



PROFESSION

4 items added to serious reportable events list

The medical mistakes once touted as "never events" have widely influenced public reporting and payment policies.

By **KEVIN B. O'REILLY**, amednews staff. *Posted June 27, 2011.*

The National Quality Forum in June proposed an updated version of its list of serious reportable events, such as medication errors that kill or gravely injure patients.

Hospitals in 24 states and the District of Columbia are required to report on some version of the National Quality Forum's list, and items from the list have been selected for nonpayment by private health plans, Medicare and many state Medicaid programs.

Four new items -- part of the first update to the list since 2006 -- are:

- Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen (e.g., for a biopsy).
- Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
- Death or serious injury of a patient or staff associated with the introduction of a metallic object into the magnetic resonance imaging area.

The list now contains 29 serious reportable events.

"Our objective is to identify important events that need to have some light shined on them so action is taken, because they're resulting in patients being seriously harmed or dying," said Janet M. Corrigan, PhD, president and CEO of the National Quality Forum, a standards-setting organization that counts the American Medical Association as one of hundreds of members. "The intent in encouraging public reporting is to promote actions that result in safer systems so it doesn't happen again."

When adopted in 2002, NQF officials touted the medical mistakes in its reporting list as "never events" -- errors that never should occur. The term prompted backlash from some physicians. Doctors said that despite efforts to adhere to best practices, mistakes sometimes happen, and that using the word "never" held physicians and others in health care to an impossible standard.

NQF now shies away from the term -- and for good reason, said Gregg S. Meyer, MD, co-chair of the committee that proposed the updated list.

"We would like to think we'd always do our best to prevent serious pressure ulcers from occurring, for example, but the fact is some patients in extreme circumstances will get pressure ulcers," said Dr. Meyer, senior vice president of the Center for Quality and Safety at Massachusetts General Hospital in Boston. "The notion that these things should never happen is demeaning to the medical community and disheartening."

Indeed, the organization's criteria for items on its serious reportable events list is that they be "largely preventable," not that they always could be avoided in the current health care environment.

Dr. Meyer said the new list moves patient safety forward by moving beyond the hospital environment in search of opportunities for improvement. Missed test results, for example, can seriously harm patients in the office-based setting as well as in the hospital. He said that even without interoperable health information technology systems, physicians can use "closed-loop" communication techniques to ensure that the right information about test results gets shared among physicians and with patients.

Is public reporting working?

Despite the influence the NQF's list has had in mandated reporting and payment policies, its effectiveness in improving safety is yet to be proved definitively.

Many states where reporting of serious mistakes is required have shown no substantial drop since hospitals started sharing the information publicly. In Connecticut, for example, hospitals submitted information on 239 serious mistakes in the first year of public reporting in 2005. That figure rose to 265 in 2009, the last full year of public reporting data available in the state.

Reporting varies by hospital, making it difficult to tell whether a rise in reported incidents reflects worsening safety or a more vigorous approach to sharing information about mistakes, said John Santa, MD, MPH, director of the *Consumer Reports* Health Ratings Center.

He applauded the new items added to NQF's list. But Dr. Santa said hospitals should be federally required to share

much more information about patient safety, such as the incidence of many different types of health care-associated infections.

"Most of us on the consumer side see the never-events list as a floor, not a ceiling," Dr. Santa said. "This is just a minimum of the things that everyone agrees shouldn't be happening."

Dr. Meyer, of Massachusetts General Hospital, said he believes sharing information about serious mistakes is hard to do but important.

"If you go to our hospital website, you'll see that we put these things out there, and I think we're better for it. It's not a comfortable thing to do, but it's something that we believe is right," he said.

Physicians and others have until July 12 to comment on the revised serious reportable events list.

ADDITIONAL INFORMATION:

Required reporting

Twenty-four states and the District of Columbia require hospitals to share publicly serious reportable events such as wrong-site surgeries.

- California
- Colorado
- District of Columbia
- Florida
- Georgia
- Illinois
- Kansas
- Maine
- Maryland
- Massachusetts
- Minnesota
- Nevada
- New Hampshire
- New Jersey
- New York
- Ohio
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Utah
- Vermont
- Washington

Source: National Quality Forum

To comment on the revised list

The National Quality Forum will accept comments on the revised serious reportable events list by email until July 12 (appeals@qualityforum.org).

WEBLINK

"Serious Reportable Events in Healthcare -- 2011 Update: A Consensus Report," National Quality Forum, March 18 (www.qualityforum.org/workarea/linkit.aspx?Itemid=54409)

Massachusetts General Hospital's list of serious reportable events (qualityandsafety.massgeneral.org/measure/sre.aspx?id=720)

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