NEVER EVENTS IN CLINICAL ORTHODONTIC PRACTICE

WHAT IS A NEVER EVENT?

A never event is a description of an action, event, or failure that should never happen if appropriate policies, protocols, or preventive measures are in place and are followed. A never event must be clearly identifiable or definable; it must be able to be measured or amenable to metric evaluation; if it does occur it must have the potential to result in either serious, significant, or costly harm; and finally, it must be preventable.

WHY ARE NEVER EVENTS BEING EXAMINED?

There is growing international evidence that in all “high risk” industries, healthcare being one of them, there are certain strategies that can be adopted to maximize patient safety by reducing variation and increasing standardization regarding how certain activities are conducted. If any healthcare provider, be it an institution or a private practitioner, finds that never events are occurring with any degree of frequency, it would be indicative that there was a clear and present problem in that institution’s or practitioner’s methodology for delivering safe, effective healthcare.

CAN THERE EVER BE AN EVENT THAT TRULY NEVER HAPPENS?

No. Almost anything has, does, or will happen. Because of this, organizations and institutions recognize that certain events, if they do occur, carry the potential for serious injury or harm to occur. Developing an awareness of this reality permits every profession, industry or endeavor to study ways to prevent a particular happenstance from occurring or, at the very least, to reduce its occurrence to the point of where it can be considered what is now called a never event.

OUR STUDY

THE BEGINNING

The first questionnaire, that was distributed over two years ago, proposed 20 “never events” that were distilled from 51 initial proposals. These initial proposals were solicited from 10 orthodontists whose backgrounds include private practice environments (private fee for service, primarily Medicaid reimbursement, and DSO employment), academia (full time and part time), leadership positions in organized dentistry and orthodontics, journal editing, DSO management positions, and a consultant for a State’s orthodontic program. They were all asked, based on their personal experience, and if they so desired to consult with colleagues, to submit proposed never events for consideration by a larger group of orthodontists. Based on the input received, a group of 4 orthodontists with over 100 years of combine orthodontic practice experience designed a questionnaire, the first round of a Modified Delphi Protocol, that was sent to the first group of respondents. From their responses we eliminated certain proposed events and added others. We then sent out the modified questionnaire, the second round, and collated those responses, once again refining the statements, deleting some and adding others.

WHERE ARE WE NOW

This is now the third Phase of our Modified Delphi study to continue evaluating whether NEVER EVENTS exist in clinical orthodontic practice; and if they do, to identify them. We are now asking you to respond to these proposals. Because many of the respondents asked for clarification and or examples regarding a number of the NEVER EVENT statements, each one now carries an exemplar of the NEVER EVENT statement. You will probably agree with many of the proposed considerations and you may disagree with some of them. That is precisely what you are being asked to do. All that is required is for you to “agree” or “disagree” with the proposed never event statement. If you disagree, it is **very important** to tell us why, as we may have overlooked a reason why the statement should not be considered a never event thus rendering the resulting outcome as something that can and does happen and is nothing more than an unfortunate occurrence. We have made every effort to insure that the wording of the proposed never event has been properly crafted; please read each statement carefully. If you believe the wording of the never event statement needs improvement or clarification, please note that as well.

FINALTHOUGHTS

Finally, after completing the survey, if you believe that there are still never events that we have not included or addressed please list them at the end of the survey. Remember a never event is patient and staff safety oriented and should never happen if appropriate policies, protocols, or preventive measures are in place and are followed. NEVER EVENTS must be clearly identifiable or definable; they must be able to be measured or amenable to metric evaluation; if they do occur they must have the potential to result in either serious, significant, or costly harm; and finally, they must be preventable.

THANK YOU.