Medication Safety Notice

Issued by Medicines and Technology Programs, SA Health
www.sahealth.sa.gov.au/medicationsafety

A patient **Safety Notice** strongly advises the implementation of particular recommendations or solutions to improve quality and safety.

We recommend you inform:

- Chief Executives
- General Managers
- Directors of Pharmacy
- Medical Directors
- Nursing/Midwifery Directors
- Safety and Quality Directors
- Clinical Directors
- Medical Officers
- Pharmacists
- Nurses/Midwives

Contact details:

T: (08) 8204 1944

F: (08) 8226 6235

Government of South Australia
SA Health

Adrenaline 1 in 10,000 prefilled syringe - Link Brand

- An SLS incident report has been received regarding failure of 2 syringes of adrenaline 1 in 10,000 prefilled Link brand syringes leading to a delay in administration during a resuscitation procedure.
- In both, the staff were unable to expel any liquid from the syringes.
- The blockage appears to be in the tip of the syringe and can't be seen without removing the cap and interlink connector on the end of the syringe.
- Not all syringes of this brand appear to be affected as others were able to be used without issue.

Action required by SA Health professionals:

1. Be aware of the contents of this notice and there may be potential for delay in administration of adrenaline if the Link brand of prefilled syringes is used.
2. If problem is observed it should be reported to Safety Learning System (SLS) and the Therapeutic Goods Administration (TGA).

Action Required by SA Health Services:

1. As a precaution, while this is investigated further, SA Pharmacy has reviewed the pharmacy stocks and ward imprest holdings across sites where the Link brand has been issued and have replaced the syringes with an alternative brand.
2. **However there may also be stock held in other locations including emergency trolleys and other ward locations where it may have been moved to beyond the imprests.**

   If so, it is recommended ward/clinical staff check these locations and seek replacement stock from your Pharmacy for any Link brand preloaded syringes.

3. Ensure all staff have access to this notice and undertake actions accordingly.

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