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The Power of Safety: State Reporting Provides Lessons in Reducing Harm, Improving Care

EXECUTIVE SUMMARY

While many states are making important strides toward establishing public reporting systems for medical errors, the need to establish broader adverse event reporting systems continues. These systems can facilitate substantive reporting, and the information derived then can be evaluated and acted upon to improve care and reduce errors.

In late 2009, the National Quality Forum (NQF) convened government agency officials representing more than 20 state patient safety reporting systems.

This first meeting provided the opportunity to:

- increase understanding by states of NQF's list of 28 Serious Reportable Events (SREs) and their potential basis for public reporting nationwide;

- highlight the key issues faced by state safety reporting systems and how state-level experiences can help develop a framework to guide the work of NQF, the states, and the entire healthcare community; and

- facilitate communication among managers of state reporting systems, many of whom are in the early stages of developing their systems.

To date, 27 states and the District of Columbia have enacted reporting systems to help practitioners identify and learn from medical errors. The majority of those states incorporate at least some portion of NQF's list of 28 SREs to help establish a more uniform set of criteria by which to report and act. Despite the existence of these standardized SREs, significant incongruities remain among state efforts; differing implementation approaches and perspectives toward reporting patient safety events have led to inconsistent results for improving adverse outcomes from these events.

Within the next 10 years, 1 in every 5 dollars spent in the United States will go toward healthcare costs.[1] These rising costs, coupled with the prevalence of medical errors nationwide, underscores a struggle behind consistent measurement and reporting of patient safety events is an initiative that can save lives and dollars.

Consider these facts about the impact of medical harm in America:

- The Institute for Healthcare Improvement (IHI) estimates that nearly 15 million instances of medical harm occur in the United States each year.[2] Preventable medical errors in hospitals exceed deaths from car accidents, breast cancer, and AIDS.[3] (See FIGURE 1.)

- In 2008, the Agency for Health Care Research and Quality (AHRQ) reported that preventable medical injuries rise annually.[4]

- Slightly more than half of the states have reporting systems to track and take corrective action on medical errors.[5, 6]

FIGURE 1

Preventable Hospital Deaths Caused by Medical Errors Exceed Those from Car Accidents, Breast Cancer, and AIDS*
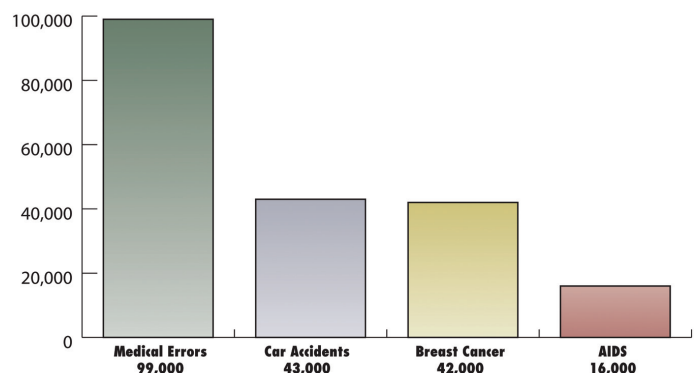
*Source: Institute of Medicine (IOM). *To Err Is Human: Building a Safer Health System,* Washington, DC: National Academy of Science; 1999, p. 26.

The fiscal impact of medical errors is also astounding:

◆ The costs associated with medical harm have been estimated to range from $17 billion to $29 billion per year in healthcare expenses, lost worker productivity, lost income, and disability.[7]

◆ Eighteen types of medical errors account for 2.4 million extra hospital days and $9.3 billion in excess charges each year.[8]

◆ Readmissions of patients within 30 days of discharge from hospitals due to medical errors cost Medicare an estimated $15 billion.[9] In addition, 20 percent of those patients are likely to experience another preventable readmission within 6 months—sending the price tag up by $729 million or $7,400 per readmission.[10]

Adverse medical events can be reduced with careful implementation of appropriate reporting policies and procedures. While many states are making important strides toward establishing effective public reporting systems for medical errors, the need for broader establishment of adverse event reporting systems is clear and urgent, particularly as states consider cutting back on measurement and reporting in the current economic climate. These systems can ensure substantive reporting that can be effectively evaluated and acted upon to improve care and reduce errors.[11]

The Leadership Role for States

Many states continue to struggle to secure the resources and guidelines necessary to create, maintain, or strengthen patient safety reporting systems in today's economic climate.

