NSW Health

Safe prescribing and administration of palliative care syringe drivers

SAFETY INFORMATION 008/24

Issue Date:	25 November 2024
Distributed to:	Chief Executives; Directors of Clinical Governance
KEY MESSAGE:	To provide recommendations to NSW Health clinicians regarding the safe prescribing and administration of syringe drivers in palliative care.
ACTION REQUIRED BY:	Chief Executives, Directors of Clinical Governance.
REQUIRED ACTION:	1. Distribute this Safety Information to all relevant clinicians and clinical departments for awareness. 2. Drug and Therapeutics Committees should consider the information and recommendations contained within this Safety Information in consultation with relevant clinicians and the local eMeds/ICT team. 3. Escalate any concerns to CEC-MedicationSafety@health.nsw.gov.au. 4. Report any incidents associated with the prescribing and administration of palliative syringe drivers via the incident management system (e.g., ims+).
DEADLINE:	N/A - For information only
We recommend you also inform:	Directors, Managers and Staff of: • Palliative Care • Medical Services • Nursing and Midwifery • Community nursing • Pharmacy Drug and Therapeutic Committees Chief Information Officers Chief Clinical Information Officers All other relevant clinicians and clinical departments.
Website:	https://www.health.nsw.gov.au/sabs/Pages/default.aspx http://internal.health.nsw.gov.au/quality/sabs/index.html
Review date:	November 2026

Contact: Clinical Excellence Commission
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CEC-MedicationSafety@health.nsw.gov.au

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Situation

There is a risk of medicines intended for subcutaneous infusion over 24 hours via a syringe driver being administered as individual bolus injections. Contributing factors include:

- Unfamiliarity with palliative care syringe driver prescribing and administration practices within the local facility (especially relevant when clinicians rotate between facilities with different practices).
- The use of both electronic and paper-based systems for syringe driver prescribing ('hybrid' systems).
- Lack of communication between the medical and nursing teams in confirming the syringe driver medication order.

This has led to a review of prescribing and administration practices related to syringe drivers across NSW Health facilities, with a focus on ensuring their safe and appropriate use in palliative care settings.

Background

In the palliative care setting, syringe drivers are used to deliver medicines to patients subcutaneously at a continuous rate, usually over a 24-hour period. Syringe drivers eliminate the need for repeated doses of medicines, minimise fluctuations in drug therapeutic levels and can be used to administer multiple medicines concurrently. Syringe drivers are commonly used in palliative care for patients with swallowing difficulties, altered level of consciousness, weakness and poor absorption of oral medicines.

Assessment

Syringe drivers play a significant role in palliative care by providing continuous and effective medication management for patients. While there are numerous benefits of using syringe drivers in this setting, there are a number of important safety considerations that clinicians should be aware of.

Within NSW Health facilities, there are differing practices related to the prescribing and administration of palliative care syringe drivers. Currently there are facilities that prescribe palliative care syringe drivers in electronic Medication Management (eMM) systems while other facilities continue with paper-based prescribing. These variations may result in prescribing and administration errors and contribute to delays in treatment. Clinicians often move between wards/facilities/Local Health Districts (LHDs)/Specialty Health Networks (SHNs) and unfamiliarity with local practices related to syringe drivers may lead to errors that impact patient safety.

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Recommendations

- Local practices related to the prescribing and administration of palliative care syringe drivers should be documented clearly, particularly where hybrid systems are used (that is, use of both paper charts and eMM systems).
- 'Quick Reference Guides' or equivalent resources related to the prescribing and administration of palliative care syringe drivers should be available to clinicians.
- All staff responsible for prescribing, preparing and administering palliative care medicines via syringe drivers should receive comprehensive training and education. Rotational, after-hours and casual staff working in palliative care settings should be aware of local policies, guidelines and resources related to prescribing and administering syringe drivers.
- When prescribing syringe drivers, advice from the palliative care team should be sought to ensure the treatment protocol is safe and appropriate for the patient, and to assist with the prescribing process.
- Where the prescribing and administration of syringe drivers occurs within eMM systems, it is recommended that the medication order specify the route and frequency of administration in the following way (as recommended by the ACI Palliative Care Network and supported by the eHealth NSW Medication Management Continuous Improvement Design Working Group):
    - Route of administration: 'Subcutaneous infusion via SYRINGE driver'
    - Frequency: 'Infuse over 24 hours'.
- The wording recommended above for route of administration and frequency should also be applied when the prescribing and administration of syringe drivers occurs on a paper chart.
- Where a medication order is unclear, the administering clinician should contact the prescriber to clarify and/or amend the medication order prior to administration.
- Clinicians should adhere to their local policy/guidelines regarding the prescribing and administration of syringe drivers in palliative care settings, including independent second person check procedures where applicable (see NSW Health Medication Handling Policy Directive (PD2022_032)).

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