

MEMORANDUM

TO: All DC-Licensed Healthcare Facilities

FROM: Health Systems and Preparedness Administration (HSPA), DC Health

DATE: August 19, 2026

SUBJECT: Launch of DC Health’s Serious Adverse Event Reporting System – Sept. 1, 2026

Key Information

- DC Health is launching a new Serious Adverse Event Reporting System under DC Official Code § 7-161, aligned with the 2025 Joint Commission/NQF Serious Reportable Event (SRE) List.
- **Applies To:** All DC-licensed healthcare facilities
- **What’s Reportable:** 28 national SREs plus 4 DC-specific events – full list on page 2
- **Where to Report:** <https://redcap.link/DCSAERS>
- **Who Reports:** Facilities report on behalf of their professionals; independent practitioners not covered by a facility report directly.
- **Office of Health Facilities (OHF) Reporting Continues Unchanged:** Facility notifications to the OHF/Ms. Cooper are still required in parallel – this system does not replace that pathway.
- **Timeline:** Soft Launch: August 19, 2026; Hard Launch: September 1, 2026.

Purpose

This memorandum is intended to notify all healthcare facilities licensed by DC Health of the launch of a new Serious Adverse Event Reporting System, established in compliance with [DC Official Code § 7-161](#). This memorandum describes the reportable event types, the reporting tool and process, reporting expectations and responsibilities, and the technical resources available to support compliance.

Background

In January 2026 (updated May 2026), the Joint Commission and National Quality Forum (NQF)

jointly published Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events. This report reflects the first comprehensive revision of the NQF Serious Reportable Events (SRE) List since 2011 and establishes a coordinated alignment between the NQF's SRE List and the Joint Commission's Sentinel Events List.

DC Health's Serious Adverse Event Reporting System adopts the 2025 NQF SRE List as the foundation for the District's reportable event definitions, consistent with the statutory reporting authority and requirements established under DC Official Code § 7-161. This alignment brings the District's reporting framework current with the leading national patient safety taxonomy.

Reportable Event Types

The following 28 Serious Reportable Events (SREs), drawn from the 2025 NQF SRE List, and four (4) DC-Specific Events (DCEs) are reportable under the District's Serious Adverse Event Reporting System. Detailed definitions, inclusion criteria, exclusions, and clinical application guidance for each SRE are provided in the Technical Guidance document reference below.

Procedural Events

No.	Reportable Event
SRE01	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
SRE02	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
SRE03	Patient harm associated with perioperative or periprocedural anesthesia or sedation of an ASA Class I or ASA Class II patient
SRE04	Medically assisted reproduction with the wrong donor sperm or egg, regardless of the outcome
SRE05	Introduction of an unapproved, unscreened, or inappropriately approved device, implant, or object into an MR Zone IV area, regardless of the outcome
SRE06	Patient harm associated with an MRI-related thermal injury
SRE07	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

No.	Reportable Event
SRE08	Patient harm associated with the use of contaminated drugs, devices, or biologics
SRE09	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
SRE10	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
SRE11	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

No.	Reportable Event
SRE12	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
SRE13	Patient harm associated with the disappearance or unauthorized departure of a patient who does not have decision-making capacity
SRE14	Patient suicide or suicide attempt that occurs after presentation for care or within seven days of discharge or release, regardless of the outcome
SRE15	Patient harm associated with the use of chemical restraints, physical restraints, or seclusion
SRE16	Sexual abuse or sexual assault within or on the grounds of a healthcare setting, regardless of the outcome

