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*Washington State Hospital Association*

**NEVER EVENTS? OR**

**HARDLY EVER EVENTS:**

**WHICH IS IT IN  
YOUR HOSPITAL?**

**by**

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# Gov. Gregoire Agreement to Improve Patient Safety and Reduce Costs

## **Health Care Association Pledge on Adverse Event Billing**

The Boards of Trustees of the Washington State Hospital Association, Washington State Medical Association, and the Washington Ambulatory Surgery Center Association have each adopted a policy to ensure that no patient (or payer) will pay for care related to an adverse event.

WSHA resources <http://www.wsha.org/page.cfm?ID=AdverseEvent>

**EVEN SMALL HEALTHCARE  
INSTITUTIONS ARE COMPLEX,  
BARELY MANAGABLE PLACES...  
LARGE HEALTHCARE INSTITUTIONS  
MAY BE THE MOST COMPLEX  
ORGANIZATIONS IN HUMAN HISTORY.**

**Peter Drucker**

# WHAT IS A NEVER EVENT?

## SEVERAL DIFFERENT DEFINITIONS:

- **Errors in Medical Care that are Clearly Identifiable, Preventable, and Serious in Their Consequences for Patients, and that Indicate a Real Problem in The Safety and Credibility of a Health Care Facility.**  
*NQF; CMS.*
- **“INEXCUSABLE Outcomes in a Health Care Setting”** *Wikipedia*

# WHAT IS A NEVER EVENT?

## SEVERAL DIFFERENT DEFINITIONS:

- **Errors that should NEVER occur in a hospital or health care facility**
- **Errors or Events Which are COMPLETELY PREVENTABLE**
- **Errors or Events Which Play VERY Badly in the Media and the Public**
- **Errors or Events Which Payers Identify that they will NEVER Pay For**
- **YOUR DEFINITION?**

NEVER EVENTS ARE A SYMPTOM OF  
A HEALTH CARE SYSTEM THAT IS  
BROKEN. PATTERNS OF NEVER  
EVENTS, OR RECURRING NEVER  
EVENTS ARE A SYMPTOM OF A  
HEALTH CARE SYSTEM OR  
ORGANIZATION THAT IS  
UNRESPONSIVE – OR *WORSE!*

# SEPT. 2006 HEADLINE: “HOSPITAL CHANGES PROCEDURES AFTER PREEMIE DEATHS”

- THREE PREEMIES DIE AFTER THEY RECEIVE ADULT DOSES OF HEPARIN AT METHODIST HOSPITAL IN INDIANAPOLIS.
- “Sam Odle, CEO of Methodist, said a pharmacy technician with more than 25 years experience accidentally took the wrong dosage from inventory and stocked it in the drug cabinet in the Newborn ICU. Nurses, who are accustomed to only one dosage of heparin being available, then administered the wrong dose. The adult and infant doses have similar packaging.”

**NOV. 2007 HEADLINE: “DENNIS QUAID’S  
NEWBORN TWINS GIVEN 1,000 TIMES  
INTENDED DOSE OF BLOOD THINNER”**

- **The CMO At CEDARS-SINAI MEDICAL CENTER in LA Stated:**

“As a result of a preventable error, the patients’ IV Catheters were flushed with heparin from vials containing a concentration of 10,000 units per milliliter instead of from vials containing a concentration of 10 units per milliliter.”

NOV. 2007 HEADLINE:  
“HOSPITAL REPEATS WRONG-  
SIDED BRAIN SURGERY”

- “For the third time this year, doctors at Rhode Island Hospital have operated on the wrong side of a patient’s head – an action that has brought about censure from the state Department of Health and a \$50,000 fine.”

