

Never events

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Many national health services and institutions now require that all incidents are managed, reported and investigated. Incidents can be defined as events that could have or did result in unintended and/or unnecessary serious harm. One subset of serious incidents is a never or serious reportable event . These events are considered to be wholly preventable; for example, a retained abdominal swab or instrument, where guidance providing strong systemic protective barriers should have been implemented, namely checklists. Each 'never event' type has the potential to cause serious harm to the patient or even death. However, serious harm or death is not required to have occurred for that incident to be categorised as a 'never or serious reportable event'. As previously described clinical incidents of this nature, by definition, mandate an open disclosure process with patients and their carers.

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