Patient Safety Surveillance and Improvement Program (PSSIP)

Thanks for joining!

We will be starting shortly

Please introduce yourself in the chat and say hello by sharing your name, role and organization

UTAH DEPARTMENT OF HEALTH

Annual Patient Safety Report for Events Reported in Utah, CY 2020

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MISSION & VISION

The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Our vision is for Utah to be a place where *all* people can enjoy the best health possible, where *all* can live and thrive in healthy and safe communities.

STRATEGIC PRIORITIES

Healthiest People – The people of Utah will be among the healthiest in the country.

Optimize Medicaid – Utah Medicaid will be a respected innovator in employing health care delivery and payment reforms that improve the health of Medicaid members and keep expenditure growth at a sustainable level.

A Great Organization – The UDOH will be recognized as a leader in government and public health for its excellent performance. The organization will continue to grow its ability to attract, retain, and value the best professionals and public servants.

ABOUT THE OFFICE OF HEALTH CARE STATISTICS

Office of Health Care Statistics:

- **Collects:** We collect and produce data that are relevant and useful to our stakeholders
- **Analyzes:** We create valuable enhancements to our data resources and our systems have the analytic capacity to transform them into useful information
- **Disseminates:** We make the data and information we collect and produce available to the *right people* at the *right time* for the *right purposes*

ABOUT THE OFFICE OF HEALTH CARE STATISTICS

Responsible for the following data series:

- **Healthcare Facilities Data:** Includes all institutional "patient encounters" that are provided in the State of Utah by qualifying licensed facilities

- **Surveys of Customer Satisfaction with Health Plans (CAHPS):** Health plans (commercial and Medicaid, medical and dental) conduct annual surveys of their members (Required by statute - implemented by rule)

- **Self-reported Quality Metrics for Health Plans (HEDIS):** Quality of care measures - Healthcare Effectiveness Data and Information Set (HEDIS), which is developed and maintained by the National Committee for Quality Assurance (NCQA).

- **All Payer Claims Database**: Includes claims paid on behalf of Utah residents for the majority of health plans, Medicaid, Medicare Advantage, and third party administrators including PBMs.

- **Patient Safety Surveillance and Improvement Program (PSSIP):** A reporting mechanism which captures patient safety events (injuries, death or other adverse events) associated with healthcare delivery and administration of anesthesia, which fosters conversations on how to minimize adverse patient safety events in Utah.

UTAH ADMINISTRATIVE CODE

The rules that apply are:

- R380-200. Patient Safety Surveillance and Improvement Program (PSSIP).
- R380-210. Health Care Facility Patient Safety Program.
- R434-150. Adverse Events from the Administration of Sedation or Anesthesia; Recording and Reporting.

SPECIAL THANKS

- Kimberly Partain McNamara, Office of Health Care Statistics
- Mary Dy, Office of Health Care Statistics
- Sri Bose, Center for Health Data and Informatics

IN THIS REPORT

- Reported Patient Safety Events in Utah, 2010-2020
- Reported Patient Safety Events in Utah, CY 2020
  - Contributing factors
  - Actions taken
  - Patient Outcomes
- Major takeaways

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 1: 2010-2020 data

Occurrence Category	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Surgical Event	42	41	42	36	32	34	40	42	24	33	41	407	37.8%
Care Management Event	22	13	21	16	20	8	13	41	38	36	39	267	24.8%
Patient Protection Event	7	13	11	8	16	10	19	14	21	20	21	160	14.8%
Care Management Continued Events	3	5	18	4	11	6	17	2	5	5	8	84	7.8%
Product Device Event	5	5	0	4	0	2	3	5	9	10	10	53	4.9%
Unknown	3	4	5	4	2	6	6	1	8	7	5	51	4.7%
Criminal Event	1	1	4	3	2	1	1	2	7	4	2	28	2.6%
Environmental Event	0	0	0	1	2	1	5	1	4	1	5	20	1.9%
Not Sentinel Event	0	0	1	0	0	0	0	1	0	1	1	4	0.4%
Radiological Event	0	1	0	0	1	0	0	0	1	0	1	4	0.4%
Total	83	83	102	76	86	68	104	109	117	117	133	1078	

Legend:
Dark red denotes higher frequency

The top 3 occurrence categories (surgical, care management and patient protection events) accounted for 77.4% of all events reported over the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 2: Contributing Factors 2010-2020 data

Contributing Factors	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	39	26	50	28	33	27	30	41	46	44	68	432	17.7%
Human Factors	29	18	30	22	16	20	23	30	40	54	62	344	14.1%
Process Breakdowns	18	15	16	11	17	18	28	24	31	32	48	258	10.5%
Procedural Compliance	15	21	28	6	15	15	13	21	17	27	22	200	8.2%
Other	18	16	18	15	21	14	9	15	18	11	18	173	7.1%
Patient Assessment	16	6	23	10	13	8	11	17	12	14	17	147	6.0%
Availability of Information	11	11	16	7	10	15	11	21	7	4	7	120	4.9%
Equipment - List Equipment used	13	8	16	13	8	5	9	7	8	7	10	104	4.3%
Failure to Recognize Changes	12	4	14	7	6	6	11	15	10	8	11	104	4.3%
Orientation / Competency / Training	6	8	10	9	6	3	10	11	11	15	10	99	4.0%
Care Planning	5	4	13	2	10	4	5	8	11	13	13	88	3.6%
Organization Culture	3	5	9	2	7	2	12	6	10	12	12	80	3.3%
Lack of Monitoring	7	0	10	2	2	4	9	8	8	13	16	79	3.2%
Environ. Safety / Security	4	4	9	5	7	7	6	11	8	6	5	72	2.9%
Continuum of Care	1	2	7	0	0	0	1	3	14	7	8	43	1.8%
Device Breakdowns	4	5	4	4	0	3	5	6	3	3	5	42	1.7%
Leadership	1	2	4	2	0	0	1	1	9	8	4	32	1.3%
Staffing	0	2	2	0	5	3	2	5	1	6	3	29	1.2%
Total	202	157	279	145	176	154	196	250	264	284	339	2446	

