PPIC Closed Claim Case Review

Prevention of Never Events

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Abstract

The Centers for Medicare and Medicaid Services define "never events" as high-cost or high-volume conditions that are avoidable through the application of evidence-based guidelines (CMS, 2007). "Never events" are easily preventable medical errors that can cause severe and costly injury and death to their victims; in other words, they're mistakes that should never happen. Examples of never events are performing surgery on the wrong body part, operating on the wrong patient, transfusing incompatible blood, or leaving foreign objects in a patient after surgery. Some form of screening system that enables the detection and the prevention of potentially harmful events is essential for the safety of patients.

Overview

A 70-year-old woman presented for a surgical removal of a malignant nodule in her left lung. The insured operated on her right lung instead. Failing to find anything in the lung while in surgery, he had staff check with her primary care physician and discovered the mistake. He closed the plaintiff and explained to the family what occurred. Unfortunately, the patient had to wait a month before she was able to undergo surgery on the correct lung. Additional surgeries were necessary to remove a previously diagnosed nodule. She was diagnosed with early stage lung cancer, which was treated by the surgery on the correct lung.

While the claimant had signed a prior consent form indicating right side surgery, she maintains that she didn't read the form as her sight was poor. The patient also had a pre-surgery meeting with the anesthesiologist, who indicated that surgery would be on the right lung as well. The patient alleged that she tried to correct him, but he did not listen. The anesthesiologist reported that the claimant never corrected him. Even so, it is unlikely that a jury would place blame on her as she was obviously an elderly patient.

The insured surgeon ultimately admitted that he failed to consult the medical report and films prior to or during surgery. He provided a reasonable explanation, although it did not relieve him of being found negligent for his actions. He testified that he had received this case from a fellow MD who specialized in pulmonology. The insured misinterpreted a report indicating that the plaintiff had lesions in both the right and left lung, but that the lesion in the left lung had become more hypermetabolic. He based this information on his review of a CT scan, which indicated that two small nodular densities, one in the base of each lung, were present on the previous exam. The scan comment went on to state that the nodule in the right lung may be fractionally larger than the left, but the slight difference was difficult to accurately measure.

The insured then read a PET scan impression, which stated that the faint area of increased hypermetabolic activity noted on the last two PET scans was far more intense than it had been on a previous exam and consistent with neoplasm. According to the insured, he interpreted the right lung size change to mean that the increased hypermetabolic activity was also found in the right lung. Unfortunately, the insured did not read the comment portion of that PET scan, which stated, "the CT scans again showed the lesion in the left upper lobe and it does not appear to be significantly changed or minimally changed from previous studies, however, the PET scan is intensely hypermetabolic at this time." Had the insured read this, he would have known that the surgery was to be performed on the left lung rather than the right.

Expert Opinion

No expert reviews were performed as it was obvious to all parties that a mistake had been made. The case settled for $125,000.

Discussion

CMS and many major health care insurers are targeting preventable errors, including the 28 "never events" that a patient can incur in a hospital. Some of these events include:

- Surgery performed on wrong body part or on wrong patient
- Wrong surgery performed on patient
- Retention of foreign object in patient following surgery
  Patient harm related to a device being used for functions other than which it is intended
- Infant discharged to wrong person
- Patient harm related to their elopement or disappearance

- Patient harm related to a medication error (e.g., wrong drug, wrong dose, wrong patient, wrong route, etc.)
- Patient harm related to receiving incompatible blood or blood products
- Maternal harm associated with labor or deliver in a low-risk pregnancy while in a health care facility
- Patient harm related to hypoglycemia while in a health care facility
- Death or serious disability/kernicterus related to failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a health care facility
- Patient harm associated with electric shock or cardioversion while in a health care facility
- Patient harm related to a fall while in a health care facility
- Patient harm associated with use of restraints or bedrails while in a health care facility

CMS made this list in order to codify common adverse events that need to be recognized and investigated. These events also need to be analyzed for root cause and reported any time they occur.

Risk Prevention Strategies

There are many ways healthcare providers can implement processes or use technology to reduce errors. Some of these may include:

- Computerized physician order data entry
- Smart pumps or computerized adverse drug event monitoring systems for IV/medication administration
- Barcodes on medications
- Automated process checklist
- Electronic patient records
- Radio frequency identification systems

Summary

Before the term "never event" entered the common language, most hospitals already had a policy for not billing for preventable medical errors that occurred on their property. This included if the hospital committed the error, contributed to its cause, or even merely furnished its facilities. Most insurers would reject benefit payment for any medically unnecessary procedure, such as performing surgery on the wrong patient or surgical site. Never event policies symbolize another side of quality improvement. Instead of the insurers offering incentives such as pay for performance, we can expect to see these types of actions continue as healthcare purchasers are increasingly asked for assurances that services are delivered in a high quality and efficient manner. One example is Medicare's active research of the practicability of expanding its practice of rejecting payment for healthcare acquired conditions into other care settings.

Clinicians do not like to admit mistakes are made. Unfortunately, no one is immune from failure. A report from the Agency for Healthcare Research and Quality (AHRQ) determined that potentially preventable medical errors that occur during or after surgery cost employers nearly $1.5 billion a year (Bennett, 2008). Research is important to identify the extent and cause of medical errors, because these mistakes are no longer swept under the rug and never events should never occur.

References

CMS. (2007). Incidence of Medicare program: Changes to the hospital inpatient prospective payment systems and fiscal year 2008 rates. Fed Regist. 72(162):47200-47218.

Bennett, D. (2008, November). Medical mistakes new caveat in contracting terms. Managed healthcare executive. 18(11). pp23-25.