# HEY, *WHO'S* RUNNING THESE HOSPITALS?!



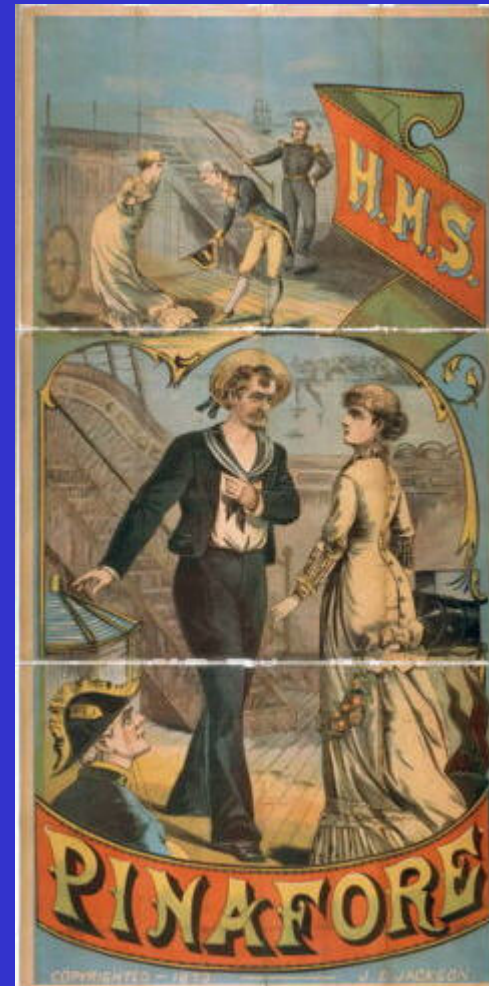
# NEVER EVENTS

WELL...

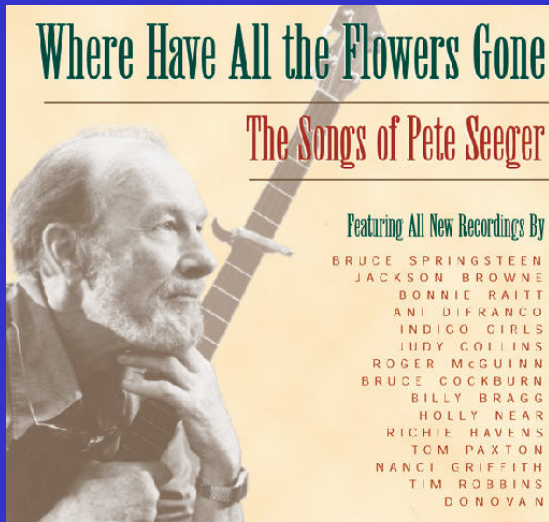
HARDLY EVER EVENTS

OR,

*"When Will We  
Ever Learn??"*



*"What,  
never?"*  
*"No,  
never!"*  
*"What,  
never?"*  
*"Well,  
hardly  
ever!"*



# NEVER EVENTS CHRONOLOGY

- **1999 - IOM study: up to 98,000 Patient Deaths Annually Due to Medical Error. Why Pay for This?**
- **In 2002, the National Quality Forum (NQF) released a list of 27 so-called “Never Events.” (28 in 2006)**
- **In 2003 Minnesota requires Hospitals to Publicly Report Data on Never Events. Other States Follow.**
- **In August 2007 CMS (Medicare) Issues Rule that it Won’t Reimburse Hospitals for Eight Preventable Events (Never Events), Takes Effect October 1, 2008.**
- **2007 + Commercial Payers Announce they will Stop Paying Hospitals for Never Events. Most Recent: On April 3, 2007 WellPoint Halts Payments for 11 Never Events. WellPoint covers 35 Million Americans.**

# CEO'S MOST SIGNIFICANT CONCERNS IN 2007 (2006)

- 1. Financial Challenges – 70% (72% # 1)**
- 2. Care for the Uninsured 38% (37% # 3)**
- 3. Physician-Hospital Relations – 35% (40% # 2)**
- 4. Quality – 33% (29% # 5)**
- 5. Personnel Shortages – 30% (30% #4)**
- 6. PATIENT SAFETY – 29% (27% # 6)**
- 7. Government Mandates – 22% (23% #7)**
- 8. Patient Satisfaction – 17% (16% # 8)**
- 9. Capacity – 11% (11% #9)**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## **SURGICAL EVENTS:**

- **Surgery performed on the wrong body part**
- **Surgery performed on the wrong patient**
- **Wrong surgical procedure on a patient**
- **Retention of a foreign object in a patient following surgery or other procedure**
- **Intra-operative or immediate post-operative death in a normal-health patient**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## **PRODUCT OR DEVICE EVENTS:**

- **Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility**
- **Patient death or serious disability associated with the use or function of a device in which the device is used or functions other than as intended**
- **Patient death or serious disability associated with an intravascular air embolism that occurs while being cared for in a health care facility**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## CARE MANAGEMENT EVENTS:

- **Patient death or serious disability associated with a medication error**
- **Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products**
- **Maternal death or serious disability associated with labor or delivery on a low-risk pregnancy**
- **Patient death or serious disability associated with hypoglycemia, the onset of which occurs while patient is being cared for in a health care facility**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## **CARE MANAGEMENT EVENTS Continued**

