Appendix 1 - List of potential Never Events in general practice

Section A: Mistaken patient identity
1. The wrong action is taken, or the right action is taken but for the wrong patient; for example, referral, clinical entry, prescription, acting on a test result, or drug administration.
Section B: Acts of omission
2. An agreed referral is not made.
3. Transport (ambulance) is not arranged while admitting a patient as an emergency.
4. Discharging patients without advance notification of practice, district nurses, or making necessary arrangements.
5. Not carrying out an agreed house visit.
Section C: Investigations
6. An abnormal investigation result is not received by the practice that requested it.
7. An abnormal test result is received by a practice but not considered for action, or the considered action is not performed.
Section D: Medication (prescribing, dispensing, administration, monitoring)
8. The 'wrong' drug is prescribed, dispensed, or given.
9. Drugs are prescribed at the request of non-practice clinicians and from other healthcare settings without clear, complete, and written requests.
10. Prescribing medication when known, absolute contraindications exist: • 10a.Prescribing teratogenic drugs to a patient known to be pregnant. • 10b.Specific previous incidents, for example, combined oral contraceptive after previous confirmed DVT/PE. • 10c.Specific medical conditions (metformin, nitrofurantoin or NSAIDs in renal failure (or eGFR <30); beta-blockers for asthmatics; oestrogen only HRT for women with intact uterus). • 10d.Previous allergic reaction to the drug.
11. Prescribing two drugs with known and potential serious interaction together.
12. Prescribing or giving the wrong dose of medication. Specifically, prescribing doses higher than the maximum recommended in the BNF.
13. Making changes to medication (dose, new, discontinue) without informing the patient or patient representative and documenting the change and rationale.
14. Prescribing 'high risk' medication without ensuring adequate monitoring took place and results were satisfactory.
15. Dispensing medication or providing a prescription to anyone other than the patient or patient representative.
16. Giving the right drug via the wrong route or at the wrong site.

17. Failure to reconcile medication after receiving hospital discharge documentation.
Section E: Medico-legal and ethical incidents
18. Non-clinical team members should not perform clinical tasks.
19. Physical assault of patients or healthcare workers.
20. 'Ignoring' a patient's living will.
21. Breaching patient confidentiality.
22. A practice team member works while intoxicated.
23. 'Losing' controlled drugs.
24. Accessing patient records for purposes other than delivery of care.
25. Performing invasive or intimate procedures without offering a chaperone.
Section F: Clinical management
26. Omission of certain, specific clinical actions in given scenarios are 'never events'. • 26a.Prescribing repeated courses of antibiotics without a clinical assessment. • 26b. Not examining a febrile child. • 26c.Not obtaining and recording a blood pressure reading for patients presenting with acute-onset headache. • 26d.Not recording a peak-flow measure in patients with asthma presenting with an acute exacerbation. • 26e.Not referring a patient presenting with and treated for anaphylaxis to secondary care for observation. • 26f.Not referring a child suspected to have non-accidental injuries urgently. • 26g.Performing a speculum examination in patients >36/40 pregnant
27. A patient suffers 'severe burns' from cryotherapy.
28. Using non-sterile equipment.
29. Performing a cervical smear without visualising the cervical os.
Section G: Practice systems
30. A practice does not have an up-to-date and secure backup of their data.
31. Medical waste and hazardous substances discarded in an inappropriate manner.
32. If equipment is not in working order, maintained, available, or checked regularly.
33. Inappropriate triage or refusal of access.
34. Sending correspondence to a deceased patient.
35. Patients should never be unsupervised (left alone) inside the practice.
36. A death in the practice.
Section H: Teamwork and communication
37. A new member of staff is not made aware of the known 'high risk' status of a patient before a consultation.
38. Medical trainees are not provided with adequate supervision.

Appendix 2 – Prospective Hazard Analysis – Quality Improvement Activity for Appraisal

What system did you choose?

Why did you choose this system? Consider personal relevance, evidence of previous error or organisational priority.

What members of the team did you involve? Front line team members who really know the system should be involved.

Understanding the system. Did you use process mapping or another method to understand the system? Please insert process map if applicable.

Analysis of system. How did you identify the hazards? How did you prioritise them?

Hazards. Please list the hazards you found.

Implementation of change. Please define how you have or plan to change systems in a sustainable manner to ensure that the identified hazards do not lead to harm.

How will you ensure this happens? Who is responsible for change or monitoring? Is there a need for an audit next year?

Reflection and learning. What were the challenges in this process and what went well? What have you learned from completing this project?

Appendix 3 – Guide words for use in SWIFT

Wrong person
Wrong place
Wrong things e.g. equipment, medication
Wrong understanding
Wrong time (or delay)
Wrong process
Wrong amount