Patient Safety Surveillance and Improvement Program (PSSIP)

Annual Utah patient safety report
CY 2024

Utah Department of
Health & Human Services
Data, Systems & Evaluation

Division of Data, Systems, and Evaluation

The Office of Research and Evaluation

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Patient Safety Surveillance and Improvement Program

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Executive summary

The Utah Department of Health and Human Services (DHHS) Data, Systems and Evaluation manages the Patient Safety Surveillance and Improvement Program (PSSIP). The program works to make sure patient safety events (injuries, death, or other adverse events) associated with healthcare delivery are reported to DHHS. The program also partners with healthcare providers on how to minimize adverse patient safety events in Utah.

It is important to understand that data presented in this report is based on events reported from medical facilities according to the administrative rule. This report only includes those patient safety events that have been reported and may not include all of them. This report provides insight only regarding events and data reported over time.

The PSSIP is governed by Utah Administrative Code R429-1 and R429-2. Utah medical facilities are required to report all patient safety events within 72 hours of the facility's determination that a patient safety event has occurred. Reporting occurs online via a secure, web-based system called REDCap. Data provided in this report, came from the reported events in REDCap. A reportable patient safety event is a medical incident or condition that could have caused or did cause harm to a patient while in care at a healthcare facility. Events need to be related to the medical processes rather than a patient's underlying medical condition.

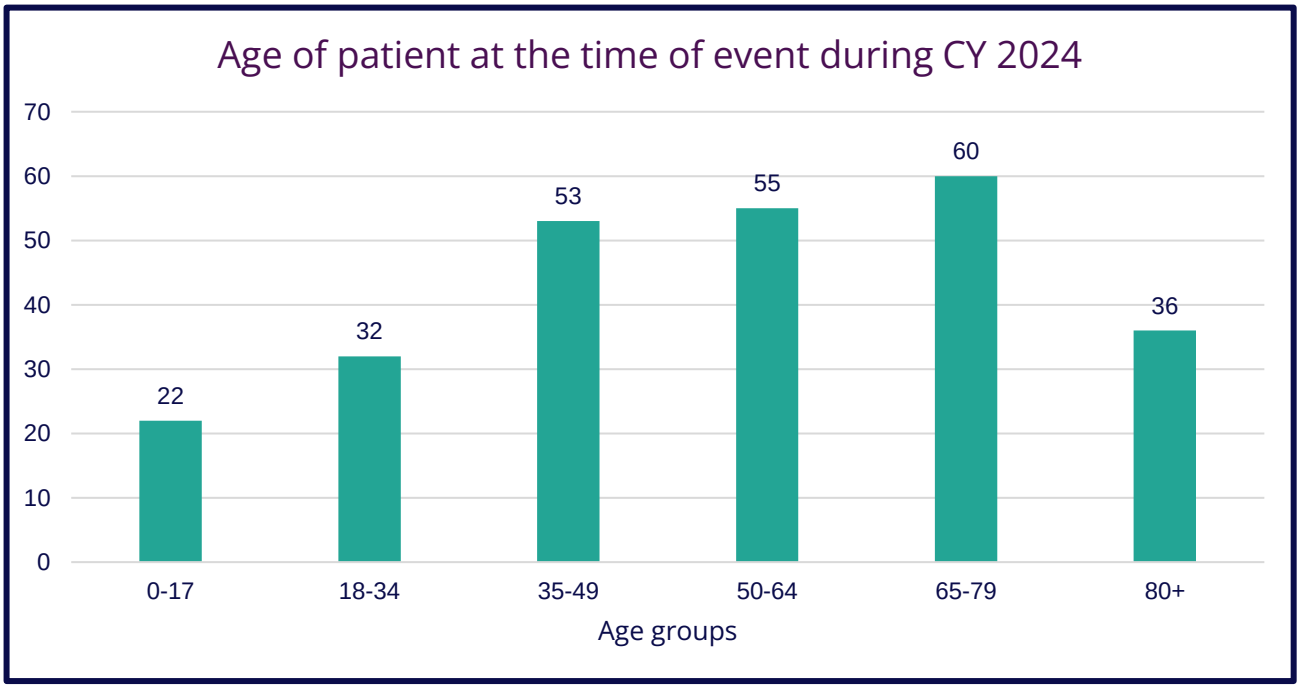
A total of 258 event were reported in REDCap during 2024. There was also an increase in engagement and outreach to healthcare facilities in 2024. This has led to an improvement in reporting requirement awareness. Data presented represents patient safety events that occurred during 2024 and were reported in REDCap before February 1st, 2025. Events reported after February 1st, 2025, even though they occurred in 2024, may not be reflected in this report.

