28 Items Included in NQF List of Never Events

**Historical Perspective on Identifying and Defining 'Never Events'.**

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

-Special Presentation:

The National Quality Forum has developed a list of 28 'never events' - health care-related adverse events that are serious, largely preventable, and of concern to both the public and health care providers.

In 1998, the Joint Commission recognized the need to identify serious yet preventable adverse health care-related events which were happening consistently across the United States that were associated with bad patient outcomes. These events were labeled as 'sentinel events.' In 1999, the National Quality Forum (NQF) was created by presidential decree, and its members were given a charge to look at the overall health care system, issues of quality within the health care system, and setting performance standards for patient safety. The NQF is a "think tank" based in Washington, DC. Also in 1999, the report *To Err Is Human: Building a Safer Health System* was published (Kohn LT, Corrigan JM, Donaldson MS, eds. Washington, DC; National Academies Press; 2000), which identified systematic problems across the health care industry that caused harm and sometimes death to both inpatients and outpatients. For the purpose of public accountability, the NQF worked from its inception in 1999 until 2002 to develop a list of adverse events that are serious, largely preventable, and of concern to both the public and health care providers. The NQF labeled these events as 'never events.' The initial list of 'never events' was 27 items and has since been increased to 28 items. These 'never events' are applicable broadly across the health care industry. In 2007 and 2008, the Centers for Medicare and Medicaid Services (CMS) joined the effort to get rid of these 'never events' by informing hospitals that there would be payment ramifications if an event of this kind occurred in their hospital. These ramifications deal with reimbursements - how much or how little a hospital will receive for not only the care that resulted in the 'never event' but also for subsequent care. As such, this is becoming an incredibly complicated issue. To be simplistic, if there is an operation in which a sponge is left in the patient, then whether you can bill for the underlying operation becomes a concern. Obviously, you are not going to get paid for removing the sponge. How much or how little of the underlying operation you get reimbursed for is a whole issue. This billing issue is important, especially with CMS. Now commercial insurers are following the government's lead, and they are imposing the same type of restrictions. They are not going to pay for these supposedly preventable 'never events.' This is an issue that must be worked out with your billing and compliance people. This review is an abstract of an audio presentation from *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Despite Precautions, Wrong-Site Surgeries Still Occur

Despite everyone's best efforts to avoid the 'never event' of wrong-site surgery, this preventable error continues to occur. For example, 1 wrong-site surgery occurs in Pennsylvania every 5 days.

'Never events,' as defined by the National Quality Forum (NQF), include a list of 28 preventable medical errors that result in adverse patient outcomes. Other terminologies may overlap with 'never events.' The term 'never events' may be intermingled with 'sentinel events,' particularly in the State of Pennsylvania where we are currently practicing. Also the term 'serious events' often overlaps with 'never events.' Therefore, something that could be labeled as a 'never event' for billing purposes, for Centers for Medicare and Medicaid Services (CMS) purposes, or for insurance purposes may be considered a sentinel event as defined by the Joint Commission and by the Pennsylvania Patient Safety Authority. These serious recordable events can be classified into 6 different categories. The first of these categories involves surgical or procedural complications, which contains several items.

**Wrong-Site Surgery:** The first item is surgery performed on the wrong body part. There has been an enormous amount written on how to prevent this error. Every existing hospital has a procedure or policy on how to prevent wrong-site surgery. However, in the 2009 National Patient Safety Goals, the Joint Commission indicated that this was a continuing problem across the United States and introduced the idea of the "Universal Protocol." The Universal Protocol means that, in the operating room, health care personnel must stop or take a time-out before the procedure begins to verify that they have the right patient, the right devices, the right implantables, and the correct body part on which surgery will be performed. Despite everyone's best efforts, wrong-site surgery continues to occur. For example, based on reports to the Pennsylvania Patient Safety Authority, there is 1 wrong-site surgery in Pennsylvania every 5 days despite the adoption of the Universal Protocol. This review is an abstract of an audio presentation from *Practical Reviews*. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Verify That Correct Patient Is Present for Surgical Procedure

Never Events: Wrong Surgical Patients and Wrong Surgical Procedures.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation;

Two items included on the surgical 'never events' list include (1) a surgical procedure performed on the wrong patient and (2) the wrong surgical procedure performed on a patient.

Serious preventable medical errors associated with surgical procedures can occur while caring for inpatients and outpatients. The 'never events' for surgical procedures include a list of reportable errors that include several items. Surgery performed on the wrong patient is one such item. This event occurs less frequently than does surgery being performed on the wrong body part. How can a surgical procedure be performed on the wrong patient? Well, with certain kinds of simple surgical procedures, a hospital or clinic will schedule a large number of patients during the course of the day who are all undergoing the same kind of procedure with minor variations. On occasion, patient #4 will be in the chair when you are expecting to see patient #3. The health care team must ensure that the right implantables and the right equipment are available for that patient. One type of surgery for which this is an area of concern is ophthalmic surgery for lens implantation. The health care team must ensure that they have the right patient and the right implantable for that particular procedure. We are familiar with a number of situations where, just before implanting the lens, the surgical team realized that the person in the chair was different than the patient they were expecting. Another item on the surgical 'never events' list is the wrong surgical procedure performed on a patient. This item is distinct from the wrong patient discussed above. A good example of this surgical complication is when an L3-L4 procedure is performed on a spinal surgery patient who is scheduled for an L2-L3 procedure. An example of another similar situation would be a patient coming in for excision of a breast mass and the patient has several areas of concern. This patient is scheduled for excision of a mass at the 2 o'clock location, but excision is performed at the 4 o'clock or 10 o'clock position. These may be related lesions, but the wrong procedure is performed. Perhaps it is true that the patient needed to have these other lesions removed, but that was not the plan for the day, and the wrong lesion was excised at that time. In these situations, people are very emotional and upset. Focus on the patient first and then figure out why the error happened later. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Human Error Results in Surgical Foreign Object Retention

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

One of the most concerning 'never events' associated with surgical procedures is that of the unintended retention of foreign objects in a patient after a procedure, including objects ranging from a Cottonoid to a malleable retractor.

(Card 1 of 2) Good health care must ensure patient safety. Yet, severe preventable surgical errors occur. The National Quality Forum has developed a list of severe 'never events' associated with surgical procedures as well as other health care-related situations. One of the most concerning or frightening surgical situations is that of unintended retention of foreign objects in a patient after a procedure. The more familiar of the retained foreign bodies range from a Cottonoid, which is very small (the size of the tip of a Q-tip), to a malleable retractor, which is 1 foot long and very thin but is also big and metal. In these situations, no malicious intentions on the part of the surgical team are identified. Instead, errors occur because of handoff, hectic activity in the operating room, or complications encountered during the surgical procedure. For dozens of reasons, a count is missed or is wrong. However, there is no reason to suspect that something was left inside until the patient complains of pain, there are nonhealing issues, or an x-ray reveals something completely unexpected. When a scan reveals the object, then it must be retrieved. An example of such a situation is when a shunt is placed in a patient and one physician works on the head while another physician works in the abdomen with the retractor. If an emergent situation arises regarding the brain, then the surgical team's focus is shifted to the head region, and the retractor may somehow slip in or be left in the abdomen. After the problem in the head region is addressed, then the team returns to the abdomen and closes it. The retained retractor is discovered only after the patient later complains, at which time the patient must undergo a second procedure to retrieve the retractor. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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New Technologies Help Prevent Foreign Object Retention

Never Events: Postoperative Unintended Retention of Foreign Objects - Part 2.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

New technologies being developed to prevent the retention of foreign objects in surgical patients include placing radiofrequency identifiers on sponges or surgical items and trash cans that count items as they are discarded.

