Aligning Patient Safety Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events Capstone Webinar

On Demand Webinar Transcript
March 2026

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Sentinel Events and Serious Reportable Events. I'm Jessica Woodruff, Project Manager, and today I'll be serving as this webinar's moderator. Please note CE credit is available for this webinar for participants joining the live broadcast and the on-demand recording that will be published afterward.

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Before we begin the webinar, we would like to offer just a few tips about webinar platform functionality. Audio is by voice over internet protocol only. Use your computer speakers, headphones to listen. There are no dial in lines. And participants are connected in listen only mode. Feedback or dropped audio are common for live streaming events. Refresh your screen if this occurs. We will not be recognizing the raise a hand or chat features. And to ask a question, click on the question mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are available and designed to follow Americans with Disability Act rules.

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Many attending this webinar will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout we've included with this webinar and also has been communicated within the webinar registration information. The attachment includes the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain certificate. So be sure to download that attachment to learn more. Credit is available for the live webinar broadcast and the on-demand recording that will be published afterward.

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The learning objectives are: Explain the alignment of Joint Commission's Sentinel Events List and the National Quality Forum's Serious Reportable Events List, identify the key four updates to NQF's SRE List, and use the report to review patient safety events for qualifications as SREs.

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All staff and subject matter experts have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content. I will now take a moment to introduce our speakers.

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Today's Capstone presentation will feature Elizabeth Mort, Vice President and Chief Medical Officer from Joint Commission, and Kimberly Streett, Director of Performance Improvement from National Quality Forum.

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Our panelists today will be Kristin Duncan, Senior Director of Patient Safety Risk Management from Texas Health Resources, Melinda Sawyer, Vice President and Chief Quality and Patient Safety Officer from United Health Group, and Carole Stockmeier, Senior Vice President of Safety and Reliability from Press Ganey.

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Today's agenda will address key updates to NQF's Serious Reportable Events and Joint Commission Sentinel Events, a panel discussion covering implications of the 2025 updates, and audience Q&A. I will stop here and turn things over to Kim Streett. Kim, whenever you're ready, please take it away.

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Thank you, Jessica. Hello everyone and thank you for joining us today. The goal of this webinar is to highlight key components of the recently published report, Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events. Whether you are deeply involved in patient safety event reporting or support a broader quality or risk program, our goal today is to give you practical takeaways you can use in your work. The updates will discuss and reflect meaningful changes in how Serious Reportable Events or SREs are defined, interpreted, and applied.

As we walk through the material, I encourage you to think about how these updates might affect your current review processes, reporting decisions, and internal discussions. With that context in mind, let's dive into the key updates to the NQF Serious Reportable Events and Joint Commission Sentinel Events.

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Before sharing what changed, I want to ground us in why the 2025 SRE List was updated. The goal was to develop a consensus-based, modernized SRE List and guidance that reflects how care is delivered today. At its core, this update centers on patient safety, focuses on serious and largely preventable events, and promotes more consistent reporting across settings.

As healthcare delivery has evolved, it was essential that the SRE List evolve as well, so it remains relevant, practical, and actionable. A key emphasis of this update is reducing ambiguity by providing clear, event-specific clinical application guidance to support more consistent decision-making across healthcare organizations and settings.

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Updating the SRE List was a large, consensus-based effort. NQF engaged more than 60 multi-stakeholder experts across multiple advisory groups to ensure the updates reflect today's healthcare landscape and patient safety priorities. Expert advisors guided the overall update to ensure balanced direction, while the expert panels evaluated events for inclusion and developed the clinical application guidance. Importantly, this work was also included in garnering public input. Members of the general public submitted feedback on the updated inclusion criteria, proposed events, and the draft SRE List. Collectively, this process was designed to ensure the updates to the SRE List and guidance are transparent, expert-informed, and broadly applicable across healthcare settings.

NQF launched the initial work in 2023 with support from Elevance Health and the Centers for Medicare & Medicaid Services. Recognize the importance of the project and its relevance to accredited organizations Joint Commission supported its completion throughout 2025.

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This effort resulted in the published report that we're here to talk about today. The report includes two distinct parts. Part one provides an overview of Joint Commission's plan to align with and adopt NQF's SRE List into its Sentinel Event List and a summary of the updates to the NQF SRE List itself. Part two provides detailed clinical application guidance designed to help healthcare organizations, care teams, and individuals who review Sentinel Events and or Serious Reportable Events determine whether an event qualifies as a Serious Reportable Event.

This section can also aid anyone who oversees, implements, or operationalize patient safety event reporting programs or who seeks information about SREs. Our goal is that this report becomes a useful tool for all healthcare organizations, care teams, and those individuals who review Sentinel Events and or Serious Reportable Events.

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Beginning in January 2027, Joint Commission will update the Sentinel Events List by adopting the updated NQF SRE List, the updated inclusion criteria, and the accompanying clinical application guidance detailed in the report. Alignment of these previously parallel measurement systems aims to reduce healthcare organization reporting burden and allows organizations to focus more on improvement. It's important to emphasize that reporting events to Joint Commission will remain voluntary. The report also provides a crosswalk showing how current Sentinel Events map to the updated Serious Reportable Events.

In addition to adopting the SRE List, Joint Commission will continue to champion workforce safety as a vital priority throughout its accredited healthcare organizations by maintaining three legacy workforce safety events, homicide of a staff member, sexual abuse or sexual assault of a staff member, and physical assault of a staff member.

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Recognizing that this alignment will be a significant change, Joint Commission will be offering multiple avenues of support to ensure organizations are informed, supported, and confident well ahead of the transition.

First, we'll be offering a series of webinars that take a deeper dive into the updated SREs and what adoption into the SRE List will mean in practice. These sessions are designed to build understanding incrementally and address common questions as they arise. In addition to webinars, we'll be hosting office hours. These are opportunities for you to ask questions about SREs, the alignment process, and topics covered in the webinars. Think of these as more interactive discussion-based sessions.

We'll also be sharing a chapter update that organizations can review in advance of the January 1, 2027 transition date. If questions come up as you're reviewing the report or thinking about how this applies in your organization, you can submit them at any time to SREinquiries@jointcommission.org. That inbox is monitored to ensure timely response to your questions related to SREs, Sentinel Events, as well as alignment.

