

Network of Patient Safety Databases

2026

CHARTBOOK



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NETWORK OF PATIENT SAFETY DATABASES CHARTBOOK, 2026

U.S. DEPARTMENT OF
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INTRODUCTION TO THE NPSD AND COMMON FORMATS

The Network of Patient Safety Databases (NPSD) provides an interactive, data-informed management resource for healthcare provider organizations, Patient Safety Organizations (PSOs) and others. The U.S. Department of Health and Human Services was authorized to create the NPSD by the [Patient Safety and Quality Improvement Act of 2005 \(PSQIA\)](#), and it is implemented by the Agency for Healthcare Research and Quality (AHRQ), the lead federal agency for patient safety.

AHRQ developed the Common Formats, a standardized reporting format using common language and definitions, to collect information about patient safety events and concerns from across the nation. PSOs collect voluntary reports from healthcare providers and submit data to the PSO Privacy Protection Center (PSOPPC).

The PSOPPC ensures the Common Formats data are non-identifiable before being sent to the NPSD for aggregation and analysis. All event-related dates are removed and converted to years. The transfer process from the PSOPPC to the NPSD includes both the de-identification of providers and PSOs and the de-duplication of reports due to PSO resubmissions of the same report.

These data can then be used to identify trends and patterns in patient safety concerns, and to provide insight into how to mitigate patient safety risks and reduce harm across healthcare settings nationally. Submission of patient safety event data by providers across the country to PSOs and then submission of those data by PSOs to the PSOPPC is completely voluntary. Each provider and PSO that participates by contributing data advances knowledge about patient safety.

Common Format for Event Reporting – Hospital (CFER-H)

This chartbook uses data collected with both CFER-H V1.2 and CFER-H V2.0. CFER-H V1.2 became active in 2012, and CFER-H V2.0 became active in 2018. While the CFER-H is primarily used as intended to capture patient safety events in hospital settings, provider

Highlights

- The most commonly reported event types during the past 10 years were *Other, Medication and Other Substance* and *Fall*.
- Two-thirds of all events were *Incident* report types meaning the issue “reached the patient.”
- *Incidents* and *Near miss* report types showed very similar patterns of reported contributing factors, especially when *Other* is excluded. *Human factors* was the leading contributing factory category for both, at 70%. In contrast, *Unsafe conditions* showed a distinct pattern of contributing factors, with *Multiple* and *Communication* factors reported most frequently. See **Figure 9**.
- Among Incident reports only:
 - The majority of incidents (62%) were reported as causing no residual harm to the patient, only 2% resulting in moderate harm and 1% each for severe harm and death. As such, the events reported to the NPSD suggest a meaningful opportunity for learning from patient safety concerns before significant harm occurs to patients.
 - Patient residual harm was most frequently reported among Pressure Injury, Perinatal and Venous Thromboembolism (VTE) event types.

organizations may also have used the CFER-H to report data from other care settings. Trends in data submission can be found in **Appendix A**.

After the development of the CFER-H V1.2, reporting healthcare-associated infection (HAI) through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) has been mandated by the Centers for Medicare & Medicaid Services (CMS) and many states. Additionally, in 2018, AHRQ decided not to include HAI as an event type in CFER-H Version 2.0. Given the small number of CFER-H V1.2 HAI reports submitted between January 1, 2016 - December 31, 2025 (n=17,517) and the high quality of data collected through NHSN, HAI events are not included in this chartbook.

NPSD Case Exclusion Criteria

The CFER-H was designed to exclude reports of patient safety events where the nature of the patient safety concern could not be attributed to the hospital (i.e., present on admission), did not appear to involve incorrect actions or were otherwise not part of the focus of the event-specific module. Therefore, each report goes through a validity review using the CFER-H NPSD Exclusion Criteria.

If any of the event-specific exclusion criteria are met, then the reported event is deemed “invalid” and excluded from the NPSD. These exclusions are important for the standardization of event reporting. This results in the NPSD as a unique and valuable resource of standardized patient safety events that is used for research and for learning about how to improve patient safety and prevent patient harm.

Detailed descriptions of the NPSD Case Exclusion Criteria by Event Type and the associated CFER-H Data Element (DE) can be found in **Appendix B**.

Previous NPSD Chartbooks (2023 – 2025)

The [2025 NPSD Chartbook](#) focused on *pressure injury* events submitted using CFER-H Versions 1.2 and 2.0 for events that took place January 2010 through December 31, 2024. The number of reports was 93,807. The [2024 NPSD Chartbook](#) focused on *Medication and Other Substance* events submitted using CFER-H Version 1.2 for events that took place January 2010 through December 31, 2023. The number of reports was 486,543. Two Chartbooks were presented for 2023. The [2023 NPSD Falls Chartbook](#) focused on *fall* events submitted using CFER-H Version 1.2 for events that took place January 2010 through December 31, 2022. The number of reports was 243,449. The second [2023 Generic Chartbook](#) included an overview of events using data from the 2,617,691 reports collected with CFER-H V1.2 January 2010 through December 31, 2022.

UNDERSTANDING THE 2026 CHARTBOOK

This Chartbook provides a cross-sectional overview of patient safety concerns reported in CFER-H V1.2 and CFER-H V2.0. Unlike the previous two years' event-specific Chartbooks, this Chartbook focuses on the standardized DEs that are collected across all event types, such as contributing factors, events locations and patient residual harm.

2026 NPSD Chartbook Data

This Network of Patient Safety Databases Chartbook (2026 NPSD Chartbook) focuses on the past 10 years of patient safety data submitted to the PSOPPC in Common Formats for Event Reporting – Hospital (CFER-H) from January 2016 – December 31, 2025. All DEs presented in the 2026 Chartbook underwent monitoring of volume and variability for reliable reporting and to comply with non-identification requirements.

The data presented have initial report dates from January 1, 2016, through December 31, 2025. In CFER-H, the **INITIAL REPORT DATE** is collected with DE30 in response to “What is the date the Common Formats patient safety module was completed?”

In CFER-H, the **EVENT TYPE** is collected with DE21 in response to the generic question: “Which of the following categories are associated with the event or unsafe condition?” After the reporter selects an event type, they move to an event-specific module that asks questions specific to the event type. These event types were developed because they were identified as the most frequently occurring events.

In this Chartbook, we do not report on *Surgery* (alone) or *Anesthesia* (alone) event types because a) too few of the CFER-H V2.0 submitted reports were sufficiently complete for meaningful analysis and b) CFER-H V1.2 collects these events as one combined event type. Therefore, the data collected with CFER-H V2.0 for these two events have been combined as *Surgery or Anesthesia*.

Several of the sections in this Chartbook are also reported on AHRQ's website as interactive dashboards among the NPSD Generic Dashboard accessible at <https://www.ahrq.gov/npsd/data/dashboard/generic.html>.

NPSD Chartbook Text Formatting

The text of the NPSD Chartbook has been formatted to assist readers in recognizing when the discussion relates to a Common Formats Event Type, Data Element and Answer Value. Event Types represent the distinct modules of the CFER-H (e.g., *Blood or Blood Product*, *Device or Medical/Surgical Supply*, *Fall*, *Medication or Other Substance*, *Perinatal*, *Pressure Injury*, *Surgery or Anesthesia* and *Venous Thromboembolism*). DEs refer to the concepts reported in the CFER-H and captured through individual questions asked of event reporters for each patient safety concern reported (e.g., “What is being reported?”). Answer Values represent the unique response options for each Data Element. Following the previous example, DE3: “What is being reported?” has three Answer Values: *Incident*, *Near miss* and *Unsafe condition*.

Each of these types of information contained in the CFER-H is formatted differently in the text to clarify the context of the information for readers. The following formatting is used throughout the remainder of this document:

- Event Types: All key words have first-letter capitalization and are italicized (e.g., *Blood* or *Blood Product*)
- Data Elements: When introduced within a section of this Chartbook, all letters are capitalized and bold-faced (e.g., **CATEGORY ASSOCIATED WITH EVENT OR UNSAFE CONDITION**)
- Answer Values: First letter of the first word is capitalized and all letters are italicized (e.g., *Unsafe condition* or *Moderate harm*)
- All reports are referred to as “events.”
- “CFER-H” refers to the use of Version 1.2 and Version 2.0 of the Common Formats for Event Reporting – Hospital, unless stated otherwise.

RESULTS: ALL REPORT TYPES

The total number of reports analyzed for this 2026 Chartbook is 3,087,813; 63.5% of the data were submitted with CFER-H V1.2 and 36.5% of the data were submitted with CFER-H V2.0.

Volume by Event Type

Table 1 below lists the mutually exclusive Event Types reported in this Chartbook.

Table 1: Volume by Event Type in 2026 Chartbook

Event Type	# of Events Jan 2016 – Dec 2025	Percent of Total Events
Medication or Other Substance*	527,113	17.1%
Fall*	375,726	12.2%
Surgery or Anesthesia*	146,232	4.7%
Device or Med/Surg Supply*	80,110	2.6%
Pressure Injury*	59,253	1.9%
Blood or Blood Product*	40,614	1.3%
Perinatal*	21,443	0.7%
Venous Thromboembolism (VTE)	639	0.02%
Other	1,833,849	59.4%
Multiple Event Types**	2,834	0.1%
TOTAL Events	3,087,813	100%

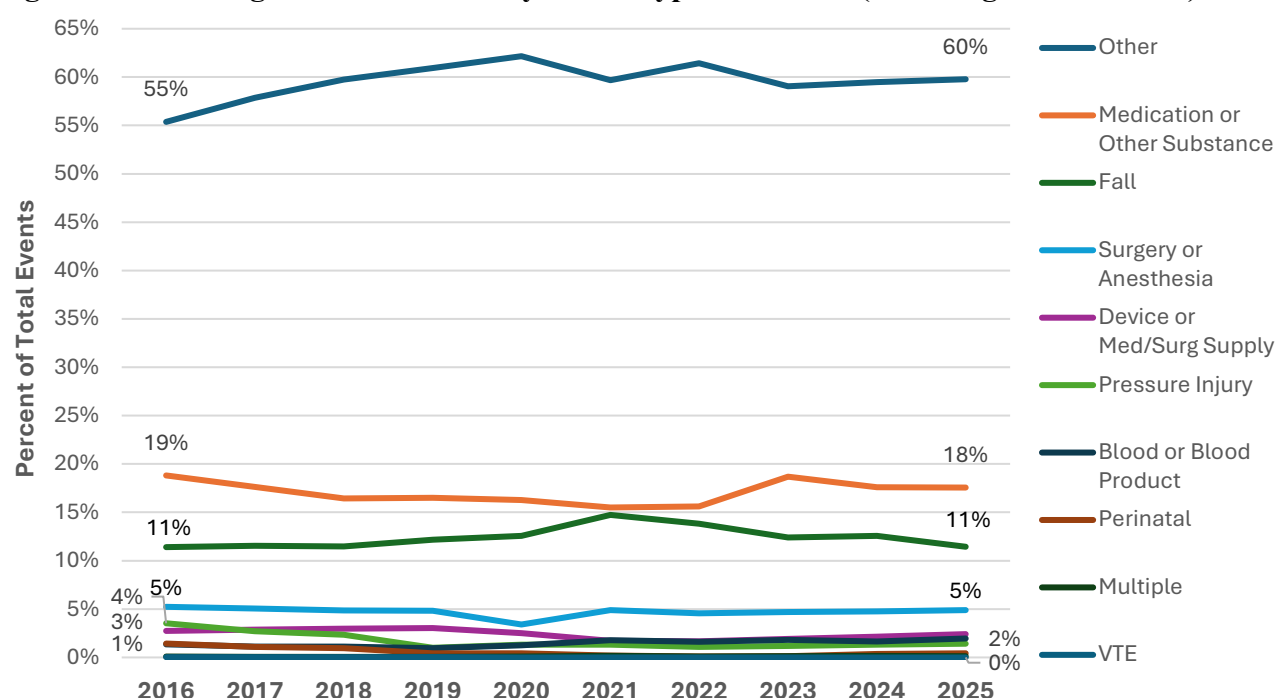
* Event-specific details can be found using the interactive NPSD Dashboards available at <https://www.ahrq.gov/npsd/data/dashboard/index.html>.

** *Multiple EVENT TYPE* is when more than one event type was submitted in a single report. This could be because one person experienced multiple patient safety concerns or event types. The most common event types within the 2,834 reports categorized as *Multiple* event type are *Device or Medical/Surgical Supply* (62%), *Medication or Other Substance* (50%), *Other* (47%) and *Surgery or Anesthesia* (23%).

Patient Safety Event Type Trends

Figure 1 below displays the **EVENT TYPE** of the patient safety concern as a percentage of all event types identified in reports received in CFER-H V1.2 and CFER-H V2.0, by event report year between January 1, 2016, and December 31, 2025.

Figure 1: Percentage of Total Events by Event Types and Year (including Other Events)



Over the last 10 years (2016-2025), the most frequently reported **EVENT TYPE** was *Other*, with 55.0% in 2016 (209,921 / 379,126) and 60% in 2025 (74,592 / 124,795).

The large percentage of *Other* events reported may reflect issues encountered when mapping data from primary event-reporting systems into the CFER-H and/or specific concerns not captured by any of the event-specific modules. Examples of issues reported as *Other* event type are events that are related to the laboratory process (e.g., specimen handling, labeling, result communication), patient health record documentation, transitions in care (i.e., arrivals, transfers, discharges), workplace safety or patients leaving against medical advice.

