

## Adverse Events List

### National Quality Forum (NQF) Serious Reportable Events

Adverse events are medical errors healthcare facilities could and should have avoided. The National Quality Forum (NQF) has identified the following 28 adverse event types that state law requires facilities to report whenever they occur. Definition of terms, additional specifications and guidance follow on pages 2 – 12. To download the full NQF report click on this [link](#).

Surgical Events	
1.	Surgery performed on the wrong body part
2.	Surgery performed on the wrong patient
3.	Wrong surgical procedure performed on a patient
4.	Unintended retention of a foreign object in a patient after surgery or other procedure
5.	Intraoperative or immediately post-operative death in an ASA Class 1 patient
Products or Device Events	
6.	Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
7.	Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended
8.	Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
Patient Protection Events	
9.	Infant discharged to the wrong person
10.	Patient death or serious disability associated with patient elopement (disappearance)
11.	Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility
Care Management Events	
12.	Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong routes of administration)
13.	Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
14.	Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while cared for in the healthcare facility
15.	Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
16.	Patient death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
17.	Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
18.	Patient death or serious disability due to spinal manipulative therapy
28.	Artificial insemination with the wrong donor sperm or egg
Environmental Events	
19.	Patient death or serious disability associated with electric shock while being cared for in a healthcare facility
20.	Any incident in which a line designed for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
21.	Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
22.	Patient death or serious disability associated with a fall while being cared for in a healthcare facility
23.	Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
Criminal Events	
24.	Any instance of care ordered by a or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
25.	Abduction of a patient of any age
26.	Sexual assault on a patient within or on the grounds of a healthcare facility
27.	Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

*DOH recommends using the listed criteria and definitions in determining whether an adverse event has occurred.*

### Box A – Criteria and Definitions

#### Criteria for Inclusion

Items included on the list of Serious Reportable Events in Healthcare are events that are:

- of concern to both the public and healthcare professionals and providers;
- clearly identifiable and measurable and thus feasible to include in a reporting system; and
- of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility.

In addition, to qualify for the list, an event must be unambiguous, usually preventable, serious, and any of the following:

- adverse; and/or
- indicative of a problem in a healthcare facility's safety systems; and/or
- important for public credibility or public accountability.

#### Definitions of Terms Used in the Criteria

- **Event** means a discrete, auditable, and clearly defined occurrence.
- **Adverse** describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.
- **Preventable** describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
- **Serious** describes an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility or, when referring to other than an adverse event, an event the occurrence of which is not trivial.
- **Unambiguous** refers to an event that is clearly defined and easily identified.
- **Usually preventable** recognizes that some of these events are not always avoidable, given the complexity of healthcare; therefore, the presence of an event on the list is not an a priori judgment either of a systems failure or of a lack of due care.

### Box B – Definitions of Key Terms

- **Associated with** means that it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship.
- **Disability** means a physical or mental impairment that substantially limits one or more of the major life activities of an individual. (This report acknowledges that states and other entities may use alternate definitions for the term disability. The definition used by NQF was derived from the Americans with Disabilities Act: 5 U.S.C.301; 28 U.S.C. 509, 510; 42 U.S.C. 12186(b). Source: Order No. 1513-91, 56 FR 35592, July 26, 1991.)
- **Healthcare facility** means any licensed facility that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence, or other care of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare facilities include, but are not limited to, hospitals, nursing homes, rehabilitation centers, medical centers or offices, outpatient dialysis centers, reproductive health centers, independent clinical laboratories, hospices, and ambulatory surgical centers.

To download the full NQF report click on this [link](#).

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

*Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.*

**SURGICAL EVENTS**

EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE <sup>i</sup>
<p><b>A. / DOH event 1.</b>  <b>Surgery performed on the wrong body part</b></p>	<p>Defined as any surgery performed on a body part that is not consistent with the correctly documented informed consent for that patient<sup>ii</sup>.            Surgery includes endoscopies and other invasive procedures.            Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), level (spine).</li> <li>▪ Wrong site surgery, even if corrected intraoperatively, as long as the surgery had begun, based on the definition below.</li> </ul> <p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Changes in plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).</li> </ul> <p>Surgery is defined as an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include the use of instruments such as otoscopes or procedures such as drawing blood.</p> <p>Organizations may choose to adopt a list of surgical procedures to supplement the definition above; for example, the Institute of Clinical Systems Improvement list of procedures is commonly used.</p> <p>Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.</p> <p>Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).</p> <p>Although an incorrectly placed surgical mark could result in surgery being performed on the wrong body part, surgery does not begin at the time a surgical mark is made on the patient. Placing a mark on the wrong body part does not in itself constitute wrong site surgery.</p>

i. Implementation guidance amplifies statements in the event and additional specifications based on the experience of those organizations/entities that have implemented the reporting of the events and the recommendations of NQF Members and the public. As such, the guidance does not purport to be—nor is it required to be— either comprehensive or uniform across the events.

