Never Events
Today's Speaker
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Saint Mary Home

NEVER EVENTS:
Clinical Imperative

Objective for Today's Presentation
- History of how the “Never” Event programs were initiated and developed.
- Explain the process, and outcomes of implementing the “Never” Event programs.
- Learn how the “Never” Event programs integrate with initiatives to reduce rehospitalizations & ED outcomes
- Understand how the “Never” Events programs and their link to Financial Considerations and Value Based Purchasing
FACT

Adverse events “Never” events in healthcare are one of the leading causes of death in the United States today.


WHAT IS A NEVER EVENT?

- The National Quality Forum, a non-profit national coalition of physicians, hospitals, businesses, and policy-makers, has identified 28 events as occurrences that should never happen in a hospital and can be prevented.
- Never events are PREVENTABLE medical errors.

WHAT THE FINAL RULE SAYS

The final rule addresses nonpayment for hospital-acquired conditions by:
- Explaining the criteria used to adopt a policy of nonpayment for reasonably preventable hospital-acquired conditions
- Suggesting currently available standards and guidelines that hospitals can adopt to help prevent hospital-acquired conditions
- Creating a new coding process that will indicate to CMS that a hospital-acquired condition was present on admission (POA)
- Defining circumstances under which CMS will continue to pay for treatment of hospital-acquired conditions
LIST OF CMS NEVER EVENTS (NE)

Object left in during surgery
Air embolism
Blood incompatibility
Catheter-associated urinary tract infection (CA-UTI)

Pressure ulcers
Vascular catheter-associated infection
Post CABG surgical site infection
Hospital acquired injury (falls and trauma including fractures, dislocations, intracranial injuries, crushing injuries and burns)

The Affordable Care Act -2010

The Affordable Care Act (ACA) required the Secretary of Health and Human Services to "establish a national strategy to improve the delivery of healthcare services, patient health outcomes, and population health."

HR 3590 & 3011, amending the Public Health Service Act (PHSA) by adding 399HH (a)(1)

The principles of the National Quality Strategy are:

Nine Areas of Focus

Catheter – associated urinary tract infections (CAUTI)
Central line associated blood stream infections (CLABSI)
Injuries from falls and immobility
Adverse drug events
Obstetrical adverse events

Pressure ulcers
Surgical site infections (SSI)
Venous thromboembolism
Ventilator-associated pneumonia (VAP)
Partnership for Patient Goals

By the end of 2013, preventable hospital-acquired conditions would decrease by 40-percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.

Help patients heal without complication. By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20-percent compared to 2010. Achieving this goal would mean more than 1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.


HHS 2011 National Quality Strategy: Six National Priorities

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care through the continuum of care.
4. Promoting the most successful prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to support wide use of best practices to enable health living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

BEYOND ACUTE CARE

Time to re-assess our own care processes
Advancing Excellence in Nursing Homes
National Nursing Home Campaign
Only the excellent will survive in the future

Never Events ARE coming to Long Term Care
HOW DEVELOPED

- May 2010: Initial discussion (joint CHE LTC/CAPS/ION) Council meeting
- Jul 2010: Agreement to conceptualize participation in Advancing Excellence in Nursing Homes
- Jul 2010: CHE organizations/organizations interested in participating in MDS education meeting
- Sept 2010: Volunteers solicited for task force group
- Oct – Dec 2010: Collaborate with acute care colleagues; work with clinical experts to develop protocols, etc.

WHERE DO WE START?

Recommendations for our Long Term Care Never Events

**FACILITY ACQUIRED ONLY**
1. Low risk pressure ulcers
2. Falls with injury
3. Medication errors that require additional monitoring due to potential side effects and beyond (actual harm)
4. Infection resulting in unit and/or facility outbreak
5. Acute care readmissions within 30 days
6. ED visits within 30 days without hospitalization.

