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Never Events in UK general practice: a survey of the views of General Practitioners on their frequency and acceptability as a safety improvement approach

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**What was known before your paper was published?**

In hospitals 'Never Events' are rare but serious preventable incidents, such as operations where something went wrong (e.g. wrong limb amputated). They must be reported to NHS England and information about how often Never Events are reported is regularly published to encourage learning within the NHS. This Never Events approach has not been used in general practice to date. A list of ten Never Events suitable for use in general practice has been developed through discussions with general practitioners (GPs) and other practice staff. However, we did not know how often these Never Events were happening, or their acceptability to GPs as a method to improve patient safety in general practice. A list of these ten Never Events is at the end of this document.

**What did you do?**

We asked GPs in Scotland and Greater Manchester to anonymously estimate how often the ten Never Events had occurred in their practice, how often they thought they might occur in the future, how they had reacted to a Never Event happening and whether they agreed that the event should be called a 'Never Event'. Altogether 556 GPs from 412 practices responded to our survey.

**What did you find?**

Some Never Events happened very rarely, for example, prescribing aspirin to a child younger than twelve years occurred in less than 1% of practices during one year. Other Never Events had happened quite often, for example an abnormal investigation result being received by a practice but not reviewed by a clinician was reported in around half of the practices during one year. Most GPs thought that all ten of the Never Events could

happen within their practice during the next 5 years. Almost all GPs reported that they would take the occurrence of a Never Event extremely seriously and undertake a serious event analysis, a process used by practices to discuss and learn from mistakes or problems. The majority of GPs agreed that the Never Event title was appropriate for most of the Never Events but GPs who reported a Never Event to have occurred in their practice were less likely to agree with the Never Event title.

**What insights/knowledge did you add?**

The Never Events approach does not transfer easily from hospital care to general practice suggesting that the more common Never Events might be useful to monitor safety in general practices and the rarer Never Events could be used to monitor patient safety in a similar way as in hospitals. GPs would need to be reassured that the use of Never Events should be to identify weaknesses in the system and prevent Never Events from occurring rather than as a way to criticise general practice. Replacing the "Never Events" title with one that describes the missed opportunity to prevent the incident might improve their acceptability to GPs.

List of 10 Never Events

1. Prescribing Aspirin for a patient less than 12 years old (unless recommended by a specialist for specific clinical conditions e.g. Kawasaki's disease)

2. Prescribing Methotrexate daily rather than weekly (unless initiated by a specialist for a specific clinical condition e.g. leukaemia)

3. Adrenaline/Epinephrine is NOT available within minutes when clinically indicated for a medical emergency in the practice or GP home visit

4. Prescribing a teratogenic drug to a patient the clinician knows to be pregnant (unless advised to do so by a clinical specialist)

5. Prescribing systemic oestrogen-only Hormone Replacement Therapy for a patient with an intact uterus

6. A planned referral of a patient, prompted by clinical suspicion of cancer, is not sent

7. Ambulance transport is not arranged if this had been agreed when deciding to admit a patient as an emergency

8. A needle-stick injury due to a failure to dispose of 'sharps' in compliance with national guidance and regulations

9. Prescribing a drug to a patient that has correctly been recorded in the practice system as having previously caused her/him a severe adverse reaction

10. An abnormal investigation result is received by a practice but is not reviewed by a clinician