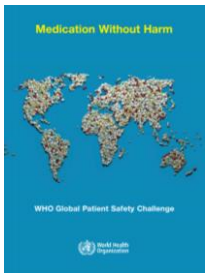
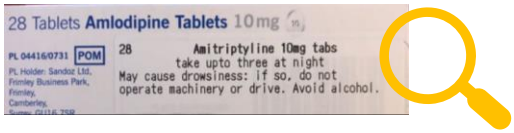
LASA, the journey so far…



In 2017, the World Health Organisation recognised the significant challenge that similar looking or sounding medicine names present…

> Confusing 'look-alike, sound-alike' (LASA) medicines names and/or labelling and packaging are frequent sources of error and medication-related harm that can be addressed

1.1 billion prescriptions were dispensed in the community in England alone in 2018. Of these, nearly **78 million** prescriptions were for the medicines deemed to be the highest risk Look-Alike Sound-Alike (LASA) combinations i.e. medicines which have similar looking and/or sounding names: amlodipine/amitriptyline, allopurinol/atenolol, azathioprine/azithromycin, carbamazepine/carbimazole, prednisolone/propranolol and rivaroxaban/rosuvastatin.

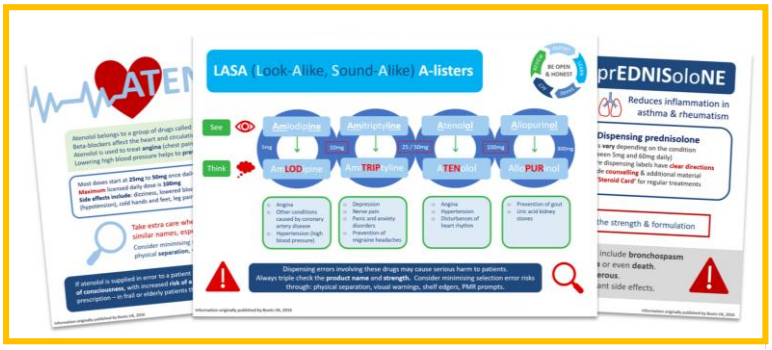


What we did…

The safety risks associated with LASA medicines have frequently been discussed at meetings of the Community Pharmacy Patient Safety Group (CPPSG).

During one of our dedicated **share and learn** slots, an MSO on our group shared her experience of a tragic patient death linked to a LASA incident occurring in their pharmacy, describing not just the impact on the patient and their family, but also on the pharmacy team involved.

Other MSOs on the group **shared insight and best practice** from their own organisations – including some fantastic 'drug of the month' posters which Boots UK had produced for their pharmacy teams. These posters inspired us to create a series of tools which pharmacy teams across the country could access and use.



We wanted to produce a set of engaging resources for frontline pharmacy teams to use to support them in their learning. The posters help spark **open conversations** about the risks associated with LASA medicines with the aim of reducing the likelihood of errors.

March 2017
Patient death following LASA error was shared at our meeting

May 2017
WHO recognises global LASA challenge

2018
LASA risks included in Pharmacy Quality Scheme

2019
PSG produces resources to support pharmacy discussions about LASA

We recognised it wouldn't be possible to eliminate *all* LASA errors, so we decided to **focus on the key pairs** deemed to be the most likely to occur and/or most likely to cause significant harm.

The resources were issued in February 2019, and in the first two and half weeks since we launched the resources online, they were **downloaded over 2,200 times** and website traffic increased by 120%. Through Twitter, the resources also reached over **100,000 people.**

We also shared our work with colleagues at the **MHRA**, who have previously helped us link in with manufacturers to address the LASA challenge.

What has changed…

We know that it is not possible to eliminate all errors that occur in community pharmacy but taking a multi-faceted approach and encouraging **open and honest sharing** about safety errors can contribute to reducing the likelihood of things going wrong.

We have heard about how our resources have been used in pharmacies to raise awareness and encourage safety discussions about LASA medicines.

Our MSOs told us about actions that have been taken at a local level to minimise the likelihood of dispensing errors occurring, including:

- Segregating stock
- Shelf labels for high risk LASA medicines
- Improved checking procedures

One of our MSOs has even used the resources to create a great **training video** about risk minimisation measures that can reduce the likelihood of LASA errors occurring. This video produced by Paydens pharmacy has also been included in the CPPE pack on LASA medication.

"As a team we discussed how to reduce LASA errors in more depth. We have physically separated the high-risk LASA medicines and since doing so we have had no dispensing errors with these and only one near-miss."

"Pharmacy staff have started using 'LASA' stickers on prescription bags to introduce a further check of the high-risk LASA medicines. This has encouraged patients to discuss any queries that they have with their medicines"

With so many Look Alike Sound Alike medicines out there utilise these great resources from @PharmacySafety to reduce the risk of errors.
ow.ly/NG4g50kN93G
#LASA #safepharmacy

Top quality resources, essential for all the pharmacy team on Look-Alike Sound-Alike medicines by @PharmacySafety

Have you seen the fab, new @PharmacySafety resources on #LASA errors? Useful to assist with meeting the patient safety report quality criterion of the #QualityPayments Scheme #PharmacyHour
ow.ly/4ooU30nF6C5

What next…

LASA medicines remain an important part of the **Pharmacy Quality Scheme** (PQS) which forms part of the pharmacy contract in England. The addition of a new pair of medicines in the 2019/20 scheme (rivaroxaban/rosuvastatin) demonstrates that this problem is not limited to a handful of medicines and ongoing work needs to be done to continue to raise awareness about the risks associated with LASA medicines.

We will continue to collaborate with **NHS England & Improvement** to ensure that the LASA component of the PQS achieves the best possible outcome in raising awareness and reducing the likelihood of errors. We will also share learning and best practice across the community pharmacy network in Great Britain.

The PSG will continue work to **monitor and share** insight about LASA errors as well as sharing best practice and learning from what goes right as well as what goes wrong.

One of our MSOs has committed to **eliminating incidents** involving amlodipine and amitriptyline in their pharmacies by November 2020, demonstrating the intent among our group to tackle this patient safety issue. They have committed to sharing their learning and experience from this challenge to help inform work in across the pharmacy sector.

We will look into how patients prescribed a LASA medicine can be better informed and empowered to understand the risks associated with their medicine if it is mixed up. Pharmacy teams can **help patients understand** what their medicines are for and the importance of checking before taking them and querying any differences.

Using the knowledge and experience of our members we will explore how **automation and technology** can contribute to reducing the likelihood of LASA errors occurring, including through the use of scanning technology.