Hospital-Acquired Conditions, Never Events, and the Oncology Nurse

Lisa Hartkopf Smith, RN, MS, AOCN®, CNS

Hospital-acquired conditions, including medical errors, continue to be a leading cause of morbidity and mortality in the United States and contribute significantly to the escalating costs of health care (Centers for Medicare and Medicaid Services [CMS], 2008b; National Quality Forum, 2006a). The Agency for Healthcare Research and Quality (2008) reported that as many as one in 25 patients suffers injuries from medical errors and that preventable healthcare-related conditions cost the economy $17 billion–$29 billion each year.

In response to such escalating problems, CMS (2008a) no longer will reimburse hospitals for additional expenses incurred from conditions identified on a list it developed. Other health insurance companies are expected to follow. Oncology nurses play an important role in promoting safety and evidence-based practice to prevent hospital-acquired conditions and the associated negative financial implications.

Hospital-Acquired Conditions and Reimbursement

In 2005, Congress passed the Deficit Reduction Act, which required adjustment in Medicare Diagnosis-Related Group (DRG) reimbursement for specified hospital-acquired conditions (CMS, 2008a). A hospital-acquired condition is a preventable condition that occurs after a patient’s admission. More specifically, the Deficit Reduction Act defined hospital-acquired conditions as conditions that (a) are high cost, high volume, or both; (b) result in the assignment of cases to DRGs that have higher payments; and (c) could have been prevented with evidence-based practice (CMS, 2008a). CMS and healthcare systems jointly review a patient’s medical chart to determine whether primary and secondary healthcare problems were present on admission. The payment provision for hospital-acquired conditions applies only to acute, inpatient hospitals with prospective payment systems and does not apply to cancer hospitals, children’s inpatient facilities, critical access hospitals, long-term care hospitals, and other selected systems (CMS, 2008b).

In July 2008, CMS announced a new inpatient prospective payment rule that denies coverage for the hospital-acquired conditions listed in Figure 1 (CMS, 2008b). The new payment rule began for patient discharges after October 1, 2008.

The CMS list of hospital-acquired conditions includes some, but not all, never events. A never event is a term used to refer to events that should never happen in a hospital and, if they do, can cause serious injury or death to a patient (CMS, 2008a). The National Quality Forum (2006b) identified a list of never events (called serious reportable adverse events) and categorized them as (a) surgical events, (b) product or device events, (c) patient-protection events, and (d) care-management events, environment effects, and criminal events. Examples of never events include wrong-site surgery, death or disability associated with an intravascular air embolism, and death or disability associated with a medication error.

Role of Oncology Nurses

Oncology nurses can play a significant role in hospital-acquired conditions by (a) performing accurate, detailed assessments to assist in determining whether a patient’s condition was present on admission; (b) implementing the National Quality Forum’s (2006a) Safe Practices for Better Health Care to prevent never events; and (c) using evidence-based practice guidelines to prevent hospital-acquired conditions.

On admission, oncology nurses should perform a detailed history and physical examination to identify any primary or secondary diagnoses present. In addition to obtaining a patient history for medical diagnoses, oncology nurses should assess and document signs and symptoms of potential problems. For example, when a nurse assesses and documents that a patient complains of burning, urgent, and frequent urination, that may result in a further workup and diagnosis of a urinary tract infection (UTI). If the symptoms are not caught at the time of admission, not only would the patient’s treatment be delayed, but the condition may later be coded as a hospital-acquired condition and the hospital would not receive reimbursement.
for treatment of the UTI. According to CMS (2008c), “a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis (sic).”

The National Quality Forum (2006a) endorsed and published a set of 30 evidence-based safe practices to serve as a tool for healthcare providers to reduce the risk of harm to patients and, thus, prevent never events. Many healthcare institutions throughout the United States have adopted the guidelines voluntarily to create a culture of safety. The safe practices include many recommendations that apply to oncology, such as central venous catheter bloodstream infections, high-alert medications, and deep vein thrombosis.

Finally, and perhaps most importantly, oncology nurses should be knowledgeable about and use available evidence-based practice guidelines to prevent hospital-acquired conditions. The National Guideline Clearinghouse (www.guideline.gov), an initiative of the Agency for Healthcare Research and Quality, can assist oncology nurses in finding practice guidelines for many of the hospital-acquired conditions listed in Figure 1. In addition, the Oncology Nursing Society Evidence-Based Practice Resource Area and Outcomes Resource Area (www.ons.org) provide evidence-based guidelines for care of patients with cancer.

**Practice Example:**

**Vascular Catheter-Associated Infection**

One hospital-acquired condition not reimbursed by CMS since October 1, 2008, is a vascular catheter-associated infection. The average cost of a hospital-acquired vascular catheter-associated infection has been cited as $103,027 for a hospital stay (CMS, 2008a). Patients with cancer often have venous access devices, receive IV therapy, and are immunocompromised, and thus are at risk for the hospital-acquired condition. In addition, patients sometimes are admitted with existing venous access devices; therefore, healthcare professionals must determine whether a line is infected at the time of admission. Numerous evidence-based practice guidelines are available to help prevent vascular catheter-associated infections (see Figure 2).

For additional resources on this topic, visit the following Web sites: CMS at www.cms.hhs.gov, the National Quality Forum at www.nationalqualityforum.org, and the National Guideline Clearinghouse at www.guideline.gov.

**Prevention Interventions**

- Practice maximal sterile barrier precautions during insertion of central line, including peripherally inserted central lines (i.e., cap, mask, sterile gown, sterile gloves, and large sterile drape).
- Clean catheter site with 2% chlorhexidine.
- Use sterile gauze or sterile transparent semipermeable dressing.
- Use gauze dressing if the site is bleeding or the patient is diaphoretic.
- Do not use topical antibiotics on catheter exit sites.
- Clean all injection ports with 70% alcohol or iodophor before accessing.

**Evidence-Based Guidelines**

- Centers for Disease Control and Prevention, 2002
- Infusion Nurses Society, 2006

**Figure 2. Preventing Hospital-Acquired Vascular Catheter-Associated Infections, a Never Event**

**Author Contact:** Lisa Hartkopf Smith, RN, MS, AOCN®, CNS, can be reached at lsmith2@ohiohealth.com, with copy to editor at CJONEditor@ons.org.

**References**


---

**Figure 1. Hospital-Acquired Conditions With Medicare and Medicaid Payment Implications**

*Note:* Based on information from Centers for Medicare and Medicaid Services, 2008a.
definitions_of_HACs


Do You Have an Interesting Topic to Share?

Safety offers information on safety issues affecting patients with cancer and those caring for them. Length should be no more than 1,000–1,500 words, exclusive of tables, figures, insets, and references. If interested, contact Associate Editor Lisa Hartkopf Smith, RN, MS, AOCN®, CNS, at lsmith2@ohiohealth.com.