

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

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