What will make us successful? (see Critical Success Factors handout)
Advancing Clinical Transformation Plan

Overall map/diagram - Outlines the process
- Critical Success Factors
- Work Plan for Facility- Acquired Conditions
- Performance Improvement & Hardwiring

Each “Never” Event has a coordinating BUNDLE
Every BUNDLE identifies the work of each task group
BUNDLES are used for both communication and training tools

Bundle For Fall Prevention
S.A.F.E.T.Y

SAFE ENVIRONMENT FOR RESIDENTS
ASSESS/RE-ASSESS RESIDENT DEFICITS
(SENSORY, BALANCE, COGNITION, GAIT AND MOBILITY)
FALL RISK ASSESSMENT AND REASSESSMENT
ELIMINATION NEEDS MUST BE MET
TEACH RESIDENTS & THEIR FAMILIES ABOUT FALL PREVENTION
YOUR FALL PREVENTION TEAM MUST BE MULTI-DISCIPLINARY

Task Force Groups

Volunteers - all levels of staff
Speakers - clinical experts
Protocols / Assessments / Policies
Root Cause Analysis - Internal & External
Changes in Internal Educational Practices
- Competency tests
- Education with Hospitals
- Partner with Acute Care
- Interact II Tool
Organizational Readiness - reporting to Advancing Clinical Transformation Committee (ACT)
Learning opportunities- both success’s and challenges shared
Clear identification of each of the 4 "Never" Events Care Dimensions

Defined definitions involving measurement of the 4 areas

Development of Constructs using Evidence Based Criteria:
- Falls – Resident Assessment Instrument, RAI Manual
- Medication Errors- American Pharmacists Association, APA & Victorian Consultant Pharmacists, VCP
- Infections Outbreak – CDC Definitions, Mc Geer Criteria
- PU's - Resident Assessment Instrument, RAI Manual & Braden Scale

System wide communication and education on indicator tools, process and collection of the data

Long Term Care Clinical Indicator Data Collection Form

**CARE DIMENSION**: Resident Falls with Major Injury

**CHE Never Events Target**: 0%

**INTENT**: Consistent with our values of providing a full range of services that support healthy individuals and to improve the quality of care this indicator focuses on the prevention of falls with injury of residents. To improve the residents quality of life by minimizing preventable fall related injuries and their consequences resulting from a fall.

**DEFINED AS**: Total # of Documented Falls which Resulted in Major Injury

_________________________________________ x 1000 resident days

**Total # Resident Days for the Month**

**Major Injury**: Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma, injury related to a fall – Any resident evaluated and/or treatment given in facilities emergency room, to a resident who sustained an injury in the facility, or were admitted for treatment that same day. Any resident reported to have sustained a fall within a day, after which a resident is found to be injured.

**RULES/DATA COLLECTION INSTRUCTIONS**:

**NUMERATOR** – Total # of Documented Falls which Resulted in Major Injury

**DENOMINATOR** – Total # Resident Days for the Month

**Exclusions**:

**DEFINITIONS FALL**:
- RAI Manual

**Further Definitions**

- **Resident Day**: A resident day is calculated by adding the census for each day in that reporting period (a reporting period is one month). It does not include days in which the resident was transferred to another facility.
- **Unwitnessed Fall**: Either self-reported or when a resident is found on the floor or other object but no one knows how he/she got there.
- **Documented Fall**: A fall that is noted in an official facility document, e.g., medical record, incident report, risk management report.
- **Treatment**: A resident that is sent to an ED or physician office for evaluation and/or treatment (in that setting). It does not include further evaluations or treatment for an injury sustained at the facility.

