From the Deputy Chief Medical Officer
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Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Reference: HSC (SQSD) 16/22 **Date of Issue: 24th May 2022**

For Action:

Chief Executives HSC Trusts for onward transmission to:
- *community services*
- *mental health services*

Deputy Secretary, SPPG for onward transmission to:
- *general practices*
- *community pharmacy*

Chief Executive, PHA
Chief Executive, RQIA
Chief Executive, NIMDTA

Related documents

HSC (SQSD) 34/14 Risk of death or serious harm from accidental ingestion of potassium permanganate preparations

Implementation: 23 November 2022

DoH Safety and Quality Circulars including Patient Safety Alerts can be accessed on: https://www.health-ni.gov.uk/topics/safety-andquality-standards/safety-and-quality-standards circulars

Inadvertent oral administration of potassium permanganate

SUMMARY

NHS England and NHS Improvement (NHS E&I) has issued a Patient Safety Alert **NatPSA/2022/003/NHS** which highlights the risk of inadvertent oral administration of potassium permanganate.

ACTION

Chief Executives of HSC Trusts are asked to:

1. Disseminate this circular to relevant staff within your organisation.

2. Appoint an executive member of staff, supported by clinical leaders in dermatology, nursing, and pharmacy to oversee the implementation of the actions outlined below.

3. Review the overall use of potassium permanganate at trust/area Drugs and Therapeutics Committee, to consider if the benefit of use outweighs the risk.

4. Unless eliminating the use within the trust/locality, ensure procedures/guidelines for use of potassium permanganate align with all British Association of Dermatologists (BAD) recommendations, including:

a) In secondary care:

- Remove all stock supply (except for use within outpatient departments) and supply on a named patient basis only
- Potassium permanganate is prescribed as 'potassium permanganate 0.01% topical solution' and the dispensing label must include the warning 'HARMFUL IF SWALLOWED'
- Potassium permanganate is not stored with medicines for oral/internal use, including the ward drug trolley; dilution should occur away from the patient, and neither the concentrated form nor the diluted form, should be left near the patient.

b) All settings:

- Prescriptions are only issued by an appropriate prescriber
- If potassium permanganate is to be used in a patient's home, a risk assessment must be undertaken before prescribing
- All patients must be supplied with a patient information leaflet.

5. Please confirm that actions 1-4 above have been completed by returning a 3rd Line of Assurance Template to the Governance and Safety Directorate, Strategic Planning and Performance Group at Alerts.SPPG@hscni.net by 23rd November 2022

General Practitioners and Community Pharmacy are asked to:

1. Review the overall use of potassium permanganate in your practice to consider if the benefit of use outweighs the risk.

2. If potassium permanganate is to be used in a patient's home, a risk assessment must be undertaken before prescribing

3. Unless eliminating the prescribing /use , ensure that procedures/guidelines for use of potassium permanganate align with all British Association of Dermatologists (BAD) recommendations, including:
    - Prescriptions are only issued by an appropriate prescriber
    - Patients are not on repeat prescriptions for potassium permanganate
    - Prescriptions include clear instructions to dilute before use
    - Dispensing label includes the warning 'HARMFUL IF SWALLOWED'

- All patients must be supplied with a patient information leaflet.

Deputy Secretary of Strategic Performance And Planning Group should:

1. Disseminate this circular to all relevant staff including those in primary care.

2. Assess the Trust 3rd line assurance templates and the assurance that can be taken and address any concerns.

3. Notify the Quality, Safety and Improvement Directorate (qualityandsafety@health-ni.gov.uk) of the Department, of any ongoing concerns.

Chief Executive PHA should:

1. Disseminate this circular to all relevant PHA staff.

2. Ensure relevant professionals work with colleagues in SPPG to assess the Trust's 3rd line assurance template and the assurance that can be taken and work with SPPG to address any concerns.

Chief Executive of RQIA should:

1. Disseminate this circular to all relevant Independent Providers.

2. Implement relevant actions from this circular through the normal RQIA monitoring processes for assurance of implementation of guidance.

Chief Executive of NIMDTA should:

1. Disseminate this circular to doctors in training in all relevant specialties.

BACKGROUND

Potassium permanganate is routinely used in the NHS/HSC as a dilute solution to treat weeping and blistering skin conditions, such as acute weeping/ infected eczema and leg ulcers. It is not licensed as a medicine.

Supplied in concentrated forms, either as a 'tablet' or a solution, it requires dilution before it is used as a soak or in the bath. These concentrated forms resemble an oral tablet or juice drink and if ingested are highly toxic; causing rapid swelling and bleeding of the lips and tongue, gross oropharyngeal oedema, local tissue necrosis, stridor, and gastrointestinal ulceration. Ingestion can be fatal due to gastrointestinal haemorrhage, acute respiratory distress syndrome and/or multi-organ failure. Even dilute solutions can be toxic if swallowed.

HSC (SQSD) 34/14 issued by DOH in 2015 highlighted incidents where patients had inadvertently ingested the concentrated form, and risks in relation to terminology and

presenting tablets or solution in receptacles that imply they are for oral ingestion, such as plastic cups or jugs.

A review of the National Reporting and Learning System by NHS E&I over a two-year period identified that incidents of ingestion are still occurring. One report described an older patient dying from aspiration pneumonia and extensive laryngeal swelling after ingesting potassium permanganate tablets left by her bedside. Review of the other 34 incidents identified key themes including:

- healthcare staff administering potassium permanganate orally
- patients taking potassium permanganate orally at home, or when left on a bedside locker
- potassium permanganate incorrectly prescribed as oral medication.

The British Association of Dermatologists (BAD) 'Recommendations to minimise risk of harm from potassium permanganate soaks', includes advice on formulary management, prescribing, dispensing, storage, preparation and use, and waste.

The BAD patient Information leaflet is available here.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Safety Strategy Unit
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BELFAST
BT4 3SQ
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Yours sincerely

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Distributed for information to:

Chief Executive, NIAS
Medical Directors, HSC Trusts
Governance Leads, HSC Trusts
Executive Medical Director/Director of Public Health, PHA

Director of Nursing and Allied Health Professions, PHA
Director of Performance Management & Service Improvement, PHA
Safety and Quality Alerts Team, SPPG
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Director of Centre for Medical Education, QUB
Head of School of Pharmacy QUB
Head of School of Nursing, UU
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