FAQ

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Frequently Asked Questions: Alignment of Patient Safety Event Reporting Update

This document is a collection of questions and answers about the Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events Report and is available on our website. Whether you are fielding questions about the report, updates to NQF Serious Reportable Events (SRE), or the alignment of Joint Commission sentinel events and SREs, this document aims to provide answers you are looking for in one convenient spot.

Questions about the report

Q: What is the purpose of the report?

A: *The Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* builds on the previous NQF SRE publications – 2002, 2006, 2011, and provides an overview of how two previous parallel patient safety adverse event lists are aligning.

Q: Who should read the report?

A: (1) healthcare organizations, care teams, and individuals who review Sentinel Events and SREs (2) Joint Commission accredited organizations, both domestic and international (3) other healthcare stakeholders (e.g., state and federal agencies) who oversee, implement, or operationalize SRE reporting programs, both mandatory and voluntary (4) individuals seeking information about SREs.

Q: Where can I access the report?

A: The *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* Report is available to the public and can be downloaded from our website. Additionally, the Serious Reportable Events web page of the NQF website will be updated with additional information and supporting documents in the coming months.

Q: Who should I contact if I have questions about the report?

A: For more information, please visit our website and if you have further questions, please contact SREInquiries@jointcommission.org.

Questions about alignment

Q: Why is Joint Commission aligning Sentinel Events with the NQF SRE List?

A: The alignment of these previously parallel measurement systems aims to reduce healthcare organization reporting burden. We trust that this will also enhance the effectiveness of safety event reporting, and drive learning opportunities that will ultimately reduce the occurrence of preventable harm and contribute to safer care environments.

Q: When will Joint Commission adopt the NQF SRE List?

A: The transition will go into effect January 1, 2027. Joint Commission will adopt the NQF SRE List and maintain three legacy workforce safety events.

Q: How will this alignment impact Joint Commission accredited healthcare organizations?

A: Joint Commission will maintain its expectation that all accredited healthcare organizations identify sentinel events, examine the root causes and contributing factors, and make improvements to mitigate the risk of reoccurrence. In January 2027, Joint Commission will revise both the domestic and international Sentinel Event Chapter and adopt the 28 SREs, the updated SRE Inclusion Criteria, and the SRE Clinical Application Guidance. In addition to the SREs, Joint Commission will also maintain three legacy workforce sentinel events: Homicide of a staff member, Sexual abuse/assault of a staff member, and Physical assault of a staff member.

Q: Will reporting requirements change for Joint Commission accredited healthcare organizations?

A: No. The reporting of sentinel events to Joint Commission will remain voluntary.

Q: Where should I go to learn more about the Sentinel Event transition?

A: Joint Commission will provide a webinar series with the goal of supporting accredited organizations in understanding and adopting the NQF SRE List and Clinical Application Guidance. For more information, please visit our website and if you have further questions, please submit them to SREInquiries@jointcommission.org.

Questions about SREs

Q: What are Serious Reportable Events?

A: Serious Reportable Events, SREs, are a subset of patient safety events deemed serious, harmful, preventable and therefore indicative of vulnerabilities in a healthcare setting's safety systems. Since 2002, the purpose of the NQF SRE List has included facilitating consistent reporting, driving national improvement via shared learning, and preventing the recurrence of these events. By assessing the underlying causes of these events, healthcare organizations can identify causative factors and bolster their quality improvement efforts.

Q: Who uses the NQF SRE List?

A: Today, more than 30 states and the District of Columbia have statutes, regulations, or policies addressing SRE reporting requirements, in addition to many public and private healthcare organizations who use it to guide voluntary reporting or guide their own policies and practices.

Q: How does this report differ from the *Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report*?

A: With guidance from experts and the public, the 2025 NQF SRE List update includes four key changes:

1. **Simplified Inclusion Criteria** – NQF streamlined the criteria used for identifying an SRE and updated each criterion's definitions to create alignment with patient safety advancements.

