LifeWINGS

Better Teams. High Reliability Systems. Sustained Culture Change.

Six Things You Must Know about Never Events

March 2010 | By: Steve Harden

1

"Never Events" is the nickname given to "Serious Reportable Events" (SRE) developed by the National Quality Forum (NQF).

Although endorsed by CMS, it was actually the NQF that developed a list of 28 Serious Reportable Events. These are currently defined by the NQF as "preventable, serious, and unambiguous adverse events that should never occur." Being a mouthful, someone soon coined the term "Never Events" and that term has been adopted by CMS to describe events like surgery on the wrong body part or mismatched blood transfusion that cause serious injury or death to beneficiaries and result in increased costs to the Medicare program to treat the consequences of the error.

Currently, NQF is proposing to change "never" to "not." Their rationale:

- In reality, these events occur regularly and the term "never" creates a perception that they are rare;
- Some of these events are not always preventable;
- The use of the word "never" may imply that a solution exists for preventing SREs from ever occurring, which is not always the case;
- The term "never" implies that a SRE is punishable;
- Removing "never" would create a broader definition and may help improve the quality of reporting.

Visit **http://www.cms.hhs.gov** for a complete list of Serious Reportable Events.

2

Never Events cost hospitals money.

A recent study concluded that "never events" add significantly to Medicare hospital payments, ranging from an average of an additional $700 per case to treat decubitus ulcers to $9,000 per case to treat postoperative sepsis. Another study, reviewing 18 types of medical events, concluded that medical errors may account for 2.4 million extra hospital days, $9.3 billion in excess charges (for all payers), and 32,600 deaths.

Effective in October 2008, Medicare stoppedpaying for the costs associated with the following six conditions related to Never Events:

- certain serious pressure ulcers;

- acquired urinary tract infections from catheter use;

- acquired blood stream infections from catheters;

- air embolism (air bubble in a blood vessel);

- giving the wrong blood type;

- foreign objects left in surgical patients.

According to CMS, paying for Never Events is not consistent with the goals of Medicare payment reforms. For CMS, reducing or eliminating payments for Never Events means more resources can be directed toward preventing these events rather than paying more when they occur.

Furthermore, hospitals and other providers are prevented from balance billing these costs to patients who have been harmed. And, this is just the beginning, with CMS looking to add conditions like ventilator-caused pneumonia and drug-resistant staphylococcus infections to its "no pay for Never Events" list.

On the heels of CMS' new rules for Never Events, many private insurers are evaluating and adopting their own policies for not paying for these egregious medical errors. Aetna, BlueCross BlueShield Association, Pennsylvania Medicaid and WellPoint are but a few payors lining up behind CMS or developing their own policies.

3

Preventing Never Events requires significant changes in operations.

Hospitals must identify, document and code those conditions present upon admission. In order to avoid being tagged with preventable never-event errors, hospitals will have to work harder at admission to identify secondary diagnoses and pre-existing conditions. For example, did a patient have a pressure ulcer prior to or after hospital admission? Failure to code this correctly will cost the hospital an average of $2,683 for every instance it is coded incorrectly.

Furthermore, doctors may need to make changes in medical practice such as ordering additional tests at admission to more fully gauge each patient's condition.

Hospitals must also prevent conditions and errors that allow Never Events to occur once the patient is admitted (addressed more completely in items 5 and 6 below).

4

Coding and other administrative tasks will get more complicated as hospitals try to avoid the financial effects of getting tagged with a Never Event.

Purchasers will have to begin including suitable language in provider contracts that link waiving fees for services needed because of an identified medical error or adverse condition. Reimbursement coding will also have to be developed for waiving of applicable charges. Of course, the devil is in the details of identifying these adverse medical events in such a way as to be able to carve out services for waiving payments. It is likely that Utilization Review and concurrent Case Management may be most effective in recognizing complications due to "Never Events". Retrospectively, data will be used to capture hospitalizations and services that fall outside of normative guidelines.

5

The best way to prevent Never Events is to create a culture of safety in your organization.

The Institute of Medicine emphasizes that most medical errors are systems-related, and not attributable to individual negligence or misconduct. Lessons from other industries have demonstrated that system improvements – especially those that foster a culture of safety can lead to reductions in error rates.