Overall, this roadmap is about giving you multiple touch points, education, dialog, and written guidance so you're prepared for the transition.

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Now let's review the four major updates to the 2025 NQF Serious Reportable Events List: simplified SRE inclusion criteria, expanded applicable health care settings, updated events, and improved clinical application guidance. Even for experienced reviewers, these updates represent changes that may affect how events are evaluated and reported. A key goal of these updates is to decrease ambiguity in variation and interpretation, particularly across different settings and care environments. While Part 1 of the report introduces the upcoming alignment of Sentinel Events, it also provides the foundation for understanding these four updates to the SRE List. For the next several slides, we'll take each update in turn, focusing on what changed and how you can apply it in practice as a reviewer or program lead.

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The first major update to the 2025 SRE List is the SRE inclusion criteria. NQF streamlined both the criteria themselves and their definitions to foster alignment with patient safety advancements. For the 2025 SRE List, an event must meet three core criteria to qualify as an SRE. The event must be clearly tied to a patient encounter with the health care delivery system, the event must be serious, and the event must be largely preventable.

This represents a meaningful shift from the 2011 SRE inclusion criteria, which included other qualifiers: unambiguous, adverse, important for public credibility, and indicative of a problem in a health care setting safety systems. While these do not appear in the streamlined inclusion criteria, they are incorporated throughout the report, especially in the clinical application guidance. Importantly, while the criteria have been simplified, they remain intentionally rigorous, supported with definitions and additional information at the beginning of Part 2, and they serve as the foundation for the new clinical application guidance to support consistent interpretation, which we'll discuss in later slides.

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The second major update to the 2025 SRE List is the applicable health care settings. NQF recognized that serious patient safety events are not limited to traditional inpatient environments and can occur across the full continuum of care. As a result, the 2025 SRE List applies to all patient care environments rather than being limited to a defined subset of settings. This is a significant shift from the 2011 SRE List and reflects where health care is delivered today across all health care setting types: acute care, outpatient care, post-acute care, home care, and virtual care.

The report provides a crosswalk identifying which Serious Reportable Events may apply to which setting types. It's also important to emphasize that not every SRE applies to every health care setting, so reviewers should use the crosswalk and the SRE-specific clinical application guidance to determine applicability.

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The third major update is the events themselves. Using a consensus-based process, NQF made substantial revisions to the SRE List, resulting in 28 events. 23 were on the 2011 list, but were updated or modified. 5 events are new and have been added based on gaps identified through expert input and public comment.

In addition to updating individual events, NQF reorganized SREs into four categories: procedural events, product and device events, patient protection events, and care provision events to foster clarity for those using or referencing the list and to support categorization efforts in future updates.

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As with prior versions of the SRE List, event names are intentional and designed to convey reporting expectations at a high level. In this update, NQF introduces two naming conventions used across all SREs. This is a shift from the 2011 SRE List where event names and varied used, excuse me, event names varied and used phrases such as death or serious injury, any incident, or the event name only, without clarity on harm thresholds.

While the standardized names provide an important signal, reviewers must still rely on the full SRE-specific clinical application guidance, including intent, definitions, and reporting considerations to determine whether an event qualifies as an SRE. This standardization process resulted in 19 Serious Reportable Event names beginning with patient harm.

This naming convention signals to the reviewer that SRE reporting is heavily influenced by the level of harm experienced by the patient. As an example, patient harm associated with the medication error. Nine Serious Reportable Event names include regardless of the outcome. This naming convention signals to the reviewer that SRE reporting is not influenced by the level of harm experienced by the patient. Although all SREs are serious and should never occur, these denoted regardless of the outcome signal that there are no circumstances under which the occurrence of this event should go unreported and its occurrence, including a near-miss event, qualifies as an SRE.

An example of this is introduction of an unapproved, unscreened, or inappropriately approved device, implant, or object into an MRI zone 4 area regardless of the outcome.

Overall, this naming structure coupled with the use of the clinical application guidance is intended to promote consistent interpretation and reporting across settings and reduce variation driven by interpretation of event titles alone.

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The procedural events category includes events associated with a surgical procedure, an invasive procedure, or other procedure for diagnosis or treatment. Events in this category are peri-procedural and may occur in specified care environments, involve specially trained staff, and this category was formerly named surgical or invasive procedure events. This category now includes five returning SREs and two new SREs.

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The product or device events category includes events that occur during diagnostic or treatment services involving the use of a product, medical device, or digital tools and technologies. These events may occur in any healthcare setting and include products or devices that come in direct contact with the patient or provide support for patient care. This category includes three returning SREs and one new SRE.

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The patient protection events category includes events that impact the intrapersonal or interpersonal safety in a healthcare setting during diagnostic or treatment services. These events may involve but are not limited to vulnerable populations such as patients who do not have decision-making capacity or patients who are a danger to themselves or others. This category includes five returning SREs.

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And lastly, the care provision events category includes events associated with processes of care during diagnostic or treatment services. These events may involve direct care processes as well as processes that support direct care and was formally named care management. This category includes 10 returning SREs and two new ones.

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The fourth major update to the 2025 SRE List is the introduction of robust clinical application guidance. Located in part two of the report, this technical guidance is structured event-specific guidance to support reviewers in determining whether an event qualifies as an SRE. The level of detail did not exist in earlier versions of the SRE List.

Through public comment and expert input, NQF consistently heard that differences in terminology, interpretation, and application across organizations were leading to variation in reporting. This guidance was developed not to add burden, but to reduce ambiguity, improve confidence in reporting decisions, and promote more comparable decision-making across organizations and settings. Over the next few slides, I'll break down the key components of the clinical application guidance.

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Let's start with the first part, the intent. This section explains what the intent is meant to capture and what it's not, so you're not relying on the title alone. It also calls out where the event applies, who it applies to, and highlights what's changed from prior versions. You'll also see clear exclusions which help avoid misclassifications. Think of the intent as your starting point. It sets you up for consistent, confident reporting decisions.

