

A large, red life preserver with white rope is positioned on the right side of the page, partially overlapping the text. The life preserver is a classic ring shape with two thick red bands and white rope wrapped around it.

# Words that Save

Ensuring that “never events”  
never happen.

**By Rich Bluni, RN and Julie O’Shaughnessy**

When patients come to the hospital they are frequently anxious or focused on the uncertainty of a clinical outcome. One thing a patient doesn’t usually worry about is falling out of bed...or learning that a foreign object was left inside his body after surgery...or that he will develop a secondary infection. The Centers for Medicare and Medicaid Services (CMS) has named these medical errors “never events” because they should never occur for patients. Further, as of Oct. 1, 2008, CMS will not reimburse hospitals for 11 conditions that were not present upon admission.

Each year, more than 650,000 patients experience one of these preventable errors leading to needless pain, injury and even death. Furthermore, four of these hospital-acquired conditions—infections, injuries, pressure ulcers and objects retained after surgery—comprise 12.2 percent of total medical liability costs.

CMS has identified preventable, high-cost, high-volume conditions that result in additional costs to CMS. The list is expected to grow annually with other payors and states following suit. Current never events include the following:

- foreign object retained after surgery
- air embolism
- blood incompatibility
- stage III and IV pressure ulcers
- falls and trauma
- catheter-associated urinary tract infection
- vascular catheter-associated infection
- surgical site infection (mediastinitis) after coronary artery bypass graft
- surgical site infections following certain elective procedures (certain orthopedic surgeries and bariatric surgery)
- certain manifestations of poor control of blood sugar levels
- deep vein thrombosis or pulmonary embolism following total knee replacement and hip replacement

An infection that occurs after a coronary artery bypass graft can cost as much as \$30,000 to treat. Now hospitals will not receive reimbursement for that treatment cost. Similarly, the 257,412 cases of Stage III and IV pressure ulcers in 2007 (not present on admission) cost a non-reimbursable average of \$43,180 per stay. And 193,566 cases of falls and trauma cases in 2007 cost an average of \$33,894 that CMS will no longer pay.

And yet, when we conducted a brief e-mail survey to senior healthcare marketers at well-known organizations, more than half of respondents said that communicating to internal and external audiences about never events is not on their radar.

### Communicate the Impact

As a marketing and communications professional, you can play a key role in reducing never events by consistently communicating the impact of these occurrences and the benefits of reducing them to patients, physicians and employees.

When you share your organization's plans for reducing never events with your medical staff, you essentially re-recruit your physicians by demonstrating your commitment to providing quality patient care. Ask physicians to take an active role in reviewing gaps and potential interventions by drilling down at medical staff meetings.

Storyboards in employee and patient areas can highlight your organization's safety record and showcase staff members who had a good catch or prevented an injury. Articles in employee newsletters can help raise awareness about this impor-

tant patient safety issue and connect back to your organization's mission and vision.

Chances are good that reducing never events is a high priority issue for your CEO. In fact, on the American College of Healthcare Executives 2008 survey, 77 percent of CEOs ranked financial challenges as the top challenge (out of 12) that they face. Forty-two percent of CEOs ranked safety/quality second. Incidentally, never events also account for one in six malpractice claims, comprising 12.2 percent of total medical professional liability costs! This isn't an issue to be delegated to the quality department. Eliminating these events requires the commitment of every individual in the organization. Does your organization understand the significance of these changes to your hospital's reimbursement and financial health?

### Connect to Purpose

Progressive organizations use evidence-based practices to prevent never events. Your organization's ability to always use these strategies determines if an error will occur. In Studer Group's work with hundreds of healthcare organizations, we observe a higher level of compliance with new behaviors and practices when leaders take the time to explain why a change is being made. Just as with an effective marketing message, this type of communication needs to occur multiple times using a variety of tools to get heard.

When we fail to connect to purpose—why we do the things we do—we miss the opportunity to engage the hearts of our employees and fail to protect our patients from harm and injury. When leaders talk to staff, be sure they address the “why” for practices that will prevent errors.

For example, discuss the “why” of hand washing with staff (e.g., it decreases the number infections, thereby saving lives, expediting discharges, decreasing re-admissions and lowering the acuity of the patients staff are caring for). Ask families to help by washing hands before touching patients they are visiting.

