The College of Emergency Medicine

Never Events

Could they occur in your Emergency Department?

Safer Care

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The College of Emergency Medicine

Never Events 2013 – Could they occur in your Emergency Department?

Never Events are incidents which are considered unacceptable and eminently preventable. The Safer Care Sub-Committee has prepared this guide which highlights Never Events that could occur within your Emergency Department (ED). It proposes examples of how to mitigate the risk of these happening and relevant NPSA ALERTS and resources.

For further information about Never Events please visit the Department of Health website:
https://www.gov.uk/government/publications/the-never-events-list-2012-to-2013

Never Event	*Relevant to the ED?*	*Relevance/examples in ED?*	*Examples of risk mitigation*	*Relevant NPSA ALERT and resources*
1. Wrong site surgery includes drain insertion	☑	Surgical intervention on the wrong site for example chest drain	• Education and competency training for medical staff • Use of checklists	*Patient Safety Alert – WHO Surgical Safety Checklist, 2009* http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/
2. Wrong implant	☒	*Not a risk in the ED*		
3. Retained foreign object post operation	☑	Retention of guide wire post central venous access insertion Retention of swabs- possible in management of heavy vaginal bleeding	• Education and competency training for medical staff • Double check guidewire removed • Check central line packs have long enough guidewires • Checklist/sticker • Count swab packs by two people • Use large swabs with tape not small swabs	*Patient Safety Alert – WHO Surgical Safety Checklist, 2009* http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/

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4. Wrongly prepared high risk injectable	☑	Includes drugs such as heparin/midazolam/ ketamine	• Trust should have own list of high risk medications • Ensure high strength ketamine and midazolam either removed or stored separately • Education to Nursing and Medical staff	*Patient Safety Alert - Promoting safer use of injectable medicines*, 2007 http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59812&p=4
5. Maladministration of K+ containing solutions	☑	Wrong route Wrong infusion rate Selection of strong K+ solution instead of other intended medication	• Check safe storage of potassium containing solutions • Up to date protocol regarding administration • Consider removing high strength potassium from ED – rarely used	*Patient safety alert – Potassium chloride concentrate solutions, 2002 (updated 2003),* http://www.nrls.npsa.nhs.uk/resources/?entryid45=59882
6. Wrong route administration of chemotherapy	☒	*Not a risk in the ED*		
7. Wrong route administration of oral/enteral medication	☑	*Possibly a risk in ED* Patient with an Naso Gastric (NG) tube inadvertently given the drug prepared for NG use via an intravenous line	• Do not use intravenous syringes to measure and administer oral medication • Stock oral and enteral syringes	*Patient Safety Alert NPSA/2007/19 - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes,* 2007, www.nrls.npsa.nhs.uk/resources/?entryid45=59808
8. Intravenous administration of epidural medication	☒	*Not a risk in the ED*		

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9. Maladministration of insulin	☑	Using any abbreviation for the words 'unit' or 'units' when prescribing insulin Unclear or misinterpreted verbal instruction Failure to use a specific insulin administration device e.g. an insulin syringe / pen to draw up or administer insulin Failure to give insulin when correctly prescribed	• Education to nursing and medical staff	*Rapid response report – Safer administration of insulin*, 2010, available at http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287 *NHS Diabetes – Safe use of insulin, 2010,* available at http://www.diabetes.nhs.uk/safe_use_of_insulin *NHSIII Toolkit – Think Glucose, 2008,* available at www.institute.nhs.uk/thinkglucose
10. Overdose of Midazolam during conscious sedation	☑	Death or severe harm as a result of overdose of midazolam injection following use of high strength midazolam (5mg/ml or 2mg/ml) for conscious sedation. Excludes areas where use of high strength midazolam **is** appropriate. These are specifically only in general anaesthesia, ITU, palliative care, or where its use has been **formally risk assessed.** Excludes paediatric care.	• Risk assessment completed for use of midazolam for conscious sedation • Competency sign-off • 2-doctor procedure	*Rapid Response Report - Reducing risk of overdose with midazolam injection in adults*, 2008, available at www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59896&p=2