Now you may be wondering, if these events are patient-focused, then why would we need to have a space dedicated to population, who the event applies to? Well, there are three Serious Reportable Events that can pose significant risk to all individuals, including healthcare workers, visitors, and vendors. These include SRE 5, which is an MRI event, SRE 11, the fire, flame, or unanticipated smoke event, and SRE 16, sexual abuse or sexual assault event.

Therefore, the population callout will alert reviewers when the event expands beyond the scope of patients only.

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The second part of the clinical application guidance is the key definitions. This section is designed to make sure reviewers are using the same language when evaluating events. Many of the terms used in event names, intent statements, and reporting considerations can be interpreted differently across organizations. The key definition section clarifies critical terms that intentionally are not new or unique to this report. Where possible they're aligned with definitions from nationally recognized patient safety resources, measurement programs, and professional societies.

Reviewers should use key definitions together with other sections, not in isolation. If there is uncertainty or disagreement during event review, this can be a good place to pause and confirm shared understanding before moving on to reporting considerations.

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The third and final part of the clinical application guidance is reporting considerations. Reviewers should use the reporting considerations after reviewing the intent and key definitions, bringing all three sections together to determine whether an event qualifies as an SRE. For the first time the updated SRE List explicitly operationalizes the SRE inclusion criteria by translating the criteria into three actionable prompts.

These prompts accompanied by circumstances and examples are designed to, again, reduce ambiguity and promote more consistent interpretation. Reporting considerations are tailored to each event and the actionable prompts differ slightly depending on whether the SRE name includes patient harm or regardless of the outcome.

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So let's walk through these prompts for a patient harm event. After reviewing the intent and key definition section, the reporting considerations walks the reviewer through the SRE inclusion criteria statement: to qualify as an SRE, an event that is clearly tied to a patient encounter with a healthcare delivery system must be serious and largely preventable. An event must meet all three to qualify as a patient harm SRE.

The first prompt asks whether the event was clearly tied to a patient encounter with the healthcare delivery system. This reinforces that SREs must be connected to the delivery of healthcare, not incidental or unrelated circumstances.

The second prompt focuses on whether the event resulted in serious patient harm. The guidance clarifies that harm may be physical, emotional, or psychological, may require major intervention, or may impair a patient's ability to perform activities of daily living.

The third prompt asks whether the event was largely preventable, was likely avoidable by any means currently available within the generally accepted performance standards of care. Deviations from either generally accepted performance standards of care or setting specific standards can signal that the event was largely preventable

It's important to note that these prompts differ for nine Serious Reportable Events with regardless of the outcome in the name. For these nine events, the questions prompt the reviewer to look at causative factors or vulnerabilities in safety systems by asking how an event occurred, leading to identification of gaps in care or factors that can lead to reoccurrence. These events signal that there are no circumstances under which the occurrence of this event should go unreported, and its occurrence, including a near-miss event, qualifies as an SRE.

Overall, the new robust clinical application guidance is a key update that provides SRE specific information to enhance Serious Reportable Event review and reporting practices.

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Now I've just highlighted the key components of our recently published report and how you can leverage the information during event review. This update will impact the audience in different ways. Today I'm honored to bring four leaders from very different perspectives to share how this update impacts their efforts and how we can leverage this update to contribute to advancing the collective goal of reducing preventable harm. In a moment, I will transition to Elizabeth Mort, Vice President and Chief Medical Officer of Joint Commission and previous expert advisor to this project, who will moderate our panel discussion.

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Before I do, I want to make sure you are aware that you can submit questions for our panelists via the question panel. Immediately following the discussion, we will have time to share some of your questions with our experts. Click the question mark icon in the audience toolbar, a panel will open for you to type and submit your question. Questions not answered during the live event will be reviewed by our team.

Slide 32- Panel Discussion 00:24:32

Now let's welcome our panelists who are here with us today to discuss the impact of this update.

Kristin Duncan leads the patient safety program across the Texas Health Resources Health System, championing high reliability initiatives and fostering a culture of safety aimed at achieving zero preventable harm. Texas Health Resources includes 29 hospital locations in the Dallas-Fort Worth area, 30 urgent care centers, 35 surgery centers and over 420 points of access. In addition to overseeing the transition to the 2025 SRE List within a state that has mandated SRE reporting, she also oversees the management of Sentinel Events as Texas Health Resources includes Joint Commission accredited organizations.

Melinda leads quality and safety patient safety at United Health Group, which serves over 150 million people and spans 50 states across multiple healthcare sectors, including health insurance, healthcare services, pharmacy services and health technology. Melinda has held pivotal roles in clinical care, patient safety and quality improvement. She has been integral in pushing towards the expansion of adverse event reporting in non-acute healthcare settings.

Carole Stockmeier leads safety and reliability at Press Ganey, an international healthcare improvement firm partnering with over 41,000 healthcare organizations. Prior to joining Press Ganey, Carole was a partner and chief operating officer of HPI. She led the earliest applications of reliability leadership methods in healthcare, including the nuclear power based daily safety check-in and she was a developer of the widely practiced SEC and SSER patient safety measurement system for healthcare, an event cause analysis methodology. And finally, Liz Mort, I'll pass it to you for opening remarks and to get our panel discussion started.

Well, thanks so much, Kim, and welcome, everyone, to the webinar today. We have almost 3,000 people participating. So that says something. That says there are a lot of people who are interested in what this alignment and update has for us to use. And before I turn to some questions for my esteemed colleagues, and I'm really grateful, Carole, Melinda, and Kristin, for you joining us, because it's amazing just to listen to your credentials.

We're talking about a list today. But each one of you has experience in taking that list and applying it in a patient safety system. You're all in different perspectives. That's what's so wonderful about this panel. So those attending are going to hear from real experts who not just now have a new list, but can advise us on what we do next. A list in a book is not going to change the world. We need to take that list and apply it appropriately.

So you've heard from Kim now. And I want to thank Kim Streett and the entire team working on this at NQF and the Joint Commission. We've been working on this for a long time. And we're proud of the result. But we appreciate that there still is so much more work to be done. So there are some key features of the 2025 update that we'll all be using. And those update components that I want to focus on are the following. We've streamlined the criteria, the old list, the criteria for whether or not an event is in or not as an SRE. We've simplified that.

