NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Humber and North Yorkshire
Health and Care Partnership

FAO: Primary Care Colleagues in North Yorkshire and York

Medicines Management Prescribing Focus – July 2022

Inadvertent oral administration of potassium permanganate

In April 2022 a joint National Patient Safety Alert was issued by the NHS England and NHS Improvement National Patient Safety Team and the British Association of Dermatologists on the risk of inadvertent oral administration of potassium permanganate.

We recognise that potassium permanganate is not prescribed very frequently in primary care, however, over 12 months **133 items** for potassium permanganate were issued in primary care across North Yorkshire and York.

Action Required – to be completed by 30 September 2022

- Review all patients prescribed potassium permanganate and ensure that none are on repeat prescriptions (A retrospective risk assessment of patients is not necessary if the action to eliminate repeat prescriptions is taken, but will be necessary when a new prescription is required)
- Ensure that all prescriptions include clear instructions to **dilute before use**
- Ensure that any dispensing label includes the warning '**HARMFUL IF SWALLOWED'**.
- Ensure that prescriptions are issued for a named patient only by an appropriate prescriber experienced in the treatment of dermatological conditions and the use of potassium permanganate.
- It should always be prescribed as an acute prescription
- If potassium permanganate is to be used in a patient's home, a risk assessment must be undertaken before prescribing. It is the responsibility of the prescriber to ensure this has occurred.
- All patients must be supplied with a patient information leaflet.

We have requested, at a national level, with NHSE/I that an alert is added to EMIS & SystmOne regarding potassium permanganate and an alert has already been added to Optimise Rx.

We are also liaising with other providers, for example, secondary care colleagues and dispensing contractors to ensure that all are aware of the alert and take appropriate steps to minimise the risk to patients.

See the BAD and NHS England & NHS Improvement guidance on the safe use of potassium permanganate soaks for further information and guidance. This guidance, and the PIL (above),

should be read together to understand fully the safest way to use potassium permanganate concentrate.

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action.

Explanation of identified safety issue

Potassium permanganate is routinely used in the NHS 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 multiorgan failure. Even dilute solutions can be toxic if swallowed.

A Patient Safety Alert issued in 2014 highlighted incidents where patients had inadvertently ingested the concentrated form, and the 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 over two years 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. A review of the other 34 incidents identified key themes:

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

We would like to take this opportunity to remind all staff involved in making alterations to medication that patients should be informed of any change. Ideally, this should be done face to face, by telephone or by letter. Alternative methods of communication may be considered but must be unambiguous.

Please share the information in this document with all relevant members of staff in the Practice.

For any queries or feedback on this topic please contact the respective teams via: nyccg.rxline@nhs.net (North Yorkshire) or hnyicb-voy.rxline@nhs.net (York).

The MMT welcomes further ideas and suggestions that you and colleagues may wish to recommend for future prescribing focus editions.

Many thanks,

North Yorkshire and York Medicines Management Team