

Vermont Department of Health
Patient Safety Surveillance and Improvement System

**Intentional Unsafe Act
Report**

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

Please complete all sections of this form by printing or typing the required information. The form may be submitted to the Patient Safety Surveillance & Improvement System via secure fax or mail. See last page of form for contact information. If you have questions about the form, please call 802- 951-1226.

1. Facility Identification

Facility name: _____
Facility street address: _____
City: _____ State: VT Zip _____

Name and title of person submitting report: _____
Telephone #: _____ Email address: _____

2. Employee Information:

Full name of staff person involved with unsafe act: _____

3. Patient Information

Patient name: _____
If a child, Parent name(s): _____
Address: _____

Date of Birth: _____ Gender: _____
Primary Diagnosis: _____
Secondary Diagnosis: _____

If more than one patient was involved, complete the following. If additional patients were involved, attach a separate page with the patient information included.

Patient Name: _____
If a child, Parent Name(s): _____
Address: _____

Date of Birth: _____ Gender: _____
Primary Diagnosis: _____
Secondary Diagnosis: _____

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6. How was event discovered? (Check all that apply)

- Reported by staff
 - Nurse
 - Physician
 - 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)

- Death; date of death: _____
- Serious bodily injury – bodily injury that creates substantial risk of death or that causes substantial loss or impairment of function of any bodily member or organ or substantial impairment of health or substantial disfigurement.
- Temporary harm, higher level of care required.
- Temporary harm, increased monitoring required.
- No harm, increased monitoring of patient required.
- No harm, no increased monitoring needed.
- Near Miss – event could have caused an adverse event but did not harm patient.

8. Patient/family disclosure: Yes No

Date of notification: _____

If no disclosure, why?

9. Categorization of event: (Check all that apply)

- Alleged criminal act
- Alleged purposefully unsafe act
- Alleged alcohol or substance abuse
- Alleged patient abuse

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<p style="text-align: center;">Intentional Unsafe Act Report</p> <p style="text-align: center;">Submit no later than (7) seven calendar days following a good faith belief that intentional unsafe act occurred</p>
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10. Was the event reported to another agency?

- Yes (Check all that apply)
- | | |
|---|---------------------|
| <input type="checkbox"/> Adult Protective Services | Date reported _____ |
| <input type="checkbox"/> Department for Children and Families | Date reported _____ |
| <input type="checkbox"/> Law Enforcement | Date reported _____ |
| <input type="checkbox"/> Medical Practice Board | Date reported _____ |
| <input type="checkbox"/> Office of Professional Regulation | Date reported _____ |
| <input type="checkbox"/> Other, specify: _____ | Date reported _____ |
- No

11. Is the event also a reportable adverse event?

- Yes – Complete Reportable Adverse Event initial report form
- No

Fax completed form to: Vermont Department of Health
802-651-1787
Attention: Patient Safety Program

Or mail completed form to : Vermont Department of Health
Patient Safety Program – Commissioner’s Office
108 Cherry Street
Burlington, VT 05401