PATIENT SAFETY BLOG

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Expanding the List of Medical Misadventures that Should Never Happen

July 4, 2011 by Patrick A. Malone

Nearly 10 years ago, the National Quality Forum (NQF) published a report, Serious Reportable Events (SREs) in Healthcare. It identified 27 really horrible mistakes occurring in hospitals deemed largely preventable and of concern to both the public and health-care providers. Thanks to their extreme nature, these "adverse events" have come to be known colloquially as "never events." They include such medical misadventures as surgery on the wrong body part, festering bedsores acquired after admission, patient falls and life-threatening medication errors.

Establishing consensus of what constitutes preventable errors among everyone vested in the satisfactory delivery of health care--consumers, providers, researchers, etc.--facilitates clear accounting and resolution of them.

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The report was revised in 2006, and once again the program is updating the list of SREs.

The take-home message this time is that SREs are an equal-opportunity aspect of practicing medicine that go beyond the confines of a hospital. The mission is expanding to collect data also from:

- ambulatory and office-based surgery centers;
- long-term care settings (including skilled nursing facilities); and
- physicians' offices.

The uniform approach to measurement helps to drive national improvement in patient safety through shared learning and prevention. More than half of the states use the NQF-endorsed list of SREs in their public reporting programs.

This update adds these "never events":

- death or serious injury of a newborn associated with labor or delivery in a low-risk pregnancy;
- patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;
- patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results; and
- death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

The NQF report is widely embraced as what health-care monitor Bob Wachter calls "a dominant force in the patient safety field." It has, he notes, a real and measurable impact: Medicare, for example, has stopped paying hospitals the extra costs associated with SREs. "While the money being withheld is relatively small...," Wachter says, "the policy has captured the attention of administrators and providers everywhere."

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Still, Wachter sees room for improvement, noting that:

- many events on the list lack standard definitions, leaving them subject to interpretation;
- unintended consequences can occur, such as preventing a fall by tethering a patient to the bed who otherwise would benefit from walking;
- the "no pay for errors" policy might prompt private insurers to suspend all payments after a facility reports an SRE;
- the list doesn't capture some mistakes, such as diagnostic errors and errors of overuse; and
- some serious adverse events are not known to be fully preventable.

Greater accountability can only encourage sustained efforts to protect patients from sloppy, incompetent and witless medical behavior. Efforts to refine the process are good for both the providers and those of us who receive medical care.

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