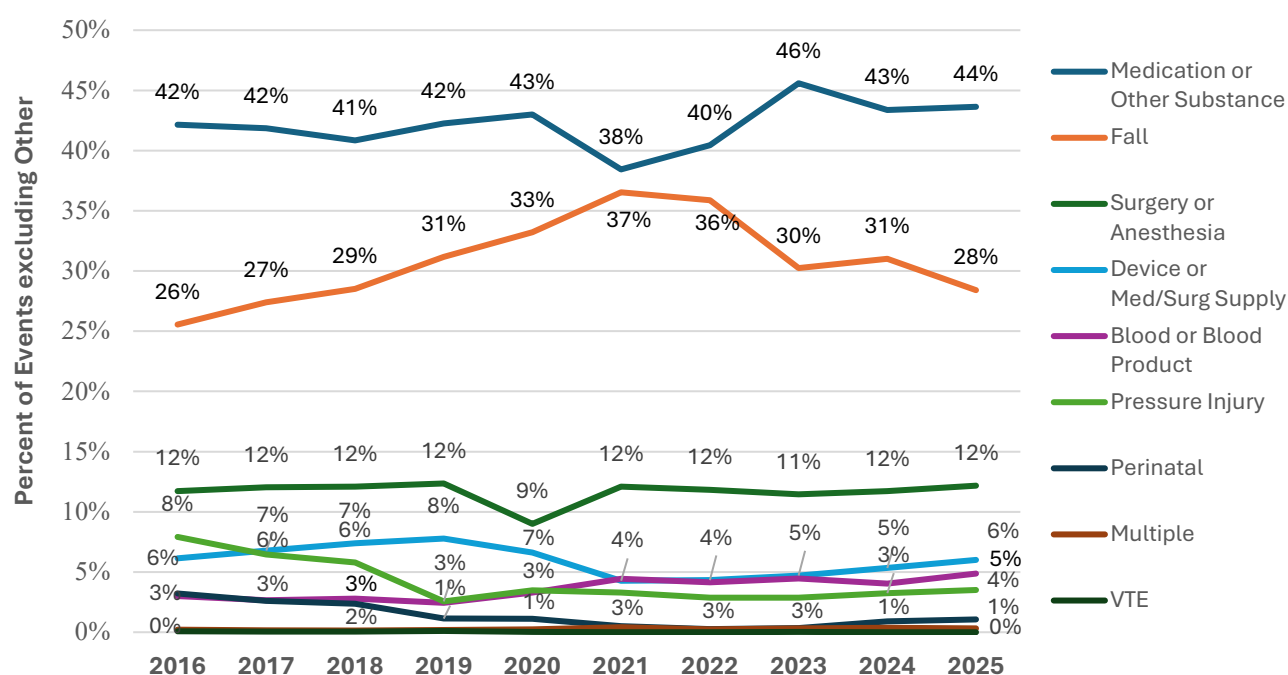
There are six **EVENT TYPES** in **Figure 1** that represent less than 5% of all the events when *Other* **EVENT TYPE** is included.

Technical Notes

- The year displayed corresponds to the year of the **INITIAL REPORT DATE** (DE30).
- N = 3,087,813 events. (100% of Total)

Figure 2 below displays the annual trend of an **EVENT TYPE** as a percentage of event types excluding *Other* events.

Figure 2: Percent of Reported Events by Event Types and Year (excluding Other Events)



Over the last 10 years (2016-2025), the most frequently reported **EVENT TYPE** excluding *Other* events was:

- *Medication or Other Substance*, with 42% in 2016 (71,336 / 169,205) and 44% in 2025 (21,901 / 50,203);
- *Fall*, with 26% in 2016 (43,238 / 169,205) and 28% in 2025 (14,267 / 50,203).

The percentage of *Medication or Other Substance* events ranged from a low of 38% in 2021 to a high of 46% in 2023. The figure also shows that, from 2020 to 2021, there was a decrease in the percentage of *Medication or Other Substance* events (from 43% to 38%) and an increase in the percentage of *Fall* events (from 33% to 37%). The changes coincide with changes in the distribution of patient age categories among *Incident* report type events during the same year, possibly due to the COVID-19 pandemic's decrease in acute admissions not related to COVID and decrease in elective surgeries.¹

Technical Notes

- In CFER-H, the **EVENT TYPE** is found in the DE21 in response to the question: "Which of the following categories are associated with the event or unsafe condition?"
- The year displayed corresponds to the year of the **INITIAL REPORT DATE** (DE30).

¹ Gallagher et.al, "Early 2021 data show no rebound in health care utilization." Aug. 17 2021.
<https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/>

- N = 1,253,964 events. (41% of Total)

Report Types by Year

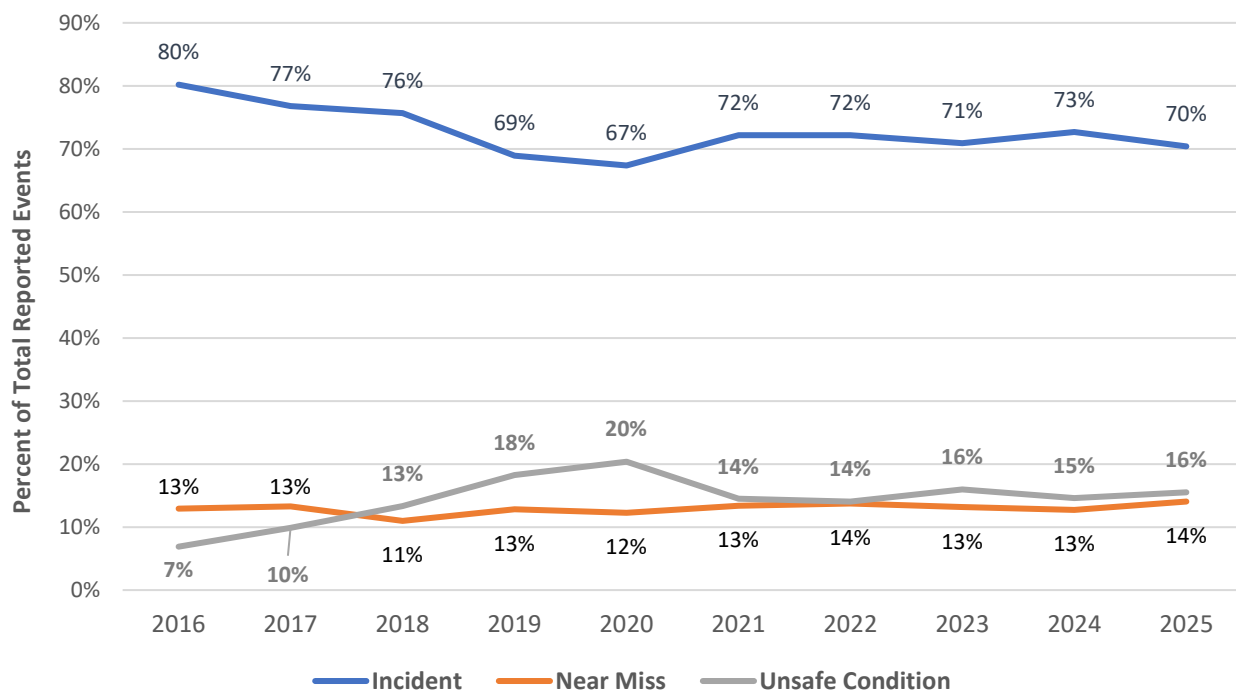
The CFER-H collects **REPORT TYPE** with Data Element 3 (DE3) in response to the question: “What is being reported?” The possible responses are *Incident*: A patient safety event that reached the patient, whether or not the patient was harmed; *Near miss*: A patient safety event that did not reach the patient and *Unsafe condition*: Any circumstance that increases the probability of a patient safety event.

For all years, among the total 3,087,813 events, 2,264,067 (73%) represent *Incidents*, 391,878 (13%) represent *Near misses* and 431,868 (14%) represent *Unsafe conditions*.

Incidents can be reported for any **EVENT TYPE**. However, *Incident* is the only report type possible for these four event types: *Fall*, *Perinatal*, *Pressure injury* and *Venous Thromboembolism (VTE)*. The event types of *Surgery or Anesthesia* can be reported as *Incidents* or *Near misses*. The remaining event types can have all three report types.

Figure 3 shows the annual trend of the percentage of report types, that is, *Incidents*, *Near misses* or *Unsafe conditions* among all events.

Figure 3: Report Type by Year



Within the last 10 years (2016-2025), *Incidents* were the majority of each of the report types, ranging from a low of 67% (240,819 / 357,462) in 2020 to a high of 80% (304,042 / 379,126) in 2016.

Technical Notes

- In CFER-H, the **REPORT TYPE** is found in DE3 in response to the question: “What is

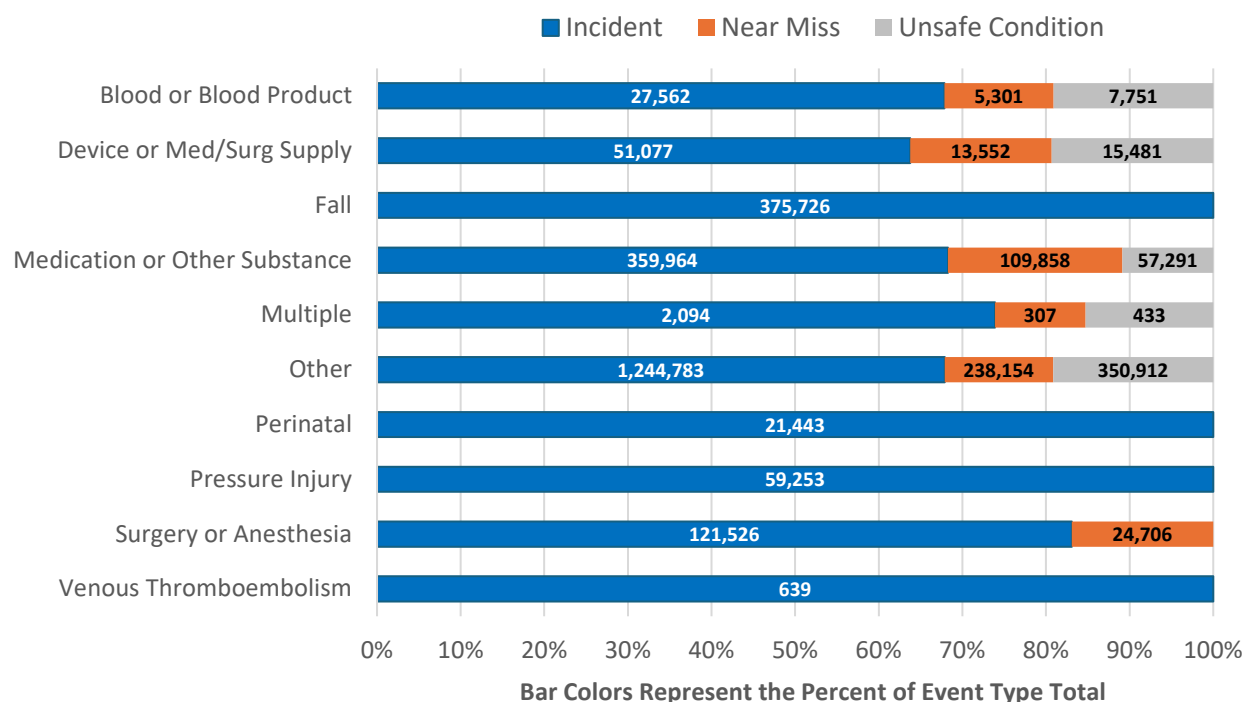
being reported?” The year displayed corresponds to the year of the **INITIAL REPORT DATE** (DE30).

- N = 3,087,813 events. (100% of Total). Percentages sum to 100% within each year, but the sum of percentages may not total 100% due to rounding.

Report Type by Event Type

Figure 4 below shows the distribution of the three **REPORT TYPES** among the **EVENT TYPES** during all years (2016-2025).

Figure 4: Report Type by Event Type



Excluding the four event types that can only be reported as incidents, the largest proportion of *Incidents* was reported for *Multiple* (74%; 2,094 / 2,834). This is not surprising because these 2,834 reports include more than one event type and, therefore, most likely are more complex and have an increased risk of an incident that reaches the patient. The most common overlaps of event types in *Multiple* being: 1) *Device or Medical/Surgical Supply* with *Anesthesia*, 2) *Device or Medical/Surgical Supply* with *Pressure Injury* and 3) *Blood or Blood Product* with *Other*. Relatively large proportions of *Incident* report types are found among *Surgery or Anesthesia* (83%; 121,526 / 146,232), *Blood or Blood Product* (68%; 27,562 / 40,614), *Medication or Other Substance* (68%; 359,964 / 527,113) and *Other* (68%; 1,244,783 / 1,833,849).

The largest proportion of *Near misses* were reported for *Medication or Other Substance* events (21%; 109,858 / 527,113), while the largest proportion of *Unsafe conditions* (19%) were reported for *Blood or Blood Product* (19%; 7,751/40,614), *Other* (19%; 350,912/1,833,849) and *Device or Med/Surg Supply* (19%; 15,481/80,110).