Ten years ago, the Institute of Medicine's (IOM) report, *To Err Is Human*, called for mandatory public reporting by states of adverse medical events that result in death or serious harm, along with voluntary reporting of near misses or minor injuries. The report galvanized a movement focused on patient safety improvements. The result: much-needed transparency to guide improvements.

While each effort provides useful resources, states indicate they too often lack clear, common, or consistent standards that can drive more effective measurement, evaluation, and learning across states and at a national level. The National Quality Forum (NQF), a consensus-based entity with a mission to

"WORKING TOGETHER WITH STATES and other partners, we are making progress by focusing on improvements in patient safety measures, reporting and practices. But, our systems for reporting and learning from errors are just a patchwork in a fragmented healthcare system and do not adequately engage the public in safety efforts.

The challenge we face moving forward is that those programs differ a good deal. Some are voluntary. Some are mandatory. Some result in public reporting. Some have a strong emphasis on root cause analysis and improvement. Some use standardized definitions of events and others don't. We have a wealth of experience we can tap to learn from and guide our collective efforts to ensure that every patient receives safe, high-quality care wherever and whenever they encounter the healthcare system."

—Janet M. Corrigan,Ph.D, MBA, President and CEO, NQF

improve the quality of healthcare in the United States, is working to help address this issue, with support from the U.S. Department of Health and Human Services. A focus of this effort is on how state-level public reporting efforts can help shape revisions to its list of Serious Reportable Events (SREs).

In an effort to develop an action plan for improving patient safety reporting systems, NQF convened state reporting officials in October 2009 to better understand what has been accomplished and what can be learned.

States indicated the levers that have the most impact on patient safety improvement efforts include:

◆ enhancing state and federal alignment in standards, resources, and exchange of best practices;

◆ measuring and reporting with precision and consistency;

◆ ensuring accountability to drive improvement;

◆ using data to drive action; and

◆ building the case for change.

While some states have established systems for reporting patient safety events, there has been an expansion of reporting standards nationwide. Sixteen of the 28 states with reporting requirements enacted or significantly revised their systems between 2005 and 2007. This includes four states — Wyoming, Vermont, Illinois, and Indiana — along with the District of Columbia, which added mandatory patient safety event reporting systems.

Enhancing and Alignment

Amid a highly charged political debate over healthcare, the devastating impact of the failures in America's healthcare system can get lost. But, many who disagree on some parts of the reform can agree on one common denominator: Improving the quality of care—and patient safety in particular—is at the heart of realizing meaningful transformation of healthcare. Quality will continue to be a primary focus for many states determined to transform the healthcare system and instill the complete confidence of all patients.

THE ROLE OF THE NATIONAL ORGANIZATIONS IN SPREADING SAFETY IMPROVEMENTS

NQF's work with the states has highlighted the increasingly vital role that national organizations can play as a partner and a driving force in advancing patient safety improvements across states. For instance, states indicate that establishing a clear, common, and consistent baseline standard from which they could build would be a significant step toward systemic improvements. Providing the necessary foundation for what constitutes a reportable error can bring greater clarity and transparency to healthcare and better opportunities to learn from mistakes and take meaningful corrective action. At the same time, states also are clear in conveying their need for flexibility to adjust or strengthen these standards to suit their own needs and conditions. States have indicated that alignment with federal reporting policies should provide a "floor and not a ceiling" for improving care and reducing harm.[12]

Common standards can provide states a potentially centralized resource of more valuable databases of information where they can capture a more up-to-date and complete view across states in all areas and learn from each other about reporting structures, challenges, unintended consequences, and best practices as they work to establish or improve their own systems. For example, through initiatives like AHRQ's Network of Patient Safety Databases and the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare, states and consumers would have access to more resources and information about patient safety performance.

