

“Never Event” Errors in Healthcare

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“Never event” errors are reportable adverse outcomes that are “serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability,” according to the National Quality Forum (NQF), a voluntary consensus standard-setting organization, established in 1999. The mission of NQF is “to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.” NQF has endorsed the following list of 28 “never events”:

1. Surgery performed on the wrong body part.
2. Surgery performed on the wrong patient.
3. Wrong surgical procedure performed on a patient.
4. Intraoperative or immediately post-operative death in an ASA Class I patient.
5. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
6. Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
7. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
8. Infant discharged to the wrong person
9. Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.
10. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.
11. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
12. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.
13. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.
14. Patient death or serious disability due to spinal manipulative therapy.

15. 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.
16. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.
17. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.
18. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
19. Abduction of a patient of any age.
20. Sexual assault on a patient within or on the grounds of the healthcare facility.
21. Artificial insemination with the wrong donor sperm or donor egg.
22. Unintended retention of a foreign object in a patient after surgery or other procedure.
23. Patient death or serious disability associated with patient elopement (disappearance).
24. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
25. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.
26. Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility.
27. Patient death or serious disability associated with a fall while being cared for in a healthcare facility.
28. 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 of the healthcare facility

No Pay for Never Events

Hospitals and physicians are confronting an emerging ethical and patient safety accountability imperative – namely, no reimbursement for medical errors that should never happen. In June 2003, Minnesota became the first state to require public reporting of the NQF list of events. In September 2006, California also adopted the list. Presently, several states use the NQF list in whole or part as the basis of their state-based public reporting system. In August 2007, the Centers for Medicare and Medicaid Services issued a rule that denies payment for eight hospital-acquired adverse events, to take effect in October 2008. In September 2007, Minnesota hospitals and insurers agreed that patients and health

plans should not be billed for “never event” errors. In November 2007, the Blue Cross Blue Shield Association announced that its plans will work toward ending payments for never events. As of January 2008, about 1,300 hospitals nationally plan to waive all costs directly associated with never events.

Queries: How will physicians be affected? Will the decision to deny payment for “never events” lead to unintended professional medical liability issues for both hospitals and physicians? Will the medical malpractice liability insurer stop covering and defending “never events”? Will the no-pay result in unintended consequences such as denial by hospitals to admit patients with co-morbidities? Indeed, there are many unanswered questions. Nevertheless, there is a patient safety and accountability epidemic that is spreading across our country, which can not be ignored.

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