

# Recommendations from National Patient Safety Agency alerts that remain relevant to the Never Events list 2018

January 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

The National Patient Safety Agency (NPSA) website has been archived and documents can be accessed through the [National Archives](#). Many of the recommendations and actions identified in previous alerts issued by the NPSA are now fully embedded in practice and no longer require a specific focus.

This document highlights those barriers identified in previous alerts that NHS organisations still need to routinely consider as part of clinical governance and ensure are embedded in clinical practice to prevent Never Events.

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### **Safer Practice Notice – *Wristbands for hospital inpatients improves safety (2005)***

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This alert highlights that all hospital inpatients in acute settings should wear wristbands (also known as identity bands) with accurate details that correctly identify them and match them to their care.

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### **Safer Practice Notice – *Standardising wristbands improves safety (2007)***

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This alert identifies the requirement that all NHS organisations in England that use wristbands should only include the following core patient identifiers:

- last name
- first name
- date of birth
- NHS number (if the NHS number is not immediately available, a temporary number should be used until it is).

If any additional identifiers are thought to be necessary, these should be formally risk assessed.

Only white wristbands with black text should be used. If you wish to have a system for identifying a known risk (eg an allergy or where a patient does not want to receive blood or blood products), the wristband should be red with patient identifiers in black text on a white panel on the wristband.

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### **Patient Safety Alert – *WHO surgical safety checklist (2009)***

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The national safety standards for invasive procedures (NatSSIPs) now incorporate the contents of the WHO surgical safety checklist. This alert requires the checklist

to be completed for every patient undergoing a surgical procedure (including local anaesthesia).

This alert also determines that the overall responsibility for the site marking for regional blocks lies with the operating surgeon. The anaesthetist should only proceed with a regional block after confirming that the site for surgery has been marked.

### **Safer Practice Notice – *Reducing the risk of retained throat packs after surgery (2009)***

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The principles of ensuring that throat packs are included in swab counts are now included in the NatSSIPs. This Safer Practice Notice identifies the additional requirement that a visually based procedure is followed whenever a throat pack is deemed necessary. Recommended visual procedures are to:

- label or mark the patient either on their head or, exceptionally, on another visible part of their body with an adherent sticker or marker
- label the artificial airway (eg tracheal tube or supraglottic mask airway)
- attach the pack securely to the artificial airway
- leave part of the pack protruding.

### **Rapid Response Report – *Reducing the risk of retained swabs after vaginal birth and perineal suturing (2010)***

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Normal vaginal deliveries do not involve any invasive procedures and so are not covered by NatSSIPs.

This Rapid Response Report highlights the requirement for swabs to be counted when used in a vaginal delivery (including for perineal suturing) and the need to ensure that lead professionals (midwives and obstetricians) are aware of their responsibility for documenting the completed swab count in the woman's health record.

### **Patient Safety Alert – *Potassium chloride concentrate solutions (2002; updated 2003)***

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This alert recommends that potassium chloride concentrate solutions should be restricted to pharmacy departments and to those critical care areas where they are needed for urgent use. All supplies should come directly from the pharmacy

department and be stored in a separate locked cupboard away from common diluting solutions such as sodium chloride (normal saline) solution.

### **Patient Safety Alert – *Promoting safer measurement and administration of liquid medicines via oral and other enteral routes (2007)***

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An ISO standard has now been developed for enteral equipment (EnFit).

This alert is the key source for the recommendation that intravenous syringes are **not** used to measure and administer oral liquid medication; only approved oral/enteral (EnFit) syringes that cannot be connected to intravenous catheters or ports should be used. Patients or carers who need to administer oral liquid medicines with a syringe must be supplied with approved oral or enteral (EnFit) syringes.

### **Patient Safety Alert – *Safer practice with epidural injections and infusions (2007)***

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This alert identifies the requirements to clearly label infusion bags and syringes for epidural therapy (whether purchased commercially, manufactured by the hospital pharmacy or prepared in clinical areas) '**For Epidural Use Only**' in a large font. Judicious use of colour and design should differentiate these products from those for intravenous and other routes of administration.

Risk of the wrong medicine being selected should be reduced by storing epidural infusions in different cupboards or refrigerators from those holding intravenous and other types of infusions.

**We recognise that while these actions remain best practice and should still be followed, the intravenous delivery of a medicine intended to be administered via the epidural route cannot be considered a Never Event until further notice, as identified in the Never Events list 2018.**

### **Rapid Response Report – *Safer administration of insulin (2010)***

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This Rapid Response Report introduced the requirement for all regular and single insulin (bolus) doses to be measured and administered using an insulin syringe or commercial insulin pen device. It also determined that the term 'units' is written out in full in all contexts and not abbreviated. An insulin syringe must always be used to

measure and prepare insulin for an intravenous infusion. Insulin infusions are administered in 50 mL intravenous syringes or larger infusion bags.

### **Patient Safety Alert – *Improving compliance with oral methotrexate guidelines (2006)***

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Two actions in this alert still require monitoring:

- All electronic prescribing and dispensing software programmes in primary and secondary care locations must include oral methotrexate alerts and prompts.
- Patients taking oral methotrexate should be given a patient information leaflet and monitoring document.

### **Rapid Response Report – *Reducing risk of overdose with midazolam injection in adults (2008)***

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This Rapid Response Report recommends that the storage and use of high strength midazolam (5 mg/mL in 2 mL and 10 mL ampoules or 2 mg/mL in 5 mL ampoules) is restricted to general anaesthesia, intensive care, palliative medicine and clinical areas/situations where its use has been formally risk assessed – for example, where syringe drivers are used. It also recommends that other clinical areas store and use low strength midazolam (1 mg/mL in 2 mL and 5 mL ampoules), not high strength.

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