

## **Serious Reportable Events (SREs)**

### **Transparency & Accountability are Critical to Reducing Medical Errors**

*“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 financially, 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.<sup>1</sup> In the intervening nine years, that statistic has not improved as much as one would hope. Patient safety measures indicate that our nation is improving in this area only 1 percent each year.<sup>2</sup> The fiscal impact is also astounding: Eighteen types of medical errors account for 2.4 million extra hospital days and \$9.3 billion in excess charges each year.<sup>3</sup>

Many of these events can be reduced with careful implementation of appropriate policies and procedures. By creating a clear, unambiguous, and 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.

#### **NQF’s Serious Reportable Events**

In 2002, The National Quality Forum (NQF) created and endorsed a list of serious reportable events (SREs) to increase public accountability and consumer access to critical information about healthcare performance. There are 28 events and each is classified under 1 of 6 categories: surgical, product of device, patient protection, care management, environment, or criminal.

The SRE list 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. The events are largely preventable, but also very serious. The errors are of concern to the public and healthcare providers and warrant careful investigation that should be targeted for mandatory public reporting.

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

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<sup>1</sup> Institute of Medicine, *To Err Is Human: Building a Safer Health System*, Washington, DC, National Academy Press; 1999.

<sup>2</sup> National Healthcare Quality Report, Agency for Healthcare Research and Quality, 2007

<sup>3</sup> The Journal of the American Medical Association (JAMA), *Excess Length of Stay, Charges, Mortality Attributable to Medical Injuries During Hospitalization*; 2003.

The SRE list was updated in 2006 and can be found at the end of this document.

### **Progress in Applying the SRE List**

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

*“Greater reporting and transparency can marshal faster, more responsive lessons, improvements and innovative solutions. – 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 across the nation.

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, on October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) will reduce payment to treat a list of complications CMS deems preventable with good care. Many of these complications are included on NQF’s SREs list. The Medicare payment provision encourages the adoption of evidence-based patient safety practices aimed at preventing hospital acquired conditions. 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 corrections and interventions.

### **Working Alongside the SRE List**

To help spur lessons learned through reporting, NQF commissioned the *Safe Practices for Better Healthcare* report in 2002 and updated it in 2006. The report identifies 30 safe practices that should be universally used to reduce the risk of harm to patients. These practices range from creating and sustaining a culture of safety to information management and continuity of care to matching healthcare needs with service capability.

Together, the SRE list and the Safe Practices report aim to improve public reporting and accountability, transparency, and systematic learning and improvement in healthcare safety. The eventual goal of these two lists would be to improve the things that help and prevent the things that harm.

### **What NQF Is Doing**

NQF has committed to regular maintenance and updating of the list of SREs and safe practices. NQF is currently reviewing the 2006 Safe Practices, strengthening implementation guidance, updating research recommendations, and evaluating new practices to ensure that the set remains current and appropriate.

It also is dedicated to improving the quality of healthcare in America. To that end, NQF has convened a group of 28 national, health, government, and consumer organizations that 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 28 organizations, which include the Institute for Healthcare Improvement, the American Medical Association, Consumers Union, AARP, the nation's governors, and others, can achieve greater transparency and information sharing and help implement swift action to correct errors and improve patient safety.

NQF also continues its important work of 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 NQF**

The mission of NQF 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 nonprofit organization ([www.qualityforum.org](http://www.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 *Serious Reportable Events in Healthcare—2006 Update* or the companion report *Safe Practices for Better Healthcare—2006 Update*, contact Stacy Fiedler, NQF's media relations specialist, at [press@qualityforum.org](mailto:press@qualityforum.org), or 202-783-1300 ext. 179.

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 an ASA Class I patient

#### **Product of Device Events**

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

- 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

### **Patient Protection Events**

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient leaving the facility without permission
- 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 (abnormal breakdown of red blood cells) 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 associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns
- 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 from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility