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

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RISK OF DEATH AND SEVERE HARM FROM FAILURE TO OBTAIN AND CONTINUE FLOW FROM OXYGEN CYLINDERS

For Action:

Chief Executives HSC Trusts for cascade to:
- *Directors of Pharmacy and Medicines Management*

Chief Executive HSCB/PHA for cascade to:
- *General Medical Practitioners*
- *Providers of oxygen services*

Chief Executive RQIA
Chief Executive, NIMDTA
Chief Executive, NIAS

For Information:
Distribution as listed at the end of this circular.

Related documents:

N/A

Implementation: 23rd February 2018

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

SUMMARY

NHS Improvement has issued the Patient Safety Alert NHS/PSA/W/2018/001- **Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders** – identifying a risk to patient safety from the incorrect set up and operation of the integral valves on these cylinders and outlining the actions required by healthcare providers in order to reduce this risk.

ACTION

Chief Executives of HSC Trusts should:

- Distribute this circular to all relevant clinical and managerial staff in units where Oxygen and other Medical Gas cylinders are used, even if only in emergencies.
- Identify a named individual to take responsibility for coordinating the delivery of the actions required within this circular.
- Review current operational procedures and staff training for oxygen and medical gas cylinders, and if appropriate develop an action plan to ensure that all

relevant staff are trained and competent in the correct operation of these gas cylinders with integral valves.

- Ensure that any locally developed good practice resources in this area are shared via the medicines governance network or the medical device liaison officer network.

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff.
- Cascade to all general practitioners.
- Disseminate this circular to all providers of oxygen services including community pharmacies
- Consider it through the normal HSCB/PHA processes for assuring implementation of safety and quality alerts.

Chief Executive, RQIA should:

- Disseminate this circular to all appropriate Independent Sector providers.

Chief Executive, NIMDTA should:

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

Chief Executive, NIAS should:

- Disseminate this circular to all relevant NIAS staff.
- Identify a named individual to take responsibility for coordinating the delivery of the actions required within this circular.
- Review current operational procedures and staff training for oxygen and medical gas cylinders, and if appropriate develop an action plan to ensure that all relevant staff are trained and competent in the correct operation of these gas cylinders with integral valves.
- Ensure that any locally developed good practice resources in this area are shared via the medicines governance network and/or the medical device liaison officer network.

BACKGROUND

In a recent three-year period, over 400 incidents affecting patient safety involving incorrect operation of oxygen cylinder controls were reported to the NHS National Reporting and Learning System (NRLS). The incidents involved portable oxygen cylinders of all sizes on trolleys, wheelchairs, resuscitation trolleys and neonatal resuscitaires, and larger cylinders in hospital areas without piped oxygen. Investigation into these incidents identified that the majority occurred due to user error in the operation of the integral valve.

With the recent changes to cylinder design there is a need to ensure that staff are fully trained in the operation of these integral valves ensuring that they understand the differences in operation between the old style cylinders and newer integral valve cylinders.

All the identified incidents occurred in hospitals, but similar issues could arise in mental health units, general practices, care homes, ambulances or patients' own homes, particularly when oxygen cylinders are used in an emergency. They could also occur with other medical gas cylinders that have an integral valve.

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

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Distributed for information to:

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