Medication Safety Watch

Issue 10 – June 2014

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Medication Safety Watch

A bulletin for all health professionals and health care managers working with medicines or patient safety.

Key messages

- Safe medicine administration through enteral feeding tubes
- Metoprolol alert
- England's medication error incident reporting and learning alert
- Incidents and cautions

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Medication alerts and safety signals

These alerts and safety signals provide information and actions about high-risk medicines and situations. They are issued to health care staff, managers and organisations. For more information, contact Beth Loe at beth.loe@hqsc.govt.nz.

UPCOMING: The focus of the Health Quality & Safety Commission's *Open for better care* campaign will shift to high-risk medicines, with an emphasis on opioids, from October 2014.

Contribute to Medication Safety Watch

Are you or your organisation working on a new medication safety initiative? Has there been a medicine-related incident or error that you would like to warn others about? If so, contact Beth Loe at beth.loe@hqsc.govt.nz.

Safe medicine administration through enteral feeding tubes

Patients with enteral feeding tubes in place are frequently prescribed medicines that would normally be administered orally.

There are some questions that prescribers, pharmacists and administrators must ask before medicines are prescribed and dispensed for administration, or administered down an enteral feeding tube. Administering medicines down an enteral feeding tube is time consuming because of the manipulations required, particularly if a patient is on multiple medicines. Each medicine needs to be prepared and administered separately; it is not appropriate to crush and administer multiple medicines at the same time. The following questions should be considered and apply to all types of enteral tubes.

1. Are all the medicines prescribed still required? If not, stop any unnecessary medicines.
2. Does the medicine have to be given down the tube or can the route be changed? For example, consider changing oral isosorbide mononitrate to transdermal glyceryl trinitrate.
3. When a medicine is to be given multiple times a day, is there an alternative that could be given once daily to reduce the number of manipulations? For example, changing to a longer acting medicine, ie, a medicine with a long half-life (but not a sustained release/long acting preparation).

Once these questions have been answered, the dose form used to administer a liquid dose has to be decided. Ask these questions:

1. Is there an approved liquid or soluble tablet formulation? Be aware:
   - some liquid preparations are suspensions of small granules not suitable for administering via an enteral feeding tube
   - changing to a different formulation may require changing the dose because the bioavailability may vary between solid and liquid dosage form
   - some liquid preparations contain sorbitol, which can act as a laxative.
2. Can the tablets be dispersed in water or the capsule opened and the contents given? Check that a medicine can be administered in this way because not all medicines are suitable and some capsules are too small to manipulate.
3. For tablets not able to be dispersed directly in water, are the tablets suitable for crushing? Tablets not suitable for crushing include:
   - sustained/slow/extended release and long acting tablets
   - enteric coated tablets
   - cytotoxics and hormones.
4. Can the injectable preparation be given orally?

Liaising with pharmacy is often beneficial in identifying alternative products or routes, and whether or not medicines can be given down enteral feeding tubes.

The next edition of *Medication Safety Watch* will detail administration methods through enteral feeding tubes, medicine-food interactions, tube blockage and other considerations.

Useful resources:

BAPEN: Guidance on drug administration via enteral feeding tubes. www.bapen.org.uk/professionals/publications-and-resources/bapen-reports#guidanceDrugAdmin

Pharmaceutical Press: *Handbook of Drug Administration via Enteral Feeding Tubes*. www.pharmpress.com/product/9780853699286/handbook-of-drug-administration-via-enteral-feeding-tubes

The Society for Hospital Pharmacists of Australia: *Australian Don't Rush to Crush Handbook: therapeutic options for patients unable to swallow solid oral medicines*. www.shpa.org.au/scripts/cgiip.exe/WService=SHPA/ccms.r?PageId=10243

What's new?

Metoprolol alert

The Commission circulated a draft metoprolol alert for feedback in April 2014. The closing date for feedback was 7 May 2014. We would like to thank everyone who provided their views. The final content of the alert will be agreed once all feedback has been considered.

Medication Error Reporting Programme to expand

The Medication Error Reporting Programme (MERP) will expand later this year, facilitated by the Commission. This confidential voluntary programme was initiated by the New Zealand Pharmacovigilance Centre and successfully piloted in primary care in 2011–12. A small group of general practitioners and community pharmacists reported medication and vaccine errors online in a similar and complementary way to the adverse reactions reported to the Centre for Adverse Reactions Monitoring. The Commission will be custodian of the residual funds of Preferred Medicines Centre Inc (PreMeC), a predecessor to bpac^{NZ}. PreMec's expressed wish was that the funds would be used to support the expansion of MERP across the primary care sector. Look out for regular updates.

NHS England's and the Medicines and Healthcare Products Regulatory Agency's medication error incident reporting and learning alert

Key functions of the disbanded National Patient Safety Agency (NPSA) have been transferred to NHS England. A new patient safety alert was issued in March 2014, 'Medication error incident reporting and learning', identifying actions for implementation by different sized organisations. While targeting English health organisations, some of the proposed actions are pertinent to the New Zealand health sector. *www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-device-inci.pdf*

An associated document contains supporting information for the alert, including the number of errors reported to the National Reporting and Learning System. There is also information on details not included in medication error reports which can lead to problems in identifying a system change to prevent the incident and the associated patient harm recurring. *www.england.nhs.uk/wp-content/uploads/2014/04/psa-med-dev-0414.pdf*

Incidents and cautions

Oxycodone name change

The brand name of the funded controlled release formulation of oxycodone is changing again. When the contract for Oxycontin® expired the tender process resulted in the funding of Oxydone BNM®. PHARMAC and the manufacturer (InterPharma) have acted on safety concerns raised by the sector and changed the brand name to Oxycodone controlled release®. All strengths (10, 20, 40 and 80mg) will be available as New Zealand stock of Oxydone BNM® is exhausted.

The appearance of the tablets will not change but the external labelling will.

Error prone abbreviations:
CSL – do you know what it stands for? Is it Commonwealth Serum Laboratories (blood product manufacturer) or compound sodium lactate infusion? CSL appears on every blood product box and bottle manufactured by Commonwealth Serum Laboratories. Using the abbreviation CSL for compound sodium lactate could result in your patient being given an unsuitable fractionated blood product – use the full name, compound sodium lactate, instead.

Do not leave oral or intravenous syringes unlabelled if they are not for immediate administration. There is a danger that the medicine in the syringe will be given to the wrong patient or by the wrong route. For example, a medicine intended for intravenous injection could be given intramuscularly.

Intravenous administration of oral medicines

Three incidents or near misses have been reported of oral liquids (either pre-formulated or dissolved tablets) being drawn up in syringes and either given intravenously or left with parents to give to their child later. The latter raised the question from parents later: was it to be given via the cannula? In each case there was no harm but there was potential for harm either from the constituents of the oral liquid given intravenously or direct damage to the veins.

Does your organisation use oral syringes that are clearly differentiated from intravenous syringes in colour and luer connection? This prevents inadvertent administration of a liquid intended for oral use being administered intravenously.

The ideal oral syringe is a distinctive colour and will not fit an intravenous luer connection.

Upcoming events

- The 3rd APAC Forum, Melbourne, 1–3 September 2014. See *apacforum.com* for more information.
- The 13th HINZ Annual Conference and Health Innovation Marketplace, Auckland, 10–12 November 2014. See *www.hinz.org.nz/page/home/conference-link-from-homepage* for more information.