HOUSE MEMORIAL 103

51ST LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2013

INTRODUCED BY

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A MEMORIAL

REQUESTING THE DEPARTMENT OF HEALTH TO CONSIDER REQUIRING NEW MEXICO HOSPITALS TO REPORT "NEVER EVENTS" TO THE DEPARTMENT AND MAKING "NEVER EVENT" DATA AVAILABLE TO THE PUBLIC ONLINE.

WHEREAS, in December 2012, after a cautious and rigorous analysis of national malpractice claims, Johns Hopkins patient safety researchers announced that, in the United States, surgeons leave a foreign object, such as a sponge or towel, inside a patient's body after an operation thirty-nine times per week, perform the wrong procedure on a patient twenty times per week and operate on the wrong body site twenty times per week; and

WHEREAS, these researchers estimate that eighty thousand of these so-called "never events" occurred in American hospitals between 1990 and 2010; and

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WHEREAS, according to the researchers, these estimates probably undercount the true number of these "never events"; and

WHEREAS, there is universal agreement within the medical profession that these events should never happen in surgery and are totally preventable; and

WHEREAS, the centers for medicare and medicaid services' list of "never events" includes:

A. surgery on the wrong body part;

B. objects left in the body during surgery;

C. mismatched blood transfusions;

D. those that cause serious injury or death;

E. air embolism;

F. injuries from patient falls;

G. pressure ulcers;

H. urinary tract infections;

I. vascular-catheter-associated infections; and

J. mediastinitis, an infection following heart surgery; and

WHEREAS, the Johns Hopkins study showed that "never events" most often involve patients aged forty to forty-nine, and that surgeons in this same age group were responsible for more than one-third of "never events" — twice as many "never events" as surgeons over the age of sixty; and

WHEREAS, procedures have long been in place to count

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sponges, towels and other surgical items both before and after surgery, and most hospitals are moving toward electronic bar coding on instruments and materials to enable precise counts and prevent human error; and

WHEREAS, in 2008, medicare stopped paying hospitals for additional care required to treat medical conditions resulting from "never events"; and

WHEREAS, the office of the inspector general of the federal department of health and human services reports that, while twenty-five states and the District of Columbia collect "never event" data from hospitals, there is variation as to whether reporting is voluntary or mandatory, as to the types of events required to be reported and the amount of detail required; and

WHEREAS, there is no federal standard that requires states to operate adverse event reporting systems; and

WHEREAS, from among the list of "never events", New Mexico's department of health requires hospitals to report only two types of health-care associated infections; and

WHEREAS, the physician who led the Johns Hopkins "never event" study advocates public reporting of "never events" to give consumers information to make more informed choices about where to undergo surgery and to "put hospitals under the gun to make things safer";

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF

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REPRESENTATIVES OF THE STATE OF NEW MEXICO that the department of health be requested to consider requiring New Mexico hospitals to report additional "never events" to the department; and

BE IT FURTHER RESOLVED that the department be requested to consider making "never event" information reported to the department available online to the public to provide consumers with information upon which to make more informed choices about where to undergo surgery; and

BE IT FURTHER RESOLVED that the department be requested to report on expanding "never event" reporting by hospitals to the department and on making such information available online to the consuming public to the legislative health and human services committee no later than August 31, 2013; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the secretary of health, the New Mexico hospital association, the center for nursing excellence and health action New Mexico.

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