Second, we know that most of the reporting historically has been in the hospital setting. And the new guidance intentionally requests everyone to think about this as a tool to use not just in the inpatient setting, but in the ambulatory setting. And in fact, across all of our healthcare delivery settings now. And that's going to be a challenge, but it's also a great opportunity. You know how those things go hand in hand.

Kim shared with you that we updated the events. We tweaked some old ones. We eliminated a few. And we added some new ones. And maybe most importantly, we developed the clinical application guidance. So for those of you who have looked at the report, it's over 100 pages. And most of that is sort of the technical assistance that users of the list hopefully will find helpful as they look at an event and determine whether it meets the criteria of an SRE. So those are the four aspects. And from your perspective, what I'd like you all to talk about is how will this update with those characteristics that I've just highlighted, how is that going to impact the field? So Carole, can I ask you to start?

Sure. Sure. Thanks, Liz. I'll kick us off with two ways. I think the NQF SRE update will impact healthcare. First, the Joint Commission adoption of the NQF SRE List as a complement to its Sentinel Event reporting. I think that moves us further towards a unified system and methodology for event reporting.

Over the past several years, we've seen this same coalescing and aligning of direction among national patient safety efforts like the National Action Plan to Advance Patient Safety or the National Action Alliance and the CMS Patient Safety Structural Measure. And this alignment between NQF and the Joint Commission, I think, is another example of industry leading steps towards standardization, which we definitely need in the healthcare industry.

00:30:14

A second point of significance is the recognition of emotional harm when considering Serious Reportable Events. Historically in healthcare, our definition of harm has focused on physical harm to patients. Yet medical error clearly has broader and longer lasting effects on patients and their families, including emotional harm, financial harm, and socio-behavioral impacts. So, this aspect of considering emotional harm, I don't think it's as simple as it may seem. You know, leaders have to lead the way. Considering emotional harm may result in an increased count of failures in an organization, and leaders need to say that that increase is part of and important to learn where we can do better. And assessing emotional harm is not as straightforward as assessing physical harm. It really has to be assessed from the patient perspective, which involves talking to the patient. And communication and resolution programs embedded in a developed analysis can really help us out there.

So, you know, maybe one starting point tip on this emotional harm aspect, Liz, is whenever we have a failure, whether that's in safety or quality or experience, let's always ask two questions, did this failure cause physical harm and did this failure cause emotional harm? So I hope that's a good start for us there, Liz.

Well, thank you for highlighting the emotional harm piece. It actually was there in the previous SRE List, but it's been just highlighted. And thank you also for the practical tip. It's like, okay, what do we do now? Well, what you do now is you ask that question. Was there physical harm? Was there emotional harm? And I agree, Carole, I think organizations, individuals are going to debate on that, but we'll move the efforts forward to encompass a broader range of what patients feel is harm. So, thank you for highlighting that important impact. Kristin, what are your thoughts? I'm not hearing Kristin. Melinda, can you nod your head if you hear Kristin?

No. No.

We'll work in the background with Kristin. If you want to move on to Melinda, we'll try to get-

Okay. We'll just plan B it here. Okay.

Melinda, what are your thoughts on the impact?

Yeah, from my perspective, the important impact on this update is that it extends risk identification and attention to our system vulnerabilities across all healthcare settings. That is something I'm very passionate about, not just what we've historically focused on, which has been inpatient care. Because the fact of the matter is most healthcare happens outside of hospitals, both in volume and frequency. And by having a common risk lens to look at health risks across the system, we can try to better surface identify and then mitigate those risks and really work towards becoming a more learning system as an industry.

I think another thing that this really does is pushes us towards more proactive prevention. Right? So, we don't have to wait for an event to happen at a site, at one site in an ambulatory setting. We can hopefully be learning from what other ambulatory settings are going through and put in risk mitigation efforts before it happens in our own site. And so those are the things I'm really, really excited about and believe very deeply will have a really big impact on our field.

And so essentially, it's this really amazing shift from seeing risk wherever a patient is, not just when they're in the hospital and they're the most ill. And I'm excited about this work moving forward and what it can do for us.

Thanks, Melinda. I just want to ask a follow-up on that while we then turn to Kristin in a minute. But can you just remind the audience how big your system is?

Yes, we're very big. So on our care delivery side, we have several thousand ambulatory clinics. We have virtual mental health care. We have in-person mental health care. We have large pharmacies. We have small pharmacies. We have infusion sites. We do in-home care. We do every type of care that this extends into, we are essentially in. And so this really impacts our organization. And we think it is the absolute right move for our industry. And so, is it going to be hard? Do people think it's going to be hard to do? Absolutely, it's going to be hard, but it is the moral imperative we have for our patients. If a harm happens anywhere, we owe it to our patients to identify that, talk about it, and learn from it, meaning mitigate it. And this is really extending that expectation out of hospitals into ambulatory care.

Yeah, thanks, Melinda. I just wanted the audience to appreciate how big your role is at UnitedHealth Group. And they're lucky to have you in the position to have the vision of wanting to make this happen. This meaning taking something you learn in one part of your system and sharing it. So much of healthcare in the United States is delivered in delivery systems of different sizes and shapes. And if we think about those as learning organizations, the list gets used in a way that has impact at scale. So, thank you, Melinda. Kristin, how's your audio going?

00:35:50

I wanted to talk a little bit more about the application of the emotional harm definitions that Carole spoke about. I think with the update with the SRE, the inclusion of having those standard definitions of emotional harm is critical. We haven't had a taxonomy to follow that provides definitions and examples of how to classify that level of harm in the past. So that consistency really gives us a common language and it supports a more meaningful learning across organizations. So having that commonality in our language models is not just about the immediate physical injury, but also the longer term emotional impact on our patients and our families and our staff.

Even if the emotional harm, if it doesn't result in physical injury, it can have those serious long lasting consequences with patients with typically anxiety, distress in our healthcare organizations, or even a diminished quality of life, which aligns with the whole purpose of the NQF SRE, is to identify those types of events that are serious and largely preventable. And that kind of takes you into a different point.