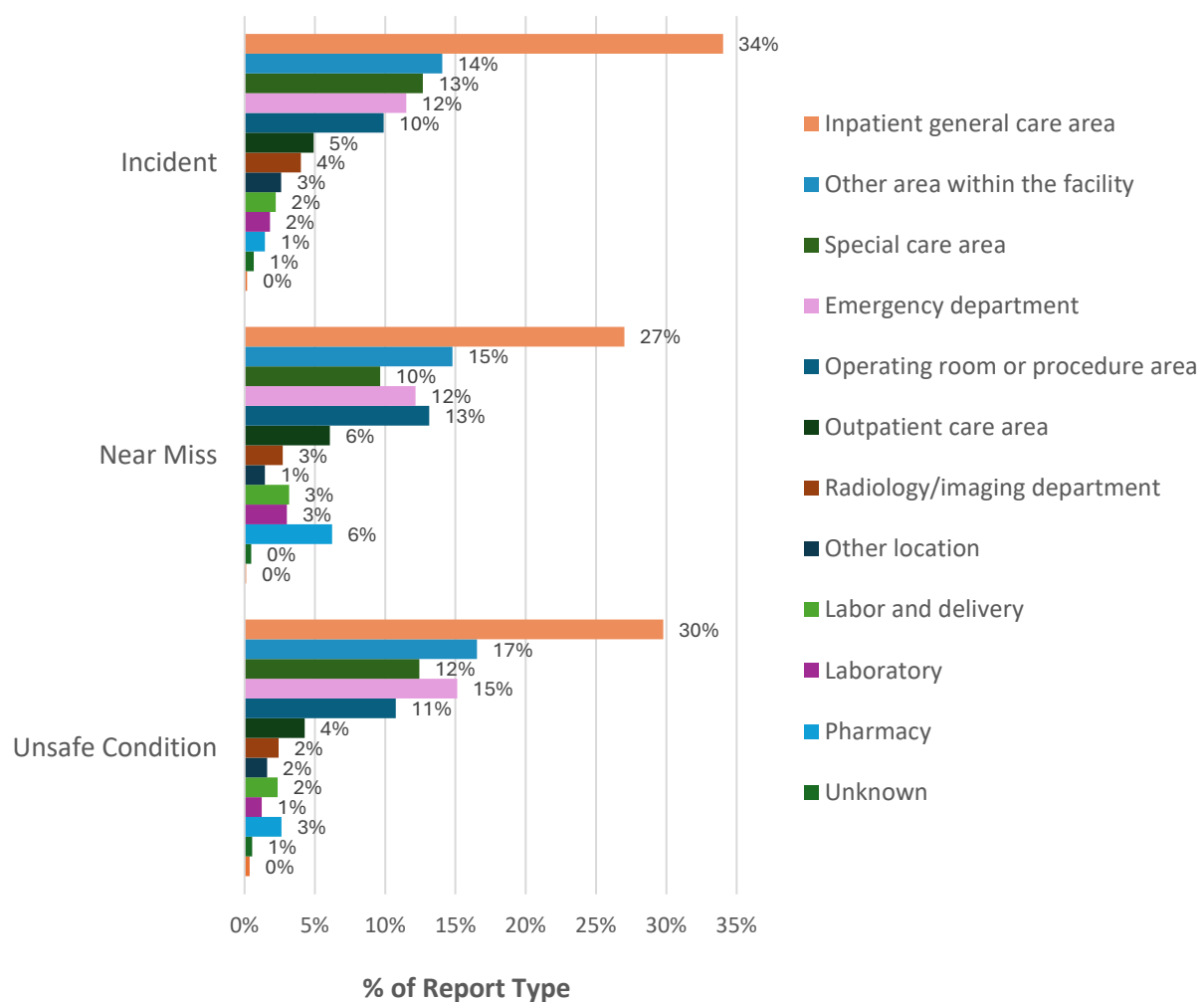
Technical Notes

- In CFER-H, the **EVENT TYPE** is found in the DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?” The **REPORT TYPE** is found in the DE3 in response to the question: “What is being reported?”
- The data presented above indicate the types of reports within each category of **EVENT TYPE** as a percentage of all events in that category.

Location by Report Type

Figure 5 examines the percentage of each **EVENT LOCATION** by **REPORT TYPE**.

Figure 5: Event Location by Report Type



Across all **REPORT TYPES**, *Inpatient general care area* was the most frequently reported location (32%; 844,577 of the total 2,604,197 events with non-missing **EVENT LOCATION**) making up 34% (631,906 / 1,856,985) of *Incidents*, 27% (96,205 / 355,974) of *Near misses* and 30% (116,466 / 391,238) of *Unsafe conditions*.

Outside of *Inpatient general care area*, *Incidents* mostly occurred in *Other area within the facility* (14%), *Special care area* (13%), *Emergency department* (12%) and *Operating room or procedure area* (10%). *Near misses* and *Unsafe conditions* were similarly distributed; however, a larger share of *Near misses* occurred in *Operating room or procedure area* (13%), *Pharmacy* (6%) and *Outpatient care area* (6%) than for either *Unsafe conditions* or *Incidents*. *Other area within the facility* and *Emergency department* locations were more frequent among *Unsafe condition* reports (17% and 15%, respectively) than either *Incidents* or *Near misses*.

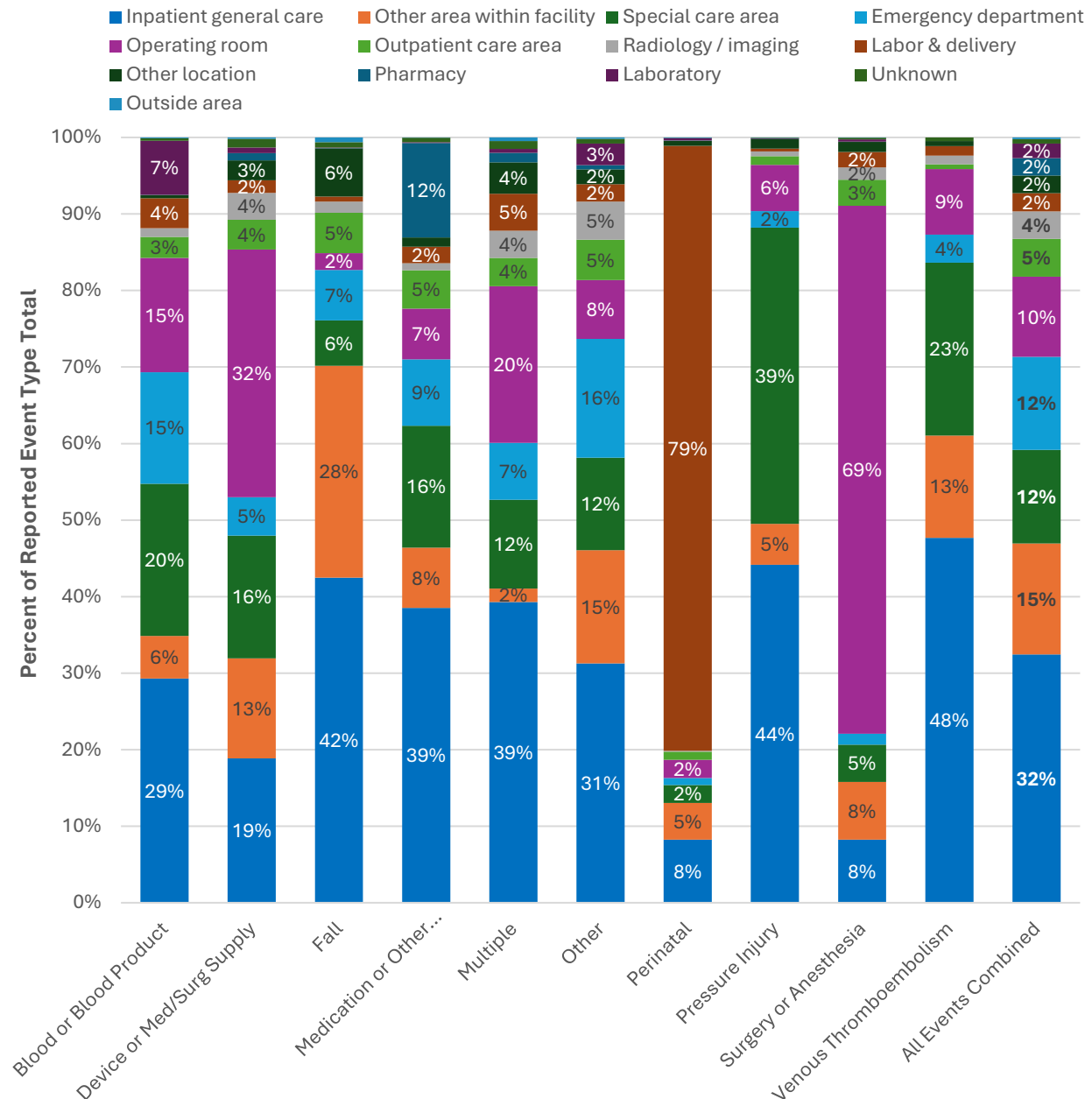
Technical Notes

- In CFER-H V1.2, the **REPORT TYPE** is found in the DE3 response to the question: “What is being reported?” **EVENT LOCATION** is defined by DE78 in response to the question “Where did the event or unsafe condition occur?”
- Five **LOCATIONS** have longer and more descriptive labels than those shown in the figure: Inpatient general care area (e.g., medical/ surgical unit); Special care area (e.g., ICU, CCU, NICU); Operating room or procedure area (e.g., cardiac catheter lab, endoscopy area), including PACU or recovery area; Radiology/imaging department, including onsite mobile units and Laboratory, including pathology department and blood bank.

Event Location by Event Type

Figure 6 examines the percentage of each **EVENT LOCATION** by **EVENT TYPE**. The last bar in the figure provides the percentage among all event types combined. Value labels are not shown in the graph for any blocks with less than 2%.

Figure 6: Event Location by Event Type



Inpatient general care area was the most frequently reported location among all **EVENT TYPES** combined (32%; 844,577 of the total 2,604,197 events with non-missing **EVENT LOCATION**).

Inpatient general care and *Special care areas* made up about half of locations where *Blood or Blood Product* events occurred, accounting for 29% (9,990 / 34,113) and 20% (6,782 / 34,113) of these events, respectively. *Operating rooms or procedure areas* and *Emergency departments* accounted for 15% each.

Operating rooms or procedure areas made up almost a third of reported locations for *Device or Medical/Surgical Supply* (32%; 22,647 / 69,975) events. *Inpatient general care* (19%) and *Special care areas* (16%) were also common locations for these events. *Other area within the facility* locations made up 13% of reported locations for *Device or Medical/Surgical Supply*.

Over a third of *Falls* occurred in *Inpatient general care* areas (43%; 132,794 / 312,583). *Other area within the facility* was the second most common reported location for *Falls* (28%).

Thirty-nine percent (156,697 / 406,732) of *Medication or Other Substance* events occurred in *Inpatient general care* areas. Not surprisingly, in comparison to other event types, *Medication or Other Substance* events had the highest proportion of reports that occurred in the *Pharmacy* setting (12%).

Intuitively, most *Perinatal* events were reported from *Labor and delivery* (79%; 9094 / 11,504) and the majority of *Surgery or Anesthesia* (69%; 84,637 / 122,687) events were reported from *Operating rooms or procedure areas*.

While *Pressure Injuries* were reported most often in *Inpatient general care* areas (44%; 19,403 / 43,924), a common location for *Pressure Injuries* was also *Special care areas* (39%). Lastly, nearly half of *Venous Thromboembolism (VTE)* (48%; 300 / 629) were reported in *Inpatient general care* areas.

Technical Notes

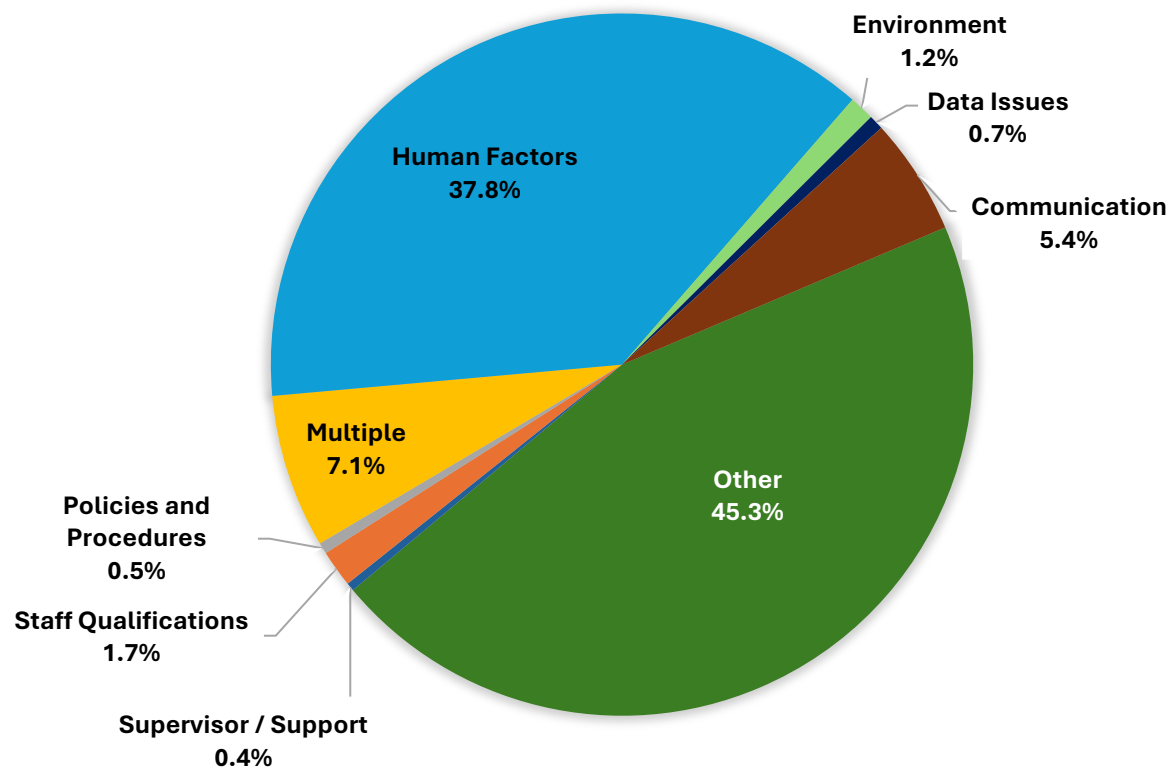
- In CFER-H, the **EVENT TYPE** is found in DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
- **EVENT LOCATION** is defined by DE78 in response to the question “Where did the event occur, or if an unsafe conditions, where does it exist?”
- Event totals are less than those shown in Table 1, as this figure further excludes 483,616 events (16% of total) where DE78 is missing. The sum of percentages may not total 100% due to rounding.

