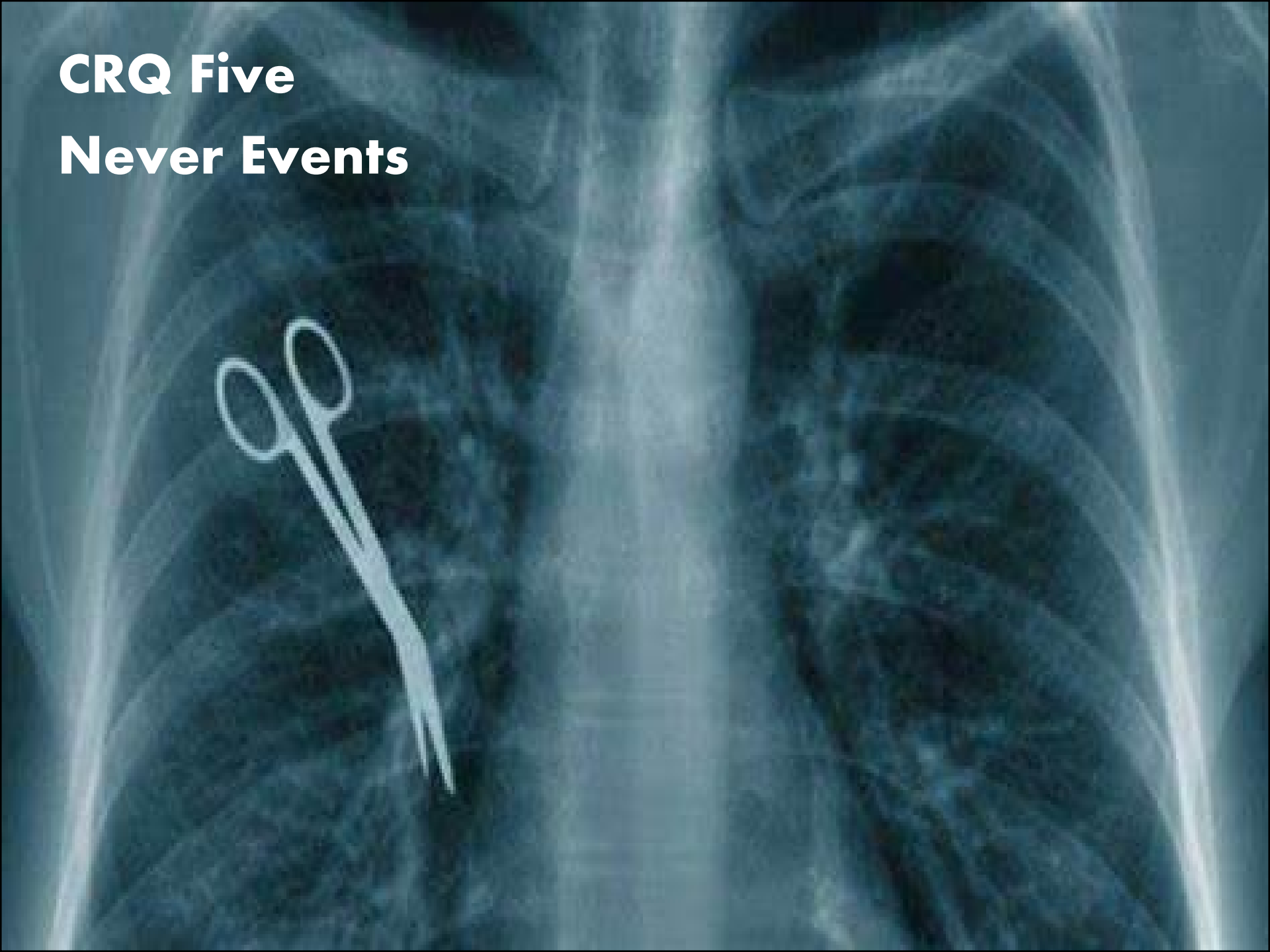
CRQ Five
Never Events



Never Events

a) What is the definition of a "never event"? (2 marks)

b) List eight never events that are directly or indirectly linked to anaesthesia (8 marks)

c) List ten systems/resources are in place to reduce clinical risk in your daily practice (10 marks)

