NHS England

# Never Events List 2015/16

| Publications Gateway Reference: | |
|---|---|
| **Document Purpose** | Policy |
| **Document Name** | Never Events List 2015/16 |
| **Author** | NHS England Patient Safety Domain |
| **Publication Date** | 27 March 2015 |
| **Target Audience** | CCG Clinical Leaders, CCG Accountable Officers, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing |
| **Additional Circulation List** | |
| **Description** | The Revised Never Events Policy and Framework provides clarity for staff providing and commissioning NHS funded services who may be involved in identifying, investigating or managing Never Events. It is relevant to all NHS funded care. |
| **Cross Reference** | Serious Incident Framework |
| **Superseded Docs** (if applicable) | The Never Events Policy Framework - October 2012 |
| **Action Required** | Implement policy within organisations providing NHS funded care |
| **Timing / Deadlines** (if applicable) | **To be implemented from 1 April 2015** |
| **Contact Details for further information** | Patient Safety Domain<br>NHS England<br>Skipton House<br>80 London Road<br>London<br>SE1 6LH |

## Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes."

## The never events list 2015/16

The following never events list is the list that all organisations providing NHS care should use. It is applicable for all incidents that occur on or after 1 April 2015.

| **SURGICAL** |
| --- |
| **1. Wrong site surgery** |
| A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure.<br>• Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines.<br>• Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes.<br>• Excludes incidents where the wrong site surgery is due to incorrect laboratory reports/ results or incorrect referral letters<br>**Setting:** All patients receiving NHS funded care.<br>**Guidance:**<br>- *Safer Practice Notice – Standardising Wristbands improves patient safety, 2007,* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824<br>- *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/<br>- *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901<br>*- Safe Anaesthesia Liaison Group – Stop before you block 2011*<br>https://www.rcoa.ac.uk/sites/default/files/CSQ-PS-sbyb-supporting.pdf<br>*-Standards for providing a 24 hour interventional radiology service, 2008, The Royal College of Radiologists.* Available at http://www.rcr.ac.uk/docs/radiology/pdf/Stand_24hr_IR_provision.pdf |

**2. Wrong implant/prosthesis**

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the patient is other than that specified in the surgical plan either prior to or during the procedure and the incident is detected at any time after the implant/prosthesis is placed in the patient.

- Excludes where the implant/prosthesis placed in the patient is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure
- Excludes where the implant/prosthesis placed in the patient is intentionally planned and placed but later found to be suboptimal.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *Safer Practice Notice – Standardising Wristbands improves patient safety, 2007,* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59824
- *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/
- *Safer Surgery Checklist for Cataract Surgery,* 2010, available at http://www.rcophth.ac.uk/page.asp?section=365&sectionTitle=Information+
- *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901

**3. Retained foreign object post-procedure**

Retention of a foreign object in a patient after a surgical/invasive procedure.

'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas

'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) **except where:**

- Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure

and they are not removed

- Items are inserted during the procedure that are subject to the counting/ checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patients notes
- Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention

See the **Appendix A on page 11** for examples of correct application of this never event definition.

**Settings:** All patients receiving NHS funded care.

**Guidance:**
- *Standards and recommendations for safe perioperative practice*, 2007, available at http://www.afpp.org.uk/news/safe-practice-highlighted-in-new-afpp-publication
*Accountable items, swab, instrument and needle count*, AfPP 2012, available at http://www.afpp.org.uk/careers/Standards-Guidance
- *Patient Safety Alert – WHO Surgical Safety Checklist, 2009,* available at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/
- *How to Guide to the five steps to safer surgery', 2010,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=92901
- *Reducing the risk of retained throat packs after surgery*, 2009, available at
-http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59853
-*Reducing the risk of retained swabs after vaginal birth and perineal suturing,* 2010, available at
http://www.nrls.npsa.nhs.uk/resources/?EntryId45=74113
- *Risk of harm from retained guide wires following central venous access*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132829
- *Tracking subsequent removal of intentionally retained swabs*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132834&p=2

## MEDICATION

### 4. Mis – selection of a strong potassium containing solution

Mis - selection refers to:

- When a patient intravenously receives a strong[1] potassium solution rather than an intended different medication

[1] ≥10% potassium w/v (e.g. ≥ 0.1g/ml potassium chloride, 1.3mmol/ml potassium chloride)

