UTAH DEPARTMENT OF HEALTH

Patient Safety Surveillance and Improvement Program (PSSIP)

Annual Patient Safety Report for Events Reported in Utah, CY 2021

April 28, 2022

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 oversight includes:

- **Collect:** We collect and produce data that are relevant and useful to our stakeholders

- **Analyze:** We create valuable enhancements to our data resources and our systems have the analytic capacity to transform them into useful information

- **Disseminate:** 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:

R429-1: Patient Safety Surveillance and Improvement Program (PSSIP)

R429-2: Health Care Facility Patient Safety Program

R429-3: Adverse Events from the Administration of Sedation or Anesthesia; Recording and Reporting (repealed on July 1, 2022)

VISION, MISSION, AND OBJECTIVES FOR UTAH'S PSSIP

Vision

Safe patients through collaborative event reporting and patient safety improvement solutions

Mission

Improve patient safety through transparent and nationally-consistent standards for reporting adverse patient safety events, assessment of those events, exploration of best practices and use of quantitative and qualitative data to educate and promote statewide patient safety improvement solutions.

Objectives

- Public accountability and transparency through event reporting
- Adherence to national standards of event-reporting
- Healthcare facilities have processes in place to identify and report all reportable adverse events
- Agreement on which patient safety events should be reported
- Educated stakeholders and statewide patient safety improvement solutions based on quantitative and qualitative data from event reporting
- Quarterly meetings with all healthcare systems represented

ADMIN RULE SURVEY RESULTS & DISCUSSION

71.4% of the responses from facilities said yes to including the F level in our R429-1 rule
64.3% of the responses from facilities want to include the definition of the maternal and child health adverse events in our R429-1 rule

Additional suggestions:

- Reporting on harm to behavioral health patients related to delays in placement, as well, as autistic patients. As well, a reporting method for harm related to equity (prisoners, minorities, psych issues) would be a fabulous addition.
- Errors when users have bypassed safety guardrails as in barcoding for vasoactive, analgesic, paralytic medications
- Harm levels E-I
- Nonconsensual sexual contact with a patient, staff member, or visitor and if those need to be aligned with the definitions of consensual from DCFS.
- Guidance on "Major Surgery" "Minor Surgery" to help zero in on "intervention to sustain life" and "permanent harm".

TODAY'S PRESENTER

Riley Voss - *Public Health Associate Program, Center for State, Tribal, Local, and Territorial Support, Centers for Disease Control and Prevention on assignment to the Utah Department of Health*

IN THIS REPORT

- Reported Patient Safety Events in Utah, 2011-2021
  - Contributing factors
  - Actions taken
  - Patient outcomes
- Reported demographic information for patient safety events, CY 2021
- Major takeaways

DISCLAIMER

These data in this report are not considered representative of patient safety events in Utah and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Table 1: Reported Patient Safety Events, 2012-2021

Occurrence Category	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Surgical Event	42	36	32	34	40	42	24	33	43	37	362	35.9%
Care Management Event	39	20	31	14	30	43	43	41	49	78	388	33.6%
Patient Protection Event	11	8	16	10	19	14	21	20	21	27	166	15.4%
Product Device Event	0	4	0	2	3	5	9	10	10	12	55	5.1%
Unknown	5	4	2	6	6	1	8	7	5	2	46	4.3%
Criminal Event	4	3	2	1	1	2	7	4	2	4	30	2.8%
Environmental Event	0	1	2	1	5	1	4	1	6	3	24	2.2%
Not Sentinel Event	1	0	0	0	0	1	0	1	1	1	5	0.5%
Radiological Event	0	0	1	0	0	0	1	0	1	0	3	0.3%
Total	102	76	86	68	104	109	117	117	138	164	1081	

Legend
dark yellow denotes higher value
white denotes lower value

Top 3 occurrence categories (**Surgical**, **Care Management**, and **Patient Protection events**), accounted for **84.9%** of all events reported over the last decade

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Legend
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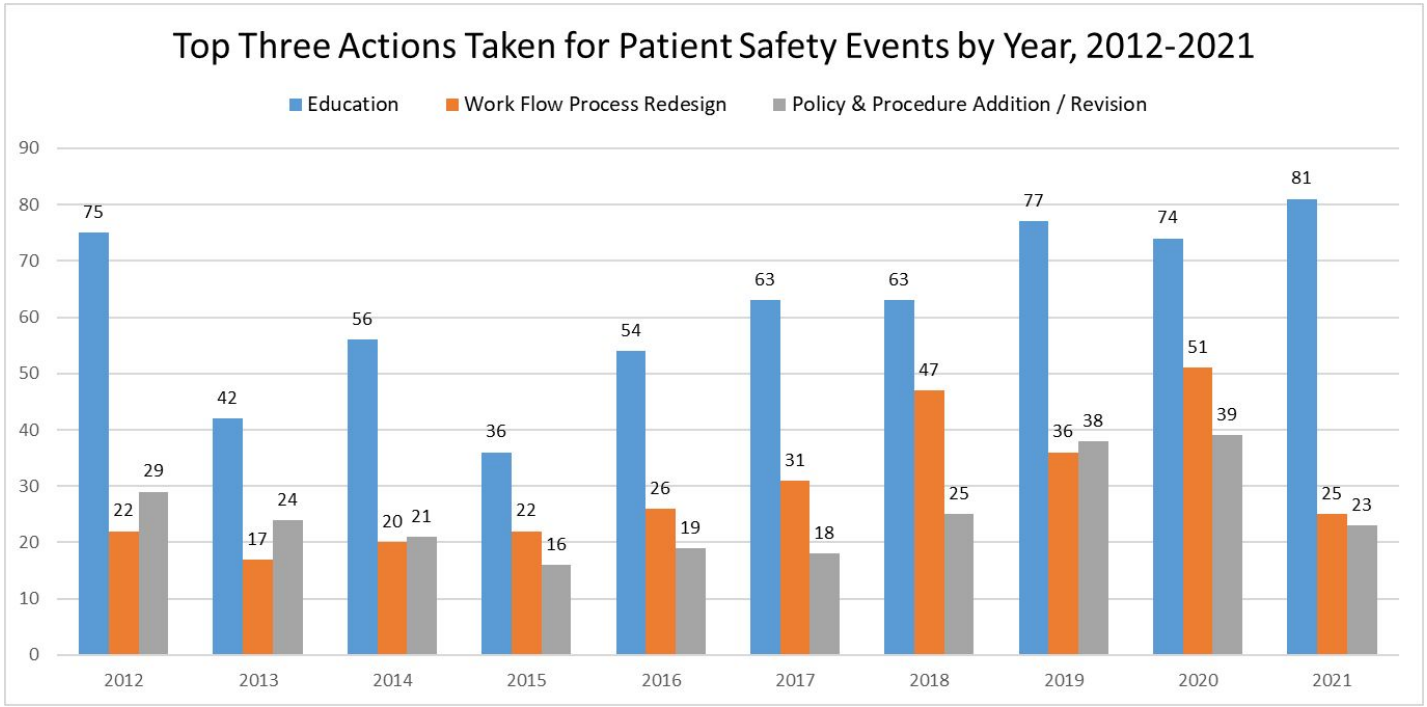
Top 3 contributing factors (**communication**, **human errors**, and **process breakdowns**), accounted for **43.3%** of all events reported over the last decade

