# Safety Notice 017/23

**Issue date**
**27 July 2023**

**Distributed to:**
Chief Executives
Directors of Clinical Governance
Director, Regulation and Compliance Unit

**Action required by:**
Chief Executives
Directors of Clinical Governance

**We recommend you also inform:**
- NSW Health Pathology Laboratory Managers
- Directors of: Medical Services; Pharmacy; Nursing and Midwifery
- Nurse/Midwifery Unit Managers
- Blood Management Committees
- Drug and Therapeutics Committees

All other relevant clinicians and clinical departments where these products are prescribed, stored and administered.

**Expert Reference Group**

**Content reviewed by:**
NSW Blood Management Clinical Advisory Committee

**Clinical Excellence Commission**
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**Review date**
**August 2024**

## Intravenous and subcutaneous Immunoglobulins (IVIg and SCIg): Potential for error: look-alike / sound-alike

### Situation

There is the potential for errors involving four IVIg and SCIg products bearing look-alike packaging and sound-alike names.

**Privigen and Privigen AU** and **Hizentra and Hizentra AU**

### Background

In NSW IVIg products are provided to eligible patients under the National Blood Supply Arrangements. Under these arrangements, procurement of both domestic and imported IVIg products is overseen by the National Blood Authority (NBA). Two new products have been procured, Privigen® AU in April 2023 and Hizentra® AU from August 2023.

### Assessment

These similarly named products are different products. Domestic and imported products are NOT interchangeable. Patients receiving product under the National Blood Supply Arrangements must only be prescribed, dispensed and administered the IVIg or SCIg product authorised for them in the NBA BloodSTAR system. See Figures 1 and 2 below.

*Figure 1*


*Figure 2*


### Clinical Recommendations

It is recommended that clinicians involved in the prescribing, dispensing and administration of these products be made aware of the risk of selection error due to their look-alike presentation. Local risk mitigation strategies are to be

employed to minimise the risk of selection errors. Recommendations include:

In accordance with NSW Health Policy Directive Medication Handling PD2022_032:

- Clinicians should adhere to local policy regarding safe and accurate medication administration, including the 6 Rights (right patient, right drug, right dose, right time, right route and right documentation) and independent second person checks. These checks should include (but are not limited to) carefully reading the medication label to verify the name, strength, form and route of administration against the medication order, and NOT rely on packaging or label recognition.
- Reviews of IVIg and SCIg storage equipment (e.g., trolleys/areas, dispensary shelves and laboratory fridges) should be regularly performed to ensure medicines are in their correct locations and any look alike medicines are appropriately flagged and physically separated.

Consider the Australian Commission on Safety and Quality in Health Care (ACSQHC) Principles for the safe selection and storage of medicines, including (but not limited to):

- Physically separating different medicines and strengths in storage areas by using shelf dividers or positioning in separate drawers or shelves. Storage of look-alike medicines within the same multiple compartment drawer should be avoided (including within automated dispensing cabinets).
- Utilising barcode scanning to conduct checks when restocking automated storage systems, and during the dispensing process in Pharmacy Departments.
- Considering the use of additional warning labels on shelving to differentiate products and to alert the potential risk of selection error involving look alike products (e.g., 'PLEASE CHECK CAREFULLY – product with a similar name or appearance').

Specifically, for IVIg and SCIg, all product and identity checks must be in accordance with NSW Policy Directive Blood Management PD2018_042:

- Second person patient identity and product verification checks
- Patients collecting SCIg for use at home should be educated to ensure they can identify the correct SCIg product.

## Required actions for the Local Health Districts/Networks

1. Distribute this Safety Notice to all relevant clinicians and clinical departments where IVIg and SCIg products may be dispensed, stored or administered.
2. Report any incidents associated with these products via the local incident management system (e.g., ims+) and to the TGA.