



For action:

Chief Executives of HSC Trusts
Chief Executives HSS Boards
Chief Pharmacists in HSC Trusts/Boards

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For information:

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Medical Directors HSC Trusts
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Directors of Nursing HSS Boards/HSC Trusts
Directors of Public Health in HSS Boards
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NI Medicines Governance Team
Directors of Primary Care in HSS Boards for cascade to

- Prescribing advisers; and
- GP advisers

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Circular HSC (SQSD) 28/2007

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Regulation and Quality Improvement Authority (for cascade to relevant regulated establishments and independent hospitals, clinics and hospices)

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Northern Ireland Clinical and Social Care Governance Support Team

Chief Executives NIMDTA, NICPPET, NIPEC

Dear Colleague

RE: NPSA SAFE MEDICATION ALERTS

- **Actions that make anticoagulant therapy safer – Alert 18**
- **Promoting safer measurement and administration of liquid medicines via oral and other enteral routes – Alert 19**
- **Promoting safer use of injectable medicines – Alert 20**
- **Safer practice with epidural injections and infusions – Alert 21**

Introduction

1. On the 15th March 2007, the NPSA issued five safe medication alerts as part of their safer practice work programme (2007/2008), which is linked to the findings of their National Reporting and Learning System. NPSA Safe Medication Alerts 18-20 are covered in this circular. Alert 22 on reducing the risk of hyponatraemia when administering intravenous fluid therapy to children is highlighted in circular HSS(SQS)20-2007 and is available on www.dhsspsni.gov.uk/hsc_sgsd_20-07.pdf. Each Alert is accompanied by templates and exemplar documents. Organisations should ensure that Alerts are adapted locally and that they meet the requirements of specialist clinical areas and services. All Alerts are available at www.npsa.nhs.uk/health/alerts.
2. The purpose of this circular is to highlight the content of **NPSA Safe Medication Alerts 18-21**. These have been endorsed by the Department and are recommended to the HSC for implementation.
3. The Department recommends that Chief Executives should nominate Chief Pharmacists, Pharmaceutical Directors/Advisers and Heads of Pharmacy and Medicines Management in HSC organisations to lead the action required to implement the safer practice recommendations listed in these four Patient Safety Alerts and link this work with that of the Fifth Patient Safety Alert on Hyponatraemia (Alert 22). The Chief Pharmacist, Pharmaceutical Director/Adviser and Head of Pharmacy and Medicines Management will need to be supported by the Chief Executive and key members of the Executive Clinical Team in implementing these safer practice recommendations.
4. Circular HSS(SQS)20-2007 on hyponatraemia requires Chief Executives to make a return to the Department, actions have been completed by **30 September 2007**.
5. The content of these Alerts is also applicable to independent sector providers and those regulated establishments which provide relevant services. As they are written in the context of the NHS, we would wish to draw your attention to some additional information:

NPSA Alert 18- Actions that make anticoagulant therapy safer

6. The safer anticoagulants therapy Alert (18) and supporting materials are available on www.npsa.nhs.uk/health/alerts. They aim to help manage the risks associated with anticoagulants and reduce the chance of patients being harmed in the future. They include:
 - (a) patient safety Alert 18;
 - (b) e-learning modules;
 - (c) work competencies (including dental surgery);
 - (d) relevant national standards and guidelines;
 - (e) information to patients and carers; and
 - (f) risk assessment reports/grid.
7. The following points are relevant to practice in Northern Ireland and should be noted:
 - The available warfarin strengths in Northern Ireland have been successfully rationalised to 1mg and 3mg tablets to minimise the risk of confusion between

different strengths. These will continue to be the recommended strengths of warfarin tablets in Northern Ireland and all users are reminded of the importance of ensuring this consistent approach; and

- Additional supplementary information concerning tablet strengths must continue to be included in the anticoagulant books used in Northern Ireland.