With a shared understanding that aligned federal and state policies and efforts can enhance healthcare quality and patient safety improvements, the National Academy for State Health Policy (NASHP) has also worked with states to identify key areas where enhanced federal and state coordination could affect safety improvement efforts, including support for research and policy expertise, and funding for programs and projects. Federal action in this area also could foster a greater sense of urgency for improving a system-wide, patient-centered focus, streamlining efforts, strengthening engagement among providers, avoiding unintended consequences, fostering innovation and best practices among states, reducing costs, and benchmarking against nationally recognized standards.[13]

STATE EFFORTS DEMONSTRATE PROVING GROUND FOR IMPROVEMENTS

As major purchasers of healthcare and regulators of providers and health plans, states are invested in and responsible for improving quality. While states are demonstrating innovation and establishing substantive reporting systems, they indicate there is still a need for the federal government to provide additional support and leadership by establishing baseline standards to measure and report patient safety efforts.

To date, 27 states and the District of Columbia have enacted reporting systems to help practitioners identify and learn from errors, breakdowns in performances, and best practices. As a healthcare measure, SREs represent adverse healthcare outcomes that are largely avoidable. The majority of those states incorporate NQF's list of 28 SREs, which have emerged as a baseline for determining criteria by which to report and act. (See FIGURE 2 on page 4.)

States including Indiana, Massachusetts,[14] Minnesota, Pennsylvania, and Washington underscore a growing momentum to ensure effective public reporting incorporates accountability and best practices to drive down errors, infection rates, and harm to patients. They demonstrate the commitment and innovation required for dramatic improvements in patient safety, and they represent the challenges to advancing this work.

Although there is a lack of federal and state alignment in standards for adverse event reporting, many states already have moved ahead with the help of resources like NQF's SREs and are pursuing approaches that are having an impact in safety improvement, many of which are instructive innovations.

Facilities can more effectively ensure that staff are properly trained by providing additional clarity in defining aspects of

public reporting systems, particularly SREs and other indicators. Staff will then know what to report, how best to analyze and act on data, and which reporting system structures and technologies work most effectively. In addition, Pennsylvania's Patient Safety Authority is developing PassKey, an online community for patient safety officers statewide. Visitors to the site can initiate a discussion thread, gain access to a library of resources, and share information about individual facility policies, procedures, and programs that can foster an exchange about lessons learned, challenges, and best practices.

At the same time, these new policies are evolving quickly, which can result in "change fatigue" among practitioners at the state level. Such fatigue can affect how best to prioritize various initiatives or policies designed to improve the reporting system and foster an environment that ensures compliance, transparency, and accountability.
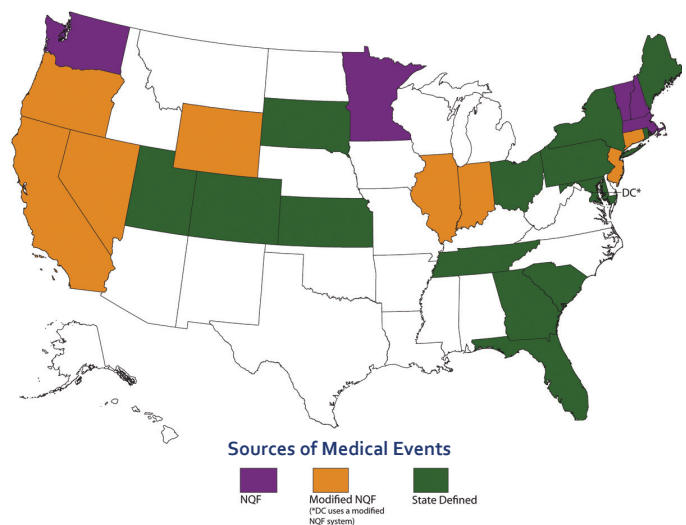
Precision and Consistency in Measurement

In healthcare, measuring and reporting performance drives improvement. NQF's standardized measures and practices aim to reduce harm and eliminate the risk of injuries and mistakes; about 20 percent of NQF's measures are directly related to patient safety issues.