**HIGH RISK PRESSURE ULCERS**

**Overall Rate**
**Stage II**
**Stage III**
**Stage IV**
**Unstageable**

**Construct**: Facility-acquired pressure ulcer (by stage) x 1000 resident days
FALLS WITH INJURY

Minor Injury
Major Injury

Construct: falls with injury x 1000
resident days

MEDICATION ERRORS

Categories
- Overall Rate
- Category B
- Category C
- Category D
- Category E
- Category F
- Category G
- Category H
- Category I

Types
- Wrong dose
- Wrong route
- Wrong resident
- Wrong frequency
- Wrong time
- Wrong medication
- Omission
- Transcription

Construct: med error by category and type
x 1000
resident days

INFECTION CONTROL

By unit (cluster) and facility (outbreak)
- Overall Rate
- Pneumonia
- Influenza
- GI
- UTI – with and w/o Foley
- MRSA
- VRE
- C Diff
- General

Construct: infection by unit (cluster) or facility (outbreak) by type x 1000
resident days
ACUTE CARE READMISSIONS W/I 30 DAYS
By short term (ST) and long term (LTC) residents

Construct:

\[
\frac{\text{# of LTC/ST residents readmitted to acute care hospital}}{\text{average daily census of LTC/ST residents in NF in given month}} \times 1000
\]

ED VISITS
By short term (ST) and long term (LTC) residents

Construct:

\[
\frac{\text{# of LTC/ST residents seen in ED but not admitted to acute care hospital in given month}}{\text{average daily census of LTC/ST residents in NF in given month}} \times 1000
\]

GOALS
0%

- 0% target with exception of falls with minor injury, ED visits & acute care hospitalizations
- Setting baseline for 2010
- Not there yet

No tolerance
- 0% tolerance to substandard practice
NEVER EVENTS:

CULTURE OF SAFETY

- Openness
- Feedback about error
- Handoffs/Transitions
- Across units
- Within units
- Supervisor/manager expectations and action promoting safety
- Management support for patient safety
- Nonpunitive response to errors
- Frequency of errors
- Learning – continuous improvement
- Staffing
- Of resident safety

Foster a Just Culture:
- Through management support and encouragement:
  - Provide opportunities for staff to contribute ideas for process improvement.
  - Share information:
    - Via newsletters
    - At staff and committee meetings
    - Use the data to tell the story
- Provide meaningful feedback about errors/safety (re-tell the story).

**AHRQ Patient Safety Culture Focus Areas**

**CULTURE OF SAFETY**

- **Reward Reporting:**
  - Implement incentives to increase reporting
    - Reward buttons
    - Staff breakfasts
    - Contests between units
  - Create incentives for *safe* behavior and increased awareness; remove incentives for *at-risk* behaviors.
  - Ensure staff are educated about data use to examine systems not people.

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**CULTURE OF SAFETY**

- **Characteristics of a Just Culture**

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Duties</th>
<th>Manage Through</th>
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</thead>
<tbody>
<tr>
<td>Normal error:</td>
<td>Admit to making mistakes, witnessing risky behavior</td>
<td>System changes in processes, procedures, training, design, and environment.</td>
</tr>
<tr>
<td>Professionals will make mistakes as part of our current system design.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentional risk-taking:</td>
<td>Participate in a learning culture</td>
<td>• Understanding at-risk behaviors</td>
</tr>
<tr>
<td>Professionals can develop unhealthy norms</td>
<td></td>
<td>• Creating incentives for safe behavior and removing incentives for at-risk behaviors</td>
</tr>
<tr>
<td>Intentional risk-taking:</td>
<td>Avoid reckless conduct</td>
<td>• Increased awareness</td>
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**CULTURE OF SAFETY**

- **Questions to Ask Regarding Just Culture and Open Communication**
  - Are errors used to measure system performance?
  - Is value, respect, appreciate, and reward all contributions to safety?
  - Is meaningful feedback provided and memorable stories told?
  - Are managers taught blame-free management style? Are they mentored?
  - Are leaders visible where staff work to learn about barriers to safe practice?
  - Is the culture just?
DATA COLLECTION/REPORTING

Facility template
- Data entry/submission
- Calculated dashboard/ graphs

CHE Dashboard
- Compilation of facility data
- Ability to track/trend as a System