To me, the most meaningful emphasis on the SRE List is on those two important criteria around harm and preventability. It moves the conversation beyond what happened as to more why it was possible that it happened. Patient safety is often defined by harm, what went wrong and who it hurt. With the harm alone, it's really an incomplete measure of safety. So having that true patient safety is about preventability and understanding where the harm had to happen at all. And when we focus only on outcomes, we're minimizing events or even thinking of them as being inevitable. So, I like the idea of us focusing more on the presentability and asking those harder, more meaningful questions that takes a conversation away from blame and more from learning. It takes us from reacting to events to designing that safer care model.

Thank you. I'm going to ask you to put on mute. So I'll share with you that my experience of your audio was a little scratchy. I'm going to ask the team if they can do anything to help with that. But I appreciated your comments, again, your focus on emotional harm and getting your whole system, all the people in the hospital and the nurses and the docs that you work with thinking about that. That's a real advancement in the culture and the way we're thinking about patient harm. So thank you guys for that all. Thank you all for those comments about the impact of the new list and the new focused areas.

So, you know, a driving factor in this update was alignment and alignment on many, many different parameters. Obviously the alignment of the Sentinel Event program and the SRE List is big. We can talk more about that. But tell me, now that we do have alignment there, can you share with me if this update has changed the way your teams think about event reporting, and their teams may not have had a chance to really digest that, but what guidance would you offer to organizations who are navigating this change? Because even though we consider that one list is an advance towards alignment, it's one step in a long journey. So I would really appreciate your thoughts.

And I'm going to start with Melinda to give the team a little bit more time to work with Kristin's audio, if that's okay.

So, we'll go Melinda, Carole, and then back to you Kristin, to give the team a little time.

Yeah, this update has changed how our team thinks about event reporting, right? Because it makes our end goal really clear. This isn't just about compliance. It's not just about the wanting to report. It's really driving us towards enabling meaningful comparisons across organizations to drive national learning. And that's what we need to progress in the United States, if we're really going to get serious about tackling our goal to eliminate harm, right?

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And this report, I like the stance the report's taken because it says that where states and health systems adopt the list but modify it, it puts the burden on the care providers, the organizations, to adapt and report really differently. So, we have ambulatory sites, we have clinics, we have care in all 50 states of the United States. And so as long as there's variation in what we have to report and how we report, that's time we're taking away from learning to put in to adapt to this. So that's one lesson we really have. It's like, it's focusing all of us to move towards this common set of criteria so that we can really be focusing on the good work which is improving.

And I would say, at our organization, we've been on this path, right? So, if I was in your shoes, you know, the 2,700 folks out there who are listening today, and you're thinking about, well, "How do we navigate this change, right?"

My advice to you, because this is work I had to do kind of coming into this organization, is kind of threefold. One is adopt the criteria and the guidance as soon as you can because that's your common reference, right? Two is use the harm crosswalk to map your current scale to the serious threshold. And then three, do calibration exercises across your organization to make sure your teams and your sites are doing that, right? One can imagine that with over 2,000 clinical sites in ambulatory care across 50 states, we can have a lot of calibration opportunities, right? And so, calibration is really important. And that just starts with a kind of culture of trust and not only what are you reporting and let's calibrate on that, but what are you not reporting and how to make sure we're calibrating correctly there. So that inter-rater reliability. And then, you know, I'll just pause there and see, and hand it back to you because I think hopefully other, Kristin's able to get back online and I want to share some time with her as well.

Great. Kristin, let's give you another shot at, you're really talking about the impact in your organization.

Can you hear me better now? Perfect. Okay. So, you know, implementation of the SREs, it's necessary and also it can be challenging, especially across such a large and diverse health system in which we work and many of you do as well. One of the biggest hurdles that we face is that our state reporting requirements, they don't map cleanly to the updated NQF SRE framework. So that can create some confusion around what must be reported to the state versus what meets the SRE criteria. So, we want to be sure internally that it doesn't cause any further ambiguity on what we expect for learning and improvement. We don't want the focus to be on the variation between reporting and really more focused on the learning aspect.

So, to address that, what we've done, if anyone else on the call is having the same experiences, we've developed internal crosswalks. There's an excellent crosswalk that's included in the SRE update. And so just looking at that and aligning that crosswalk and being able to differentiate between the state required events, the accreditation driven events, and then the NQF alignment with the SREs and how we're using that for our internal review is that, you know, ultimately they are all Serious Reportable Events and not to get too hung up on where it goes other than how we manage the mandatory reporting.

That clarity has really been essential for our teams until we can get further clarification on the state alignment. One of the things that we've done is we've encouraged our peers and patient safety to connect with our state departments, asking for that alignment, just better understanding that that consistency helps us all as healthcare organizations to have a unified focus. And so, we're hopeful, and I know many states have already aligned and we're hoping that our state will follow suit.

Another consideration, you know, that can be challenging, and Melinda touched on this a little bit as well, is that historically the safety and reporting expectations, that they vary by care setting. So, what this update reinforces is that while the application may differ by setting and risk, that the expectation of safety and preventability is the same. And that consistency is especially important as accountability expands beyond our traditional inpatient care. It helps teams to understand that the serious events, they're defined by impact and preventability, not by location. So, as we introduce these new models of care with urgent care centers, virtual care, care at home programs, et cetera, that this is really helpful for us to have that common focus with the Serious Reportable Events.

00:45:50

Your audio is fine now. Whatever you did magically is working. And I just want to emphasize the point that you made, Kristin, is that there's a lot of states that use SREs, but the state legislation is not always the same. So here we have updated a report. We have lots of guidance. There's still work to do to think about individuals in different states working with their local DPHs and doing that crosswalk internally. And eventually, this is one big step forward, but there still is work to do. Carole, comments on this one, and then we have one last question before I turn it back to Kim for Q&A.

Yeah, sure. You know, in our Press Ganey safety culture data, prevention and reporting is the highest ranking, actually, of the safety culture domains, though that does not mean that there's not still work to be done. And I think that's especially true in those non-acute care delivery settings that Melinda mentioned, like ambulatory and home care, remote delivery mechanisms like telehealth or hospital at home and commercial retail-type pharmacies, where event consideration and reporting may even be less robust.

