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.

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

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?

☐ Emergency Department
☐ Labor and Delivery
☐ Medical/Surgical Floor
☐ Radiology
☐ Intensive Care Unit
☐ Surgical Services Department
☐ Pediatrics
☐ Laboratory
☐ Grounds
☐ Other:_____

7. What Happened?

National Quality Forum (NQF): List of Serious Reportable Events (SREs)

NQF: Serious Reportable Events in Healthcare 2011 (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