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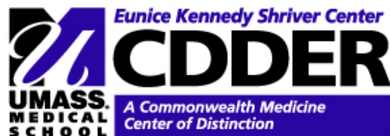

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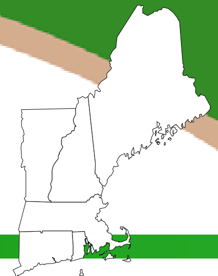
QUALITY BRIEF

For Developmental Disability Services in New England



FOCUS

Never Events: *Should we use them in DD Programs?*

Hospitals in the U.S. have recently adopted a new safety concept they call **"never" events**. These are extremely serious incidents that represent mistakes or errors that are identifiable, preventable and that result in substantial harm to an individual. They include things such as being very seriously disabled due to falling while in the care of a hospital, or death due to being given the wrong dose of medication. In essence, such "never" events should simply "never" happen. There should be zero tolerance for such events and facilities and programs should take very aggressive action to report, review and put in place preventive strategies if and when they do take place.

QUESTION: ***Is this idea something that could help promote safety and reduce very harmful and serious incidents in service programs supporting people with a developmental disability?***

Did You Know?

- Research suggests that every month about 1 in 10 people in a nursing home will suffer a medication related injury.
- In the United States general population injuries are one of the leading causes of death. However, for people with ID they are one of the least common causes.
- In New England, over 80% people supported by DD agencies receive annual health exams. However, only about 21% of adults in the U.S. general population receive a preventive health exam each year.

Congratulations New England: As of the summer of 2009 not one state DD agency in the region will have the term "Mental Retardation" in their name!

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Never Events:

Should we use them in DD State Systems?

Some Background

The National Quality Forum (NQF) has established a set of criteria for defining "never" events in order to encourage standardized incident reporting across the country, increase healthcare facility accountability and promote injury prevention. In order to be classified as a "never" event the NQF suggests that an incident must be:

1. **Unambiguous**—clearly identifiable and measurable, and thus feasible to include in a reporting system; and
2. Usually **preventable**—recognizing that some events are not always avoidable, given the complexity of health care; and
3. **Serious**—resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
4. Any of the following:
   - **Adverse** and/or,
   - Indicative of **a problem in** a health care facility's safety **systems** and/or,
   - Important for public credibility or **public accountability**.

The NQF has developed a listing of "never" events for use by hospitals and healthcare facilities. Some simple adaptation of their list for potential use in DD programs is possible.

WHAT types of events do you think should be considered as NEVER events in service and support programs for people with developmental disabilities?

Never Events:

Should we use them in DD State Systems?

Examples from Health Care

Examples of “never” events used in hospitals and other health care settings that could be applicable in DD programs and services[1] include:

- **PRODUCT or DEVICE EVENTS**
  - Death or serious disability associated with the **use of contaminated drugs** or devices provided in and by the program
  - Death or serious disability associated with the **use or function of a device** where the device is used or functions other than as intended
- **PROTECTION EVENTS**
  - Death or serious disability associated with **elopement** from a program (disappearance) for more than four hours where requirements for close supervision were present
  - **Suicide**, or attempted suicide resulting in serious disability, while being supported/supervised in a program
- **CARE MANAGEMENT EVENTS**
  - Death or serious disability associated with a **medication error** (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
  - Stage **3 or 4 pressure ulcers** acquired in a supervised program
  - Death or serious disability caused by **choking** for an individual on a special diet or feeding program while under the supervision/care of program staff
  - Death or serious disability resulting from **being left alone** (unsupervised) while in a program/service and where clear requirements for supervision were present

[1] Wording has been changed to reflect the characteristics of DD services. Some events that are highly specific to hospitals have been eliminated in this list. Additional “never” events for DD services have been added in italics – these latter types of events are considered by the author to be very serious adverse events that are, unfortunately, not all that uncommon in DD programs.

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- **ENVIRONMENTAL EVENTS**
  - § Death or serious disability associated with an **electric shock** while being supported in a program
  - § Death or serious disability associated with a **burn** incurred from any source while being supported in a program
  - § Death or serious disability caused by a **fall** while being supported and supervised in a program
  - § Death or serious disability associated with the use of **restraints** or **bedrails** while being supported in a program
- **CRIMINAL EVENTS**
  - **Sexual assault** on an individual by a staff member at any time or by another service recipient while in a supervised program
  - Death or significant injury of a consumer or staff member resulting from a **physical assault** (i.e., battery) that occurs within a supervised program

POSSIBLE ACTION

In an effort to stress the importance of the need to prevent these serious types of incidents CMS is considering establishing consequences for “never” events including the withholding of Medicare payment whenever they take place in hospitals. In addition, a number of states are considering developing mandatory reporting laws for “never” events.

Most state DD systems already have requirements for reporting serious incidents. However, very few have designed structured protocols for classifying adverse events and requiring preventive actions or establishing “consequences” for the most serious and harmful types of events. ***What if they did?***

SOME CONSIDERATIONS FOR DD

Rather than implement sanctions or other punitive consequences such as are being considered by CMS for healthcare facilities, what if DD systems took a more positive and proactive approach to the issue of safety and prevention of the most serious and harmful (and preventable) types of adverse events that happen within services and programs that serve people with ID/DD?

WHAT IF state systems were to select a small number of reportable incidents and classify them as “never” events (i.e., they simply should not happen)?

WHAT IF there were a requirement that more progressive and intensive review (e.g., Root Cause Analysis) take place whenever a “never” event occurred?

WHAT IF there was a system expectation that following the review a structured Safety Improvement Plan (with goals, actions and measurement) should be initiated?

Such an approach would not only focus greater attention on addressing the most serious and “preventable” incidents, but would promote organizational learning that could be spread throughout the DD system. It could be an even more powerful learning tool if the state system established a mechanism for sharing “lessons learned” between and across the provider system.

Think about it. It probably wouldn’t be too difficult. It just might enhance efforts at establishing a meaningful “culture of safety.” And, it would send a very powerful message to service recipients, families and service providers that ***serious and preventable deaths and injuries should not only not happen, but when they do, you will take action to prevent them from happening again.***

Steven D. Staugaitis, Ph.D.
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May, 2009

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TO LEARN MORE ABOUT
Never Events in Health Care

Go to this link:

CMS (2006) Eliminating serious, preventable and costly medical errors – never events

OTHER INTERNET RESOURCES
Re: Quality of Service in DD systems

NCI. *The National Core Indicators presents data on system performance and consumer/family ratings of quality for over 25 state Developmental Disability systems in the U.S. Data allows comparison of state systems across a wide range of quality measures. To view the NCI reports go to the following web site and select "reports" on the top of the page:* **http://www.hsri.org/nci/**

HCBS Clearinghouse. *The HCBS Clearinghouse for the Community Living Exchange Collaborative provides access to literally thousands of articles and resources related to services and supports for persons with disabilities. To look for information related to quality and developmental disabilities, go to the following web site:*
http://www.hcbs.org/browse.php/topic/216/Quality

LOOK for the next Quality Brief
Issue date: August 2009

FOCUS TOPIC: Health and Wellness:
Measuring Quality of Health Care for People with a Developmental Disability

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Quality Briefs can be accessed by going to
The UMASS Medical School/CDDER web site at:
www.umassmed.edu/cdder