



Llywodraeth Cymru
Welsh Government

GUIDANCE, DOCUMENT

Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder (WHC/2024/036)

Directions to local health boards and NHS trusts following a regulation 28 prevention of future deaths report and oxygen cylinders patient safety notice (PSN) about oxygen cylinders.

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Details

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Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder.

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All health boards and NHS trusts.

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30 September 2024.

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Enclosures:

Letter.

Oxygen cylinders: regulation 28 report and patient safety notice 041 reminder

Dear Sir or Madam

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A **regulation 28 prevention of future deaths coroner's report** has been received following the death of a patient in Welsh NHS after the incorrect use of Oxygen CD cylinders manufactured by BOC. The Cabinet Secretary for Health and Social Care has raised several questions following the regulation 28 report. Whilst these questions have been addressed, further assurance is required, and officials are taking this opportunity to further highlight the issue to all health boards and trusts in Wales.

The regulation 28 report relates to an incident at one health board in Wales, however, oxygen CD cylinders from BOC are the portable cylinder of choice used across NHS Wales. NHS shared services partnership - specialist estate services (NWSSP-SES) have been contacted following the report, and highlighted its concerns about patient safety across NHS Wales. This follows events reported through their medical gas committee meetings and local Datix Cymru systems.

A patient safety notice (PSN) 041 was issued in 2018, which related to the operation of oxygen CD cylinders, manufactured by BOC. Given the number of incidents that are still happening, the **recommendations in PSN 041 do not appear to have been fully implemented or addressed**.

All NHS Wales organisations need to consider the lessons to be learnt from this regulation 28 report, and the actions in PSN 041. These include:

- lessons from the regulation 28 report
- ensuring that all actions in PSN 041 are in place and effectively monitored and audited
- ensure all oxygen CD cylinder incidents, whether a near miss or Nationally Reportable Incident (NRI), are reported on Datix Cymru and **alerted to the Medicines and Healthcare Products Regulatory Agency (MHRA) through the yellow card scheme**
- making sure guidance and training arrangements are in place for oxygen administration and medical devices, which should be monitored to ensure all

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- staff who have any role in oxygen administration are trained accordingly
- reviewing patient safety incident themes and identify any areas for improvement and learning, report any risks or actions accordingly via board governance

The main actions in PSN 041 are as set out below:

- to identify if oxygen cylinders are used in your organisation, even if only in emergencies
- to bring this notice to the attention of all those with a leadership role in ensuring clinical staff understand how to operate oxygen cylinders safely
- to consider if immediate local action is needed and ensure that an action plan is underway to reduce the risk of incorrect use of oxygen cylinders
- to communicate the key messages in this notice and your local action plan to all relevant staff

As a direct consequence of the regulation 28 report and following discussions with NWSSP-SES we would expect the following actions to also be taken:

- ensure medical gas groups include these actions on their agenda and report progress
- ensure medical gas training is mandated for all NHS staff using or handling medical gases (not just cylinders)
- ensure staff complete the **BOC free online training in the operation of oxygen CD cylinders**

As previously stated, oxygen CD cylinders from BOC are used by most health boards. Other training is available for medical gases on the all-Wales ESR platform. We have requested that the NHS Wales Executive monitor onward compliance across all relevant NHS Wales organisations in terms of the actions set out in the PSN.

Our expectations are for the actions set out in this letter to be taken forward

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within

1 month. They all work towards learning lessons from this adverse incident and improving compliance with PSN 041. Implementing the actions will help to ensure safer patient care throughout the NHS.

Yours sincerely

Sue Tranka

Prif Swyddog Nyrsio / Chief Nursing Officer

Cyfarwyddwr Nyrsio GIG Cymru / Nurse Director NHS Wales.

Professor Pushpinder Mangat

Dirprwy Brif Swyddog Meddygol / Deputy Chief Medical Officer

Gwasanaethau Iechyd / Health Services.

Ian Gunney

Dirprwy Gyfarwyddwr / Deputy Director

Ystadau a Chyfleusterau'r GIG / NHS Capital, Estates and Facilities.

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