

Identification of Common Themes from Never Events Data Published by NHS England

Islam Omar ¹, Yitka Graham ^{1,2}, Rishi Singhal ³, Michael Wilson ⁴, Brijesh Madhok ⁵, Kamal Mahawar ^{1,2}

1. Bariatric Unit, Department of General Surgery, Sunderland Royal Hospital, South Tyneside and Sunderland NHS Trust, UK
2. Faculty of Health Sciences and Wellbeing, University of Sunderland, UK
3. Birmingham Heartlands Hospital, University Hospital Birmingham NHS Foundation Trust, Birmingham, UK
4. NHS Forth Valley, Larbert, Scotland, UK
5. Royal Derby Hospital, University Hospitals of Derby & Burton NHS Foundation Trust, Derby, UK

Background:

Never events (NEs) are serious clinical incidents that cause potentially avoidable harm and impose a significant financial burden on healthcare systems. The purpose of this study was to identify common never events.

Methods:

We analysed the NHS England NE data from 2012 to 2020 to identify common never events category and themes.

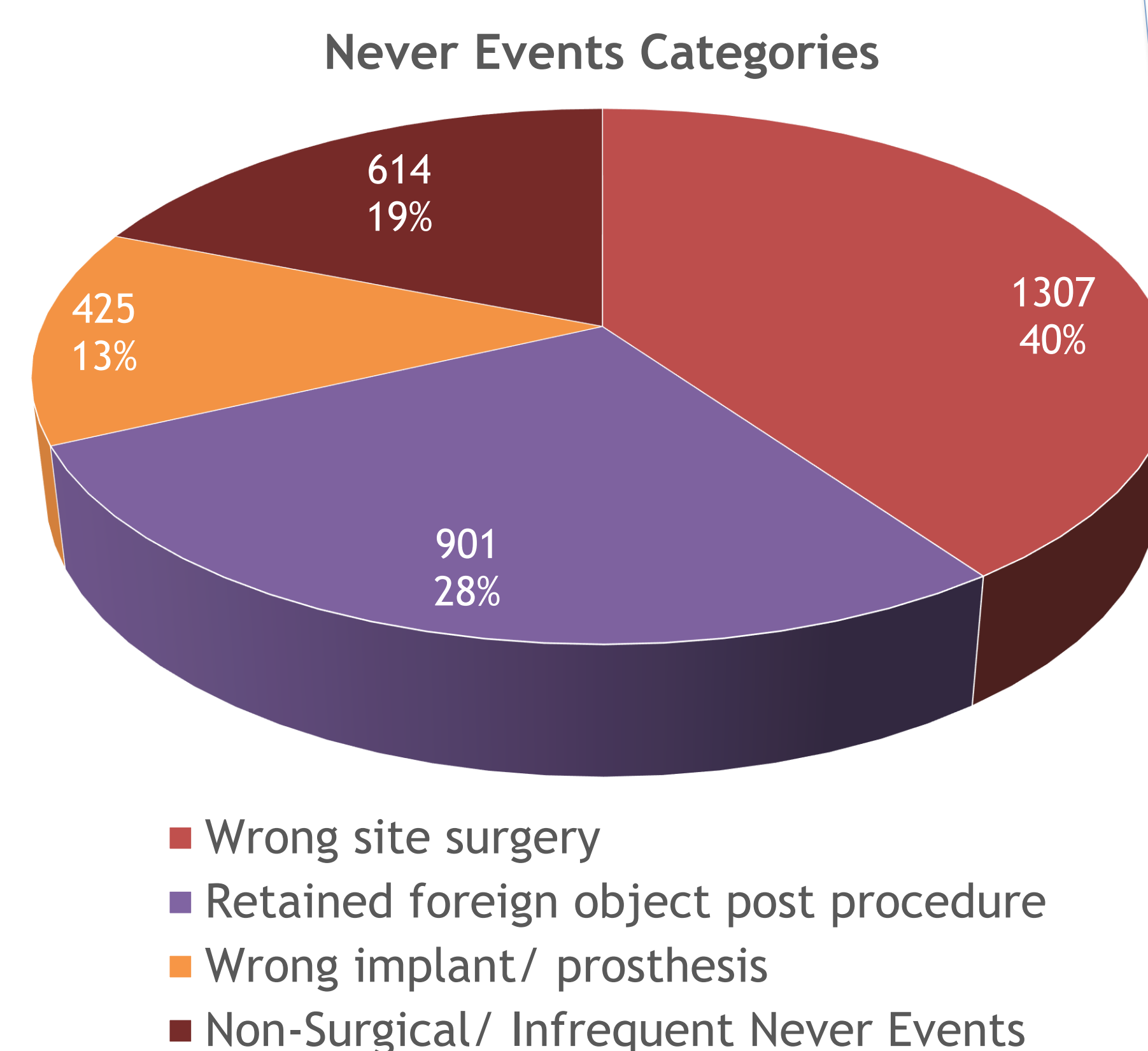


Figure 1. Never Events Main Categories

Results:

- We identified 51 common NE themes in 4 main categories out of a total of 3247 NE reported during this period (Figure 1).
- Wrong-side (laterality) and wrong tooth removal were the most common wrong-site NE accounting for 300 (22.95%) and 263 (20.12%) incidents, respectively.
- There were 197 (15%) wrong-site blocks, 125 (9.56%) wrong procedures, and 96 (7.3%) wrong skin lesions excised.
- Vaginal swabs were the most commonly retained items (276;30.63%) followed by surgical swabs (164;18.20%) and guidewires (152;16.87%). There were 67 (7.44%) incidents of retained parts of instruments and 48 (5.33%) retained instruments.
- Wrong intraocular lenses (165; 38.82%) were the most common wrong implants followed by wrong hip prostheses (n = 94; 22.11%) and wrong knees (n = 91; 21.41%).
- Non-surgical events accounted for 18.9% (n = 614) of the total incidents. Misplaced naso-or oro-gastric tubes (n = 178;29%) and wrong-route administration of medications were the most common events in this category (n = 111;18%), followed by unintentional connection of a patient requiring oxygen to an air flow-meter (n = 93; 15%).

Conclusion:

- This paper identifies common NE categories and themes.
- Awareness of these might help reduce their incidence.