Additional information, including resources and reports can be found on the patient safety state website: https://patientsafety.utah.gov/. Authorizing, and implemented or interpreted law: 26B-1-224: 26B-8-406; 26B-8-407; 26B-1-202; 26B-2-201, 26B-7-202.

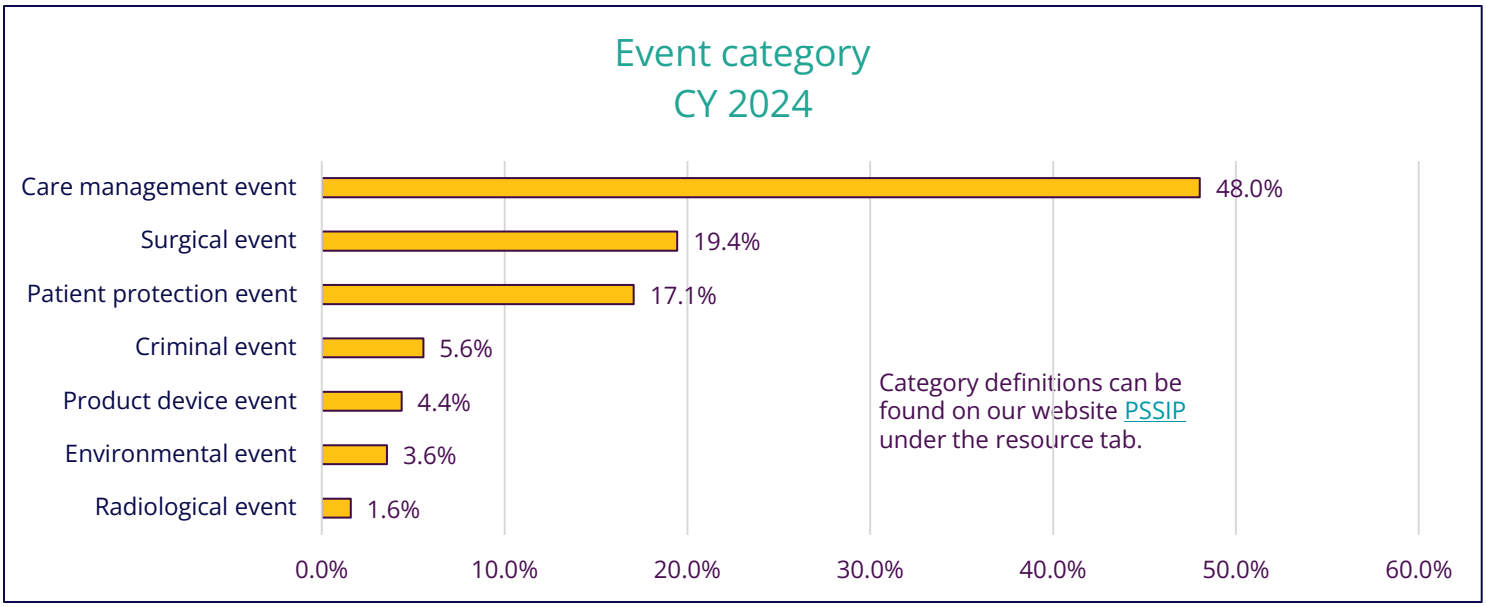
The Patient Safety Surveillance And Improvement Program

2024 At-a-glance

- During 2024, 258 total events were reported via REDCap. This is an increase compared to 2023. The increase does not infer an overall increase but rather shows an increase of awareness in reporting requirements.
- 9.7% of the reported events affected Medicaid patients. As of August 2024, 9.5% of Utahn's were enrolled in Medicaid.
- 52.5% of the events reported involved men and 47.1% of the events involved women. A small number of reported events (.4%) did not report the patient sex.