- **Death or serious disability associated with a failure to identify and treat hyperbilirubinemia in neonates**
- **Stage 3 or 4 pressure ulcers acquired after admission**
- **Patient death or serious disability due to spinal manipulative therapy**
- **Artificial insemination with the wrong donor sperm**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## **PATIENT PROTECTION EVENTS**

- **Infant discharged to the wrong Stage 3 or 4 pressure ulcers acquired after admission**
- **Patient death or serious disability associated with patient elopement (disappearance/AMA) for more than four hours**
- **Patient suicide, or attempted suicide resulting in serious disability, while being care for in a health care facility**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## **ENVIRONMENTAL EVENTS**

- **Patient death or serious disability associated with an electric shock**
- **Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances**
- **Patient death or serious disability associated with a burn incurred from any source**
- **Patient death or serious disability associated with a fall**
- **Patient death or serious disability associated with the use of restraints or bed rails.**

# NATIONAL QUALITY FORUM'S NEVER EVENTS LIST

## CRIMINAL EVENTS

- **Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider**
- **Abduction of a patient of any age**
- **Sexual assault on a patient within or on the grounds of a health care facility**
- **Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds**

# MEDICARE'S HIT LIST OF 8 NEVER EVENTS

- **Beginning on October 1, 2008, Medicare will change the way it pays hospitals and health systems for hospital-acquired complications. Hospitals that include a complication code in a DRG must document that the condition was Present on Admission (POA). If Medicare determines that the condition was not POA, or was a result of a mistake in the hospital, the cost of care that is related to that complication will not be reimbursed – and will be borne by the hospital.**

# MEDICARE'S HIT LIST OF 8 NEVER EVENTS

- **Air Embolisms**
- **Mediastinitis – Surgical Site Infection Post CABG (coronary artery bypass graft)**
- **Catheter-Associated Urinary-Tract Infection (UTI)**
- **Vascular Catheter-Associated Infections**
- **Blood Incompatibility**
- **Objects Left in the Patient During Surgery**
- **Falls/Trauma**
- **Pressure Ulcers**

Source: CMS

# WELLPOINT'S HIT LIST OF 11 NEVER EVENTS

**On April 3, 2008, WellPoint, the Nation's Largest Commercial Health Insurer, Announced it will NOT Pay Hospitals for 11 Preventable Errors. These 11 Never Events include the list of 8 from Medicare PLUS:**

- **Surgery on the Wrong Body Part**
- **Wrong Surgery Performed on a Patient**
- **Surgery on the Wrong Patient**

**Source: WellPoint**

**“WELLPOINT’S MOVE IS PART OF AN  
EFFORT ACROSS THE HEALTH CARE  
INDUSTRY TO BETTER LINK  
REIMBURSEMENT RATES WITH  
QUALITY OF CARE.”**

**“THOSE HOSPITALS THAT HAVE FOCUSED ON  
PATIENT-CENTERED CARE ARE GOING TO  
HAVE A BUSINESS ADVANTAGE”**

Indianapolis Star April 3, 2008

# POP QUIZ

WILL THE LIST OF NON-REIMBURSED  
NEVER EVENTS:

- a. STAY THE SAME?
- b. SHRINK?
- c. GROW?

# NOT AT MY HOSPITAL!

- A 2003 survey of 1,050 hand surgeons regarding wrong site surgical procedures found that a total of 217 surgeons (21%) admitted to operating on the wrong site at least once, and another 173 (16%) reported recognizing they had prepared the wrong side immediately prior to incision. The most common locations noted were the fingers, then the hands and wrists.

Meinberg RG, Stern PJ. Incidence of wrong-site surgery among hand surgeons. *J Bone Joint Surg Am.* 2003;85:193–197

# **NEVER MEANS ALWAYS!**

**For Something to NEVER Happen, Something Else Must ALWAYS Be Done.**

**How Do Leaders Insure That Something ALWAYS Happens in the Hospital (the most complex organization in human history)?**

**Highly Reliable Organizations (HROs)**  
**“operate under very trying conditions**  
**all the time and yet manage to have**  
**fewer than their fair share of**  
**accidents.”**