Care Provision Events

No.	Reportable Event
SRE17	Patient harm associated with a fall
SRE18	Patient harm associated with an unintended burn from any source
SRE19	Patient harm associated with a medication error
SRE20	Patient harm associated with unsafe processing or administration of blood products
SRE21	Patient harm associated with a Stage 3 pressure injury, Stage 4 pressure injury, unstageable pressure injury, or deep tissue pressure injury acquired after admission
SRE22	Patient harm associated with the irretrievable loss of a biological specimen that is irreplaceable or is only replaceable through an invasive procedure
SRE23	Patient harm resulting from failure to act on clinically significant laboratory, pathology, or radiology test results
SRE24	Patient harm associated with an intravascular air embolism
SRE25	Maternal patient harm associated with labor or delivery in a low-risk pregnancy
SRE26	Neonatal patient harm associated with labor or delivery in a low-risk pregnancy
SRE27	Patient harm associated with the care of a neonate
SRE28	Patient harm associated with unrecognized clinical deterioration

DC-Specific Events (DCEs)

In addition to the 28 NQF SREs, the District requires reporting of the following four events, which are not part of the national SRE List, but which DC Health has identified as critical to public safety and oversight of the healthcare system:

No.	Reportable Event
DCE01	Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
DCE02	Physical assault (i.e., battery) of any person within or on the grounds of a healthcare setting, regardless of outcome
DCE03	Suicide or attempted suicide of a licensed healthcare professional employed by or privileged at a licensed healthcare facility, regardless of outcome or location
DCE04	Homicide of any person within or on the grounds of a healthcare setting

Reporting Tool

Reports must be submitted using the online DC Health Serious Adverse Event Reporting System, accessible at: <https://redcap.link/DCSAERS>

Reporting Expectations and Responsibilities

Who Reports

- Facilities are expected to submit reports on behalf of healthcare professionals operating within their facility.
- Independent healthcare professionals (e.g., dentists, massage therapists, social workers, and others practicing outside of a facility that reports on their behalf) shall be responsible for reporting directly and we will be working with them in the future to ensure they understand the reporting pathway.

DC Health is pursuing a statutory change to more clearly define reporting responsibilities between facilities and individual healthcare professionals. In the interim, facilities and professionals should coordinate directly to minimize duplicate submissions of the same event.

Relationship with Existing Office of Health Facilities Reporting Requirements

Healthcare facilities regulated by the DC Health Office of Health Facilities (OHF) must continue to notify Ms. Cooper and the OHF of unusual and serious adverse events, exactly as they have done previously. This existing reporting pathway remains fully in effect and is not replaced by the new Serious Adverse Event Reporting System at this time. DC Health may deduplicate these

reporting pathways in the future; until such time, facilities are expected to comply with both reporting requirements.

Notification Timeframes

Notification requirements, including applicable reporting timeframes, are established by statute under DC Official Code § 7-161(d)(1). Currently, the requirement is that the report must be submitted no later than 60 days from the occurrence or when made aware, unless the timeframe is officially shortened through action taken by the DC Board of Medicine, which has not occurred to date. Reporting entities are encouraged to report as soon as possible.

Non-Compliance

Non-compliance with required reporting (i.e., failure to submit) is governed by DC Official Code § 7-161(d)(2) and “... shall be punishable by a penalty of not less than \$500 or more than \$2,500.”

Reference and Technical Guidance Materials

The following documents provide detailed guidance to support compliance with this reporting system and should be consulted in conjunction with this memorandum:

- [HSPA-HF-TG-01-001-v01.0 – Serious Adverse Event Reporting System Technical Guidance](#)
- [HSPA-HF-TG-01-002-v01.0 – Serious Adverse Event Reporting System Codebook](#)

Joint Commission and National Quality Forum (NQF). Aligning Patient Safety Event Reporting: 2025 Updates to Sentinel Events and Serious Reportable Events. Washington, DC: NQF, January 2026 (Updated May 2026). Accessible via:

<https://digitalassets.jointcommission.org/api/public/content/b4e8988066e74717ae9801edb2bfb9de>

Questions

Questions regarding this memorandum, the Serious Adverse Event Reporting System, or the reportable event definitions should be directed to the Health Systems and Preparedness Administration at DOH.Reporting-HSPA@dc.gov.