Legend:
Dark red denotes higher frequency

The top 3 contributing factors (communication, human factors and process breakdowns) accounted for 42.3% of all contributing factors reported over the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

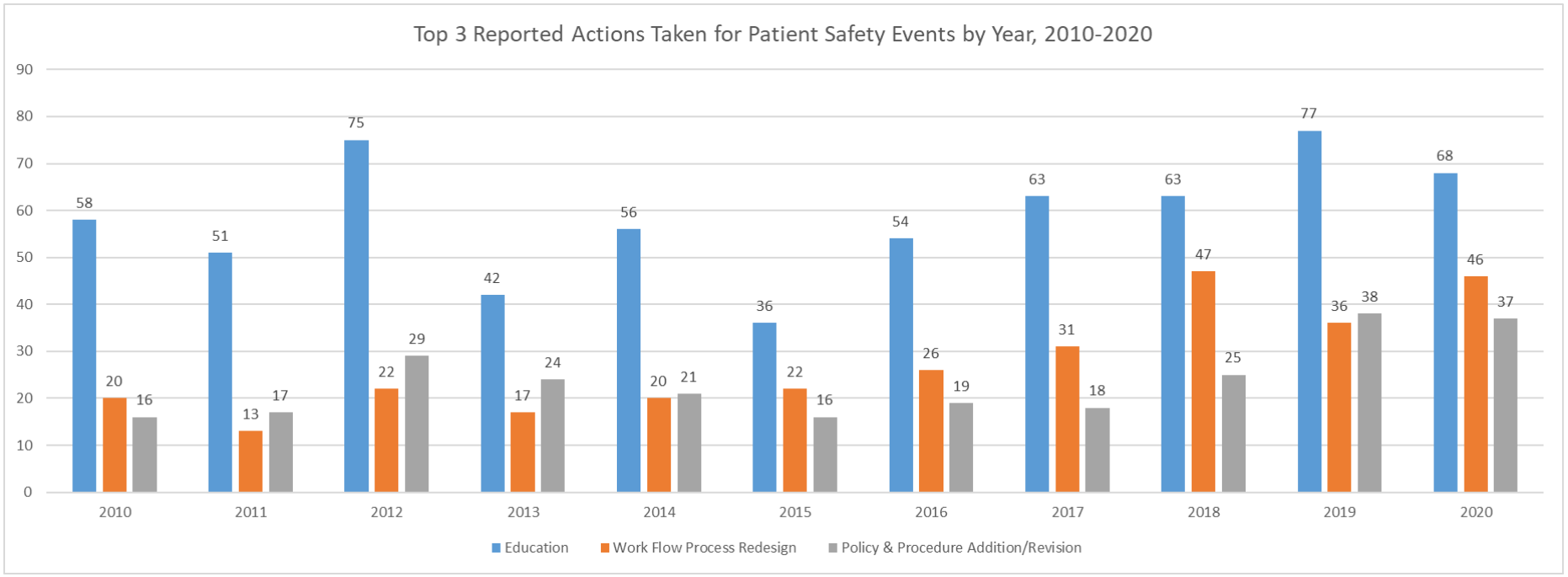
Table 3: Actions Taken 2010-2020 data

Actions Taken	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Education	58	51	75	42	56	36	54	63	63	77	68	643	36.4%
Work Flow Process Redesign	20	13	22	17	20	22	26	31	47	36	46	300	17.0%
Policy & Procedure Addition/Revision	16	17	29	24	21	16	19	18	25	38	37	260	14.7%
Other	23	22	23	19	23	19	13	9	27	24	17	219	12.4%
Documentation Changes: Other	13	5	9	3	4	5	1	7	12	9	11	79	4.5%
Documentation Changes: Checklist	3	3	6	6	1	4	4	8	8	7	8	58	3.3%
Equipment Taken Out of Service	7	4	3	5	4	1	5	5	4	3	7	48	2.7%
Documentation Changes: Charting Tool	4	4	5	2	3	3	4	5	3	6	8	47	2.7%
Information System Change	4	3	2	1	3	3	1	2	6	8	8	41	2.3%
Staffing Changes	3	3	3	2	4	0	5	7	2	5	3	37	2.1%
Documentation Changes: Form	6	4	6	2	1	1	3	2	2	4	2	33	1.9%
Total	**157**	**129**	**183**	**123**	**140**	**110**	**135**	**157**	**199**	**217**	**215**	**1765**	

Legend:
Darker green denotes higher frequency

The top 3 actions taken (education, workflow process redesign and policy/procedure revisions) accounted for 68.2% of all actions taken reported over the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020



The main action taken reported is “education”, each year, for the last 10 years.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 4: Communication Issues: Actions Taken 2010-2020 data

Actions Taken	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Education	33	20	42	22	25	18	21	30	36	35	47	329	36.5%
Work Flow Process Redesign	15	5	12	12	6	14	9	12	23	19	35	162	18.0%
Policy & Procedure Addition/Revision	10	9	15	16	12	8	9	5	15	18	27	144	16.0%
Other	9	8	7	5	7	7	0	1	10	8	5	67	7.4%
Documentation Changes: Other	7	1	8	2	3	3	1	4	8	5	9	51	5.7%
Documentation Changes: Checklist	2	3	4	6	1	3	3	1	5	4	7	39	4.3%
Documentation Changes: Charting Tool	3	1	4	2	2	2	2	2	1	3	7	29	3.2%
Information System Change	3	2	1	1	3	2	0	1	3	7	5	28	3.1%
Documentation Changes: Form	5	3	5	2	1	0	1	1	0	3	1	22	2.4%
Staffing Changes	1	2	2	1	2	0	0	2	2	4	2	18	2.0%
Equipment Taken Out of Service	2	0	2	3	1	1	1	0	0	0	3	13	1.4%
Total	90	54	102	72	63	58	47	59	103	106	148	**902**	

Legend:
Darker green denotes higher frequency

For events where the contributing factor was “communication issues”, the top action taken is “education”.

