

Guidance Regarding Serious Preventable Events – approved May 2008

Alabama's hospitals are committed to providing the highest quality care possible for all patients. However, there are times when despite best efforts, errors are made that could possibly have been prevented. This paper provides guidance to hospitals in discussing this issue with their boards, medical staff and employees and developing internal policies related to these events, particularly in reference to expected payment.

Identifying serious preventable events:

Hospitals should have effective and non-punitive methods for identifying serious preventable events and learning from them so as to not repeat them in the future.

Discussing these events with patients:

When serious preventable events occur due to an error, hospitals should give serious consideration to immediately and openly informing patients and their families regarding the situation.

Guiding Principles:

Setting policy with regard to expected payment is not an easy task. The following principles are offered to assist hospitals in determining the types of events for which payers and/or patients should not be expected to pay:

- 1) The error or event must be preventable.** Hospitals should not be held accountable for an occurrence that could not be reasonably prevented by the hospital in the first place. An internal root cause analysis may be required to determine preventability.
- 2) The error or event must be within control of the hospital.** Hospitals should not be held accountable for errors that may have occurred, for example, in the manufacture of drugs, devices or equipment, before the materials in question were received by the hospital. An internal root cause analysis may be required to determine the source of the error.
- 3) The error or event must be a result of a mistake made in the hospital.** The event must clearly and unambiguously be the result of a preventable mistake made and hospital procedures not followed and not an event that could otherwise occur.
- 4) The error or event must result in significant harm.** The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- 5) Any process for identifying non-payable events would need to actively incorporate some element of case-by-case review and determination.** While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek additional payments for cost directly resulting from the occurrence of the following events. For reporting purposes hospitals can file claims with non-coverage indicators.

Serious Preventable Events

Based on the previously stated guiding principles, certain types of serious events would be considered more likely to be preventable and to be under the direct control of the involved hospital and to result in significant harm. The following are those situations:

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on a patient
4. Unintended retention of a foreign object in a patient after surgery or other procedure
5. Patient death or serious disability directly attributable to an intravascular air embolism that occurs while being cared for in a health care facility
6. Patient death or serious disability directly attributable to a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
7. Hospital-acquired pressure ulcers (decubitus ulcers) - stage 3 and 4
8. Hospital-acquired catheter associated urinary tract infections
9. Hospital-acquired vascular catheter - associated infection
10. Hospital-acquired mediastinitis after coronary artery bypass surgery
11. Falls and trauma (hospital acquired) - fractures, dislocations, intracranial injuries, crushing injuries and burns

Events for Which Payment Should not be Expected:

Based upon the overall scope of care delivered, and the proportion of care related to the adverse event, the hospital where the event occurred may determine that either a partial payment or no payment should apply. These guidelines may not apply to the entire episode of care – only the care made necessary by the serious adverse event. This should be based on the hospital's determination that a serious preventable event has occurred **meeting the guiding principles and falling within one of the serious preventable events categories**. The following situations shall be deemed serious preventable events:

1. A procedure that was performed on the wrong patient or wrong body part, or the wrong surgical procedure was performed.
2. An additional procedure that is performed to correct an error in a previous procedure in that same facility (e.g. an object that is retained during surgery).
3. An event that results in an increased length of stay, level of care or significant intervention; the facility will do its best to “split out” those additional charges.
4. Re-admissions directly attributable to an event that occurred in that same facility including services provided which are directly related to that event.
5. Extenuating circumstances: If there are extenuating circumstances, or uncertainty that an event actually occurred, determination of any payment adjustment should be made on a case-by-case basis.

These guidelines are intended to specifically address payment expectations related to serious preventable events and are not intended to provide any guidance or recommendations related to compliance with existing or proposed CMS regulations or Joint Commission standards, nor any portion of state or federal law.