



Rapid Response Report

Subject:

Safer Ambulatory Syringe Drivers

For action by:

Chief Executive, HSC Board for cascade to :
Director of Integrated Care, HSCB
Assistant Director, Primary Care, HSCB
Assistant Director of Pharmacy & Medicines Managements, HSC Board
for cascade to:
Pharmacy & Medicines Management Team
Chief Executives, HSC Trusts for cascade to:
Directors of Pharmacy
Medical Directors
Directors of Nursing
Community Nurses
CSCG leads
Chief Executive RQIA for cascade to:
Independent hospitals and clinics
General Practitioners

For Information to:

Chief Executive, Public Health Agency
Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir. of Performance Management & Service Improvement, HSCB
Assistant Director of Performance Management, HSC Board
Paul Cunningham, HSC Board
Chief Executive, Business Services Organisation
Prof. David Woolfson, Head of School of Pharmacy, QUB
Prof. Linda Johnston, Head of Nursing & Midwifery, QUB
Prof. Hugh McKenna, Head of Life & Health Sciences, UU
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of School of Pharmacy, UU
Post Graduate Dean, NIMDTA
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development

Summary of Contents:

The purpose of this circular is to highlight correct use Safer Ambulatory Syringe Drivers

Enquiries:

Any enquiries about the content of this circular should be addressed to:
Safety & Quality Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST BT4 3SQ

Tel: 028 9052 2239

qualityandsafety@dhsspsni.gov.uk

Related documents

Superseded documents

N/A

Status of Contents:

For completion of actions and assurance templates by 21 July 2011

Implementation:

Immediate

SQSD material can be accessed on:

<http://www.dhsspsni.gov.uk/index/phealth/sqs.htm>

Dear colleagues

SAFER AMBULATORY SYRINGE DRIVERS

Ambulatory syringe drivers are widely used in palliative and end of life care and for long term care in the community and in hospital. As a result they are often used to deliver opioids and other palliative and end of life care medication. Over-infusion of these medications can cause death through respiratory depression, while under-infusion can leave the patient in pain and distress.

The content of the attached circular at Annex A has been reviewed by relevant professional colleagues in the Department and approved for regional dissemination.

I would ask you to bring this to the attention of relevant practitioners and key health and social care staff within your organisation. They should consider the best practice for their setting and take appropriate steps to minimise the risks to patients.

I would also draw your attention to the attached 'assurance template' which is a means of recording the response from the Trusts and Board in circumstances where SQS Circulars require action to be taken by a given date.

Yours sincerely

A handwritten signature in black ink, appearing to read "Jim Livingstone". The signature is written in a cursive, slightly slanted style.

Dr J F Livingstone

Director, Safety, Quality & Standards

SAFER AMBULATORY SYRINGE DRIVERS

Issue

1. Ambulatory syringe drivers are widely used in palliative and end of life care and for long term care in the community and in hospital. As a result they are often used to deliver opioids and other palliative and end of life care medication. Over-infusion of these medications can cause premature death through respiratory depression, while under-infusion can leave the patient in pain and distress.
2. While the majority of syringe drivers and pumps used in healthcare have rate settings in millilitres (ml), some older types of ambulatory syringe drivers have rate settings in millimetres (mm) of syringe plunger travel. This is not intuitive for many users and not easy to check. Errors include the wrong rate of infusion caused by inaccurate measurement of fluid length or miscalculation or incorrect rate setting of the device. Dose errors also occur because of different models using mm per hour or mm per 24 hours. Other issues include syringes becoming dislodged, inadequate device alarms and lack of internal memory (a technical issue which makes establishing the reason for any over or under-infusion difficult)