Remind your staff that what they do is important. During huddles or rounds, share stories about catches of near-misses and note individuals, departments and units that have gotten great patient safety results. Explain that the steps they take to keep patients safe aren't to please a manager, but to save a patient.

Connect-to-purpose messages resonate and increase compliance among staff much more effectively than a “Do this because I said so” approach. We find that staff members frequently thank their leaders for explaining why and role modeling behaviors themselves.

### Use Storytelling

Big numbers can make a statement—especially to senior executives—but caregivers will respond best to real stories of patients who suffered medical errors needlessly. The best stories probably already live in your organization. Take time to harvest

them and look for communication interventions. Ask nurses, “Can you tell me about a recent patient fall that happened because a patient didn’t know he was on fall precaution?”

At Seton Edgar B. Davis hospital, leaders engage patients and their families with a fall “contract.” The contract explains that falls can easily happen in hospitals due to the side effects of medications or disorientation and requests that patients let staff know when they’d like to get out of bed so staff can stand by or assist to ensure safety. The hospital also uses flags outside of rooms and yellow patient bracelets to alert staff to patients who should not be left unattended.

Since the purpose of sharing stories isn’t to assign blame, keep them anonymous when you share them. But go public and be specific with reward and recognition when employees use behaviors that reduce never events. When Edgar B. Davis hit its 200th day with no falls, it celebrated in a big way with a party and congratulatory e-mails. Physicians thanked nurses by sharing the significance of this important milestone for patient safety in a newsletter article.

Remember that people will respond most positively when prevention efforts yield positive outcomes, so develop a strategy organization-wide celebration. This might include weekly celebrations for inpatient nursing units when there are no falls as

## When we talk about key words, we are really talking about building a relationship with our patients.

well as celebrations for critical care units to celebrate the lack of central line infections.

Hand-written thank-you notes to physicians who are observed washing hands also are a good idea. Also consider sharing wins related to discharge phone calls, especially patient safety catches. Ask staff to note names of employees cited when making calls. Then share with the team.

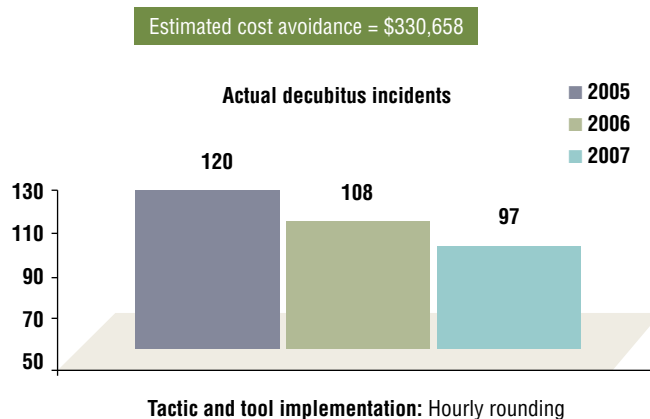
Recognize environmental services when nosocomial infection rates drop, and acknowledge every department, leader and staff member who identifies and reports errors. Remember you are creating a culture where it feels safe and rewarding to be a second set of eyes. Finally, borrow safety ideas from other industries. Factories, for example, frequently post a “35 days without a safety issue.” Imagine a high-performing nursing unit posting “60 days without a fall!”

### Key Words Can Help

At Studer Group, we use key words to help patients understand our actions and care better and to provide a more

### Exhibit 1

Multi-panel ChannelCare display targeting all audiences



Source: Tennessee Organization

Admissions: 15,598, Bed size: 304, >1400 employees, Employees=1441

personal experience. Key words reduce patient fear and anxiety and align the behavior of the staff to the needs of the patient.

When we talk about key words, we are really talking about building a relationship with our patients.

Successful organizations also use specific key words to reduce never events. They explain why specialty equipment is being utilized.

**To reduce infections.** “At Chester Medical Center, we are committed to preventing our patients from getting infections. One of the best ways to do that is for all of us to wash or disinfect our hands before and after caring for you.

Our goal is to do this 100 percent of the time. Will you please remind us if we ever forget or if you’re not sure if we cleaned our hands?”

**To reduce IV infections.** “It is very important for us to assess your IV site. We will do that regularly to prevent an infection. If you notice any redness, drainage or burning at the site, please let us know right away.”

**To reduce falls.** At Edgar B. Davis, Senior Director of Nursing April Haynes says, “When the patient is admitted, the nurse or aide goes over safety initiatives for falls, pressure ulcers and infections. We tell them we will be rounding on them hourly and that we do this for the safety. We explain the high risk of falls which is why we ask them to wait until we round or to call us so we can help them to the bathroom.”

