Serious Reportable Events (SREs)
Transparency, accountability critical to reducing medical errors and harm

"Tens of thousands of lives are forever changed each year as a result of healthcare errors. There is a critical need to enhance health system capacity, so that all patients will receive care that is safe and effective." - NQF President and CEO Janet Corrigan

The Cost of Medical Mistakes

The United States pays a high price for medical errors, not just in money, but in resources and lives. We know about the prevalence: A 1999 Institute of Medicine report estimated that as many as 44,000 to 98,000 people die in U.S. hospitals each year as the result of medical errors – more than deaths caused by car accidents, breast cancer or AIDS[1]. In the intervening 9 years, that statistic has not improved appreciably. And we know about the fiscal impact: 18 types of medical errors account for 2.4 million extra hospital days, $9.3 billion in excess charges, each year[2].

We also know what to do. Many of these events can be reduced with careful implementation of appropriate policies and procedures. Yet patient safety measures indicate our nation is improving in this area only 1 percent per year[3].

NQF's "Serious Reportable Events"

To increase public accountability and consumer access to critical information about healthcare performance, in 2002, the National Quality Forum created and endorsed a list of Serious Reportable Events (SRE's) which was updated in 2006. The 28 events in the list are largely preventable, grave errors and events that are of concern to the public and healthcare providers and that warrant careful investigation and should be targeted for mandatory public reporting.

NQF's list of serious reportable events includes both injuries caused by care management (rather than the underlying disease) and errors that occur from failure to follow standard care or institutional practices and policies.

Like all NQF-endorsed consensus standards, the SRE list reflects a consensus among representatives of all parts of the healthcare system, including national, regional, state, and local groups representing consumers; public and private purchasers; physicians, hospitals, and other healthcare providers; accrediting bodies; supporting industries; and organizations involved in healthcare research or quality improvement.

By creating this clear, unambiguous, standardized list, NQF aims to bring greater transparency to healthcare and an opportunity to learn from mistakes and take swift actions to improve patient safety.

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[1] To Err is Human: Building a Safer Health System, Institute of Medicine, 1999
[2] JAMA Study, Agency for Healthcare Research and Quality, 2003
[3] National Healthcare Quality Report, Agency for Healthcare Research and Quality, 2007

How the SRE List Drives Improvement

The National Quality Forum report "Safe Practices for Better Healthcare" identifies 34 safe practices that should be universally utilized in applicable clinical care settings to reduce the risk of harm to patients. .

Both the NQF list of Safe Practices and the list of serious reportable events aim to improve public reporting and accountability, transparency, and systematic learning and improvement in healthcare safety, with the end goal of improving the things that help and preventing the things that harm.

Progress in Applying the SRE List

To date, no less than 25 states require licensed healthcare facilities to report serious reportable events. Some use the NQF list, others use lists they have developed, and some use a hybrid.

> *"Fortunately, in the last six years, we've witnessed remarkable improvements and innovative solutions emerge in response to healthcare providers' careful review and audit of these Serious Reportable Events." – Dr. Janet Corrigan, NQF president and CEO*

Use of the NQF list, with its definitions and specifications facilitates a national, systematic way to capture data about these events. This enables comparability and learning across reporting groups (states, systems) so that information is shared and learning is expanded, potentially nationally.

In 2003, Minnesota became the first state to require reporting of the entire NQF list. It has since been joined by California, Connecticut, Illinois, Indiana, Massachusetts, New Jersey, Oregon, Vermont, Washington, and Wyoming, and a number of other states are considering implementation of the list in whole or in part.

Under new Medicare authority, as of October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) no longer pay the higher Diagnosis Related Group (DRG) for a CMS-defined list of hospital-acquired conditions (HACs), some of which overlap with SREs. The Medicare payment provision encourages the adoption of evidence-based patient safety practices aimed at prevention of HACs. As the CMS payment provision is implemented, it will be important to closely monitor results, share lessons learned, and respond to unintended negative consequences with appropriate mid-course corrections and interventions.

What the National Quality Forum is doing

NQF has committed to regular maintenance and updating of the Serious Reportable Events, as well as the NQF Safe Practices for Better Healthcare.

The National Quality Forum is dedicated to improving the quality of health care in America. To that end, NQF has convened a group of 32 national, health, government, and consumer organizations who will commit to specific, measurable actions and goals for performance measurement and public reporting. One of those long-term national priorities is patient safety. The collective force of these 32 organizations, including the Institute for Healthcare Improvement, the American Medical Association, Consumers Union, AARP, the nation's

governors and others, can achieve greater transparency, information-sharing, and swift action to correct errors and improve patient safety.

NQF also continues its important work endorsing consensus-based national standards for the measurement and public reporting of healthcare performance data, which provides meaningful information about whether care is safe, timely, effective, patient-centered, equitable, and efficient.

About the National Quality Forum

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs. NQF, a non-profit organization (qualityforum.org) with diverse stakeholders across the public and private health sectors, was established in 1999 and is based in Washington, DC.

Additional Resources

For a copy of the 2006 full consensus report on "Serious Reportable Events in Healthcare" or the companion report "Safe Practices for Better Healthcare" contact Stacy Fiedler, NQF's media relations specialist at press@qualityforum.org or 202-783-1300 ext. 436.

For more information on the Medicare hospital-acquired conditions payment provision, contact the CMS Office of External Affairs at 202-690-6145.

Serious Reportable Events[*]

Surgical Events

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediately postoperative death in a ASA Class I patient

Product of device events

- Patient death or serious disability associated with the use of contaminated drugs, devices or biologics provided by the healthcare facility
- Patient death or serious disability 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 disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility

[*] See the full report for applicable care settings for each event, detailed specifications, additional background and references.

Patient Protection Events

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient elopement (disappearance)
- Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility

Care Management Events

- Patient death or serious disability 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 disability associated with a hemolytic reaction due to the administration of ABO/HLA – incompatible blood or blood products
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinermia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulative therapy
- Artificial insemination with the wrong donor sperm or wrong egg

Environmental Events

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

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 of any age
- Sexual assault on a patient within or on the grounds of a healthcare facility
- Death or significant injury of a patient or staff member resulting form a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility