Pharmacy Regional Newsletter

September 2024

Supplement: Look-Alike Sound-Alike (LASA) Medication Errors

Medication errors that occur when medicines have similar-looking (orthographic) or similar-sounding (phonetic) names, and/or shared features of products or packaging are called LASA errors and are a well-recognised cause of medication errors.

Look-alike medicines appear visually the same with respect to packaging, shape, colour and/or size, while sound-alike medicines are similar in the phonetics of their names, doses and/or strengths. Confusion can occur between brand–brand, brand–generic or generic–generic names. There is, however, no universally accepted, clear definition of LASA errors. If a person feels two medicines look or sound similar at all this can be classified as a LASA error.

LASA errors can occur at any stage of medication use: prescribing, transcribing or documenting, dispensing, administering and monitoring.

In 2023, 5% of the community pharmacy incidents reported to the Strategic Planning and Performance Group (SPPG) related to a LASA dispensing error, and most commonly involved pregabalin and gabapentin.

Examples of LASAs include:	
Amlodipine	Amitriptyline*
Carbamazepine	Carbimazole
Risperidone	Ropinirole
Desmopressin	Dexamethasone
Clomipramine*	Chlorpromazine
Escitalopram	Enalapril
Paracetamol	Co-codamol

* Amitriptyline and clomipramine have been confused with other drugs as well.

Gabapentin
Max dose 3600mg/day

Pregabalin
Max Dose 600mg/day

The gabapentinoids were rescheduled as controlled drugs in 2019. There are still a significant number of **dispensing** adverse incidents involving the two drugs.
In most cases the wrong one has been dispensed, when the other one has been prescribed. The large range of available dosage forms, including liquids has compounded the problem.

Pregabalin is roughly 6 times as potent as gabapentin. So, patients have come to harm and been admitted to hospital where the dispensing error has been detected. Conversely, when gapapentin has been dispensed in error for pregabalin, the medical indication (e.g. epilepsy or pain) may worsen, which can also lead to morbidity.

What can be done to minimise LASA errors?

All medication errors are potentially avoidable and the risk of these occurring can therefore be greatly reduced or even prevented. *Confusing 'look-alike sound-alike' medicines names and/or labelling and packaging are frequent sources of error and medication-related harm that can be addressed* (WHO Global Patient Safety Challenge 2017: Medication Without Harm).

A recent publication from the World Health Organisation (WHO) Medication Safety for look-alike, sound-alike medicines and previous PRN newsletters have highlighted many LASA incidents and provide advice on how to reduce these errors. While there is limited evidence available on the effectiveness of solutions for addressing the impact of LASA errors, the following could be considered to **STEER** away from LASA errors.

System Changes | **T**hree Point Check | **E**ducate staff | **E**ngage patients | **R**eport incidents

System changes: Examine what changes could be made within the pharmacy to reduce LASA errors, appropriate measures will be specific to each pharmacy.

Be pro-active, where possible avoid purchasing medicines with similar packaging and appearance or report safety concerns about look-alike, sound-alike medicines before an error occurs. Report to the MHRA using the email on page 3 and directly to the marketing authorisation holder. Principles of purchasing for safety can be found on the SPS website.

Examples include:

- A 'watch' list of LASAs occurring in the pharmacy
- Clearly labelled shelves / segregated storage of LASA medications / colour coding to ensure differentiation
- Adding alerts to the patient medication record
- Identification via barcode scanners
- Use of typographic interventions such as Tall Man Lettering (TML)*

* TML is the practice of making letters in sound-alike, look-alike medicine names standout in order to avoid medication errors. There are different methods for TML; one example is "prednisone" and "prednisolone" could be written as "prednisone" and "prednisOLone".

Three Point Check: Check that the name on the prescription, product and label all match. The dose, strength and the quantity should also alert if they don't match.

Educate staff: on LASA errors. All dispensing staff should be made aware of this article. Promote regular discussion around LASAs in safety huddles so staff are at ease with reporting LASA medication errors.

Engage with patients: in their treatment, educate them on potential LASAs, remind them to double-check names of medicines before taking or ask them to confirm that the item is what they are expecting as advised with insulin.

Patients can contribute significantly to improving the safety of medication use and failure to engage patients in their treatment at each stage of the medication use process can potentially result in LASA errors reaching the patients.

The Know Check Ask (KCA) medication safety campaign encourages patients to know their medications.

Report: dispensing incidents to SPPG for learning. Incidents including 'near misses' can be reported anonymously via the new website Community Pharmacy Incident Reporting.

NB: Incidents involving controlled drugs (including gabapentinoids) should not be reported this way. Notify the Controlled Drugs Accountable Officer (CDAO) ControlledDrugsAccountableOfficer@health-ni.gov.uk **and the Medicines Regulatory Group (MRG)** mrg_inspectors@health-ni.gov.uk**.**

Report suspected adverse reactions associated with medication incidents, including those involving LASA medicines via the Yellow Card Scheme.

In the absence of harm, safety concerns with LASA medicines can be reported to the Medicines and Healthcare products Regulatory Agency (MHRA) via patient.information@mhra.gov.uk.

Yellow Card

Medicines & Healthcare products Regulatory Agency