

# Promoting safer use of injectables — implementing the NPSA alert

Two multidisciplinary workshops were held last month to help those involved in implementing the NPSA alert on safer use of injectable medicines.

Christine Clark reports on the proceedings

In March this year the National Patient Safety Agency (NPSA) issued an alert entitled “Promoting safer use of injectable medicines”. Coming as it did at the same time as four other medicines-related alerts it generated a considerable amount of work for chief pharmacists. Baxter Healthcare has recently run two multidisciplinary educational programmes, designed to help those involved in the implementation of the alert. In addition to formal presentations, each day involved workshops designed to test a simple risk assessment tool for injectable medicines.

## Unrecognised risk

Injectable medicines remain an unrecognised risk in many trusts, rarely cited by clinical governance managers as being high-risk items, David Cousins, head of safe medication practice at the NPSA, told the audience. Yet the NPSA receives 800 incident reports a month concerning injectable medicines, and 58 per cent of incident reports leading to death and severe harm involve these products.

The NPSA alert calls for risk assessments of all injectable products in clinical areas and the development of action plans to minimise high risks when they are identified. One key question to ask is whether there is adequate technical information available to the staff responsible for preparing and administering injectable medicines, Professor Cousins said. European legislation requires a patient information leaflet in every pack, but not information about dilutions, volumes and speed of administration for injectable products, he noted. Everyone assumes that someone else will know what to do.

The programme for “Safety with injectable medicines — implementing the NPSA alert” consisted of two workshops held on 13 June in London and on 25 June in Harrogate. The programme was designed by an independent advisory group and the meetings were supported by an unrestricted educational grant from Baxter Healthcare. **Christine Clark** is a freelance journalist. Her travel expenses were paid by Baxter Healthcare.



Cathy Mooney: Pharmacy cannot “go it alone”

Recommended risk reduction measures include simplification of product ranges, “purchasing for safety” and the provision of additional guidance on how to prescribe, prepare and administer a product, he said. If there is no way of reducing risk with a given product, then it should be added to the trust’s risk register so that the organisation is aware of it. If risk reduction measures are deemed to be unaffordable, then this is a decision that needs to be made at the highest level and should be documented, advised Professor Cousins. “You cannot be too formal in this situation,” he commented.

In the workshop sessions participants tested a tool designed to simplify the risk assessment process and to help practitioners to identify appropriate risk reduction measures. Injectable medicines used in intensive care areas and ward areas were risk assessed and stark differences quickly emerged.

## Multidisciplinary response

The concept of risk is well-embedded in the NHS but patient safety is not seen as quite the same thing, according to Cathy Mooney, director of governance and corporate affairs,

Chelsea and Westminster Hospital NHS Foundation Trust. Furthermore, medicines are not seen as a “top risk” alongside finance, strategy and performance. This impression is reinforced in Ms Mooney’s trust by the reporting pattern — the highest number of incident reports relate to blood, she explained, and medicines rank third. One of the reasons for this is that the laboratory staff are diligent about reporting, she noted.

Although a multidisciplinary response is called for in the alert there is often a local perception that “pharmacy will sort it” and that this is an additional task rather than something that is integral to the work of the organisation. Pharmacy cannot “go it alone” because it is a multidisciplinary issue and needs input from several quarters, she said. It is important to work out what help is needed and who might provide it.

If the NPSA alert does not mean a lot to people in your organisation, then you have to make it into something important, Ms Mooney said. Focus on the elements of the alert that will improve patient safety, she advised. Use local data, especially case studies if they are available, because examples are always more memorable than raw numbers.



Jane Harden: Cytotoxic injections are still being prepared on wards

When it comes to implementation, prioritise your efforts and concentrate on those areas where the risks are highest — this is important for your credibility and for good use of your energy, she advised. It also helps to dispel the popular impression that pharmacists are largely process-driven.

Implementation of the NPSA alert should be in the trust audit plan and, most importantly, it should be in the trust risk register. The risk could be recorded as non-compliance with the NPSA alert or individual risks identified during the implementation process could be recorded. Either way, this is a critical step said Ms Mooney, “because you are building help for when something goes wrong — getting information to the right level.”

### Meeting reports

*Hospital Pharmacist* welcomes submissions about meetings and conferences. Please contact the editorial department before sending in a report, ideally before the meeting takes place, to check that it is not already being covered and to discuss the length of the report and press deadlines. Contact Hannah Pike (e-mail [hannah.pike@pharmj.org.uk](mailto:hannah.pike@pharmj.org.uk), telephone 0207 572 2425).

In practice a group or team is likely to be needed to implement the alert fully and it is important to have the right people in the group, Ms Mooney said. The person or body to whom the group reports has the liability for the scheme. So far, no such group has involved a patient but this would be a major step forward.

In summary, Ms Mooney said that enormous enthusiasm was needed to drive this type of initiative successfully, that it is critical to make explicit the link between the alert and patient safety, and that the outcomes of the initiative should be measured and publicised. We should aim to shift from reports that emphasise process to those that focus on outcomes — from, for example, “we have done risk assessments on x wards” to “we have stopped these practices from happening....”

### — More audit data needed

Problems with prescribing and administration of intravenous medicines have already emerged as key issues in a study that it currently under way, according to Jane Harden, senior lecturer in nursing at Cardiff University. The study, conducted by York Health Economics Consortium and the Cardiff School of Nursing and Midwifery Studies, Cardiff University, was designed to

collect baseline data against which the impact of the NPSA alerts on anticoagulant management and injectable medicines can be measured.

“We are keen to visit nurses and junior doctors in clinical areas and see where injections are really made,” explained Dr Harden. Twenty acute trusts representing a wide geographical spread and small, medium and large hospitals have been recruited.

Amongst the issues that have emerged so far are the following:

- For weight-based doses, junior doctors commonly guess patients’ weights but they can be wrong by several stone
- Diluents, volumes and rates of administration are not prescribed — it is assumed that the nurse will know them (When questioned nurses say they look it up or use the information in the pack, which usually does not contain such details.)
- The use of single-dose vials to prepare multiple injections is still common in theatres
- Cytotoxic injections are still being prepared on wards

In conclusion, Dr Harden said there are many “black holes” in this area and little in the way of audit data. The evaluation will be complete by the end of July 2007.