**Setting:** All patients receiving NHS funded care.

**Guidance:**
*- Patient safety alert – Potassium chloride concentrate solutions, 2002 (updated 2003),* available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59882

## 5. Wrong route administration of medication

The patient receives one of the following:

- Intravenous chemotherapy administered via the intrathecal route
- Oral/enteral medication or feed/flush administered by any parenteral route
- Intravenous administration of a medicine intended to be administered via the epidural route

**Setting**: All patients receiving NHS funded care.

**Guidance**:
*- HSC2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy, 2008, available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_086870*

*- Rapid Response Report NPSA/2008/RRR004 using vinca alkaloid minibags (adult/adolescent units), 2008, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59890*

*- Minimising Risks of Mismatching Spinal, Epidural and Regional Devices with Incompatible Connectors, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=132897*

*- Patient safety alert on non-Luer spinal (intrathecal) devices for chemotherapy 2014. available at http://www.england.nhs.uk/2014/02/20/psa-spinal-chemo/*

*- Patient Safety Alert NPSA/2007/19 - Promoting safer measurement and administration of liquid medicines via oral and other enteral routes, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59808*

*- Patient Safety Alert NPSA/2007/21, Safer practice with epidural injections and infusions, 2007, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59807*

## 6. Overdose of Insulin due to abbreviations or incorrect device

Overdose refers to:

- When a patient receives a tenfold or greater overdose of insulin because a prescriber abbreviates the words ‘unit’ or ‘international units’ , despite the care setting having an electronic prescribing system in place
- When a health care professional fails to use a specific insulin administration device i.e. does not use an insulin syringe or insulin pen to measure insulin

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *Rapid response report – Safer administration of insulin*, 2010, available at http://www.nrls.npsa.nhs.uk/alerts/?entryid45=74287Diabetes: insulin, use it safely Patient information booklet 03 January 2011 - NHS Diabetes and Kidney Care

Available at
http://www.nhsiq.nhs.uk/resource-search/publications/nhs-dakc-insulin-use-it-safely.aspx

Insulin use safety: Patient Safety Resource Centre The Health Foundation
Available at

*http://patientsafety.health.org.uk/area-of-care/diabetes/insulin-use-safety*

## 7. Overdose of methotrexate for non-cancer treatment

Overdose refers to

- When a patient receives methotrexate ,via any route, for non-cancer treatment which results in more than the intended weekly dose being taken, despite the care setting having an electronic prescribing and administration system , or in primary care an electronic prescribing and dispensing system, in place

**Setting:** All patients receiving NHS funded care.

**Guidance**:
- *Patient safety alert - Improving compliance with oral methotrexate guidelines*, 2006, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59800

**8. Mis – selection of high strength midazolam during conscious sedation**

Mis - selection refers to

- When a patient receives an overdose due to the selection of a high strength midazolam preparation (5mg/ml or 2mg/ml) rather than the 1mg/ml preparation, in a clinical area performing conscious sedation.
- Excludes clinical areas where the use of high strength midazolam is appropriate. These are generally only in general anaesthesia, intensive care, palliative care, or where its use has been formally risk assessed within an organisation.

Setting: All healthcare premises.

Guidance:

- Rapid Response Report - Reducing risk of overdose with midazolam injection in adults, 2008, available at http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59896&p=2

- Safe sedation, analgesia and anaesthesia with the radiology department, 2003, available at http://www.rcr.ac.uk/publications.aspx?PageID=310&PublicationID=186

- Over sedation for emergency procedures in isolated locations, 2011, available at http://www.nrls.npsa.nhs.uk/resources/type/signals/?entryid45=94848

**MENTAL HEALTH**

**9. Failure to install functional collapsible shower or curtain rails**

Involves either;

- failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted/ successful.
- failure to install collapsible rails and an inpatient suicide is attempted/successful using these non-collapsible rails

**Setting:** All mental health inpatient premises.

**Guidance**:
*Health Building Note (HBN)03-01 – Adult Acute Mental health Units, 2006, available at https://www.gov.uk/government/publications/best-practice-design-and-planning-adult-acute-*

*mental-health-units*
*- NHSE SN (2002) 01: Cubicle rail suspension system with load release support systems,* 2002, available at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_4122863?PageOperation=email- *Clinical guideline 16 – self-harm: the short term physical and psychological management and prevention of self-harm in primary and secondary care,* 2004, available at www.nice.org.uk/guidance/CG16

**GENERAL**

**10. Falls from poorly restricted windows**

A patient falling from poorly restricted window.

