

THE NATIONAL QUALITY FORUM

FOR IMMEDIATE RELEASE
October 16, 2006

Press Inquiries: Jerry Mullins
202.974-8305

National Quality Forum Updates Endorsement of *Serious Reportable Events in Healthcare*

Washington, DC – Adverse healthcare events are a leading cause of death and injury in the United States. In 2002, the National Quality Forum (NQF) endorsed a list of 27 adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability. In June 2003, Minnesota became the first state to require public reporting of the NQF-endorsed™ list of events; in September 2006, California also adopted the list. Today 11 states use the report in whole or part as the basis of their state-based public reporting system.

Neither the 2002 list of events (nor the 2006 update), captures all events that might possibly be useful to report. Rather, the items on the list are events that are: of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable (and thus 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 organization.

To ensure the list of events reflected new evidence and innovation, NQF undertook an effort to update the list, and today announces endorsement of 1 new event and 6 events from the initial list whose specifications were materially changed; 21 events remain unchanged. Accordingly, the new NQF list encompasses 28 serious reportable events.

The new event is:

- Artificial insemination with the wrong donor sperm or donor egg

The six events whose specifications were materially are:

- Unintended retention of a foreign object in a patient after surgery or other procedure
- Patient death or serious disability associated with patient elopement (disappearance)
- 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
- Patient death or serious disability associated with an electric shock or elective cardioversion 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

Also endorsed were recommendations for additional research.

Detailed specifications and information on the research recommendations may be found at www.qualityforum.org.

The 21 unchanged events not subject to appeal are:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Intraoperative or immediately post-operative death in an ASA Class I patient
- 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
- Infant discharged to the wrong person
- Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care 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 hyperbilirubinemia 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
- 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 the use of restraints or bedrails while being cared for in a healthcare facility
- 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 the 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 the healthcare facility

NQF is a voluntary consensus standard-setting organization. Any party may request reconsideration of the recommendations, in whole or part, by notifying NQF in writing no later than 6:00 p.m. EST, November 14, 2006 (601 13th Street, NW, Suite 500 North, Washington, DC, 20005; fax 202.783.3434). For an appeal to be considered, the notification letter must include information clearly demonstrating that the appellant has interests that are directly and materially affected by the NQF-endorsed™ recommendations and that the NQF decision has had (or will have) an adverse effect on those interests.

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.