FIGURE 2

States with Adverse Reporting Systems**

Sources of Medical Events

NQF | Modified NQF (*DC uses a modified NQF system) | State Defined

**Source: http://www.nashp.org/sites/default/files/shpsurveyreport_adverse2007.pdf

In the October 2009 meeting, state representatives were clear that NQF's efforts to establish a portfolio of SREs, measures, and Safe Practices had helped them. They also called, however, for more precision and specification from current measures and for expansion of the safety portfolio to new areas.

PENNSYLVANIA, WHICH HAS AN AGGRESSIVE REPORTING PROGRAM for healthcare-acquired infections, published its first report in 2006 on hospital and nursing home infection rates that arise largely from intravenous catheters and tubes left in the body too long. The state also has developed trainings sessions to ensure awareness of and consistency in reporting, as well as interactive analytical reports so facilities can act on the data.[15] The results have been promising:

- Infection numbers the following year fell 7.8 percent as hospitals took corrective action.[16] (See FIGURE 3.)

- The average cost in 2006 for hospitalization where a patient acquired an infection was $53,915. With no infection, the average price tag was $8,311, according to state reports.[17]

FIGURE 3

Improving Safety and Reducing Costs in Pennsylvania*
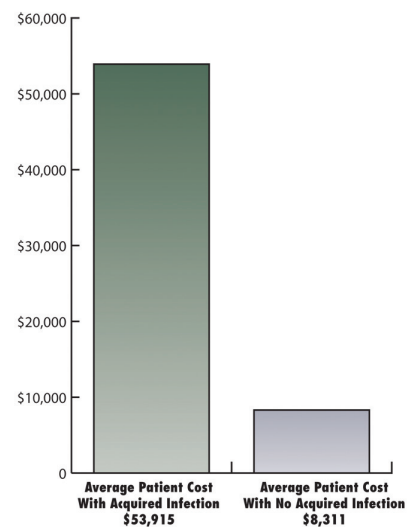
*Source: PHC4 (Pennsylvania Health Care Cost Containment Council). Hospital-acquired infections in Pennsylvania.Nov2006. [Accessed April 7, 2008]. http://www.phc4.org/reports/hai/05/docs/hai2005report.pdf

SREs AND QUALITY IMPROVEMENT

Working with states and national partners, NQF is seeking to integrate its overall quality improvement portfolio and its patient safety work, including SREs, Safe Practices and performance measures, particularly those that address patient safety. Originally established in 2003, NQF's *Safe Practices for Better Healthcare* were designed to work in concert with its SREs. Both have been updated periodically and will continue to be refined.

NQF's portfolio of endorsed measures continues to evolve to address not only outcomes, like SREs, that result in quantifiable change, but also process measures that may influence the quality of care provided. In total, these metrics aim to continue improving healthcare performance through measurement, public reporting, and quality improvement efforts.

NEAR MISSES

Some states are taking into consideration the inclusion of "near misses" as serious reportable events. Many agree that near misses are thought to be particularly valuable in determining how systems or procedures should be refined to facilitate broader policy or procedural improvements and prevent greater numbers of additional near misses or actual medical errors.