Contributing Factors

The contributing factor of an event is a circumstance determined retrospectively to have increased the likelihood of the event and that is generally external to the patient. Contributing factors frequently relate to the physical environment or to the care delivery system.

Figure 7 shows the distribution of the **CONTRIBUTING FACTOR** categories across all 10 years, all **REPORT TYPES** and **EVENT TYPES**. The list of the CFER-H response values within each contributing factor category can be found in **Appendix C**.

Figure 7: Distribution of Contributing Factors



Among the total events used for this Chartbook (N=3,087,813), a known **CONTRIBUTING FACTOR** was reported for 56.1% of the total (n=1,732,452); 1.3% had “No Known” contributing factor reported and contributing factor was missing for the remaining 42.6% of the total events.

The most common contributing factor was *Other* (45.3%; 784,496 / 1,732,452).

The second most reported contributing factor was *Human Factors* (37.8%; 655,178/1,732,452). *Human Factors* include fatigue, stress, inattention, cognitive factors and/or health issues experienced by medical staff.

The third most reported contributing factor was *Multiple* (7.1%; 122,718/1,732,452). The common contributing factors that constitute the *Multiple* category are *Human Factors*, *Other*, *Staff Qualifications* and *Communication at Handover/Handoff*.

Technical Notes

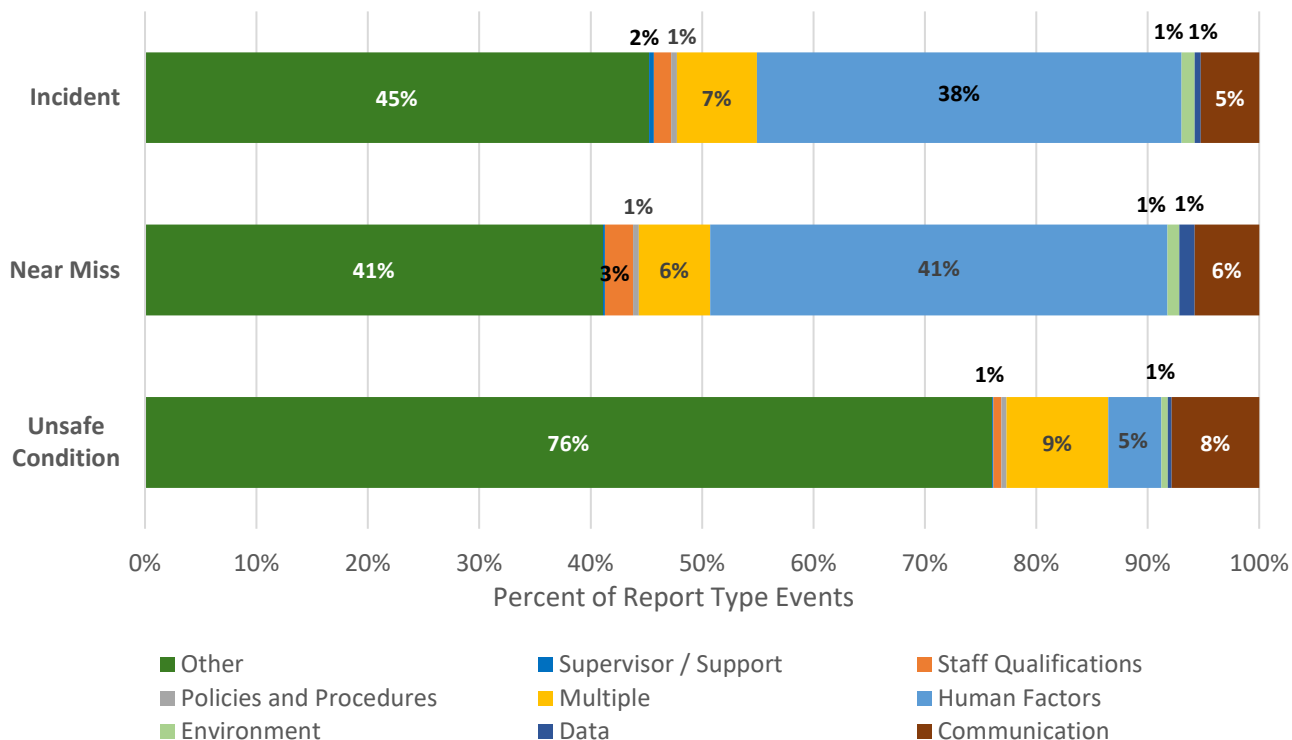
- **CONTRIBUTING FACTOR(S) FOR EVENT** is defined by DE105 in response to the question “What factor(s) contributed to the event?” (See **Appendix C** for more detail.)
- To avoid potential risk of disclosure due to small counts and to integrate CFER-H V1.2 and V2.0, possible responses for DE105 were recategorized into broader contributing factors. For instance, for reports where the contributing factors were *Data: Availability*, *Data: Accuracy*, *Health Information Technology (HIT)* or *Data Issues* (e.g., *availability*, *accuracy*), the contributing factor category is presented as *Data Issues*.

- Among the reports with more than one **CONTRIBUTING FACTOR** (n=122,718), the most common overlaps of contributing factors within the *Multiple* category are 1) *Staff Qualifications* with *Human Factors* and 2) *Policies and Procedures* with *Supervisor / Support*.

Contributing Factor by Report Type

Figure 8 examines the percentage of **CONTRIBUTING FACTORS** by **REPORT TYPE**.

Figure 8: Contributing Factor by Report Type (including *Other* Contributing Factor)

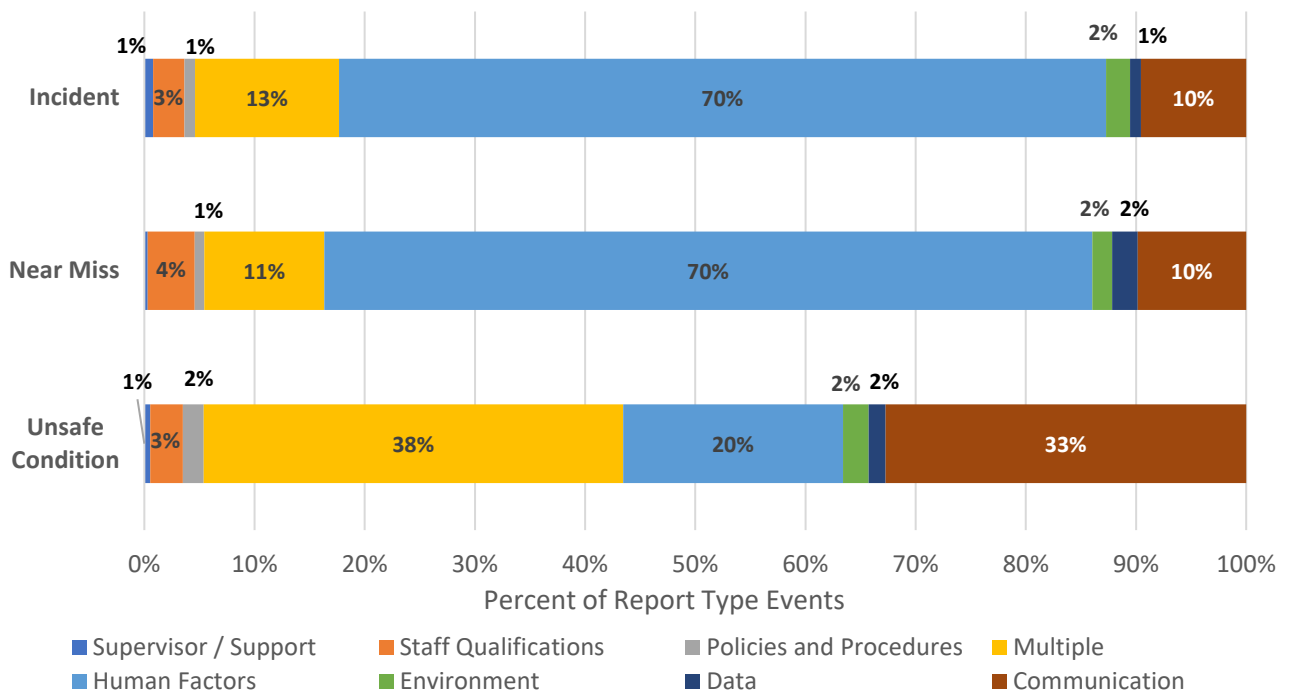


As shown in **Figure 8**, *Other* is the most common **CONTRIBUTING FACTOR** among *Incident* reports (45%; 635,899 / 1,405,907) and *Unsafe conditions* (76%; 31,310 / 41,180). *Human Factors* and *Other* each represent 41% of *Near misses* (117,180 / 285,365 and 117,287 / 285,365, respectively).

Technical Notes

- In CFER-H, the **REPORT TYPE** is found in the DE3 in response to the question: “What is being reported?” **CONTRIBUTING FACTOR(S) FOR EVENT** is defined by DE105 in response to the question “What factor(s) contributed to the event?”
- This figure includes 1,732,452 reports with a usable response to DE105, meaning it excludes reports with a *No Known CONTRIBUTING FACTOR* or a missing response to DE105.

Figure 9: Contributing Factors by Report Type (excluding *Other* Contributing Factor)



As shown in **Figure 9**, excluding reports where *Other* factors contributed to the event or unsafe condition,

- *Human Factors* was the most frequently reported contributing factor (69%; 665,178 / 947,956 reports) making up 70% (536,030 / 770,008) of *Incidents*, 70% (117,180 / 168,078) of *Near misses* and 20% (1968 / 9,870) of *Unsafe conditions*.
- *Communication* was a contributing factor for a third of unsafe conditions (33%) and for 10% of both *Incidents* and *Near misses*. As shown in **Appendix C**, *Communication* issues can include communication issues among staff or team members, among staff to patient (or family) or among supervisor to staff.
- *Multiple Factors* contributed to over a third of *Unsafe conditions* (38%; 3,759 / 9,870). Among these 3,759 reports, the two most prevalent contributing factors were *Other* and *Communication*. Furthermore, the most common overlaps are 1) *Staff Qualifications* with *Human Factors* and 2) *Environment* with *Data Issues*.

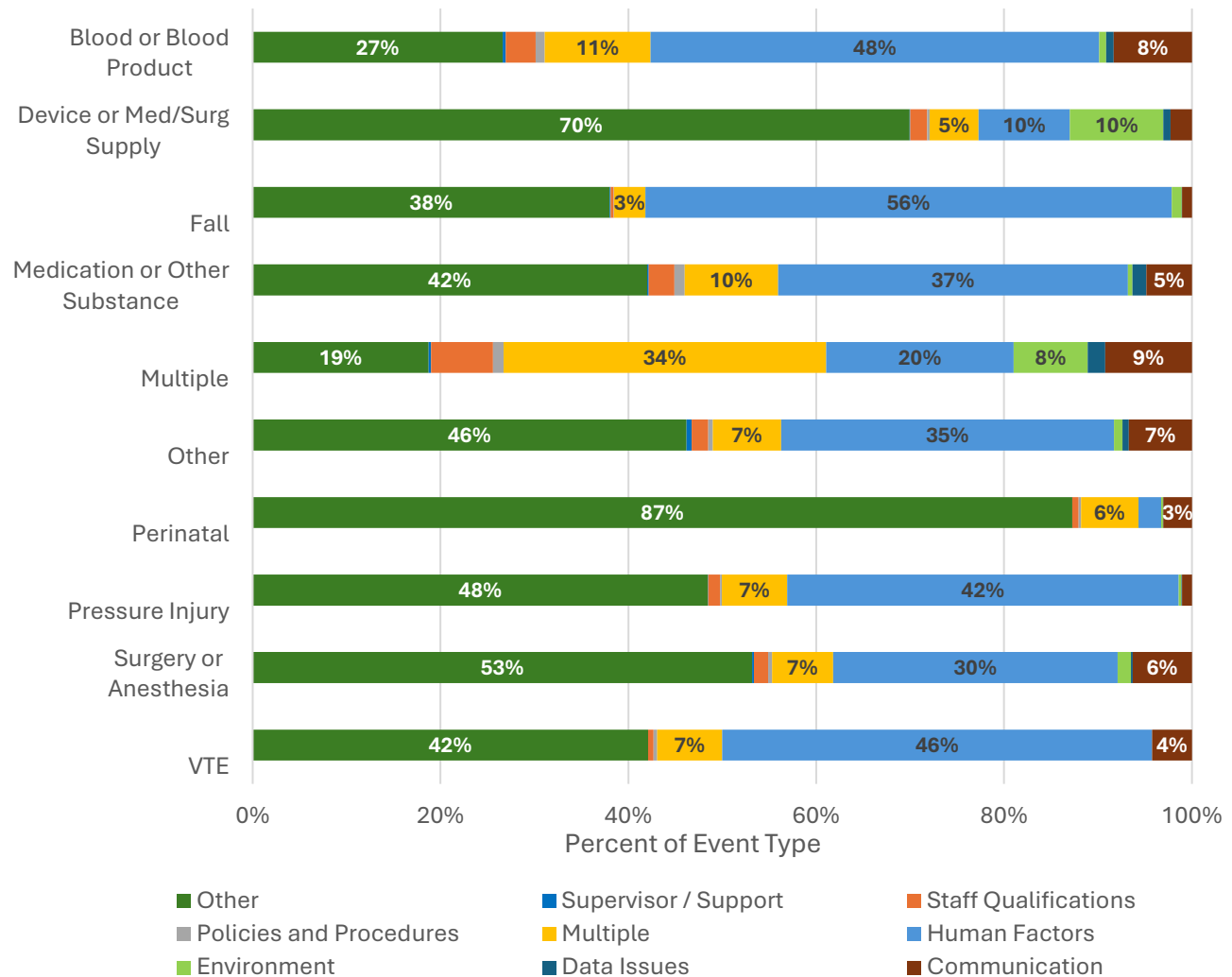
Technical Notes

- In CFER-H, the **REPORT TYPE** is found in the DE3 response to the question: “What is being reported?” **CONTRIBUTING FACTOR(S) FOR EVENT** is defined by DE105 in response to the question “What factor(s) contributed to the event?”
- This figure excludes 784,496 reports with missing response to **CONTRIBUTING FACTOR** or a response of *No Known* or *Other*. The data used for analysis included 947,956 reports (1,732,452 – 784,496). Percentages sum to 100% within each row, but the sum of percentages may not total 100% due to rounding.