# Characteristics of Highly Reliable Organizations...

## Preoccupation with Failure

Regarding small, inconsequential errors as a symptom that something's wrong

## Sensitivity to Operations

Paying attention to what's happening on the front-line

## Reluctance to Simplify

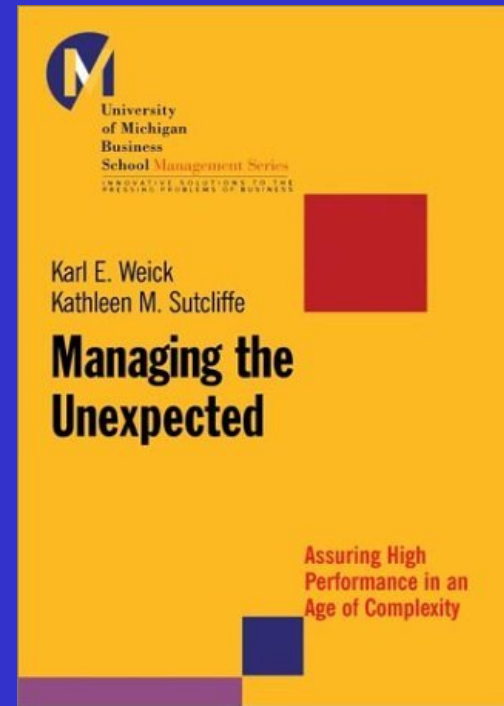
Encouraging diversity in experience, perspective, and opinion

## Commitment to Resilience

Developing capabilities to detect, contain, and bounce-back from events that do occur

## Deference to Expertise

Pushing decision making down and around to the person with the most related knowledge and expertise



# Is Your Hospital an HRO?

If your organization **regards near misses as a sign of success...**  
...you might not be an HRO.

If your organization's leaders **don't know the top 10 operational problems of the front line...**  
...you might not be an HRO.

If your organization **discourages opposing points of view...**  
...you might not be an HRO.

If your organization **thinks that "it can't happen here"...**  
...you might not be an HRO.

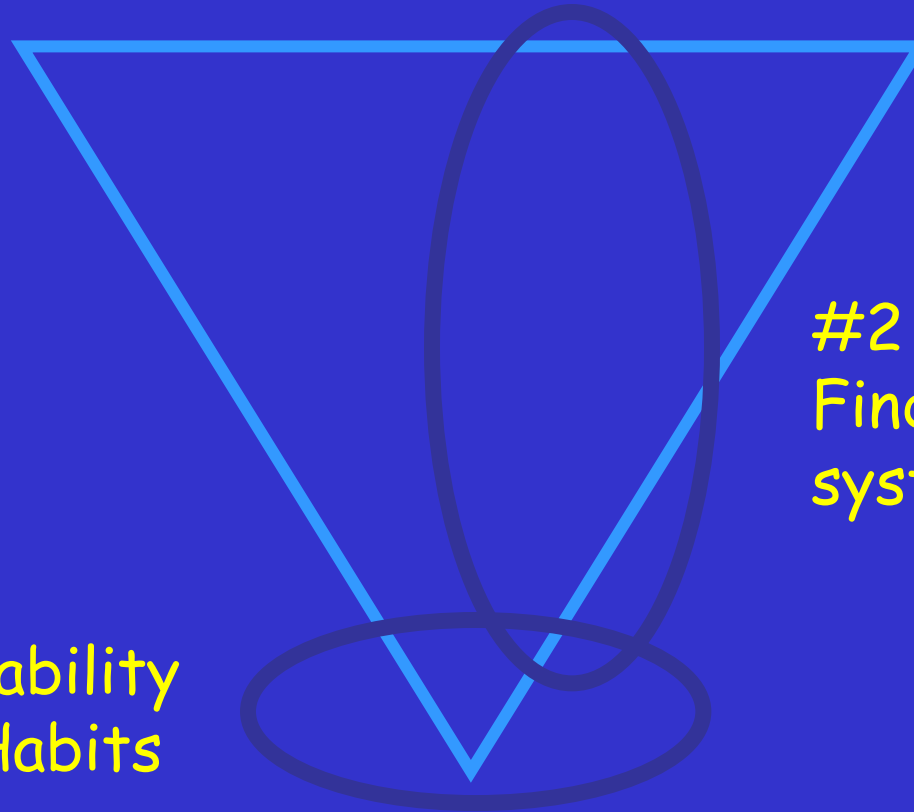
If your organization **values experience over expertise...**  
...you might not be an HRO.

*Kerry Johnson, Healthcare Performance Improvement*

# What Will It Take to Reduce Never Events?

## A One-Two Punch

**# 1**  
**Build Accountability**  
**for Practice Habits**



**#2**  
**Find and Fix**  
**system causes**

# RED RULES vs. BLUE RULES

**RED RULES:** Rules That **CANNOT** be Broken, **EVER!** (Things That are **ALWAYS** Done, No Exceptions!) They Exist to Protect The Life and Well-Being of the Patient.