(Card 2 of 2) One of the most concerning preventable surgical errors is that of unintended retention of foreign objects in a patient. This error is included on the list of 28 'never events' developed by the National Quality Forum, which defines preventable medical errors resulting in adverse patient outcomes. If surgical team members find that their instrument counts, sponge counts, or needle counts are not correct, then they must proceed through a series of steps to account for all objects, including taking x-rays in the operating room, which often can be a difficult task. However, for cases that we have followed up by interviewing the staff and reviewing the documentation, the counts appear to be correct. Therefore, the unintended retention of a foreign object is a difficult situation, and it is one of the most difficult situations for the patient. Some technologies are being developed to help prevent this surgical error. One new technology is exploring the placement of radiofrequency identifiers on sponges or different surgical items. When the operating field is either closed or about to be closed, a wand can be waved over the surgical field and any labeled object that is retained will be identified and can be retrieved. Another new technology under development involves trash cans that count sponges and other items as they are thrown away. Despite these technological advances, human error will always be a risk factor because people are involved in the process. Some institutions do not perform counts at all. Instead, their approach to preventing retained objects is that they x-ray every patient before leaving the operating room. This is a luxury that many hospitals and clinics cannot afford. Therefore, most surgical teams at clinics and hospitals must perform counts during procedures, leaving them vulnerable to the potential for human error. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Preop Time Out May Prevent Intraoperative Deaths

*Never Events: Intraoperative or Immediately Postoperative Death in Normal Healthy Patients.*

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

-Special Presentation: ()

A major surgical 'never events' item is the intraoperative or immediate postoperative death in ASA Class 1 patients, who represent patients with the least amount of surgical risk and are the easiest to care for in the operating room.

Most preventable medical errors do not result from individual recklessness. Nonetheless, a list of serious preventable 'never events' has been developed that includes a series of errors associated with the surgical care of inpatients and outpatients. A major item on this list of surgical 'never events' is the intraoperative or immediately postoperative death in an American Society for Anesthesiologists (ASA) Class 1 patient. The ASA classifies surgical patient risk based on their presenting history. ASA Class 1 patients present to the hospital or clinic for a minor surgical procedure. They have no chronic conditions, no issues with their airway, and no other identified conditions. These ASA Class 1 patients represent the least amount of risk and are the easiest patients to care for in the operating room. However, on rare occasions, an intraoperative or immediately postoperative death will occur for an ASA Class 1 patient, which is considered a 'never event.' To prevent such deaths, the surgical team must know the patient's history and possible risks during various portions of the intended procedure. To help prevent surgical 'never events' like this, the Joint Commission published the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery. The Pennsylvania Patient Safety Authority organized the Universal Protocol into 3 different phases. In phase 1 - the preoperative verification process - all the different documents and studies are reviewed, and preparations are made for the procedure. In phase 2, the protocol describes the proper marking of the operative site and who is responsible for this task. An "X" is not used to mark the operative site because it is ambiguous. Instead, initials are preferred (or the word "yes" can be used) for marking the site with an indelible marker. In phase 3, a "time out" is taken before starting the procedure so that the anesthesia team, surgeon, physician, and nursing staff can review the paperwork, evaluate the process, and verify that the patient, the equipment, and the operative site are all correct. If this verification process is delayed until after the procedure, then someone on the team is going to misremember some item. Do not rely on a checklist. This step cannot be done by rote or by saying, "We're here for this specific procedure. Yeah, okay, let's get going." This final step must be taken seriously and performed appropriately. By following the Universal Protocol, fewer intraoperative or postoperative deaths should occur. Physicians, surgeons, and surgical staff members should take all possible precautions to prevent these deaths, both before and during the procedure. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Wrong-Site Surgeries Remain Problem Despite Precautions

*Surgical 'Never Events': How Common Are Adverse Occurrences?*
West JC:
ASHRM Journal; 26 (1): 15-21

In Minnesota, the surgical error of wrong-site surgeries continues to be a problem despite adoption of the Universal Protocol and state reporting requirements for this serious error.

Background: Surgical errors are typically the easiest to understand of the 28 'never events' (serious preventable medical errors) listed by the National Quality Forum (NQF). Many preventive guidelines have been published in an attempt to reduce these surgical 'never events.'

Objective: To describe the Minnesota experience since 2003 with the NQF's 'never events' list.

Results: The Minnesota legislature passed the Adverse Health Care Event Reporting Act, and hospitals were required to report the different 'never events' to the Minnesota authorities. With respect to surgical 'never events,' hospitals had to report surgical errors, including surgery on the wrong patient, surgery on the wrong body part, the wrong procedure, foreign body retention, or the intraoperative or immediately postoperative death of a healthy patient (ASA Class 1). From July 2003 to October 2004, these hospitals reported performing 356,000 surgical procedures during which the following surgical 'never events' occurred: 31 retained foreign bodies, 13 wrong-site procedures, 5 wrong procedures, 2 deaths of healthy individuals, and 1 surgery on the wrong patient. However, from October 2004 to October 2005, the surgical error list included 26 wrong-site procedures. From October 2005 to October 2006, 31 wrong-site procedures were reported.

Reviewer's Comments: Despite the emphasis on preventing these surgical errors, the adoption of the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery, and the reporting requirements, these errors continue to be an issue and a problem. Whenever people are involved in a process, the potential exists for human error. Because people are involved, you must incorporate redundancies and several steps in an attempt to prevent these different surgical 'never events' in your practice.

Additional Keywords: Never Events

print tag: () Refer to original journal article.
Universal Protocol Applies to Many Health Care Situations

Never Events: Applying the Universal Protocol Beyond the Operating Room.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
- Special Presentation: ()

The Joint Commission's Universal Protocol is designed for more than just the operating room and should be used for all health care situations in which the staff must verify the right patient, the right procedure, and the right body part(s).