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11. Opiate overdose of an opioid naïve patient	☑	Death or severe harm as a result of an overdose of an opioid given to a patient who was opioid naïve. Specifically this means: 1) A dose is used that is not consistent with the local agreed protocol for opioid-naïve patients 2) Failure to ensure familiarity with the characteristics of opioid prescribed	• Ensure protocol exists for safe dosing of opioid medication • Excluded are cases where the patient was already receiving opioid medication	*Rapid Response Report – Reducing dosing errors with opioid medicines,* 2008, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59888 *Guideline, Nasal diamorphine for children* http://secure.collemergencymed.ac.uk/asp/document.asp?ID=5013
12. Inappropriate administration of daily oral methotrexate	☑	*Possibly a risk in ED*	• Do not allow the prescription of methotrexate in ED- discuss with pharmacy to ensure they do not dispense to ED	
13. Suicide using non collapsible rails	☒	*Does not apply in the ED as setting is for mental health inpatient premises.*	• Check with estates that curtain & shower rails are collapsible	
13. Escape of a transferred prisoner	☒	*Does not apply in the ED, setting is medium and high secure mental health inpatient premises*		

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14. Falls from unrestricted windows	☑	Applies to windows "within reach" of patients Includes deliberate or accident fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall	• Check with estates that window restrictors are fitted and not damaged	
15. Entrapment in bedrails	☑	Death or severe harm as a result of entrapment of an adult in bedrails that do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) dimensional guidance	• Check with Medical equipment that bedrails comply.	*Safer practice notice – Using bedrails safely and effectively,* 2007, available at www.nrls.npsa.nhs.uk/resources/?EntryId45=59815-*DB2006(06)* *Safe use of bed rails,* 2006, available at http://www.mhra.gov.uk/home/idcplg?IdcService=GET_FILE&dDocName=CON2025397

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17. Transfusion of ABO incompatible blood components	☑	Death or severe harm as a result of the inadvertent transfusion of ABO-incompatible blood	• Training and education and competency assessment for medical and nursing staff • Clear protocol for naming unknown patients • Double transfusion samples	*Safer Practice Notice – Right Patient, Right Blood*, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59805 *SHOT Lessons for clinical staff*, 2007, available at www.shotuk.org/wp-ontent/uploads/2010/03/SHOT-lessons-for-clinical-staff-website.pdf *SHOT Lessons for Clinical Staff* 2009, available at www.shotuk.org/wp-content/uploads/2010/12/Lessons-for-Clinical-Staff-Dec-2010.pdf
18.Transplantation of ABO / HLA incompatible organs	☒	*Not a risk in the ED*		
19. Misplaced naso or orogastric tubes	☑	Death or severe harm as a result of a naso- or oro-gastric tube being misplaced in the respiratory tract	• E-learning packages available	*Patient safety alert – Reducing harm caused by misplaced nasogastric feeding tubes*, 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59794

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20. Wrong gas administered	☑	Death or severe harm as a result of the administration of the wrong gas, or failure to administer any gas	• Remove all air flow meters to reduce risk	*Rapid Response Report - Oxygen Safety in Hospitals*, 2009, available at http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=62811
21. Failure to monitor and respond to oxygen saturation	☑	Death or severe harm as a result of failure to monitor or respond to oxygen saturation levels in a patient undergoing conscious sedation. Includes failure to have monitoring in place, and failure to act on information from monitoring oxygen saturation.	• Conscious sedation policy to include monitoring and responding to oxygen saturation • Checklists	*Report of an intercollegiate working party chaired by the Royal College of Anaesthetists,* 2001, available at http://www.rcoa.ac.uk/system/files/PUB-SafeSedPrac.pdf *Safe Sedation in the Emergency Department* **-** *Report and Recommendations*, Royal College of Anaesthetists and College of Emergency Medicine, 2012, available at http://secure.collemergencymed.ac.uk/Shop-Floor/Clinical%20Guidelines/College%20Guidelines/default.asp
22. Air Embolism	☑	Introduction of an air embolism after the insertion of a central venous catheter, through the line, and during its removal, is included	• competency sign-off • training	*Section 9.8 - Air Embolism, RCN; Standards for Infusion Therapy,* 2010, available at http://www.rcn.org.uk/__data/assets/pdf_file/0005/78593/002179.pdf

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23. Misidentification of patients	☑	Death or severe harm as a result of Administration of the wrong treatment following inpatient misidentification due to a failure to use standard wristband Failure to follow clear and consistent processes for producing, applying and checking patient wristbands Printing several labels with patient details at one time	• Check Trust compliance with wristband production • Protocol in place and education and training	*Safer Practice Notice – Standardising Wristbands improves patient safety, 2007,* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824
24. Severe Scalding of patients	☑	Death or severe harm as a result of a patient being scalded by water used for washing/bathing	• Check with estates that water temperature is regulated	
25. Maternal death due to post partum haemorrhage after elective caesarean section	☒	*Not a risk in the ED*		