- Applies to windows "within reach" of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.
- Includes windows located in facilities/areas where healthcare is provided and where patients can and do access.
- Includes where patients deliberately or accidentally 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.
- Includes where patients are able to deliberately overcome a window restrictor by hand or using commonly available flat bladed instruments as well as the 'key' provided.

**Setting:** All patients receiving NHS funded care

**Guidance:**
*- Health Building Note (HBN) 00-10 Part D: Windows and associated hardware*, available via https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273867/20131223_HBN_00-10_PartD_FINAL_published_version.pdf
*- DH(2014)/003 – Window restrictors of cable and socket design, 2014, available at https://www.cas.dh.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102246*

*- Risk of falling from windows*, available at http://www.hse.gov.uk/healthservices/falls-windows.htm

**11. Chest or neck entrapment in bedrails**

Entrapment of a patient's chest or neck within bedrails, or between bedrails, bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance

**Setting:** All settings providing NHS funded healthcare, including NHS funded patients in care home settings, and equipment provided by the NHS for use in patients' own homes.

**Guidance:**
- *Safer practice notice – Using bedrails safely and effectively,* 2007, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59815
- *DB 2006(06) v 2.1 Safe use of bed rails,* Dec 2013, available at http://www.mhra.gov.uk/home/groups/dts-bs/documents/publication/con2025397.pdf
- *Local Authority Circular - Bed Rail Risk Management,* 2003, available at http://www.hse.gov.uk/lau/lacs/79-8.htm
- *Safe use of bedrails*, available at http://www.hse.gov.uk/healthservices/bed-rails.htm

**12. Transfusion or transplantation of ABO-incompatible blood components or organs**

Unintentional transfusion of ABO-incompatible blood components.

- Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management.

Unintentional ABO mismatched solid organ transplantation.

- Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately
- In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *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 http://www.shotuk.org/wp-content/uploads/2010/03/SHOT-lessons-for-clinical-staff-website.pdf
- *SHOT Lessons for Clinical Staff* 2009, available at http://www.shotuk.org/wp-

content/uploads/2010/12/Lessons-for-Clinical-Staff-Dec-2010.pdf
- *BSHI and BTS Guidelines for the Detection and Characterisation of Clinically Relevant Antibodies in Allotransplantation,* 2010, available at http://www.bts.org.uk/Documents/Guidelines/Active/A6.pdf
- *Antibody incompatible transplant guidelines*, 2011, available at http://www.bts.org.uk/Documents/Guidelines/Active/AiT%20guidelines%20Jan%202011%20FINAL.pdf
- *Patient Safety Alert – WHO Surgical Safety Checklist,* 2009*,* available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59860

**13. Misplaced naso- or oro-gastric tubes**

Misplacement and use of a naso- or oro-gastric tube in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration.

**Setting:** All patients receiving NHS funded care.

**Guidance:**
- *Patient safety alert – Reducing harm caused by misplaced nasogastric feeding tubes,* 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59794
- *Patient safety alert – Reducing harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units*, 2005, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59798&q=0%c2%acnasogastric%c2%ac
- *Reducing the harm caused by misplaced naso-gastric feeding tubes in adults, children and infants*, 2011, available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=129640&p=2
- *Harm from flushing of naso-gastric tubes before confirmation of placement*, 2012. available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=133441

*Patient safety alert on placement devices for nasogastric tube insertion* - http://www.england.nhs.uk/2013/12/05/psa-ng-tube/

**14. Scalding of patients**

Patient being scalded by water used for washing/bathing

- Excludes scalds from water being used for purposes other than washing/bathing (e.g. from kettles)

**Settings:** All patients receiving NHS funded care.

**Guidance:**
- *Health Technical Memorandum 04-01 - The control of* Legionella*, hygiene, "safe" hot water, cold water and drinking water systems*, 2006, available via https://www.gov.uk/government/publications/hot-and-cold-water-supply-storage-and-distribution-systems-for-healthcare-premises
- *Health Building Note 00-10 Part C - Sanitary assemblies,* 2013, available via https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/148497/HBN_00-10_Part_C_Final.pdf

- *Scalding risks from hot water in health and social care LAC: 79/5,* 2007, available at http://www.hse.gov.uk/lau/lacs/79-5.htm
- *Scalding and burning*, available at http://www.hse.gov.uk/healthservices/scalding-burning.htm

## Appendix A: Retained foreign object post procedure

Earlier definitions of the never event type 'Retained foreign object post operation' were not consistently applied, so examples are provided below to assist consistent application of the current clarified definition. The examples below are intended solely as **illustrative examples of the principles of the definition**, not a complete list of circumstances where the definition applies.