The top 3 actions taken for communication issues reported make up 70.4% of all actions taken for patient safety events where communication was a driver.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 5: Human Factors: Actions Taken 2010-2020 data

Actions Taken	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Education	20	17	23	15	9	11	11	22	28	41	42	239	33.7%
Work Flow Process Redesign	5	5	8	10	6	9	10	17	23	21	24	138	19.4%
Policy & Procedure Addition/Revision	7	4	10	10	3	3	7	9	11	18	23	105	14.8%
Other	8	4	8	9	3	9	3	3	11	11	9	78	11.0%
Documentation Changes: Other	3	0	4	2	2	1	1	5	6	3	9	36	5.1%
Documentation Changes: Checklist	1	0	4	4	0	2	2	5	4	5	3	30	4.2%
Documentation Changes: Charting Tool	0	1	1	1	2	2	2	3	1	4	6	23	3.2%
Information System Change	2	1	0	1	0	1	0	1	6	5	6	23	3.2%
Staffing Changes	2	1	0	0	0	0	2	4	1	1	3	14	2.0%
Documentation Changes: Form	2	1	1	2	0	0	0	1	1	3	2	13	1.8%
Equipment Taken Out of Service	1	1	2	0	2	1	1	0	0	1	2	11	1.5%
Total	51	35	61	54	27	39	39	70	92	113	129	710	

Legend:
Darker green denotes higher frequency

For events where the contributing factor was “human factors”, the top action taken is “education”.

The top 3 actions taken for events caused by human factors make up 67.9% of all actions taken for human factors reported over the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 6: Surgical Event: Contributing Factors 2010-2020

Contributing Factors	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	21	19	22	16	16	16	14	21	13	19	26	203	21.3%
Human Factors	15	8	9	16	9	10	10	14	11	22	24	148	15.5%
Process Breakdowns	11	11	13	11	11	14	12	11	8	15	24	141	14.8%
Procedural Compliance	7	16	18	4	9	9	6	12	9	8	6	104	10.9%
Availability of Information	8	6	7	5	4	8	6	10	4	2	2	62	6.5%
Equipment - List Equipment used	4	4	7	9	4	3	1	3	2	2	4	43	4.5%
Other	5	6	4	2	7	7	3	5	0	1	3	43	4.5%
Orientation / Competency / Training	3	5	3	5	1	2	3	6	3	2	5	38	4.0%
Organization Culture	0	5	3	2	4	1	3	2	2	4	4	30	3.2%
Failure to Recognize Changes	5	2	2	4	3	2	1	3	1	2	2	27	2.8%
Patient Assessment	7	1	4	2	3	1	1	3	1	1	3	27	2.8%
Care Planning	3	1	2	1	4	3	3	1	1	2	5	26	2.7%
Device Breakdowns	1	2	3	3	0	2	3	1	1	0	0	16	1.7%
Leadership	1	2	1	0	0	0	0	1	4	4	2	15	1.6%
Staffing	0	0	1	0	1	1	2	2	0	2	1	10	1.1%
Continuum of Care	1	1	3	0	0	0	0	0	1	1	2	9	0.9%
Lack of Monitoring	3	0	2	0	0	1	0	0	0	0	1	7	0.7%
Environ. Safety / Security	1	0	1	0	0	0	0	0	0	0	1	3	0.3%
Total	96	89	105	80	76	80	68	95	61	87	115	**952**	

Legend:
Dark red denotes higher frequency

When observing surgical events reported over the last 10 years, communication, human factors and process breakdowns come are the top 3 contributing factors, which make up 51.7% of all contributing factors reported for surgical events over the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 7: Care Management Event: Contributing Factors 2010-2020

Contributing Factors	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Communication	10	3	11	5	5	3	5	10	15	11	19	97	15.6%
Human Factors	10	2	6	2	4	2	3	10	18	15	16	88	14.1%
Process Breakdowns	2	2	0	0	1	0	3	11	15	7	12	53	8.5%
Other	6	4	5	7	5	2	1	7	7	3	5	52	8.4%
Patient Assessment	6	2	5	2	1	2	1	9	7	6	8	49	7.9%
Failure to Recognize Changes	5	0	7	0	0	1	4	6	6	3	5	37	5.9%
Lack of Monitoring	4	0	3	1	1	1	4	7	3	5	6	35	5.6%
Environ. Safety / Security	1	0	5	2	5	3	3	7	1	3	1	31	5.0%
Procedural Compliance	4	1	2	0	1	0	0	5	3	7	8	31	5.0%
Orientation / Competency / Training	2	0	3	2	1	0	5	3	3	7	2	28	4.5%
Care Planning	1	1	3	0	2	0	0	5	4	6	5	27	4.3%
Availability of Information	1	3	3	1	2	2	0	5	2	0	4	23	3.7%
Organization Culture	2	0	0	0	1	0	1	4	4	6	2	20	3.2%
Equipment - List Equipment used	3	0	0	1	1	0	3	4	2	2	3	19	3.1%
Continuum of Care	0	0	1	0	0	0	0	2	6	2	2	13	2.1%
Leadership	0	0	0	2	0	0	0	0	2	4	0	8	1.3%
Staffing	0	0	0	0	1	1	0	1	1	3	1	8	1.3%
Device Breakdowns	0	0	0	0	0	0	0	1	0	0	2	3	0.5%
Total	57	18	54	25	31	17	33	97	99	90	101	622	

