

What's New in the Patient Safety World

September 2019

Leapfrog's Never Events Policy

The Leapfrog Group's "Never Event Policy" ([Leapfrog Group 2019](#)) calls on healthcare organizations to do the following when a never event has occurred in their facility/organization:

- Apologize to the patient;
- Report the event;
- Perform a root cause analysis;
- Waive costs directly related to the event;
- Provide a copy of the hospital's policy on never events to patients and payors upon request.
- Involve patients and families in the root cause analysis when willing and able to participate
- 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
- 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
- Perform an annual review to ensure compliance with each element of Leapfrog's Never Events Policy for each never event that occurred

The first 5 elements have been in place since 2007 but the last 4 items were added in 2017. There was some drop off in hospital compliance with the standards after the 4 latter elements were added. Overall, about 75% of both teaching and non-teaching hospitals most recently have met all the standards.

The Leapfrog report mentions a couple key resources to aid organizations comply with the standards: the AHRQ's CANDOR toolkit (see our June 2016 What's New in the Patient Safety World column "[Disclosure and Apology: The CANDOR Toolkit](#)") and the NPSF RCA² tool (see our July 14, 2015 Patient Safety Tip of the Week "[NPSF's RCA2 Guidelines](#)").

Some of our prior columns on Disclosure & Apology:

July 24, 2007	“Serious Incident Response Checklist”
June 16, 2009	“Disclosing Errors That Affect Multiple Patients”
June 22, 2010	“Disclosure and Apology: How to Do It”
September 2010	“Followup to Our Disclosure and Apology Tip of the Week”
November 2010	“IHI: Respectful Management of Serious Clinical Adverse Events”
April 2012	“Error Disclosure by Surgeons”
June 2012	“Oregon Adverse Event Disclosure Guide”
December 17, 2013	“The Second Victim”
July 14, 2015	“NPSF’s RCA2 Guidelines”
June 2016	“Disclosure and Apology: The CANDOR Toolkit”
August 9, 2016	“More on the Second Victim”
January 3, 2017	“What’s Happening to “I’m Sorry”?”
October 2017	“More Support for Disclosure and Apology”
April 2018	“More Support for Communication and Resolution Programs”
August 13, 2019	“Betsy Lehman Center Report on Medical Error”

Other very valuable resources on disclosure and apology:

- IHI’s “Respectful Management of Serious Clinical Adverse Events” ([Conway 2010](#))
- The Canadian Disclosure Guidelines ([Canadian Patient Safety Institute 2008](#))
- The Harvard Disclosure Guidelines ([Massachusetts Coalition for the Prevention of Medical Errors 2006](#))
- The ACPE Toolkit ([American College of Physician Executives](#))
- Oregon Patient Safety Commission [Oregon Adverse Event Disclosure Guide](#).

Some of our prior columns on RCA’s, FMEA’s, response to serious incidents, etc:

July 24, 2007	“Serious Incident Response Checklist”
March 30, 2010	“Publicly Released RCA’s: Everyone Learns from Them”
April 2010	“RCA: Epidural Solution Infused Intravenously”
March 27, 2012	“Action Plan Strength in RCA’s”
March 2014	“FMEA to Avoid Breastmilk Mixups”
July 14, 2015	“NPSF’s RCA2 Guidelines”
July 12, 2016	“Forget Brexit – Brits Bash the RCA!”
May 23, 2017	“Trolling the RCA”

References:

Leapfrog Group. Never Events Report. 2019

<https://www.leapfroggroup.org/never-events-report-2019>



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