Tall Man Lettering List. The panel follows a systematic process to decide on the medicine name pairs that would most benefit from the application of Tall Man lettering.

The National Tall Man Lettering List has evolved since its introduction in 2011. The majority of issues lodged on the Commission’s Issues Register have been addressed in the [*National Tall Man Lettering List 2017*](https://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/national-tall-man-lettering-list/), so it is important that these issues and their outcomes are reported and publicly available. Figure 1 lists the issues and outcome summaries.

This report also contains information about the rationale for the general revision of the National Tall Man Lettering List.

It should be noted that monoclonal antibodies (MABs) and tyrosine kinase inhibitors are not included in the National Tall Man Lettering List 2017, and will be considered in future revisions. Further explanation is provided within this report under the rationale for general revision of the National Tall Man Lettering List.

For further information refer to [*National Tall Man Lettering List 2017*](https://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/national-tall-man-lettering-list/)available on the Commission’s website.

The Commission invites requests for changes to the National Tall Man Lettering List, which can be made to your state or territory representative on the Health Service Medication Expert Advisory Group. Requests should be accompanied by evidence of confusion, including other possible factors contributing to the risk of patient harm. For health services with no state or territory representative, please contact the Commission at [accreditation@safetyandquality.gov.au](mailto:accreditation@safetyandquality.gov.au).

# Figure 1: Issues and outcome summaries

| No | Issue | Issue summary | Proponent | Date | Outcome | Reason |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | Medicine name pair:  lincomycin and linezolid | Three (3) mixup incidents within a four-month period. Both medicines are 600mg strength, although packaging distinctly different:  2 mL vial and 300 mL infusion bag respectively | South Australia | Sept 2017 | **Added to Tall Man Lettering List 2017** | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion |
| 2 | Medicine name pairs:  - adrenaline and noradrenaline | Concern raised re potential rather than actual incidence of adverse events and near-misses and that this may be an under-representation. | Queensland | Sept 2017 | Not to be added to the Tall Man Lettering List 2017 | Considered by expert advisory panel.  BISIM and risk assessment result showed a **low risk** of confusion, also noting application of International Harmonisation of Medicine Names to:   * adrenaline (epinephrine) * noradrenaline (norepinephrine) |
| 3 | Medicine name pair:  dexmedetomidine and dexamethasone | A near miss incident occurred where the difference between the names was not recognised. Dexamethasone dose/rate selected in the smart pump when the dexmedetomidine dose was charted, prepared for administration. | NSW | Sept 2017 | Not to be added to the Tall Man Lettering List 2017 | Considered by expert advisory panel BISIM and risk assessment result showed a **low risk** of confusion |
| 4 | Medicine name pair: mercaptamine (cysteamine) and mercaptopurine | TGA has released a safety advisory re the change of ingredient name of cysteamine to mercaptamine at  https://www.tga.gov.au/alert/mercaptamine-cysteamine-and-mercaptopurine. | NSW | Sept 2017 | **Added to Tall Man Lettering List 2017** | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion. |
| 5 | Medicine name clozapine:  misreading potential with other medicine names such as clomipramine and clonidine | Suggestion that the names are very similar and orders could be misread, especially for staff less familiar with clozapine. | NSW | Sept 2017 | Not to be added to the Tall Man Lettering List 2017 | Considered by expert advisory panel.  BISIM and risk assessment result showed a **low risk** of confusion. |
| 6 | Medicine name pair: risedronate and alendronate | Potential for harm identified (no actual incident reported) relating to look-alike packaging: Sandoz brand. | NSW | Sept 2017 | Not to be added to the Tall Man Lettering List 2017 | Considered by expert advisory panel.  BISIM and risk assessment result showed a **low risk** of confusion. |
| 7 | **BRAND NAMES**  Medicine name pair: Pradaxa (dabigatran) and Praxbind (idarucizumab) - | Following the listing of the dabigatran reversal agent overseas initially during 2015, and now in Australia on the ARTG (May 2016), the need to consider whether there is a risk in the Australian environment. | International Medication Safety Network (IMSN) | Sept 2017 | Not to be added to the Tall Man Lettering List 2017 | Brand name pair considered by expert advisory panel.  BISIM and risk assessment result showed a **low risk** of confusion. |
| 8 | Medicine name pair: tramadol and tapentadol | Several incidents involving administration of tapentadol instead of tramadol. These medicines have a common indication and considered at increased risk of selection error. | Western Australia | Sept 2017 | **Added to Tall Man Lettering List 2017** | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion. |
| 9 | Medicine name pair: rifampicin and rifaximin | Potential for harm identified internationally by the Institute for Safe Medication Practices (ISMP) and medicines available in Australia (no known incidents reported). | International listing | Sept 2017 | **Added to Tall Man Lettering List 2017** | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion. |
| 10 | Medicine name pair: saxagliptin and sitagliptin | Potential for harm identified internationally by ISMP and medicines available in Australia (no known incidents reported). These agents are same class of medicine. Sitagliptin already listed. | International listing | Sept 2017 | **sAXagliptin added to Tall Man Lettering List 2017**  **Application of Tall Man lettering adjusted**:  siTagliptin (changed from sITAGLIPTIn) | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion. |
| 11 | Medicine name pair: aripiprazole and rabeprazole | Potential for harm identified internationally by ISMP and medicines available in Australia (no known incidents reported). | International listing | Sept 2017 | **Added to Tall Man Lettering List 2017** | Considered by expert advisory panel.  BISIM and risk assessment result demonstrated a **medium to high risk** of confusion. |

# Rationale for the general revision of the National Tall Man Lettering List

## Discontinued medicines (including brands of medicines)

The [*Australian Register of Therapeutic Goods*](https://www.tga.gov.au/australian-register-therapeutic-goods) (ARTG) provides information on therapeutic goods that are available and can be supplied in Australia.

