Leapfrog Never Events Report

Some mistakes in the hospital are so egregious that they are 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. Through a multi-stakeholder process, the National Quality Forum defined a total of 29 such events as "serious reportable events that should never happen". Leapfrog calls these events "never events."

The list of serious reportable events contains events that stakeholders agree are always preventable, and always harmful to patients, though it is not intended to capture all of the adverse events that could possibly occur in hospital facilities. For over ten years, Leapfrog has mobilized a response.

Leapfrog's Never Events Policy

Unfortunately, never events still occur in hospitals more often than "never". When there is a never event, Leapfrog and its constituency of employers and other purchasers expect hospitals to respond with the highest levels of respect and compassion for patients and their families, sound business principles that apply in any industry when a serious and harmful error occurs, and system-wide actions to prevent future reoccurrences.

Beginning in 2007, The Leapfrog Hospital Survey asked hospitals to **commit to five actions** if a never event occurred 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;

5. Provide a copy of the hospital's policy on never events to patients and payors upon request.

When the Policy was first added to the Leapfrog Hospital Survey in 2007, 53% of hospitals fully met Leapfrog's standard of all five actions above. By 2014, that had risen to 79%. Since that time, hospitals indicating they respond to a never event with the original five actions has plateaued at roughly 80%.

In recent years, new research and experience have further informed evidence on best practices for addressing never events. In particular, notable organizations have developed and tested resources to help health care organizations improve the way they address medical errors, adverse events, and near misses. The Agency for Healthcare Research and Quality developed the CANDOR Toolkit, designed to assist health care institutions and practitioners in responding in a timely, thorough, and just way when unexpected events cause patient harm. Likewise, the National Patient Safety Foundation Root Cause Analysis and Action (RCA2) tool identifies methodologies and techniques that can lead to more effective and efficient use of root cause analysis to achieve the ultimate objective of improving patient safety.

In light of this new evidence on best practices, in 2017 Leapfrog added four additional actions to its Never Events Policy to further ensure that patients and families, as well as caregivers, receive appropriate follow-up if a never event occurs. Leapfrog's expanded and more robust Never Events Policy now asks hospitals to **commit to four additional actions**:

6. Involve patients and families in the root cause analysis when willing and able to participate

7. Inform the patient and family of the action(s) that the hospital will take to prevent future recurrences of similar events based on the findings from the root cause analysis

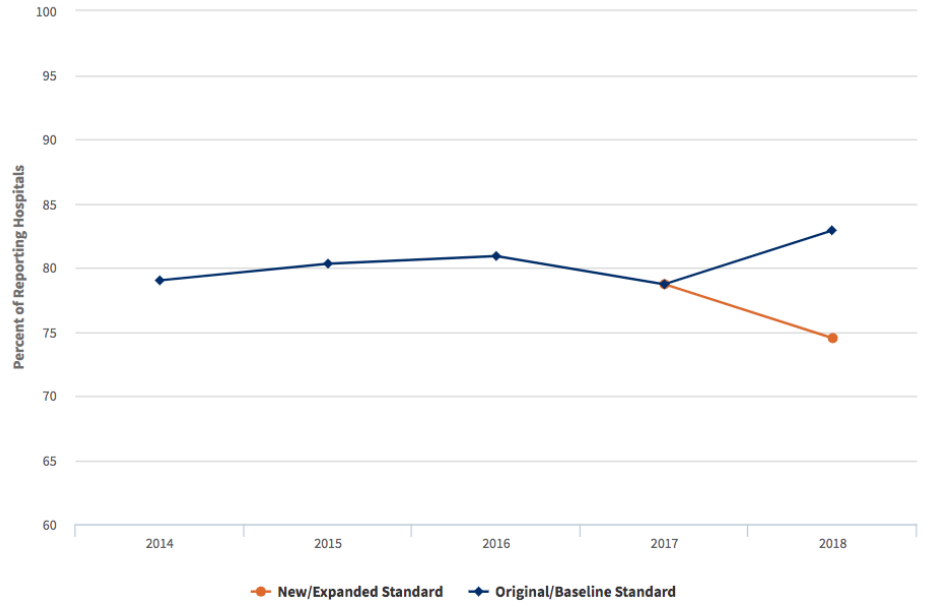
8. Have a protocol in place to provide support for caregivers involved in never events, and make that protocol known to all caregivers and affiliated clinicians

9. Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred

Employers and other purchasers strongly support Leapfrog's Never Events Policy; in industries outside of health care, the principles embodied within the policy are core business principles. When an exceptionally harmful error occurs, most businesses will apologize to the customer, not charge for the services that led to the error, do a root cause analysis, and make sure they prevent it from happening again. Leapfrog asserts that regardless of its environment, setting, or type of patients it treats, 100% of hospitals should comply with all nine elements of Leapfrog's Never Events Policy. Employers and other purchasers expect hospitals to abide by these basic pillars of respect in addressing never events. Yet in 2018, roughly one in four reporting hospitals (25.4%) failed to meet Leapfrog's expanded standard.

Figure 1: Percent of Hospitals Meeting Leapfrog's Standard for Never Events (2014-2018)

Source: Leapfrog Hospital Survey



Note: *Leapfrog changed its standard from five to nine actions in 2017 and began publicly reporting on the new standard in 2018. This chart shows adherence to the first five actions since 2014 and includes a split to show the expanded standard.*

The scale on this chart has been zoomed in to magnify the data points. Hover over each data point to see the percentage.

Which Hospitals are Meeting Leapfrog's Standard?

When the expanded Never Events Policy was put in place in 2018, hospital performance dropped for both urban and rural hospitals. Rural hospital performance on the Never Events Policy fell more significantly by 9.9% (63.8% of hospitals fully meeting) compared to urban hospitals, which fell 5.1% (76.4% of hospitals fully meeting).

Figure 2: Rural Hospitals Meeting Leapfrog's Standard for Never Events (2014-2018)
Source: Leapfrog Hospital Survey

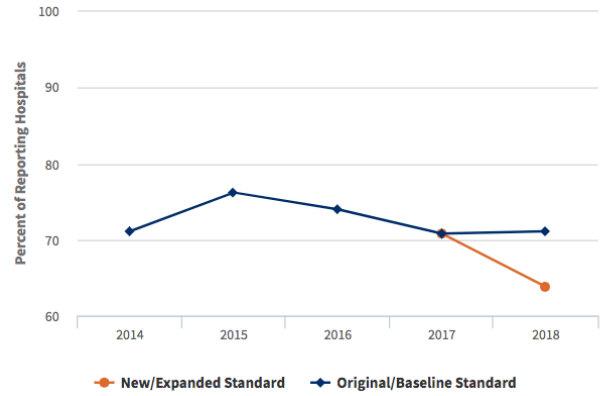
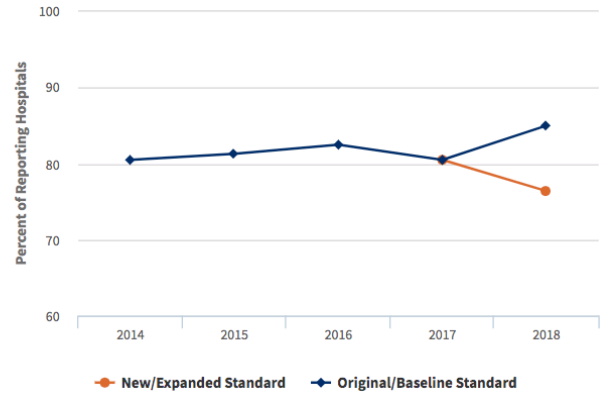


Figure 3: Urban Hospitals Meeting Leapfrog's Standard for Never Events (2014-2018)
Source: Leapfrog Hospital Survey



Note: *Leapfrog changed its standard from five to nine actions in 2017 and began publicly reporting on the new standard in 2018. These charts show adherence to the first five actions since 2014 and include a split to show the expanded standard.*

The scale on this chart has been zoomed in to magnify the data points. Hover over each data point to see the percentage.