Pennsylvania was the first state to require public reporting of near misses, which resulted in corrective action. Through its public reporting system, a hospital in the state revealed a near miss involving healthcare workers who nearly failed to rescue a heart attack victim because the nurse had provided the patient a yellow wristband by mistake, designating the patient as DNR (do not resuscitate). The nurse also worked in a

"ALTHOUGH OUR LAW HAS NQF SERIOUS REPORTABLE EVENTS WORD FOR WORD, you would think it would be fairly black and white, but it is not. We get all sorts of questions from reporting facilities about how to interpret some of those events. A good example recently is the question that we have struggled with for the last few years: When does the surgery end? When you are looking at whether something like a retained foreign object is reportable, you've got to know when that procedure ended. That has ramifications for what is reportable and what is not."

— Diane Rydrych, Assistant Director, Division of Health Policy, Minnesota Department of Health

NEAR MISS — A medical event that could have resulted in an accident, injury, illness, or death, but was avoided by chance or through timely intervention. For example, a wrong site surgery that was almost performed due to a lapse in some verification but was caught before the surgery occurred. Near misses are opportunities for learning and developing preventive strategies and actions.

nearby hospital, where a yellow wristband meant something else entirely.

The Patient Safety Authority surveyed facilities to determine how widespread this problem could be and uncovered how many colors were used for different designations. The issue was reported in the *Patient Safety Advisory*, a journal that includes actual event stories to inform facilities about their public reporting data and help them learn from and prevent events. As a result, Pennsylvania facilities in the central and northeastern regions of the state formed the "Color of Patient Safety Task Force" and standardized the use of color-coded wristbands, which has been recommended statewide. This near miss and resulting action generated national attention and prompted more than 30 states to adopt some form of the standardized colors and methods.[18]

Ensuring Accountability To Drive Improvement

Ensuring all reporting systems are compliant requires a shared understanding that meaningful reporting prompts evaluation and analysis to reveal patterns, trends, and learning opportunities that trigger corrective action and improvement in care. But reaching such an understanding is difficult, and many states struggle to make sure every hospital or facility is reporting every event.

Reporting standards vary significantly nationwide. For example, Pennsylvania received reports of 200,000 events in 2006, compared to 10 in South Dakota.[19] Compliance and improvements require "buy-in" at all levels of the healthcare system by elected officials, government agencies, healthcare providers, hospital leadership, and practitioners. This is particularly important at the facility level, where a demonstration of the commitment and actions of senior management teams can empower every staff member to contribute and bring awareness to safety issues, share results in order to learn, improve and highlight successes, and adopt best practices.

One barrier many states face in collecting and acting on the data is striking the right balance and overcoming

entrenched cultural attitudes among facilities that a reporting system may be primarily punitive in its approach and not driven by learning and improvement.

The fear of retaliation against facilities or individuals fuels efforts to resist reporting and can shift the focus away from care, hamper morale, and foster distrust, all of which undermine efforts to establish a culture of safety. Some states, therefore, have worked diligently to include key stakeholders like hospitals and hospital associations every step of the way, which they say can foster a shared and productive focus on improving safety and the quality of care.

Making reporting easier for facilities can have an impact on compliance. A web-based resource for facility reporting, like Pennsylvania's Passkey initiative, could allow for easier and seamless reporting within a state. It also could make it possible to capture more complete and comprehensive data. Even facilities without their own infrastructures can use the state's reporting system to examine their own events, which can help inform corrective action and improvements.

To overcome some of the healthcare facility-level perceptions about the punitive nature of the reporting systems, states have worked closely with facilities to foster collaboration from the start and bring patient safety officers into the process. Trainings allow time to firmly establish the reporting processes and structure before public reporting is required. These initial, internal efforts have provided opportunities to address any operational glitches and to ensure a common understanding about the definitions and expectations of their systems.

When its adverse events reporting system bill was proposed, Minnesota brought together the state Patient Safety Coalition, a group that included representatives from the Minnesota Hospital Association, Minnesota Medical Association, and the Minnesota Department of Health. These organizations worked together to craft legislation so facilities were part of the solution and understood the new legislation was not simply being imposed on them.

