NATIONAL QUALITY FORUM

Serious Reportable Events

Adverse events in healthcare take a significant human and financial toll. Each year in the United States, more than two million healthcare-acquired conditions are responsible for 90,000 deaths and $5.7 billion in added healthcare costs.[1] Costs associated with other medical harm – including healthcare expenses, lost work productivity, lost income, and disability – have been estimated as high as $29 billion per year.[2] These statistics illustrate an urgent need and a significant opportunity to better measure and improve patient safety, as part of a broader effort to create a high-value healthcare system.

Patient safety is a core component of NQF's mission to improve health and healthcare quality. Accordingly, NQF – in collaboration with a range of healthcare stakeholders – has worked over the past decade to develop and refine a list of Serious Reportable Events (SREs) designed to help organizations assess, measure, and report performance in providing safe care.

Defining SREs

NQF considers a **serious reportable event** to be unambiguous, largely, if not entirely, preventable, serious, and any of the following:

- Adverse;
- Indicative of a problem in a healthcare setting's safety systems; and
- Important for public credibility or public accountability.

Additionally, SREs are events that are:

- Of concern to both the public and healthcare professionals and providers;
- Clearly identifiable and measurable;
- Feasible to including in a reporting system; and
- Of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility.

NQF's list of SREs includes both injuries occurring during care management (rather than underlying disease) and errors occurring from failure to follow standard care or institutional policies and procedures.

Advancing Patient Safety across the Healthcare Spectrum

NQF first created its list of SREs in 2002 to encourage learning across healthcare organizations, drive national improvements in patient safety, and prevent future adverse events. Recognizing that healthcare delivery has increasingly moved beyond just hospital settings, NQF has now updated its list of SREs to address patient safety across a range of settings where patients receive care, including office-based practices, ambulatory surgery centers, and skilled nursing facilities. The updated list also offers guidance to stakeholders just beginning to report adverse events, gleaned from those who have previously reported on SREs.

In NQF's Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report, 29 events – four new and 25 updated – are recommended for endorsement as voluntary consensus standards suitable for public reporting in a variety of settings:

Surgical or Invasive Procedures

1A. Surgery or other invasive procedure performed on the wrong site *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

Product or Device Events

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. 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 *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

Patient Protection Events

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or serious injury associated with patient elopement (disappearance) *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Care Management Events

4A. 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) *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or serious injury associated with unsafe administration of blood products *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy *(new)*

Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen *(new)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results *(new)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Environmental Events

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. 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 *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Radiologic Events

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area *(new)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

Potential Criminal Events

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. 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 *(updated)*

Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

About NQF

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.

To learn more about NQF's SREs or other patient safety efforts, visit www.qualityforum.org.

[1] National Quality Forum, (NQF), *National Voluntary Consensus Standards for the Reporting of Healthcare-Associated Infection Data: A Consensus Report*, Washington, DC: NQF; 2008.
[2] Kelly R, *Where Can $700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?* New York, NY: Thomson Reuters; 2009. Available at: **www.ncrponline.org/PDFs/Thomson_Reuters_White_Paper_on_Healthcare_Waste.pdf**. Last accessed June 2011.