In an effort to reduce the incidence of surgical errors, the Joint Commission has published the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery for use in the operating room. However, the Universal Protocol can and should be used in health care situations beyond the operating room as well. Any time an interventional procedure is scheduled in a radiology department or in any other practice area, and any time a central line is being placed at a bedside, the Universal Protocol should be incorporated. The Universal Protocol applies to all situations in which the staff must verify the right patient, the right procedure, and the right body part(s). As an industry, health care has not done a great job checking all these important points of information when providing care to a patient outside of the operating room. Based on these events, Kathleen Hale and her staff have produced an educational video about wrong-site events, wrong surgeries, etc. This video is used to educate all new and existing personnel in many hospitals and clinics. The Department of the Army has made use of that video as well. They distribute it to all their different medical facilities as learning lessons. A second video has also been produced to help with communication among all the different providers. Among health care workers, the catch phrase "I need some clarity" has been introduced. If there is an issue between providers, for example a nurse who has a question for a physician or one physician does not understand the plan of care, then this phrase allows them to say something very non-confrontational instead of accusing somebody of being stupid. The whole point is to deal with issues and questions as they arise, to deal with them in real time, and to straighten out any misunderstandings or mistakes. The goal is to avoid 'never events' by allowing the health care team members to communicate with each other.

Resources: To obtain a copy of the patient safety videos entitled "Doing the Right Thing," please contact Kathleen Hale at halekm@upmc.edu. Episode 1 is entitled "Wrong-Site Surgery." Episode 2 is entitled "I Need Some Clarity." In March 2009, a third episode was in the concept stage. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events
A nonprofit organization called the Institute for Safe Medication Practices provides objective information and good safety points about how to prevent medication errors.

A list of 28 serious preventable medical errors, termed 'never events,' has been defined by the Joint Commission. One group of 'never events' is contained under the heading of care management events. A few of the categories under this heading are somewhat controversial. However, the first category of care management events is fairly well understood by most clinicians - patient death or serious disability associated with medication errors. These errors involve wrong drug, wrong dose, wrong patient, wrong time of administration, wrong rate, wrong preparation, or wrong route of administration. This is another portion of health care that has been repeatedly evaluated and investigated, and it is probably the most complex portion of health care delivery. The process requires that a medication order from a physician go to a pharmacist who must be able to read the order and then find the appropriate medication, dose, strengths, etc. Then, the pharmacist must get the medication to the nursing unit in a timely fashion. The nursing staff then must administer the medication as the order specifies. Therefore, legibility can be an issue with the handwritten prescription, especially for items such as identifying the proper drug and dosage. Computerized physician order entry can overcome some of the problems of legibility, but it creates its own set of problems, such as clicking on the wrong drug. There are technical issues with the technological cures for these types of problems, so the health care team must be aware of the types of problems involved with handwritten and computerized medication orders. A nonprofit organization called the Institute for Safe Medication Practices focuses on medication error prevention and safe medication use. They have an enormous amount of expertise, and they also have a terrific Web site that provides information about how to prevent medication errors, what other clinicians have lived through, and what others have found in terms of breakdowns in their systems. Anyone who is interested in objective information and good safety points on medication use and administration can go to the Web site at http://www.ISMP.org. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Numerous distractions occur in pharmacies and on nursing floors that contribute to medication errors, which may result in death or severe patient disability.

Medication errors that result in patient death or serious disability are included in one group of 'never events' (serious preventable medical errors) defined by the Joint Commission. The entire process of medication administration begins with a handwritten or computerized medication order from the physician. Next, the order is delivered to the pharmacy, which is responsible for filling the order as it is written. The pharmacist may need to get clarification from the physician. When ready, the pharmacist starts mixing various compounds. Because many of the materials in a pharmacy are clear liquids, the pharmacist must ensure that the correct concentration is used and that the correct clear liquids are mixed together to make the product needed by the patient. The number of distractions that can occur during this process is innumerable. Most pharmacies have a double-check system, but even these systems are not foolproof. Inpatient pharmacies in which only one pharmacist works have many challenges associated with this work environment. Their work is double-checked, but staff members often get distracted or are very busy and they go through only the motions of doing the double-check system. Therefore, medication errors may get missed in the pharmacy. When the medication arrives on the hospital floor, the nursing staff must ensure that the medication gets to the right patient and is administered via the right route and at the right time. Medication errors can occur because an inpatient nursing unit can be very busy with many distractions and frequent reprioritizations. Getting medication into patients without error is an increasingly challenging situation in these environments. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Patient Participation Helps Avoid Medication Errors

Medication Errors: Encourage Patient Participation to Reduce Errors.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

A factor that appears to make a huge difference in avoiding medical errors is instructing and encouraging patients to be involved in their own health care, whether it be the right site for surgery or the right medication.

Medication errors that result in death or severe patient disability are under intense evaluation for developing good preventive practices. At the bedside, new scanning technologies are now available so that the nurse can scan the patient's identification bracelet and then scan the medication to verify that everything matches correctly. This and other available technologies designed to help the staff have been met with mixed responses. While the technology can make things go much more rapidly, it does not replace the need for the nurse to read and verify that the right medication is being given at the right strength to the right patient. By scanning all that information, errors can still occur. It is very unfortunate when these errors occur, but it all goes back to the really simple things of talking to the patient and verifying that he or she is the correct individual for whom the medication is intended. Often, after an error has occurred, the investigator is told, "Well, I was taking care of both patients in that room and I knew them both." A simple human error can cause a medication error that can result in harm to a patient. As with most 'never events,' communication breakdown is an issue that leads to the problem for the patient. Whenever possible, involving the patient in his/her own care makes a huge difference in avoiding medical errors, such as the right site for surgery or the right medication. Patients must be instructed and encouraged to speak up. That way, when the nurse brings the purple pill to them and they have not regularly been receiving that pill, they can feel comfortable enough to say, "This is something different," or "Why is this pill being given now?" This makes the patient part of the health care team. One of the more cumbersome changes in health care during the last few years has been medication reconciliation. The purpose of medication reconciliation is to know what medications a patient receives at home and also to bring the patient into that entire process so that we can, in fact, ask them to participate actively and tell us if they are not familiar with a drug or the way it looks. Once questioned, the nurse can explain what the medication is, or the nurse may be able to say, "You're right. I don't want to give you that pill. I want to give that to your roommate," or "I want to give that to the other patient who has the same last name on the unit right now." Communicating with your patients is as important as talking to your fellow team members. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Patient Verification Key to Preventing Transfusion Reactions

Never Events: Hemolytic Transfusion Reactions Due to Administration of Incompatible Blood.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

The most common reason for hemolytic transfusion reactions due to administration of ABO incompatible blood appears to be in the failure to verify that the correct patient is receiving the blood.

Part of the Joint Commission’s list of ‘never events’ includes preventable medical errors that are categorized under the heading of care management events. One of these items is patient death or serious disability associated with hemolytic transfusion reaction due to administration of ABO incompatible blood or blood product. An enormous amount of time and energy has been spent to create a safe system for blood transfusion. An enormous amount of testing must happen in the lab to find out what kind of blood the patient has, whether they have antigens, and whether there is going to be difficulty transfusing a patient. We need to be acutely aware of the complicated nature of this system. Most people deal with only 1 piece of the system and do not look at the overall system. We recently investigated a situation in which a patient received the wrong blood, which led to the patient’s death. In going backward from the point of transfusion, everything in the transfusion system was predicated on the person who encountered the patient in the previous step in the process doing everything the right way. What the investigation revealed was that an error had been made in the first step - at the step of patient identification. Therefore, talking to patients and following the steps required for transfusion are both keys to preventing transfusion reactions. Other transfusion-related events with which we have become familiar all involved the same thing - "I thought I had the right person." The error does not usually involve the blood that comes from the blood bank or the double-checking process with which people are so familiar. Instead, the error usually involves the simple points of: "Do I have the right person in front of me?" and "Is his/her band giving me the same information that the patient is giving me?" You cannot assume anything, and you cannot assume that someone else has done what they are supposed to have done, especially if you are serving as the double check or the redundancy in the system. You must ensure that everything has been done and not just rely on someone saying, "Yeah I did the math here. I've done that." You must double-check things from step 1. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag:
No Trends Recognized for Cause of Delivery-Related Maternal Deaths

Never Events: Maternal Death or Disability Associated With Labor or Delivery in a Low-Risk Pregnancy.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

Despite investigations and studies, no trends have been identified to help develop measures to avoid maternal deaths or serious disability associated with labor or delivery in a low-risk pregnancy.

The National Quality Forum has compiled a list of 28 serious health care-related errors, or ‘never events,’ classified into 6 different categories. One of these 6 major categories is care management events, which includes several different issues. One such issue is that of maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility. The expectation today is that women receive prenatal care, regardless of whether they plan to deliver at a birthing center, in a hospital with an obstetrician, with a midwife, or with a family practitioner. Regardless, the expectation is that there will be prenatal care. Although the numbers are not huge, every now and then we encounter a maternal death that completely catches everyone by surprise. If, during the investigation of this event, the investigators go backward through the entire process, they find that something was missed. Hindsight being what it is, we try to capture information to determine if there is a pattern or a trend associated with these unexpected maternal deaths/disabilities. However, we are not aware of any such identified trends. This is one of those serious adverse events that people look at and say, “There must be a way to prevent this.” Communication is a key element in the management of these events. Hopefully, the obstetrician and the anesthesiologist are on the same page, working together to overcome whatever the issue may be, such as bleeding. Whatever the unanticipated problem that develops during delivery, the obstetrician and anesthesiologist must be working together to attack the problem. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag:
Poor Patient Compliance May Cause Hypoglycemia in Hospital

Never Events: Serious Patient Disability Associated With Hypoglycemia.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

One defined 'never event' is serious patient disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. The preventability of this event is somewhat controversial.

'Never events' are serious medical errors made while providing health care to inpatients and outpatients. According to the National Quality Forum, 'never events' are preventable, and one such item is serious patient disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility. The preventability of this event is somewhat controversial because the patient can have a significant impact on this medical error. The most common scenario for this problem is when the patient is NPO (nothing per os or by mouth) before a procedure. Although the patient who normally receives insulin has restricted intake, their insulin is not held. As a result, the patient's blood sugar level drops to a number that is very uncomfortable for everyone, and then additional care must be provided. Usually, the patient does not suffer any significant problems, but there are other situations in which the patient ends up with long-term problems. Again, this is a somewhat controversial 'never event' because patients are human and can be noncompliant. They do not always tell the health care team about their situation. For instance, some patients come to the hospital and use their own insulin in addition to what is being administered in the hospital. At that point, the error becomes focused on communication. Patients need to understand why it is important to be truthful about what they have taken and about what they have and have not eaten. The health care team must make sure that they are on top of what they are giving the patient - that the patient is receiving the right insulin at the right time and at the right dose. Therefore, physicians must be familiar with the various insulin protocols. Insulin preparations have changed so much in the last 10 years that physicians writing the orders have to practically be experts in diabetes management to make sure that the insulin being provided to the patient meets his or her needs and keeps blood sugar levels where they need to be throughout the day. Errors can be made in just choosing the wrong kind of insulin. Pharmacists are also well aware of this, but the order writing starts with the physicians. Often, other members of the health care team do not know the patient well enough to question whether the insulin choice is correct. Once the rest of the team gets to know the patient, there can be more input, but typically the attending physician is the one who knows the patient best. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Untreated Hyperbilirubinemia in Newborns Rare Error

*Never Events: Failure to Identify and Treat Hyperbilirubinemia in Newborns.*

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

-Special Presentation:

Because pediatricians usually identify and treat hyperbilirubinemia immediately, untreated hyperbilirubinemia in newborns is a rare medical error in the United States.

A list of 28 'never events' compiled by the National Quality Forum defines serious but preventable medical errors. This list contains a medical error that deals with a very specific patient population: the death or serious disability associated with failure to identify and treat hyperbilirubinemia in newborns. This is a very rare event in the United States. Most neonatal intensive care units or basic nurseries have bili lights (a phototherapy tool used to treat newborn hyperbilirubinemia) and have access to the technology and the testing needed to keep the baby safe. According to the Centers for Disease Control and Prevention, newborns should be assessed for hyperbilirubinemia (jaundice) every 8 to 12 hours during the first 48 hours after birth and again before 5 days of age. High levels of bilirubin potentially can cause brain damage and kernicterus. However, hyperbilirubinemia is easily treated with phototherapy. Approximately 60% of babies have jaundice, with risk factors including preterm birth, darker skin color (harder to recognize the jaundice), East Asian or Mediterranean family heritage, and feeding difficulties. Again, this is a very rare medical error because pediatricians are often identifying the hyperbilirubinemia and getting the patient back into an acute care setting so that they can treat it quickly and easily. Although this is a rare error, it still occurs from time to time in the United States. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

-print tag: ()
Physician Records Critical in Stage III/IV Pressure Ulcers

Never Events: Stage III or IV Pressure Ulcers Acquired After Admission to a Health Care Facility.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

- Special Presentation: ()

Stage III or IV pressure ulcers acquired after admission to a health care facility are incredibly controversial 'never events' items because skin breakdown may still occur despite best efforts to maximize care and protect the skin.

Several items on the 'never events' list developed by the National Quality Forum regarding serious medical errors are considered to be controversial. Perhaps the most controversial item is that of Stage III or IV pressure ulcers acquired after admission to a health care facility. This is an incredibly controversial item because, when a patient comes through the door, we often have an individual with poor nutrition who is immobile or who is so sick or injured that we do not have the ability to turn them, to reposition them, to perform the proper skin care, or to do all the treatments required to keep their skin healthy and intact. Despite best efforts with maximizing nutrition, using specialty beds and overlays, and providing all sorts of other things to protect the skin, breakdown occurs. When these patients enter the hospital, their arrival condition must be carefully documented. They may already have an ulcer or may be starting to develop one on arrival. This must be documented, and perhaps even photographed, because this condition is on the 'never events' list. Your patient's lawyer will argue that these pressure ulcers should never happen, despite all the problems that you have pointed out in dealing with these patients. Most likely, the patient's lawyer will take photographs of these horribly ugly ulcers and blow them up into a big poster to show to a jury. With these ulcer cases, we have found that our hospital documentation is generally poor, meaning we may have provided all the appropriate care, including a consultation from appropriate nursing personnel, but we either did not document this care or did not document it well. It is difficult to prove appropriate care when there are holes or gaps in the patient's medical record. In the world of documentation, "present on admission" documentation is recognized only if a physician documents it. Even if the hospital has provided excellent care for the condition, proving adequate care will become more difficult from a legal perspective unless the physician includes that patient's skin condition on admission and the subsequent care in his or her notes. Therefore, the physician needs to talk to all involved health care team members and to consider the information they are providing, particularly when it comes to skin issues. This is one of the places where physician documentation often becomes the center of attention. This is especially true with elderly or incapacitated patients who are bouncing between nursing homes and hospitals. In these cases, blame for the ulcer is often placed on the other care facility. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Communications Vital to Avoid Spinal Injury, Wrong Donor Sperm

Two 'Never Events' Disability Due to Spinal Manipulative Therapy and Artificial Insemination With the Wrong Donor Sperm or Egg.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

- Special Presentation:

The two separate 'never events' of (1) serious patient disability due to spinal manipulative therapy and (2) artificial insemination with the wrong donor sperm or egg can be prevented with good patient communications.

The National Quality Forum has listed serious patient disability due to spinal manipulative therapy as 1 of the 28 serious but preventable health care-related errors defined as a 'never event.' This is a rare situation, and very few clinicians actually practice this type of procedure. Therefore, the error of patient disability due to spinal manipulative therapy is restricted to a small number of clinicians and to a small patient population. Nonetheless, because the resulting disability is the focus of this 'never event,' the level of care provided to the patient is very important. If you are performing spinal alignments and/or if you are working as a chiropractor, then you must immediately move patients up to the next level of care if they experience tingles and nerve issues. In these situations, communications between physician and patient are very important. For example, patients may be getting care from a chiropractor, but their physicians do not know about this situation. The danger is that the patient may not report receiving these "outside" spinal manipulations and something unexpected may happen to the patient while under the physician's care. The physician is totally in the dark as to what is going on because of lack of communication with the patient or chiropractor. As the clinician, you must listen carefully to the patient and find out as much information as you can about procedures/care being performed outside your practice. Another 'never event' related to care management is artificial insemination with the wrong donor sperm or wrong egg. This is a devastating situation when it happens. It can be prevented with communication, making sure you get your patient involved. Before the procedure, communications with the patient should include statements such as, "Okay, here are all the things that we're working with today. Here's what the labels say. Is this the correct donor? Who are you and what is this your date of birth?" Getting the patient involved decreases the risk of using the wrong products when trying to help get her pregnant. In this highly emotional situation, to use the wrong donor sperm or egg is not inconceivable, but it is easily prevented. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
HAIs Considered Reportable Events in Some States

Never Events: Health-Care Associated Infections - Part 1.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation: ()-

In some states such as Pennsylvania, health care-associated infections must be reported to state officials, and a letter must be sent to the patient informing him or her about the infection.

(Card 1 of 2) An item that appears on some lists of 'never events' (serious preventable medical errors) developed by the National Quality Forum is health care-associated infections (HAIs). This is a big issue in several states, including Pennsylvania. In 2007, the Pennsylvania legislature passed Act 52, which requires health care facilities to report HAIs to the Pennsylvania Patient Safety Authority. Act 52 amends the Medical Care Availability and Reduction of Error (MCARE) Act by requiring the reporting of these HAIs. Therefore, an infection that develops in a Pennsylvania inpatient must be disclosed. The HAI must be treated. A letter must be sent to the patient informing him or her about the HAI. This practice has prompted a lot of feedback from patients. Now patients are looking to the health care provider to treat the infection and reimburse them for costs incurred with the infection. In addition, insurance companies are jumping on the bandwagon and not paying for treatment of these types of infections. In Pennsylvania, the HAI situations that we have encountered have been very diverse. Perhaps the infection that has surprised the most people is that of Clostridium difficile, which is a gastrointestinal infection. Much work has been done with indicators and markers to make sure that patients do not receive excessive amounts of antibiotics, which may have been administered in previous eras. Despite research and new antibiotic treatment regimens, we are still seeing large numbers of C difficile cases. Most of these infections are readily treatable, but on occasion, they may result in a patient needing a colectomy. Therefore, we have been focusing on minimizing C difficile infections in addition to methicillin-resistant Staphylococcus aureus (MRSA) infections. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Discuss Potential for HAIs With Patients on Admission

Never Events: Health-Care Associated Infections - Part 2.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

In some states, urinary tract infections that may have been present at admission and surgical site infections are among the various health care-associated infections that must be reported to state authorities.

(Card 2 of 2) One reason that health-care associated infections (HAIs) may be classified as a 'never event' on some lists but not on others is that the genesis of the infection is not always known. Health care providers are working to identify infections and colonizations that are present in the patient at admission, which allows preemptive treatment and minimizes transmission to other patients. If a patient is admitted with an unknown infection or if we do not suspect that they have an infection, then we do not isolate them and, in turn, risk spreading that infection to other inpatients. The HAI issue that has caused a lot of controversy, particularly in Pennsylvania, involves urinary tract infections (UTIs). Because we are testing for them now, we are discovering them when the patient is in the hospital. Reality says that some significant percentage of patients, particularly elderly patients, has a low-grade UTI most of the time, which we are just identifying and treating as they come into the hospital. Yet, UTIs are considered serious events in the state of Pennsylvania, and so a lot of time and energy is devoted to the paperwork that comes with identifying and treating these UTIs. The HAI issue is a controversial point when it comes to 'never events.' HAIs can include surgical site infections, of which some are readily treated and others are not. Newspapers have featured several recent reports about professional athletes who have surgical site infections, particularly from knee surgeries. Tom Brady (first-string quarterback for the New England Patriots) was one such athlete who ended up in the news, and there are a couple of other people who are headlining now because of infections. Therefore, these infections can affect everybody and are an ongoing problem. In an effort to reduce these infection-related issues, the physician needs to talk to the patient at or before admission and before a procedure. Patients should be warned that they may develop an infection, and some of these infections arise from microorganisms that are already residents on the patient's skin. Patients must be prepared for the possibility of acquiring an infection and must be educated as to how and why these infections occur and how they are treated. Using this approach, patients may not be so surprised when they receive a letter disclosing that he/she acquired an infection during hospitalization. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events
Check Out Medical Equipment When Small Shocks Reported

Two Never Events: Electric Shock and Gas Line Delivery Errors.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

Two environmental 'never events' include patient death or serious disability linked to either an electric shock or the switching of lines designated for oxygen with the wrong gas while being cared for in a health care facility.

Six major categories of preventable medical errors are incorporated into the National Quality Forum's list of 28 'never events.' One of these major categories is environmental events, which include items such as electrical shock, fires, and switched gas lines. The first item in the environmental events category is patient death or serious disability associated with an electrical shock while being cared for in a health care facility. This is a very rare event. When investigating cases of electrical shock, we find that typically there were hints that the health care team did not take seriously before the actual patient shock. Therefore, when staff members report getting a shock when touching a piece of equipment, do not always assume that the problem is static electricity. The assumption of static electricity being the causative factor is not a great conclusion to draw when touching medical equipment. If you get a shock or if the patient talks about feeling tingles or anything similar, stop and have that piece of equipment investigated regardless of how "off the wall" the request may seem at the time. The second item on the list of environmental events is any incident in which a line designated for oxygen or another gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances. Probably the most frequent switch seen is oxygen and carbon dioxide (CO2). Meters used to deliver oxygen and CO2 are different colors, and they are not interchangeable. However, the tubing used to deliver these gases can be interchangeable, which is where the error usually occurs. Oxygen is typically delivered off of a green meter and CO2 is delivered off of a yellow meter, but the equipment that attaches to these meters is comparable. Therefore, it is not unheard of to switch the 2 gases, which can be devastating for the patient. There are also some reported cases of switches with anesthetic gases that can be problematic. On rare occasions, you will have contamination of a tank line, which can be picked up in many ways. With contamination at that level, you are going to be delivering gases to a large number of patients, and the health care team picks up quickly on what is happening. All these types of incidents are considered a 'never event.' This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Preventing OR Fires Requires Anesthesia, Surgeon Coordination

Never Events: OR Fires and Burns Resulting From Inappropriate Use of Bovie.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
- Special Presentation: ()

Flash fires occur in the operating room when there is a pooling of oxygen due to the anesthesia technique and the Bovie (instrument used for electrosurgical dissection and hemostasis) being used simultaneously by the surgical team.

In any health care facility, environmental errors can result in serious patient injury or death. Several environmental errors are listed on the National Quality Forum's list of 28 'never events.' One of these items is that of patient death or disability associated with a burn incurred from any source while being cared for in a health care facility. The first source of burns is from fires in the operating room (OR). A great deal has been written about OR fires, and there are some incredible trainers who will educate you about OR fires, how they happen, and how you can prevent them. These trainers can give a little pyrotechnic show to demonstrate exactly what can happen and how to prevent certain types of fires. Nonetheless, OR fires continue to occur. Consistently, the situation is the same for these fires. A patient who presents for head and neck surgery is placed under moderate anesthesia care rather than under general anesthesia. Because there is a drape over the patient's face, there is pooling of oxygen. When someone in the OR uses the Bovie (instrument used for electrosurgical dissection and hemostasis), you suddenly have a flash fire. To prevent Bovie-related fires in the OR requires coordination between the surgeon and anesthesiologist. When the Bovie goes on, the oxygen must be turned off. When the Bovie is switched off, the oxygen can be turned on. There are many ways to prevent these fires, and most people have read about those things but do not apply them to their practice unless they have, in fact, been involved in an OR fire. Fortunately, these Bovie-related fires are rare, but OR staff members need to be aware of these issues and preventive measures. In addition to OR fires, use of the Bovie can also be associated with serious burns. If someone does not return the Bovie to the holster or if there is an inadvertent use of the Bovie, someone will probably get burned. Usually it is a surgical team member who gets burned in these situations. These burns do not happen frequently, but following protocol should help avoid this error. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Patient Education About Flammability of Oxygen Is Critical

Never Events: Serious Errors Due to Equipment Fires or Patients Smoking While Receiving Oxygen Therapy.

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

-Special Presentation: ()-

Flash fires that result from a patient lighting a cigarette while receiving low-level oxygen therapy may be a truly devastating event because, when an airway is scorched, recovery may or may not be possible.

Patient death or disability associated with a burn incurred from any source while being cared for in a health care facility is considered an environmental error and is included on the National Quality Forum's list of 28 'never events.' One category of fires in a health care facility involves equipment that suddenly catches fire. However, in truth, equipment generally does not 'suddenly' catch on fire. Instead, it usually smolders for a time, particularly with beds. Most beds used in health care facilities have electronic mechanisms somewhere within them. We place a mattress over these mechanisms, and the equipment will usually smolder before eventually causing a fire. This is a very rare event. When investigating these events, we learn that there is often a telltale shock that hints at the problem in advance of the fire. When these shocks are reported, the health care team needs to begin looking for the cause. Perhaps the most devastating fires in health care facilities are those fires resulting from patients on oxygen therapy who sneak a smoke. We see this problem with some regularity. A number of patients who need low-level oxygen also have a significant need for ambulation and independence, so we accommodate them by giving them long oxygen cords and encouraging them to walk around their bed. Those patients who are smokers will sometimes take advantage of the long cord and walk into the far corner of a room or walk into a bathroom and light up a cigarette. Because they have oxygen going into their airway, lighting the cigarette is associated with a tragic flash fire. These patients have horrible facial and upper airway burns. In many cases, the melted plastic requires surgical excision. Usually, patients who experience this do not understand that the oxygen going in their nose could explode. Health care providers are struggling with how to help this patient population that needs oxygen and also desires to smoke. Although the nicotine patch and various other mechanisms for smoking cessation are available, it is not just the nicotine that these patients crave. They also crave the routine and the satisfaction they get from the act of smoking. In conclusion, this type of flash fire may be a truly devastating event because, when an airway is scorched, recovery may or may not be possible. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Patient Falls Require Thorough Documentation

Never Events: Falls Occurring at the Health Care Facility - Part 1.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

- Special Presentation: ()

In the hospital, a patient fall must be carefully documented because the patient may initially blame himself or herself but later change the story after talking with family members and/or a lawyer.

(Card 1 of 2) Patient death or serious disability associated with a fall while being cared for in a health care facility is 1 of the 28 items on the National Quality Forum’s list of ‘never events.’ This is a controversial ‘never event’ because it involves whether or not patients are compliant with the instructions they were given and whether or not patients understand their own limitations. Fortunately, many falls do not involve death or serious disability, but they could. One example is that of a new mother. She has just given birth, has gone through quite an experience, and feels that the worst is over. She has had an epidural, and she wants to get back to her normal routine. Despite the fact that she cannot feel her feet, she gets up to walk and experiences a fall. Because these types of falls occur in young and healthy individuals, usually there is not a serious injury, but the potential for a serious injury is present. Enormous amounts of research have been performed across the United States in terms of preventing falls in general, preventing falls with serious injury, and identifying individuals who are at risk for injury if they fall. We need to accept that patients will fall in the hospital and that we need to try and limit the frequency and severity of those falls. This requires good communications with patients to explain to them that they are at risk for falls and why they are at risk. To better manage risks of falling or later litigation, the health care team must perform an initial evaluation when the patient arrives to determine if the patient is at risk for falls. This evaluation must be carefully documented, instructions given to the patient must be carefully documented, and any falls also must be carefully documented. Documentation helps the health care team understand the level of care required by the patient, but it also helps protect the facility if a legal claim is filed. The situation that we are now seeing with increasing frequency is that the patient falls and initially blames himself or herself. At this point, the health care team should document the fall and use patient quotes in their records. However, once the patient leaves the hospital with the broken arm or leg resulting from their fall, they begin talking to the family and then they talk to a lawyer. Suddenly, the patient’s story about the fall may change. The hospital needs to have the original account of the fall carefully documented in case the staff later needs to prove what happened. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

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Not All Patient Falls Are Predictable, Preventable

Never Events: Falls Occurring at the Health Care Facility - Part 2.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation:

Several leadership organizations in the health care industry would like to further explore the applicability and implications of the 'never events' defined by the National Quality Forum, especially regarding the issue of patient falls.

(Card 2 of 2) Despite patient education and good care, patients may fall while being cared for in a health care facility, which may result in death or serious disability. One interesting case study of such a fall was documented by a nurse who was caring for a patient with a cardiac history and atrial fibrillation (A-fib). Because of the patient's A-fib, he was receiving anticoagulation therapy, and as a result, he had an elevated International Normalized Ratio (INR; measure of blood clotting potential). In addition, the patient was experiencing other kinds of arrhythmias at the same time. The patient was taken to the cardiac catheterization lab for ablation therapy and had some success with this treatment. In addition, new medications were added to the patient's treatment regimen. Because of the intensity of these new medications, the decision was made to keep the patient in the hospital. The health care team wanted to avoid complications from patient immobility, so the patient was encouraged to walk and appeared to be very steady on his feet. Then, one day, as the patient was walking down the hall, he experienced a potentially lethal cardiac arrhythmia that caused him to lose consciousness, and he abruptly fell down and hit his head. He experienced a fairly significant cerebral bleed because his INR was elevated. In the end, this man who came in to have his cardiac arrhythmias treated died in the hospital from a bleed associated with the fall. Was the fall for this particular case predictable or preventable? Probably neither. Nonetheless, the fall was considered a 'never event.' This case and others like it generate a lot of discussion and even some controversy. Because of cases like this, some of our leadership organizations would like to further explore these 'never events' and their implications. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag:
Problems With Products, Devices May Cause Never Events

*Never Events: Problems With Products or Devices Used in Health Care.*

Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation: ()

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Products or devices used in a health care facility may cause problems when they are contaminated, when they malfunction, or when their use results in an intravascular air embolism.

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The National Quality Forum's list of 28 'never events' is classified into 6 different main categories. One of these categories involves products or devices used in health care, which is a fairly short list. The first item on the list is death or serious disability associated with use of contaminated drugs, devices, or biologics provided by the health care facility. The health care facility needs to know where their products and devices are coming from and whether they have been certified by the Food and Drug Administration. If certain products or devices are being reused, then the processes for reusing them must be reliable, and culturing must be performed at every possible point to check for contamination. The next item in the products or devices category is that of death or disability associated with use or malfunction of a device used in patient care. The most frequent kinds of events in this situation deal with use of infusion pumps. Investigation usually shows that the pump performed exactly as programmed, but a staff member or a clinician had not read it appropriately, had programmed in cc/hour instead of mg/kg, had chosen a wrong medication concentration, or had substituted a medication. Most infusion pumps come with a library of things in their formularies, which helps with ease of use. In addition, you can type in almost any drug, in which case significant double-check protocols must be in place to ensure that the correct drug and concentration have been entered. Another fairly common device malfunction is seen with use of intraoperative staplers. During investigation of these events, there is always a question of whether the stapler misfired or whether user error occurred. These situations are not always easily fixed. True stapler-related problems occur when blood vessels or soft organs (such as liver or kidneys) have been injured. The third item in the 'never events' products or devices category is that of death or disability associated with intravascular air embolism that occurs while being cared for in a health care facility. These very rare events typically involve central line placement or removal. There are simple things that can be done while inserting or removing a line to minimize the risk of embolism. Most staff members are very conscious of these practices, but on occasion, you find a situation where an embolism occurred when a patient took a breath at an inopportune time or the staff was unaware of what was going on with patients while they were draped. This review is an abstract of an audio presentation from *Practical Reviews.* If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

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**Additional Keywords:** Never Events

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Facilities Need Protocols, Personnel for Product Recalls

Recommendations for Response to and Protocols for Managing Product Recalls.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD

Special Presentation:

Health care facilities must have a process in place allowing for prompt and appropriate responses to product recall notices and for thorough documentation of each facility's response to the recall.

From time to time, health care facilities must deal with the issue of product recalls. When responding to these recalls, the facility must ensure that they do not rely solely on the representative from the device or drug manufacturer to make sure that all recalled items have been retrieved. Instead, the facility must verify that all recalled products are managed appropriately by relying on their own processes and personnel. The "Dear Doctor" recall letters are very important. We must pay attention to these letters when they announce recalls or issues with drugs or devices. Our health care facilities must also have a process in place allowing for prompt and appropriate responses to these recall notices and for thorough documentation of each facility's response to the recall. Most hospitals and clinics have a process in place and a dedicated staff member or two to handle product recalls. You probably want to consider having a staff member who is responsible for knowing what kind of equipment is in the office, what kind of products are being used, what kind of medications you have, and so forth. You need to keep an inventory of anything that is stocked in the facility or used on patients so that when a recall notice arrives, there are no surprises. In the past 10 years or so, a couple of recalls have impacted hundreds and sometimes thousands of patients. In the early 2000s, a recall on bronchoscopes impacted hundreds of patients across the United States. An even larger recall involved ETHICON sutures in the late 1990s. Because sutures are so ubiquitous to any health care situation, attempting to identify lot numbers of what was in stock and what had been used was a daunting task. Therefore, make sure you know what products are coming into the facility and how each is being used. This allows more efficient tracking of products or devices should a recall occur. There are specific regulations for products that are implanted in patients, regardless of whether done on an inpatient or outpatient basis. Hospitals and associated clinics have an obligation to track these implanted devices, and they typically have protocols in place to do just that, making recalls of implanted devices a little easier to handle. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Dementia, Closed Head Injury Patients at Risk for Wandering

Never Events: Patient Protection Errors at Health Care Facilities.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation: ()-

Serious health care errors in patient protection include items such as discharging an infant to the wrong person and patient injury or death related to the patient wandering away from the facility without permission.

Patient protection events are included in one major category of serious medical errors considered to be 'never events' as defined by the National Quality Forum. The first item in this category is discharging an infant to the wrong person. This is a very rare situation and is different than an infant abduction. Typically in these situations, someone arrives to take the infant home and misrepresents themselves (perhaps as a sister or cousin) as having been given the authority to take the child home. Situations like this more commonly occur when a healthy baby is discharged before the mother or when a baby has needed prolonged hospitalization and the mother was discharged earlier. To avoid this problem, health care facilities need to have a system of double checks to verify that the right person is taking the baby home. Another serious patient protection error is patient death or serious disability associated with a patient leaving the facility without permission. Patients who are most at risk for this problem are those who have a cognitive impairment but appear to be normal to the average person. Two groups of patients who are at risk of wandering are patients who have any degree of dementia and patients who have had a closed head injury and yet appear strong and healthy. These patients must initially be identified, and the risk for wandering as well as protective measures must be documented. One protective measure may be as simple as a brightly colored gown so that staff members will recognize that this person is not to be wandering on the floor. Other measures may include locators to help find a wandering patient, or other technologies that sound an alarm when the patient tries to leave the floor. Whatever measures are taken, this care plan must be carefully documented. In addition, families must be involved with caring for patients at risk for wandering. It can be difficult for families to understand that patients with brain injury may look terrific but they have no judgment and are at risk for hurting themselves in many ways. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Patients at Risk for Suicide Need Careful Observation

*Never Events: Patient Suicide While at a Health Care Facility.*
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
- Special Presentation: ()

When dealing with patients at risk for suicide, the health care team must initially recognize and identify these patients, document their care plan, and carefully follow through with that care plan.

