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: 802-229-2449
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
- ☐ Medical/Surgical Floor
- ☐ Intensive Care Unit
- ☐ Grounds
- ☐ Inpatient Rehab/Sub-acute Care
- ☐ Outpatient Clinic/Ambulatory Clinic
- ☐ Surgical Services Department
- ☐ Other
- ☐ Laboratory
- ☐ Rehab Department
- ☐ Pediatrics
- ☐ Inpatient Psychiatry
- ☐ Labor and Deliver
- ☐ Radiology
- ☐ Telehealth

7. What Happened?

National Quality Forum (NQF): List of Serious Reportable Events (SREs) NQF: Patient Event Reporting 2026

Procedural Events

- ◯ **SRE 1.** Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong procedure, regardless of the type of procedure or the outcome
- ◯ **SRE 2.** Unintended retention of a medical or surgical item in a patient after surgery or other invasive procedure, regardless of the type of procedure or the outcome
- ◯ **SRE 3.** Patient harm associated with perioperative or periprocedural sedation of an ASA Class I or ASA Class II patient
- ◯ **SRE 4.** Medically assisted reproduction with the wrong donor sperm or egg, regardless of the outcome

- **SRE 5.** Introduction of an unapproved, unscreened, or inappropriately approved device, implant, or object into an MR Zone IV area, regardless of the outcome
- **SRE 6.** Patient harm associated with an MRI–related thermal injury
- **SRE 7.** Administration of radiotherapy to the wrong patient, to the wrong body region, by an unintended procedure, or that is the wrong dose, regardless of the outcome

Product or Device Events

- **SRE 8.** Patient harm associated with the use of contaminated drugs, devices, or biologics
- **SRE 9.** Patient harm associated with the use or function of a medical device in patient care, in which the device is used or functions other than as intended
- **SRE 10.** Patient harm occurring when systems designated for oxygen or other gas to be delivered to a patient contain no gas, the wrong gas, or are contaminated by toxic substances
- **SRE 11.** Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the healthcare setting, regardless of the outcome

Patient Protection Events

- **SRE 12.** Discharge or release of a patient who does not have decision-making capacity to other than an authorized person or entity, regardless of the outcome
- **SRE 13.** Patient harm associated with the disappearance or unauthorized departure of patient who does not have decision-making capacity
- **SRE 14.** Patient suicide or suicide attempt that occurs after presentation for care or within seven days of discharge or release, regardless of the outcome
- **SRE 15.** Patient harm associated with the use of chemical restraints, physical restraints, or seclusion
- **SRE 16.** Sexual abuse or sexual assault within or on the grounds of a healthcare setting, regardless of the outcome

Care Provision Events

- ◯ **SRE 17.** Patient harm associated with a fall
- ◯ **SRE 18.** Patient harm associated with an unintended burn from any source
- ◯ **SRE 19.** Patient harm associated with a medication error
- ◯ **SRE 20.** Patient harm associated with unsafe processing or administration of blood products
- ◯ **SRE 21.** Patient harm associated with a Stage 3 pressure injury, Stage 4 pressure injury, unstageable pressure injury, or deep tissue pressure injury acquired after admission
- ◯ **SRE 22.** Patient harm associated with the irretrievable loss of a biological specimen that is irreplaceable or is only replaceable by an invasive procedure
- ◯ **SRE 23.** Patient harm resulting from failure to act on clinically significant laboratory, pathology, or radiology test results
- ◯ **SRE 24.** Patient harm associated with an intravascular air embolism
- ◯ **SRE 25.** Maternal patient harm associated with labor or delivery in a low-risk pregnancy
- ◯ **SRE 26.** Neonatal patient harm associated with labor or delivery in a low-risk pregnancy
- ◯ **SRE 27.** Patient harm associated with the care of a neonate
- ◯ **SRE 28.** Patient harm associated with unrecognized clinical deterioration