Similar to differences between urban and rural hospitals, the dichotomy between teaching and non-teaching hospitals is noteworthy. Teaching hospitals have been more likely to fully meet Leapfrog's standard than non-teaching hospitals for the last four years.

When the expanded standard was put in place, hospital performance dropped for both types of hospitals. Teaching hospital performance on the Never Events Policy fell 8.7% compared to non-teaching hospitals which fell 3.4%. There is now very little difference in performance between the two hospital types, with 74.3% of non-teaching hospitals fully meeting the standard compared to 75.2% of teaching hospitals.

Figure 4: Teaching Hospitals Meeting Leapfrog's Standard for Never Events (2014-2018)

Source: Leapfrog Hospital Survey

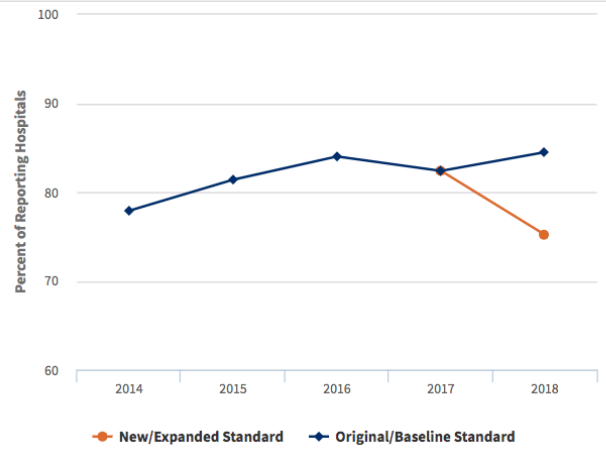
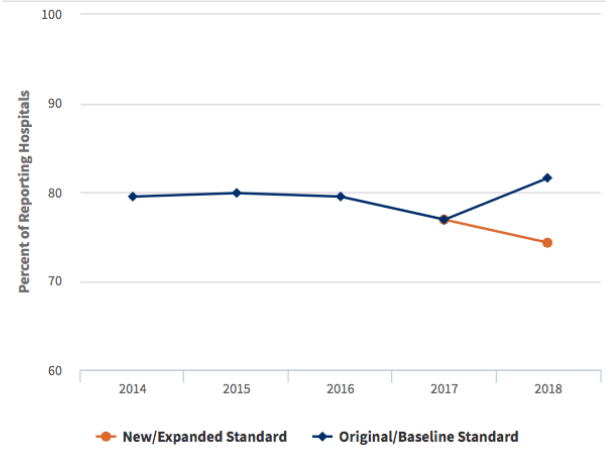


Figure 5: Non-Teaching Hospitals Meeting Leapfrog's Standard for Never Events (2014-2018)

Source: Leapfrog Hospital Survey



Note: *Leapfrog changed its standard from five to nine actions in 2017 and began publicly reporting on the new standard in 2018. These charts show adherence to the first five actions since 2014 and include a split to show the expanded standard.*

The scale on this chart has been zoomed in to magnify the data points. Hover over each data point to see the percentage.

What Employers and Purchasers Can Do

Leapfrog's Never Events Policy can reassure purchasers that if their employee or dependent does experience the worst, the hospital pledges to respect patient dignity and comply with good business practices.

Though the majority of U.S. hospitals are reporting to the Leapfrog Hospital Survey and thus sharing information about their Never Events Policy, many decline to publicly disclose this critical information. For these facilities, purchasers and patients have no way of knowing if the hospital has a Never Events Policy and how their employee will be treated should a never event occur. Purchasers should ask that all hospitals report to the Leapfrog Hospital Survey to verify that they abide by an evidence-based Never Events Policy.