

# Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

Name of organisation	Audit prepared by	Date

## Actions

Committees with responsibility for medication safety processes are advised to ensure their organisation fulfils the following action points.

Actions	Compliance	Date action taken
1. Disseminate the high risk medicines 'WRONG ROUTE ADMINISTRATION OF ORAL LIQUID MEDICINES <b>ALERT</b> ' to relevant committees with responsibility for the review and action of these recommendations.	Relevant committees:	
2. Assess the benefits and risks of current practices for oral liquid medicine administration.  Identify areas of risk that require urgent review.	Priorities for review:  1.  2.  3.	
3. Develop or review guidelines on oral liquid medicines in accordance with the <b>ALERT</b> recommendations. Include: <ul style="list-style-type: none"> <li>• dispensing</li> <li>• distribution</li> <li>• administration.</li> </ul>		

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

# Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

## Actions

Committees with responsibility for medication safety processes are advised to ensure their organisation fulfils the following action points.

Actions	Compliance	Date action taken
4. Ensure a formal process exists for approving guidelines and information sheets, before use, in your organisation.	Documents requiring approval: <ul style="list-style-type: none"> <li>▪</li> </ul>	
5. Ensure the dissemination of guidelines for oral liquid medicine use to all relevant clinical staff. Assess systems for training and competency, including: <ul style="list-style-type: none"> <li>▪ orientation programs</li> <li>▪ continuing education programs</li> <li>▪ competency assessments.</li> </ul>	Dissemination of guidelines to: <ul style="list-style-type: none"> <li>▪</li> </ul>	
6. Maintain adequate supplies of oral dispensers.	Ensure the relevant oral dispenser supplier maintains supplies of oral dispensers and any adaptors or connectors required.	
7. Provide effective communication to all relevant staff of changes to processes for oral liquid medicines preparation and administration.	Relevant staff are aware of processes for preparation and administration of oral medicines.	
8. Design or review incident reporting processes.	Ensure that the reporting process is designed to capture wrong route errors and near misses.  Use reported events to develop error prevention strategies.	

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines **AUDIT tool**

From the Victorian Medicines Advisory Committee

### Actions

Committees with responsibility for medication safety processes are advised to ensure their organisation fulfils the following action points.

Actions	Compliance	Date action taken
9. Provide feedback to committees with responsibility for action.	Feedback/ results of audit sent to:	
10. Use the findings of the audit tool to monitor oral route administration of oral liquid medicines and review regularly.	Committee to initiate next review:  Date of next review:	

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
1. Identify devices as 'oral dispensers' <b>NOT</b> oral syringes, and actively promote the use of oral dispensers.	<ul style="list-style-type: none"> <li>▪ Promotional materials</li> <li>▪ Guidelines</li> <li>▪ Training and education materials</li> </ul>	<ul style="list-style-type: none"> <li>▪ Random clinical area audit of promotion materials</li> <li>▪ Random clinical staff survey</li> </ul>	Materials reviewed: <ul style="list-style-type: none"> <li>▪</li> </ul> Staff surveyed: <ul style="list-style-type: none"> <li>▪</li> </ul>		

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines **AUDIT tool**

From the Victorian Medicines Advisory Committee

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
<p>2. Oral liquid medicine administration guidelines should articulate items below.</p> <p>Oral dispensers should be:</p> <ul style="list-style-type: none"> <li>▪ clearly distinguished from IV syringes by colour and shape</li> <li>▪ labelled 'FOR ORAL/ENTERAL USE ONLY'</li> <li>▪ not be able to be connected with IV access devices</li> <li>▪ able to be connected with all enteral tubing (if using an adaptor ensure it cannot be connected to IV tubing).</li> <li>▪ Oral dispensers should be readily available in clinical areas, preferably located near oral</li> </ul>	<ul style="list-style-type: none"> <li>▪ Guidelines</li> <li>▪ Clinical staff awareness of oral dispensers and their appropriate usage</li> <li>▪ Oral dispensers are labelled appropriately and are clearly distinguishable from IV syringes</li> <li>▪ Oral dispensers readily available on wards</li> </ul>	<ul style="list-style-type: none"> <li>▪ Conduct a clinical staff survey on implementation and distribution of guidelines for oral liquid medicine administration.</li> <li>▪ Random clinical area audit to ensure oral dispensers are available, appropriate and visible for use with oral liquids.</li> </ul>	<p>Number of clinical staff with awareness of guidelines:</p> <p>Number of clinical staff surveyed:</p> <p>Number of clinical areas audited:</p> <p>Number of clinical areas with oral dispensers readily available:</p> <p>Number of clinical areas audited:</p>		

