**TxHSN**

**PAE Reporting Schedule**

<table>
<thead>
<tr>
<th>Reporting Quarter</th>
<th>Q1: Jan 1 – Mar 31</th>
<th>H1: Jan 1 – June 30</th>
<th>Q3: Jul 1 – Sept 30</th>
<th>H2: Jul 1 – Dec 31</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility data submission deadline</td>
<td>Within 60 days of end of reporting quarter</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>DSHS takes preliminary data snapshot</td>
<td>Jun 1</td>
<td>Sept 1</td>
<td>Dec 1</td>
<td>Mar 1</td>
</tr>
<tr>
<td>DSHS sends email to facilities to review data</td>
<td>~Jun 15</td>
<td>~Sept 15</td>
<td>~Dec 15</td>
<td>~Mar 15</td>
</tr>
<tr>
<td>Facility data corrections due</td>
<td>Jun 30</td>
<td>Sept 30</td>
<td>Dec 31</td>
<td>Mar 1</td>
</tr>
<tr>
<td>DSHS takes final data snapshot</td>
<td>July 1</td>
<td>Oct 1</td>
<td>Jan 1</td>
<td>Apr 1</td>
</tr>
<tr>
<td>DSHS sends email to facility to review data summary and make comments</td>
<td>NA</td>
<td>Oct 15</td>
<td>NA</td>
<td>Apr 15</td>
</tr>
<tr>
<td>Facility comment period deadline</td>
<td>NA</td>
<td>Oct 30</td>
<td>NA</td>
<td>Apr 30</td>
</tr>
<tr>
<td>DSHS review of comments</td>
<td>NA</td>
<td>Nov 15</td>
<td>NA</td>
<td>May 15</td>
</tr>
<tr>
<td>Public posting of data summary and approved comments</td>
<td>NA</td>
<td>Dec 1</td>
<td>NA</td>
<td>Jun 1</td>
</tr>
</tbody>
</table>

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*Last day to verify no PAEs to report for half year.
If any dates fall on a weekend or holiday submit on the next business day.

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**CHECK IT OUT!**

Find information, news, resources and training info at [www.PAETexas.org](http://www.PAETexas.org)

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For questions email us at PAETexas@dshs.state.tx.us

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**Effective January 1, 2015**

for all General Hospitals And Ambulatory Centers

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**Published 09/14 Revised 04/18**
First Tier PAE Reporting Beginning
January 1, 2015

1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
2. Foreign object retained after surgery.
3. Intraoperative or immediately postoperative / postprocedure death of an ASA Class 1 Patient.
4. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
5. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.
7. Sexual abuse or assault of a patient within or on the grounds of a health care facility.
8. Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a health care facility.
9. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
10. Patient death or severe harm associated with unsafe administration of blood or blood products.
11. Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
12. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
13. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.
14. Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.

Second Tier PAE Reporting Beginning
January 1, 2016

1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
2. Iatrogenic Pneumothorax with venous catheterization.
3. Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.
4. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
5. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
6. Patient death or severe harm associated with patient elopement.
7. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
8. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.
9. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.

Third Tier PAE Reporting Beginning
January 1, 2017

1. Surgical site infections following a spinal procedure, shoulder procedure, elbow procedure, laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.
2. Artificial insemination with the wrong donor sperm or wrong egg.
3. Poor glycemic control: hypoglycemic coma.
4. Poor glycemic control: diabetic ketoacidosis.
5. Poor glycemic control: nonketotic hyperosmolar coma.
7. Poor glycemic control: secondary diabetes with hyperosmolarity.
8. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.
9. Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
10. Patient death or severe harm associated with intravascular air embolism that occurs while being cared for in a health care facility.
11. Patient death or severe harm associated with a medication error.