Johns Hopkins Patient Safety Experts Call for Changes in Policy to Reduce Serious, Preventable Safety Harms to Hospitalized Patients

Gaps persist in the way "never events" information is collected and acted on, researchers say

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Reflecting on more than a decade of efforts by hospitals to reduce the rate of so-called never events that kill and injure patients, two leaders in patient safety research at Johns Hopkins conclude that such harms continue at a "troubling frequency." They recommend changes for improving ways of collecting, analyzing and acting on information about lapses in care.

What's more, they say in an essay published in the May 26 *The Joint Commission Journal on Quality and Patient Safety*, it remains unclear whether public reporting of such harms and financial penalties on hospitals that have too many of them — known as pay for performance — have influenced the frequency of these events.

Never events is a term coined 15 years ago to describe "egregious" health care errors — such as operating on the wrong patient or organ — that are entirely or largely preventable and should "never" occur.

Since then, according to authors J. Matthew Austin, Ph.D., and Peter Pronovost, M.D., Ph.D., federal and national health care regulators, professional associations, insurance companies and health care systems have undertaken a vast array of programs designed to reduce safety lapses, including the subset of never events, and are estimated to cause more than 200,000 deaths and up to $29 billion in extra costs each year in the U.S. alone.

Policymakers and regulators have required public reporting of never events and have implemented penalties for health care organizations that fail to meet standards. However, there are a number of states that don't require public reporting and that only provide limited and sometimes unidentifiable data. Austin and Pronovost say that the number of never events should be transparently reported in all states. "Without this information, it is almost impossible for other hospitals to understand where there are successes and challenges in their search for best practices," they say.

They call for creation of a standardized list of definitions for never events and petition for them to be transparently reported and publicly shared. They also suggest the systems used to report this data should include independent oversight to ensure the scientific integrity of all the data — especially self-reported information.

"The nonsystematic collection of data on valid measures of never events and the lack of longitudinal public reporting at the national level in the United States make it difficult to understand how hospitals are performing over time," they write.

"Although we group never events in a different class than other preventable but less serious harms, hospital progress in reducing all preventable harms has been slow, suggesting that the barriers to improvement are not unique to never events," they add.

“From both a policy and research perspective, it is unclear how efforts such as public reporting of never event data and linking that performance to payment have influenced the rates of these events,” they say, suggesting far more research must be done to consider those best practices.

Overall, they conclude, “if we hope to see reduction in the frequency of these events, we need to change the decadelong decentralized approach of ‘collect, report and improve’ to an approach that entails standardized definitions of events, greater transparency of performance, and collective learning and accountability to drive performance forward.”

Austin is an assistant professor in the Johns Hopkins Armstrong Institute for Patient Safety and Quality and in the Johns Hopkins University School of Medicine Department of Anesthesiology and Critical Care Medicine.

Pronovost is a professor of anesthesiology and critical care medicine at the Johns Hopkins University School of Medicine, senior vice president of patient safety and quality for Johns Hopkins Medicine, director of the Armstrong Institute, and a member of the journal’s editorial board.