Finding "Never" Land

by E. Strode Weaver, FACHE, MBA, MHSA

Recently, I learned about a National Quality Forum project that defines 27 "never events." As many of you know, the National Quality Forum (NQF) is a private, non-profit, voluntary consensus standards-setting organization. To learn more about NQF's mission, visit the organization website at *www.qualityforum.org.*

NQF has pursued a number of consensus building projects around healthcare safety; one of the most interesting is the consensus report on *Serious Reportable Events in Healthcare* that features a consensus list of 27 specific events that should "never" take place.

Not surprisingly, the "never" list starts with surgical procedures and contains a litany of untoward events that anyone would fear—wrong patient, wrong body part, wrong procedure, retention of a foreign object, and finally, unexpected death during or following the surgical procedure.

As I scanned the 27 items, several caught my attention because of their potential to occur in the cancer care setting. Patient death or serious disability associated with a medication error is an important issue to everyone in the cancer care field, but we also need to keep the risks related to more "generic" patient injuries—such as those sustained during a fall—on our radar screens. For example, the safety reporting system in my institution recently brought to light an increase in patient falls within our radiation therapy area. We immediately organized a quality improvement project. Based on a root-cause analysis, we identified several specific causation factors and took corrective action to eliminate these factors.

As cancer care providers of infusion services, we are well aware of the serious consequences of patients receiving incompatible blood or blood products. For years, nurses and blood bank staff have followed a number of procedure safeguards in this arena and yet—as the list of 27 "never" events implies—we are only as good as our ability to say it has "never" happened or it will "never" happen in our institution.

A final specific area of the "never list" relates to harm to patients through criminal events. Those cancer programs that have specific buildings or large portions of a facility that are devoted exclusively to cancer care cannot assume that the security department alone has the accountability for the safety of patients, employees, and visitors while on the premises. Like any other safety issue, individuals in a leadership position need to be attentive and proactive in this area as well.

In closing this column, my call to action is to ask you to take a few minutes from your busy schedule, visit the NQF website, and access NQF's list of 27 "never" events. We all can play a role in ensuring that they "never" happen to our cancer patients.

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