ii. Except in the case of an emergency, a physician must obtain a patient’s agreement (informed consent) to any course of treatment. Physicians are required to tell the patient anything that would substantially affect his or her decision. Such information typically includes the nature and purpose of the treatment, including its risks and benefits, and alternative courses of treatment, including risks and benefits. The American Medical Association definition of informed consent is “a process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention” (see [www.ama-assn.org/ama/pub/category/4608.html](http://www.ama-assn.org/ama/pub/category/4608.html)).

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

**1. SURGICAL EVENTS (continued)**

EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p><b>B. / DOH event 2.</b> <b>Surgery performed on the wrong patient</b></p>	<p>Defined as any surgery on a patient that is not consistent with the correctly documented informed consent for that patient.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Surgical procedures (whether or not completed) initiated on one patient that were intended for a different patient.</li> </ul> <p>Surgery is defined as an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include the use of instruments such as otoscopes or procedures such as drawing blood.</p> <p>Organizations may choose to adopt a list of surgical procedures to supplement the definition above; for example, the Institute of Clinical Systems Improvement list of procedures is commonly used.</p> <p>Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.</p> <p>Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).</p>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

**1. SURGICAL EVENTS (continued)**

EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p><b>C. / DOH event 3.</b> <b>Wrong surgical procedure performed on a patient</b></p>	<p>Defined as any surgical procedure performed on a patient that is not consistent with the correctly documented informed consent for that patient.</p> <p>Surgery includes endoscopies and other invasive procedures.</p> <p>Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Insertion of the wrong medical implant into the correct surgical site.</li> </ul> <p>This event is not intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Changes in plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).</li> </ul> <p>Surgery is defined as an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include the use of instruments such as otoscopes or procedures such as drawing blood.</p> <p>Organizations may choose to adopt a list of surgical procedures to supplement the definition above; for example, the Institute of Clinical Systems Improvement list of procedures is commonly used.</p> <p>Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.</p> <p>Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).</p>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

SURGICAL EVENTS (continued)		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p><b>D. / DOH event 4.</b></p> <p><b>Unintended retention of a foreign object in a patient after surgery or other procedure</b></p>	<p>Excludes a) objects present prior to surgery that are intentionally left in place; b) objects intentionally implanted as part of a planned intervention; and c) objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention (such as microneedles, broken screws).</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>▪ Occurrences of unintended retention of objects at any point after the surgery ends, regardless of setting or of whether the object is removed.</li> </ul> <p>Surgery is defined as an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include the use of instruments such as otoscopes or procedures such as drawing blood.</p> <p>Organizations may choose to adopt a list of surgical procedures to supplement the definition above; for example, the Institute of Clinical Systems Improvement list of procedures is commonly used.</p> <p>Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.</p> <p>Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).</p>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

SURGICAL EVENTS (continued)		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p><b>E. / DOH event 5.</b></p> <p><b>Intraoperative or immediately postoperative death in an ASA Class I patient</b></p>	<p>Includes all ASA Class I patient deaths in situations in which anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>Immediately postoperative means within 24 hours after surgery or other invasive procedure was completed, or after administration of anesthesia (if surgery was not completed).</p>	<p>This event is intended to capture:</p> <ul style="list-style-type: none"> <li>▪ ASA Class I patient death associated with the administration of anesthesia, whether or not the planned surgical procedure was carried out.</li> </ul> <p>Surgery is defined as an invasive operative procedure in which skin or mucous membranes and connective tissue is incised or an instrument is introduced through a natural body orifice. Surgeries include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include the use of instruments such as otoscopes or procedures such as drawing blood.</p> <p>Organizations may choose to adopt a list of surgical procedures to supplement the definition above; for example, the Institute of Clinical Systems Improvement list of procedures is commonly used.</p> <p>Surgery begins, regardless of setting, at the point of surgical incision, tissue puncture, or the insertion of an instrument into tissues, cavities, or organs.</p> <p>Surgery ends after counts have concluded, the surgical incision has been closed, and/or operative device(s) such as probes have been removed, regardless of setting (e.g., postanesthesia recovery unit, surgical suite, endoscopy unit).</p>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

