

**Serious Reportable Event (SRE)**

Submit no later than (7) seven calendar days from discovery of event

**Please complete all sections of this form and submit to the Patient Safety Surveillance & Improvement System (PSSIS) administered by 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 (PSSIS) contact:

Vermont Program for Quality in Health Care, Inc. (VPQHC)

132 Main Street Montpelier, VT 05602

Phone: 802-229-2152

Email: [sre@vpqhc.org](mailto:sre@vpqhc.org)

**1. Facility Identification**

Facility name: \_\_\_\_\_

**2. Contact Information**

Title of person submitting report: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**3. Patient Information**

Date of facility encounter/admission: \_\_\_\_\_

Patient age: \_\_\_\_\_

**4. When did the event occur?**

Date the event occurred: \_\_\_\_\_

Date the hospital Patient Safety Staff became aware of the event: \_\_\_\_\_

Date of event report to the (PSSIS): \_\_\_\_\_

**5. Brief factual narrative about event:** *(If you prefer, you may attach a separate document containing this information.)*

**6. Where did the event occur?**

- |   |   |
|---|---|
| <input type="checkbox"/> Emergency Department   | <input type="checkbox"/> Labor and Delivery           |
| <input type="checkbox"/> Medical/Surgical Floor | <input type="checkbox"/> Radiology                    |
| <input type="checkbox"/> Intensive Care Unit    | <input type="checkbox"/> Surgical Services Department |
| <input type="checkbox"/> Pediatrics             | <input type="checkbox"/> Laboratory                   |
| <input type="checkbox"/> Grounds                | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Inpatient Psychiatry   |   |

**7. What Happened?**

*National Quality Forum (NQF): List of Serious Reportable Events (SREs) [NOF: Serious Reportable Events in Healthcare 2011 \(qualityforum.org\)](http://qualityforum.org)*

**Surgical or Invasive Procedure Events**

- A. Surgery or other invasive procedure performed on the wrong site.
- B. Surgery or other invasive procedure performed on the wrong patient.
- C. Wrong surgical or other invasive procedure performed on a patient.
- D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure.
- E. Intra-operative or immediately postoperative/ post procedure death in an ASA Class I patient.

**Product or Device Events**

- A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
- B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
- C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

**Patient Protection Events**

- A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
- B. Patient death or serious injury associated with patient elopement (disappearance).
- C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

**Care Management Events**

- A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- B. Patient death or serious injury associated with unsafe administration of blood products.
- C. Maternal death or serious injury associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare setting.
- D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy.
- E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
- F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
- G. Artificial insemination with the wrong donor sperm or wrong egg.
- H. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
- I. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

**Environmental Events**

- A. Patient or staff death or serious injury associated with an electric

shock during a patient care process in a healthcare setting.

- B.** Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
- C.** Patient or staff death or serious injury associated with a burn incurred from any source during a patient care process in a healthcare setting.
- D.** Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.

### **Radiological Events**

- A.** Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

### **Potential Criminal Events**

- A.** Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- B.** Abduction of a patient/resident of any age.
- C.** Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
- D.** Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.