National Context

3. Between 1 January 2005 and 30 June 2010 the NPSA received reports of eight deaths and 167 non-fatal reports involving ambulatory syringe drivers. Four of the deaths were reported in 2009. Many of these incidents described infusions that had either run through much quicker than expected or had not infused at all.
4. Some cancer centres and palliative medicine centres in the UK have replaced all their mm-calibrated ambulatory syringe drivers with ml-calibrated devices which include additional safer design features. Therefore a co-ordinated approach and timescale for the changeover will help to minimise additional risks arising from the introduction of safer equipment.
5. NPSA has produced Rapid Response Report NPSA/2010/RRR019: Safer Ambulatory Syringe Drivers which is available on:
<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=92908>

Local Context

6. All HSC and independent sector organisations should ensure that:

1. Develop a purchasing for safety initiative that considers the following safety features before ambulatory syringe drivers are purchased:
 - rate settings in millilitres (ml) per hour;
 - mechanisms to stop infusion if the syringe is not properly and securely fitted;
 - alarms that activate if the syringe is removed before the infusion is stopped;
 - lock-box covers and/or lock out controlled by password;
 - provision of internal log memory to record all pump events.
2. Agree an end date to complete the transition between existing ambulatory syringe drivers and ambulatory syringe drivers with additional safety features (as soon as locally feasible, and within five years of this RRR).
3. Take steps to reduce the risks of rate errors while older designs of ambulatory syringe drivers remain in use, based on a locally developed risk reduction plan which may include: raising awareness, providing information to support users with rate setting, and using lock-boxes.
4. Take steps to reduce the risks during any transition period when both types of design are in use, including:
 - reviewing and updating policies and protocols to include the safe operation of all designs of ambulatory syringe driver in local use;
 - revising user training programmes to include the safe operation of all designs of ambulatory syringe driver in local use.

Action Required

7. You will wish to bring the contents of this document to the attention of staff, particularly those involved in governance and risk management within your organisation. Organisations need to be aware of this best practice circular in order to assist in complying with the Quality Standards for Health and Social Care –
 - Criteria 4.3(i) (the appropriate management of risk);
 - Criterion 5.3.1(f)(viii) (ensuring safe practice in medicines management);and
 - Criterion 5.3.3(f) (implementation of evidence-based practice through guidance, for example, NPSA guidance);and
8. HSC Trusts should take immediate action to implement this Rapid Response Report as outlined in paragraph 6 above by 21 July 2011 following which they should provide assurance on this action to the HSC Board by completing Section 1 of the attached template.
9. The HSC Board should complete Section 2 of the attached assurance template and forward to the Department by 22 August 2011.

SQS CIRCULARS: ASSURANCE TEMPLATE FOR HSC BOARD AND TRUSTS

**Circular number: HSC (SQSD) 18/10 Safer Ambulatory Syringe Drivers
For Implementation by: 21 July 2011**

(Section 1 is to be completed by HSCT and forwarded to HSCB for consideration. Section 2 should then be completed by HSCB and forwarded to DHSSPS)

SECTION 1:

To: Chief Executive, HSC Board

I can confirm that the required actions set out in the above circular have been implemented in full by the due date.

I can confirm that the actions in the above correspondence have been partially implemented by the due date. The issues impacting on full implementation along with the timescales for resolving these issues are set out in the box below:

I can confirm that the organisation has been unable to implement any actions of the above circular for the reasons set out in the box below. (The actions being taken/required to resolve or clarify the issues preventing implementation and the timescales for this should be outlined):

I confirm that the HSC Trust's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the HSC Board.

Response submitted by: _____ (Name & contact details of person submitting response)
on behalf of _____ HSC Trust. Date: _____

SECTION 2:

To: Director, Safety, Quality & Standards Directorate, DHSSPS

I note the response from the Trust and –

I can confirm that the HSC Board is content the action(s) taken, referred to in Section 1, complies with the requirements of the above circular.

I can confirm that further action, as outlined in the box below, is needed to ensure compliance with the requirements of the above circular

I confirm that the HSC Board's Chief Executive and designated senior manager have been advised of this response and are content that it should be submitted to the Department.

Response submitted by: _____ (Name & contact details of person submitting response)
on behalf of HSC Board. Date: _____