Legend:
Dark red denotes higher frequency

In the last 10 years of care management events reported, the top 3 contributing factors were communication, human factors and process breakdowns, which made up 38.3% of all contributing factors reported for care management.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 7.4: Surgical Procedure Event Details, 2010-2020

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
UNINTENDED RETAINED FOREIGN OBJECT in a patient after surgery or other procedures requiring consent	22	25	21	21	15	15	22	24	8	9	10	192	47.8%
WRONG BODY PART Surgery or procedures requiring consent; (Harm Scale A-I);	11	8	16	10	7	9	12	9	5	11	13	111	27.6%
Other	2	6	6	3	3	5	3	5	3	1	2	39	9.7%
INCORRECT SURGERY OR PROCEDURE requiring consent performed on a patient	1	0	0	2	0	1	0	5	9	5	9	32	8.0%
INTRAOPERATIVE/POSTOPERATIVE DEATH	3	2	0	0	5	4	1	0	0	0	0	15	3.7%
Wrong Patient	3	0	0	0	2	0	4	0	0	2	2	13	3.2%
Total	42	41	43	36	32	34	42	43	25	28	36	402	

Legend:
Dark red denotes higher frequency

When observing surgical procedure events reported over the last 10 years, the top item reported under event details was unintended retained foreign object in patient, followed by wrong body part. These two event details make up 75.4% of all surgical procedure event details reported in the last decade.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Care Management Event Details 2010-2020 data

Types of Care Management Events	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
FALL while being cared for in a health care facility	13	6	13	7	13	6	6	11	7	14	15	111	29.6%
INFANT DEATH, born at gestation equal to or greater than 32 weeks excluding congenital causes	5	3	1	5	7	2	5	1	11	4	2	46	12.3%
Other	3	2	4	2	0	1	1	8	4	1	6	32	8.5%
FAILURE TO FOLLOW UP or communicate laboratory, pathology, or imaging test results	1	0	1	1	0	0	0	1	0	1	1	6	1.6%
PRESSURE ULCERS, Stage 3 or 4 acquired after admission	0	2	14	2	7	2	5	4	10	5	8	59	15.7%
MEDICATION ERROR	1	1	3	1	1	2	7	8	10	8	8	50	13.3%
LABOR OR DELIVERY while being cared for in a facility	1	2	1	1	4	1	5	4	3	10	12	44	11.7%
Other	0	1	1	0	0	1	0	6	3	3	4	19	5.1%
IRRETRIEVABLE LOSS of an irreplaceable biological specimen	0	0	0	0	0	0	0	3	1	1	1	6	1.6%
NEONATAL HYPERBILIRUBINEMIA, where bilirubin is greater than 25 milligrams per deciliter	1	0	0	0	0	0	1	0	0	0	0	2	0.5%
Total	25	17	38	19	32	15	30	46	49	47	57	**375**	

Legend:
Dark red denotes higher frequency

When observing care management event reported over the last 10 years, the top event detail reported was a fall, followed by infant death, which made up 41.9% of all event details provided for care management.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 7.5: Patient Protection Event Details, 2010-2020

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
Patient Suicide or Unsuccessful Attempt	2	4	2	4	3	5	11	5	15	12	13	76	43.9%
Unexpected Death	3	3	7	3	8	3	5	5	8	7	7	59	34.1%
Other	2	5	1	1	4	1	3	3	1	0	2	23	13.3%
Elopement or disappearance of a patient with cognitive impairment	0	2	2	0	1	1	0	4	1	2	2	15	8.7%
Total	7	14	12	8	16	10	19	17	25	21	24	173	

Legend:
Dark red denotes higher frequency

Patient suicide or unsuccessful attempt is the top reported detail for patient protection events. This and unexpected death made up 78% of all event details provided for patient protection events over the last 10 years.

PATIENT SAFETY EVENTS IN UTAH, 2010-2020

Table 7.3: Patient Outcomes, 2010-2020

Patient Outcomes	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Total	Percent
I - Patient Death	0	2	15	6	11	7	6	16	27	23	25	138	21.0%
E - Temp Harm - Req non-life threatening Intervention	0	0	8	8	6	11	14	19	17	16	20	119	18.1%
C - No Harm;	0	0	6	4	4	4	6	24	13	15	13	89	13.5%
H - Intervention to Sustain Life	0	0	7	1	0	1	4	8	21	22	14	78	11.9%
F - Temp Harm - Reg Hospitalization	0	0	1	2	6	3	7	11	5	14	18	67	10.2%
D - Additional Monitoring/Treatment to Prevent Harm	0	0	1	3	7	2	6	13	13	9	8	62	9.4%
G - Permanent Patient Harm	0	0	0	0	0	1	4	9	11	14	19	58	8.8%
B - Near Miss (event stopped prior to reaching patient)	0	0	0	0	0	0	1	1	1	3	10	16	2.4%
A - Unsafe Conditions	0	0	0	0	0	0	3	3	6	0	2	14	2.1%
Determined not to be a Sentinel Event	0	0	0	2	0	0	1	3	1	0	2	9	1.4%
Other	0	0	2	0	0	0	0	1	2	0	2	7	1.1%
Total	0	2	40	26	34	29	52	108	117	116	133	**657**	