March 2017

Question 2 (Blue Book)

a) List the implications for the patient of an inadvertent wrong-sided peripheral nerve block. (5 marks)
b) Summarise the recommendations of the "Stop Before You Block'' campaign, (4 marks) and list factors that have been identified as contributing to the performance of a wrong side block. (5 marks)
c) Define the term "never event" (2 marks) and list four drug related never events. (4 marks)

September 2019

Question 12 SAQ (Grey Book)

a) List the implications for the patient of an inadvertent wrong-sided peripheral nerve block. (5 marks)
b) Summarise the recommendations of the "Stop Before You Block'' campaign. (4 marks)
c) List the factors that have been identified as contributing to a wrong side block being performed. (5 marks)
d) Define the term "never event" (2 marks) and list four drug related never events. (4 marks)

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Question 2: Wrong side block and never events

Pass rate 39.0%

This question related to an important safety initiative. Candidates did not have adequate knowledge of the factors contributing to the performance of a wrong side block such as distraction, the patient being lateral or prone or site mark being covered by blankets.

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Question 12: SAQ Wrong-sided block
Pass rate 56.5%

This question had one of the highest correlations with overall performance i.e. candidates who did well in this question performed well in the written paper overall. This question had been used previously and weaker candidates showed similar failings. Candidates did not have adequate knowledge of the factors contributing to the performance of a wrong side block, such as distraction or the site mark being covered up. Drug-related, 'never' events are specific to certain medications and many candidates answered in far too general terms.

Never Events

a) What is the definition of a “never event”? (2 marks)

Serious largely preventable patient safety clinical incident that should not occur if relevant preventive measures have been put in place.

b) List eight never events that are directly or indirectly linked to anaesthesia (8 marks)

c) List ten systems/resources are in place to reduce clinical risk in your daily practice (10 marks)

NHS Improvement

Never Events list 2018

First published January 2018 (last updated February 2021)

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Surgical

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post procedure

Medication

4. Mis-selection of a strong potassium solution
5. Administration of medication by the wrong route
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation

Mental health

9. Failure to install functional collapsible shower or curtain rails

General

10. Falls from poorly restricted windows
11. Chest or neck entrapment in bed rails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter

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15. Unintentional connection of a patient requiring oxygen to an air flowmeter
16. Undetected oesophageal intubation Temporarily suspended as a Never Event

Never Events

c) List ten systems/resources are in place to reduce clinical risk in your daily practice (10 marks)

- WHO surgery safety checklist and team briefs
- AAGBI machine checklist
- AAGBI minimum monitoring standards
- Other AAGBI safety guides - MRI, obesity, DM, A-lines, cement implantation, #NOF, elderly, recovery, infection control, controlled drugs, MH, anaphylaxis, anticoagulation and CNB, vascular access, skin antisepsis, equipment management etc
- RCOA standards - ophthalmic surgery, “The Good Anaesthetist”, “Anaesthesia Provision”
- Standardised syringe labelling
- Non-compatible syringes with colour coding for enteral, IV and regional local anaesthetic drugs
- Yellow colour coded infusion line for epidural medication
- O2-N2O interlink on anaesthetic machine to prevent delivery of hypoxic gas mixture
- “Stop before you block”

Never Events

c) List ten systems/resources are in place to reduce clinical risk in your daily practice (10 marks)

- "Matching Michigan" CVC-related sepsis standards
- Surviving Sepsis care bundle - 6hr and 24hr resuscitation phases
- The Ventilator Bundle - elevation of bed head - 30 degrees, daily sedation holds and assessment of readiness to extubate, peptic ulcer prophylaxis, VTE prophylaxis
- Electronic patient record - ensure legibility
- "Electronic prescribing" - reduce drug errors
- Adequate staffing of rotas
- "Senior cover" available at all times
- Adequate "breaks" taken
- RSI checklist
- Trained assistance at all times
- "Mandatory Training"
- Blood transfusion policies - e.g. Major haemorrhage protocols
- Appropriate skill mix

Never Events

c) List ten systems/resources are in place to reduce clinical risk in your daily practice (10 marks)

- Drug checks
- Consent policies
- Acute pain policies - e.g. epidural, PCA analgesia
- Training standards achieved - FRCA examinations
- Simulator training undertaken
- Appraisal undertaken and revalidation achieved