Common Formats Supplemental Details

In order to facilitate standardized data collection, AHRQ coordinates the development of a set of common definitions and reporting formats (Common Formats) that allow health care providers to voluntarily collect and submit standardized information regarding patient safety events.

The term "Common Formats" refers to the common definitions and reporting formats, specified by AHRQ, that allow health care providers to collect and submit standardized information regarding patient safety events. The Common Formats are not intended to replace any current mandatory reporting system, collaborative/voluntary reporting system, research-related reporting system, or other reporting/recording system; rather the formats are intended to enhance the ability of health care providers to report information that is standardized both clinically and electronically.

The scope of Common Formats applies to all patient safety concerns including:

- incidents – patient safety events that reached the patient, whether or not there was harm,
- near misses or close calls – patient safety events that did not reach the patient, and
- unsafe conditions – circumstances that increase the probability of a patient safety event.

The Common Formats include two general types of formats, generic and event-specific. The generic Common Formats pertain to all patient safety concerns. The three generic formats are: Healthcare Event Reporting Form, Patient Information Form, and Summary of Initial Report. The event-specific Common Formats pertain to frequently-occurring and/or serious patient safety events. The Common Formats for acute care hospitals include the following event-specific formats: Blood, Device or Supply, including Health Information Technology; Fall; Healthcare-Associated Infection; Medication or Other Substance; Perinatal; Pressure Ulcer; and Surgery/Anesthesia. In AHRQ's Beta version for skilled nursing facilities the event-specific formats are: Device or Supply, including Health Information Technology; Fall; Healthcare-Associated Infection; Medication or Other Substance; and Pressure Ulcer.

The formats include descriptions of patient safety events and unsafe conditions to be reported, specifications for patient safety aggregate reports and individual event summaries, delineation of data elements to be collected for specific types of events, and a user's guide and quick guide.

Common Formats Development

In anticipation of the need for Common Formats, AHRQ began their development in 2005 by creating an inventory of functioning private and public sector patient safety reporting systems. This inventory provides an evidence base that informs construction of the Common Formats. The inventory now numbers 69 and includes many systems from the private sector, including prominent academic settings, hospital systems, and international reporting systems (e.g., from the United Kingdom and the Commonwealth of Australia). In addition, virtually all major Federal patient safety reporting systems are included, such as those from the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Department of Defense (DoD), and the Department of Veterans Affairs (VA).

Since February 2005, AHRQ has coordinated an interagency Federal Patient Safety Work Group (PSWG) to assist AHRQ with developing and maintaining the Common Formats. The PSWG includes major health agencies within the HHS – CDC, Centers for Medicare & Medicaid Services, FDA, Health Resources and

Services Administration, the Indian Health Service, the National Institutes of Health, the National Library of Medicine, Office of the National Coordinator for Health Information Technology (ONC), the Office of Public Health and Science, the Substance Abuse and Mental Health Services Administration – as well as the DoD and the VA.

The PSWG assists AHRQ with assuring the consistency of definitions/formats with those of relevant government agencies as refinement of the Common Formats continues. When developing Common Formats, AHRQ first reviews existing patient safety event reporting systems from a variety of health care organizations. Working with the PSWG and Federal subject matter experts, AHRQ drafts and releases beta versions of the Common Formats for public review and comment. To the extent practicable, the Common Formats are also aligned with World Health Organization (WHO) concepts, framework, and definitions contained in their draft International Classification for Patient Safety (ICPS).

Common Format Releases & Next Steps

Historically, AHRQ issued the initial release of the formats, Version 0.1 Beta, in August 2008, the second release, Version 1.0, in September 2009, a third release Version 1.1, on March 31, 2010, followed by a modification in October 2010 to allow for reporting data on patient safety events related to Health Information Technology. AHRQ received comments on all versions from the public. These public comments, as well as comments from PSOs, encouraged the development of Common Formats for additional healthcare settings (beyond the hospital scope of current published versions).

March 7, 2011, AHRQ released, Common Formats Skilled Nursing Facility Beta Version, which modified the acute care hospital Common Formats (Version 1.1) to allow for reporting patient safety events that occur in skilled nursing facilities. These modifications resulted in a smaller set of Common Formats reflective of the type of events that occur in skilled nursing facilities and the environmental language of this setting. The Skilled Nursing Facility Beta Version includes two general types of formats, generic and event-specific.

Common Formats data can be submitted by PSOs electronically to the PSO Privacy Protection Center (PPC) for data de-identification and transmission to the Network of Patient Safety Databases (NPSD). AHRQ will use data from the NPSD to analyze national and regional statistics, including trends and patterns, regarding patient safety events. Findings are to be made public and included in AHRQ's annual *National Healthcare Quality and Disparities Reports.*

The process for updating and refining the formats will continue to be an iterative one. Future versions of the Common Formats will be developed for ambulatory settings, such as ambulatory surgery centers and physician and practitioner offices.