

Definition of Never Events

The National Quality Forum, a nonprofit national coalition of physicians, hospitals, businesses and policy-makers, has identified 28 events as occurrences that should never happen in a hospital and can be prevented. They termed them “serious reportable events”, or never events. They include surgical events, such as performing the wrong surgical procedure; product or device events, such as contaminated drugs or devices; and criminal events, such as abduction of a patient. See a complete list of never events:

<http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf>

General Information about Never Events

Adverse events in health care are one of the leading causes of death and injury in the United States today. The National Quality Forum’s list of 28 events is not intended to capture all of the adverse events that could possibly occur in hospital facilities. Rather, the list contains events that are “of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable (and thus feasible to include in a reporting system); and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare organization.” (Press Release. Source: National Quality Forum. 13 October, 2006)

It is difficult to assess how often never events occur. By definition, they are – or should be – quite rare, but since they are also rarely disclosed except to

confidential reporting programs, precise numbers on their frequency are not available. Minnesota has had a mandatory reporting program for never events in place for four years and has averaged roughly 100-150 reported never events per year.

The Leapfrog Group wants to promote patient safety and quality in a standardized manner by supporting the consensus work of the National Quality Forum which based its standardized set of never events from an extensive review of the research as well as clinical and consumer input on the subject of never events.

Leapfrog’s Policy on Never Events

Leapfrog’s policy asks hospitals to commit to five actions if a never event occurs within their facility: 1) apologize to the patient, 2) report the event, 3) perform a root cause analysis, 4) waive costs directly related to the event, and 5) provide a copy of the hospital’s policy to patients and payers upon request.

- 1) It is Leapfrog’s belief that it is within the best interest of all parties involved for the hospital staff to give a verbal apology and explanation of the known circumstances surrounding the never event to the patient and/or family affected. Research indicates that patients who are victims of adverse events feel the most anger when they perceive that no one is willing to take responsibility for what has happened. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient and may reduce the hospital’s risk of liability. (When Things Go Wrong: Responding to Adverse Events. Mass Coalition for the Prevention of Medical Errors. Boston, 2006)

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- 2) According to the National Quality Forum, “the primary reason for identifying a standardized set of serious reportable events that would be mandatorily reported is to facilitate public accountability for the occurrence of these adverse events in the delivery of healthcare.” (Serious Reportable Events in Healthcare: A Consensus Report. NQF. 2002) Since the U.S. health care system does not currently have one national reporting program in place, the Leapfrog Group asks hospitals to choose at least 1 of 3 reporting options: the Joint Commission, a state reporting program, or a Patient Safety Organization. It asks that the hospital reports to its chosen entity within 10 days of its self-determination that a never event has occurred.
- 3) Perhaps the most important action for a hospital to take in the aftermath of a never event is a prompt and thorough root cause analysis. An RCA gives the hospital a structured method to learn from its mistakes by identifying the basic or causal factors that underlay the never event and to improve its systems and processes. All of the reporting programs that Leapfrog endorses have instructions for how to perform an RCA of adverse events that will help to guide the hospital through the necessary steps.
- 4) Leapfrog’s policy on never events is about improving patient care. It goes without saying that a patient who is a victim of a never event should not have to pay for it. Therefore, Leapfrog asks hospitals to determine on a case-by-case basis which costs are directly related to the never event and to waive those costs so that the patient and no third-party payer receives a bill for those costs. Leapfrog understands that specific details of what constitutes “waiving cost” requires the hospital to rigorously examine the individual set of circumstances surrounding the never event; our policy asks the hospital staff to use its best judgment during this examination to protect the patient from inappropriate payment.
- 5) A hospital that implements Leapfrog’s policy on never events agrees to be transparent with key stakeholders on their implementation of this policy. A copy of the policy should be made available to all patients, patients’ families, and payers upon request.

Policy Implementation

- 1) Hospitals can adopt the policy by incorporating each of its four points into an internal policy that is implemented in their facility.
- 2) Hospitals that report to the Leapfrog Hospital Survey will have an opportunity to indicate their implementation of the policy in a section of the survey. If they have not yet implemented the policy at the time of submission, they have an opportunity to commit to doing so in the next 60 days.
- 3) Hospitals’ answers to the survey questions about whether or not they have implemented the Leapfrog never events policy will be publicly accessible on the consumer display of The Leapfrog Group’s web site.

References

Adverse Health Events in Minnesota: Fourth Annual Public Report. Minnesota Department of Health. January 2008.

Serious Reportable Events in Healthcare: A Consensus Report. The National Forum for Healthcare Quality Measurement and Reporting. 2002.

When Things Go Wrong: Responding to Adverse Events. Massachusetts Coalition for the Prevention of Medical Errors. Boston, 2006.