Organizations that are already rounding hourly on patients find it easy to incorporate these tips into their rounding to prevent pressure ulcers: note the patient position on the rounding log, assess pressure points and explain to patients why they are repositioning them.

## Bedside Shift Reports

With bedside reports, the nurse reports off to the nurse who will assume the patient's care during the change of shift at the patient's bedside. This has a number of benefits. It creates a partnership with patients so they feel informed and experience less anxiety as they witness well-coordinated care.

With respect to patient safety and never events, bedside reports create communication to catch potential medical errors in blood incompatibility, catheter-associated urinary tract infections, vascular catheter-associated infection, surgical site infections and air embolism—all on the CMS list of hospital-acquired complications of never events.

A bedside shift report conversation might go something like this: "Hello Mrs. Smith. We wanted to go over your care today. Your nurse for the next shift is Marie. Marie's been working at Excellence Hospital for 15 years. She's an experienced and certified cardiac nurse. Mrs. Smith, we want to ensure that we provide you with the safest care. We also want to protect you from the risk of getting an infection so we will ensure that we always wash our hands. One of the ways that you can help is to let us know if you notice any redness, swelling or drainage from your I.V. in your hand. Please let Marie know if you notice these symptoms."

## Set Objective, Measurable Goals

The organizations Studer Group works with use an objective leadership evaluation tool to set and cascade all organizational goals and measure progress quarterly by individual and department. Because the goals cascade from the CEO to all leaders in the organization, everyone is aligned and accountable.

Some examples of objective, measurable goals for leaders addressing never events include the following:

- Chief Nursing Officer—reduce the incidence of never events resulting in a cost avoidance of \$500,000 by the end of the fourth quarter
- Chief Medical Officer—reduce the incidence of surgical site infections by 25 percent
- Nursing Director of Critical Care—reduce the incidence of vascular catheter-associated infections by 30 percent
- Nursing Director of Medicine—reduce the incidence of patient falls by 50 percent

## What Marketers Can Do

Send monthly e-mails to all employees and physicians that share never event goals and track progress with reduced incidences and cost savings. Send a note from the CEO to reinforce the organization's commitment to reducing never events and recognize high-performing employees. Inform new employees about this important patient safety initiative and how they can

keep current. Use medical staff meetings to discuss examples of never events in the organization (or from other organizations) and ask them to assess risk points and opportunities for intervention.

In addition, educate families and patients when appropriate. Develop an informational flier for patient rooms or patient contract about how to partner to ensure reduced falls. Signs outside patient rooms or bracelets for those at risk for falls also raise awareness for caregivers. Post information in the volunteer lounge and on communication boards in hallways. Your volunteers are ambassadors to the community. Let them know what your organization is doing to reduce never events and progress made. Tell families that patient safety comes first at your organization.

It's also a good idea to set a milestone. When your organization reaches a key never events goal (e.g., 200 days without a fall), throw a party. Design an internal marketing campaign. Focus on one never event each month. Use internal newsletters and electronic communications to talk about the incidence, cost to the organization and what the organization is doing. Be sure to capture wins: When you move onto the second never event in month two, report out on cost savings and track reduced incidences from last month so everyone knows how their efforts are improving patient safety. Each month, report cumulative metrics (reduced incidences and cost savings) from all of the prior months.

## Small Hospital, Big Results

You don't have to have a big staff to get serious about making a difference on never events. Just ask Neal Kelley, CEO of Seton Edgar B. Davis, a 25-bed critical access hospital in Luling, Texas, with a large geriatric patient population.

"If you're not talking about never events frequently to leaders, patients, families and physicians, you won't see progress," predicts Kelley. "It's important to use communications that educate, share results and recognize staff who prevent an injury."

The hospital, which hasn't had a sentinel event since 2003, has also reduced its pressure ulcers by 5 percent and fall rate by 77 percent since implementing hourly rounding on patients. A fall "contract" also engages patients and families as partners in their care by asking those at risk for a fall to let staff know when they need to get out of bed.

Because the hospital is small and has reduced never events so effectively, medical staff study incidents from other Seton hospitals for learnings that physicians and leaders can apply at Edgar B. Davis. "Recently we had a near miss that we traced back to the lack of a formal handoff from an ED physician to an attending physician," Kelley explains. "Sometimes handoffs can be monotonous, but it was a good example of how variation from our standardized process can end up in patient harm. It provides a good opportunity for us to revisit the importance of our process with physicians."