Review of the ARTG identified eight medicines\* as being discontinued and no longer available in Australia since publication of the National Tall Man Lettering List in 2011. As a result, the Commission **removed the following medicine name pairs** from the National Tall Man Lettering List:

* alphapril\*/alphapress
* meruvax\*/merieux
* metohexal\*/mellihexal\*
* noroxin\*/neurontin
* trimipramine\*/imipramine
* cycloblastin\*/cyclizine
* taxol\*/taxotere.

## International harmonisation of medicine names

In different countries, different names are used to describe the same medicinal ingredient.

The Therapeutic Goods Administration (TGA) issued guidance on the introduction of name changes in Australia, according to the program for international harmonisation of names ([www.tga.gov.au/updating-medicine-ingredient-names](http://www.tga.gov.au/updating-medicine-ingredient-names)).

The list of affected active ingredient names and additional information is available on the TGA website, at: [www.tga.gov.au/updating-medicine-ingredient-names-list-affected-ingredients](http://www.tga.gov.au/updating-medicine-ingredient-names-list-affected-ingredients).

The Commission has incorporated the new medicine names within the National Tall Man Lettering List 2017 in alignment with the international medicine name changes. To assist software vendors and health services during the transition phase, the Commission has included the ‘old’ medicine name in brackets within the National Tall Man Lettering List 2017*.*

The medicines on the National Tall Man Lettering List 2017affected by the international name changes are listed in Table 1, the list of medicines requiring dual labelling.

### Table 1: Tall Man Lettering: List of medicines with dual labelling

|  |  |
| --- | --- |
| Current label | Dual label |
| cephalexin | cefaLEXin (cephaLEXin) |
| cephazolin | cefaZOLin (cephaZOLin |
| cyclosporin | ciclosPORIN (cyclosPORIN) |
| cysteamine | mercaptAMine (cysteamine) |
| dothiepin | doSULepin (doTHiepin) |
| trimeprazine | alimemazine (trimEPRAZINE) |

## Other revisions relating to use of ‘sans serif’ font

Care should be taken with sans serif fonts, as ‘L’ and ‘I’ may be visually identical, depending on their respective cases. Internationally, and according to the Institute for Safe Medication Practices (ISMP) Canada’s [*Principles for the application of TALLman Lettering in Canada*](https://www.ismp-canada.org/download/TALLman/Principles_for_the_Application_of_TALLman_Lettering_in_Canada.pdf), capitalisation of ‘I’ is not recommended.

This issue also became apparent when the Commission developed [*National guidelines for on-screen display of medicines information*](https://www.safetyandquality.gov.au/our-work/Medication-safety/Electronic-medication-management/National-Guidelines-for-On-Screen-Display-of-Medicines-Information/)*.* As a result the **application of Tall Man lettering has been amended for the following medicines**:

* amiODAROne
* amiTRIPTYLine
* amiNOPHYLLine
* aziTHROMYCIN
* ciPROFLOXAcin
* deRALin
* Diazepam
* iSOtretinoin
* lamiVUDine
* lanVis
* lipiDil
* MOXifloxacin
* PACLitaxel
* riSPERIDONe
* siTagliptin
* Sirolimus
* zinVit
* ciSplatin
* iDArubicin
* iFOSFamide

## Monoclonal antibodies (MABs)

Concern has been expressed regarding the application of Tall Man to only a handful of monoclonal antibodies (MABs). Alternatively, applying to ALL would dilute the importance of having Tall Man lettering in the first place. As a class of medicines it is acknowledged that future consideration of MABs is required by the panel at the next revision of the National Tall Man Lettering List.

In the meantime, no further MAB medicine name pairs will be added and the following MAB medicine name pair **has been removed** from the *National Tall Man Lettering List 2017*:

* infliximab and rituximab.

## Neuromuscular blocking agents (NMBAs)

Neuromuscular blocking agents (NMBAs) such as pancuronium and suxamethonium have similar names and packaging and are stored close to one another in the fridge.

The application of Tall Man lettering may not be the answer and consideration of this class of medicines has been delayed.

Once discussions with other health and government agencies regarding potential packaging changes have come to completion, the similarities with these medicines will be considered in a future revision of the National Tall Man Lettering List.

In the meantime, the Commission suggests organisations adhere to best practice recommendations for high risk medicines such as NMBAs, according to the[*Medication Safety Self Assessment for Australian Hospitals 2015*](http://www.cec.health.nsw.gov.au/patient-safety-programs/medication-safety/mssa)as described below in Figure 2:

### Figure 2: Best-practice recommendations for NMBAs

|  |  |
| --- | --- |
| Key Element | 5. Medication Standardisation, Storage and Distribution |
| **Core Characteristic** | 9. Unit-based ward or imprest stock is restricted |
| **Self-assessment item** | **128A:** Neuromuscular blocking agents are not available as ward or imprest stock and/or in automated dispensing cabinets (except in operating room/anesthesia stock). |
| **128B:** If available in critical care units and/or the ED, neuromuscular blocking agents are sequestered from other ward or imprest stock medications (including those stocked in automated dispensing cabinets) and labelled with auxiliary warnings to clearly identify the drugs as respiratory paralysing agents that require mechanical ventilation when used. |



Level 5, 255 Elizabeth Street, Sydney NSW 2000  
GPO Box 5480, Sydney NSW 2001

Phone: (02) 9126 3600   
Fax: (02) 9126 3613

Email: accreditation@safetyandquality.gov.au   
Website: www.safetyandquality.gov.au