NATIONAL PATIENT SAFETY AGENCY
PATIENT SAFETY ALERT

Safer Use of Injectable Medicines
In Near-Patient Areas

Wide Stake Holder Consultation – Response Form

Please send complete form to injectable-medicines@npsa.nhs.uk
Friday 31st March 2006

Your contact details

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1) What are your views on the risks associated with the use of injectable medicines, identified by the NPSA, that contribute to patient safety incidents? Are there any risks that we have not identified or are inappropriately included?

2) Will the recommendation to undertake a risk assessment help to identify high risk products and local risk management priorities? Will the NPSA risk assessment tool be useful in this process?

3) Is there a need for written protocols and procedures and will the NPSA multidisciplinary practice standard and standard operating procedure assist you in this process?

4) Is there a requirement for technical information concerning injectable medicines at the point of care? Are the data elements identified by the NPSA sufficient to ensure safe practice? Is this information readily available now? Is there a requirement for a nationally produced reference source?
5) Is there a need for guidance on monitoring infusion therapy? Does the proposed guidance meet this need or is more detail guidance required?

6) What are your views about the purchasing for safety recommendations where safer ready to use and ready to administer products should be purchased in preference to those that pose patient safety risks? Where licensed products of this type are not available, what are your views of using unlicensed products manufactured in NHS pharmacies or by a commercial supplier?

7) We believe that most healthcare organisations have some form of staff training programme for injectable medicines. Is this training available to staff of all disciplines who use injectable medicines? How effective is this training? What are your views concerning the use of work competence templates and assessments?

8) Will the requirement for an annual injectable medicines report in your organisation that will summarise risk assessment results, incident reports, compliance with NPSA recommendations and in year actions, improve risk management?

9) What are the barriers that may prevent the successful implementation of this guidance? Will any new risks be introduced by implementation?

10) How could the presentation of the final patient safety alert be improved?
11) Do you have any other comments concerning the draft NPSA Safer Practice Alert?

Thank you for providing feedback on our consultation over proposed safer practice recommendations for preventing wrong route errors with oral/enteral medicines feeds and flushes.