2. **Expansion of Applicable Healthcare Settings** – NQF expanded the applicable healthcare settings from a select few to all patient care environments.

3. **Updated Events** – The 2025 SRE List consists of 28 events, 23 are updated or modified from the 2011 list, and five are new. In addition, NQF updated the SRE List to focus primarily on patient harm, only including harm to healthcare workers in the SRE-specific guidance when applicable.

4. **SRE-Specific Guidance** – NQF developed robust SRE-specific guidance to reduce ambiguity in whether an event qualifies as an SRE and to enhance consistent SRE interpretation and reporting.

Part I of the *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* Report provides additional information on each of these updates.

Q: What was the process for including events on the 2025 NQF SRE List?

A: The 2025 SRE List was developed via a consensus-based process that included input from three expert panels and the public. Experts evaluated all 29 events from the 2011 SRE List in addition to candidate events submitted via public comment using the SRE Inclusion Criteria. The criteria served as the threshold for determining which events were considered for and included on the 2025 SRE List. This process resulted in 28 SREs.

Q: Does the SRE List only address patient harm?

A: No. Expert review and discussion throughout this update acknowledged workforce safety as a critical and complex issue which should be addressed separately. NQF, in agreement, updated the 2025 SRE List to focus primarily on patient harm, only including harm to healthcare workers in the SRE-specific guidance when applicable. Three of the 28 events, SRE 5, SRE 11, and SRE 16, include reporting harm to any individual, including patients, healthcare workers, visitors, and vendors.

Q: What is patient harm?

A: The level of patient harm that is associated with an SRE is closely linked to the SRE Inclusion criteria and accompanying definitions. Additionally, NQF standardized SRE names. Nineteen SRE names include "patient harm" which signifies that the event in review must be clearly tied to a patient encounter with a healthcare delivery system and meet both the *serious* and *largely preventable* criteria to qualify as an SRE. Nine SRE names include "regardless of the outcome" which signifies that all instances in review that are clearly tied to a patient encounter with a healthcare delivery system qualify as an SRE.

Q: Why do some SREs require reporting if the event does not result in serious harm?

A: As part of this update, NQF standardized the naming conventions for SREs to lend insights into the reporting qualifications. Nine of the 28 events are noted to be "regardless of outcome" indicating that any occurrence of these events signal a vulnerability in a healthcare setting's safety systems that could lead to serious patient harm and can be prevented by following generally accepted performance standards of care. While all SREs are serious and should not occur, those denoted "regardless of the outcome" signal that there are no circumstances under which the occurrence of this event should go unreported regardless of whether the event was caught before reaching the patient (i.e., near miss), reached the patient and resulted in no harm, or reached the patient and resulted in any level of harm.

Q: How will the 2025 NQF SRE updates impact my organization?

A: NQF encourages healthcare organizations who use the SRE List for voluntary reporting and event analysis to adopt the 2025 Inclusion Criteria, SRE List, and Clinical Application Guidance. For states with mandatory reporting, reporting requirements may be subject to existing legislation. NQF encourages these organizations and entities to review their current jurisdictional reporting requirements and identify which elements of the updated SRE guidance should be implemented.

Q: Where should I go to learn more about the 2025 NQF SREs?

A: Part I of the *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* Report provides additional information about the updates, and Part II provides specific guidance for evaluating whether an event aligns with the updated SRE Inclusion Criteria.

For more information, please visit our website and if you have further questions, please submit them to SREInquiries@jointcommission.org.

Do you have specific questions about....

Applicable Healthcare Settings

Q: Are all SREs relevant to all healthcare settings?

A: No. Not all SREs are relevant to all healthcare settings. However, the risk of serious patient harm exists across the care continuum and because of this, the NQF SRE List is now applicable to all healthcare settings, ambulatory/outpatient, hospital/acute care, post-hospital/sub-acute, home, and virtual. The Clinical Application Guidance highlights whether an SRE may be applicable to each setting type.

Q: How do I know if an SRE is relevant to my healthcare setting?

