NQF to Update and Harmonize Serious Adverse Event Reporting Criteria Essential to Protect Patients From Preventable Harm

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'Focus on HARM' initiative to refresh 'Never Events' to reflect the full range of today's care delivery settings and develop consensus on reporting standards

Washington, DC – The National Quality Forum (NQF) has launched a "Focus on HARM" patient safety initiative to address the high rates of avoidable medical errors and preventable patient harms that continue despite decades of efforts to remediate these events. A 2022 report from the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) found that 25 percent of Medicare patients were harmed during hospital stays in October 2018, and 43 percent of those were preventable. The Focus on HARM (Harmonizing Accountability in Reporting and Monitoring) initiative will begin by re-examining the most egregious events, often referred to as "Never Events" because they should never occur in healthcare. These events were first defined by NQF in 2002 with the introduction of the Serious Reportable Event (SRE) list.

Focus on HARM aims to reduce preventable harm by first modernizing the criteria for what constitutes an SRE and aligning standards for reporting such events across different accountability systems—an essential step to strengthen efforts to pinpoint and address the causes of preventable harm.

NQF founding CEO, Kenneth W. Kizer, coined the phrase "Never Events" in 2001 to describe particularly flagrant medical errors, such as a foreign object left inside a surgical patient. To be included on the SRE—or "Never Events"—list, harmful clinical events must be serious, unambiguous, and largely preventable. The list, maintained through periodic updates, is used by national and state-based event reporting systems to increase accountability and improve patient safety. Currently, 28 states and the District of Columbia use the SRE list or elements of it for mandatory accountability reporting.

Today's healthcare landscape has changed significantly since the list's last update—care is increasingly delivered in different settings and modalities, including ambulatory care facilities, home care, and telehealth—necessitating a review of the SREs and the specifications used to define them.

"The lack of reliable, consistent, objective data standards related to measuring patient safety events limits our ability to quantify the magnitude of the problem and track our progress as we mitigate avoidable patient harm," said Dana Gelb Safran, ScD, President & CEO, NQF. "This work represents a critical and overdue step needed to enable systematic measurement, tracking, and improvement as we continue national efforts to make healthcare safe for every patient, every time, in every setting."

In its recent Report on Transforming Patient Safety, The President's Council of Advisors on Technology and Science (PCAST) underscored the urgent need to upgrade public reporting of serious, avoidable harm events as a national priority for patient safety improvement. With NQF's long history serving as a public-private partnership and support from Elevance Health as the launching sponsor, the initiative will address this need, first by engaging a diverse range of healthcare stakeholders to develop consensus on updating and modernizing the SRE list.

"The root causes of avoidable patient harm events are most often systemic failures," said NQF Board Member Dora Hughes, MD, MPH, Acting Chief Medical Officer and Acting Director of the Center for Clinical Standards and Quality (CCSQ) for the Centers for Medicare & Medicaid Services (CMS). "Reducing preventable harm to patients starts with having accurate data so that common, recurring systemic problems contributing to harm events can be quickly identified and addressed."

"Patient safety is a national priority, and it is imperative that we take action to reduce errors, which include diagnoses that are either inaccurate, delayed, or not communicated to the patient," said NQF Board Member Robert Otto Valdez, PhD, MHSA, Director of the Agency for Healthcare Research and Quality (AHRQ). "By updating the criteria we use to classify and report on events that harm patients across healthcare systems and care settings, we can harness improved data to accelerate research, development, and implementation of policies and technologies to fuel much-needed improvements in patient safety in the United States."

The project also aims to reduce the burden on providers of multiple, differing, unaligned patient safety event reporting structures by developing consensus on common reporting standards. NQF will convene a broad array of stakeholders to establish a consensus-based, unified framework for harmonizing the taxonomies used to track and report patient safety events.

“Currently, different reporting systems may require a hospital or other healthcare provider to report a single patient harm event to multiple entities in multiple, different formats, creating additional administrative burden on health systems but doing little to improve patient safety,” said Shantanu Agrawal, MD, MPhil, Chief Health Officer, Elevance Health. “Streamlining taxonomies will help reduce inconsistencies in the data that currently hinder efforts to track, compare, and reduce preventable harm—all critical steps necessary to improve accountability.”

Building on the updated SRE list and taxonomy framework, in the next stage of work, NQF will convene multistakeholder experts to develop novel approaches that sustainably improve accountability for patient safety and harm reduction. The findings and consensus-based recommendations will be shared with healthcare systems and providers, federal and state agencies, and other organizations to bolster safety improvement efforts across healthcare settings.

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