The Leapfrog Group Policy on "Never Events"

Frequently Asked Questions

What are never events?

The National Quality Forum, a nonprofit national coalition of physicians, hospitals, businesses and policy-makers, has identified 28 events as occurrences that should never happen in a hospital. They termed them "serious reportable events", or 'never events'. They include surgical events such as performing the wrong surgical procedure, product or device events such as contaminated drugs or devices and criminal events such as abduction of a patient. See a complete list of never events: http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf

How often do never events occur?

By definition, never events are incredibly rare. They are also rarely disclosed, except in confidentiality to reporting programs like the Joint Commission http://www.jointcommission.org/SentinelEvents/PolicyandProcedures) so precise numbers on their frequency are not available. Some states, such as Minnesota, now have mandatory reporting laws that track never events. In the past few years, Minnesota has averaged around 100 reported never events per year.

If never events are so rare, why is Leapfrog choosing to focus on them?

While never events are rare, they do sometimes happen – causing serious harm to the patient. Leapfrog wants to promote patient safety and quality consistently by supporting the National Quality Forum's extensive research and recommendations on the subject of never events. We also want to recognize those hospitals that are leading the effort in patient safety by being willing to apologize to the patient affected by the never event, investigate its cause and improve processes in response to their analysis.

How does the issue of never events relate to other Leapfrog initiatives?

Leapfrog's "leaps", which in four categories address the 30 Safe Practices for Better Healthcare, also created by the National Quality Forum, (http://www.leapfroggroup.org/media/file/Leapfrog-National_Quality_Forum_Safe_Practices_Leap.pdf) are intended to work together with NQF's 28 Serious Reportable Events in addressing both the processes and outcomes related to adverse events. The implementation of the 30 Safe Practices is intended to prevent adverse events from happening in the first place. The list of never events identifies the rare events that sometimes do happen and makes recommendations for what hospitals can and should do if a never event occurs in their facility.

Are there other voices in the health care arena giving attention to the issue of never events?

Yes. In May 2006 the Centers for Medicare and Medicaid Services came out with a public statement on never events, (http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863) in which it announced its intention to work with Congress, hospitals, and other health care organizations to reduce payments for never events and to provide more information to the public about when they occur. In August 2007 they passed the Medicare Rule, in which they announced that CMS would no longer pay for

the costs of treating 8 Hospital Acquired Conditions, 3 of which are never events – objects left in a patient during surgery; blood incompatibility; and air embolism. Hospitals began reporting secondary diagnoses present on admission of patients starting on October 1, 2007. Beginning October 1, 2008, Medicare no longer pays the higher rate for these 8 conditions unless present on admission.

Won't Leapfrog's request to have hospitals apologize to the patient put the hospital at risk for liability?

Not necessarily. Research indicates that malpractice suits are often the result of a failure on the hospital's part to communicate openly with the patient and apologize for its error. Patients feel the most anger when they perceive that no one is willing to take responsibility for the adverse event that has occurred. A sincere apology from the responsible hospital staff can help to heal the breach of trust between doctor/hospital and patient. (When Things Go Wrong: Responding to Adverse Events. Boston, 2006. Mass Coalition for the Prevention of Medical Errors)

What if a Never Event is not reportable as a Sentinel Event to the Joint Commission, nor under any state program for reporting adverse medical occurrences, or is handled under the Joint Commission's Alternative 4 for sharing Sentinel Event-Related Information? Can we still meet Leapfrog principles for this policy if we do not report such Events to someone?

With respect to a Never Event for which there is no state-required reporting program or requirement in effect for reporting same to the Joint Commission, or where a Hospital communicates with the Joint Commission regarding the Event under Joint Commission's Alternative 4 for sharing Sentinel Event-Related Information, the Leapfrog reporting requirement is waived with respect to that Event. The Hospital must still perform an internal root cause analysis with respect to the Never Event.

Are there health plans that are currently working with hospitals around the issue of never events?

Yes, such as Health Partners in Minnesota, Aetna, BCBS Association, WellPoint, Anthem, and Cigna.

Do hospitals already waive charges related to never events?

Some hospitals already waive charges related to "never events." We commend this practice and through this policy are encouraging more hospitals to take this approach.

When reporting Never Events, what "state reporting program for medical errors" applies in my state?

Congress has passed legislation requiring all states to develop a reporting program for medical errors. At this time, many states have already enacted or adopted some requirement that hospitals report serious medical errors or similar adverse events to a state agency(ies). Others are still implementing legislation or regulations that define that requirement. States that have developed programs may also define reportable events differently.

The reportable adverse events defined by our state's reporting program don't include all 28 Never Events endorsed by the National Quality Forum (NQF) and adopted in the Leapfrog policy. Will reporting only the state-required reportable events to the state agency suffice for meeting Leapfrog's requirement for reporting Never Events to an external agency? Does our hospital have to report other Never Events, as defined by NQF/Leapfrog, to that state agency even though not required by our state's reporting program?

Hospitals should report all state-required reportable events to the state agency. All other Never Events, as defined by NQF/Leapfrog, that can not be reported to the state agency, should be reported to the hospital's governance board.

What if there is no "state reporting program for medical errors" in my state? Do we still have to report Never Events to meet Leapfrog principles for this policy? To whom?

Hospitals in states that do not have a state reporting program or requirement in effect can meet the reporting requirement of Leapfrog's principles for implementation of a Never Events policy by reporting all Never Events voluntarily to either the Joint Commission or a Patient Safety Organization. If there is no state-required reporting program in effect, no available Patient Safety Organization to which your hospital can report, and your hospital is not Joint Commission accredited, the Leapfrog requirement for reporting to an external agency is waived. Hospitals must report the Never-Event to their governance board. And, hospitals must still perform a root-cause analysis internally of each Never Event to meet Leapfrog's principle for full implementation of its Never Events policy.