Table 2: Reported Patient Safety Events: Contributing Factors, 2012-2021

Contributing Factors	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Communication	50	28	33	27	30	41	46	44	72	42	413	17.2%
Human Factors	30	22	16	20	23	30	40	54	67	65	367	15.3%
Process Breakdowns	16	11	17	18	28	24	31	32	53	31	261	10.9%
Procedural Compliance	28	6	15	15	13	21	17	27	24	12	178	7.4%
Other	18	15	21	14	9	15	18	11	19	28	168	7.0%
Patient Assessment	23	10	13	8	11	17	12	14	17	10	135	5.6%
Availability of Info	16	7	10	15	11	21	7	4	7	10	108	4.5%
Equipment - List Equipment used	16	13	8	5	9	7	8	7	12	11	96	4.0%
Failure to recognize changes	14	7	6	6	11	15	10	8	11	7	95	4.0%
Orientation / Competency / Training	10	9	6	3	10	11	11	15	11	14	100	4.2%
Care Planning	13	2	10	4	5	8	11	13	13	11	90	3.7%
Organization Culture	9	2	7	2	12	6	10	12	12	3	75	3.1%
Lack of Monitoring	10	2	2	4	9	8	8	13	16	11	83	3.5%
Environ. Safety / Security	9	5	7	7	6	11	8	6	7	10	76	3.2%
Device Breakdowns	4	4	0	3	5	6	3	3	6	8	42	1.7%
Continuum of Care	7	0	0	0	1	3	14	7	8	4	44	1.8%
Leadership	4	2	0	0	1	1	9	8	5	2	32	1.3%
Staffing	2	0	5	3	2	5	1	6	5	13	42	1.7%
Total	279	145	176	154	196	250	264	284	365	292	2405	

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021



Top 3 actions taken (**Education**, **Workflow & Process Redesign**, and **Policy & Procedure Revision**), accounted for **68.3%** of all events reported over the last decade.

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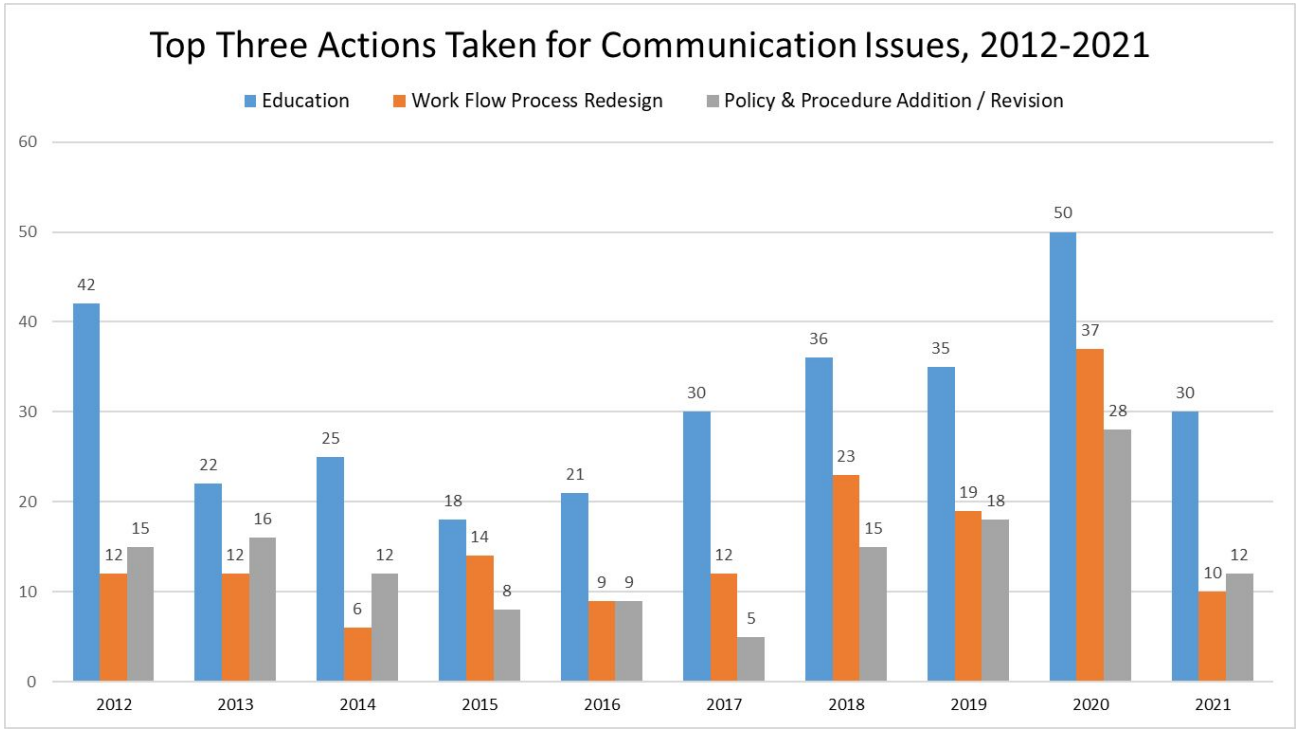
PATIENT SAFETY EVENTS IN UTAH, 2012-2021



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 **71.5%** of all actions taken for patient safety events where communication was a driver.

