(Oak Brook, Ill., May 26, 2015) Joint Commission Resources, Inc. today released the June 2015 issue of The Joint Commission Journal on Quality and Patient Safety. The issue features an article, “‘Never Events’ and the Quest to Reduce Preventable Harm.”

Never events are events that should never occur in health care, including wrong-site surgeries, patient suicides, medication errors and surgical site infections. The article highlights how findings from adverse events, serious reportable events, sentinel events and patient safety events play a prominent role in reducing patient harm.

The authors, J. Matthew Austin, Ph.D., and Peter J. Pronovost, M.D., Ph.D., FCCM, from the Armstrong Institute for Patient Safety and Quality, Johns Hopkins Medicine, Baltimore, discuss the evolution and data collection of never events, and provide recommendations to improve the tracking and reporting of these events, as follows:

• Policy makers and Patient Safety Organizations should agree on a standard definition of a never event.
• The health care community should establish standards for the accuracy of never events derived from administrative data, relative to chart review, and publicly report the accuracy of these measures.
• The number of never events should be transparently reported, much like Minnesota has done for more than a decade.
• Health care policy makers, insurers, providers and patients should create mechanisms to share best practices for reducing all types of never events.

“Never events are occurring with a troubling frequency,” Drs. Austin and Pronovost state. “Many of these events, such as wrong-patient surgery, are deemed ‘fully preventable’. If we hope to see reductions in the frequency of these events, we need to change the decade-long decentralized approach of collect, report and improve to an approach that entails standardized definitions of events, greater transparency of performance, and collective learnings and accountability to drive performance forward.”

The remaining articles from the June 2015 issue are as follows:

**Adverse Events**

**Using Administrative Discharge Diagnoses to Track Hospital-Acquired Pressure Ulcer Incidence—Limitations, Links, and Leaps**

*Jennifer Meddings, M.D., M.Sc.*

Despite the facilitated generation of hospital-acquired pressure ulcer (HAPU) incident rates from administrative data that are encouraging because of the reported sustained decreases, administrative data do not meet the strict criteria for a true surveillance dataset of HAPUs and other hospital-acquired conditions.

**Comparative Effectiveness of Quality Improvement Interventions for Pressure Ulcer Prevention in Academic Medical Centers in the United States**

*William V. Padula, Ph.D., M.S.; Mary Beth F. Makic, RN, Ph.D.; Manish K. Mishra, M.D., M.P.H.; Jonathan D. Campbell, Ph.D.; Kavita V. Nair, Ph.D.; Heidi L. Wald, M.D., M.S.P.H.; Robert J. Valuck, Ph.D., R.Ph.*

A survey instrument on quality improvement (QI) interventions used for hospital-acquired pressure ulcer (HAPU) prevention addressed whether an evidence-based prevention protocol was in place, as well as which QI interventions were used. For 53 (96 percent) of 55 University HealthSystem Consortium academic medical centers surveyed from September 2007 through February 2012, each of five QI interventions was associated with reductions in HAPU incidence rates by greater than one case per
1,000 patient discharges per quarter. Hospitals investigating novel approaches to HAPU prevention should consider bundling these QI interventions to improve their effectiveness.

Hospital-Acquired Pressure Ulcers at Academic Medical Centers in the United States, 2008–2012: Tracking Changes Since the CMS Nonpayment Policy
William V. Padula, Ph.D., M.S.; Mary Beth F. Makic, RN, Ph.D.; Heidi L. Wald, M.D., M.S.P.H.; Jonathan D. Campbell, Ph.D.; Kavita V. Nair, Ph.D.; Manish K. Mishra, M.D., M.P.H.; Robert J. Valuck, Ph.D., R.Ph.

Among 210 University HealthSystem Consortium academic medical centers from 2008 to June 2012, hospital-acquired pressure ulcer (HAPU) incidence rates decreased from 11.8 to 0.7 cases per 1,000 patients (p < .001; 95 percent confidence interval: 8.39–8.56). An analysis of covariance identified the Centers for Medicare & Medicaid Services 2008 nonpayment policy for costs associated with HAPUs as a significant covariate of changing trends in incidence rates. The hospitals appeared to be reacting efficiently to economic policy incentives by improving prevention efforts.

Methods, Tools, and Strategies
Using the Integrated Nurse Leadership Program to Reduce Sepsis Mortality
Julie Kliger, RN, B.S.N., M.P.A.; Sara J. Singer, M.B.A., Ph.D.; Frank H. Hoffman, M.A.

The Integrated Nursing Leadership Program (INLP) is a collaborative improvement model focused on developing practical leadership skills of nurses and other frontline clinicians to lead quality improvement efforts. In the 22-month INLP Sepsis Mortality Reduction Project, sepsis mortality decreased by 44 percent (from 28 percent to 16 percent) for eight of the nine San Francisco Bay Area participating hospitals (Hospital 9 joined the program late, six months after it began), significantly for five of the hospitals. Reductions were sustained for more than one year.

Departments, Field Notes
Patient-Collected Audio for Performance Assessment of the Clinical Encounter
In a new strategy for collecting clinical performance data, which continues to be implemented after 24 months, patients volunteer to audio record their physician visits. Audio recordings are coded (for example, for “contextual red flags”) and at one- to two-month intervals, a customized report is generated and presented at physicians’ and staff’s standing meetings. Physicians may request individualized reports of their own performance. Similar reports are now generated for tracking the performance of mid-level providers and clerical staff.

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