Legend:
Dark red denotes higher frequency

Patient death is the top patient outcome reported for patient safety events over the last 10 years.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 8 : Event type, by month, CY2020	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Surgical Event	2	2	5	0	2	8	1	3	2	5	9	2	41	30.8%
Care Management Event	3	1	4	1	4	6	3	7	1	5	2	2	39	29.3%
Patient Protection Event	0	3	1	1	1	2	0	3	3	4	2	1	21	15.8%
Product Device Event	0	0	0	0	1	0	1	1	0	5	1	1	10	7.5%
Care Management Continued Events	1	0	0	1	0	1	1	2	1	0	1	0	8	6.0%
Environmental Event	1	0	0	1	0	0	1	1	0	0	1	0	5	3.8%
Unknown	2	0	0	1	0	0	0	0	2	0	0	0	5	3.8%
Criminal Event	0	1	0	0	1	0	0	0	0	0	0	0	2	1.5%
Not Sentinel Event	0	0	0	0	0	1	0	0	0	0	0	0	1	0.8%
Radiological Event	0	0	0	0	0	1	0	0	0	0	0	0	1	0.8%
Total	9	7	10	5	9	19	7	17	9	19	16	6	133	

Legend:
Dark red denotes higher frequency

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 9: Contributing Factors 2020 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Communication	5	2	7	3	5	11	3	5	7	10	8	2	68	20.1%
Human Factors	4	3	6	2	4	9	2	8	4	10	7	3	62	18.3%
Process Breakdowns	1	3	6	1	5	6	2	2	3	9	8	2	48	14.2%
Procedural Compliance	2	0	1	0	4	2	2	3	2	5	1	0	22	6.5%
Other	2	0	1	1	2	2	1	1	3	3	1	1	18	5.3%
Patient Assessment	1	2	1	0	1	2	0	4	1	1	2	2	17	5.0%
Lack of Monitoring	0	1	0	0	4	1	1	2	1	5	1	0	16	4.7%
Care Planning	1	0	2	1	3	2	0	0	2	1	1	0	13	3.8%
Organization Culture	1	1	2	0	1	1	0	0	1	3	2	0	12	3.5%
Failure to Recognize Changes	0	1	1	0	0	3	1	1	1	0	3	0	11	3.2%
Equipment - List Equipment used	0	1	1	1	2	3	0	1	0	0	1	0	10	2.9%
Orientation / Competency / Training	1	0	2	1	0	2	0	1	1	0	2	0	10	2.9%
Continuum of Care	0	0	1	1	2	2	0	0	1	0	0	1	8	2.4%
Availability of Information	0	1	1	2	0	2	0	0	1	0	0	0	7	2.1%
Device Breakdowns	0	1	0	0	1	1	0	0	0	1	0	1	5	1.5%
Environ. Safety / Security	1	0	1	0	1	0	0	1	0	1	0	0	5	1.5%
Leadership	0	0	0	0	1	0	0	0	0	1	2	0	4	1.2%
Staffing	0	0	1	0	0	0	0	0	1	1	0	0	3	0.9%
Total	19	16	34	13	36	49	12	29	29	51	39	12	339	

Legend:
Dark red denotes higher frequency

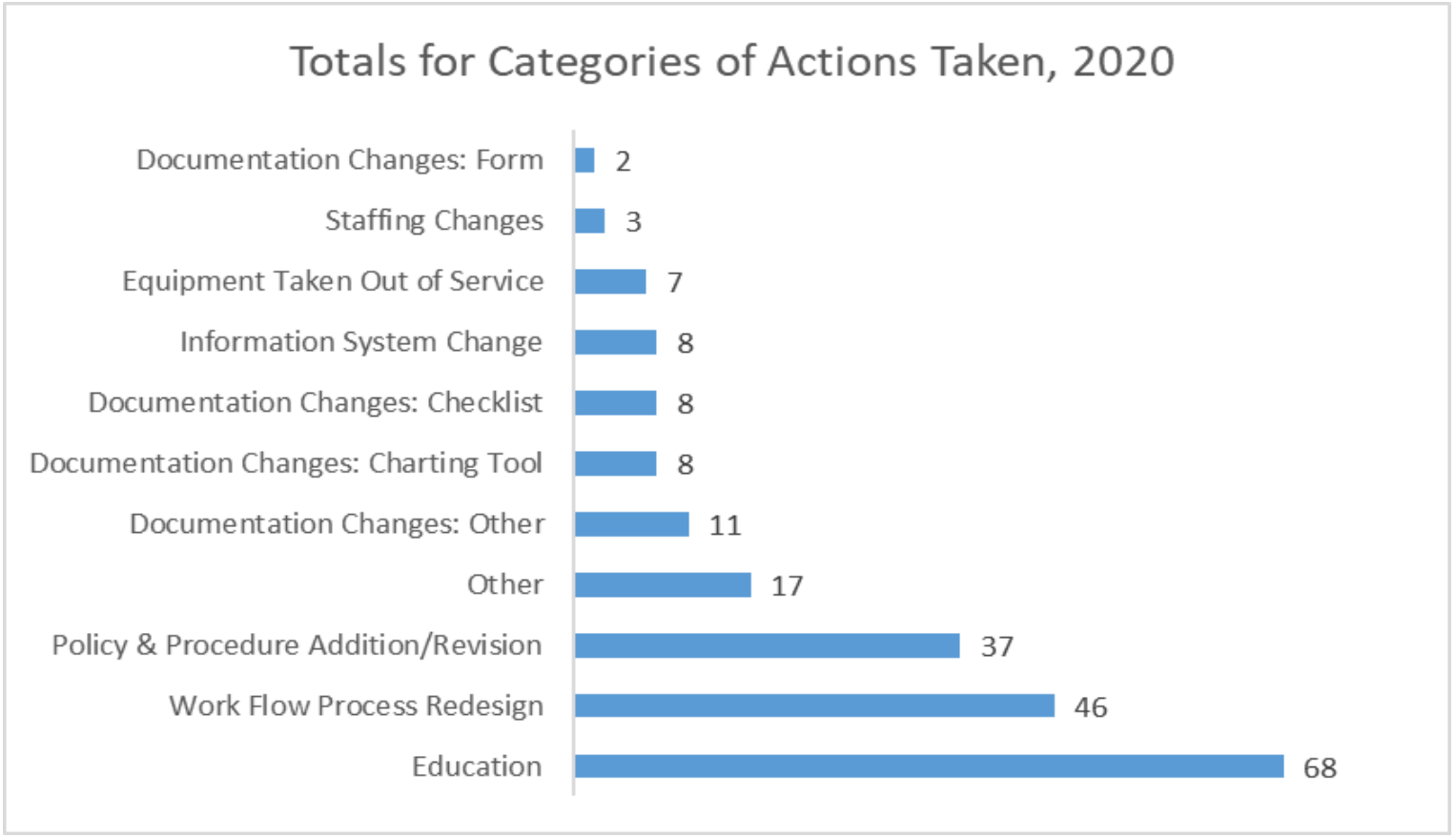
PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 10: Actions Taken 2020 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Education	6	3	7	3	2	8	2	8	2	13	11	3	68	31.6%
Work Flow Process Redesign	5	1	6	3	3	6	3	1	5	7	5	1	46	21.4%
Policy & Procedure Addition/Revision	2	0	2	1	4	6	3	4	3	6	5	1	37	17.2%
Other	0	3	2	0	0	3	0	3	2	0	2	2	17	7.9%
Documentation Changes: Other	0	0	2	0	2	3	0	2	1	0	0	1	11	5.1%
Documentation Changes: Charting Tool	1	0	1	1	1	0	0	0	2	0	1	1	8	3.7%
Documentation Changes: Checklist	0	0	1	0	2	0	0	1	1	2	1	0	8	3.7%
Information System Change	0	1	1	0	2	0	0	2	0	1	0	1	8	3.7%
Equipment Taken Out of Service	0	1	0	0	1	0	0	0	0	2	2	1	7	3.3%
Staffing Changes	0	0	0	1	0	0	0	0	0	1	1	0	3	1.4%
Documentation Changes: Form	0	0	1	0	0	0	0	1	0	0	0	0	2	0.9%
Total	14	9	23	9	17	26	8	22	16	32	28	11	215	