Massachusetts coordinated its efforts when it adopted NQF's SREs in 2008 as the standard for its reporting system. To overcome apprehension, Massachusetts Department of Health officials reached out to hospitals and consumer organizations to establish a common focus on safety that helped alleviate the concerns over a system that could be seen as solely punitive. The new system fostered stronger collaboration among stakeholders. It also ensured accountability as a priority and a more unified focus on examining the findings and the key areas in need of corrective action.[20]

An additional consideration for states is that until systems are fully implemented and functional, state health systems may benefit from being allowed to gather and examine the data internally for a period of time before they are released publicly.

Strategies to incentivize reporting are an integral part of creating a meaningful system of patient safety event reporting. Although fines can be imposed for those hospitals not reporting, it is equally important to balance putative measures with efforts to learn from the reporting data, as well as collaborating and highlighting successes that contribute to a strong culture of safety. Most state reporting systems initially were set up to improve patient safety by holding individual healthcare facilities accountable for preventable adverse events and perhaps secondarily to improve quality and patient safety across facilities; however, over the years, many states note their systems now encompass a broader focus on accountability and quality improvement.[21]

Using Data to Drive Action: Root Cause Analysis and Corrective Action

Acting on adverse event data can be particularly challenging. Even with mandatory reporting systems, ensuring compliance is difficult because many states have no true enforcement structure in place. In addition, data, with no context or analysis, can be easily misinterpreted.

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IN WASHINGTON STATE, the Patient Safety Adverse Event Advisory Committee, which is represented by numerous stakeholders, including the Washington State Hospital Association, the Washington State Ambulatory Surgery Center Association, Qualis Health, and numerous hospital representatives, meets regularly to discuss the program and share ideas. The committee has also supported the Department of Health's plan to implement a new "check-in" policy designed to boost compliance by establishing contact with facilities on a quarterly basis to make sure they are reminded of the reporting requirements for declaring adverse events.[22]

"*OUR FOCUS IS ON QUALITY IMPROVEMENT rather than discipline. We believe that there are more benefits to reforming systems than punishing individuals. We help each facility understand what went wrong, determine the underlying causes, and then help them develop an action plan.*"

— *Linda Furkay, PhD, RN, Patient Safety-Adverse Event Officer, Office of Community Health Systems, Washington Department of Health*

IOM cautions that "the goal of reporting programs is not to count the number of reports, but to analyze and use the information they provide and match it with the right tools, expertise, and resources to help correct the errors."[23]

While many states require that root cause analysis (RCA) or corrective action plans be submitted in response to serious adverse events, many facilities do not or cannot, indicating that staffing constraints limit their capacity to review such information. Many states also noted that limited feedback was due to budget constraints.[24]

Washington state's adverse event reporting law calls for a vendor to establish and manage a comprehensive RCA effort, but funding constraints have prevented it from happening. As a result, the state Department of Health has assumed sole responsibility for this work, even as it struggles with its own capacity issues in gathering the data, issuing reports, conducting RCAs, consulting with facilities, and supporting the development of corrective action plans.[25]

Some states have been able to effectively establish and sustain RCA efforts to improve. Indiana launched a 15-month initiative to address pressure ulcers, the most reported adverse event. The state Department of Health worked with more than 160 facilities in the state to include nursing homes, hospitals, and home health agencies. The initiative included hosting three learning sessions for participating facilities to examine how to identify ulcers at an earlier stage and how to reduce the number of incidents. It was thought to be the first time all of the facilities and healthcare associations had met together in one place.