Patient protection errors at health care facilities are 1 of the 6 major categories of items included on the 'never events' list developed by the National Quality Forum. Among the patient protection errors, one very concerning item is that of patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility. This is always a devastating event, and staff members do a great deal to prevent these situations. The thing that we have found interesting in investigating events like this is that staff members expect the patient to think in the same way that they think in terms of what could be used to cause personal injury or to attempt suicide. In recent investigated situations, we have had patients who have been very creative with their clothing as a means of harming themselves. We have also had patients who have done serious damage to themselves and large blood vessels in their body by somehow removing the sharp edge on a paper towel dispenser and using it as a weapon. The health care team must initially recognize and identify at-risk patients, document their care plan, and carefully follow through with that care plan. For example, if the care plan calls for observation at 15-minute intervals, then each of these observations must be carried out and documented. One incidence in which a problem was found had a care plan calling for observation of an at-risk patient at 15-minute intervals. The documentation showed that all observations were made through the night. Unfortunately, the patient died about 4 AM by hanging himself, and yet we had 15-minute observations documented all the way until 8 AM the next morning after the death. This case emphasizes the point that, if observations are being made, then the staff member must actually enter the room, look at the patient, and make sure that the patient is still breathing. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events

print tag: ()
Question Personnel Who Do Not Have Proper ID

Never Events: Criminal Events Occurring at the Health Care Facility.
Kathleen Hale, RN, BSN, MHSA, and Richard P. Kidwell, JD
-Special Presentation: ()

Criminal events on the list of 'never events' include impersonating a health care provider, abduction of a patient, and sexual or physical assault of a patient within or on the health care facility's grounds.

Patient death or disability resulting from a criminal event occurring while at the health care facility is 1 of the 6 major categories of 'never events' defined by the National Quality Forum. The first item on this list includes any incidents of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider. To prevent impersonation, we must ensure that background checks to verify past employment, education, licensure, and other such items are performed for each new employee. This process is sometimes cut short or done incorrectly. The second item on the criminal events list is abduction of a patient at any age. The most frequently involved populations are infants and vulnerable adults. Although most facilities have a reasonable handle on how to prevent infant abduction, they can still get fooled when someone arrives impersonating a clinician. Make sure that all staff members in your organization wear identification tags that contain a photograph and a name. If you have someone without the proper tag, ask who they are and what it is they are doing. If you have any suspicion at all, call security and make sure this person is checked out. The third item on the criminal events list is sexual assault on a patient within or on the grounds of a health care facility. Health care facilities have many vulnerable patients, adolescents, and people whose judgment is impaired. There are many scenarios with the potential for a sexual assault. No matter how outlandish an allegation of sexual assault may be, it must be investigated. These investigations tend to be very difficult because some very unpleasant and personal questions must be asked. To investigate the allegation properly, you must set up a time line to ensure that you do not have a problem either on the part of your staff or the patient. The fourth item on the criminal events list is death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of the health care facility. Because our facilities contain patients with behavioral, cognition, and disorientation problems, many scenarios for physical assault exist. We can help avoid these situations by having readily available panic buttons or teams to swarm on a situation for controlling the behavior of the people involved. Our focus is typically patient-centered, but this is a situation in which we have to make sure that staff members as well as patients are protected. This review is an abstract of an audio presentation from Practical Reviews. If you do not have access to this presentation and would like to purchase a copy, please call 1-800-633-4743, email service@oakstonepub.com, or write Oakstone Medical Publishing, 100 Corporate Parkway, Suite 600, Birmingham, Alabama 35242.

Additional Keywords: Never Events
Communication Errors Cause Most Wrong-Site Surgeries

_How to Do the Right Things to Correct Wrong-Site Surgery._

**PA Patient Safety Authority:**

_PA-PSRS Patient Safety Advisory; 4 (June): 1, 4-17_

Causative factors associated with wrong-site surgery include the surgeon specifying a wrong site, not completing a proper "time out" before the surgery, and poor patient positioning thereby concealing the surgical mark.

**Background:** Between 1987 and 1995, the average payment made to a plaintiff in a wrong-site surgery malpractice claim was $54,790. Wrong-site surgery is considered a preventable serious medical error that has been listed as a 'never event' by the National Quality Forum.

**Objective:** To compare the experiences of the Pennsylvania Patient Safety Reporting System (PA-PSRS) with the experiences of others regarding wrong-site surgeries.

**Results:** The most common sites for wrong-site errors are the lower extremities. The medical specialties most frequently involved in wrong-site surgeries include orthopedic/podiatric surgery (41%), general surgery (20%), neurosurgery (14%), and urology (11%). A survey of orthopedic surgeons found that 25% of surgeons practicing for 35 years reported having at least 1 wrong-site surgery. Factors that may have been responsible for a wrong-site surgery include: (1) surgeon specifying wrong site, (2) not completing a proper "time out" before the surgery to identify the patient and the operative site, (3) not verifying consents or site markings, (4) inaccurate consents/diagnostic reports or images, and (5) poor patient positioning concealing the surgical mark or promoting site confusion. In >70% of wrong-site surgeries, the causative factor was a breakdown in communications between patient and/or family members or surgical team members. A failure to communicate the correct information, a failure to understand the information, or a failure to communicate changes or corrections in information can lead to a wrong-site surgery. The Joint Commission proposed a Universal Protocol in 2003 to help avoid wrong-site surgeries. This protocol has been endorsed by many medical professional societies. In this protocol, time is taken to verify the patient's identity preoperatively, the operative site is marked by the physician using the word "Yes" or the physician's initials, the surgical site is verified preoperatively, and a brief "time out" is taken in the operating room before making the skin incision to verify the patient's identity and the surgical site and procedure. Several organizations have developed additional measures to avoid wrong-site surgeries. For example, in one hospital, the blade is not placed on the scalpel handle until a preoperative "time out" is satisfactorily completed.

**Conclusions:** The error of wrong-site surgeries indicates a breakdown in communications and teamwork. Punishing these errors will not fix the problem. Studying the psychology behind these errors can help identify causative factors and prevent errors before they occur.

**Reviewer’s Comments:** This article is a "good read," both entertaining as well as informative. Multiple examples of the problem (wrong-site surgery) are given, including analyses of causes and methods for prevention. Unfortunately, there is no perfect formula or set of guidelines that will accomplish elimination of these 'never events.'

**Additional Keywords:** Never Events

**print tag:** Refer to original journal article.