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Medication Safety Bulletin

The Medication Safety Bulletin (MSB) is published by the HA Medication Safety Committee (MSC) biannually (May and Nov) as an educational publication to share issues related to medication safety. Please refer to the HA Risk Alert (HARA) for sharing of medication incident cases reported in HA.

Inside this issue:

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Hospital Authority Medication Safety Forum 2025 Highlights

While HA Medication Safety Forum 2025 was cancelled, the full suite of speakers' slides and abstracts is now available on the HADF and CPO Intranet. You are encouraged to browse these resources for best practice dissemination and mutual learning.

The Digital Defenses

The Kowloon East Cluster **(KEC)** presents a compelling case for the **SMART Infusion Pump Dashboard**. Inventory management also gets a digital update: the New Territories East Cluster **(NTEC)** showcases a **"Smart Drug Replenishment"** system, while the Kowloon West Cluster **(KWC)** introduces a **bar-coded tool** to enforce accuracy in pharmacy stock management. Binding these innovations together, Health Informatics **(HI)** advocates the philosophy of **"Less Clicks, More Care"** in the Clinical Management System.

The Human Element

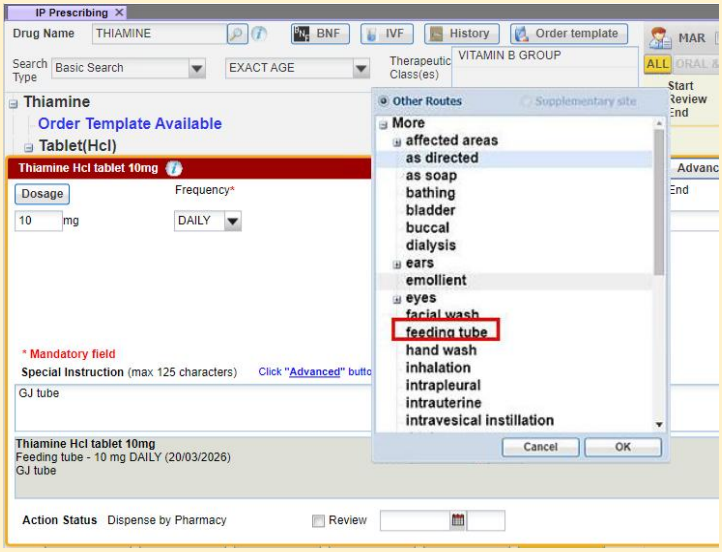
Beyond the code, the forum addresses the "heartware" of safety. The New Territories West Cluster **(NTWC)** abstracts offer a practical guide to **"Building a Medication Safety Culture"**, extending the focus from system to people. This cultural reinforcement is complemented by the Head Office Nursing Services Department's **(HO NSD)** strategy to promote **safety among nurses**, and the Hong Kong West Cluster's **(HKWC)** strategic approach to **bridging gaps in high-alert medication safety**. The Hong Kong East Cluster **(HKEC)** offers critical insights through **collaborative case sharing on high-risk medications**, ensuring institutional memory is preserved. Finally, the Kowloon Central Cluster's **(KCC)** targets a specific high-alert medication with their dedicated campaign on **Insulin Safety**.

In a changing healthcare landscape, the most resilient system is one that learns continuously

New Generic Route/Site "Feeding Tube 餵飼管" in Medication Order Entry System

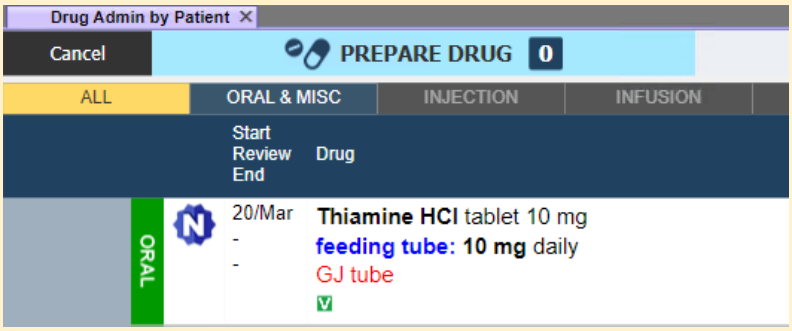
To balance different feeding tubes with medication safety, a **new generic route/site "feeding tube 餵飼管"** is added on **27 August 2025**. Clinicians may supplement free-text remarks for additional details, when necessary. **Existing** route/sites -- nasogastric (**NG**) tube & percutaneous endoscopic gastrostomy (**PEG**) tube are **retained**.