Note that the principles of the definition relate to items that should be subject to a formal counting or checking process at the commencement of the procedure and a counting or checking process before the procedure is completed. The size of the retained foreign object and the potential for harm from the retained foreign object is irrelevant to its designation as a never event.

| **Circumstances** | **Does this fit the never event definition?** |
|---|---|
| *A patient underwent gynaecological surgery and had a vaginal pack/vaginal tampon intentionally left in place at the end of surgery, with removal planned for 48 hours after surgery. Unfortunately, the planned removal did not take place, and the error was only brought to light after the patient was sent home and she went to her GP complaining of vaginal discomfort and discharge. He examined her and found the pack.* | This does not meet the definition of a never event, as the vaginal pack was intentionally retained after the procedure; once outside the controlled counting processes in theatre, the never event principle of being eminently preventable if existing guidance was followed does not apply. This incident is still likely to fit the definition of a Serious Incident and should be reported via STEIS and the NRLS, with all possible steps taken to prevent similar events occurring in future. |
| *A patient needed suturing after an episiotomy during vaginal birth. To create a clear view for the suturing procedure, three swabs were placed in the vagina. The intention was to remove these as soon as suturing was complete, but only two swabs were removed. The error was only brought to light when the swab fell out a few days after the patient and her baby went home.* | This meets the definition of a never event; the swab was not intentionally retained and all swabs should have been counted at the time of the procedure. |
| *A patient undergoing eye surgery as day case had a pledget (a small swab) inserted under her eyelid an hour pre-operatively to deliver topical medication. The pledget should have been removed during the surgery but was not. The patient telephoned for advice on a painful eye the day after her procedure and when she came back to the unit to be examined the pledget was found and removed.* | This does not meet the definition of the never event, as the pledget was inserted outside the controlled counting processes in theatre, therefore the never event principle of being eminently preventable if existing guidance was followed does not apply. This incident is still likely to fit the definition of a Serious Incident and should be reported via STEIS and the NRLS, with all possible steps taken to prevent similar events occurring in future. |

| | |
|---|---|
| *A patient undergoing eye surgery as day case had a pledget (a small swab) inserted under her eyelid at the beginning of the procedure. The pledget should have been removed at the end of the surgery but was not. The patient telephoned for advice because her eye was painful the day after her procedure and when she came back to the unit to be examined the pledget was found and removed.* | This meets the definition of a never event; the pledget was not intentionally retained and all pledgets should have been counted at the time of the procedure. |
| *A patient had an interventional cardiology procedure using a guidewire. When the doctor tried to remove the guidewire, it appeared to be stuck. It was left in place so that x-rays could be taken and expert advice sought before its removal was attempted.* | This does not meet the definition of the never event, as the guidewire was known to be retained prior to the completion of the procedure, but immediate action to retrieve it would be impossible or be more damaging than retention. This incident is still likely to fit the definition of a Serious Incident and should be reported via STEIS and the NRLS, with all possible steps taken to prevent similar events occurring in future. Additional reporting to the MHRA would also be required if an equipment fault could have been implicated. |
| *A patient had an interventional cardiology procedure using a guidewire. No problems with the procedure were noticed at the time, but when an x-ray was taken for another reason several days later, a broken-off guidewire tip was found lodged in a blood vessel.* | This meets the definition of a never event as the guidewire should have been checked for completeness when it was removed at the end of the procedure. |

