Definition of Never Event
In 2011, the National Quality Forum released a revised list of 29 events that they termed “serious reportable events,” which are extremely rare medical errors that should never happen to a patient. Often referred to as “never events,” these include errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or death resulting from devices or contaminated drugs. A copy of the 2011 report is available at the National Quality Forum website, www.qualityforum.org.

General Information about Never Events
Adverse events in health care are one of the leading causes of death and injury in the United States today. The National Quality Forum’s 2011 list of 29 events is not intended to capture all of the adverse events that could possibly occur in hospital facilities. Rather, the list contains events that are of concern to patients, policy makers, and healthcare professionals and providers. These events are clearly identifiable and measurable (and thus feasible to include in a reporting system); and of a nature such that the risk of occurrence can be reduced by establishment of protocols, policies, and procedures within healthcare organizations.

While more than 25 states and the District of Columbia have mandatory reporting¹, only a few states report publicly. Minnesota has had a mandatory reporting program for never events in place since 2005 and has averaged roughly 100-150 reported never events per year.²

Never events are indeed relatively rare, and Leapfrog recognizes that processes sometimes fail and human error can occur. Leapfrog wants to recognize hospitals that are willing to take all the right steps in the rare event that a serious reportable adverse event occurs in their facility.

The Leapfrog Group promotes patient safety and quality in a standardized manner by supporting the consensus work of the National Quality Forum, which based its standardized set of never events on an extensive review of the literature as well as clinical and consumer input.

Leapfrog’s Policy on Never Events
The Leapfrog Group’s policy asks hospitals to commit to five actions if a never event occurs within their facility: 1) apologize to the patient; 2) report the event; 3) perform a root cause analysis; 4) waive costs directly related to the event; and, 5) provide a copy of the hospital’s policy on never events to patients and payers upon request.

1. The Leapfrog Group believes it is in the best interest of all parties involved that the hospital staff gives a verbal apology and explanation of the known circumstances surrounding the never event to the patient and/or family affected. Research indicates that patients who are victims of adverse events feel most angry if they perceive that no one is taking responsibility for what happened to them. A sincere apology from the responsible hospital staff can help to heal the breach of trust between the doctor/hospital and patient, and may reduce the hospital’s risk of liability.³

2. According to the National Quality Forum, “the primary reason for identifying a standardized set of serious reportable events that would be mandatorily reported is to facilitate public accountability for the occurrence of these adverse events in the delivery of healthcare.”⁴ Since the U.S. health care system does not currently have one national reporting program in place, The Leapfrog Group asks hospitals to choose at least 1 of 3 reporting options: The Joint Commission, a state reporting program, or a Patient Safety Organization. The Leapfrog Group asks that the hospital report to its chosen entity within 10 days of determining a never event occurred.

3. Perhaps the most important action for a hospital to take in the aftermath of a never event is to conduct a prompt and thorough root cause analysis (RCA). An RCA gives the hospital a structured method to learn from its mistakes by identifying the basic or causal factors that underlay the never event and to improve its systems and processes. All of the reporting programs that The Leapfrog Group endorses have instructions for how to perform an RCA of adverse events that will help to guide the hospital through the necessary steps.

4. The Leapfrog Group’s policy on never events is about improving patient care. It goes without saying that a patient who is a victim of a never event
should not have to pay for it. Therefore, The Leapfrog Group asks hospitals to determine, on a case-by-case basis, which costs are directly related to the never event and to waive those costs so that the patient and no third-party payer receives a bill for those costs. The Leapfrog Group understands that specific details of what constitutes “waiving cost” requires the hospital to rigorously examine the individual set of circumstances surrounding the never event; our policy asks the hospital staff to use its best judgment during this examination to protect the patient from inappropriate payment.

5. A hospital that implements The Leapfrog Group’s policy on never events agrees to be transparent with key stakeholders on their implementation of this policy. A copy of the policy should be made available to all patients, patients’ families, and payers upon request.

Policy Implementation

1. Hospitals can adopt the policy by incorporating each of its five points into an internal policy that is implemented in their facility.

2. Hospitals that report to the Leapfrog Hospital Survey will have an opportunity to indicate their implementation of the policy in the survey.

3. Hospitals’ answers to the survey questions about whether or not they have implemented The Leapfrog Group’s never events policy will be publicly accessible as part of the hospital acquired conditions section on the consumer display of The Leapfrog Group’s web site: http://leapfroggroup.org/compare-hospitals

Why Purchasers Need to Get Involved

Using their leverage as purchasers, Leapfrog members can recognize and reward hospitals that have implemented The Leapfrog Group’s policy on never events. Also, purchasers, including health plans, can promote dialogue about never events by educating consumers and calling attention to the importance of choosing hospitals with zero or low rates of never events. Importantly, purchasers can continue to apply pressure on hospitals to be transparent about incidents of never events, with a focus on prevention.

References