Never Events: Do I need to report this?

Focused review of adverse events, including never events, provides a valuable opportunity to learn what went wrong, to prevent similar events from happening in the future and to support the staff, providers and patients involved. At UCSF, adverse events are reviewed in a variety of forums—division and department case reviews, morbidity and mortality conferences, and root cause analyses. Some adverse events, deemed "never events," require reporting to the California Department of Public Health (CDPH) under Health and Safety Code 1279.1. Examples of such reportable events include wrong site or wrong patient surgery, retained foreign objects, patient death or disability associated with device malfunction or medication error, and inpatient fall resulting in death or serious injury, among many others. The primary purpose of reporting is to facilitate improvement and to hold healthcare organizations like UCSF accountable for the care they provide to patients.

What happened?

A patient underwent a gastrectomy, which required the creation of an anastomosis between the esophagus and the small bowel. To create the anastomosis, a stapler was used. During the procedure, a temperature probe located in the esophagus became ensnared in the staples and broke. Part of the probe was retained in the anastomosis. The patient was monitored with serial chest x-rays and ultimately, it was decided that it would be safer to remove the broken temperature probe via endoscopy after the patient healed from surgery.

How incident reporting leads to improvement:

The event was reported immediately through the incident reporting system and a call to Risk Management. The Patient Safety Committee convened a root cause analysis (RCA) to understand what happened and how to prevent this type of event from happening in the future. Several improvements that were implemented include: discontinuing use of esophageal or nasopharyngeal temperature probes in upper GI surgeries, a pause to assure removal of all orogastric and nasogastric tubes prior to stapling or suturing, and verification that removed devices are fully intact. This event was reported to CDPH as a retained foreign object, a full investigation was conducted and no deficiencies were identified. The error was disclosed to the patient immediately after surgery and she returned for close outpatient follow up with her providers. Unintentional delays in reporting never events have occurred, at times because providers are not aware that they should report. For example, there was a delay in reporting a retained glove tip fragment. This led to a delay in the RCA and improvement work.

Adverse Events and Reporting

How do I report an adverse event or safety concern?

The incident reporting system is the most reliable way to report an adverse event. To file an incident report, logon to a UCSF computer or via remote access, and click on the Incident Reporting link on Care Links. Incident reports are not used in a punitive manner but help expedite the RCA process and facilitate patient safety improvement efforts. The average time to complete an IR at UCSF is 11 minutes.

When should I notify risk management?

Consider notifying risk management directly if the event has resulted in or has the potential to result in an adverse patient outcome that might be unexpected or preventable, practice was outside the standard of care, or a patient/patient’s family has expressed distress or agitation. You can page 443-2284 to reach Risk at anytime.

How do I refer an event for an RCA?

Filing an incident report at the time of the event is a great way to do this. You can also email any of the individuals listed below.

How is the decision to report to CDPH made?

An RCA is held to understand what sequence of events led to the event. Leadership then makes a decision to report to CDPH using the California reporting law as a guide.

From the UCSF Patient Safety Committee. Editors: Adrienne Green MD (Professor of Medicine, Chief Medical Officer), Jim Stotts RN (Assistant Clinical Professor of Nursing, Patient Safety Manager), and Kiran Gupta, MD, MPH (Assistant Clinical Professor of Medicine, Assistant Medical Director for Patient Safety). Please contact Kiran Gupta at Kiran.Gupta@ucsf.edu with questions. Disclaimer: Clinical details of cases have been altered to protect patient & provider confidentiality.