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Executive Office of Health and Human Services
Department of Public Health
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Circular Letter: DHCQ 08-06-489

TO: Hospital Chief Executive Officers
Risk Managers

FROM: Paul Dreyer, Ph.D.
Bureau Director

Stancel Riley, MD.
Director, PCA Division
Board of Registration in Medicine

DATE: June 4, 2008

SUBJECT: Hospital Reporting of Serious Incidents (SREs)

This letter is intended to provide hospitals with additional guidance regarding the reporting of incidents that meet the definition of a "serious reportable event" and to supplement the information contained in Circular Letter DHCQ 07-12-478.

The Department, in consultation with the Board of Registration in Medicine and its partners in the hospital community, seeks to provide additional information that will promote consistency among all Massachusetts hospitals in determining what constitutes a serious reportable event.

In order to determine whether a hospital event is a serious reportable event, hospital staff responsible for reporting such events must be familiar with the criteria for reporting and with applicable definitions, especially the definition of "serious disability", which is used extensively in the NQF process. We have attached for your use the current NQF definition of 'serious disability', as well as guidance issued by the Minnesota Hospital Association in conjunction with that state's Patient Safety Registry for determining whether a specific event outcome meets the definition of serious disability. In addition, hospital staff must be familiar with the NQF table of reportable events that list each of the 28 event types, together with any additional specifications and implementation guidance.

We would also like to clarify some recent confusion about whether or not the preventability of an event has any bearing on whether it meets the definition of an SRE. Several risk managers recently suggested to us that in instances where patients have fallen in spite of a properly executed care plan, the fall could not be classified as an SRE because it was not preventable. Please be advised that this interpretation is incorrect. If an event meets the definition of an SRE as contained in attachments 1-3, then that event must be reported as an SRE, whether or not it might have been preventable. Please note that the concept of 'preventability' is not discussed as a factor in any of the attached definitions.

The Department will continue to monitor incident reports made under state licensing regulations to determine if an incident appears to be a serious reportable event as well, and will follow up with hospitals on a case by case basis where there are questions.

Similarly, it is important to note that the regulatory requirements for reporting to PCA remain the same, and this letter only serves to provide guidance to health care facilities to determine whether an event reported pursuant to 243 CMR 3.08 would also qualify as an SRE. Nothing has changed with respect to the confidentiality protections PCA provides to Safety and Quality Reviews (SQRs) in accordance with Massachusetts law. (M.G.L. c.111, §§ 204 & 205 and 243 CMR 3.04)

Should you have any questions about this matter, or a specific event, please contact Lillian Jette at the Division of Health Care Quality at 617-753-8204 or Stancel Riley at the PCA at 617-654-9828.

Attachments:

1. NQF Table 1 – List of Serious Reportable Events
2. NQF Box A – Criteria for Inclusion and Definition of Terms Used in the Criteria
3. Minnesota Hospital Association "Definition of Serious Disability"