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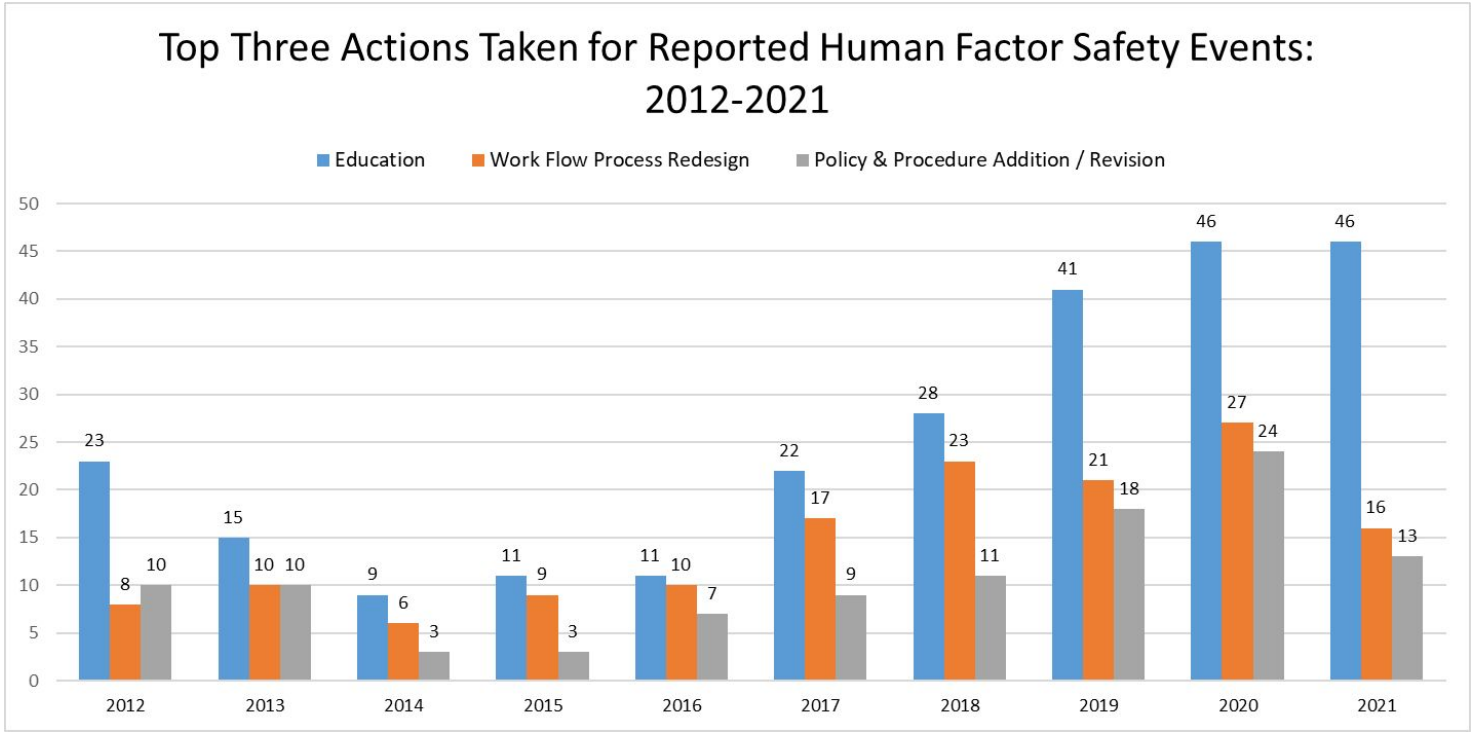
PATIENT SAFETY EVENTS IN UTAH, 2012-2021



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 **68.1%** of all actions taken for human factors reported over the last decade.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

EXAMPLES OF EDUCATIONAL ACTIONS TAKEN FOR PATIENT SAFETY EVENTS IN 2021

- Safety story sharing in department and workgroup meetings
- Informing patients of policies (ex. Smoking is prohibited in facilities)
- Whiteboard reminders for staff
- Reminders during rounds
- Reviewing proper procedures with staff involved in incident
- Adding signs for patients about hazards
- Ensuring proper communication among support staff when transferring patients
- Shift change reminders
- Dissemination process developed for personnel who didn't attend rounds
- Review of medication ordering process with personnel
- Review of patient safety expectations
- Mandatory documentation trainings for personnel who chart

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Legend
dark yellow denotes higher value
white denotes lower value

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 **54.0%** of all contributing factors reported for surgical events over the last decade.

Table 6: Reported Surgical Safety Events: Contributing Factors 2012-2021

Contributing Factors	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Communication	22	16	16	16	14	21	13	19	29	15	181	21.0%
Human Factors	9	16	9	10	10	14	11	22	26	20	147	17.1%
Process Breakdowns	13	11	11	14	12	11	8	15	27	14	136	15.8%
Procedural Compliance	18	4	9	9	6	12	9	8	8	5	88	10.2%
Availability of Info	7	5	4	8	6	10	4	2	2	3	51	5.9%
Equipment - List Equipment used	7	9	4	3	1	3	2	2	5	0	36	4.2%
Other	4	2	7	7	3	5	0	1	3	3	35	4.1%
Orientation / Competency / Training	3	5	1	2	3	6	3	2	5	9	39	4.5%
Organization Culture	3	2	4	1	3	2	2	4	4	0	25	2.9%
Patient Assessment	4	2	3	1	1	3	1	1	3	2	21	2.4%
Failure to recognize changes	2	4	3	2	1	3	1	2	2	0	20	2.3%
Care Planning	2	1	4	3	3	1	1	2	5	1	23	2.7%
Device Breakdowns	3	3	0	2	3	1	1	0	0	1	14	1.6%
Leadership	1	0	0	0	0	1	4	4	2	1	13	1.5%
Staffing	1	0	1	1	2	2	0	2	2	2	13	1.5%
Continuum of Care	3	0	0	0	0	0	1	1	2	1	8	0.9%
Lack of Monitoring	2	0	0	1	0	0	0	0	1	2	6	0.7%
Environ. Safety / Security	1	0	0	0	0	0	0	0	2	1	4	0.5%
Total	105	80	76	80	68	95	61	87	128	80	860	

