National Quality Forum
Patient Safety Initiatives

Melinda L. Murphy, RN, MS, CNA
NQF Facts

- a private, not-for-profit membership organization
- 375+ organizations representing every sector of the healthcare system
- voluntary consensus standards setting body as specified by NTTAA
- uses a specific process for setting standards (consensus, openness, balance of interest, appeals; encourages federal government participation)
NQF-endorsed Patient Safety Products

- Safe Practices
- Serious Reportable Events (SRE)
- Patient Safety Taxonomy
- Others
  - Patient experience – HCAHPS
  - Setting-specific – Hospital, NH, HH, AC
  - Physiologic-specific – Cardiac, DM
  - Discipline-specific – Nursing-sensitive care
NQF – endorsed™
Serious Reportable Events
Serious Reportable Events in Healthcare 2006 Update

A CONSENSUS REPORT
Adverse events are a major healthcare quality problem

Patient harm common; most preventable

Desire to agree on set of events that could form basis for national state-based reporting and improvement

Public accountability

Safety improvement
“The public expects healthcare professionals and providers and their organizations to take all necessary steps to ensure that care is safe and the public looks to government and other oversight authorities to make sure that this is done.”
SRE in Healthcare

- Originally endorsed 2002, updated 2006
- 28 events
- 6 event types
2002 SRE Selection Process

- Committee of stakeholders set criteria, collected and reviewed potential SREs
- Advisory panel of state health policy makers gave insights about state adoption
- Literature, including National Academy for State Health Policy report, reviewed
- Survey of states’ requirements
- Input from NQF Members/non-members
To be included, events are:

- of concern to public & healthcare professionals & providers;
- clearly identifiable, measurable and thus feasible to include in a reporting system;
- of a nature such that the risk of occurrence is significantly influenced by policies & procedures of the organization.
An event must be unambiguous, usually preventable, serious, and any of:

- adverse; and/or
- indicative of a problem in the facility’s safety systems; and/or
- important for public credibility or public accountability
2006 SRE Update

- Committee of stakeholders including from 2002 group
- Survey of state adopters
- Criteria affirmed
- Material change to 6 events, 1 new event
- Definitions and implementation guidance added
Surgical Events

1. Surgery on wrong body part
2. Surgery on wrong patient
3. Wrong surgical procedure
4. Unintended retention of foreign object
5. Death of ASA Class 1 patient, intra- or immediate post-op
Product or Device Events

Death or serious disability associated with:
1. Use of contaminated drugs, devices or biologics
2. Use or function of device in patient care where device is used or functions other than as intended
3. Intravascular air embolism
Patient Protection Events

1. Infant discharged to wrong person
2. Patient death or disability associated with patient elopement
3. Patient suicide, or attempted suicide resulting in serious disability
Patient death or serious disability:
1. associated with medication error
2. associated with hemolytic reaction due to administration of ABO/HLA incompatible blood/products
3. associated with hypoglycemia, when onset occurs while patient being cared for in healthcare facility
4. associated with failure to identify and treat hyperbilirubinemia in neonates
5. due to spinal manipulative therapy
6. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility
7. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
8. Artificial insemination with the wrong donor sperm or wrong egg
Patient death or serious disability associated with:
1. electric shock
2. burn incurred from any source
3. fall
4. use of restraints or bedrails while being cared for in a healthcare facility.
5. 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.
Criminal Events

1. Care ordered or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
2. Abduction of a patient of any age
3. Sexual assault on patient within or on grounds of healthcare facility
4. Death or significant injury of patient or staff from physical assault
Outcomes to patients are serious
All are largely preventable
The events continue to happen
Healthcare industry at all levels should be proactive
- Potential patients should be made aware
- Patients/families who experience the events should be told
- Incentives and demand for improvement should be created
Welcome to the National Quality Forum

REGISTER NOW
Spring Meeting and Conference on Care Coordination
March 26-28, 2008
Advanced registration closes March 14

15th ANNUAL NQF QUALITY HEALTHCARE AWARD
Congratulations to Baylor Health Care System.
Join us at a Gala Reception and Dinner to celebrate Baylor's achievement.
Overview of Award | Prior Recipients

CAREERS AT NQF

The National Quality Forum is a private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting. Learn more about the NQF

03.06.08
NQF's President and CEO Testifies Before Congressional Committee on Hospital Value-Based Purchasing
Read / Print Dr. Corrigan's submitted testimony

03.10.08
NQF Schedule of Events