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Never Events in Primary Care

Introduction

Never Events are defined as: "Serious, largely preventable patient safety incidents that should not occur if the available preventable measures were implemented by healthcare workers". [1] An example in an acute hospital setting is performing a surgical procedure on the wrong limb. Early Never Event research focused on secondary care settings but it is recognized that these errors can also happen in primary care. To fulfill the criteria of a Never Event the following factors must **all** be present.

A never event:

1. Is known to cause severe harm to a patient, or has the potential to do so
2. Is largely preventable by a healthcare professional, a team, or an organisation
3. Can be clearly and precisely defined
4. Can be detected
5. Is not the result of an unlawful act

We are used to performing Significant Event Analysis (SEAs). These are events that any member of the team feels are significant but may not meet all the criteria to be termed a Never Event. Although we would hope that Never Events would never happen, we will all be aware that they do occasionally occur and can cause a great deal of distress to patients and staff, and create extra work for teams.

The authors of this module are aware of current increasing demands on primary care and that the idea of looking for more work might not be popular! However, when Never Events do occur in a practice they can create huge amounts of work for many in the primary care team. Some of the work relating to the prevention of Never Events can be delegated to others in the primary care team.

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