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Legend
dark yellow denotes higher value
white denotes lower value

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 **37.1%** of all contributing factors reported for care management

Table 7: Reported Care Management Safety Events: Contributing Factors 2012-2021

Contributing Factors	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Communication	19	5	10	6	9	10	18	12	22	23	134	14.8%
Human Factors	11	2	5	3	7	10	18	16	23	30	125	13.8%
Process Breakdowns	1	0	2	3	8	11	17	7	15	13	77	8.5%
Other	11	9	7	3	2	7	8	4	7	20	78	8.6%
Patient Assessment	14	2	4	6	8	11	7	8	11	7	78	8.6%
Failure to recognize changes	9	0	0	3	10	7	6	3	6	7	51	5.6%
Lack of Monitoring	5	1	1	1	6	7	4	5	7	6	43	4.7%
Environ. Safety / Security	5	2	4	3	3	7	1	3	2	0	30	3.3%
Procedural Compliance	5	0	2	3	4	5	5	8	10	6	48	5.3%
Orientation / Competency / Training	5	2	2	0	6	4	5	9	6	4	43	4.7%
Care Planning	9	0	3	0	2	6	4	7	5	6	42	4.6%
Availability of Info	8	1	3	4	3	5	2	1	5	4	36	4.0%
Equipment	7	1	2	1	4	4	2	2	4	6	33	3.6%
Organization Culture	4	0	1	0	7	4	6	6	4	0	32	3.5%
Continuum of Care	3	0	0	0	1	2	6	3	2	2	19	2.1%
Staffing	0	0	2	1	0	1	1	3	2	8	18	2.0%
Leadership	1	2	0	0	1	0	3	4	1	0	12	1.3%
Device Breakdowns	1	0	0	0	0	1	0	0	2	3	7	0.8%
Total	118	27	48	37	81	102	113	101	134	145	906	

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Table 7.3: Patient Outcomes for Reported Patient Safety Events, 2012-2021

Patient Outcomes	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Patient Death	15	6	11	7	6	16	27	23	25	21	157	19.2%
Temp Harm - Req non-life threatening Intervention	8	8	6	11	14	19	17	16	22	33	154	18.8%
No Harm	6	4	4	4	6	24	13	15	14	18	108	13.2%
Intervention to Sustain Life	7	1	0	1	4	8	21	22	15	20	99	12.1%
Temp Harm - Reg Hospitalization	1	2	6	3	7	11	5	14	18	29	96	11.8%
Additional Monitoring/Treatment to Prevent Harm	1	3	7	2	6	13	13	9	9	12	75	9.2%
Permanent Patient Harm	0	0	0	1	4	9	11	14	19	15	73	8.9%
Near Miss (event stopped prior to reaching patient)	0	0	0	0	1	1	1	3	10	3	19	2.3%
Unsafe Conditions	0	0	0	0	3	3	6	0	2	3	17	2.1%
Determined not to be a Sentinel Event	0	2	0	0	1	3	1	0	2	1	10	1.2%
Other	2	0	0	0	0	1	2	0	2	2	9	1.1%
Total	40	26	34	29	52	108	117	116	138	157	817	

Legend
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white denotes lower value

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

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PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Table 7.1: Reported Care Management Safety Events, 2012-2021

Care Management Safety Events	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Fall	13	7	13	6	6	11	7	14	15	27	119	28.9%
Pressure Ulcers	14	2	7	2	5	4	10	5	9	12	70	17.0%
Medication Error	3	1	1	2	7	8	10	8	9	16	65	15.8%
Labor of Delivery	1	1	4	1	5	4	3	10	12	17	58	14.1%
Infant Death	1	5	7	2	5	1	11	4	2	3	41	10.0%
Other	5	2	0	2	1	14	7	4	10	1	46	11.2%
Irretrieveable Loss	0	0	0	0	0	3	1	1	1	1	7	1.7%
Failure to Follow Up	1	1	0	0	0	1	0	1	1	0	5	1.2%
Neonatal Hyperbilirubinemia	0	0	0	0	1	0	0	0	0	0	1	0.2%
Total	38	19	32	15	30	46	49	47	59	77	412	

Legend
dark yellow denotes higher value
white denotes lower value

When observing **care management events** reported over the last 10 years, the top event detail reported was a **fall**, followed by **pressure ulcers**, which made up **61.7%** of all event details provided for care management.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Table 7.4: Reported Surgical Procedure Safety Events, 2012-2021

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
Unintended Retained Foreign Object	21	21	15	15	22	24	8	9	10	8	153	43.5%
Wrong Body Part	16	10	7	9	12	9	5	11	13	11	103	29.3%
Incorrect Surgery Or Procedure	0	2	0	1	0	5	9	5	11	7	40	11.4%
Other	6	3	3	5	3	5	3	1	2	2	33	9.4%
Intraoperative/Postoperative Death	0	0	5	4	1	0	0	0	0	2	12	3.4%
Wrong Patient	0	0	2	0	4	0	0	2	2	1	11	3.1%
Total	43	36	32	34	42	43	25	28	38	31	352	

Legend
dark yellow denotes higher value
white denotes lower value

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 **72.7%** of all surgical procedure event details reported in the last decade.