1. Prescribing



2. Dispensing

3. Administration



Overseas Alert to Fatal Risk of Tranexamic Acid Intrathecal Injection

Global regulators issue urgent warnings as Tranexamic Acid intrathecal injection proves fatal

The US Food and Drug Administration (FDA), the European Medicines Agency (EMA), and Singapore's Health Sciences Authority (HSA) have issued warnings regarding the inadvertent intrathecal injection of Tranexamic Acid – a medication error that transforms a life-saving antifibrinolytic into a potent neurotoxin.

The Global Response

Regulatory bodies are moving from observation to intervention.

- **US FDA (10/2025):** Has mandated stricter labelling requirements to explicitly **warn against neuraxial administration**, citing a series of life-threatening injuries.
- **EMA (10/2025):** Recommends **enforcing clear differentiation** and **separate storage of Tranexamic Acid from intrathecal medications**.
- **HSA (1/2026):** Emphasises that Tranexamic Acid injection is **authorized solely for intravenous use** and warning of the fatal risks of inadvertent intrathecal injection of Tranexamic Acid.

Key Updates on *HA Guidelines on Safe Medication Management – Prescribing, Dispensing and administration*

1. All Sections: Standardisation of terminology	
From	**To**
Tall man lettering	TALL man lettering

2. Prescribing guidelines	
Clause	**Key Updates**
1.1.10 1.1.19	Refine the prescription requirements for parenteral medications – specify **dilution**, **injection duration** or **infusion rate** too, if applicable

3. Dispensing guidelines	
Clause	**Key Updates**
2.1.3	Refine the prescription requirements for parenteral medications – specify **dilution**, **injection duration** or **infusion rate** too, if applicable
2.1	Address the availability of **electronic prescriptions** for outpatients and inpatients
2.6.2	Address the availability of **electronic tickets** as a patient identifier when issuing medications to patients

4. Administration guidelines	
Clause	**Key Update**
3.6	Add **Electronic Injection Record**, **Immunization Record** and **Treatment Sheet** for documenting drug administration, other than Medication Administration Record (MAR) and Inpatient Medication Order Entry (IPMOE)

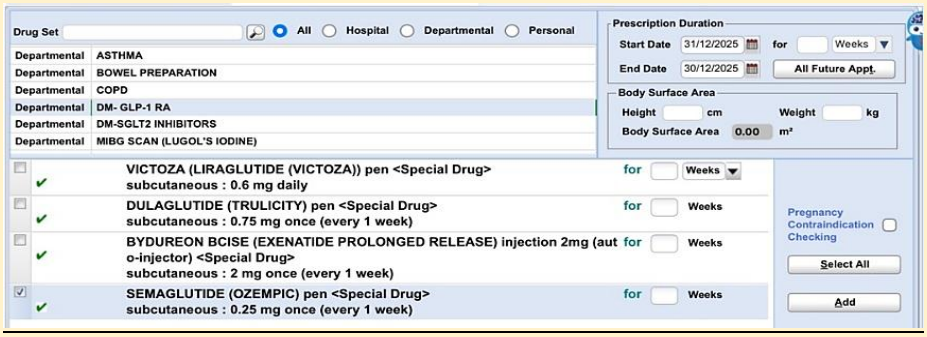
5. Annex I: Adverse drug reaction (ADR) reporting	
NEW	• Establish a framework for ADR reporting to Hospital Authority and Department of Health • Encourage the reporting of ADR cases, as follows: 1. suspected **serious** ADR 2. suspected ADR for **new drugs** and **complex biological medicines** 3. ADR resulting from suspected, clinically significant drug interactions not found in product information or labelling 4. ADR deemed medically significant by the healthcare professional 5. Unexpected ADR

6. Annex II: Guidelines for the Safe Use of Smart Cabinets	
NEW	• Standardise the priority uses, operational practice and general specifications of Smart Cabinets.

The guidelines are available on HADF Intranet and CPO Intranet. Consult your hospital pharmacist when necessary.

