ABM University Health Board	
Date of Meeting: 1st February 2018 **Name of Meeting: Quality & Safety Committee** **Agenda item: 4.7**	
Subject	*ABMU Health Board Never Event Report*
Prepared by	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services
Approved by	Cathy Dowling, Interim Deputy Director of Nursing & Patient Experience
Presented by	Angela Hopkins, Interim Director of Nursing & Patient Experience

1. Purpose

This report is to provide the Quality & Safety Committee with an analysis of never events which have been reported to Welsh Government during the period April 2014 to January (22nd) 2018.

2. Background

A never event is classed as an incident which should never happen, the grade of the incident can vary and the grade is not dependent on whether it should be reported as a never event. The fact that a never event occurs, regardless of the severity of the incident, requires it to be reported and investigated as a never event incident.
The current Never Event list of incidents to be reported is as follows:

- Wrong site surgery
- Wrong implant/prosthesis
- Retained foreign object post procedure
- Mis-selection of a strong potassium containing solution
- Wrong route administration of medication
- Overdose of insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non cancer treatment
- Mis-selection of high strength midazolam during conscious sedation
- Failure to install functional collapsible shower or curtain rails
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Transfusion or transplantation of ABO incompatible blood components or organs
- Misplaced naso- or oro- gastric tubes
- Scalding of patients

NHS Improvement have issued new never event reporting criteria which will come into place form 1st February 2018 with the main changes identified as the following types of incidents now being classed as never events:

- Unintentional connection of a patient requiring oxygen to an air flow meter and;
- Undetected oesophageal intubation.

3. Never Events reported in the Health Board

During the period April 2014 to January (22nd) 2018 a total of 18 never events were reported to Welsh Government which are summarised in table 1 by type of never event and root cause/theme.

Table 1

Type of Never Event	Root Causes/Themes
9 wrong implant/prosthesis	• WHO checklist not used (5) • No whiteboard used (5) • Noise & distractions • Change to surgical procedure (2) • Product: packaging • storage • familiarity/unfamiliarity (3) • Staffing • Procedures (3) • Training re components • Safety briefing & debrief • Training re components
3 Wrong Site Surgery	• Difficult procedure not anticipated • Locum • Change from planned procedure not verbalised by surgeon to team
3 retained foreign object	• Communication (2) • Handover • Roles and responsibilities • Checking procedures
2 Misplaced Naso Gastric tubes	• NG placed out of hours, not in line with policy • Documentation • Communication between professional Groups • Health Board Policy did not cover free drainage • Non compliance with Nasogastric Feeding Tube Insertion and Position Checking Procedures for Adults. • Education and training

1 Wrong route medication	• No standardised process for topping up epidurals • Safety design, syringes fit on epidural and IV cannula's (All Wales Neuralaxial Connectors Group looking at this risk)

There are four never events which are under investigation as they occurred in quarter 3 and 4 of 2017/18 relating to wrong implant/prosthesis (2) and wrong site surgery (2).

4. Actions Taken by the Health Board

The Health Board has taken a number of actions to learning from the never events and take action to minimise recurrence which include:

4.1 External Review of Theatres

The Health Board commissioned an external review of theatres following the never events reported in 2015/16 following which an action plan was developed and is being implemented. The action plan has been updated following each never event which has occurred in theatres and is currently being updated and reviewed by external clinical leads for orthopaedics and theatres, commissioned following a never event in quarter 3 of 2017/18.

4.2 Management of Naso Gastric Tubes Task & Finnish Group

A Group was established to review the recommendations following the investigation of a never event involving a naso gastric tube. The Group is chaired by the Deputy Medical Director and has overseen the review and updating of the policy and procedures for the management of naso gastric tubes and reviewed training requirements. A report identifying the training options available to the Health Board will be considered by the next Nursing & Midwifery Board.

4.3 National Safety Standards for Invasive Procedures (NatSSIPs) Group

A Group was established to review and oversee compliance with the Patient Safety Alert to standardise processes. Compliance with the alert was achieved ahead of the deadline. The learning and recommendations from the never events relating to theatres and orthopaedics which occurred in 2016/17 were presented to the NatSSIP Group last year.

4.4 Revised Process for the Management of Never Events

A revised process for the management of never events was introduced in September 2017 which starts with an Executive led Strategy meeting held as soon after notification of the never event as possible. Unit Directors and clinicians from the service area where the incident occurred attend the meeting to agree the approach to be taken to investigate the incident and also identify any immediate learning and actions to be taken.]

Examples in approach include an external Consultant and Nurse appointed as the clinical leads to support the Serious Incident Team with their investigation of a never event reported in T&O, Theatres, Morriston.

The meeting covers the patient contact ensuring they are fully informed and there is a plan to keep them updated and also it considers any safeguarding issues, the wellbeing of the staff involved and ensuring all stakeholders are aware of the incident and identifying any immediate learning.

4.5 Reflective Practice Workshops

A new approach to investigating incidents is being trialled, moving away from the traditional approach of interviewing staff and then writing the investigation report. The approach taken on one never event has been to hold a reflective practice workshop where all staff attend and discuss the events leading up to and during the incident. Contributory factors and care/service delivery issues are identified together with learning and immediate actions to be taken. There has been positive feedback from staff, following the initial trial and an evaluation is planned after further testing the methodology in the two ophthalmology incidents workshops.

4.6 Human Factors Training

Morriston theatres and trauma & orthopaedics teams have attended human factors training which was externally facilitated and focussed on safety in team work. The Serious Incident Team in December attended external training on human factors to support them in their investigations of serious incidents and never events.

5. Next Steps

The Assurance & Learning Group in March 2018 will review all these never events, the learning identified, actions taken and the level of assurance which can be obtained from the actions implemented. The Group will also consider whether any further action is required, in light of the recent never events relating to wrong implant/prosthesis and wrong site surgery.

6. Recommendations

The Quality & Safety Committee are requested to note the contents of the report and the further actions being taken.