

Oxygen safety in hospitals: information for doctors and non-medical prescribers

In September 2009, the National Patient Safety Agency (NPSA) issued a Rapid Response Report (RRR) to all hospital settings with actions to improve oxygen safety. Full details are available from www.nrls.npsa.nhs.uk/resources/type/alerts/

Why did the NPSA do this?

Oxygen is one of the most common medicines used in hospital settings and should always be prescribed – except in emergencies, where oxygen should be given first and documented later. Oxygen can save lives by preventing severe hypoxaemia. However, there is a potential for serious harm and even death if it is not administered and managed appropriately. Common safety concerns from the review of incidents, local investigations and other sources are:

Prescribing	failure to or wrongly prescribed
Monitoring	patients not monitored, abnormal oxygen saturation levels not acted upon
Administration	confusion of oxygen with medical compressed air, incorrect flow rates, inadvertent disconnection of supply
Equipment	empty cylinders, faulty and missing equipment

What is the NPSA asking your organisation to do?

The NPSA has asked your organisation to:

- minimise the use of oxygen cylinders on wards;
- ensure reliable and adequate supplies of oxygen cylinders in transfer and emergency situations;
- assess the risks of confusing oxygen and medical compressed air;
- ensure that oxygen is prescribed and pulse oximetry is available
- ensure a multidisciplinary group has responsibility for the safe use of oxygen in your hospital.

For staff prescribing oxygen: What can YOU do?

Because of the risks from poor oxygen management, medical staff should question:

- Have I prescribed oxygen for the patient?
- Have I recorded the target saturation on the drug chart/ in the medical notes?
- How can I recognise inadequate tissue oxygenation?
- How is oxygen best delivered and is humidification necessary?
- When should oxygen therapy be reviewed?
- If something has gone wrong, have I reported this as an incident?

Further information at: www.nrls.npsa.nhs.uk/resources/type/alerts/

Full clinical guidelines at: www.brit-thoracic.org.uk