## Appendix B - Rationale for amendments to the Never Events List (including consideration of October 2014 open consultation)

| Action | Never Event | Rationale |
|---|---|---|
| **Removed** | Maternal death due to post-partum haemorrhage after elective caesarean section | The guidance for a post-partum haemorrhage is not considered to be any more robust than for any other major haemorrhage and therefore, does not meet the definition that requires the availability of strong systemic protective barriers to make it wholly preventable. This Never Event was also defined by an outcome (death) that would not in itself reflect how significant the failure of barriers had been, as it could be affected by a number of other factors<br>*313 consultation respondents agreed with the removal of this Never Event and 38 did not.* |

| | | |
|---|---|---|
| **Removed** | Wrongly manufactured high-risk injectable medication | Note the existing Never Event was not sufficiently specific in terms of its scope, and no Never Events had ever been reported under this category. It had been most commonly understood to be encompassing local manufacture of medication within a pharmacy department (though some responses to consultation considered it could or should apply to any reconstitution of high risk medication in a ward area, e.g. setting up a heparin pump). The strong systemic protective barriers required i.e. the national availability of, and the use in all clinical areas, of ready to administer injectable medication products requires a national plan that was beyond the timescales of this review. We recognise the support that inclusion of this Never Event has received and with this in mind we look to undertake an impact assessment with NHS partners that will be reviewed again in 2016 to ensure that this gets a high level of attention as a prime candidate for future inclusion on the list under the appropriate circumstances.<br>It is important to note that the majority of feedback responses were contradictory in that they agreed there were currently no strong barriers to prevent human error, and yet still supported its retention as a Never Event. This may relate to persistent belief amongst pharmacists in the 'perfection myth' (that if individuals strive hard enough not to make error, they will not make errors).<br>*305 consultation respondents agreed with this Never Event and 46 did not, so it will be reviewed next year for inclusion with further information.* |
| **Removed** | Opioid overdose of an opioid/opiate-naïve patient | The strong systemic protective barriers to prevent this are not strong enough at present as they rely on the provision of clinical guidance and the education and training of health professionals only<br>*313 consultation respondents agreed with the removal of this Never Event and 38 did not.* |
| **Removed** | Escape of a transferred prisoner | This was removed from the list as the barriers to prevent this are not strong enough. It was felt that they are treated as a serious incident and investigated and this is the important issue.<br>*During the consultation 154 from 174 responses agreed that it should be removed as a never event* |

| | | |
|---|---|---|
| **Removed** | Wrong gas administered | The guidance relating to the administration of gases does not represent a sufficiently strong systemic protective barrier to prevent inappropriate administration – hence this category does not meet the Never Event criteria<br>*296 consultation respondents agreed with the removal of this Never Event and 55 did not.* |
| **Removed** | Failure to monitor and respond to oxygen saturation | The overwhelming majority of respondents agreed with removal of this incident as a Never Event However there was some discomfort about removing this, most notably from the Royal College of Anaesthetists. They felt that as pulse oximetry is so commonly used now that it should remain but be renamed as 'Failure to respond to oxygen saturation'. A small number of others commented that although the current barriers are weak, keeping it as a Never Event but working on strengthening the barriers was the way forward. On evaluation however, the current barriers which are the use of standard operating procedures, the implementation and use of protocols and guidelines, education and awareness were not felt to be strong enough to prevent the incident occurring, and therefore the incident did not fit the required criteria to remain a Never Event<br>*142 consultation responses agreed that it should be removed and 31 disagreed.* |
| **Removed** | Air embolism | The barriers relating to air embolism are not considered to represent a sufficiently strong barrier to protect against inappropriate administration – hence this category does not meet the Never Event criteria. *321 consultation respondents agreed with the removal of this Never Event and 30 did not.* |
| **Removed** | Misidentification of patients | A majority of respondents agreed with removal of this incident as a Never Event. However there was some discomfort about removing this as it was suggested that removing from the list would remove any incentive for change. There was a mixed response regarding whether the barriers were strong enough and supported further work on developing stronger barriers. The core team considered this in detail and felt that as wrong identification of patients was often picked up through other Never Events, most notably Wrong Site Surgery that it should be removed from the list at |

| | | |
|---|---|---|
| | | this time<br>*285 consultation responses agreed that this should be removed and 66 disagreed.* |
| **Merged** | Wrong route medication, was:<br>Wrong route chemo<br>Wrong route oral/enteral treatment<br>Intravenous admin of epidural medication | Merged for simplification<br><br>*339 consultation respondents agreed with these changes and 12 did not.* |
| **Merged** | Transfusion or transplantation of ABO-incompatible blood components or organs, was;<br>Transfusion of ABO incompatible blood components<br>Transplantation of ABO incompatible organs | Merged for simplification. The changes in the ABO incident relate to the appropriate risk assessment of administration of ABO incompatible products (which happens in very high risk patients that are appropriately managed by specialists).<br>*341 consultation respondents agreed with these changes and 10 did not.* |