NPSA Alert 19- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes-

8. The patient safety alert, patient briefing, resource pack and audit document are available at www.npsa.nhs.uk/health/alerts. They identify that the choice of medical devices and methods used to administer oral liquid medicines can improve patient safety. They include:
 - (g) patient safety alert 19;
 - (h) poster promoting the use of oral syringes;
 - (i) patient information; and
 - (j) template audit form.
9. The following points are relevant to practice in Northern Ireland and should be noted:
 - Purple oral/enteral syringes should be used across Northern Ireland. The NI Medicines Governance Team policy for the use of oral syringes (November 2003) advised the use of amber oral syringes. This policy will be updated to recommend the use of purple oral/enteral syringes that are not compatible with IV equipment in line with NPSA.

Alert 20- Promoting safer use of injectable medicines

10. The patient safety alert and support materials are available at www.npsa.nhs.uk/health/alerts. They identify actions that can make the use of injectable medicines safer. They include:
 - (a) patient safety alert 20;
 - (b) patient briefing;
 - (c) risk assessment tool for administration and preparation of injectable medicines;
 - (d) exemplar standard operating procedures; and
 - (e) a multi-disciplinary practice standard using core principles of safe practice.
11. The following points are relevant to practice in Northern Ireland and should be noted:
 - existing pharmacy networks should explore the potential for collaborative work within these documents. The Aseptic Pharmacists Group should consider product assessment and the Medicines Information Group, the provision of technical information.
 - The workforce competence statements and template Standard Operating Procedures provide a foundation for the delivery of education and training programmes for all staff involved in the use of medicines and should be delivered on a regional basis. This is similarly important at undergraduate level training.

- It is noted that within the NPSA documentation the workforce competences for injectable medicines do not explicitly highlight allergy status in either the prescribing or monitoring statements. It is, however, vitally important to include it in education and training programmes allied to the use of injectable medicines.
- While the NPSA alert is a generic document, attention is drawn to the fact that the NI Medicines Governance Team has issued specific guidance on safer use of injectable medicines, for example, minimising the risk of bolus administration of vancomycin and clarithromycin. Continued vigilance is therefore of paramount importance allied to the specific characteristics of individual products and their recommended usage.

Alert 21- Safer practice with epidural injections and infusions

12. The Patient Safety Alert (21) on safer practice with epidural injections and infusions, patient briefing and audit document are available at www.npsa.nhs.uk/health/alerts.
13. The following points are relevant to practice in Northern Ireland and should be noted:
 - where 'judicious use of colour' is advocated in the NPSA Alert, a single colour is recommended to be used across Northern Ireland. Yellow has traditionally been used and Trusts should work towards implementing this formally.
 - However, in some cases yellow is currently being used for Trust intravenous additive labels. Therefore, to avoid any confusion, a programme to withdraw the use of this colour for IV additive labelling should commence. It will be important to ensure that Chief Pharmacists in collaboration with clinical teams and procurement personnel agree a definite date of change across all HSC organisations. An adequate 'washout' period should be allowed before introducing yellow for epidural injections and infusions.

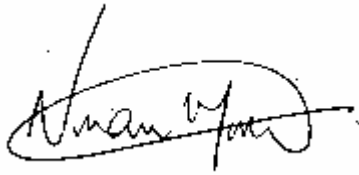
Action

14. The Department endorses these four NPSA Safe Medication Alerts for implementation in HSC organisations. It recognises that these are also applicable to the independent and regulated sectors. Given the medicines focus of these alerts, chief pharmacists should lead implementation and should work with clinical colleagues, the Northern Ireland Medicines Governance Team and educational establishments to co-ordinate implementation. All actions should be completed **by 30 June 2008**.
15. Organisations need to be aware of these NPSA Medication Alerts, in order to assist in complying with criteria 5.3.1(f)(8&9) and 5.3.3(f) of the Quality Standards for Health and Social Care (Ensuring Safe Practice and the Appropriate Management of Risk, and Implementation of Evidence Based Practice through guidance, for example, NPSA guidance).

Conclusion

16. The NPSA Safe Medication Alerts have been designed to promote good practice and reduce the risk of harm. They are linked to the outcomes of the National Reporting and Learning System which has highlighted areas of high risk. Trust Chief Executives are asked to cascade this circular widely to staff and, through HSC Chief Pharmacists, put in plans to ensure effective implementation linked to the work of existing multi-disciplinary prescribing groups and teams, including the Northern Ireland Medicines Governance Team.

Yours sincerely



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