Contributing Factors by Event Type

This figure examines the percentage of **CONTRIBUTING FACTORS** by **EVENT TYPE**. Across all event types with a known contributing factor, *Other* factors were the most common (45%; 784,496 / 1,732,452).

Figure 10: Contributing Factors by Event Type



As shown in **Figure 10**, *Other* is the majority **CONTRIBUTING FACTOR** among three of the 10 **EVENT TYPES**: *Device or Medical/Surgical Supply*, *Perinatal* and *Surgery or Anesthesia*.

Human Factors was a relatively large contributing factor among *Fall* events (58%), *Blood or Blood Product* events (48%) and *VTE* events (46%).

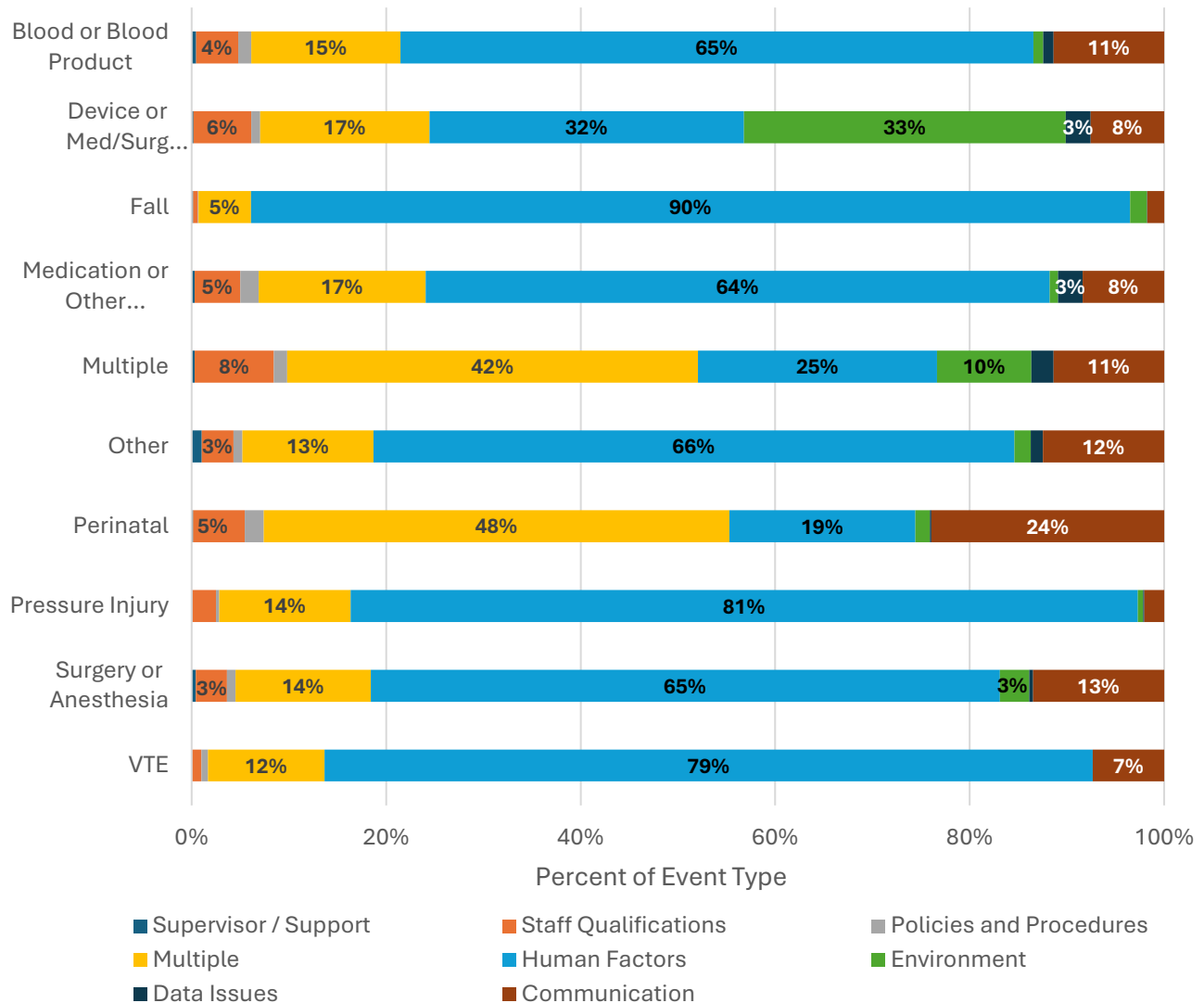
Technical Notes

- In CFER-H, the **EVENT TYPE** is found in DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
CONTRIBUTING FACTOR(S) FOR EVENT is defined by DE105 in response to the

question “What factor(s) contributed to the event?”

- This figure includes 1,732,452 reports with a usable response to DE105 meaning it excludes reports with a *No Known CONTRIBUTING FACTOR* or missing response to DE105.

Figure 11: Contributing Factors by Event Type (excluding OTHER Contributing Factor)



As shown in **Figure 11**, after excluding *Other CONTRIBUTING FACTOR*, *Human Factors* was the most frequently reported contributing factor across most **EVENT TYPES**, particularly for *Falls* (90%; 140,444 / 155,368), *Pressure Injuries* (81%; 8,367 / 10,337) and *VTEs* (79%; 237 / 300). *Human Factors* was also the leading contributor for *Other* events (66%; 361,690 / 548,856), *Surgery or Anesthesia* events (65%; 25,548 / 39,495) and *Blood and Blood Product* events (65%; 9,087 / 13,960).

Environment Factors were minor contributors for events, except for *Device or Medical/Surgical Supply* events (33%; 5,126 / 15,487) and *Multiple* events (10%, 63 / 651). *Environment Factors*

include physical surroundings (e.g., lighting, noise), management and culture of safety.

Multiple Factors accounted for a large proportion of contributors to *Perinatal* event type (48%; 290 / 606). Among the 290 reports, *Other* and *Communication* were the most common contributing factors and the largest overlap was found with *Human Factors* and *Supervisor / Support*.

Multiple Factors also accounted for a large proportion of contributors to reports with *Multiple* event types (42%; 275 / 651). Among the 275 reports, *Human Factors* and *Communication* were the most common contributing factors and the largest overlap was found with *Environment* and *Supervisor / Support*.

Technical Notes

- In CFER-H, the EVENT TYPE is found in DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
CONTRIBUTING FACTOR(S) FOR EVENT is defined by DE105 in response to the question “What factor(s) contributed to the event?”
- This figure excludes 784,496 reports with missing response to **CONTRIBUTING FACTOR** or a response of *No Known* or *Other*. The data used for analysis included 947,956 reports (1,732,452 – 784,496). Percentages sum to 100% within each row, but the sum of percentages may not total 100% due to rounding.

RESULTS: INCIDENT REPORT TYPE ONLY

The CFER-H collects **REPORT TYPE** with Data Element 3 (DE3) in response to the question: “What is being reported?” The possible responses are *Incident*: A patient safety event that reached the patient, whether or not the patient was harmed; *Near miss*: A patient safety event that did not reach the patient and *Unsafe condition*: Any circumstance that increases the probability of a patient safety event.

Patient residual harm and patient information (such as age and sex) are only collected for *Incident* report types.

In CFER-H, the **PATIENT RESIDUAL HARM** is collected with Data Element 55 (DE55) in response to the question “After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention(s))?” Residual harm is captured by AHRQ’s Harm Scale and is defined as harm to the patient after discovery of the incident and any attempts to minimize adverse consequences. The possible responses by the event reporter are *No Harm*, *Mild Harm*, *Moderate Harm*, *Severe Harm*, *Death* or *Unknown*. Due to small counts across the more severe categories of harm, most often this chartbook will report on the **EXTENT OF HARM** which uses three categories: *Harm* (a combined category of including death, severe harm, moderate harm and mild harm), *No Harm* or *Unknown*.

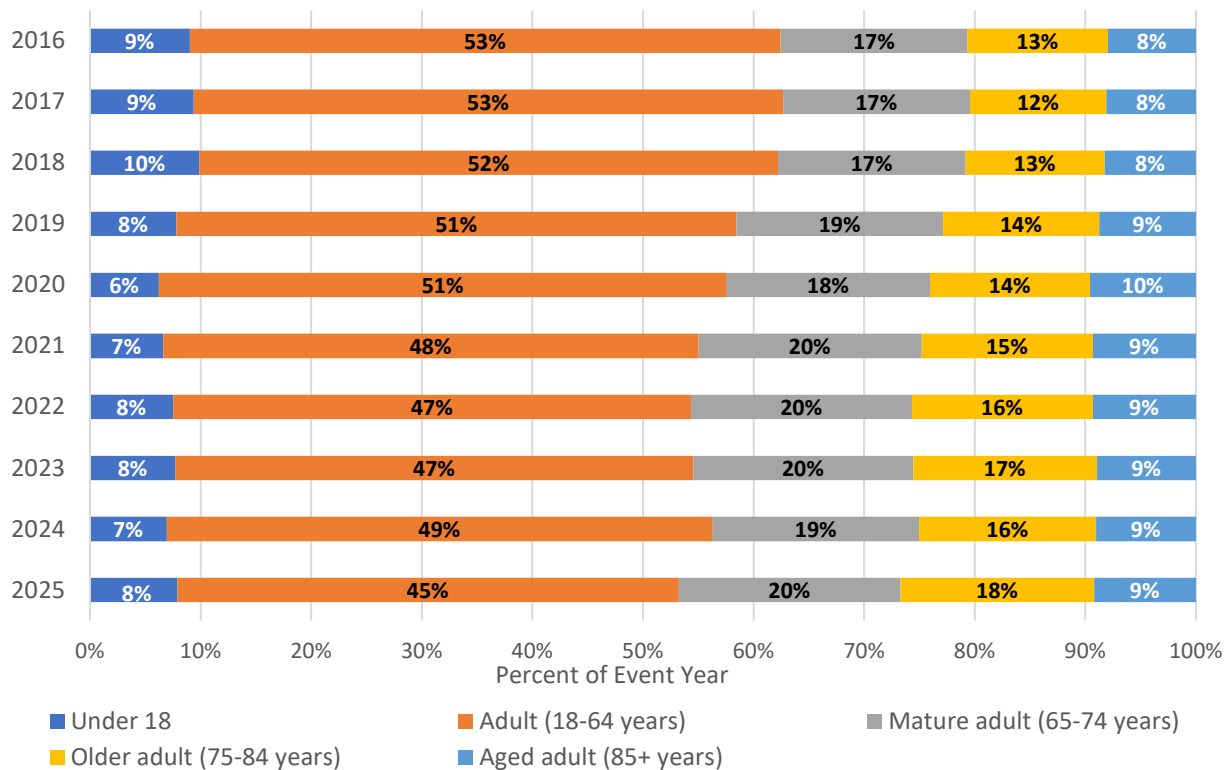
More detail of harm and patient characteristics by event type are available within the event-specific NPSD Dashboards accessible at <https://www.ahrq.gov/npsd/data/dashboard/index.html>.

The following figures include *Incident* **REPORT TYPES** only.

Patient Age Category by Event Year

Figure 12 shows the distribution of patient age category for each of the 10 years.

Figure 12: Distribution of Patient Age Category by Year



Adult (18-64 years) patients represented roughly half of the total patients each year. However, that age category has seen a decrease in representation from 53% in 2016 to 45% in 2025. From 2020 to 2021, there was a small dip in the percentage of *Adult (18-64)* from 51% to 48%. These trends are possibly due to the COVID-19 pandemic and the reduction in elective/non-emergency hospitalizations and non-COVID care.²

Technical Notes

- In CFER-H, the **EVENT TYPE** is found in the DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
- In CFER-H, **PATIENT AGE** is indicated by DE45. While the AHRQ Age Scale provides the following possible responses: *Neonate (0-28 days)*, *Infant (>28 days <1 year)*, *Child (1-12 years)*, *Adolescent (13-17 years)*, *Adult (18-64 years)*, *Mature Adult (65-74 years)*, *Older Adult (75-84 years)* and *Aged Adult (85+ years)*, the *Neonate* through *Adolescent* categories were condensed into a single *Under 18* age group due to small cell counts and to reduce risk of disclosure. The age-specific figures above are based on reported data for 178,180 *Under 18*, 1,097,518 *Adult (18-64 years)*, 389,655 *Mature Adult (65-74 years)*, 301,516 *Older Adult (75-84 years)* and 186,121 *Aged Adult (85+ years)*. Age was reported *Unknown* for

² Gallagher et.al, “Early 2021 data show no rebound in health care utilization.” Aug. 17 2021.

