

## NEVER EVENTS

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# Patient Death or Serious Harm Due to the Administration of the Wrong Inhalation or Insufflation Gas

## Definition

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This event includes the administration of the wrong gas due to any cause, such as provider error, a labelling error, or the incorrect use of gas-specific connectors. These gases may be inhaled or blown into a body cavity, such as to sinuses or the abdomen.

Source: [Never Events for Hospital Care in Canada](#)

## Harm Prevention Strategies

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This list is intended for quick reference and is not comprehensive; facility-specific factors should be evaluated carefully before implementing any strategy.

- Use a combination of prevention strategies. A one-size-fits-all approach is not applicable; consider strategies that influence as many steps of the process for safe medical gas use as possible.
- Implement clear labelling or barcoding systems to ensure proper identification.
- Adopt product-specific valves, connectors, or tubing to avoid mix-ups.
- Restrict access and keep supplies limited in patient care areas where usage is infrequent.
- Standardize workflows and documentation procedures.

Sources: [ASHP Guidelines on Preventing Medication Errors in Hospitals](#), [Medication Safety in High-Risk Situations, Reducing the Risk of Oxygen Tubing Being Connected to Air Flowmeters](#)

## Resources for Health Care Teams

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### National and Provincial

- Ontario Health: [Medication Safety](#) quality standard
- Institute for Safe Medication Practices Canada (ISMP Canada):
  - [Canadian Pharmaceutical Bar Coding Project](#)
  - [Canadian High-Alert Medication List](#) and related [user guide](#) and [safety bulletin](#)

## International

- American Society of Health-System Pharmacists (ASHP): [ASHP Guidelines on Preventing Medication Errors in Hospitals](#)
- Health and Social Care Northern Ireland: [Reducing the Risk of Oxygen Tubing Being Connected to Air Flowmeters](#) (Learning Matters, Special Edition 15)
- ISMP (United States): [Targeted Medication Safety Best Practices for Hospitals](#) (best practice 18)
- World Health Organization: [Medication Safety in High-Risk Situations](#) (technical report)

Additional tools and resources are available in our [Quality and Patient Safety Program Community of Practice](#) on Quorum, as well as on our [Medication Safety Quality Standard: Tools for Implementation](#) Quorum page.

To learn more about Ontario Health's Never Events Reporting program for hospitals, please visit [Never Events](#).

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, [info@OntarioHealth.ca](mailto:info@OntarioHealth.ca)

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