National Patient Safety Alert

NHS England

Identified safety risks with the Euroking maternity information system

Date of issue:	7 December 2023	Reference no:	NatPSA/2023/014/NHSPS

This alert is for action by: all organisations providing maternity services.

This is a safety critical and complex National Patient Safety Alert. Implementation should be co-ordinated by an executive lead (or equivalent role in organisations without executive boards) and supported by clinical leaders in maternity, governance and IT, including the chief clinical information officer (CCIO).

Explanation of identified safety issue:

Potential serious risks to patient safety have been identified with the use of Magentus Software Limited's Euroking maternity information system.

These concern specific data fields:

(i) certain new patient information, recorded during a patient contact, can overwrite ('back copy') information previously recorded in the patient's pregnancy record.

(ii) certain pregnancy-level data (information relevant only to a specific pregnancy event) can be saved at a patient level (where information relevant throughout a person's life is recorded), causing new information to overwrite ('back copy') previously recorded data across an entire patient record.

(iii) certain recorded pregnancy-level data can pre-populate into new pregnancy records ('forward copy'), which can mean clinicians will see incorrect patient information, and attempts to correct this can result in the issue described at (ii) above.

Organisations configure Euroking locally. The technical issues with this are outlined in the 'Additional information' section.

Actions required

Actions to be completed by 7 June 2024

Organisations using Euroking:

1. must consider if Euroking meets their maternity service's needs and ensure that their local configuration is safe. To do this they will need to work with their supplier to make changes to their existing system, and this will need to be overseen by their clinical safety officer.

2. must review and ensure that each data field within the system does not copy forward or backward – see 'Additional information'.

3. if procurement of a new system is deemed necessary, organisations must ensure that all clinical information is appropriately backed-up, accessible for any future requirement and, when Euroking becomes a legacy system, must comply with action 4.

Organisations with legacy Euroking contracts:

4. must implement a process to ensure users who access any legacy Euroking records will be alerted to the issues identified in this alert.

Organisations currently using another maternity information system/EPR:

5. must reassess the clinical safety of their maternity EPR with a suitably qualified clinical safety officer and, as a minimum, must ensure that the issues listed under 'Additional information' relating to the back and forward copying of information do not occur.

6. must assess that their current maternity EPR complies with the core maternity capabilities in the Maternity Digital Capabilities Framework.

For further detail, resources and supporting materials see: https://www.england.nhs.uk/2023/12/identified-safety-risks-with-the-euroking-maternity-information-system

Failure to take the actions required under this National Patient Safety Alert may lead to CQC taking regulatory action

Additional information:

Identified risks to patient safety (**Note**: this is **not** an exhaustive list of the technical issues with the Euroking maternity information system):

1. **Clinical record inaccuracies as a result of forward copying across a patient record.**

- Partner details are saved at patient level, not pregnancy level. When a clinician opens a new pregnancy record, Euroking will have automatically copied the partner details from any previous pregnancy into this new record, which can result in incorrect management of the pregnancy and subsequent harm. Partner details can be manually updated, but the new partner details will then be back copied and overwrite those in previous pregnancy records and the partner details for any previous pregnancies will then be incorrect.

2. **Perceived clinical inaccuracies and lack of contemporaneous record keeping as a result of overwritten records.**

- Recording of a cervical sweep at 40 weeks' gestation is back copied across the pregnancy record, and this clinical intervention will show as having been inappropriately undertaken at 18 weeks.
- Leaving a blank data field for blood group removes any previously populated blood group data, resulting in no identifiable blood group in the patient's record. This could impact patient care and delivery.

3. **Incorrect safeguarding information as a result of back copying within a pregnancy record.**

- Any new information about agencies that the patient is involved with is back copied and overwrites the information recorded at time of booking. This can distort the full picture of who is or was involved and when and whether the case is open or closed.
- If domestic abuse is disclosed late in pregnancy, recording of referral to the Independent Domestic Violence Advocate will be back copied and suggest referral at all previous antenatal admissions for the current pregnancy before the abuse was disclosed.
- If female genital mutilation is disclosed or identified after booking, this information is back copied to the booking workflow, suggesting healthcare professionals were aware of concerns earlier than they were, and had not taken appropriate action.

4. **Unclear gravidity and parity data**

- When a midwife updates a patient's gravidity and parity in the postnatal workflow, this information is back copied to the antenatal workflows. Organisations are often required to report by parity and gravidity, and this means their antenatal submissions could appear inaccurate. Filters used to report data are changed during the pregnancy resulting in organisations inappropriately reporting parity and gravidity data.

Patient safety incident data:
A search of the National Reporting and Learning System (NRLS and LFPSE) and of STEIS (Ref: PSI170.2023), and feedback from users, found evidence of back and forward copying of information has impacted patient care.

References:
Under the Health and Social Care Act 2012 organisations must comply with DCB0160 - Clinical Safety standard Maternity Framework https://www.england.nhs.uk/mat-transformation/harnessing-digital-technology/

Stakeholder engagement:

- All trusts with active contracts alerted in June 2023
- NHS England National Director of Patient Safety
- Chief Midwifery Officer and Chief Nursing Officer for England
- NHS England CCIO
- HSSIB
- NHS Resolution
- CQC
- National Patient Safety Advisory Panel: for a list of members and organisations represented on the panel see Our National Patient Safety Alerts

Advice for Central Alerting System (CAS) officers and risk managers
This is a safety critical and complex National Patient Safety Alert. In response to CHT/2019/001 and CHT/2023/002 your organisation should have developed new processes to ensure appropriate oversight and co-ordination of all National Patient Safety Alerts. CAS officers should send this Alert to executive lead nominated in their new process to coordinate implementation of safety critical and complex National Patient Safety Alerts, copying in the leads identified on page 1.