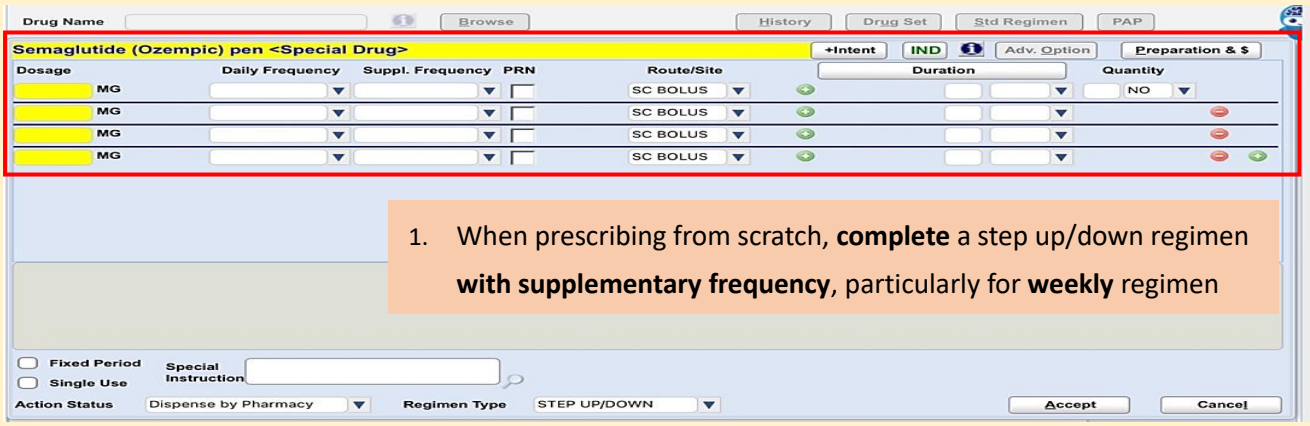
New Territories West Cluster's Sharing:
Beware of Supplementary Frequency in Step-up/Step-down Regimen

Case Sharing: A 35-year-old female patient with Diabetes Mellitus was newly prescribed with Semaglutide (Ozempic®) pen, a glucagon-like peptide 1 receptor agonist with subcutaneous administration once per week. While a departmental "drug set" with **weekly regimen** was used in Clinical Management System for prescribing, the clinician **intended to** prescribe **"step up/down" regimen** for dose titration, resulting in **prescribing from scratch**. The supplementary frequency was missed and Semaglutide was prescribed as a daily regimen.

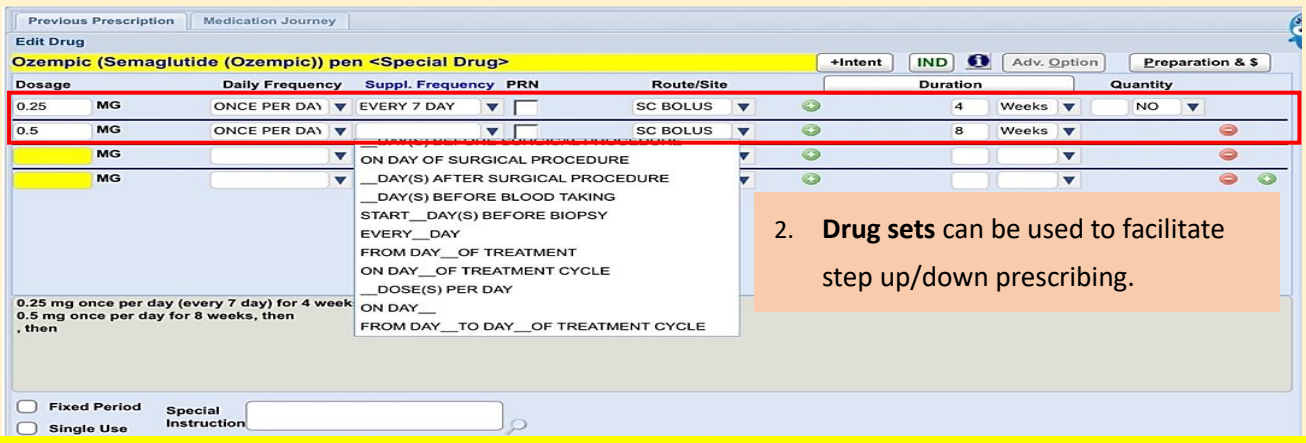


Incorrect prescription	OZEMPIC (SEMAGLUTIDE (OZEMPIC)) pen <Special Drug> subcutaneous : 0.25 mg once per day for 4 weeks, then 0.5 mg once per day for 8 weeks
Intended prescription	OZEMPIC (SEMAGLUTIDE (OZEMPIC)) pen <Special Drug> subcutaneous : 0.25 mg once per day (every 1 week) for 4 weeks, then 0.5 mg once per day (every 1 week) for 8 weeks

Points to note: When prescribing from scratch, clinicians should **complete** a step up/down regimen with **supplementary frequency**, particularly for **weekly regimen**. Departments are also encouraged to **prepare drug sets** for step up/down prescribing. Upon ordering through a drug set, clinicians may edit the dosage regimen based on the clinical condition of a patient.



1. When prescribing from scratch, **complete** a step up/down regimen **with supplementary frequency**, particularly for **weekly** regimen



2. **Drug sets** can be used to facilitate step up/down prescribing.

Take Home Message: Always remember to check the whole regimen details after prescribing