PRODUCT OR DEVICE EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<p><b>A. / DOH event 6.</b> <b>Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility</b></p>	<p>Includes detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.</p>	<p>The term detectable is intended to capture contaminations that can be seen with the naked eye or with the use of detection mechanisms that are in general use; these contaminations are to be reported when they become known to the provider or healthcare facility. Detection mechanisms may include cultures and tests that signal changes in pH or glucose levels.</p>
<p><b>B. / DOH event 7.</b> <b>Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended</b></p>	<p>Includes, but is not limited to, catheters, drains and other specialized tubes, infusion pumps, and ventilators.</p>	<p>This event is intended to capture occurrences whether or not the use is intended or described by the device manufacturers' literature.</p> <p>The Food and Drug Administration defines medical device as "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is:</p> <ul style="list-style-type: none"> <li>▪ recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,</li> <li>▪ intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or</li> <li>▪ intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes." </li></ul>
<p><b>C. / DOH event 8.</b> <b>Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility</b></p>	<p>Excludes death or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p>	<p>High-risk procedures, other than neurosurgical procedures, that include a small but known risk of air embolism are reportable under this event, including, but not limited to, those involving the head and neck, vaginal delivery and cesarean section, spinal instrumentation procedures, and liver transplantation.</p>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

PATIENT PROTECTION EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<b>A. / DOH event 9.</b> <b>Infant discharged to the wrong person</b>		Stedman's Online Medical Dictionary defines an infant as a child under the age of one year.
<b>B. / DOH event 10.</b> <b>Patient death or serious disability associated with patient elopement (disappearance)</b>	Excludes events involving competent adults.	This event is not intended to capture death or serious disability that occurs due to circumstances unrelated to the elopement (after the patient is located).  The term competent adult should be interpreted in accordance with prevailing legal standards.
<b>C. / DOH event 11.</b> <b>Patient suicide, or attempted suicide, resulting in serious disability while being cared for in a healthcare facility</b>	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility.	This event is not intended to capture patient suicide or attempted suicide when the patient is not physically present in the "healthcare facility" (defined in box B, previously).
CARE MANAGEMENT EVENTS		
<b>A. / DOH event 12.</b> <b>Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)</b>	Excludes reasonable differences in clinical judgment involving drug selection and dose.  Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.	This event is intended to capture: <ul style="list-style-type: none"> <li>▪ The most serious medication errors, including occurrences in which a patient known to have serious allergies to specific medications/ agents receives those medications/agents, resulting in serious harm or death. These events may occur as a result of failure to collect allergy information; failure to review available allergy information; failure to assure the availability of allergy information and prominently display it; or through other system failures that are determined by investigation to be the cause of the adverse event.</li> <li>▪ Occurrences in which a patient dies or suffers serious disability as a result of failure to administer a prescribed medication.</li> <li>▪ Occurrences in which a patient dies or suffers serious disability as a result of the wrong administration technique.</li> </ul> This event is not intended to capture: <ul style="list-style-type: none"> <li>▪ Patient death or serious disability associated with allergies that could not reasonably have been known or discerned in advance of the event.</li> <li>▪ All situations in which two or more medications are administered for which there are drug-drug interactions with known potential for death or serious disability—only those that result in death or serious disability.</li> </ul>
<b>B. / DOH event 13.</b> <b>Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products</b>		This event is not intended to capture: <ul style="list-style-type: none"> <li>▪ Patient death or disability associated with organ rejection, other than those attributable to a hyperacute hemolytic reaction.</li> <li>▪ Patient death or disability when the cause is not detectable by ABO/HLA matching.</li> </ul>

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

CARE MANAGEMENT EVENTS continued		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<b>C. / DOH event 14.</b> <b>Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility</b>	<p>Includes events that occur within 42 days post-delivery.</p> <p>Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.</p>	<p>This event is not intended to create a new obligation; the organization's obligation is to report the event when it is made aware of the maternal death or serious disability either by re-admittance or by the patient's family.</p> <p>A low-risk pregnancy is defined as a pregnancy occurring in a woman aged 18-39 who has no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome.<sup>iii</sup></p>
<b>D. / DOH event 15.</b> <b>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>		<p>Hypoglycemia is defined as blood glucose levels &lt;60mg/dL (ICD-9, 251.0).</p>
<b>E. / DOH event 16.</b> <b>Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates</b>	<p>Hyperbilirubinemia is defined as bilirubin levels &gt;30 mg/dl.</p> <p>Neonate refers to the first 28 days of life.</p>	<p>The organization's obligation is to report the event when it is made aware of the death or serious disability either by re-admittance or by the patient's family.</p>
<b>F. / DOH event 17.</b> <b>Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility</b>	<p>Excludes progression from Stage 2 to Stage 3, if Stage 2 was recognized upon admission.</p>	
<b>G. / DOH event 18.</b> <b>Patient death or serious disability due to spinal manipulative therapy</b>		<p>Spinal manipulative therapy encompasses all types of manual techniques, including spinal mobilization (movement of a joint within its physiologic range of motion) and manipulation (movement beyond its physiologic range of motion), regardless of their precise anatomic and physiologic focus or their discipline of origin. iv</p>
<b>H. / DOH event 28.</b> <b>Artificial insemination with the wrong donor sperm or wrong egg</b>		<p>The organization's obligation is to report the event when it is made aware of the occurrence.</p>

