Kent and Medway Cancer Network

Network Guidance Document

Systemic Anti-cancer Therapy Care Pathway

Intrathecal

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Contents

Intrathecal Systemic Anti-Cancer Therapy

Individual Trusts within the Kent & Medway Cancer Network have a separate policy for the administration of intrathecal systemic anti-cancer therapy within that Trust to cover the individual operational aspects of the preparation, supply, prescribing, checking, administration and training of personnel involved in the administration of intrathecal systemic anti-cancer therapy.

Each Trust within the Kent & Medway Cancer Network will assess annually the number of intrathecal administrations which have been undertaken over the previous 12 months. If the number falls below 10 per year, a risk assessment for all those involved in the process of administration in intrathecal systemic anti-cancer therapy will be undertaken. This assessment should be repeated on an annual basis.

Under no circumstances should any Trust within the Kent & Medway Cancer Network administer intrathecal systemic anti-cancer therapy to children under the age of 16 years. All intrathecal systemic anti-cancer therapy for children and adolescents will be administered at the Paediatric Oncology Centre.

A written local protocol covering all aspects of the national guidance from prescribing through to administration should be produced.

For copies of these National guidelines please visit http://www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrr/using-vinca-alkaloid-minibags/, and http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_086870, and refer to local Trust policy.

On 31st January 2011, the NPSA issued an alert around the use of safer spinal (intrathecal), epidural and regional devices NPSA/2011/PSA001
There have been fatal cases where intravenous medicines have been administered by the spinal (intrathecal) route, and where epidural medicines have been administered by the intravenous (vein) route.

There is also the potential for medicines intended for regional anaesthesia to be administered by the intravenous route, with fatal outcomes.
This Patient Safety Alert builds on previous safe practice guidance to further minimise the risk of these wrong route errors.
All NHS healthcare organisations are asked to ensure that:

- from 1 April 2012 all spinal (intrathecal) bolus doses and lumbar puncture samples are performed using syringes, needles and other devices with connectors that **cannot** connect with intravenous Luer connectors (Part A)
- from 1 April 2013 all epidural, spinal (intrathecal) and regional infusions and boluses are performed with devices that use safer connectors that **cannot** connect with intravenous Luer connectors or intravenous infusion spikes (Part B)

This Patient Safety Alert is being issued in two parts to allow two separate timescales for implementation

The European Medicine Agency also highlighted in January 2012 that Bortezomib had been given by the spinal route, leading to patient death.

It is recommended that NHS organisations record the risk and consider adding the necessary information to their training programmes.

NHS organisations will need to review and update their procedures and clinical protocols to include the use of devices with safer connectors, and clearer labelling for Bortezomib.

This Patient Safety Alert is being issued in two parts to allow two separate timescales for implementation

See link below to access full details

http://www.nrls.npsa.nhs.uk/resources/?entryid45=94529&p=3

In March 2012 the NPSA issued an alert 'Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors' NPSA/2011/RRR003

For IMMEDIATE ACTION by all organisations in the NHS and independent sector who use spinal, epidural and regional devices. Deadline for ACTION COMPLETE: 31 March 2012.

1. Alert healthcare staff who order, receive, transport, restock and clinically use spinal, epidural and regional devices of the risk of mis-matching connectors.

2. Check current stocks of spinal, epidural and regional devices to ensure these devices are compatible.

3. Amend written distribution and clinical procedures to confirm the identity of the connectors used in devices. Checks should not solely rely on catalogue code numbers. The term 'Luer' and where neuraxial connectors are fitted, the device trademark should be used to identify different connector designs. Currently Correctinject, Hall Lock, Neurax, Surety, UniVia are trademarks being used. Only devices with the same connector descriptors are compatible. In addition, other design elements such as colour, text and symbols should assist users to identify the type of connector used in the device.

4. Use procedure packs where feasible and appropriate to ensure that all the devices required for a specified procedure are compatible and readily available.

5. Recommend clinical staff check all devices required for a procedure are fitted with the same connector design before commencing the procedure.

See link below for further details

http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/patient-treatment-procedure/?entryid45=132897

Document Administration

Approval Record

Approval		
Date	**Name / Title**	**Signature**
07/05/09	Circulated for comments and feedback to Network Systemic anti-cancer therapy Group, Network Nursing and Pharmacy Group and local Trust Systemic anti-cancer therapy groups	
21/05/09	Ratified at Network and Pharmacy Sub-group	
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Document Location

The document is located in the Kent and Medway Cancer Network office, in hardcopy and in electronic format on the Kent & Medway Cancer Network website at www.kentmedwaycancernetwork.nhs.uk

DATE OF NEXT REVIEW

This item is next to be reviewed in **April 2013** by Network Macmillan Senior Chemotherapy Nurse Specialist

Revision History

Date	Version	Status	Author	Summary of Changes
1/04/09	V0.1	Draft	Bryony Neame	Words 'chemotherapy, cytotoxic and monoclonal' replaced by 'systemic anti-cancer therapy' to reflect NCEPOD report
1/04/09	V0.1	Draft	Bryony Neame	Most updated links to relevant documents inserted
28/05/09	V0.2	Draft	Bryony Neame	Wording changes made as suggested by Kent Oncology Centre systemic anti-cancer therapy staff. No operational changes.
28/05/09	V1	Published	Bryony Neame	
02/12/09	V2	Final	Bryony Neame	Addition of NPSA alert for intrathecal devices to include link
10/04/2012	V2.1	Draft	Bryony Neame	Update of NPSA alert re administration from 2009 to 2011 version Addition of NPSA alert re spinal needles 2012