Policy update: never events

The latest guidance can help nurses review practice and provide safer care for patients

In this article...

- What defines a never event
- Never events for 2011/12
- What nurses’ involvement may be

Never events for 2011/12
Eight patient safety incidents were chosen to test the initiative in the first year (from April 2009); these were modified slightly during the second year of the policy (Box 1).

In the first year, 111 never events were reported in England (NPSA, 2010b). Lessons have been learnt from incidents, with most never events relating to wrong site surgery and misplaced nasogastric tubes.

The government wants to continue to embed patient safety in the NHS, including encouraging the reporting of patient safety incidents, and ensure that serious preventable failures where there are guidelines in place will not be tolerated. The expansion of the never events list is part of this strategy; there are now 25 never events, mostly in acute care (Box 2) (DH, 2011). This new list can be split into broad categories:

- Surgical care (never events 1-3);
- Medication (never events 4-12);
- Mental health (never events 13-14, restricted to mental health premises);
- General healthcare (never events 15-24);
- Maternity (never event 25).

A never event constitutes an incident resulting in death or severe harm to the patient; if there is a rescue before harm occurs or a lesser degree of harm, these are “nearly never events”. These should be seen as warning signs about clinical practice, safety culture and guideline implementation.

How are nurses involved?
A national framework for reporting serious incidents in the NHS from 2010 set out a clear, nationally agreed approach to notifying, managing and learning from serious incidents (Care Quality Commission, 2010). Organisations should report never events to the Care Quality Commission as part of their registration requirements (NPSA, 2009); for English NHS trusts, this is via the national reporting and learning system.

Nursing involvement in the never events policy could range from:

- Policy and guidance implementation awareness and planning activities;

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Abstract

New never events have been introduced to the NHS in England since April 2011 by the Department of Health. By using information in this article, nurses can help prevent never events from occurring by improving their understanding of the rationale behind this guidance and reporting mechanisms.

Nurses will have been aware of the concept of never events since the term was introduced to the NHS in England in 2008 (Department of Health, 2008). It has been used in other countries to identify the most serious events and ensure they are reported (National Quality Forum, 2008). A never events policy in the NHS provides further impetus to improving patient safety through greater transparency and accountability when serious patient safety incidents occur. It gives commissioners a lever to help discuss serious incidents and their prevention with providers.

Since 2009, a national “core list” of never events has been published for use in the NHS in England; commissioners can also define their own local never events that should be to be reported to them (National Patient Safety Agency, 2009). When a possible never event in a hospital or other provider occurs, it must be taken seriously and reported locally to the commissioner of the service. The commissioner will discuss the circumstances and be involved in the investigation that should take place. From April 2010, commissioners have had the option not to pay for the contracted event if a never event happens (NPSA, 2010a).

Definition of a never event
According to the NPSA (2009), a never event is:

“A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.”

A never event must fit the following (DH, 2011) criteria:

- The incident has clear potential for, or has caused, severe harm or death;
- There is evidence of occurrence in the past, so it is a known source of risk;
- There is existing national guidance and/or national safety recommendations on how the event can be prevented, and support for implementation;
- The event is largely preventable if the guidance is implemented;
- Occurrence can be easily defined, identified and continually measured.

What nurses should know
All nurses should:

- Know how never events are defined;
- Be aware of the never events that could occur in their area of clinical practice;
- Discuss with their teams how to prevent such events from happening by using the best national guidance available;
- Report any never event appropriately, find out why it happened, and what should be put in place to stop it from happening again.
**5 key points**

1. A never event is a serious, largely preventable patient safety incident that should not occur if the available preventive measures have been implemented.

2. In most cases, a never event is defined as an incident that results in death or severe harm to patients.

3. Possible never events should be taken seriously and be reported to the service’s commissioner.

4. Nurses should take responsibility for preventing never events and other serious incidents.

5. “Nearly never events” are warning signs about clinical practice and safety culture.

Next steps

Nurses should continue to be vigilant around implementing national guidelines in their clinical areas, taking responsibility for preventing never events and other serious incidents. Reporting incidents and transparency about safety by nurses are important elements on which provider organisations depend if they are going to be trusted by commissioners to provide safe care for patients.

There will be annual reports of numbers of never events from national reporting systems but, increasingly, these events, their occurrence and investigation will be monitored and discussed locally by providers working with commissioners. There will be a need to share these discussions with the public. Nurses have a part to play in ensuring these talks with commissioners and the public are relevant, and that the development of good nursing practice leads to a reduction in such serious events.

**References**


**BOX 1. NEVER EVENTS FOR 2010/11 FOR THE NHS IN ENGLAND**

1. Wrong site surgery
2. Retained instrument post operation
3. Wrong route administration of chemotherapy
4. Misplaced naso or orogastric tube not detected prior to use
5. Inpatient suicide using non-collapsible rails
6. Escape from within the secure perimeter of medium or high-secure mental health services by patients who are transferred prisoners
7. In-hospital maternal death from post-partum haemorrhage after elective Caesarean section
8. Intravenous administration of mis-selected concentrated potassium chloride

Source: Department of Health (2011)

**BOX 2. NEVER EVENTS FOR 2011/12 FOR THE NHS IN ENGLAND**

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post operation
4. Wrongly prepared high-risk injectable medication
5. Maladministration of potassium-containing solution
6. Wrong route administration of chemotherapy
7. Wrong route administration of oral/enteral treatment
8. Intravenous administration of epidural medication
9. Maladministration of insulin
10. Overdose of midazolam during conscious sedation
11. Opioid overdose of an opioid-naïve patient
12. Inappropriate administration of daily oral methotrexate
13. Suicide using non-collapsible rails
14. Escape of a transferred prisoner
15. Falls from unrestricted window
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO or HLA-incompatible organs
19. Misplaced naso or orogastric tubes
20. Wrong gas administered
21. Failure to monitor and respond to oxygen saturation
22. Air embolism
23. Misidentification of patients
24. Severe scalding of patients
25. Maternal death due to post-partum haemorrhage after elective Caesarean section

Source: Department of Health (2011)


**LOOK OUT FOR UPCOMING ARTICLES ON NEVER EVENTS IN NURSING TIMES**

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