| **Paper ref:** | TB (04/21) 018 |
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Sandwell and West Birmingham Hospitals NHS Trust

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| **Report Title** | February Never Events: Update | | |
| **Sponsoring Executive** | David Carruthers, Medical Director | | |
| **Report Author** | Allison Binns, Deputy Director of Governance – Safety & Risk | | |
| **Meeting** | Public Trust Board | **Date** | 1st April 2021 |

## 1. Suggested discussion points *[two or three issues you consider the Committee should focus on]*

In 2016 a Patient Safety Alert was issued to Trusts following incidents related to patients being attached to air instead of oxygen. This then became one of the Never Events, when the list was published in 2018.

Two of these events occurred in February 2021, in different Groups, one day apart.

Immediate remediation occurred by removing all unused air flowmeters. Further actions are ongoing to ensure there is not a further incident of the same nature.

## 2. Alignment to 2020 Vision *[indicate with an 'X' which Plan this paper supports]*

| | | | | | |
|---|---|---|---|---|---|
| Safety Plan | | Public Health Plan | | People Plan & Education Plan | |
| Quality Plan | | Research and Development | | Estates Plan | |
| Financial Plan | | Digital Plan | | Other *[specify in the paper]* | |

## 3. Previous consideration *[where has this paper been previously discussed?]*

Trust Board (briefing) 4 March 2021

## 4. Recommendation(s)

The Trust Board is asked to:

| | |
|---|---|
| **a.** | **NOTE** the update on events |
| **b.** | **DISCUSS** and **AGREE** the actions being taken |

## 5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Trust Risk Register | | | | | | | |
| Board Assurance Framework | | | | | | | |
| Equality Impact Assessment | Is this required? | Y | | N | | If 'Y' date completed | |
| Quality Impact Assessment | Is this required? | Y | | N | | If 'Y' date completed | |

# SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

## Report to the Trust Board: 1st April 2021

## February Never Events - Update

### 1. Introduction

1.1 In 2016, NHS Improvement notified all hospitals that provide NHS funded care that supply medical air using medical gas pipeline systems of a Patient Safety Alerts (PSA) following a number of incidents. The Trust followed the recommendations form the PSA and signed this off on the Central Alerting System.

1.2 The Never Events list, published by NHS Improvement in 2018 and updated in February 2021, details fifteen adverse events that have been identified as such, because they should never happen.

1.3 The unintentional connection of a patient requiring oxygen to an air flowmeter has been a Never Event since the inception of the list.

### 2. The PSA requirements

2.1 The PSA required all Trusts to implement systems to ensure that the 3 barriers to human error were put in place in all relevant clinical areas. These were:

- 2.1.1 Medical air terminal units (wall outlets) are covered with designated caps in areas where there is no need for medical air.
- 2.1.2 Medical air flowmeters are removed from terminal units (wall outlets) and stored in an allocated place when not in active use
- 2.1.3 Air flowmeters are fitted with a labelled, movable flap

2.2 There was also a requirement to establish ongoing systems of audit or equipment checks to ensure the barriers are maintained.

2.3 At the time of the alert, the air flowmeters were all removed or fitted with moveable flaps (Fig A). The Estates team undertake annual reviews (Jan 2020) of the equipment, replacing any flaps that are no longer in place (Fig B).

2.4 Caps were not used to seal off the air outlets as, at the time, a special tool was required if the outlet needed to be used.

Fig A


Fig B

## 3. The Incidents

3.1 Critical Care - 23 February 2021

3.1.1 A patient, in the side room, dropped his oxygen levels acutely, which was the reason for his admission.

3.1.2 The patient was being cared for by a band 7 ITU nurse (who had two patients, both in side rooms) and a reservist, who was a 3rd year Paramedic.

3.1.3 As the acute episode occurred the trained ICU nurse, at the bedside, asked the student paramedic to connect the oxygen to 15L (standard management in an emergency situation) whilst she commenced achieving a seal with the Mapelson C device in order to deliver emergency oxygen.

3.1.4 This action did not have the desired effect of improving the oxygen saturation readings. Medical staff were in attendance and noted quickly that the tubing was connected to air and not oxygen. This was amended and the patient quickly recovered.

3.1.5 Air flow meters are seldom used within Critical Care; it was being used for the patient's nebuliser therapy as he was on minimal amounts of oxygen via nasal cannula. The correct air flow meter in accordance to safety recommendations with a labelled moveable flap was in use within the bed space.

3.1.6 All bed spaces on Critical care were reviewed and 2 further flowmeters found. They were removed and taken to Medical Engineering. The air outlets cannot be capped on Critical Care.

3.2 Acute Medical Unit – 24 February 2021

3.2.1 Following handover, which identified that the patient was on 4L oxygen, she checked as the patient had an oxygen saturation of 74% and noted that the tubing was attached to air rather than oxygen.

3.2.2 Airflow meters are used more routinely on wards for nebulisers, and on review of the AMU it was noted that most beds had a flowmeter attached to the outlet. An alternative option to provide a nebuliser is through a nebuliser machine.

3.2.3 The moveable flap (Fig A) was not present on the majority of beds within AMU.

3.2.4 Due to the risk of patients not receiving oxygen as required, the Matron was asked to remove all flowmeters at present.

## 4. Immediate and Ongoing actions

4.1 All the Group Directors of Nursing were contacted to advise them of the incidents and asking them to ensure that all flow meters are removed from air outlets.

4.2 As this will continue to be an issue in Midland Metropolitan University Hospital, information was shared with the Head of Medical Engineering and the Director of System Transformation, to review what, if any, changes could be made to the plans to enhance safety.

4.3 A learning alert is being produced.

4.4 Medical Engineering are looking at whether there is a cap available for the outlets which staff can remove when it is required.

4.5 All air flowmeters are being fitted with the moveable flap, where they don't exist. Groups have been asked to identify, by each ward, the number of air flowmeters required (usually 1-2) and that there is a locked cupboard identified to store them in.

4.6 A review will then take place to ensure all those on wards are fitted with moveable flaps and when not in use are stored securely. Equally the number on each ward will be checked to ensure there is no increase in availability.

## 5. Recommendations

5.1 The Trust Board is asked to:

a. **NOTE** the update on events
b. **DISCUSS** and **AGREE** the actions being taken

Allison Binns
Deputy Director of Governance – Safety & Risk
18 March 2021