<https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/>

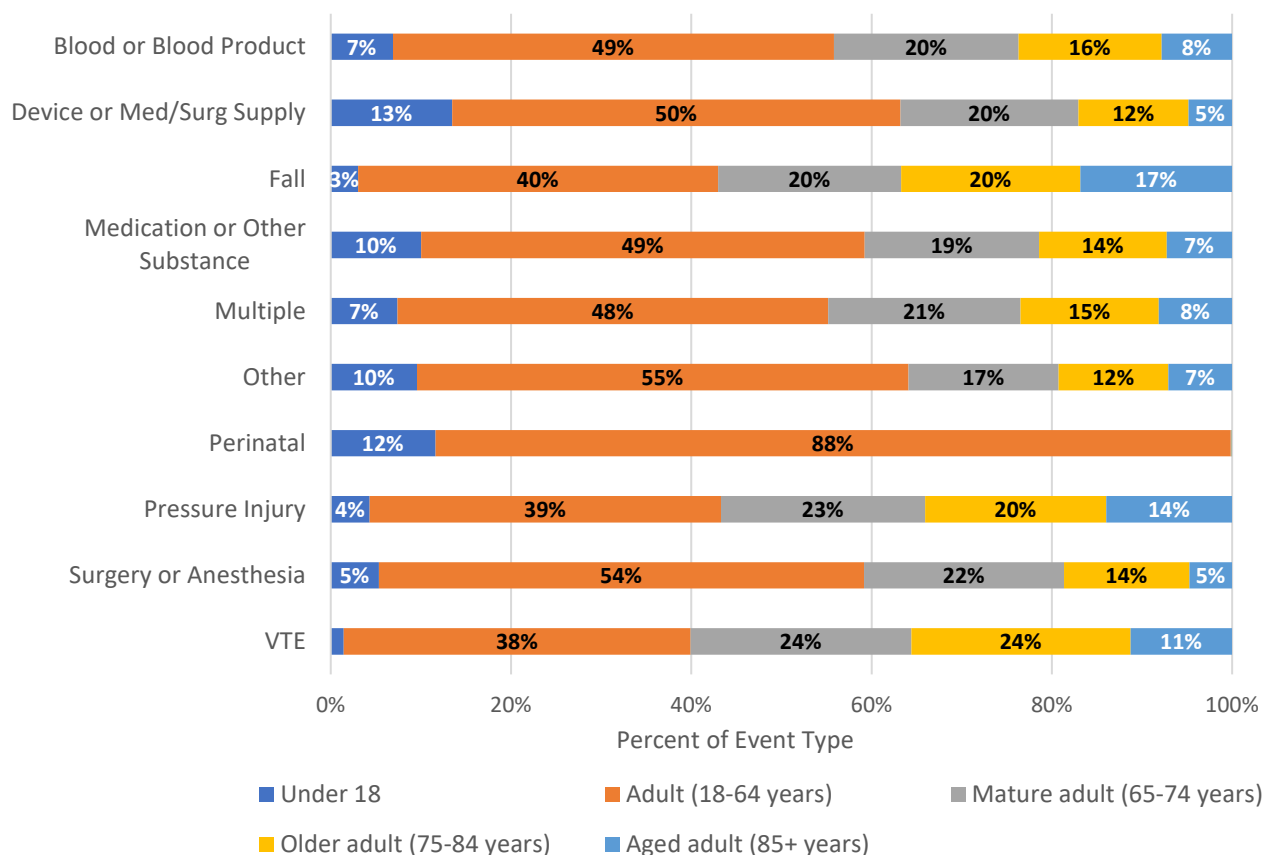
111,077 patients and was missing for 823,746 patients.

- N = 2,264,067 incident-only events. (73% of total events). Percentages sum to 100% within each event type, but the sum of percentages may not total 100% due to rounding.

Patient Age Category by Event Type

Figure 13 shows the distribution of patient age category across each **EVENT TYPE**.

Figure 13: Distribution of Patient Age Category across Event Type



Adult patients (18-64 years) represented 88% of the patients among *Perinatal* events and roughly half of the patients among *Blood and Blood Product*, *Device or Medical/Surgical Supply*, *Medication or Other Substance*, *Multiple*, *Other* and *Surgery or Anesthesia* events. As expected, *Aged Adults* (85+) had the highest representation among *Falls* (17%) and *Pressure Injury* events (14%). *Under 18* had the highest representation among *Device or Medical/Surgical Supply* (13%) and *Perinatal* (12%).

Technical Notes

- In CFER-H, the **EVENT TYPE** is found in the DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
- In CFER-H, **PATIENT AGE** is indicated by DE45. While the AHRQ Age Scale provides the following possible responses: *Neonate* (0-28 days), *Infant* (>28 days <1 year), *Child* (1-12 years), *Adolescent* (13-17 years), *Adult* (18-64 years), *Mature Adult* (65-74 years), *Older*

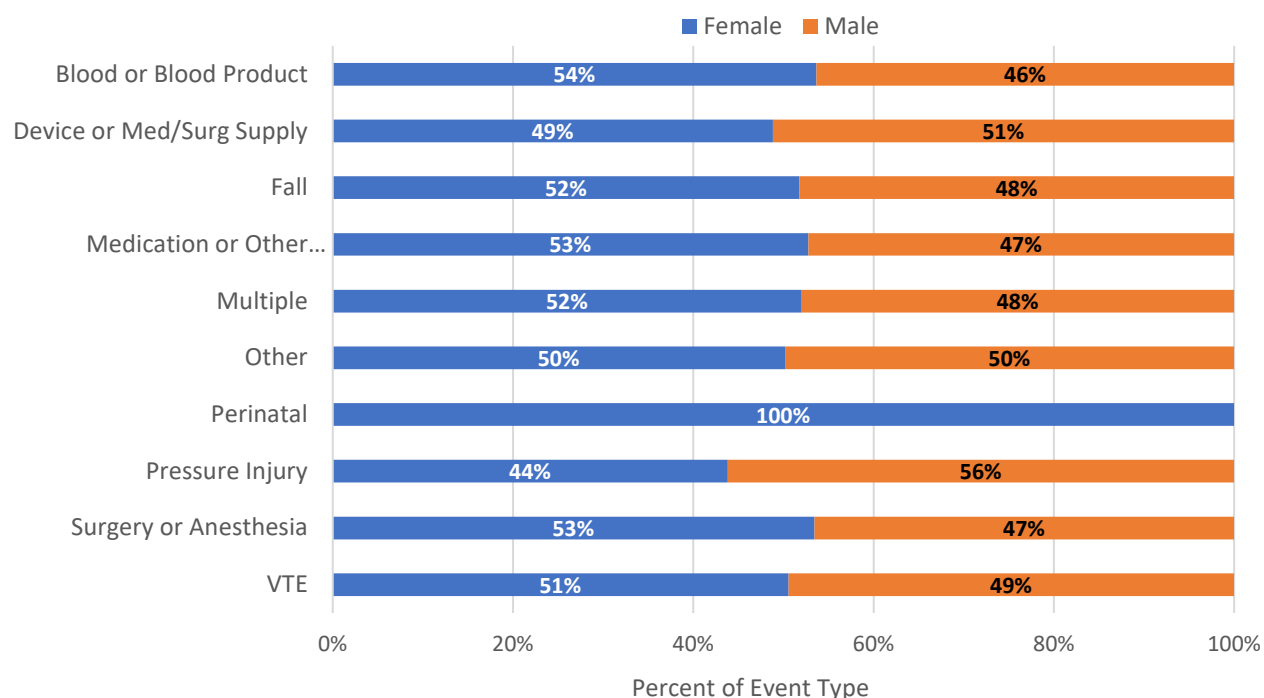
Adult (75-84 years) and Aged Adult (85+ years), the Neonate through Adolescent categories were condensed into a single Under 18 age group due to small cell counts and reduce risk of disclosure. The age-specific figures above are based on reported data for 178,180 Under 18, 1,097,518 Adult (18-64 years), 389,655 Mature Adults (65-74 years), 301,516 Older Adults (75-84 years) and 186,121 Aged Adults (85+). Age was reported Unknown for 111,077 patients and was missing for 823,746 patients.

- In CFER-H, the **REPORT TYPE** is found in DE3 in response to the question: “What is being reported?”
- N = 2,264,067 incident-only events. (73% of total events). Percentages sum to 100% within each event type, but the sum of percentages may not total 100% due to rounding.

Patient Sex by Event Type

Figure 14 shows the distribution of female and male sex among each **EVENT TYPE**.

Figure 14: Distribution of Sex by Event Type



Female patients represented 100% of the Perinatal events and slightly more than half of the patients across all event types except for Pressure Injury events (44%), Device or Medical/Surgical Supply (49%) and Other (50%).

Technical Notes

- In CFER-H, the **EVENT TYPE** is found in the DE21 in response to the question: “Which of the following categories are associated with the event or unsafe condition?”
- In CFER-H, **PATIENT SEX** is indicated by DE42 (Version 1.2) and DE1106 (Version 2.0). The figures above are based on reported data for 1,072,070 Male and 1,014,889 Female patients, respectively.

- N = 2,086,959 incident events with **SEX** reported as *Male* or *Female* (92% of total incident events). Percentages sum to 100% within each event type, but the sum of percentages may not total 100% due to rounding.

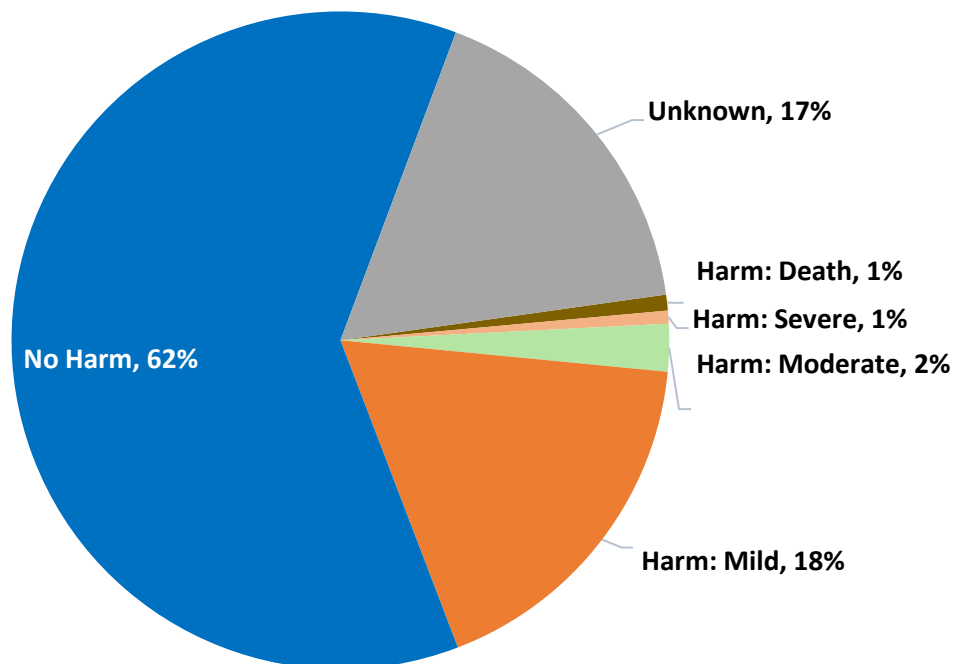
Patient Residual Harm Among Incident Events

The figure below presents the reported **RESIDUAL HARM** to patients among all *Incident* **REPORT TYPES** inclusive of all **EVENT TYPES**. When the report type is *Incident*, item DE55 in the CFER-H asks: “After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention(s))?”

The response options to DE55 are:

- Unknown
- No Harm: Event reached patient, but no harm was evident.
- Mild Harm: Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring and/or increased length of stay.
- Moderate Harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.
- Severe Harm: Bodily or psychological injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.
- Death

Figure 15: Distribution of Patient Residual Harm Scale



Among 2,178,724 *incident* events with reported harm, the distribution was 62% *No Harm*, 18%

Mild Harm, 2% *Moderate Harm*, 1% *Severe Harm*, 1% *Death* and 17% *Unknown harm*.

Any Harm was reported in 21% (466,472 / 2,178,724) of all *Incident* events. Among these events with any harm, *Moderate Harm*, *Severe Harm* and *Death* represent only 18% of the *Incident* events (81,731 / 466,472) and *Mild Harm* represents 82% (384,741 / 466,472).

