Background
Deaths and severe harms have occurred in the NHS and worldwide from the wrong route administration of intravenous chemotherapy by the spinal and intrathecal route. There have been no incidents reported in England since 2001. Deaths continue to be reported in Europe and worldwide. Any incidents that occur in England are required to be reported as ‘Never Events’.

In order to minimise risks of wrong route administration. The former National Patient Safety Agency (NPSA) issued two alerts (2009, 2011) recommending the use of new connectors, that cannot connect with intravenous Luer or infusion device connectors, for spinal (intrathecal), epidural and regional clinical procedures, when suitable devices became available. Target implementation dates of 1st April 2012 for spinal (intrathecal) bolus (Part A) and 1st April 2013 for epidural and infusion (Part B) devices were identified.

Spinal (intrathecal) chemotherapy
A complete range of non-Luer devices is available for spinal (intrathecal) bolus chemotherapy and many NHS trusts have already successfully implemented the use of these new devices. Compliance with this alert can only be achieved by the use of non-Luer devices. The use of the trust risk register for continued use of Luer devices for spinal (intrathecal) bolus chemotherapy will not enable a trust to indicate compliance with this alert.

Trusts should be aware that non-compliance with the patient safety alert could be taken into account when considering whether an adverse outcome constitutes a breach of the Care Quality Commission (Regulated Activities) Regulations 2010 and could lead to regulatory action, including by other agencies.

Anaesthetic and non-chemotherapeutic procedures
Full compliance with previous NPSA alerts in anaesthetic and non-chemotherapeutic practice is currently not possible, as the range of non-Luer and infusion devices for spinal, epidural and regional procedures remains incomplete. New products, especially infusion products, are still awaited from industry. Continued use of Luer devices should be recorded in the organisation’s risk register, with additional safety precautions taken and suitable safer devices introduced into practice as soon as they are available.

Actions
Who: All hospitals who administer spinal (intrathecal) chemotherapy
When: As soon as possible but no later than 20 August 2014

1. Systems should be in place to ensure all spinal (intrathecal) chemotherapy bolus doses are performed using syringes and needles and other devices with non-Luer connectors that cannot connect with intravenous devices.

2. In order to achieve action one, the range of new devices should be evaluated locally and action taken to minimise any potential practice risks arising from the use of the new devices.

Supporting information
More detailed information to support the implementation of this alert is available at: www.england.nhs.uk/patientsafety/psa