iii. NQF, Serious Reportable Events in Healthcare: A Consensus Report, NQF: Washington, DC; 2002.

iv. NQF, Serious Reportable Events in Healthcare: A Consensus Report, NQF: Washington, DC; 2002.

Excerpt from The National Quality Forum (NQF)  
**Serious Reportable Adverse Events in Healthcare, 2006 Update: A Consensus Report**

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

ENVIRONMENTAL EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<b>A. / DOH event 19.</b> <b>Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility</b>	Excludes events involving planned treatments such as electric countershock/elective cardioversion.	This event is intended to capture: <ul style="list-style-type: none"> <li>▪ Patient death or disability associated with unintended electric shock during the course of care or treatment.</li> </ul> This event is not intended to capture: <ul style="list-style-type: none"> <li>▪ Patient death or disability associated with emergency defibrillation during ventricular fibrillation or electroconvulsive therapies.</li> </ul>
<b>B. / DOH event 20.</b> <b>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</b>		
<b>C. / DOH event 21.</b> <b>Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility</b>		
<b>D. / DOH event 22.</b> <b>Patient death or serious disability associated with a fall while being cared for in a healthcare facility</b>	Includes but is not limited to fractures, head injuries, and intracranial hemorrhage.	
<b>E. / DOH event 23.</b> <b>Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility</b>		The event is intended to capture instances in which restraints are implicated in the death; for example, the use led to strangulation/ entrapment. Death/disability resulting from falls caused by lack of restraints would be captured under falls.  Restraint is currently defined by the Joint Commission, by the Centers for Medicare and Medicaid Services, and by some states. If none of those definitions apply to an institution, the following definition, which is intended to comprise definitions from the named organizations, is offered: Restraint is defined as any method of restricting a patient's freedom of movement that: is not a usual and customary part of a medical diagnostic or treatment procedure to which the patient or his or her legal representative has consented; that is not indicated to treat the patient's medical condition or symptoms; or that does not promote the patient's independent functioning.v

v. Adapted from the Joint Commission, Comprehensive Accreditation Manual Refreshed Core; 2006.

Note: This document has been modified from its original format. Modifications include listing Event Type with DOH numbering, for example, "Event A. Surgery Performed on the wrong body part" will be designated as "DOH event 1." Additional specifications and guidance provided by "DOH" in blue text.

CRIMINAL EVENTS		
EVENT	ADDITIONAL SPECIFICATIONS	IMPLEMENTATION GUIDANCE
<b>A. / DOH event 24.</b> <b>Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider</b>		
<b>B. / DOH event 25.</b> <b>Abduction of a patient of any age</b>		
<b>C. / DOH event 26</b> <b>Sexual assault on a patient within or on the grounds of a healthcare facility</b>		<p>Language and definitions may vary based on state statute (e.g., many states have existing statutes that may use the terms sexual assault or simple assault or criminal sexual conduct); however, the principle and intent remain regardless of the language required based on jurisdiction.</p> <p>DOH: The Joint Commission definition of "rape," includes the requirement of one of the three corroborating factors- staff-witnessed or witness by other credible source, clinical evidence or perpetrator admission.</p> <ul style="list-style-type: none"> <li>▪ In cases where there is an allegation of sexual assault, followed by a potentially unreliable admission of assault (e.g., a patient in a delirious or psychotic state), the facility will: <ul style="list-style-type: none"> <li>○ Assess the impact of the alleged perpetrator's illness on their admission of assault</li> <li>○ Decide if the admission of assault is reliable; and</li> <li>○ Proceed with a registry report if the Joint Commission definition of rape is met.</li> </ul> </li> </ul> <p>The event would be a reportable at the point at which it is substantiated by the facility. Substantiated means that it meets the definition recommendations regardless of whether there are criminal charges filed.</p>
<b>D. / DOH event 27.</b> <b>Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility</b>		<p>Language and definitions may vary based on state statute (e.g., many states have existing statutes that use the terms first degree assault or second degree assault or battery).</p>

To download the full NQF report click on this [link](#).