A: The SRE Clinical Application Guidance denotes if specific settings are excluded from reporting a specific event. In addition, recognizing that not all SREs may be relevant to all care settings, NQF developed a crosswalk showing which SREs are most likely relevant to each healthcare setting type, which can be found in Part II of the *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* Report. **NQF encourages that in the rare instance an SRE occurs in a setting labeled as excluded or not applicable in the report, the event should still be reported.**

Q: If an SRE occurs in a healthcare setting that is not indicated in the SRE Clinical Application Guidance, should the event be reported?

A: Yes. In the rare instance that an SRE occurs in a setting that is not indicated, the Reviewer should consider reporting. NQF acknowledges that the provision of care is constantly evolving and recognizes that even if a setting type is not indicated and that this alone should not deter reporting by any one setting or setting type.

Inclusion Criteria

Q: What is the SRE Inclusion Criteria?

A: The SRE Inclusion Criteria is set of parameters that are leveraged to evaluate patient safety events for the NQF SRE List and can and should be leveraged by healthcare organizations to evaluate whether an event qualifies as an SRE.

Q: How can I use the Inclusion Criteria to determine if my event qualifies as an SRE?

A: 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*.

> **Patient Encounter:** An interaction between an individual and a healthcare setting for the purposes of providing healthcare services or assessing the health status of the individual. Encounters can be billable events but are not limited to billable interactions. The patient encounter has an associated location or modality within which the interaction occurred, including synchronous and asynchronous communication (e.g., office, home, EHR, phone, e-mail, other telemedicine methods).

Serious: An event resulting in death or contributing to patient harm that includes physical, emotional, or psychological harm(s) that require major intervention (e.g., surgery, higher level of care, or treatment post discharge), or impairs a patient's ability to perform activities of daily living (ADLs).

Largely Preventable: An event that is likely avoidable by any means currently available within the generally accepted performance standards (GAPS) of care and triggers further investigation into causative factors.

To further clarify, Part II of the *Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events* Report provides SRE-specific Clinical Application Guidance that includes considerations for *patient encounter*, *serious*, and *largely preventable*.

Patient Encounter Criterion

Q: How do I know if an event is tied to a patient encounter?

A: Most of the SREs are inherently tied to a patient encounter and noted as such in the SRE-specific Clinical Application Guidance. When applicable, the Clinical Application Guidance provides additional clinical considerations to help discern if an event in review is clearly tied to a patient encounter with a healthcare delivery system.

Serious Criterion

Q: How do I determine if an event results in serious patient harm?

A: To determine if an event results in serious patient harm, Reviewers should review each of the four components of the *Serious* definition: (1) physical harm, (2) emotional or psychological harm, (3) major intervention, and (4) impairment of a patient's ability to perform ADLs. If the event under review results in one or more of these components, the *Serious* criterion is met. Healthcare organizations may use their own harm classification terminology or commonly used safety event classification systems to assess these components.

Q: Is considering emotional or psychological harm a new requirement?

A: No. Assessment of physical harm, emotional harm, and the preventability of an event were requirements for SRE identification in the *Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report*. As part of this update, NQF provides definitions and guidance to aid Reviewers with the interpretation of emotional or physiological harm as well as the other components of the *Serious* criterion.

Q: Does this update require my organization to use a new classification system for reviewing SREs?

A: No. NQF recognizes that organizations may use their own harm classification terminology or leverage one of the commonly used patient safety event classification systems (e.g., Press Ganey HPI SEC®, NCC MERP Index, AHRQ Harm Scale). To support consistent interpretation of physical harm, the Report provides a crosswalk of commonly used patient safety event classification systems to illustrate which harm levels align with the *Serious* Criterion.

Largely Preventable Criterion

Q: I'm not certain if an event is preventable. Does an SRE have to be concretely preventable to be reported?

A: No. For an event to meet the *Largely Preventable criterion,* it should be likely avoidable by any means currently available within the generally accepted performance standards (GAPS) of care and should trigger further investigation into causative factors. Reviewers should evaluate if there were deviations from generally accepted performance standards by reviewing setting-specific standards of care which may include existing technologies, clinical policies, procedures, or guidelines. If GAPS of care are associated with an event, the event aligns with the *Largely Preventable* criterion.

