



# Quality Case Review – Potential Never Event Form

Member Name \_\_\_\_\_ Member # \_\_\_\_\_

Member DOB \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Occurrence Date \_\_\_\_\_

Date Reported to QIC \_\_\_\_\_ Reported by \_\_\_\_\_ Department \_\_\_\_\_

Date Reported to Never Event Committee \_\_\_\_\_ Reported by \_\_\_\_\_

	Facility Name(s) (location of incident/concern)	Facility Type(s) (Hospital, Surgery Center)
1		
2		

	Practitioner Name(s)	Practitioner Specialty(ies)	Practitioner Credential(s)
1			
2			

Category(ies) and Summary Description(s) of Never Event –see definition pages 2-4
SURGICAL
PRODUCT/DEVICE
PATIENT PROTECTION
CARE MANAGEMENT
ENVIRONMENTAL
POTENTIAL CRIMINAL EVENTS
RADIOLOGIC

**SUMMARY OF EVENT**

**Please send report in confidential envelope to:**

**HealthPartners**

**Quality Improvement & Compliance (QIC) - MS 21108X**

**PO Box 1309**

**Minneapolis, MN 55440-1309**

**Or send it electronically to these confidential contacts:**

**Fax: 952-883-8735**

**[quality@healthpartners.com](mailto:quality@healthpartners.com)**

**If you have questions or concerns contact QIC at this confidential phone number: 952-883-6240**

**QIC send completed form to Never Event Committee via email at [NeverEventReview@HealthPartners.com](mailto:NeverEventReview@HealthPartners.com)**

**DEFINITIONS**

Below is a list of events that hospitals and licenses ambulatory surgical centers are required to report to the Minnesota Department of Health per Minnesota statutes 144.7065.

***Surgical Events***

1. Surgery or other invasive procedure 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 or other invasive procedure performed on the wrong patient;
3. The wrong surgical or other invasive 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 invasive 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 or other invasive procedure 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***

1. Patient death or serious injury 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;
2. Patient death or serious injury 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
3. Patient death or serious injury 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***

1. A patient of any age, who does not have decision-making capacity, discharged to the wrong person;
2. Patient death or serious injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and
3. Patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death 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***

1. Patient death or serious injury 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;
2. Patient death or serious injury associated with unsafe administration of blood or blood products
3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
4. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

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

5. Stage 3, 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
6. Artificial insemination with the wrong donor sperm or wrong egg;
7. Patient death or serious injury associated with a fall while being cared for in a facility;
8. The irretrievable loss of an irreplaceable biological specimen; and
9. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

**Environmental Events**

1. Patient death or serious injury associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
2. 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;
3. Patient death or serious injury associated with a burn incurred from any source while being cared for in a facility;
4. Patient death or serious injury associated with the use of or lack of restraints or bedrails while being cared for in a facility.

**Potential Criminal Events**

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
2. Abduction of a patient of any age;
3. Sexual assault on a patient within or on the grounds of a facility; and
4. Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

**Radiologic Events**

1. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

Reference: HealthPartners Administrative Policy AN 001 – Never Events