So maybe three focus areas that, Melinda, I think align or complement the areas that you mentioned quite well. The first is leadership for event detection. You know, it's leaders that provide that solid underpinning by messaging on the importance of learning from experience and inviting and recognizing those who report, and that really sets the foundation for our people knowing what to report, how to report, and being comfortable in reporting.

Number two, Kristin, you kind of commented on this, processes for detecting safety events. While just culture is an important contributor to robust reporting, you also have to have processes in place for casting a wide net to detect potential events, and that's things like, you know, do we have effective processes and technologies for event detection? Are these being used routinely? And are they being employed across the continuum? And then the third and last tip or point is shifting the safety event burden of proof. In organizations that are in the early stages of developing safety cultures, there's more of a perspective of prove to me that this is a safety event, and we want to work to shift that burden of proof to prove to me that this is not a safety event. Back to you, Liz.

Well, thank you all for those super thoughtful questions. As we round out the seminar today, and we want to leave five minutes for Q&A, let me ask each one of you to very quickly give an answer to this question. You've alluded to some of this, but okay, we have a list. Each of you are leaders in different roles, in different types of organizations. You've been doing this work, you're thinking about how to implement. Just give me one other opportunities that you can think of, one other opportunity rather, to further streamline reporting practices and foster learning about ways to achieve our goal, right, which is to reduce preventable harm. So we're going to go Melinda, Carole, Kristin, one more thing that you'd like to leave that you haven't had a chance to express with this audience.

One of the things I would, you know, have us think about is how do we continue to put the level of focus on safety as we do on quality in the United States. We've made huge strides in the quality efforts. There's a lot of alignment across all aspects of the health sector, right, from payer to provider to, you know, everyone in between. And then, you know, I love how we're moving in that direction with the patient safety structural measures. And I think this sets up the critical effort to think about how to further drive patient safety to the same level as quality in the United States. So that's what I'm most excited about. I think there's great opportunity there. And this is the critical foundation to get that done.

All right, game on. Thanks for that great comment. Carole.

Yeah, well said, Melinda. I would say, move beyond compliance to understanding reporting as a component of a comprehensive organizational learning system that seeks not just to detect events, but also to prevent events. And with that, it's important to have a learning system metrics that track indicators that reflect that more proactive approach to prevention and detection and correction and that let us know where we are. Are leaders leading the way? Are we hearing about events and experiences across all facilities, all departments and all professions? Are we hearing not just about the serious harm, but also about events where outcomes are less significant? Because it's really from those that we can reap learnings to prevent serious outcomes.

00:50:46

The CMS Patient Safety Structural Measure with Melinda, I'll put in a plug for that as well, and the National Action Plan for patient safety, those both provide very strong guidance in core elements of effective learning systems.

That's great. So, make safety as work as hard as we have made quality work. We've seen improvements in quality. Let's do the same in safety. Game on. And Carole, you're making the important point. This is not a list. Embed the list in a system. It's not just a team that does reporting. It's a reporting function that works within the context of an integrated system working on reducing preventable patient harm. I love that. Kristin, final comment.

Yeah, I'll just run this out by saying just to really sum up what Carole and Melinda had said is, you know, one of the most important values that's reflected in the updated SRE framework is the role of health care leadership and fostering a culture of safety and learning. The update makes very clear that SREs are not simply a reporting exercise. That it's a signal for learning and for system improvement and prevention. So, when reporting is met with curiosity instead of blame, that organizations can learn faster and we can prevent harm sooner. And this also reinforces the understanding that the most serious events, that they result from system breakdowns and not isolated human failures.

Thank you. That's a great way to round out the panelists' discussion. I'll turn it back to you. First of all, I want to thank our three esteemed guests today. Thank you for taking the time to contribute to the panel discussion and really add a tremendous amount of color and wisdom for the participants. And Kim, back to you for Q&A.

Live Q&A 00:52:31

Thanks so much, Liz, and thanks to all of you. Our question and answer inbox is flowing well, so I've got a couple of questions prepped and ready for you all. I think one of the most common question right now is around the emotional or psychological harm. One of the first questions was, is there a classification system for this?

And we have included that on page 28 of the report. It's Press Ganey's classification system. But this still can be very subjective, can be quite difficult conversation around the table as you're reviewing events. I wanted to ask our panelists their opinion on how to navigate this as there are varying degrees of comfort level in these conversations around emotional harm.

Carole, maybe how best to leverage that scale that Press Ganey has. And also one of the key questions that came up was if there is physical harm or if there is not physical harm, because as you said, Carole, we need to ask two questions. Was there physical harm? Yes or no? And was there emotional harm? If there is no physical harm, what's your experience with navigating that complexity in reviewing events that helps the team navigate that conversation?

Yeah, these are all very good questions, Kim, and questions that a lot of organizations are, that are kind of the first movers in emotional harm we're grappling right now. You know, one of the things that emotional harm consideration really forces us to do is broadening that definition of harm. And we often think about safety events as being those physical safety events, but truly emotional harm can be associated with an experiential event where we don't provide the best experience to a particular patient.

So one of the key things that's different about emotional harm is you have to look at it from the patient perspective. And in order to get to that patient perspective, you actually have to talk to the patient. And so that's one of the biggest challenges. You know, when we look at assessing physical harm, that's a little bit more concrete and something that we can judge from a, assess from a medical record.

But what might constitute emotional harm to me might be different from what constitutes emotional harm to Kristin or to Melinda. And so that conversation with the patient is critical in that aspect. And I think that's one of the biggest kind of transition in that is one, getting senior leadership recognizing emotional harm and talking about emotional harm. And then number two is how you operationalize it. And Kristin, I think I might turn over to you because you all at Texas Health Resources have had a lot of experience in both of those areas.

00:55:34

Yeah, thank you, Carole. And, you know, we have widely adopted and adapted the emotional harm taxonomy within all of our patient safety events and all of our complaints and grievances. And what I will say is that it is a mind shift. And, you know, usually with physical harm, what we're very accustomed to doing is, you know, the burden of proof of the physical harm is on the outcome. And the emotional harm is very different from that. And it's subjective in nature. And so it's not for us to determine if someone experienced emotional harm. We take their word at will and that is how we classify. So, it takes out any opinions in the room, and we just look at what exactly the patient said or the behaviors that they exhibited. And it makes it a lot easier to translate that taxonomy into determining the appropriate classification. It's just about that subjectivity and really listening to the voice of the customer.

