

**Intentional Unsafe Act Report**

Submit no later than (7) seven calendar days following a good faith belief that an intentional unsafe act occurred

**Please complete all sections of this form. The form must be submitted to the Patient Safety Surveillance & Improvement System administered by the Vermont Program for Quality in Health Care, Inc. via secure email at: [sre@vpqhc.org](mailto:sre@vpqhc.org)**

For questions regarding the Patient Safety Surveillance & Improvement System please contact:  
Vermont Program for Quality in Health Care, Inc.  
132 Main Street  
Montpelier, VT 05602  
Phone: 802-229-2152

**1. Facility identification**

Facility name:

**2. Contact information**

Title of person submitting report:

Telephone number:

Email address to contact if questions:

**3. Patient information**

Patient name:

If patient was a minor parent's name:

Date of birth:

Gender at birth:

Patient's diagnosis at time of incident:

If more than one patient was involved, complete the same patient information on a separate page and submit it with this form.

#### **4. Incident information**

Incident date:

Time:

Date you became aware of event:

Time:

Date reported to Patient Safety System:

Where was the patient when event occurred?

Emergency Department

Labor and Delivery

Medical/Surgical Floor

Radiology

Intensive Care Unit

Surgical Services Department

Pediatrics

Laboratory

Grounds

Inpatient Psychiatry

Other:

#### **5. Understanding of event**

**6. How was the event discovered** (check all that apply)

Reported by staff

Nurse, Physician, or other licensed staff

Unlicensed staff

Other

Assessment of patient after event

Report by family/visitor

Review of chart/record

Report by patient

Other:

**7. Outcome of event** (check only one)

No harm evident, physical or otherwise

Event reached patient but no harm was evident.

Emotional distress or inconvenience

*Event reached the patient; mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies). Distress/inconvenience since discovery and/or expected in future as a direct result of event.*

Additional Treatment

*Injury limited to additional intervention during admission or encounter and/or increased length of stay, but not other injury. Treatment since discovery and/or expected in future as a direct result of event.*

Temporary Harm

*Bodily or psychological injury, but likely not permanent. Prognosis at the time of assessment.*

Permanent Harm

*Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis at the time of assessment.*

Severe Permanent Harm

*Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life. Prognosis at time of assessment.*

Death

**8. Patient/Family disclosure:**                      Yes                      No

Date of notification:

If no disclosure, please briefly explain why:

**9. Categorization of event** (check all that apply)

Alleged criminal act

Alleged purposefully unsafe act

Alleged alcohol or substance abuse

Alleged patient abuse

**10. Was the event reported to another Agency?**

Yes (check all that apply)

Adult Protective Services

Department for Children and Families

Law Enforcement

Medical Practice Board

Office of Professional Regulation

Other, specify:

Date reported:

No

**11. Is this event also reportable adverse event?**

Yes - Complete reportable adverse event initial report form

No