Organizations with a culture of safety acknowledge the high risk, error-prone nature of the humans involved in modern healthcare. The foundation of this type of culture is nonjudgmental recognition of the ubiquity of human and system error. By understanding that error—particularly human error—is inevitable but preventable, patient safety efforts focus on improving systems and culture,

creating fail-safe mechanisms that intercept error before the bedside and implementing measures that mitigate harm when an error involves the patient.

These cultures encourage open communication about safety concerns in a non-punitive environment; they have a freedom of fear in reporting problems. In this culture, clinical staff members work with each other in more effective ways and share critical information so patient care is not compromised in a way that would lead to a Never Event. Those organizations with a true culture of safety have a focused way to set expectations for what needs to be communicated among the health care team and how to do it effectively. This type of culture maintains an environment where nurses are comfortable speaking up to physicians, taking a more proactive role in caring for the patient, as opposed to the old model of simply carrying out a physician's orders.

Only when the entire team is empowered to speak up and hold one another accountable to standards of performance, can the small mistakes everyone makes be stopped in time to prevent a Never Event. Even housekeepers should be empowered to remind physicians when they forget to apply antibacterial gel after leaving a patient's room!

6 **Safety tools such as checklists, standardized communication terminology and scripts, handoff check sheets, protocols, and briefing guides are critical elements of preventing Never Events.**

Checklists have a powerful effect on Never Events. When used correctly they stop cold the errors that result in Never Events. By using a checklist hundreds of hospitals have reached the goal of zero central line infections. Researchers at Johns Hopkins University published the results of a program in certain Michigan hospitals that instituted a simple five-step checklist designed to prevent infections by reminding doctors to wash their hands and don a sterile gown and gloves before putting large intravenous lines into patients. The program saved more than 1,500 lives and nearly $200 million. In another example, Beth Israel Medical Center in New York City has gone 1,000 days without a central line bloodstream infection in the cardiac care unit. The key was spending $30,000 to implement a
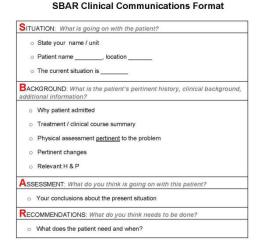
checklist that doctors and nurses must follow. This checklist saved $1.5 million in treatment costs and countless lives.

When drilling down to the root causes of medical errors contributing to Never Events, 75% are related to poor communication. Therefore many hospitals use SBAR (Situation, Background, Assessment, Recommendation), a framework originated by the U.S. Navy to help the nuclear submarine employees communicate about catastrophic events.

SBAR Clinical Communications Format

SITUATION: *What is going on with the patient?*
- State your name / unit
- Patient name _____, location _____
- The current situation is _____

BACKGROUND: *What is the patient's pertinent history, clinical background, additional information?*
- Why patient admitted
- Treatment / clinical course summary
- Physical assessment <u>pertinent</u> to the problem
- Pertinent changes
- Relevant H & P

ASSESSMENT: *What do you think is going on with this patient?*
- Your conclusions about the present situation

RECOMMENDATIONS: *What do you think needs to be done?*
- What does the patient need and when?

Along with SBAR, another proven way of reducing never events is through the use of standardized terminology to document the diagnosis and care plan for a patient. Standardized nursing language provides clarity in communication among all professionals caring for that patient, which leads to a better level of care and improved patient safety.

Standardized order sets and protocols help to reduce variability in care among providers, and thereby reduce the potential for unintended human error leading to Never Events. For example, a protocol for reducing pressure ulcers might include proactively rounding with a wound team that uses these standard steps:

1. Incorporate patient position on the rounding log;

2. During rounding, assess pressure points;

3. Tell patients why they are being repositioned.

Hourly rounding with a team using this protocol reduces pressure ulcers 14% and in one hospital saved $330,000.

Specific healthcare groups have also demonstrated the impact of using standardized processes. For example, in the field of anesthesia, the annual error rate as measured by one professional group was reduced seven-fold, from 25 to 50 errors per million procedures to 5.4 errors per million procedures. This was accomplished by using standardized guidelines, protocols, and equipment.