## Hourly Rounding

Do nurses round hourly on patients in your organization? Owensboro Hospital in Owensboro, Ky., reduced falls by 363 (or 81 percent) after implementing hourly rounding, for increased reimbursement of nearly \$1.2 million. CMS estimates the average reduction in reimbursement to be \$3,222 per fall. Owensboro Hospital reduced falls from 448 to 85 after implementing hourly rounding for a savings of \$1,169,586.

A September 2006 study in the *American Journal of Nursing* found that hourly rounding reduces pressure ulcers by 14 percent. (See Studer Group's Alliance for Healthcare Research (2006), "Effects of Nursing Rounds on Patients' Use of Call Lights, Satisfaction and Safety," *American Journal of Nursing* 106 (9), 58-70.) Not only does hourly rounding reduce never events, it gives nurses back more time because call bells go off far less frequently.

Just think—if all the organizations with Stage III and IV pressure ulcers in 2007 used hourly rounding, they could have saved a combined \$1.5 trillion. This assumes the 257,412 cases of pressure ulcers in 2007 reported by CMS to cost an average of \$43,180 were reduced by 14 percent or \$1.56 trillion.

The Institute for Healthcare Improvement (IHI) also has endorsed hourly rounding as the best way to reduce call lights and increase both the quality of care and the satisfaction of patients.

When nurses round hourly on patients they do seven very specific things to make sure patients' needs are met so they do not need to use the call button. For example, they check the three "Ps"—pain, potty and position—and track when they rounded and patient concerns that were mentioned on a rounding log for the next shift and the nurse manager.

Hourly rounding protocol for nurses consists of seven important steps:

- Assess patient pain levels using a pain assessment scale.
- Put medication as needed on the RN's scheduled list of things to do for patients and offer the dose when due.
- Offer toileting assistance.
- Assess the patient's position and comfort.
- Make sure the call light, telephone, TV remote control, bed light, bedside table and Kleenex are within the patient's reach.
- Ask the patient if they have any additional needs before leaving the room.
- Tell the patient that a member of the nursing staff will be back in the room in one to two hours.

Ultimately, it is how well we serve patients that determines market share and growth. On the ortho/neuro/surgical unit at Catholic Healthcare West's St. Bernardine Medical Center in San

## How Are You Communicating About Never Events?

In a brief e-mail survey of senior healthcare marketers, fully 55 percent of respondents said never events were not on their radar. Here are a few highlights from those who said they were addressing the issue:

**Who You're Talking to.** Only half were communicating with internal audiences. Less than 50 percent were communicating to patients, families or medical staff. Only 20 percent were talking to the community or media.

**What You're Doing.** Forty percent are communicating via employee newsletter articles; 30 percent are discussing at meetings; and 20 percent are communicating during administrative rounds, board meetings or via signage.

**Results You're Getting.** Respondents said their marketing communication efforts have significantly reduced falls and pressure ulcers. Increased attention to hand washing has led to fewer infections.

Bernardino, Calif., a new nurse began her hourly rounds, only to find that a patient with no complaints in the previous hour had dangerously low oxygen saturation an hour later. By immediately alerting the charge nurse and a respiratory therapist, she saved the patient's life. Within just a few minutes, a safety net team had arrived and re-oxygenated this 30-year-old patient and transferred him to the ICU. Hourly rounding works.

## Next Steps

Are you ready to engage? If so, first bone up on never events. You can get tips to eliminate pressure ulcers and falls at [www.studergroup.com/never](http://www.studergroup.com/never). Next, meet with leaders. Who's working on reducing never events at your organization? The CEO? The CFO? The director of quality? Find out what's happening in your organization and be ready to share ways you can help connect the dots through messaging for patients, physicians and employees. Finally, use best practices. Choose three best practices from this article to recommend or implement in the next 30 days. **MHS**

## About the Authors

**Rich Bluni**, RN is a coach with Studer Group. He may be reached at [Rich.Bluni@studergroup.com](mailto:Rich.Bluni@studergroup.com). **Julie O'Shaughnessy** is a coach with Studer Group. She may be reached at [Julie.OShaughnessy@studergroup.com](mailto:Julie.OShaughnessy@studergroup.com).