Clinical Application Guidance

Q: What is the SRE Clinical Application Guidance?

A: NQF recognized the need for clear, SRE-specific guidance to reduce ambiguity in whether an event qualifies as an SRE. The SRE Clinical Application Guidance provides Reviewers with detailed information for each SRE, organized into four categories. These categories are not strict divisions for deciding whether an event should be reported as a specific SRE, as some SREs may be applicable to more than one category. Event-specific Clinical Application Guidance comprises four key components: the event name, intent, key definitions, and reporting considerations.

Q: Who should use the SRE Clinical Application Guidance?

A: The Clinical Application Guidance is intended for healthcare professionals who review patient safety events for qualification as SREs and aims to aid anyone who oversees, implements, or operationalizes SRE reporting programs or who seeks information on SREs.

Q: If a clinical scenario is not included in the SRE Clinical Application Guidance reporting considerations, should it be reported?

A: Yes. The reporting considerations translate the high-level intent into specific clinical circumstances that further clarify whether an event qualifies as an SRE. These circumstances do not capture every possible clinical scenario, nor do they provide exhaustive examples of event classifications. Instead, the Clinical Application Guidance provides Reviewers with three actionable prompts for use when evaluating whether an event should be reported as an SRE. These prompts align with the SRE Inclusion Criteria and associated definitions for *patient encounter*, *serious*, and *largely preventable*.

Q: If an event is discovered after the patient encounter, should it be reported?

A: Yes. Individuals and healthcare organizations should report an event when made aware of the occurrence, regardless of the time passed after the event. At times, the extent of harm may not be known or apparent at the time of the patient encounter Healthcare organizations may become aware of an event via the patient, family, or another individual or during a subsequent healthcare encounter such as a readmission, follow-up appointment, or treatment.

Q: Can an event qualify for more than one SRE?

A: Yes. When evaluating events for SRE reporting, NQF recognizes that some events may qualify for multiple SREs. Reviewers are encouraged to select the SRE that is most directly associated with the event outcome. However, to drive systemic learning and reduce preventable harm, Reviewers may need to report one event as multiple SREs especially when more than one contributing factor exists.

Q: If my state has differing guidance for an SRE, which takes precedence?

A: All state, legal, or other jurisdictional boundaries take precedence in the way events are interpreted and reported. NQF is not a regulatory or governing body. The SRE List and guidance serves as a catalyst for clear understanding and consistent reporting by identifying key considerations for each SRE, including what is and is not intended to be captured, as recommended by experts.

Reporting Pathways

Q: I am part of a clinical care team and think I have witnessed an SRE. What should I do?

A: All employees of a healthcare setting are encouraged to follow your internal pathways for reporting patient safety events and escalate concerns to a higher authority as soon as possible.

Q: I identified and reported an SRE, what's next?

A: Once reported, healthcare organizations will review the event, examine root causes and contributing factors, and work towards improvements to mitigate the risk of reoccurrence.

If the employee does not feel that the healthcare organization has appropriately reviewed or addressed the event, they may escalate their concerns to Joint Commission (for Joint Commission accredited entities only), Centers for Medicare & Medicaid Services, or their state department of health.

Q: I am a patient/family member/caregiver, and I think I have experienced an SRE. What should I do?

A: If you believe you have experienced a serious reportable event, consider the following pathways:

1. Report your concerns to the clinical care team.
2. Escalate your concerns to a higher authority in the healthcare organization/facility. This may include a quality or safety leader, executive, or patient advocate.
3. Escalate your concerns as a formal complaint by contacting the healthcare organization/facility, or through other healthcare agencies, such as Joint Commission, Centers for Medicaid & Medicare Services, or your state department of health.
4. Reach out to patient safety advocacy groups for guidance or additional reporting avenues within your jurisdiction.