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PATIENT SAFETY EVENTS IN UTAH, 2012-2021

Table 7.5: Reported Patient Protection Safety Events, 2012-2021

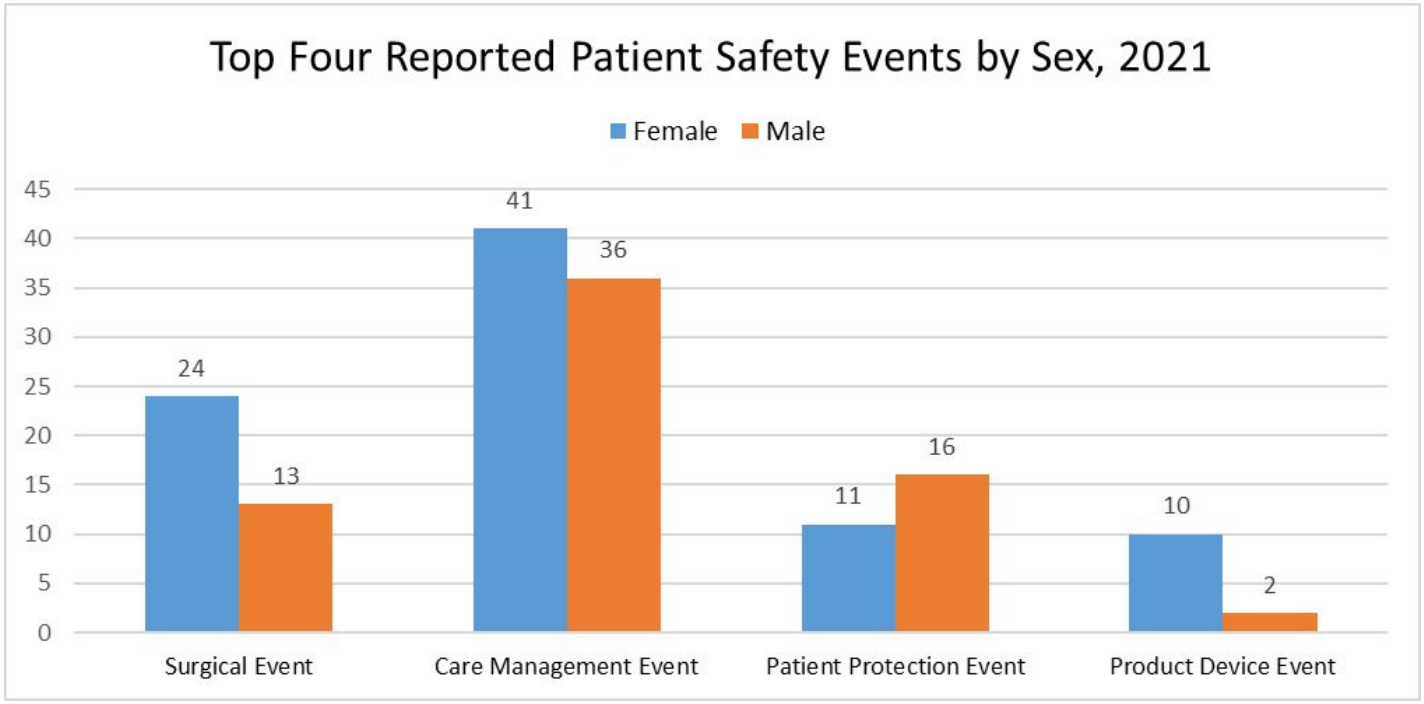
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total	Percent
PATIENT SUICIDE or unsuccessful attempt	2	4	3	5	11	5	15	12	13	6	76	45.0%
UNEXPECTED DEATH	7	3	8	3	5	5	8	7	7	8	61	36.1%
OTHER	1	1	4	1	3	3	1	0	2	1	17	10.1%
ELOPEMENT	2	0	1	1	0	4	1	2	2	2	15	8.9%
Total	12	8	16	10	19	17	25	21	24	17	169	

Legend
dark yellow denotes higher value
white denotes lower value

Patient suicide or unsuccessful attempt is the top reported detail for patient protection events. This and **unexpected death** made up **81.1%** of all event details provided for patient protection events over the last 10 years

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

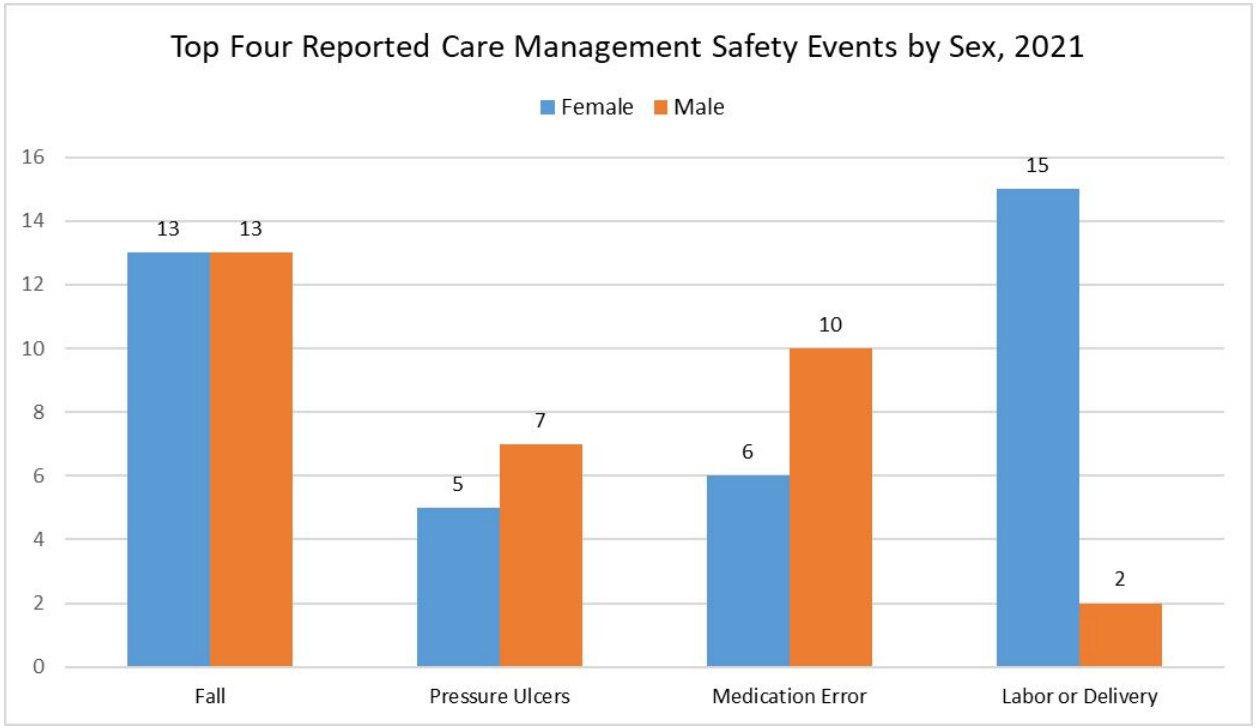
PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021



There are more reported **care management events** for those who identified as "female" compared to those who identified as "male" in **2021**

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021



There are more reported **labor and delivery events** for those who identified as “female” compared to those who identified as “male” in **2021** and the same number of falls for both “male” and “female” identified patients.

