NORTHUMBERLAND TYNE AND WEAR NHS FOUNDATION TRUST

NEVER EVENTS LIST - May 2016

Cause Group	Cause 1	Never Event
Medication	ME45 Potassium – Never Event	Mis–selection of a strong potassium containing solution
Medication	ME46 Wrong Route – Never Event	Wrong route administration of medication
Medication	ME47 Overdose of Insulin – Never Event	Overdose of Insulin due to abbreviations or incorrect device
Medication	ME48 Overdose of methotrexate – Never Event	Overdose of methotrexate for non-cancer treatment
Medication	ME49 High Strength Midazolam – Never Event	Mis–selection of high strength midazolam during conscious sedation
Self Harm	SH07 Failure of Collapsible Rail – Never Event	Failure of collapsible curtain or shower rails to collapse when an inpatient suicide is attempted/ successful
Self Harm	SH08 Failure to install collapsible rails – Never Event	Failure to install collapsible rails and an inpatient suicide is attempted/successful using these non-collapsible rails
Patient Accident	PA27 – Fall From Window – Never Event	Falls from poorly restricted windows
Patient Accident	PA28 - Entrapment in bedrails – Never Event	Chest or neck entrapment in bedrails
Patient Accident	PA29 - Misplaced naso- or oro-gastric tubes – Never Event	Misplaced naso- or oro-gastric tubes
Patient Accident	PA30 – Scalding of Patient – Never Event	Patient being scalded by water used for washing/bathing

Detailed guidance on Never Events Definitions, including mitigation to prevent.

MEDICATION	MITIGATION TO PREVENT NEVER EVENT
Mis–selection of a strong potassium containing solution When a patient intravenously receives a strong potassium solution rather than an intended different medication	Mitigating actions taken by NTW – Strong potassium solutions are not stocked by NTW
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	Mitigating actions taken by NTW – The intrathecal and epidural routes would never be utilised by NTW staff Only competent registered nurses approved for intravenous drug administration and doctors may carry out the administration of intravenous medicines and fluids.
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	Mitigating actions taken by NTW – Development of an insulin PGN (NTW(C)38pgn - PPT-PGN-06-Guidelines-Safe Prescribing-Administration-Insulin-V01-Iss2-Jul14) NTW Spotlight on Safety message
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	Mitigating actions taken by NTW – Development of a methotrexate PGN (NTW (C)38 - PPT PGN 09 - The use of Oral Anti-Cancer Medicines and Methotrexate NTW Spotlight on Safety message Only 1 dose supplied from pharmacy, prescription chart **must** accompany the order Trust communications - CAS alert and MMC newsletter

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.	Mitigating actions taken by NTW – High strength midazolam preparations are not stocked by NTW
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	Mitigating actions taken by NTW – All shower and curtain rails are collapsible by design, annual assessment carried out by external company.
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.	Mitigating actions taken by NTW – Assessments have been carried out on all in-patient wards or where patients have access to. Majority of in-patient wards designed on ground floor facilities, so fall from height mitigated by design. Tranwell Unit and Hadrian Clinic subject to significant assessment of risk with controls in place acknowledging window design above ground floors. Risk Registers updated with detailed information relating to risk.

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.	Mitigating actions taken by NTW – Bedrails provided in line with MHRA guidance. Bedrails PGN in use.
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.	Mitigating actions taken by NTW – Practice Guidance Note in use by clinicians who oversee patients with tubes. Limited use within patient population mitigates risk further.
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)**	Mitigating actions taken by NTW – Thermostatic mixing valves in use, subject to regular testing.