Thank you, Kristin and Carole. Melinda, did you want to add your thoughts on that as well?

I think just add in that, I think Carole mentioned this earlier is the importance of thinking about, you know, things like the National Action Plan, right, where we're talking about in there, we're talking about the importance of early disclosure, and how we're preparing our clinicians to have these conversations with patients to surface emotional harm in these, to look for it and ask about it in these conversations. And so that's part of the operationalization that Carole was talking about, I think is really important here.

It is. It's paramount, right? But it also, don't want to underestimate that it's not easy. This is difficult to navigate. It's difficult to mature in this space. And so, thank you, all of you for sharing your real world examples. I appreciate it. Another question that came through centers on the regardless of outcome events. And so including near miss events, right? Anything that may occur. So what are your thoughts on the nine events for which the level of harm experienced by the patient is not, it's not required to determine if it's a serious reportable event. Why is this important? Why did our expert panels shift in this direction now? And also, like, can you lend some insights from your experience on the expert panels in these conversations? I guess I'll have to call on someone. How about... You want to go first?

Yeah, I could take a stab.

Thank you.

For me, why these become really important, right, is because there's, these events are so critical, right, that we can't, and sometimes quite rare, that we really shouldn't be waiting for the really bad event to mitigate these risks, right?

For us, it's any time there's a near miss in these particular events, it's really important to make sure we have a systematic way to surface those and really strongly improve our systems so that we don't have to wait for one of those. And so for me it's just really getting to that level of you know, surfacing the severity of even a near miss, like a near miss is telling us the system is challenged, like we have a problem with our system and we need to better design it.

And Kim, I'll just add to that. I think this is a great shift in the way we are, you know, looking at harm and, you know, making sure that we're doing the appropriate cause analysis on these events is it's really a warning sign that we may have ignored in the past just based on prioritization of all of the work that we have to do is having that force function in place that, you know, just because a retained foreign object did not cause serious harm, but next time it might. And so just by all of the different safe surgery initiatives that we've had in place is that if we have an event like that, it shows a serious disruption in our processes. And it really warrants that same level and degree of analysis to ensure that the next one does not cause serious harm.

Yeah...

01:00:12

I agree. And it takes the... It speaks to culture, too, right? I was reading a recent article that talked about building a culture of safety and a just culture actually helped improve their reporting of near miss events. And Carole, you brought up just culture earlier in the panel discussion. That's a big factor in this of where the organization or even the department, the small culture, as well as the larger culture in organizations can have an effect on, I guess, maybe comfort or management of regardless of outcome events and how they're interpreted and dealt with.

Yes. You know, Kim, the other piece that I'd add on these regardless of outcome, you know, risk is a factor of two things. Probability times consequence. And in all of the regardless of outcome events, the probability may be lower on some of those, but the consequence when one of those occurs could be really, really significant. And I think that's what takes us back, Melinda, to where you started with this particular question is that really warrants understanding what went wrong, why it went wrong and how do we make it not go wrong again?

And I'll just add on in terms of just culture, right, when we combine this idea of aligning on common and clear definitions with consistent guidance and psychological safety, we really get to this really special place where we have alignment and trust. Right? And that's going to promote early reporting. That's going to promote system focus and ultimately lead to our goal, which is measurable harm reduction. And that's what we owe to our patients and to those we serve in health care.

Kim, if I could just add a word, I know we have our wonderful panelists' voices, but I'd like to add that, you know, studying near misses is really important. We published an article from Cedars-Sinai in the Joint Commission Journal recently that talked about this. They studied near misses in the ICU and they found out that the two things that got between the problem and the patient were barcoding of meds and nurse vigilance.

And I thought that was such a great paper, was really excited to publish it, and we promoted it with Cedars-Sinai team to encourage people to think about that. And, you know, using great examples in your organization is a great way to get people excited about it. We studied a near miss, this is what we learned and this is what we did. So, I just would want to, I just couldn't help adding my two cents.

Thank you so much for adding that, Liz. I guess I'll cover one last audience question before we wrap up. And that's around largely preventable, very similar to emotional harm. This is subjective. So, the three of you I know probably have great examples of how you've tackled this one.

Is there anything you could provide to help others prepare for conversations? What is largely preventable? And then how do we have those conversations? What can help drive that we're actually, it's a little bit easier to say, yes, this is largely preventable, when that term is is very subjective. Carole, would you like to, or Kristin, would you like to start with that one?

Sure, I'll jump in there, Kim. You know, two things come to mind on largely preventable. First, there's lots of areas where years ago we thought that it wasn't preventable and now we know that it is preventable. And so just because today we might not have an answer, the answer is out there somewhere. And and so that's the first kind of important thing I think we have to think about in these largely preventable types of things is the answer is out there somewhere.

The second piece is that we should always look at this from the perspective of, did we provide the best care that we could have to our patients? And that's not always dictated just by policy and procedure and, you know, what we say on paper. But if this was our mother or a family member or a friend, is this the kind of care that we would have wanted to provide to our loved one? And that also helps us navigate that. And rather than looking at it from a practice perspective, it really puts a personal perspective on it.

01:05:22

Yeah. One thing that I would say is just looking at this from, you know, determining largely preventable is I actually feel like we overcomplicate that question. Is it really as simple, you know, it's just asking ourselves very much aligning with what Carole said is what actually happened and what should have happened. And when you bring it down to that simplistic level and just looking at was there any variation, was there any deviation and what our generally accepted practice standards are? If the answer is yes to that or what did happen and what should have happened, if there's a gap there, is that means that it's largely preventable. And so not to spend so much effort in defending why it's not an event and using that time to figure out as an organization how you can put some human factors in place to keep it from happening again.

Excellent point, Kristin. Thank you. All right, we are getting close to time. I wanted to ask one last question.

What's one thing you'd encourage this audience to do differently or try differently as a result of today's discussion? And Liz, if you would go last and you could then wrap us up with some closing remarks.

So, Melinda, can I pass it to you first? What's the one thing you want this audience to try differently or to do differently?

