

**National Patient Safety Agency**

**Risk Assessment of Injectable Medicines**

**STEP 1 – Local Risk Factor Assessment.**

Carry out a baseline assessment in a near patient area (e.g., ward, clinic, home) in which injectables are prepared.

**Identify high risk  
procedures and risk reduction strategies**

**STEP 2 – Product Risk Factor Assessment**

Carry out a baseline assessment of individual injectable products stocked and used in a near patient area.

**Identify high risk  
injectable products.**

**STEP 3 - Identify Risk Reduction Measures**

**STEP 4 - Implement Risk Reduction Measures**

**STEP 1**

Risk Assessment of Local Risk Factors For Preparing and Administering Injectable Medicines	X = Risk Present	Suggested Risk Reduction / Elimination Strategies for Local Risk Factors with Injectable Medicines	Implementation Comments and Timetable
<b>Name of Near Patient Area</b>			
Use of "Open systems" (i.e. the solution under preparation comes into contact with the open air*)		Introduce closed systems	
Preparation of a cytotoxic drug outside of a safety cabinet/isolator (unless using a "closed system" licensed specifically for use in this way)		Prepare all cytotoxics drugs in an approved safety cabinet or use closed system products that can be prepared in near patient areas	
Preparation of / addition to Parenteral Nutrition, outside a pharmacy aseptic unit(unless using a "closed system" licensed specifically for use in this way)		Prepare all additions to TPN in a pharmacy aseptic unit or use closed system products that can be prepared in near patient areas	
Administration of a single container of a prepared injectable lasting more than 24 hours		Eliminate the use of single container parenteral products prepared in near patient areas with expiry dates of greater than 24 hours	
Admixture of two or more "active" medicines without pharmaceutical approval of compatibility		Discontinue the admixture of two or more medicines without pharmaceutical approval or compatibility information	
Use of an infusion pump indicated but not used		Ensure that adequate numbers of infusion pumps and syringe drivers are available for use, and users have knowledge of when this equipment should be used	
Use of unlabelled syringes and / or infusion bags (unless allowed by practice guideline)		Re-inforce and audit policy to ensure all parenteral syringes and infusions are labelled for use	
Use of an injectable medicine ampoule, vial or infusion to prepare more than a single dose (unless the product is specifically licensed for use in this way)		Re-inforce and audit policy to ensure that single use products are only used to prepare a single dose.	
Use of an unlicensed medicine or "off label" use of a licensed medicine (unless specifically approved by a written organisational protocol)		Re-inforce and audit policy on the use of 'off-label' injectable medicines. Ensure approved protocols include BNF-C recognised off label usage	
All or part of the preparation process is unfamiliar to the average operator (e.g. prepared by any individual fewer than six times in twelve months)		Re-inforce and audit policy on infrequently used products and make alternative arrangements for the preparation and administration of these medicines	
<b>Risk assessment undertaken by : Date</b>		<b>Name of pharmacist:</b>	<b>Name of clinical practitioner</b>

The identification of any local risk factor in the clinical area provides a high risk baseline for the preparation of injectables. Each risk factor present should be eliminated. Where this is not possible awareness of the implications should be raised at Risk Management / Drug and Therapeutics Committee level. Healthcare organisations may choose to ratify the practice whilst recognising the risks.

# NPSA Injectable Medicines Risk Assessment Tool

## STEP 2

NPSA Risk Assessment Of An Individual Injectable Product		
<b>Name of Near Patient Area</b>		
<b>Name and Strength of Injectable Medicine Product</b>	<b>Manufacturer</b>	<b>X =Risk Present</b>
<b>Therapeutic risk</b> - where there is a higher risk of patient harm if the medicine is not used as intended e.g., cytotoxic, opioid, vasoactive, concentrated electrolytes, insulin or heparin infusions, drug therapy that is nephrotoxic or having a narrow therapeutic index.		<input type="checkbox"/>
<b>Use of a concentrate</b> - where after reconstitution further dilution is required before use		<input type="checkbox"/>
<b>A complex calculation</b> - e.g. double dilution or complex rate of administration such as microgram/kg/hour		<input type="checkbox"/>
<b>A complex method</b> - e.g. non-standard diluent, syringe to syringe transfer, more than 5 manipulations involved		<input type="checkbox"/>
<b>Reconstitution of powder in a vial</b> - where a dry powder has to be reconstituted with a liquid		<input type="checkbox"/>
<b>Use of more than one or part use of a vial or ampoule</b> - eg. 5ml required from a 10ml vial or four x 5ml ampoules required for a single dose		<input type="checkbox"/>
<b>Use of a pump with associated calculation</b> - All pumps require some element of calculation and therefore have error potential. However this potential is considered less significant than the risks associated with not using a pump when indicated.		<input type="checkbox"/>
<b>Use of non standard giving set</b> (eg.light protected or low adsorption )		<input type="checkbox"/>
<b>Total Number of Product Risk Factors</b> Six or more risk factors = High Risk Product ( <b>Red</b> ). Risk reduction strategies are required to minimise these risks. Three to five risk factor = Moderate Risk Product ( <b>Amber</b> ). Risk reduction strategies are recommended. Less than three risk factors = Lower Risk Product ( <b>Green</b> ). Risk reduction strategies should be considered		Total  <div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto;"></div>
<b>Risk assessment undertaken by :</b> <b>Name of pharmacist:</b> <div style="display: flex; justify-content: space-between;"> <span><b>Date:</b></span> <span><b>Name of senior clinical practitioner:</b></span> </div>		

## NPSA Risk Assessment Tool for Injectable Medicines

### STEP 3

#### **NPSA Risk Reduction Measures That Can be Used to Minimise Risks With Injectable Medicine Products**

##### **Provide READY TO ADMINISTER or READY TO USE injectable products**

Licensed products should always be used in preference to unlicensed products, where available. If licensed products are not available, use of unlicensed presentations should be considered in order to mitigate risks

##### **Provide Appropriate Written Procedure-Specific Guidance**

When coupled with competency assessment, this will reduce the risks associated with, for example, complex preparation methods and calculations.

##### **Provide Organisational Approved Protocols**

Continued use of practices identified as carrying inherent risks e.g. "off label" drug use, unfamiliar infrequently-used preparation processes or any local risk factors (see step 1) should only be allowed when supported by organisationally approved protocols which state clearly the circumstances in which they are and are not acceptable

##### **Check Purchasing Appropriateness**

Ensure that where there is a choice of licensed products, the safest e.g. the most appropriate vial /ampoule size is purchased and available to ensure that preparation is as simple and as safe as possible

##### **Provide Dose Calculating Tool**

The risk of mistakes in complex calculations can be mitigated by the use of validated dose calculating tools and charts. Instructions for correct use of these aids must also be provided

##### **Ensure Availability of Pumps & Non Standard Giving Sets where indicated**

Set up a device library (NPSA 2004) or similar system to ensure the availability of the right device at the right time and facilitate effective management and safe use of all devices at all times

##### **Introduce 'Smart' Infusion Pump/Syringe Driver Software**

Error limiting software is available for many electronic devices. Administration risks will be reduced by its use. Bar coding and auto identification technologies will minimise errors associated with misidentification of products and patients.



