



QUALITY CASE REVIEW
Never Event

MEMBER NAME _____ Member # _____

Date of Birth _____ Age _____ Gender: Female [] Male []

Referral Source [X] Never Event

Occurrence Date _____ Date Reported _____

Reported by _____ Phone _____

Table with 2 columns: Facility Name(s) (location of incident/concern), Facility Type (Hospital, Surgery Center). Rows 1 and 2.

SUMMARY OF EVENT

Horizontal lines for writing the summary of the event.

Please indicate (✓) which type of never event has occurred (Definitions on back)

- Checkboxes for: Surgical, Product or Device, Patient Protection, Care Management, Environmental, Criminal.

Table with 2 columns: Number, Description. Includes a large empty box for the number.

Please send report under confidential cover to:

HealthPartners
Performance Measurement and Improvement
Mail Stop: 21108X
P.O. Box 1309
Minneapolis, MN 55440-1309
(952) 883-6150 (fax)

This report is directed to HealthPartners Quality Improvement Program.
The contents of this report are confidential in accordance with MN Statute 145.64.

Surgical Events

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
2. Surgery performed on the wrong patient;
3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

9. An infant discharged to the wrong person;
10. Patient death or serious disability associated with patient disappearance excluding events involving adults who have decision-making capacity; and
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;
17. Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
18. Patient death or serious disability due to spinal manipulative therapy.; and
19. Artificial insemination with the wrong donor sperm or wrong egg.

Environmental Events

20. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
21. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
22. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
23. Patient death or serious disability associated with a fall while being cared for in a facility.
24. Patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

25. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
26. Abduction of a patient of any age;
27. Sexual assault on a patient within or on the ground of a facility: and
28. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.