As a result of this effort, participating facilities achieved a 30 percent reduction in pressure ulcers. From January 1 to September 30 of 2009, the participating facilities saw 393 fewer pressure ulcers than the previous year, a decrease from 8.3 percent to 7.3 percent. One hospital, which recorded 14 pressure ulcers in 2008, reduced that number to zero in 2009. The state estimated saving more than $8 million from this initative.[26]

Indiana also set up a collaborative process to address quality of care issues. Indiana had ranked in the top five nationally for certain nursing home violations in which patients were in immediate danger of being harmed. Through state-fostered collaboration, they lowered their ranking to 20th nationally and reduced their number of violations by more than 70 percent.[27]

Building the Case for Change

Mustering the public and political will for change requires a clear and compelling appeal to secure the commitment from elected officials, policymakers, and industry professionals and consumers. The political and policy landscape in states also can present challenges that affect efforts to achieve truly effective reporting systems. Raising awareness about the need,

PENNSYLVANIA IS FOSTERING COLLABORATION among stakeholders to improve its reporting system. Through its Patient Safety Authority, it provided more than 20 trainings for facility-level patient safety officers to allow them time to fully understand the reporting system before they were actually required to submit reports. The Authority also created the Patient Safety Liaison Program, which dispatches representatives to work with facilities to address their patient safety challenges and to help share best practices statewide. Their roles are to implement the patient safety requirements, coordinate trainings, and share information about challenges and best practices. The effort has facilitated more regional cooperation and collaboration, and it has reinforced the Patient Safety Authority as a partner, not an enforcer.[28]

establishing a unified commitment among stakeholders, and educating decision makers about the policies and resources from management to enforcement and accountability all point to securing the right kind of support and resources to ensure that a system can be managed effectively.

States, hospitals, and insurance companies all play an important role in communicating with consumers the important role they play in strengthening the engagement of patients and families. The disclosure of adverse events to patients and families is becoming more accepted and supported behavior. In 2000, only one state required healthcare facilities to disclose to patients or their families directly when an adverse event occurred. In 2007, the most recent date that this information was collected, 11 of the 27 reporting systems did so.[29]

Just as reporting standards vary widely among states, so do funding structures. Some states rely on their legislatures for a dedicated funding stream. Some use a fee structure.

ROOT CAUSE ANALYSIS (RCA) – An in-depth examination of the reporting data for events that includes the identification of circumstances surrounding them, including when, where, and how; a timeline; analysis of contributing factors from staffing levels to procedures; and identification of learning opportunities and preventive measures.

CORRECTIVE ACTION PLAN —The resulting course of action from conducting a root cause analysis. The action plan addresses system and process failures identified during a root cause analysis, as well as providing a blueprint for developing and implementing improvement strategies to ensure that potential errors are prevented.

The majority, however, use general operating funds from state agencies or a combination of sources to finance their operations.[30] (See FIGURE 4 on page 9.)

There is growing concern regarding resources amid funding shortages. The political realities often can hinder efforts to provide long-term support for program funding or regulatory change. For example, Wyoming's state law authorizing an adverse events reporting system is set to expire in 2010.[31] States also struggle to allocate the necessary staff to clearly define and standardize SREs and other key indicators, strengthen accountability, and foster a culture of reporting as a critical component of quality improvement.

In New York, where the reporting system has been in place for more than 20 years, the state will issue this year its first statewide report in five years, due in part to funding constraints.[32] Washington's reporting system requires public

"ESSENTIALLY, THE LEGISLATION MANDATES that licensed healthcare facilities report any occurrence in a defined set of patient safety events, basically a passive surveillance system to track, assess, and analyze adverse events. The funding allocation within this legislation is incredibly inadequate. There are no resources for educating or supporting hospitals and healthcare facilities in complying with the law or for quality improvement efforts."

— Linda Chasson, MS, Administrator, Preventive Health and Safety Division, Wyoming Department of Health

reporting of adverse events. Due to funding constraints, the state has not been able to fully realize its original intent to analyze its reporting data and develop comprehensive information about adverse events for the patient safety community.[33]

These states and others are learning to do more with less, using existing resources to do the job's additional responsibilities or to take the initiative that enables them to more effectively track and act on the adverse event data and share best practices.