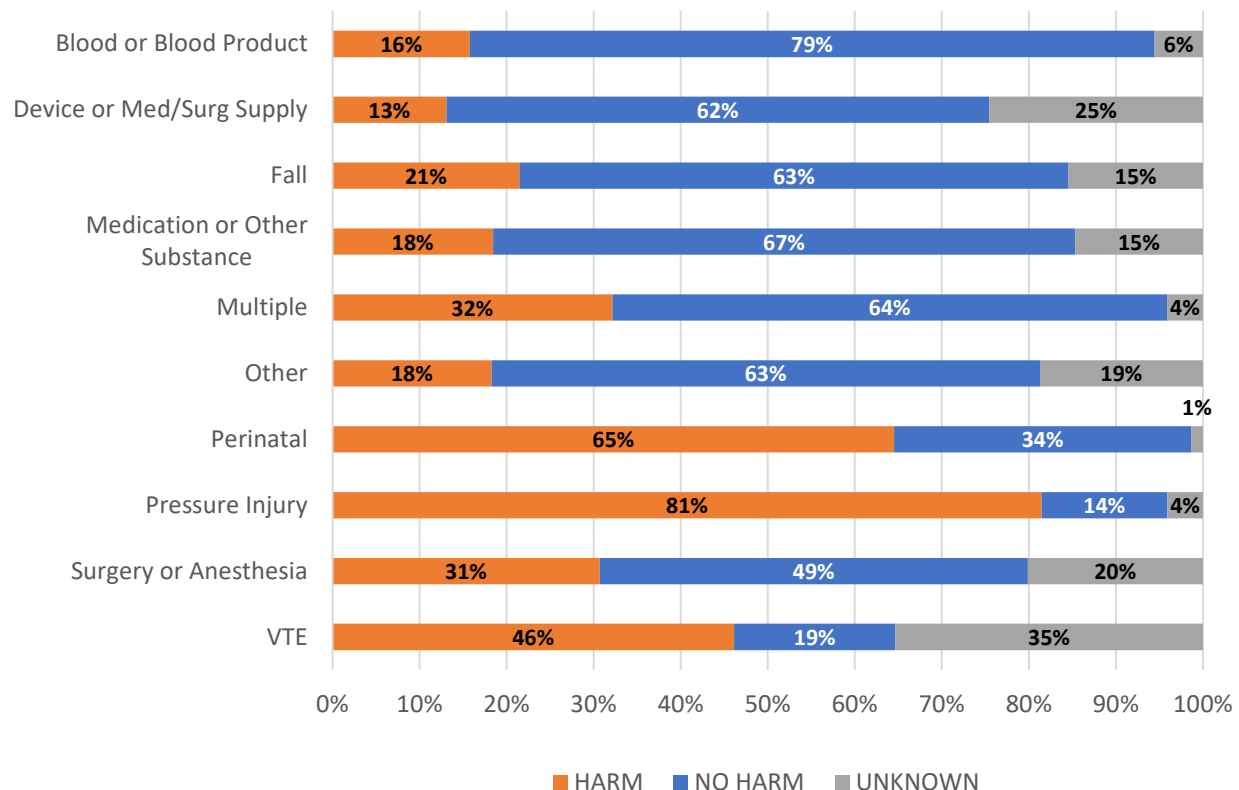
Technical Notes

- In CFER-H, **PATIENT RESIDUAL HARM** is DE55 in response to the question: “After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?”
- Percentages are taken from *Incident* events from January 1, 2016, through December 31, 2025, where valid, non-missing information for DE55 was reported. Percentages may not sum to 100% due to rounding.
- N = 2,178,724 *Incident-only* events. (96% of total incident events). DE55 was missing for 4% of *Incident* events.

Extent of Harm by Event Type

Figure 16 displays **EXTENT OF HARM** experienced by patients within each of the **EVENT TYPES**. Due to small counts across the categories of *Severe Harm* and *Death*, this figure includes three categories of extent of harm: *Harm* (which is a collapsed category of *Mild Harm*, *Moderate Harm*, *Severe Harm* and *Death*), *No Harm* and *Unknown*.

Figure 16: Extent of Harm by Event Type



The **EVENT TYPE** with the smallest proportion of *Harm* reported among *Incidents* were *Device or Medical/Surgical Supply* (13%; 6,529 / 49,902). However, the proportion of *Unknown* harm accounted for 25% of those events.

Relatively smaller proportions of *Harm* were also reported among *Blood and Blood Products* (16%; 4,298 / 27,238), *Medication and Other Substance* (18%; 60,929 / 330,391) and *Other* events (18%; 222,128 / 767,502).

Conversely, *Pressure Injuries* had the highest proportion of events that resulted in *Harm* (81%; 46,955 / 57,636). Similarly, slightly more than two-thirds of *Perinatal* events resulted in *Harm* (65%; 11,904 / 18,446) and almost half of the *VTE* events resulted in *Harm* (46%; 286 / 620). However, the proportion of *Unknown* harm accounted for 35% of *VTE* events.

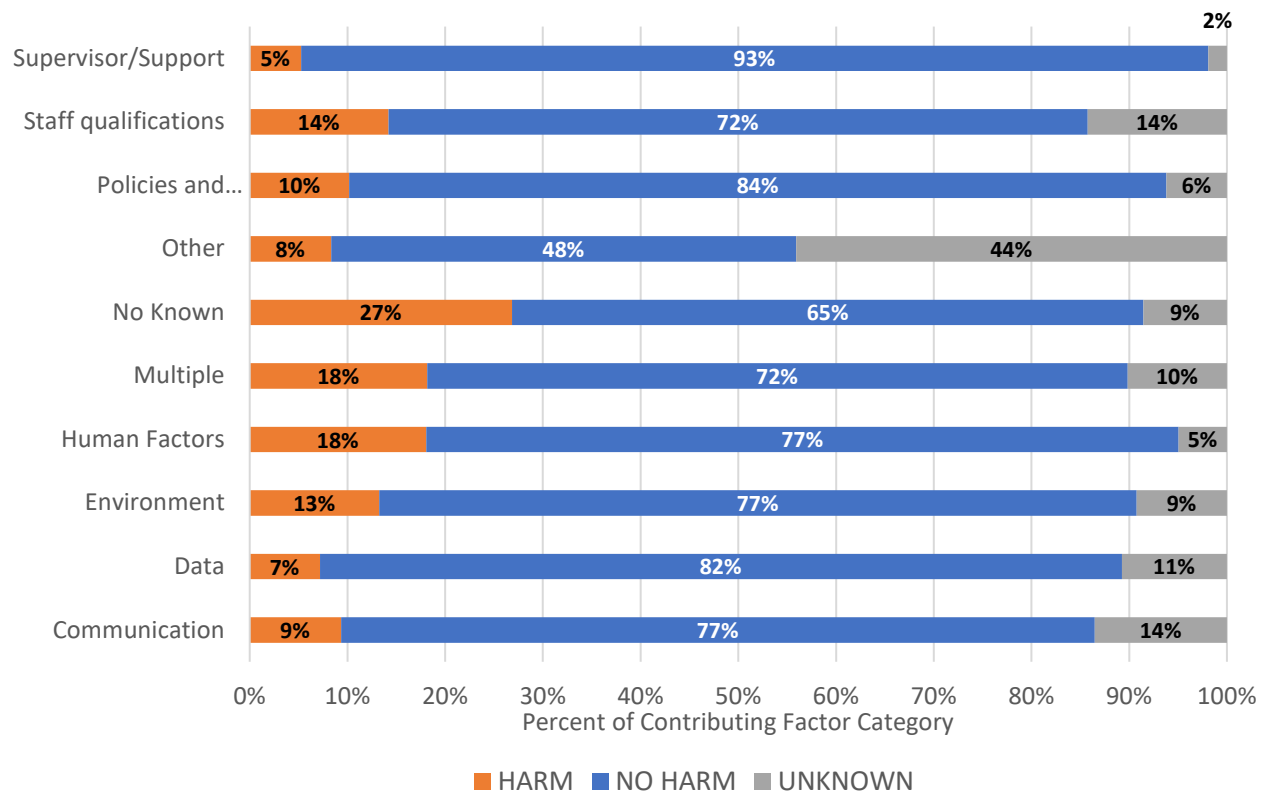
Technical Notes

- In CFER-H, the **PATIENT RESIDUAL HARM** is DE55 in response to the question: “After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?” The **EXTENT OF HARM** collapses the responses to *Harm*, *No Harm* or *Unknown*.
- Percentages are taken from *Incident* events from January 1, 2016, through December 31, 2025, where valid, non-missing information for DE55 was reported. Percentages may not sum to 100% due to rounding.
- N = 2,178,724 incident-only events. (96% of total incident events). DE55 was missing for 4% of incident events.

Extent of Harm by Contributing Factor

Figure 17 displays **EXTENT OF HARM** experienced by patients among each reported **CONTRIBUTING FACTOR**. Due to small counts across the categories of *Severe Harm* and *Death*, this figure includes three categories of **EXTENT OF HARM**: *Harm* (which is a collapsed category of *Mild Harm*, *Moderate Harm*, *Severe Harm* and *Death*), *No Harm* and *Unknown*.

Figure 17: Distribution of Harm across Contributing Factors



The **CONTRIBUTING FACTOR** category with the highest proportion of *Harm* reported among *Incidents* were *No Known* (27%; 8,982 / 33,443) followed by *Human Factors* (18%; 96,769 / 535,206) and *Multiple* (18%; 18,188 / 100,039).

Conversely, *Supervisor / Support* (which consists of clinical and managerial supervision and/or support) had the lowest proportion of events that resulted in *Harm* (5%; 318 / 6,040).

Technical Notes

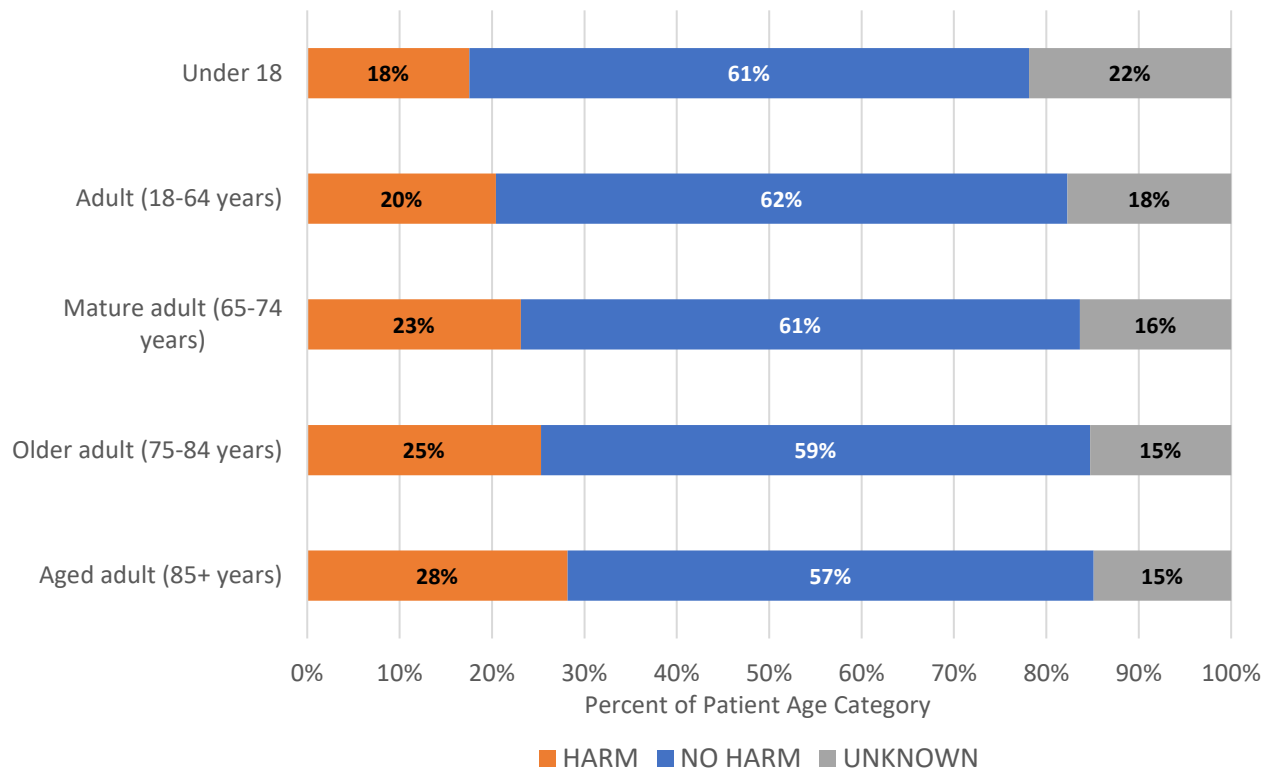
- In CFER-H, **PATIENT RESIDUAL HARM** is DE55 in response to the question: “After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?” The **EXTENT OF HARM** collapses the responses to *Harm*, *No Harm* or *Unknown*.
- **CONTRIBUTING FACTOR(S) FOR EVENT** is defined by DE105 in response to the question “What factor(s) contributed to the event?”
- Percentages are taken from *incident* events from January 1, 2016, through December 31, 2025, where valid, non-missing information for DE55 and DE105 was reported. Percentages may not sum to 100% due to rounding.
- N = 1,430,692 incident-only events. (63% of total incident events). Contributing factor was missing for 33% of incident events; DE55 was missing for 0.4% of incident events; and both contributing factor and DE55 (combined) were missing for 3% of incident events.

Extent of Harm by Patient Age Category

Figure 18 displays **EXTENT OF HARM** experienced within each patient **AGE CATEGORY**.

Due to small counts across the categories of *Severe Harm* and *Death*, this figure includes three categories of **EXTENT OF HARM**: *Harm* (which is a collapsed category of *Mild Harm*, *Moderate Harm*, *Severe Harm* and *Death*), *No Harm* and *Unknown*.

Figure 18: Distribution of Harm among Patient Age Category



The proportion of *Harm* reported was highest among *Aged Adults (85+ years)* at 28% (50,260 / 178,443) and lowest among patients *Under 18* at 18% (30,457 / 173,666).