Legend:
Dark green denotes higher frequency

Top actions taken for 2020 were “education”, “work flow process redesign” and “policy & procedure addition/revision”, which represent 70.2% of all reported actions taken in 2020.

PATIENT SAFETY EVENTS IN UTAH, CY2020



PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 11: Actions Taken for Communication Issues, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Education	3	1	6	2	2	6	1	5	2	10	7	2	47	31.8%
Work Flow Process Redesign	3	1	5	2	3	4	3	0	5	6	3	0	35	23.6%
Policy & Procedure Addition/Revision	1	0	2	1	2	6	2	2	3	4	3	1	27	18.2%
Documentation Changes: Other	0	0	1	0	2	3	0	1	1	0	0	1	9	6.1%
Documentation Changes: Charting Tool	0	0	1	1	1	0	0	0	2	0	1	1	7	4.7%
Documentation Changes: Checklist	0	0	1	0	2	0	0	0	1	2	1	0	7	4.7%
Information System Change	0	1	0	0	2	0	0	0	0	1	0	1	5	3.4%
Other	0	0	1	0	0	2	0	0	1	0	0	1	5	3.4%
Equipment Taken Out of Service	0	0	0	0	0	0	0	0	0	2	1	0	3	2.0%
Staffing Changes	0	0	0	1	0	0	0	0	0	0	1	0	2	1.4%
Documentation Changes: Form	0	0	1	0	0	0	0	0	0	0	0	0	1	0.7%
Total	7	3	18	7	14	21	6	8	15	25	17	7	148	

Legend:
Dark green denotes higher frequency

For events where the contributing factor was “communication issues”, the top action taken in 2020 was “education”, followed by workflow process redesign and policy/procedure revision, which together made up 73.6% of all reported actions taken in 2020

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 12: Actions Taken for Human Factors, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Education	3	1	5	2	1	4	1	5	2	9	6	3	42	32.6%
Work Flow Process Redesign	1	0	3	1	2	4	1	1	2	5	3	1	24	18.6%
Policy & Procedure Addition/Revision	1	0	2	1	3	3	2	2	1	5	2	1	23	17.8%
Documentation Changes: Other	0	0	2	0	2	2	0	2	0	0	0	1	9	7.0%
Other	0	3	2	0	0	0	0	2	1	0	0	1	9	7.0%
Documentation Changes: Charting Tool	1	0	1	0	1	0	0	0	1	0	1	1	6	4.7%
Information System Change	0	0	1	0	1	0	0	2	0	1	0	1	6	4.7%
Documentation Changes: Checklist	0	0	1	0	1	0	0	1	0	0	0	0	3	2.3%
Staffing Changes	0	0	0	1	0	0	0	0	0	1	1	0	3	2.3%
Documentation Changes: Form	0	0	1	0	0	0	0	1	0	0	0	0	2	1.6%
Equipment Taken Out of Service	0	0	0	0	0	0	0	0	0	1	1	0	2	1.6%
Total	6	4	18	5	11	13	4	16	7	22	14	9	129	