While NQF does not provide guidance on how states should manage the challenges of funding, it is instructive to understand better how the lack of resources can affect every stage of reporting and the potential return on investment from well-resourced systems that reduce wasteful spending on preventable errors.

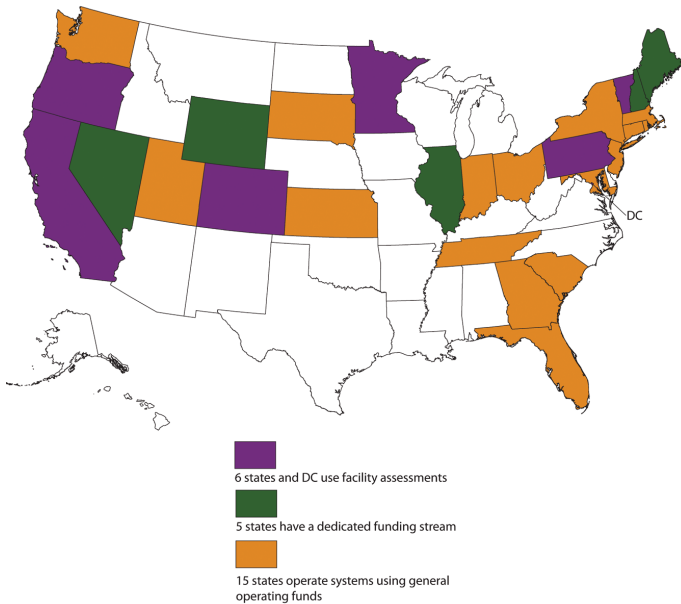## Additional Considerations and the Path Forward

The state perspectives are a valuable tool in shaping efforts nationally to establish a clear vision for what an effective patient safety public reporting system can be—from the initial event to notification, and from reporting to root cause analysis and corrective action.

The United States is developing a firm understanding of how and why too many systems are not achieving more meaningful results. We know about varying standards and a lack of clear definitions associated with reportable events. We know that entrenched attitudes can derail or strengthen patient safety accountability efforts. And we know the limitations of managing systems effectively with scant resources.

When done right, these approaches are showing what can drive learning to ensure high-quality healthcare in the United

FIGURE 4

Funding Sources for Adverse Event Reporting Systems*

6 states and DC use facility assessments

5 states have a dedicated funding stream

15 states operate systems using general operating funds

*Sources: http://www.nashp.org/sites/default/files/shpsurveyreport_adverse2007.pdf
http://www.gencourt.state.nh.us/legislation/2009/HB0592.html

States. The current economic and political environment requires that the system be continuously monitored to identify and adopt best practices that will foster more effective management, transparency, and accountability to spread these transformational changes across our healthcare system.

While there is cause for some encouragement about the potential for further improvements in strengthening state and federal coordination for reporting and improving patient safety performance, the fact remains that there are nearly 100,000 Americans who die as a result of preventable medical errors and many more who suffer avoidable harm. It is clear that our nation can no longer afford—in lives or dollars—to provide care that is unsafe.

NQF'S SERIOUS REPORTABLE EVENTS IN HEALTHCARE

1. SURGICAL EVENTS

A. Surgery performed on the wrong body part
B. Surgery performed on the wrong patient
C. Wrong surgical procedure performed on a patient
D. Unintended retention of a foreign object in a patient after surgery or other procedure
E. Intraoperative or immediately postoperative death in an ASA Class I patient

2. PRODUCT OR DEVICE EVENTS

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

3. PATIENT PROTECTION EVENTS

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

4. CARE MANAGEMENT EVENTS

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

5. ENVIRONMENTAL EVENTS

A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
B. 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
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
D. Patient death or serious disability associated with a fall while being cared for in a healthcare facility
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

6. CRIMINAL EVENTS

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
B. Abduction of a patient of any age
C. Sexual assault on a patient within or on the grounds of a healthcare facility
D. Death or significant 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 facility

Notes

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