

Quick compliance with safety alert on oral/enteral syringes

The UK's National Patient Safety Agency has released an alert on the hazards of wrong-route administration, recommending immediate action to ensure oral/enteral medications cannot be administered via an IV connection. A way to comply immediately is presented here ...

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The UK's National Patient Safety Agency (NPSA) issued an important alert on 28 March 2007, identifying the need for hospitals to ensure adequate measures are put in place to minimise errors in the administration of liquid medication.

According to the alert, inadvertent intravenous (IV) administration of oral medications resulted in numerous patient safety incidents and three reported deaths between 2001 and 2004.

The NPSA proposes actions to minimise the risk of wrong-route errors – advocating the use of oral/enteral syringes for administering oral liquids that feature clear differentiation from those used for IV medication.

The alert requires the use of oral/enteral syringes in all clinical areas by 30 September 2007, recommending the use of coloured syringes with clear labelling to help with differentiation. In addition, syringe tips must be incompatible with any IV or other parenteral devices.

The NPSA's action points indicate the removal

of Luer connections in tubeset ports, eliminating any potential confusion between central lines and feeding lines.

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In addition, the alert suggests that procedures, training and risk assessments be carried out to ensure all staff are aware of the potential for inadvertent error in administering liquid medications and are familiar with the procedures and products required to minimise risk.

All UK hospitals are expected to fully comply with the NPSA guidelines by 31 March 2008, although actions to examine current practices and begin implementation of safer practices are expected by July 2007.



Oral/Enteral Dispensers are designed for safe administration of liquids



The purple colour used for plungers is likely to become a European standard

Terry Aston, managing director of Baxa Ltd – a medical device company that provides technologies for fluid handling and delivery – pointed out that hospitals can comply with the alert immediately by using his company's Exacta-Med® Oral/Enteral Dispensers.

Inadvertent IV administration of oral medications resulted in numerous patient safety incidents and three reported deaths 2001–4

He said: "Baxa praises the move by the NPSA as a significant step in eliminating patient safety incidents involving intravenous administration of oral liquid medications."

Baxa's Oral/Enteral Dispensers are syringe-like devices specifically designed for safe administration of oral and enteral liquids and cannot be used as IV syringes.

These dispensers are clearly labelled and highly differentiated, featuring a purple plunger. Exacta-Med Dispensers also have a clear barrel to facilitate

the easy detection of air bubbles and particles within the liquid.

The cost of changing to oral/enteral syringes is documented within the NPSA's alert. Oral/enteral syringes tend to cost more than IV syringes, yet the report acknowledges that the former can be washed and re-used for single patient use and that doing so would provide significant economies.

Mr Aston commented: "Baxa Oral/Enteral Dispensers are validated for re-use up to 30 times on the same patient, so on a cost-per-use basis this already makes them cost-effective, as well as bringing additional benefits of safety."

Mr Aston said that since 1975, Baxa has focused on providing technology for health-system pharmacies that improves patient safety, reduces the risk of medication errors and facilitates compliance with regulatory requirements.

The latex-free Baxa Oral/Enteral Dispensers fit the needs of pharmacy, nursing and outpatient caregivers for safe medication administration.

The wider tip design of the Exacta-Med Dispensers was developed in cooperation with representatives and customers from children's hospitals worldwide. ■

Resources

Details of NPSA alert and guidelines
W: www.npsa.nhs.uk/display?contentId=5807

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