Serious Reportable Events in Healthcare – 2011 Update

July 19, 2011
Overview

  – Facilitate uniform, comparable public reporting
  – Enable systematic learning
  – Ensure currency & appropriateness
  – Provide guidance from implementers

  – 2011 - Expand to new settings of care
Major Changes in 2011

• Expanded committee expertise to ensure events are relevant for the targeted areas

• Broadened focus to explicitly include:
  – Hospitals
  – Office-based practices
  – Ambulatory surgery centers
  – Skilled nursing facilities

• Expanded Implementation Guidance

• Added glossary to improve clarity
Criteria

To qualify for the list of Serious Reportable Events in Healthcare—2011 Update events must have been determined 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
- important for public credibility or public accountability

Additionally, items included on the list are events that are:

- of concern to both the public and healthcare professionals and providers;
- clearly identifiable and measurable;
- feasible to include 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.
Categories of Events

• 6 categories essentially unchanged
  – Surgical or Invasive Procedure
  – Product or Device
  – Patient Protection
  – Care Management
  – Environmental
  – Potential Criminal

• 1 New
  – Radiologic
Pluses & Minuses

• 25 existing events updated

• 3 events retired
  – Hypoglycemia
  – Kernicterus
  – Spinal Manipulation

• 4 new events added

• 29 events for endorsement
Surgical or Invasive Procedure

- Wrong patient
- Wrong site
- Wrong procedure
- Unintended retention of foreign object
- Intra- or immediate post-op death of ASA Class 1 patient
Product or Device

Death or serious injury associated with:

• Use of contaminated drugs, devices, or biologics
• Use or function of device in which device is used or functions other than as intended
• Intravascular air embolism
• Discharge/release of patient (any age) who is unable to make decisions to unauthorized person
• Patient elopement
• Suicide, attempted suicide, self-harm w/ serious injury
Care Management

• Patient death or serious injury associated with:
  – Medication error
  – Unsafe administration of blood products
  – Labor or delivery in low risk pregnancy – mother
  – Labor or delivery in low-risk pregnancy - neonate (new)
  – A fall

• Artificial insemination with the wrong donor sperm or wrong egg
Care Management (cont.)

• Stage 3, Stage 4 and Unstageable pressure ulcers acquired after admission
• Patient death or serious injury resulting from:
  – Irretrievable loss of irreplaceable biologic specimen (new)
  – Failure to follow up or communicate lab, pathology, or radiology test results (new)
Environmental

• Patient or **staff** death or serious injury associated with:
  – Electric shock during patient care process
  – Burn from any source in course of patient care process

• Patient death or serious injury associated with use of physical restraints or bedrails

• Incident in which systems designated for oxygen or other gas contains no gas, wrong gas, or is contaminated
• Death or serious injury of patient or staff associated with metallic object in MRI area *(new)*
Potential Criminal

• Care ordered or provided by physician, nurse, pharmacist or other licensed healthcare provider impersonator
• Abduction of patient of any age
• Sexual abuse/assault on a patient or staff member within or on grounds of healthcare setting
• Death or serious injury of patient or staff resulting from physical assault within or on grounds of healthcare setting
Events Not Recommended

• Fluoroscopy dosing-related death or serious injury
• CLABSI-related death or serious injury
• Failure to rescue in surgical patients with serious treatable complications
• Use of an arterially misplaced CVC
• Diagnostic testing error-related death, serious disability or unnecessary invasive procedure
• Harm resulting from incorrect placement of feeding or ventilation tube
• Death or serious injury related to care by impaired healthcare worker
NQF Appeals

• Three Appeals were received
• The appeals addressed 5 events and also question the specificity of several definitions
• The appeals will be addressed over the next month
To access the updated list of serious reportable events:

NQF Serious Reportable Event Update
Questions?

Comments!