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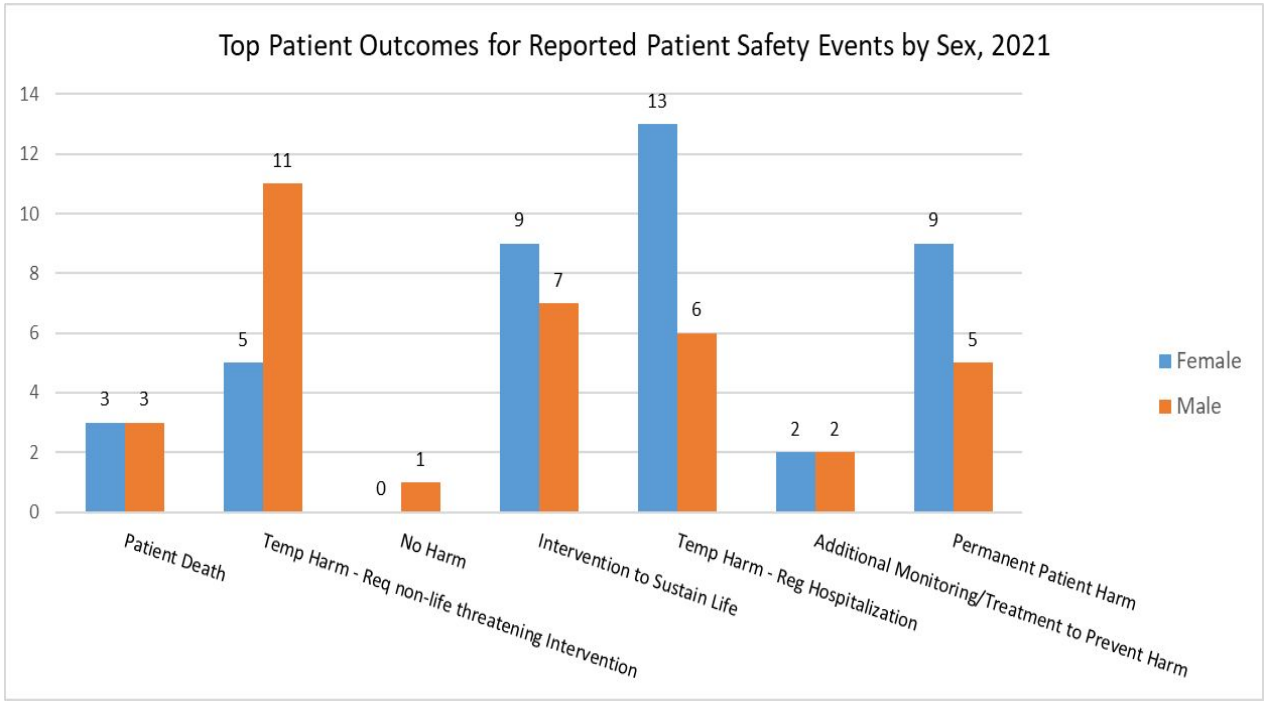
PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021



There are more reported **temporary harm events requiring hospitalization** for those who identified as “female” compared to those who identified as “male” in **2021,** whereas there were more reported **temporary harm events that required non-life threatening intervention** for “males” compared to “females” in **2021**.

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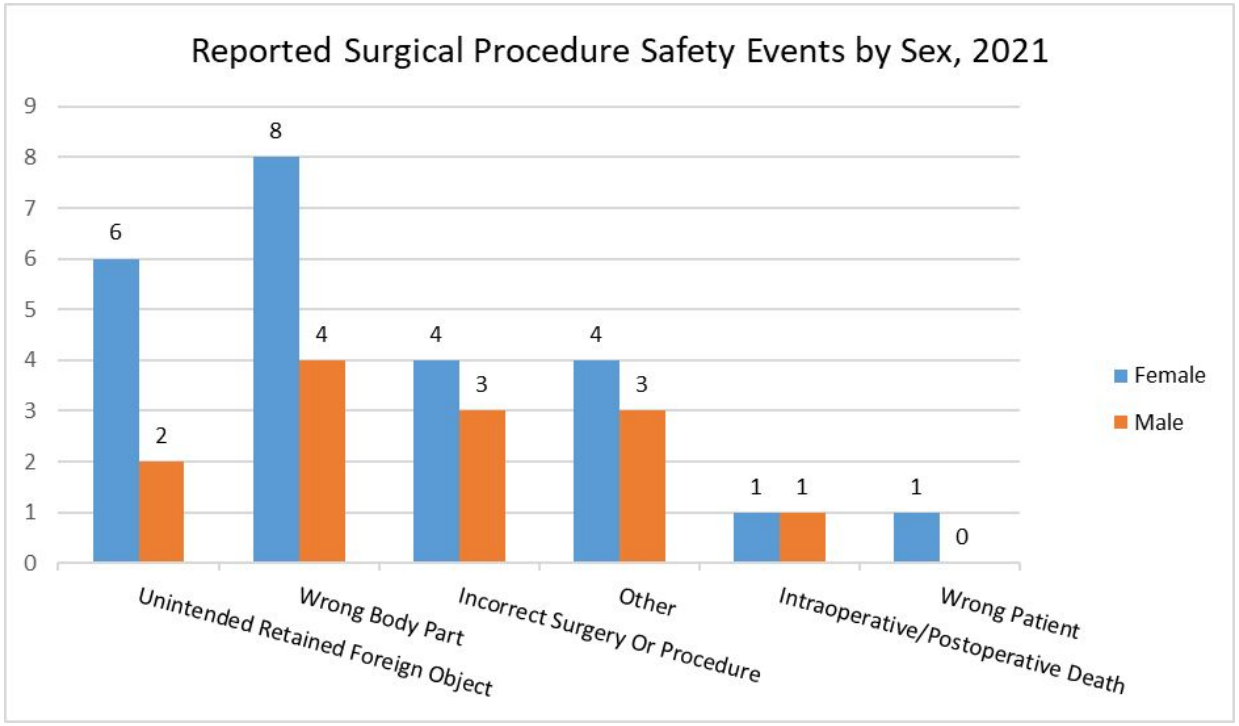
PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021



There were more reported **surgical patient safety events** for those who identified as "female" than those identified as "male" in **2021.**

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Safety Events by Race, Oct - Dec 2021

Occurrence Category	American Indian / Alaska Native	Asian	Black	Native Hawaiian / Other Pacific Islander	white	Other	Unknown
Surgical Event	0	1	0	0	5	0	3
Care Management Event	0	0	0	1	15	1	4
Patient Protection Event	0	0	0	0	6	2	0
Product Device Event	0	0	0	0	1	0	1
Unknown	0	0	0	0	0	0	2
Criminal Event	0	0	0	0	1	0	0
Environmental Event	0	0	0	0	0	1	0
Not Sentinel Event	0	0	0	0	0	0	0
Radiological Event	0	0	0	0	0	0	0
Total	0	1	0	1	28	4	10

There were more reported **patient safety events** for those who identified as "white" compared to other races in **Oct - Dec of 2021.**

Data Notes:

The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Care Management Safety Events by Race, Oct - Dec 2021

Care Management Event	American Indian / Alaska Native	Asian	Black	Native Hawaiian / Other Pacific Islander	white	Other	Unknown
Fall	0	0	0	0	5	0	0
Pressure Ulcers	0	0	0	1	1	0	0
Medication Error	0	0	0	0	3	0	0
Labor or Delivery	0	0	0	0	3	1	0
INFANT DEATH	0	0	0	0	3	0	0
OTHER	0	0	0	0	0	0	0
IRRETRIEVABLE LOSS	0	0	0	0	0	0	0
FAILURE TO FOLLOW UP	0	0	0	0	0	0	0
NEONATAL HYPERBILIRUBINEMIA,	0	0	0	0	0	0	0
Total	0	0	0	1	15	1	1

There were more reported **care management events** for those who identified as "white" compared to other races in **Oct - Dec of 2021.**

Data Notes:

The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Patient Outcomes for Reported Patient Safety Events by Race, Oct - Dec 2021

Patient Outcomes	American Indian / Alaska Native	Asian	Black	Native Hawaiian / Other Pacific Islander	white	Other	Unknown
Patient Death	0	0	0	0	3	1	1
Temp Harm - Req non-life threatening Intervention	0	1	0	1	7	0	1
No Harm	0	0	0	0	3	0	1
Intervention to Sustain Life	0	0	0	0	3	1	3
Temp Harm - Reg Hospitalization	0	0	0	0	6	2	1
Additional Monitoring/Treatment to Prevent Harm	0	0	0	0		0	2
Permanent Patient Harm	0	0	0	0	4	0	0
Near Miss (event stopped prior to reaching patient)	0	0	0	0	0	0	0
Unsafe Conditions	0	0	0	0	0	0	1
Determined not to be a Sentinel Event	0	0	0	0	0	0	0
Other	0	0	0	0	2	0	0
Total	0	1	0	1	28	4	10

There were more reported **temporary harm events that required non-life threatening intervention** for those who identified as “white” compared to other races in **Oct - Dec of 2021**.

Data Notes:

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PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Surgical Procedure Safety Events by Race, Oct - Dec 2021

Surgical Procedure Safety Events	American Indian / Alaska Native	Asian	Black	Native Hawaiian / Other Pacific Islander	white	Other	Unknown
Unintended Retained Foreign Object	0	0	0	0	1	0	0
Wrong Body Part	0	1	0	0	3	0	2
Incorrect Surgery Or Procedure	0	0	0	0	1	0	1
Other	0	0	0	0	0	0	0
Intraoperative/Postoperative Death	0	0	0	0	0	0	0
Wrong Patient	0	0	0	0	0	0	0
Total	0	1	0	0	5	0	3

There were more reported **surgical procedure safety events** for those who identified as "white" compared to other races in **Oct - Dec of 2021.**

Data Notes:

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PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Protection Safety Events, Oct- Dec 2021

	American Indian / Alaska Native	Asian	Black	Native Hawaiian / Other Pacific Islander	white	Other	Unknown
Patient Suicide	0	0	0	0	1	0	0
Unexpected Death	0	0	0	0	1	1	0
Other	0	0	0	0	4	1	1
Elopement	0	0	0	0	0	0	0
Total	0	0	0	0	6	2	1

There were more reported **patient protection safety events** for those who identified as "white" compared to other races in **Oct - Dec of 2021.**

Data Notes:

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PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Safety Events by Ethnicity, 2021

Occurrence Category	Hispanic	Non-Hispanic	Uknown
Surgical Event	1	6	1
Care Management Event	4	14	3
Patient Protection Event	2	5	2
Product Device Event	0	1	2
Unknown	0	0	0
Criminal Event	0	1	0
Environmental Event	1	0	0
Not Sentinel Event	0	0	0
Radiological Event	0	0	0
Total	8	27	8

There were more reported **patient safety events** for those who were identified as "non-hispanic" compared to other races in **2021.**

Data Notes:

The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Care Management Safety Events by Ethnicity, 2021

Care Management Event	Hispanic	Non-Hispanic	Uknown
Fall	1	5	1
Pressure Ulcers	0	1	0
Medication Error	0	4	0
Labor or Delivery	3	0	1
Infant Death	0	3	0
Other	0	1	1
Irretrievable Loss	0	0	0
Failure to Follow Up	0	0	0
Neonatal Hyperbilirubinemia	0	0	0
Total	4	14	3

There were more reported **care management events** for those who were identified as “non-hispanic” compared to other races in **2021.**

Data Notes:

The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Patient Outcomes for Reported Patient Safety Events by Ethnicity, 2021

Patient Outcomes	Hispanic	Non-Hispanic	Uknown
Patient Death	1	3	1
Temp Harm - Req non-life threatening Intervention	2	9	2
No Harm	0	3	1
Intervention to Sustain Life	2	3	2
Temp Harm - Reg Hospitalization	0	5	0
Additional Monitoring/Treatment to Prevent Harm	1	0	1
Permanent Patient Harm	1	3	0
Near Miss (event stopped prior to reaching patient)	0	0	0
Unsafe Conditions	0	0	1
Determined not to be a Sentinel Event	0	0	0
Other	1	1	0
Total	8	27	8

The top reported patient outcome, **temporary harm requiring non-life threatening intervention**, occurred the most among those who were identified as "non-hispanic" in **2021.**

Data Notes:

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*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Surgical Procedure Safety Events by Ethnicity, 2021

Surgical Procedure Safety Events	Hispanic	Non-Hispanic	Uknown
Unintended Retained Foreign Object	0	1	0
Wrong Body Part	0	4	1
Incorrect Surgery Or Procedure	1	1	0
Other	0	0	0
Intraoperative/Postoperative Death	0	0	0
Wrong Patient	0	0	0
Total	1	6	1

There were more reported **surgical procedure events** for those who were identified as "non-hispanic" compared to other races in **2021**.

