NHS England

# Never events data summary for 2012/13

THE NHS CONSTITUTION
the NHS belongs to us all

| NHS England INFORMATION READER BOX | | |
|---|---|---|
| **Directorate** | | |
| Medical | Operations | Patients and Information |
| **Nursing** | Policy | Commissioning Development |
| Finance | Human Resources | |

| **Publications Gateway Reference:** | **00868** |
|---|---|
| **Document Purpose** | Resources |
| **Document Name** | Never events data summary for 2012/2013 |
| **Author** | NHS England, Patient Safety Domain Team |
| **Publication Date** | 12 December 2013 |
| **Target Audience** | Published on NHS England website for public access |
| **Additional Circulation List** | |
| **Description** | Annual publication of never events reported as occurring between 1 April 2012 and 31 March 2013 |
| **Cross Reference** | N/A |
| **Superseded Docs** (if applicable) | N/A |
| **Action Required** | N/A |
| **Timing / Deadlines** (if applicable) | **N/A** |
| **Contact Details for further information** | Patient Safety Domain Team<br>Nursing Directorate<br>NHS England<br>4-8 Maple Street<br>London<br>W1T 5HD |

## 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

# Annual publication of never events reported as occurring between 1 April 2012 and 31 March 2013

Never events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on never events, see:

**www.england.nhs.uk/ourwork/patientsafety/never-events/**

**This report provides a summary of never events that occurred between 1 April 2012 and 31 March 2013**.

Data on never events that were reported in the previous year, that is between 01 April 2011 and 31 March 2012, were published in October 2012 as part of the Never Events Policy Framework: an update to the never events policy, October 2012 **http://www.idsc-uk.co.uk/docs-2012/never-events-policy-framework-update-to-policy.pdf** (Appendix 1)

In April 2013, NHS England became responsible for the never events policy framework. Never events data for 2012/13 has therefore been collected from the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS) by the Patient Safety Team at NHS England and is summarised in the tables below. The data from these two systems are not directly comparable due to differences in the way incidents are identified and reported as never events. These data sets do overlap though i.e. many of the incidents reported to the NRLS are also reported to STEIS. As in previous years, the data from STEIS is considered to be the more accurate reflection of the number of never events reported (Tables 1 and 2)

For the first time, NHS England is also providing more detail on the most common never events which occur in relation to surgery. Out of the 290 incidents reported to STEIS during this period, 255 relate to surgery and have been summarised in Tables 3 – 5

Since April 2013, NHS England has also been establishing a new process to improve the timeliness and accuracy of the compilation of never event data. This will enable the routine and regular publication of the data from now on. The data from the first two quarters of 2013/14 is published in a separate document alongside this one.

**Table 1 – Never events reported to the NRLS between 01 April 2012 and 31 March 2013**

| Never Event type | Apparent (free text appears to describe a never event) | Possible (some suggestion of a never event in free text) | TOTAL apparent or possible never events located in the NRLS |
|---|---|---|---|
| **Retained foreign object post procedure** | 102 | 22 | 124 |
| **Wrong site surgery** | 47 | 7 | 54 |
| **Wrong implant/ prosthesis** | 23 | 1 | 24 |
| **Misplaced naso- or oro-gastric tubes** | 12 | 8 | 20 |
| **Escape of transferred prisoner** | 0 | 2 | 2 |
| **Air embolism** | 1 | 3 | 4 |
| **Inappropriate administration of daily oral Methotrexate** | 3 | 1 | 4 |
| **Maladministration of Insulin** | 2 | 0 | 2 |
| **Falls from unrestricted windows** | 0 | 1 | 1 |
| **Opioid overdose of an opioid-naïve Patient** | 0 | 1 | 1 |
| **Wrongly prepared high-risk injectable medication** | 0 | 1 | 1 |
| **TOTAL** | **190** | **47** | **237** |

**Table 2 – Never events reported to STEIS between 01 April 2012 and 31 March 2013**

| Never Event type | Declared as a never event on STEIS and DOES appear to fit NE definition | Declared as a never event on STEIS but DOES NOT appear to fit NE definition | TOTAL Declared as a never event on STEIS |
|---|---|---|---|
| **Retained foreign object post procedure** | 130 | | |
| **Wrong site surgery** | 83 | | |
| **Wrong implant/ prosthesis** | 42 | | |
| **Inappropriate administration of daily oral Methotrexate** | 12 | | |
| **Misplaced naso- or oro-gastric tubes** | 9 | | |

| | | | |
|---|---|---|---|
| **Maladministration of Insulin** | 4 | | |
| **Wrongly prepared high-risk injectable medication** | 3 | | |
| **Transfusion of ABO-incompatible blood components** | 2 | | |
| **Air embolism** | 2 | | |
| **Escape of transferred prisoner** | 1 | | |
| **Falls from unrestricted windows** | 1 | | |
| **Wrong gas administered** | 1 | | |
| **TOTAL** | **290** | **39** | **329** |

**Table 3 – Retained foreign object post procedure between 01 April 2012 and 31 March 2013**

| **Sub theme** | **Number** |
|---|---|
| Vaginal swab, tampon, cotton wool | 47 |
| Surgical swab | 34 |
| Instruments | 11 |
| Guide wire – central line | 6 |
| Laparoscopic specimen bag (with specimen) | 5 |
| Surgical drain | 4 |
| Glove remnant | 3 |
| Pins | 2 |
| Surgical needle | 2 |
| Drill guide | 2 |
| Guide wire – chest drain | 2 |
| Throat pack | 2 |
| Unknown | 2 |
| Part of/ broken instrument | 2 |
| Hypodermic needle | 1 |
| Nasal tampon (used for a laparoscopic procedure) | 1 |
| Anterior Cruciate Ligament (ACL) implant | 1 |
| Guide wire – femoral line | 1 |
| Guide wire – shoulder surgery | 1 |
| Silicone tubing | 1 |
| **TOTAL** | **130** |

**Table 4 – Wrong site surgery between 01 April 2012 and 31 March 2013**

| Sub theme | Number |
|---|---|
| Wrong side/ laterality | 26 |
| Wrong tooth/ teeth removed | 21 |
| Wrong procedure | 12 |
| Wrong lesion | 9 |
| Wrong level spinal surgery | 8 |
| Wrong digit | 5 |
| Wrong organ removed | 1 |
| Unnecessary procedure | 1 |
| **TOTAL** | **83** |

**Table 5 – Wrong implant/ prosthesis between 01 April 2012 and 31 March 2013**

| Sub theme | Number |
|---|---|
| Ophthalmology lens | 29 |
| Knee prosthesis | 6 |
| Hip prosthesis | 5 |
| Plates +/- screws | 2 |
| **TOTAL** | **42** |

**Appendix 1 – Never events reported to NRLS and STEIS between 01 April 2011 and 31 March 2012**

| Never event | Number of never events reported to SHAs 2011/12 | Number of Incidents flagged as never events in the NRLS 2011/12 |
|---|---|---|
| **Wrong site surgery** | 70 | 41 |
| **Wrong implant/prosthesis** | 41 | 15 |
| **Retained foreign object post-operation** | 161 | 86 |
| **Misplaced naso- or oro-gastric tubes** | 23 | 15 |
| **Other types** | 31 | 6 |
| **Total** | **326** | **163** |