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines **AUDIT tool**

From the Victorian Medicines Advisory Committee

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
liquids and away from intravenous syringes.					
3. Oral dispensers should be used for: <ul style="list-style-type: none"> <li>▪ All oral liquid doses where the volume is too small to be measured in a measuring cup or there is a need for strict accuracy</li> <li>▪ all oral liquid medicines for administration via an enteral line</li> <li>▪ all oral liquid medicines that are also available in IV formulations</li> <li>▪ all oral liquid medicines administered to patients that also have IV access devices in situ.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Oral dispensers being used for oral liquid medicines</li> </ul>	<ul style="list-style-type: none"> <li>▪ Survey or spot check</li> </ul>			

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
4. Confirm oral dispensers are unable to be connected with IV devices.	<ul style="list-style-type: none"> <li>▪ Incompatibility</li> </ul>	<ul style="list-style-type: none"> <li>▪ Practical assessment</li> </ul>			
5. Confirm oral dispensers are able to be connected with all enteral tubing.	<ul style="list-style-type: none"> <li>▪ Report on nasogastric</li> <li>▪ Percutaneous endoscopic gastrostomy (PEG)</li> <li>▪ Jejunostomy tube</li> <li>▪ Paediatric tubing</li> <li>▪ Other</li> </ul>	<ul style="list-style-type: none"> <li>▪ Spot check</li> </ul>			

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
6. If an adaptor is required for oral dispenser to <b>fit enteral</b> tubing, check that the adaptor is NOT able to be connected with <b>intravenous</b> tubing.	<ul style="list-style-type: none"> <li>▪ Report</li> <li>▪ Incompatibility</li> </ul>	<p>If adaptor is required, ensure these are available with oral dispensers.</p> <p>Random clinical area audit.</p>	<p>Number of clinical areas with adaptors conveniently located with oral dispensers:</p> <p>Number of clinical areas audited:</p>		
7. Document method and quantity of oral dispensers to be supplied and reordered to each clinical area.	<p>Guidelines.</p> <p>Batch order sheets.</p> <p>Maximum/minimum re-order values.</p>		<p>Number of clinical areas with appropriate quantities of oral dispensers according to maximum/minimum re-order values.</p> <p>Number of clinical areas audited.</p>		
8. Document whether oral dispensers require sterile packaging.	<p>Guidelines.</p>				

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

### Recommendations

The following recommendations are standards that **SHOULD** be implemented in organisations that administer oral liquid medicines to patients.

Standard	What to audit	How to audit	Audit results	Standard implemented: Fully/ Partially/ No	Actions required for implementation
9. Document whether oral dispensers will be single use or single patient use, and if single patient use include details for cleaning and replacement.	Guidelines.				
10. Supply oral dispensers to patients or carers, especially those who have an IV site in situ, and are required to administer oral liquid medicines at home.	Dispensary audit				

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

### Considerations

The following consideration points are suggestions that MAY be appropriate to implement dependant on assessment of current practice.

Standard	What to audit	How to audit	Audit results	Consideration implemented Fully/ Partially/ No	Actions required for implementation
1. Where possible, provide a forcing function, such as bottle adaptor caps or straw, to oral liquid bottles dispensed/ delivered from pharmacy.	Clinical area audit.  Dispensary audit.	Random clinical area audit of oral liquid products on stock of appropriate oral liquid medicines.	Number of bottles in clinical areas with bottle adaptor caps attached:  Number of bottles audited:		
2. Consider alternative preparation techniques of oral liquid medicines for which the use of oral dispensers is not appropriate.	List of medications for which oral dispensers are not appropriate, for example, viscous liquids or crushed medicines prepared into slurries.	Random audits			

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

## Wrong route administration of oral liquid medicines **AUDIT tool**

From the Victorian Medicines Advisory Committee

### Considerations

The following consideration points are suggestions that **MAY** be appropriate to implement dependant on assessment of current practice.

Standard	What to audit	How to audit	Audit results	Consideration implemented Fully/ Partially/ No	Actions required for implementation
3. Consider a second verification for oral liquid medicines at the bedside to ensure safe oral administration.	Guidelines.	Random medication chart audit for double signature on oral liquid medicine administrations.	Number of medication charts with double signatures for oral liquid medicines:  Number of liquid medication chart administrations audits:		
4. Consider a patient information sheet for the rationale and method of use of oral dispensers for patients requiring these on discharge.	Guidelines  Patient information sheet				

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.

# Wrong route administration of oral liquid medicines AUDIT tool

From the Victorian Medicines Advisory Committee

## Review of patient safety incident data involving wrong route administration of oral liquids

Clinical outcome	Number of reports
Death	
Permanent harm	
Significant harm requiring treatment	
Temporary harm – minor treatment	
No harm – near miss	

## Overall comments and actions recommended by clinical governance

**Auditor:**

**Signature:**

**Date:**

**Next audit review date:**

The **QUALITY USE OF MEDICINES PROGRAM** provides health professionals and administrators with tools for improving the administration and safety of high risk medicines that have the potential to cause serious or catastrophic harm to patients. Use this **TOOL** for the development of appropriate local responses for the safe use of high risk medications.