Legend:
Dark green denotes higher frequency

A similar pattern emerges for patient safety events in 2020 where human factors was noted as the contributing factor. Education, workflow process redesign and policy/procedure revision make up 69% of all actions taken for human factors as contributing factor in 2020.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 13: Contributing Factors for Surgical Events, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Communication	2	1	2	0	0	6	1	1	2	3	7	1	26	22.6%
Human Factors	2	1	4	0	1	4	0	2	2	1	5	2	24	20.9%
Process Breakdowns	1	2	3	0	1	5	0	0	1	2	7	2	24	20.9%
Procedural Compliance	0	0	1	0	1	2	0	0	0	1	1	0	6	5.2%
Care Planning	0	0	1	0	1	1	0	0	1	0	1	0	5	4.3%
Orientation / Competency / Training	1	0	2	0	0	0	0	0	0	0	2	0	5	4.3%
Equipment - List Equipment used	0	0	1	0	0	1	0	1	0	0	1	0	4	3.5%
Organization Culture	0	0	2	0	0	0	0	0	0	0	2	0	4	3.5%
Patient Assessment	0	0	1	0	0	1	0	0	0	0	0	1	3	2.6%
Other	0	0	1	0	1	0	0	1	0	0	0	0	3	2.6%
Availability of Information	0	1	1	0	0	0	0	0	0	0	0	0	2	1.7%
Continuum of Care	0	0	1	0	0	0	0	0	0	0	0	1	2	1.7%
Failure to Recognize Changes	0	0	1	0	0	0	0	0	0	0	1	0	2	1.7%
Leadership	0	0	0	0	0	0	0	0	0	0	2	0	2	1.7%
Environ. Safety / Security	0	0	1	0	0	0	0	0	0	0	0	0	1	0.9%
Lack of Monitoring	0	0	0	0	0	0	0	0	0	0	1	0	1	0.9%
Staffing	0	0	1	0	0	0	0	0	0	0	0	0	1	0.9%
Device Breakdowns	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
Total	6	5	23	0	5	20	1	5	6	7	30	7	115	

Legend:
Dark red denotes higher frequency

Communication, human factors and process breakdowns represent 64.3% of contributing factors for surgical events reported in 2020. Of note, there were no surgical events reported in April, which marks the period following shutdowns, etc.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 14: Contributing Factors for Care Mgt. Events, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Communication	2	0	4	1	3	3	1	1	1	3	0	0	19	18.8%
Human Factors	1	1	1	0	2	2	1	2	1	4	1	0	16	15.8%
Process Breakdowns	0	0	3	1	2	1	1	1	1	2	0	0	12	11.9%
Patient Assessment	1	1	0	0	1	1	0	2	0	1	1	0	8	7.9%
Procedural Compliance	1	0	0	0	2	0	1	1	1	2	0	0	8	7.9%
Lack of Monitoring	0	1	0	0	2	1	0	0	1	1	0	0	6	5.9%
Care Planning	0	0	1	0	1	1	0	0	1	1	0	0	5	5.0%
Failure to Recognize Changes	0	0	0	0	0	3	0	0	0	0	2	0	5	5.0%
Other	1	0	0	0	1	1	1	0	0	0	0	1	5	5.0%
Availability of Information	0	0	0	1	0	2	0	0	1	0	0	0	4	4.0%
Equipment - List Equipment used	0	0	0	0	1	2	0	0	0	0	0	0	3	3.0%
Continuum of Care	0	0	0	0	1	0	0	0	1	0	0	0	2	2.0%
Device Breakdowns	0	0	0	0	1	1	0	0	0	0	0	0	2	2.0%
Organization Culture	0	0	0	0	0	1	0	0	0	1	0	0	2	2.0%
Orientation / Competency / Training	0	0	0	0	0	1	0	1	0	0	0	0	2	2.0%
Environ. Safety / Security	1	0	0	0	0	0	0	0	0	0	0	0	1	1.0%
Staffing	0	0	0	0	0	0	0	0	1	0	0	0	1	1.0%
Leadership	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%
Total	7	3	9	3	17	20	5	8	9	15	4	1	101	

Legend:
Dark red denotes higher frequency

Communication, human factors and process breakdowns represent 46.5% of contributing factors for care management events reported in 2020. “Leadership” was not selected at all in 2020 for care management events.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 14.4: Surgical Event Details, 2020 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
WRONG BODY PART Surgery or procedures requiring consent; (Harm Scale A-I);	1	1	3	0	1	3	1	0	0	1	2	0	13	36.1%
UNINTENDED RETAINED FOREIGN OBJECT in a patient after surgery or other procedures requiring consent	0	0	0	0	0	4	0	1	0	2	2	1	10	27.8%
INCORRECT SURGERY OR PROCEDURE requiring consent performed on a patient	0	0	1	0	0	1	1	1	2	0	2	1	9	25.0%
Wrong Patient	1	0	0	0	0	0	0	0	0	1	0	0	2	5.6%
Other	0	0	1	0	0	0	0	0	0	0	1	0	2	5.6%
Total	2	1	5	0	1	8	2	2	2	4	7	2	**36**	

Legend:
Dark red denotes higher frequency

For surgical events reported in 2020, the most selected event detail was surgery conducted on the wrong body part.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 14.x: Care Management Events Details, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
FALL while being cared for in a health care facility	2	1	2	0	2	3	1	1	0	3	0	0	15	26.3%
LABOR OR DELIVERY while being cared for in a facility	1	0	0	1	0	4	0	2	3	0	0	1	12	21.1%
MEDICATION ERROR	1	0	1	0	0	0	1	2	1	1	0	1	8	14.0%
PRESSURE ULCERS, Stage 3 or 4 acquired after admission	0	0	0	1	1	1	1	3	0	0	1	0	8	14.0%
Other	1	0	1	0	1	0	1	0	1	0	1	0	6	10.5%
Other	0	0	0	0	0	0	1	0	0	0	3	0	4	7.0%
INFANT DEATH, born at gestation equal to or greater than 32 weeks excluding congenital causes	1	0	0	0	0	0	0	0	1	0	0	0	2	3.5%
FAILURE TO FOLLOW UP or communicate laboratory, pathology, or imaging test results	0	0	0	0	0	0	0	1	0	0	0	0	1	1.8%
IRRETRIEVABLE LOSS of an irreplaceable biological specimen	0	0	0	0	0	0	0	1	0	0	0	0	1	1.8%
Total	6	1	4	2	4	8	5	10	6	4	5	2	**57**	

