Administration of Liquid Oral and Enteral Medications Policy

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Routine Disclosure: Yes

Approval

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<th>Prepared by</th>
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<td>16 May 2014</td>
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<td>6 June 2014</td>
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Revision History

<table>
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<tr>
<th>Version</th>
<th>Approved By Name</th>
<th>Approved By Title</th>
<th>Amendment Notes</th>
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This Policy may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for the Department of Health and Human Services. PLEASE DESTROY PRINTED COPIES. The electronic version of this Policy is the approved and current version and is located on the Agency’s intranet. Any printed version is uncontrolled and therefore not current.
Purpose

- Oral liquid medications administered via the wrong route can be fatal or cause serious harm\(^1\).
- The use of parenteral syringes to administer oral/enteral liquid medications increases the risk of wrong route administration errors\(^1\).
- Oral dispensers are specifically designed to prevent the operator connecting it to standard IV administration lines.
- The key purpose of this policy is to enhance patient safety by reducing the risk of wrong route administration errors, in alignment with the principles of the “Five R’s” of medication administration.

Mandatory Requirements

- This is a statewide policy and must not be re-interpreted so that subordinate policies exist. Should discreet operational differences exist, these should be expressed in the form of an operating procedure or protocol.
- **Failure to comply with this policy**, without providing a good reason for doing so, may lead to disciplinary action.
- All liquid medications intended for oral or enteral administration must be prepared and administered using an oral dispenser or unit dose oral cup. Oral dispensers and enteral feeding systems will comply with the Children’s Hospitals Australasia (CHA) *Standard for Oral Syringes and Enteral Feeding Systems*.

Key Definitions

- The **Department of Health and Human Services (DHHS)** refers to:
  - Departmental Groups that are responsible for the provision of support for policy, planning, funding, performance monitoring and improvements across the service groups; interface with government. The DHHS Departmental Groups comprise Strategic Control, Workforce and Regulation and System Purchasing and Performance.
  - Service Groups deliver services to the public. The DHHS Service Groups include Ambulance Tasmania, Children and Youth Services, Disability, Housing and Community Services and Population Health.
- The **Tasmanian Health Organisations (THO)** refers to THO North, THO North West and THO South. The THOs are responsible for delivering high quality, efficient and integrated healthcare services in their area through the public hospital system, and primary and community health services.
- An **“oral dispenser”** refers to a device that is clearly distinguishable from parenteral syringes in colour, its inability to connect to IV administration sites, and by printed words that indicate the route of intended administration such as “for oral use” and/or “for enteral use”.
- **“Oral liquid medications”** refers to all proprietary and extemporaneous preparations of mixtures, elixirs, suspensions or solutions.

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• “Parenteral administration” is defined as administration in a manner that bypasses the gastrointestinal tract, most commonly intravenously.

• “Enteral administration” is defined as administration directly into the gastrointestinal tract (distal to the oral cavity) via a tube, catheter, or stoma.

Principles

• Clinical Staff employed by a Tasmanian Health Organisation are to be educated about the risks associated with using parenteral syringes to withdraw and administer oral or enteral liquid medications.

• Devices used for measuring oral or enteral liquid doses are known as oral dispensers and not oral syringes.

• All liquid doses of medications intended for oral or enteral administration are measured and administered using an oral dispenser, except where it is appropriate to use a unit dose oral cup e.g. antacids, aperients or oral care products.

• Intravenous (IV) syringes must never be used to measure or administer liquid oral, enteral or inhaled medications.

• Oral dispensers and enteral feeding systems will comply with the Children’s Hospitals Australasia (CHA) Standard for Oral Syringes and Enteral Feeding Systems².

• Oral dispensers must be available and easily accessible in all patient care areas at all times.

• To prevent wrong route errors for patients being cared for in the community setting who have intravenous access in situ, oral dispensers must be supplied to patients (or their carers) to enable them to safely administer oral liquid medications.