Data Notes:

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*PSSIP began collecting data pertaining to race on **9/7/2021,** therefore these figures do not reflect data from all of 2021.*

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Protection Safety Events, Ethnicity 2021

Patient Protection Safety Events	Hispanic	Non-Hispanic	Uknown
Patient Suicide	0	1	0
Unexpected Death	1	1	0
Other	1	3	2
Elopement	0	0	0
Total	2	5	2

There were more reported **patient protection safety events** for those who were identified as "non-hispanic" compared to other races in **2021**.

Data Notes:

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PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Safety Events by Age, 2021

Occurrence Category	0-14	15-24	25-64	65+	unknown
Surgical Event	4	3	22	9	1
Care Management Event	10	4	41	20	3
Patient Protection Event	0	1	11	15	0
Product Device Event	1	1	8	1	1
Unknown	1	0	1	0	0
Criminal Event	0	1	3	0	0
Environmental Event	1	1	1	0	0
Not Sentinel Event	0	0	0	1	0
Radiological Event	0	0	0	0	0
Total	17	11	87	46	5

The age group that experienced the most reported **patient safety events** in **2021** were those who were identified as aged **25-64**.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Care Management Safety Events by Age, 2021

Care Management Event	0-14	15-24	25-64	65+	unknown
Fall	2	1	9	14	2
Pressure Ulcers	0	0	7	3	1
Medication Error	0	0	11	1	0
Labor or Delivery	2	2	15	0	0
Infant Death	2	0	0	0	0
Other	1	0	0	0	0
Irretrievable Loss	0	0	0	1	0
Failure to Follow Up	0	0	0	0	0
Neonatal Hyperbilirubinemia	0	0	0	0	0
Total	7	3	42	19	3

The age group that experienced the most **care management safety** events in **2021** were those who identified as aged **25-64**.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Patient Outcomes for Reported Patient Safety Events by Age, 2021

Patient Outcomes	0-14	15-24	25-64	65+	unknown
Patient Death	1	0	13	7	0
Temp Harm - Req non-life threatening Intervention	1	1	20	13	0
No Harm	2	1	10	5	0
Intervention to Sustain Life	5	1	11	3	0
Temp Harm - Reg Hospitalization	2	3	14	9	3
Additional Monitoring/Treatment to Prevent Harm	1	1	5	5	1
Permanent Patient Harm	5	2	7	3	0
Near Miss (event stopped prior to reaching patient)	0	0	1	1	1
Unsafe Conditions	0	2	2	0	0
Determined not to be a Sentinel Event	0	0	1	0	0
Other	0	0	3	0	0
Total	17	11	87	46	5

The top reported patient outcome, **temporary harm requiring non-life threatening intervention**, was reported the most among those aged **25-64** in **2021**.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Surgical Procedure Safety Events by Age, 2021

Surgical Procedure Safety Events	0-14	15-24	25-64	65+	unknown
Unintended Retained Foreign Object	1	0	5	2	0
Wrong Body Part	2	0	6	3	1
Incorrect Surgery Or Procedure	0	0	5	2	0
Other	1	1	3	2	0
Intraoperative/Postoperative Death	0	0	2	0	0
Wrong Patient	0	0	1	0	0
Total	4	1	22	9	1

The age group that experienced the most reported **surgical procedure events** in **2021** were those who identified as aged **25-64**.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

PATIENT SAFETY EVENTS IN UTAH, DEMOGRAPHICS, 2021

Reported Patient Protection Safety Events, Age 2021

Patient Protection Safety Events	0-14	15-24	25-64	65+	unknown
Patient Suicide	0	0	5	1	0
Unexpected Death	0	0	2	6	0
Other	0	1	3	7	0
Elopement	0	0	1	1	0
Total	0	1	11	15	0

The top reported **patient protection events**, "unexpected death" and "other", were reported the most for those aged **65 and older**.

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

MAJOR TAKEAWAYS

		2012-2021	2021
Top 3 Reported Patient Safety Events	Care Management Events	36.0%	48.2%
	Surgical Events	33.5%	23.7%
	Patient Protection Events	15.4%	18.7%
Top 3 Reported Contributing Factors to Patient Safety Events	Communication	17.2%	14.2%
	Human Factors	15.3%	21.8%
	Process Breakdowns	10.9%	9.2%
Top 3 Reported Actions Taken to Address Patient Safety Events	Education	36.3%	36.3%
	Workflow Process Redesign	17.3%	15.7%
	Policy & Procedure Addition / Revision	14.7%	10.8%

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

MAJOR TAKEAWAYS

- Falls are most common care management event in 2021 as well as over the last 10 years
- Among patient outcomes, temporary harm is the highest for 2021 whereas patient death occurs the most over the last decade
- “Patient suicide or unsuccessful attempt” is the highest type of reported patient protection event for the last decade, whereas “unexpected death” & “other” were reported the most in 2021
- “Wrong body part” is the most reported type of surgical procedure event in 2021 and in the last decade “unintended retained foreign object” was the top event
- While communication and human factors being top drivers of patient events, education is consistently the top corrected action taken

Data Note: The data in this report are not considered representative and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

QUESTIONS?

Thank you!

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***Disclaimer**: The findings and conclusions in this presentation are those of the Patient Safety Surveillance and Improvement Program of the Utah Department of Health and do not necessarily represent the views of the Center for State, Tribal, Local, and Territorial Support and Centers for Disease Control and Prevention.*