Overall Medication Errors

Overall Infection Control Cluster
OUTCOMES: ACUTE CARE HOSPITALIZATIONS

OUTCOMES: ED VISITS

NEVER EVENTS:
Initiatives to reduce Rehospitalizations & ED Visits within 30 days
AVOIDABLE READMISSIONS

NEVER EVENTS: Financial Considerations and Value Based Purchasing

Significant Savings Targeted by Medicare and Other Payors

- 18% of all re-hospitalizations occur within 30 days of acute care discharge.
- These re-hospitalizations accounts for $15 Billion in additional healthcare expenditures.
- It is estimated that 76% of these re-hospitalizations are avoidable and could result in savings of $12 Billion.
- CMS value based purchasing
Primary Reason for Nursing Home Readmissions to Hospital

By Order of Magnitude:
- Pneumonia
- Urinary Tract Infections
- Heart Failure
- Dehydration
- Pressure Ulcers
- Falls
- In addition, it is noted that a significant portion of readmissions occur at the end-of-life thereby making SNF based Palliative care programs and Advanced Directives increasingly important!

CHE – SNF Never Events Focus

Program is focused on preparing for value-based purchasing by targeting areas for improved patient care/safety.
- Medication Errors Resulting in Actual Harm, estimated increase healthcare expenditure due to error $45,000
- Falls with Injury, estimated increase in expenditure $70,000
- Pressure Ulcers, estimated increase in expenditure ranges from $3,500 to $60,000
- Pneumonia, actual cost varies however, it is the leading cause of avoidable readmission to hospitals and will be a key element in acute care’s efforts to reduce their readmission rates back to their facilities.

Reasons Skilled Nursing Facilities Should Focus on Never Events

- Key referral source (Hospitals) will be penalized if the rate of readmissions from nursing homes does not improve – Referrals will decline
- Payors will not pay for additional costs of care which will impact Skilled Nursing on Medicare side via Bundled Payments and ACOs.
- Consumers (patients/families) will become increasingly aware of providers rate of readmissions in relation to competitors – Hospital compare -> Nursing home compare
NEVER EVENTS: Future Plans

FUTURE PLANS

2011

- Jan 2011: Begin data collection, education for prevention strategies
- Jan 2011: Develop RCAs for each never event and associated action plans
- Ongoing: Invite outside experts to provide CHE presentations; invite facilities to present to various CHE audiences based on learnings
- March 2011: Begin reporting to various CHE audiences
- Ongoing: Use data to make improvements
- Annually: Revisit tools, definitions, constructs, what else needs to be added?

NEXT STEPS

Task force activities and increase membership
Monthly meetings
Develop bundles, evidence based protocols and policies/procedures
Share leading practices
Develop portal site for “Never “event documents
NEXT STEPS

Calculating rates isn’t enough
- Root causes
- Action plans

Use data
- Tweaking protocols so that it’s embedded as proactive prevention
- System-level monitoring to look for opportunities to improve/standardize practice/process/quality of life

Report findings
- Senior leader support
- Locally
- Board levels/ACT Steering Committee
- Share with industry leaders

NEXT STEPS: ENHANCE QUALITY

A Need For Clinical and Cultural Transformation
- Improved Professionalism
- Interconnectedness of departments
- Staff Development & Role Realignment
- Need for Consistent Processes
  - Hourly Rounding
  - AIDET Training
  - D/C Phone Calls
  - Shift Huddles
  - Scripting
  - Aligning Incentives

Why this matters – to you, your residents and your facility

- Improve quality of care for your residents
- Your team works together more effectively
- "Never" events programs takes advantage of everyone’s contributions to resident care
- Medicare is planning changes in payment that will reward lower rates of avoidable hospitalizations
- Surveyors will be examining how facilities assess and manage acute changes in status
Audience Discussion

- Tell us about your experience in reducing pressure ulcers, falls with injury, outbreaks and or medication errors.

- What practices have you put into place to actively engaged residents and families in the prevention of pressure ulcers?

- Does your organization have a system in place for educating residents and their families about their role in their care?

- What tools and resources do you need to accelerate the changes in your community?