Legend:
Dark red denotes higher frequency

For care management events reported in 2020, the most selected event detail were falls.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 14.5: Patient Protection Event Details, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
Patient Suicide or Unsuccessful Attempt	1	1	0	1	1	2	0	1	2	2	2	0	13	54.2%
Unexpected Death	0	1	0	1	1	0	0	1	1	1	0	1	7	29.2%
Elopement or disappearance of a patient with cognitive impairment	0	0	0	0	0	0	0	1	0	1	0	0	2	8.3%
Other	0	0	0	0	0	0	1	0	0	0	1	0	2	8.3%
Total	1	2	0	2	2	2	1	3	3	4	3	1	24	

Legend:
Dark red denotes higher frequency

For patient protection events reported in 2020, the most selected event detail was patient suicide or unsuccessful attempt.

PATIENT SAFETY EVENTS IN UTAH, CY2020

Table 14.3: Patient Outcomes, 2020 Data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Percent
I - Patient Death	2	2	2	2	3	1	0	2	4	3	3	1	25	18.8%
E - Temp Harm - Req non-life threatening Intervention	0	0	2	1	2	4	3	2	0	0	5	1	20	15.0%
G - Permanent Patient Harm	1	0	2	1	1	2	1	5	1	4	0	1	19	14.3%
F - Temp Harm - Reg Hospitalization	2	1	3	0	0	4	2	2	2	1	1	0	18	13.5%
H - Intervention to Sustain Life	2	0	0	1	1	3	1	2	1	1	1	1	14	10.5%
C - No Harm;	1	0	0	0	1	2	0	2	0	5	0	2	13	9.8%
B - Near Miss (event stopped prior to reaching patient)	1	1	1	0	0	1	0	2	0	2	2	0	10	7.5%
D - Additional Monitoring/Treatment to Prevent Harm	0	1	0	0	1	1	0	0	0	2	3	0	8	6.0%
A - Unsafe Conditions	0	1	0	0	0	0	0	0	0	1	0	0	2	1.5%
Determined not to be a Sentinel Event	0	0	0	0	0	1	0	0	1	0	0	0	2	1.5%
Other	0	1	0	0	0	0	0	0	0	0	1	0	2	1.5%
Total	9	7	10	5	9	19	7	17	9	19	16	6	133	

Legend:
Dark red denotes higher frequency

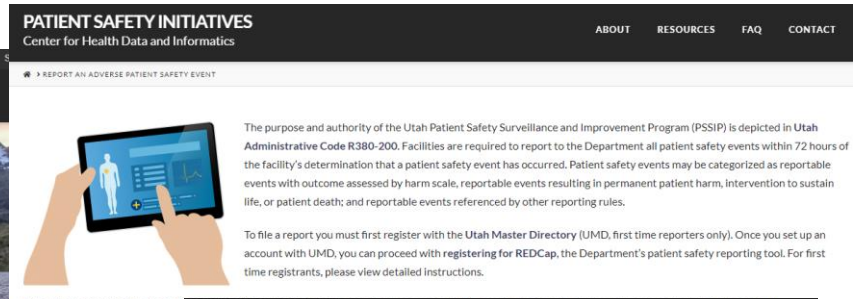
The top patient outcome reported for 2020 was patient death, followed by temporary harm (req. non-life threatening intervention, permanent harm, and temporary harm requiring hospitalization, together makes up 61.7% of patient outcomes for the year.

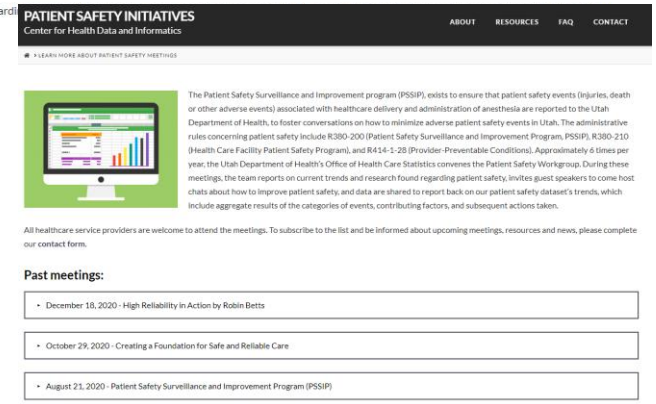
MAJOR TAKEAWAYS

- Education continues to be the most reported corrective action taken
- Falls are most common care management event
- Among patient outcomes, patient death is the highest, over the last decade and in 2020
- Patient suicide or unsuccessful attempt is the highest type of reported patient protection event
- Wrong body part and unintended retained foreign object is the most reported type of surgical procedure event
- Despite communication and human factors being top drivers of patient safety events, education consistently comes up as the corrected action taken

WHAT'S IN STORE FOR 2021

- New Patient Safety Initiatives website coming up!
- Exploration of All Payer Claims Data and Facility Discharge Data to reconcile events reported for 2021
- Additional details regarding contributing factors, actions taken and the date of the event are included in the patient safety reporting form
- Kailah Davis is no longer with UDOH, any inquiries can be directed to Carl Letamendi or Sri Bose





DISCUSSION

- Thoughts?
- Major takeaways?
- What would you like to see in 2021?