Patient Safety Concerns & Best Practices from ECRI & ISMP that Support GEDSA's ENFit® & NRFit® Patient Safety Initiatives

Guidance from ECRI[1] & ISMP[2]

ISMP Best Practice #4: Ensure that all oral liquid medications that are not commercially available in unit dose packaging are dispensed by the pharmacy in an oral syringe or an enteral syringe that meets the ISO 80369 standard, such as ENFit.

ISMP Best Practice #5: Purchase oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale.

ISMP Best Practice #14: Seek out and use information about medication safety risks and errors that have occurred outside your facility, in other organizations, and take action to prevent similar errors.

ECRI Patient Safety Concern #9 - Misuse of Parenteral Syringes to Administer Oral Liquid Medications - Using parenteral syringes (i.e., syringes with Luer connectors that can be attached to needleless intravenous [IV] systems) in order to administer oral/ enteral liquid medications, presents a risk of wrong route misadministration if the syringe is mistakenly attached to and its contents injected into an IV line.

ECRI Patient Safety Concern #8 - **Delay in Care Resulting from Drug, Supply, and Equipment Shortages** - These shortages disrupt the ability to meet patient needs across the care continuum, often causing delayed treatment and services, worse patient outcomes, and increased health system costs.

Perspectives from GEDSA

Best Practice #4: ENFit syringes ensure that the risks of inadvertent tubing misconnections and wrong route administration errors are minimized.

Best Practice #5: Historically, many legacy oral syringes had both metric and teaspoon markings. Newer ENFit syringes typically only utilize the metric scale and are therefore more aligned to this best practice.

Best Practice #14 & Patient Safety Concern #9: Medical errors should be well assessed and continuous efforts should be made minimize errors. The engineered incompatibility of ENFit and NRFit with each other, with Luer, and with other small bore connectors is the best solution to the root cause of tubing misconnections. Between the literature reviews of Simmons et al,[3] Viscusi et al,[4] and Ethington et al,[5] 345 tubing misconnection events have been identified.

Patient Safety Concern #8: Supply chain has a major impact on patient safety. Fortunately, device standardization can significantly improve supply chain reliability. As described in "*Supply Chain Benefits of ISO Standardization to the ENFit® Enteral Feeding Connector*",[6] the supply chain becomes more robust and resilient when products are standardized. ENFit standardization ensures that alternative supplies can be sourced if a primary supply disruption occurs. Conversely, proprietary systems rarely have alternative supply options.

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[1] https://ow.ly/jhqS50Tjusy
[2] https://ow.ly/53zs50TjvO2
[3] https://pubmed.ncbi.nlm.nih.gov/21586413/
[4] https://rapm.bmj.com/content/46/2/176
[5] https://ow.ly/GMqp50TjvS0
[6] https://ow.ly/7OJs50TjCVc

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