TxHSN
PAE Reporting Schedule

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

**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.

CHECK IT OUT!

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PAETexas@dshs.state.tx.us

TEXAS HEALTH CARE SAFETY NETWORK

Published 09/14 Revised 04/18

TEXAS Health and Human Services

Texas Department of State Health Services

Preventable Adverse Event (PAE) Reporting

Effective January 1, 2015

for all
General Hospitals
And
Ambulatory Centers

Texas Preventable Adverse Event Reporting 3 Tier Phase-In Implementation

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.
6. Abduction of a patient of any age.
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.
6. Poor glycemic control: secondary diabetes with ketoacidosis.
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.