**National Quality Forum's list of Serious Reportable Events
Summary of 2011 Changes**

1. For all events where "patient death or serious disability" was part of the event description, the term has been replaced by "patient death or serious **injury**". This change broadens reporting expectations by lowering the reporting threshold. This change should result in an increase in number of events reported.

2. For all events where "health care facility" was part of the event description, the term has been replaced by "health care **setting**". The NQF intended to broaden the types of facilities that report adverse events. Washington law specifies the types of health care facilities required to report adverse events. This NQF change will not affect the types of health care facilities required to report in Washington State.

3. The Surgical Events category was broadened to include surgery **or other invasive procedures**. The intent was to expand reportable surgical events to include those that may occur outside the traditional operating room. The implementation guidance and glossary clarify the intent.

4. The Patient Protection Events category had two specific changes:
   a. Infant discharged to wrong person was broadened to include discharge or release of a patient/resident **of any age, who is unable to make decisions**, to other than an authorized person.
   b. Patient suicide, attempted suicide was expanded to include **self-harm** that results in serious injury.

5. The Care Management Events category had one specific change and three new events were **added**:
   a. Pressure ulcers were broadened to include unstageable pressure ulcers.
   b. **Added:** Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
   c. **Added:** Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
   d. **Added:** Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

6. Three Care Management events were **retired**:
   a. **Retired:** Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
   b. **Retired:** Death of serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.
   c. **Retired:** Patient death or serious disability due to spinal manipulative therapy.

7. A new category for Radiologic Events was created. One radiologic event was identified:
   a. **Added:** Death of serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

8. In the Potential Criminal Events category, sexual assault on a patient was broadened to include **sexual abuse/assault on a patient or staff member**.