Technical Notes

- **AGE CATEGORY** is derived from Data Element (DE45) in response to the question: “At the time of the event what was the patient's age?” While DE45 provides the following possible responses: *Neonate* (0-28 days), *Infant* (>28 days <1 year), *Child* (1-12 years), *Adolescent* (13-17 years), *Adult* (18-64 years), *Mature Adult* (65-74 years), *Older Adult* (75-84 years) and *Aged Adult* (85+ years), due to very small counts the *Neonate* through *Adolescent* categories were condensed into a single *Under 18* age group.
- In CFER-H, **PATIENT RESIDUAL HARM** is DE55 in response to the question: “After any intervention to reduce harm, what was the degree of residual harm to the patient from the *Incident* (and subsequent intervention)?” The **EXTENT OF HARM** collapses the responses to *Harm*, *No Harm* or *Unknown*.
- N=2,071,186 (92% of total incident events). **EXTENT OF HARM** was missing for 4% of

the incidents and **AGE CATEGORY** was unknown for 5% of incidents. The sum of percentages may not total 100% due to rounding.

DATA LIMITATIONS

The NPSD is a repository of standardized, non-identifiable patient safety data collected by PSOs from multiple providers across the country. The NPSD currently includes the elements in Common Formats Event Reporting – Hospital for specific types of patient safety concerns, that have been voluntarily submitted by Agency for Healthcare Research and Quality (AHRQ)-listed PSOs.

Data submitted to the PSOPPC and sent to the NPSD are not statistically comparable to those clinical quality measures used for value-based payment or public reporting. For example, the data from clinical quality measures reported by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) focus on all eligible members of a population and can be used to estimate the incidence of an event because the population at risk (i.e. the denominator) is defined. Conversely, voluntary patient safety reporting systems are marked by variability in the rate and consistency of reporting, and denominators are typically unavailable. Hence, the event report data submitted to the NPSD cannot be used to calculate the actual incidence or prevalence of patient safety events.

Lastly, descriptive analyses of patient safety concerns in the NPSD highlight potential issues worthy of attention and provide a snapshot of safety issues, but on their own cannot be used to establish causal relationships.

DATA SECURITY AND GOVERNANCE

PSOs collect voluntary reports from healthcare providers and submit data to the PSOPPC.

The PSOPPC is maintained as a Federal Risk and Authorization Management Program (FedRAMP) Moderate system and operates under an active Authority to Operate (ATO). The system implements the management, operational and technical safeguards specified in the National Institute of Standards and Technology (NIST) SP 800-53 Moderate baseline, including encryption of data in transit and at rest, role-based access control and audit logging. This security posture is maintained through continuous monitoring and an annual Security Controls Assessment (SCA) to protect the confidentiality, integrity and availability of the non-identifiable patient safety data housed in the NPSD.

The PSOPPC ensures the Common Formats data are non-identifiable with respect to providers, reports and patients before being sent to the NPSD for aggregation and analysis. The non-identification standard for patient safety work product is set forth in 42 C.F.R. §3.212 and incorporates aspects of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. In practice, the Common Formats structured data elements and PSOPPC import processor are designed so that most of these identifiers are never collected.

The infrastructure between the PSOPPC and NPSD does not allow re-identification of providers or patients by design.

The non-identification process includes the following steps:

- The PSOPPC performs validation of submitted files against structural, semantic and business rule constraints. Only files with the status of “Accepted” proceed to de-identification.
- All event-related dates are removed and converted to years.
- No patient identifiers are kept beyond race category, age group and sex.
- Provider IDs are removed and the PSO ID becomes an encrypted surrogate ID.
- No geographic data (region, state or address) are collected in Common Formats structured

fields.

- Free-text fields are stripped entirely before data reach the NPSD.
- Data released through NPSD Dashboards, Chartbooks and authorized research channels are aggregated data only.
- The NPSD publishes data only when volumes are sufficient to maintain confidentiality. Small data volumes are suppressed in public reporting.

Appendix A: Data Submission Summary

The purpose of the figure below is to illustrate the adoption and use of the CFER-H V1.2 and CFER-H V2.0 for reporting patient safety concerns.

Cumulative Number of Reports Submitted by Common Formats Version by Year

Figure 1 displays a running total of reports submitted to the PSOPPC by calendar year (CY) from January 1, 2016, through December 31, 2025, in CFER-H V1.1 and CFER-H V1.2. The total number of reports submitted in 2016 was 15,251 and the total cumulative amount at the end of 2025 was 3,917,648. Note that this figure uses a Submission Year in comparison to the Event Year used in the other parts of this Chartbook.

Figure 1: Cumulative Number of Reports Submitted by Common Formats Version by Year

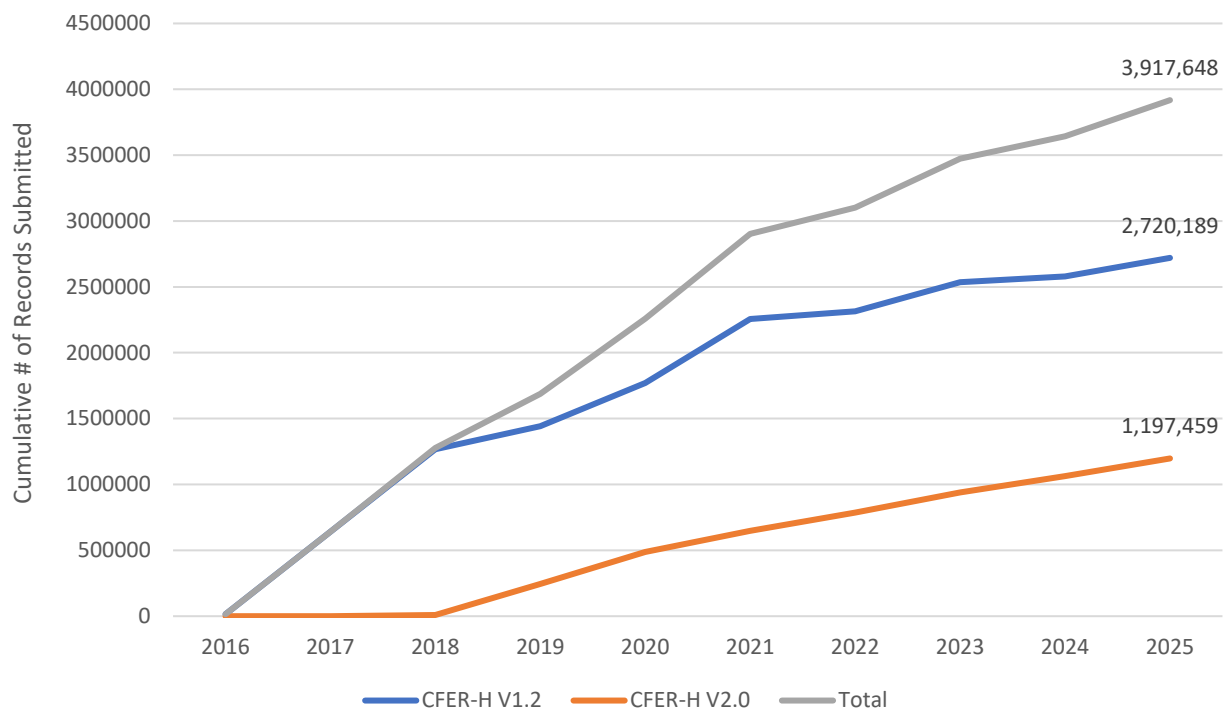


Figure 1 shows that the total number of reports submitted between 2016-2025 was 2,720,189 for CFER-H V1.2 (69%) and 1,197,459 for CFER-H V2.0 (31%) for a combined total of 3,917,648 reports.

The total number of reports submitted to the PSOPPC (n=3,917,648) exceeds the total number of events in this NPSD Chartbook (n=3,087,813) because *Healthcare-associated infection* events are excluded from the Chartbook and reports that did not pass the event-specific NPSD case exclusion criteria are excluded from the NPSD and the Chartbook. A complete list of exclusion criteria for CFER-H is in **Appendix B**.

Technical Notes

- The year displayed indicates the CY a report was submitted by a PSO to the PSOPPC. Note that this is neither the date the patient safety concern occurred nor the date the concern was

reported by the healthcare provider or facility. While not reported here, the **INITIAL REPORT DATE** is the CFER-H data element representing the date the report was initially entered into the system at the provider facility and is different from the date the report was submitted to the PSOPPC.

- The data presented indicate a running total of the number of reports submitted to the PSOPPC via CFER-H V1.2 and CFER-H V2.0. Reports that were resubmitted by a PSO (i.e., duplicates) have been removed. Counts shown in the figure are cumulative; therefore, it is not appropriate to sum the counts shown across years.

Appendix B: Common Formats for Event Reporting – Hospital Exclusion Criteria

The Common Formats for Event Reporting – Hospital was designed to exclude reports of patient safety events (including *Incident*, *Near miss* and *Unsafe conditions*) where the nature of the patient safety concern could not be attributed to the hospital, did not appear to involve incorrect actions or were otherwise not part of the focus of the event-specific module. For each section of the NPSD Chartbook, reports meeting the listed criteria are excluded from analysis.

Table 1: NPSD Case Exclusion Criteria

Event Type*	Exclusion Criteria Description
Blood or Blood Product (DE21 = A42)	<i>For CFER-H V1.2 only exclude report:</i> When the response to “Which of the following best characterizes the event?” (DE117) is either A576: Event involves adverse reaction during or following administration without any apparent incorrect action UNK: Unknown <i>(No exclusion criteria for CFER-H V2.0 because DE117 was dropped by V2.0.)</i>
Fall (DE21 = A48)	Fall events only allow Incident reports (DE3 = A3); exclude near misses and unsafe conditions
Medication or Other Substance (DE21 = A54)	<i>For both CFER-H V1.2 and V2.0, exclude report:</i> When the response to “What type of medication/substance was involved?” (DE270) is either A1213: Radiopharmaceuticals A1214: Patient food (not suspected in drug-food interactions) A1216: Drug-drug, drug-food or adverse drug reaction as a result of a prescription and/or administration of a drug and/or food prior to admission <i>For CFER-H V1.2 only, exclude report:</i> When the response to “Which of the following best characterizes the event?” (DE288) is either A1263: Adverse reaction in patient to the administered substance without any apparent incorrect action UNK: Unknown <i>(No related exclusion criteria for CFER-H V2.0 because DE117 was dropped by V2.0.)</i>
Perinatal (DE21 = A57)	Perinatal events only allow Incident reports (DE3 = A3); exclude near misses and unsafe conditions <i>For both CFER-H V1.2 and V2.0, exclude report:</i> When the response to “Which of the following did the event involve?” (DE353) is either A342: Other UNK: Unknown
Pressure Injury (DE21 = A60)	Pressure Injury events only allow Incident reports (DE3 = A3); exclude near misses and unsafe conditions <i>For both CFER-H V1.2 and V2.0, exclude report:</i> When the response to “What was the most advanced stage/type of the pressure injury or deep tissue pressure injury (DTPI) being reported?” (DE408) is either

Event Type*	Exclusion Criteria Description
	A1698: Stage 1 A1701: Stage 2 A1711: Mucosal pressure injury UNK: Unknown When the response to “What was the status on admission of the Stage 3, 4 or unstageable pressure injury that you are reporting?” (DE414) is either A1704: Stage 3 A1707: Stage 4 A1710: Unstageable A1713: Suspected Deep Tissue Injury When the response to “What was the status on admission of the deep tissue pressure injury (DTPI)?” (DE411) is A1712: Present as suspected Deep Tissue Injury (V1.2) A1713: Deep Tissue Pressure Injury (DTPI) (V2.0)
Surgery or Anesthesia (DE21 = A63, A41 or A61)	Surgery or Anesthesia events only allow Incident reports (DE3 = A3) and near miss reports (DE3 = A6); exclude unsafe conditions.
VTE (DE21 = A64)	Venous Thromboembolism (VTE) events only allow Incident reports (DE3 = A3); exclude near misses and unsafe conditions

* The event type *Device or Med/Surg Supply* and the event type *Other* do not have exclusion criteria. / DE = Data Element / A= answer.

Appendix C: Contributing Factor Categories

DE105 Question: *What factor(s) contributed to the event?*

Table 1: Contributing Factor Categories

Answer Codes*	Contributing Factor Category and Component Responses
	HUMAN FACTORS
A3021	Human Factors (e.g., fatigue, stress, inattention, cognitive factors)
A444	Human Factors: Cognitive factors
A441	Human Factors: Inattention
A447	Human Factors: Health issues
A435	Human Factors: Fatigue
A438	Human Factors: Stress
	COMMUNICATION
A429	Communication: Among staff or team members
A3009	Communication, other than at the time of handover/handoff
A3012	Communication at handover/handoff
A432	Communication: Staff to patient (or family)
A426	Communication: Supervisor to staff
	STAFF QUALIFICATIONS
A3027	Staff Qualifications (e.g., competence, training)
A390	Staff Qualifications: Competence (e.g., qualifications, experience)
A393	Staff Qualifications: Training
	DATA ISSUES
A420	Data: Availability
A423	Data: Accuracy
A3033	Health Information Technology (HIT)
A3015	Data Issues (e.g., availability, accuracy)
	ENVIRONMENT
A387	Environment: Physical surroundings (e.g., lighting, noise)
A384	Environment: Culture of safety, management
A3018	Environment (e.g., culture of safety, physical surroundings)
	SUPERVISOR/SUPPORT
A3030	Supervision/Support (e.g., clinical, managerial)
A396	Supervision/Support: Clinical supervision
A399	Supervision/Support: Managerial supervision
	POLICIES AND PROCEDURES
A402	Policies and procedures, includes clinical protocols: Presence of policies
A405	Policies and procedures, includes clinical protocols: Clarity of policies
A3024	Policies and procedures, incl clinical protocols (e.g., absence, adequacy, clarity)
A3036	UNKNOWN
A66	OTHER

* Codes in black are CFER-H Version 1.2 response options and codes in red are CFER-H Version 2.0 response options.