Comments to National Quality Forum
Definition of Serious Reportable Events
February 2, 2010

Consumers Union appreciates the opportunity to comment on the proposed changes to the National Quality Forum's definition of "serious reportable events." We have reviewed the rationale for the suggested changes and believe they will significantly set back the focus on public reporting and prevention of serious harm to patients.

"Adverse events that should never occur" vs. "…should not occur"

We strongly object to the change of "never" to "not." While there is little apparent difference in meaning between saying an event should never occur or that it should not occur, in this context this change represents a not-so-subtle shift in policy. And, rather profoundly in this context, words matter. Moreover, the proposal clearly indicates that the committee is recommending the change to create a new meaning of "serious reportable events." Specifically, the proposal states: "There was concern with the concept that all SREs are entirely preventable when it is recognized some SREs are not always preventable in certain circumstances."

The fact that SREs will occur is irrelevant to whether they should never occur. To change this language based on the belief that these events can never, in fact, be eradicated takes us back to the days of complacency and inevitability. We challenge the concept that there are no solutions to preventing serious reportable events as claimed by the proposal: "The use of the word "never" may imply that a solution exists for preventing SREs from ever occurring, which is not always the case." These are not randomly occurring events, they happen when errors are made or patients are neglected or some other action was not taken. Only when every proven prevention practice is used with every patient, should we begin talking about what is and is not preventable.

This change in language and ultimately the change in the meaning of SRE sends the wrong message to the public and medical professionals at a time when more attention is focused on prevention and reaching for a goal of zero for these harmful events.

Reporting common vs. rare events

The proposal further states that the change would allow reporting of routine events rather than rare events "that many institutions may not ever see or, at best, see only

sporadically." We believe that calling events that harm millions of patients and kill over 100,000 each year "rare" demonstrates a lack of perspective on the scope of this problem. We challenge the accuracy of this and believe this perception has contributed to a lack of urgency in preventing medical errors. Any other preventable problem existing in our culture that caused this volume of deaths and injuries would "never" be acceptable. Most recently, witness the concern around the Toyota accelerator problems and Toyota's response---suspension of sales and recall of millions of cars – all due to a problem that by all accounts has led to fewer than 50 deaths.

The proposal also recommends keeping the term "serious" (thus, not necessarily "routine" events) but to change it's meaning from events that result in "death or loss of a body part, disability or loss of bodily function …" to events that "can result in death or loss of a body part, disability or loss of bodily function or risk thereof"). This strikes us as a diversion that could confuse the public and medical professionals – is the event serious or potentially serious? The proposal claims this is to broaden SREs to "encourage reporting of close calls or near miss events." But there is absolutely no movement to publicly report those kinds of events and there's a great deal of skepticism about the ability to accurately account for near misses. Our concern is that these changes are being made to focus attention away from public reporting and toward "internal" (non-public, secret) reporting through such entities as "Patient Safety Organizations." This sort of confidential reporting has been the norm for decades and has not led us to a safer health care system.

If there is a desire to broaden public reporting of other events, not only SREs, it should be done by creating a new definition of those types of events and not attempting to substitute them for the truly serious events. We agree reporting of less serious events could provide a clearer picture of a hospital's safety record – e.g. the reporting of all falls, not just those that cause serious harm. However, we question whether this is a realistic goal in a world where reporting of significant harm continues to be minimal. Although reporting only falls that cause disability or death may fail to capture the complete picture of a hospital's safety, realistically the falls that cause harm are the ones that will come to the attention of caregivers for documentation, whereas falls that have no harmful consequences might not even be noticed and would be difficult to document in a verifiable manner. Another example of this is with hospital-acquired infections. We advocate reporting all hospital infections, not just those causing serious harm, but realistically, those are going to be the ones identified by hospitals. Many patients with hospital infections will get a treatment of antibiotics after discharge and the problem is resolved. As much as we would like to know about all infections for surveillance and prevention purposes, the hospital is unlikely to ever know or report these.

Thank you again for the opportunity to comment.

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