NQF Releases Updated Serious Reportable Events

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Washington, DC - The National Quality Forum (NQF) Board has recently approved for endorsement a list of 29 serious reportable events (SREs) in healthcare as outlined in the forthcoming report Serious Reportable Events in Healthcare-2011 Update: A Consensus Report. Of the events submitted, 25 were updated from their earlier endorsement in 2006, and 4 new events were added to the list. The full list of events will be available for a 30-day public appeals process closing July 12, 2011.

“Tens of thousands of lives are forever changed each year as a result of healthcare errors,” said Janet Corrigan, president and CEO of the National Quality Forum. “This newly expanded list of serious reportable events across multiple settings provides a critical opportunity to learn from mistakes and take swift action to improve patient safety.”

SREs represent largely preventable errors and events, such as wrong-site surgery, stage 3 or 4 pressure ulcers acquired post-admission, patient falls, or serious medication errors. The first NQF-endorsed® list of Serious Reportable Events in Healthcare was released in 2002. Originally envisioned as a set of events that might form the basis for a national state-based reporting system, the SREs continue to fulfill that purpose as states and individual organizations have put them into practice. This uniform approach to measurement helps to drive overall national improvement in patient safety through shared learning and prevention. Currently, more than half of the states use the NQF-endorsed list of SREs in their public reporting programs.

For this new endorsement project, each of the SREs has been reviewed in terms of its applicability to four specific settings of care: hospitals, outpatient or office-based surgery centers, skilled nursing facilities, and ambulatory practice settings, specifically office-based practices. The report focuses on identifying and specifying each event for public reporting within the applicable settings of care.

The purpose of the 2011 update is three-fold: 1) to ensure the continued currency and appropriateness of each event in the list; 2) to ensure the events remain appropriate for public accountability; and 3) to provide guidance gained by implementers to those just beginning to report these events, across hospitals and for three newly specified settings of care—office-based practices, ambulatory surgery centers, and skilled nursing facilities.

“The updated list of Serious Reportable Events provides an essential accountability framework for ensuring our progress in improving patient safety,” said Gregg Meyer, MD, MSc, senior vice president for the Center for Quality and Safety at Massachusetts General Hospital and co-chair of the Serious Reportable Events in Healthcare Steering Committee. “It has evolved with the evidentiary base and represents an important complement to other NQF work in patient safety, such as the NQF-Endorsed Safe Practices.”

“The inclusion of three new settings for the Serious Reportable Events represents a significant stride forward in ensuring
quality across the continuum of care,” added Sally Tyler, MPA, health policy analyst with the American Federation of State, County and Municipal Employees and co-chair of the Serious Reportable Events in Healthcare Steering Committee. “This updated report and the work that will flow from it should inspire both healthcare consumers and purchasers to be confident that improved outcomes will result.”

NQF is a voluntary consensus standards-setting organization. Any party may request reconsideration of any of the 29 endorsed SREs by notifying NQF via email at appeals@qualityforum.org no later than Tuesday, July 12. For an appeal to be considered, the notification must include information clearly demonstrating that the appellant has interests directly and materially affected by the NQF-endorsed recommendations and that the NQF decision has had (or will have) an adverse effect on those interests.

Serious Reportable Events in Healthcare—2011 Update

1. SURGICAL OR INVASIVE PROCEDURE EVENTS
   - Surgery or other invasive procedure performed on the wrong site
   - Surgery or other invasive procedure performed on the wrong patient
   - Wrong surgical or other invasive procedure performed on a patient
   - Unintended retention of a foreign object in a patient after surgery or other invasive procedure
   - Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient

2. PRODUCT OR DEVICE EVENTS
   - Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
   - Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
   - Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. PATIENT PROTECTION EVENTS
   - Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
   - Patient death or serious injury associated with patient elopement (disappearance)
   - Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting

4. CARE MANAGEMENT EVENTS
   - Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   - Patient death or serious injury associated with unsafe administration of blood products
   - Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
   - (NEW) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
   - Patient death or serious injury associated with a fall while being cared for in a healthcare setting
   - Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
   - Artificial insemination with the wrong donor sperm or wrong egg
   - (NEW) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
   - (NEW) Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. ENVIRONMENTAL EVENTS
   - Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
   - Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
   - Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
   - Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. RADIOLOGIC EVENTS
   - (NEW) Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
7. POTENTIAL CRIMINAL EVENTS
   - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
   - Abduction of a patient/resident of any age
   - Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
   - Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

NQF operates under a three-part mission to improve the quality of American healthcare by:

- building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- endorsing national consensus standards for measuring and publicly reporting on performance; and
- promoting the attainment of national goals through education and outreach programs.