**BLUE RULES:** Rules That Should be Followed, But **CAN** Be Broken Under Certain Circumstances, or at the Discretion of Staff. These are Rules to Simply Make the Hospital Experience Run More Smoothly for Patients, Staff, Family.

# **RED RULES vs. BLUE RULES: IS THE DIFFERENCE CLEAR IN YOUR HOSPITAL?**

## **RED RULES MUST:**

- **Be Simple, Easy to Remember**
- **Relate to Critical, Important, and Risky Processes or Procedures**
- **“STOP THE LINE” ANY Deviation From a Red Rule Will Bring Work to a Halt Until Compliance is Achieved**

# Safety Absolutes/Red Rules for Safety

An act that has the highest level of risk or consequence to patient or employee safety if not performed exactly, each and every time



“Red” designates the highest priority for exact compliance – STOP action if you can’t comply

*Modified from Kerry Johnson, Healthcare Performance Improvement*

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# RED RULES AND LEADERSHIP

Red Rules Must ALWAYS Be Supported by Leadership at ALL Levels of the Organization; but, Especially at the Top – by the BOARD.

This Fosters a Culture of Safety as Frontline Staff Know That They Will ALWAYS Be Supported in Following Red Rules.

**ALWAYS = NEVER!**

# Never Events and Leadership

## **WSHA Suggestions for Model Policy on Not Billing for Adverse Events**

The WSHA Board of Trustees has requested all hospitals have a policy in place to ensure patients and payers are not required to pay for care related to a preventable adverse event. (An adverse event is one of the 28 events a hospital is required to report to the state.) Hospitals can create a policy by simply adding a new sentence to their current policy on notification for adverse events. The new sentence would state that the hospital will waive charges for care related to a preventable adverse event. If hospitals are seeking a more detailed policy, we have drafted an example below.

**The power of the collective means  
following through with our actions.**

<http://www.wsha.org/files/82/WSHAModelNoBillingforAdverseEventPolicy.doc>

# NEVER EVENTS AND LEADERSHIP: The Process

- 1. Leaders Pick a Never Event.**
- 2. After Reviewing the Process, One or More Red Rules Are Developed to ALWAYS Prevent the Never Event From Occurring.**
- 3. Consequences For Failing To Follow the Red Rules Are Defined; Tested By Leadership (Will We REALLY Do This?); and Adopted.**
- 4. The Never Event, Red Rules, and Consequences Are Communicated (Multiple Times) Throughout the Organization. Every Staff Member's Responsibility Here is Defined.**
- 5. Implement The Process; Monitor Compliance; Take Corrective Action; Monitor Results.**

# **NEVER EVENTS AND LEADERSHIP: An Example**

**1. Never Event: Wrong Site Surgical Procedures.**

**2. Red Rules:**

**A. Pre-Operative Verification Process – Create a Specific Protocol With Specific Behaviors (Verify Patient; Verify Procedure; Two Staff Confirm Each)**

**B. Surgical Site Marking - Create a Specific Protocol With Specific Behaviors: Lateral –right/left distinction; multiple structures – fingers/toes; multiple levels – spine; Marking Clearly Observable After Surgical Prep and Draping are Completed. Marking Done While Patient is Awake, Patient Encouraged to Confirm Correct Site.**

# NEVER EVENTS AND LEADERSHIP: An Example (continued)

## 2. Red Rules:

**C. TIME OUT – INTENTIONAL PAUSE. An Independent Check Just Prior to Incision to Identify and Correct Any Errors.**

**NO Procedure is Started Until ALL Questions and Concerns From ALL Individuals Involved are Addressed.**

**Why? In Most Never Events, Someone Knew Something Was Wrong But Either Did Not Speak Up or Spoke Up But Was Ignored.**

# **NEVER EVENTS AND LEADERSHIP:**

## **An Example (continued)**

### **3. Defined Consequence for Failing to Follow Red Rules:**

**Immediate Termination of Privileges for Physicians.**

**Immediate Termination of Employment for Staff.**

# THE LEAPFROG GROUP'S RECOMMENDED RESPONSE TO A NEVER EVENT:

- 1. APOLOGIZE TO THE PATIENT/FAMILY**
- 2. REPORT THE EVENT**
- 3. PERFORM A ROOT CAUSE ANALYSIS**
- 4. WAIVE COSTS DIRECTLY RELATED TO THE  
EVENT**

# Monday: Wrong kidney removed from Methodist cancer patient

By MAURA LERNER and JOSEPHINE MARCOTTY /  
StarTribune

startribune.com

updated 10:30 p.m. CT, Tues., March. 18, 2008

In what officials are calling a "tragic medical error," a surgical team removed the wrong kidney from a patient with kidney cancer last week at Methodist Hospital in St. Louis Park, the hospital disclosed Monday.