• The Statewide Policy on User Applied Labelling of Injectable Medicines, Fluids and Lines must be complied with to reduce the risk of wrong route errors.

Roles and Responsibilities/Delegations

• All operational areas are required to implement the policy as a part of their quality and safety program.

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<tr>
<th>Secretary DHHS or delegate</th>
<th>Ensure that the policy is implemented across DHHS facilities.</th>
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<tbody>
<tr>
<td>THO Medication Safety and Improvement Committee</td>
<td>Create, review and audit the policy in collaboration with clinical staff.</td>
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<tr>
<td>Tasmanian Health Organisation Executive</td>
<td>Ensure that the policy is implemented and supported across their area of responsibility.</td>
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<tr>
<td>Nurse Unit Managers or other managers of operational areas</td>
<td>Ensure that the policy is disseminated to applicable staff. Provide resources to implement the policy (including access to training and oral dispensers). Participate in auditing of the policy as required.</td>
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<td>Staff</td>
<td>Follow the policy and report non compliance within the</td>
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Risk Implications

- Serious harm has occurred where medications intended for oral or enteral administration have been administered via the intravenous route. The use of parenteral needles and syringes to draw up doses has been implicated in these errors\(^3\). Multiple formulations of the same drug available for different routes of administration, interruptions between preparing a dose and administering it, different staff preparing and administering the medication, the prescribed drug form not available on the ward and simultaneous nasogastric and IV lines have been found to contribute\(^3,4\).

- The Institute for Safe Medication Practices (ISMP) states that the consistent use of oral dispensers for preparation and administration of all small volume oral/enteral liquids is an effective and economical risk reduction strategy that should be employed in all healthcare settings\(^1\).

- The ISMP has recommended 10 key strategies that promote the consistent use of oral dispensers\(^1\). These strategies are:
  - Assess medical equipment connectivity.
  - Supply all clinical areas with oral dispensers.
  - Notify pharmacy if liquid medications are required.
  - Dispense oral liquid medications from the pharmacy when possible in oral dispensers.
  - Reduce tolerance of risk by communicating the potential dangers of inadvertent administration via the wrong route.
  - Require staff to use only oral dispensers when preparing and administering oral/enteral medicines.
  - Apply labels such as “oral only” over tip or barrel of dispenser.
  - Label all access lines.
  - Improve awareness.
  - Establish training programs.

- Throughout 2008 & 2009 a number of organisations including VMAC (Victorian Medicines Advisory Committee), NSW Health and QLD Health released updated safety alerts and policies on this issue.

- This policy contributes to action on the National Safety and Quality Health Service Standards (NSQHS Standards) Medication Safety criterion 4.1.2, 4.2.1, 4.4.2 and 4.5.2.

- Use of oral dispensers and enteral feeding systems complying with the CHA Standard for Oral Syringes and Enteral Feeding Systems\(^2\) will prevent liquid oral or enteral medications being administered by the intravenous route.

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Training

• Clinical Staff employed by a Tasmanian Health Organisation are to be educated about the risks associated with using parenteral syringes to withdraw and administer oral or enteral liquid medications.

• Clinical staff should be orientated to this policy and details of its requirements upon employment.

Audit

• This policy will be included in the work program of the DHHS Internal Audit function. This work program is approved by the Audit and Risk Committee and will assess underlying systems and procedures for compliance with the requirements of this policy. The overall focus of this assessment will be one of continuous improvement to DHHS activities.

• Identified examples of non adherence to the policy should be reported within the applicable incident management system.

• Audits of compliance to the policy will be undertaken no less frequently than annually using a defined audit tool, available from Medication Strategy & Reform (System Purchasing and Performance).

Attachments


Related Documents/Useful Resources


5 NSW Health. Safety Notice 006/09. Wrong route errors with oral administration - promoting the correct administration of oral medications. 25 March 2009.