I would really push everybody to go out into the areas where you haven't historically reported and spend a lot of time with those folks to understand what are the systems they have in place to report. It is highly variable, right? And what are the challenges they have to report? And really what we found is that it takes a lot of leadership and prioritization to prepare those groups who historically have not needed to engage in this work, to get them to a place, not just functionally to be able to do it with the right systems, but to change the culture and how to do it. And so, it's really spending that time in those areas. You know, we have hospitals outside the United States

that we work with and I work with now. This is an adaptation, but it's not a far reach for them. The reach is really where it hasn't had to happen before. And so that's my suggestion.

That's a great call out. Thank you. Kristin?

One thing I would encourage everyone to do, just in the respect of thinking differently and the adoption of the SREs is, you know, whenever you are telling safety stories at the beginning of all of our meetings is incorporating the emotional harm into your safety story. You know, we all know that, you know, telling stories really is a way that we have behavior change and we have adoption of some of our different standards. And by highlighting the psychological safety and emotional impact on a patient and not just focusing on that physical harm, I think what you'll see is that your audience, meaning your, you know, your providers and your your co-workers and your peers will start seeing that level of harm in a different light.

Yeah, starting to incorporate it in conversations, normalizing it to some extent, which, Melinda, is very similar to your point, except you hit like new settings. Right? Carole, final thoughts?

Sure. You know, the title of this is the NQF Serious Reportable Events List. And I think what the one thing I would do, Kim, is I would flip that around and I would encourage people, while it is a classification system for events, I would encourage people to look at that from a process improvement opportunity perspective and engaging team members in what can we do to improve safety in... And then you could take each one of those 28. And our folks who are doing the jobs on the day to day basis, you'll be amazed at the input that you'll get from that.

01:10:07

So I encourage us to use this in twofold, not just as an event reporting classification, but a process improvement opportunity endeavor.

Oh, I like that a lot. Very much a proactive lens. And as Joint Commission accredited organizations are transitioning for that January 2027 reboot, I'll say, or to adopt the SREs, like it is a great time to look at it from that lens. So thank you. I'll pass it to you, Liz, if you'd close us out and pass it back to Jess for next steps. Thank you all so very much for this dialog.

Yeah. Thank you, Kim. I want to thank you and the team for all the hard work over the last couple of years in making this happen. And I want to thank our esteemed panelists for joining us today. Most importantly, I want to thank the nearly 3,000 people who joined this seminar to learn more about this publication. I'm not going to call it a list. It was a publication. And again, just to highlight what the publication has in it. The SRE List that was last updated in 2011 was updated in 2025. So it's new. Number one.

Number two, it has different features, some of which are going to really, I believe, accelerate the ability to improve. There will be some heavy lifting, you all have some challenges, but I think it's a very, very solid tool.

The other part that Kim mentioned is that the Joint Commission will be using the SRE List in its Sentinel Event Program. We will retain the name Sentinel Events. The Sentinel Event List, as Kim told you, will now include the new SREs plus three other workforce safety events. For those of you who are Joint Commission accredited organizations, as Kim mentioned, we will have webinars over the next year to help you prepare for any transitions.

But I really think some of the comments that our guest made, I want to just highlight in final closing comments. Melinda said, you know, let's make safety work in the way we've made quality improvement work. Let's take this new list, this new taxonomy. Game on. Let's use it in our systems of care, and all of our speakers talked about this. A list is nothing unless it's wrapped up in a system of patient safety. You all have different kinds of system. That's the challenge for you as leaders and managers is to use it effectively. So, game on. And really, the goal is to reduce preventable events. We need good safety metrics to parallel, if the reported SREs, to know if we're making progress. So there is work to do there. So I would encourage you all to use the list and to work on continuing to align efforts where you can in your own worlds so that we can extract energy and use it to reduce preventable patient harm. And that's our goal.

So thanks very, very much for joining us today. I saw the questions in the chat. They were excellent questions. I'm sorry we couldn't get to all of them. But clearly, you're all engaged in thinking about this. So for that, I am grateful, as are the patients that you serve. So I'll turn it back to my colleagues to close us off for today. And again, thanks to everyone.

Slide 33 - 01:13:31

We want to thank our moderator, Liz. And if you haven't already, you can download the full report in the FAQ document using the links listed at the bottom of this slide. Later this month on March 25th, we'll launch the Joint Commission Sentinel Event Transition Webinar, where we'll then head into our on demand series. Looking ahead to January 2027, Joint Commission will adopt the NQF SRE List while continuing to uphold the three legacy Sentinel Events related to workplace safety.

Slide 34 - 00:52:

Approximately a week following this live broadcast, you'll be able to access the recording link, slides, and transcript on Joint Commission's web page via the link provided at the bottom of this slide.

Slide 35 - 01:14:03

And after reviewing this webinar and resources, or even after today's event, you may still have questions. If you do, associated with the content today, please submit your inquiries to SREInquiries@jointcommission.org. If you have questions about webinar operations or obtaining continuing education credit, please submit them via email to tjcwebinarnotifications@jointcommission.org.

Slide 36- 01:14:40

Before we close out, here's additional information about the survey you'll receive. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. A QR code will be available on the next slide. You can use your mobile device to scan and access the survey. If you prefer to take the survey later, an automated email also delivers the link to that survey. After you complete and submit your survey responses, you'll be redirected to a page from which you can print or download a blank certificate that you complete by adding your own name and credentials. In case you missed that opportunity to download, an automated email will also be sent to you that includes the link to the certificate.

Slide 37-01:15:23

We'll leave this slide up for a few moments for those who wish to scan the survey code now.

Thank you to Jess, to Elizabeth for thoughtful... In developing and delivering today's webinar content. We also are grateful to Kristin, Melinda, and Carole for sharing their expertise, and Liz for your skillful moderation.

Thank you to our staff in the background responding to audience questions and operational support. I know we didn't get to all the questions, but we will definitely have our hands full to make sure that we review all of them carefully and provide feedback moving forward. Thank you to all of you for attending this Capstone webinar for the 2025 updates to Sentinel Events and Serious Reportable Events. This concludes our presentation today. Have a wonderful day.