Officials said the error occurred weeks before the surgery, when the kidney on the wrong side was identified on the patient's medical charts as cancerous. The patient, who was not identified, was left with the cancerous kidney when the healthy one was removed.

"We feel just profoundly responsible for this," said Dr. Samuel Carlson, chief medical officer for Park Nicollet Health Services, which owns Methodist Hospital.

Hospital officials said that they apologized to the patient and family, and "are working closely with them to support them in every way we can."

"We just feel profoundly responsible for this," said Dr. Samuel Carlson, CMO

Hospital officials said that they apologized to the patient and family, and "are working closely with them to support them in every way we can."

Officials said the family has asked for privacy, that "the patient has chosen to remain at Methodist Hospital" and that all treatment options are being discussed.

# WHAT CAN BOARDS DO?

1. INSURE THAT THERE IS A HOSPITAL-SPECIFIC LIST OF NEVER EVENTS.

2. INSURE THAT NEVER EVENTS ARE ALWAYS REPORTED TO THE FULL BOARD.

3. REGULARLY INVENTORY AND REVIEW THE RED RULES IN THE HOSPITAL; INSURE THAT THEY FOCUS ON YOUR SPECIFIC LIST OF NEVER EVENTS.

# WHAT CAN BOARDS DO?

4. DEVELOP AND FOLLOW THE PROCESS FOR RED RULES – ALWAYS IMPLEMENT THE CONSEQUENCES AND SUPPORT!!!!

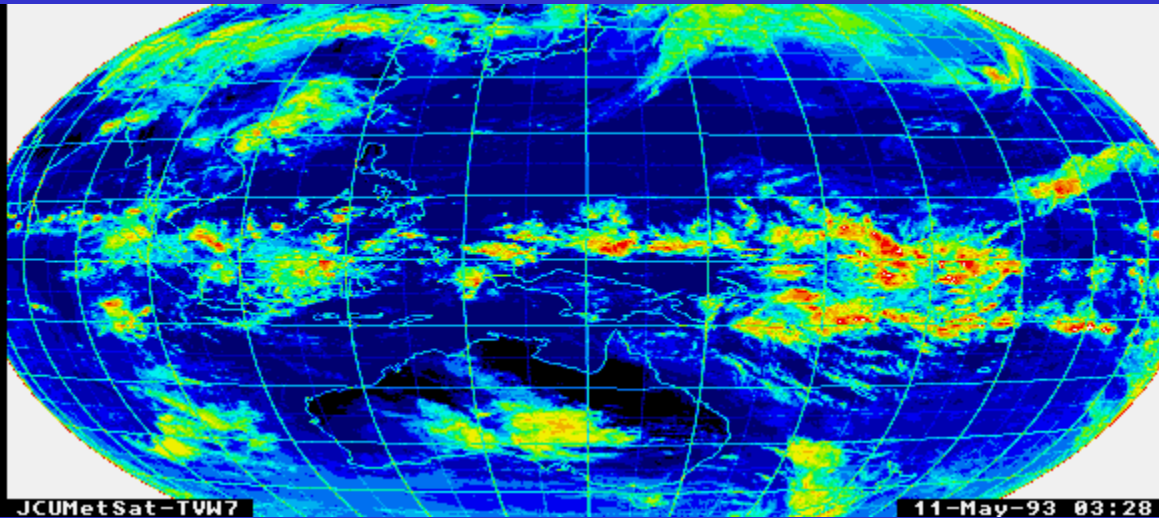
5. EDUCATE ALL BOARD MEMBERS ON NEVER EVENTS, RED RULES, AND THE BOARD'S ROLE.

6. DEVELOP AND IMPLEMENT A POLICY ON RESPONDING TO A NEVER EVENT

NEVER MEANS NEVER

ALWAYS MEANS ALWAYS

**“You Should  
Not Use an  
Old Map**



**to Explore  
a New  
World”**

**Albert Einstein**

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