The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	28 November 2011
Title:	Never Events
Executive Summary:	This report provides a descriptor of a Never Event and list of classification (25) as of 2011. It gives an overview of recent Never Events at RWHT and describes how the Trust manages and mitigates the incidence of Never Events.
Action Requested:	For information and discussion
Report of:	Cheryl Etches, Chief Nurse
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Resource Implications:	Potential oss of payment from commissioners in the event of a Never Event Potential litigation, financial claim and reputational damage to the Trust.
Public or Private: **(with reasons if private)**	Public
References: (eg from/to other committees)	Quality & Safety Committee
Appendices/ **References/** **Background Reading**	Never Events Framework: Update for 2010/11 NPSA The 'Never Events' List for 2011/12 DoH RWHT Policy OP10 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124552
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

1. Background Details

'Never Events' are serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place (DoH 2011).

A policy of 'Never Events' was introduced in April 2009 following the proposal detailed in High Quality Care for All (DoH 2008). The NPSA coproduced a list of eight 'Never Events', this formed part of wider safety improvement efforts in the NHS. The framework was intended to provide a lever for increasing transparency of reporting within organisations including reporting and learning from these very serious incidents. At the outset it was detailed that the original '8' would be phased to increase and this has now happened with '25' never events with another phase expected in the future.

From April 2010 NHS Trusts were required to report 'Never Events' to the NPSA and CQC, which alerts the CQC to risks around the organisation's compliance with registration requirements. In July the DoH committed to build on the changes to reporting and introduced financial contractual penalties to the provider when a 'Never Event' was reported.

2. Never Events

A 'Never Event' can only be classified as such when it meets at least one the following criteria:

- The incident has clear potential for or has caused severe harm/death
- The incident has clear potential for or has caused severe harm/death
- There is evidence of occurrence in the past (i.e. 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
- The event is largely preventable if the guidance is implemented
- Occurrence can be easily defined, identified and continually measured

The occurrence is an indication that an organisation may have not put in place the right systems and processes to prevent the incidents from happening and thereby prevent harmful outcomes..

In February 2011 the DoH expanded the list to 25 Never Events which includes the original 8 published in October 2010 and these are:

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 solutions
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 (applicable to mental health inpatient premises)
14. Escape of a transferred prisoner (applicable to all medium & high security mental health inpatient premises)
15. Falls from unrestricted windows
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO or HLA-incompatible organs
19. Misplaced naso or oro-gastric 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

3. Safety Systems and Improvement

A high number of NHS safety systems were developed in industry and have been adapted to healthcare. This includes Lean principles developed by Toyota which focuses on value, flow and waste reduction through service design.

Within health this relates to the development of clinical pathways and the use of care bundles to create error free processes to deliver high quality, consistent care with efficient use of resources. However, managing the human dimension of safety improvement includes managing complex change and human factors including behaviour.

The Clinical Human Factors Group (CHFG) examined a number of Never Events involving wrong site surgery; the group identified that human factors use knowledge on human behaviour in the design and operation of systems that are safe, effective and efficient. Whilst this is an established discipline in industry it is relatively new in health care. If our systems do not match the way people work, such as the way we process information or make decisions, we set staff up to fail. Safe reliable systems are those which are based on an understanding of human error, which anticipate things go wrong and build in suitable defences.

An example: in healthcare we may find ourselves working with:

- Equipment that does not match our mental models of the way things work
- Information systems that do not allow us to access data we need quickly
- Environments not designed for purpose
- Protocols that conflict with practical ways to get the job done

- Colleagues who are used to working differently
- Time pressures that force us to cut corners
- Teams that do not know each other and cause conflict

These issues can be improved by redesigning systems and processes. Organisations need to encourage reporting of safety incidents to inform the changes that are required to local systems and processes. RWHT has the reputation of being a high reported of incidents reflecting how staff feel able to report errors, this reflects the organisation's commitment to safety in supporting staff to continue with this behaviour.

'Never Events' in RWHT

During 2010 – 2011 there were no reported Never Events. In 2011 to present there have been 7 and these are detailed in Table 1. The number of reported 'Never Events' at RWHT has increased due to much improved reporting and recognition of human error combined with the expanded list of reportable events now in place. Whilst the Trust should aspire to zero tolerance this must be balanced with support to staff to continue to report and not to hide incidents including 'Never Events'.

Table 1

Date	Incident
2 March 2011	Throat pack inserted in theatre and not removed following induction of anaesthetic causing airway obstruction
11 May 2011	Swab left in vagina post delivery
13 June 2011	Biopsy performed on wrong patient
26 June 2011	Patient found unresponsive by empty oxygen cylinder. No escalation to doctor overnight
12 Aug 2011	Swab left inside patient by surgeon
15 Aug 2011	Insulin prescribed but not given for 12 days
16 Oct 2011	Methotrexate given daily instead of weekly

'Never Events' are supported by national guidance and/or patient safety alerts, which should prevent their occurrence. The Royal Wolverhampton NHS Trust has implemented a process to ensure that patient safety alerts from the NPSA and Rapid Response Reports are cascaded and acted upon within the divisions and this is governed through the Quality & Safety Committee. This will contribute to reducing the risk of never events within the organisation.

The Board is asked to note the content of the report.