What did 2024 look like for patient safety?



Event category descriptions

- The care management category include events related to medication error, lack of communication in the healthcare setting, or a patient who falls while in the medical facility.
- The surgical category include events that occurred in the surgical environment. An example would be if a patient were harmed during a surgery due to medical procedure not being followed.
- The patient protection category includes events where a patient was put in harm or risk of harm. Examples include, an infant who is discharged to the wrong person, or a patient with cognitive impairments is left alone for more than 4 hours.
- The criminal category includes events such as an abduction from a facility, criminal assault, or impersonation of a medical professional.
- The environmental category includes events where a burn, unintended electric shock, or a toxic substance cause harm to a patient.
- The product device category includes when a patient is exposed to a contaminated device or unexpected flame or smoke.
- The radiological category includes events that took place during MRI or X-ray that might have included a metal object.

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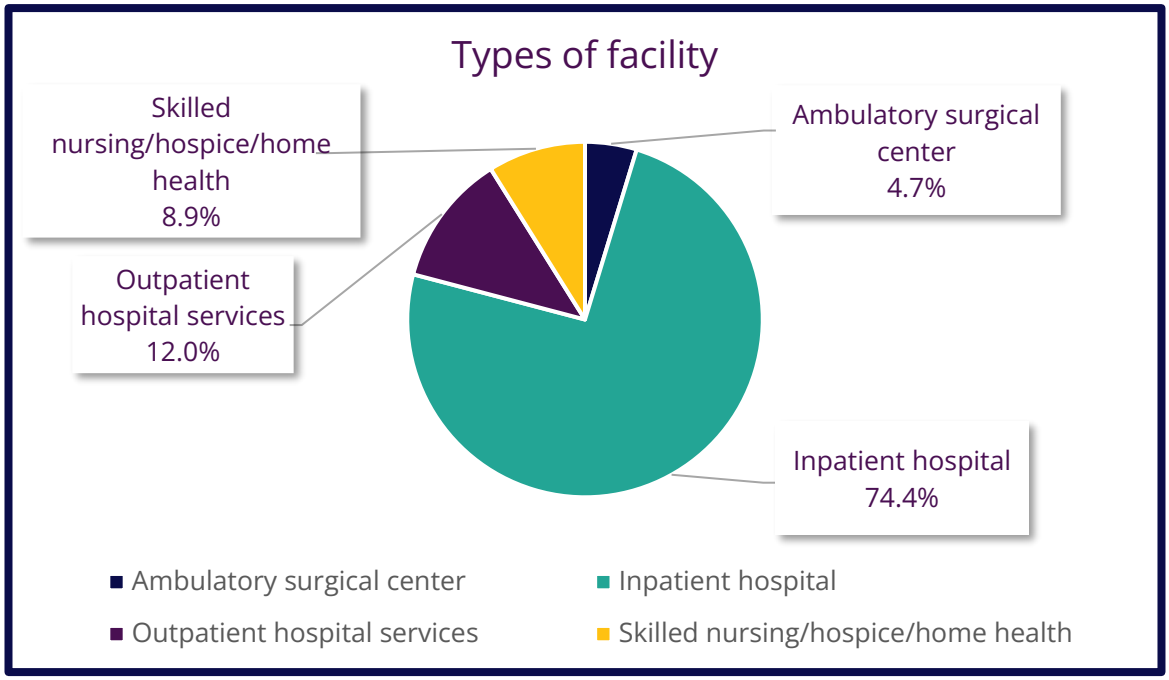
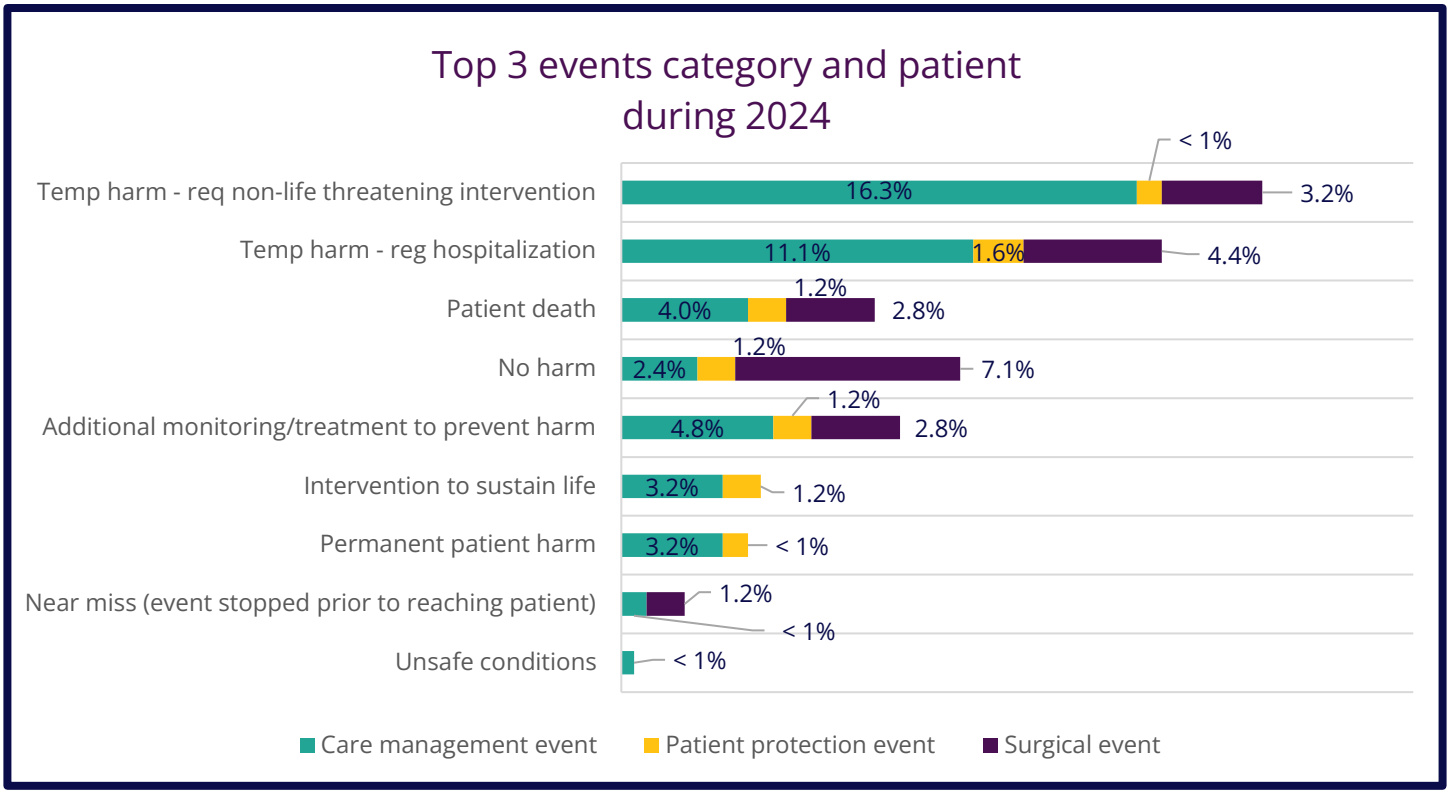
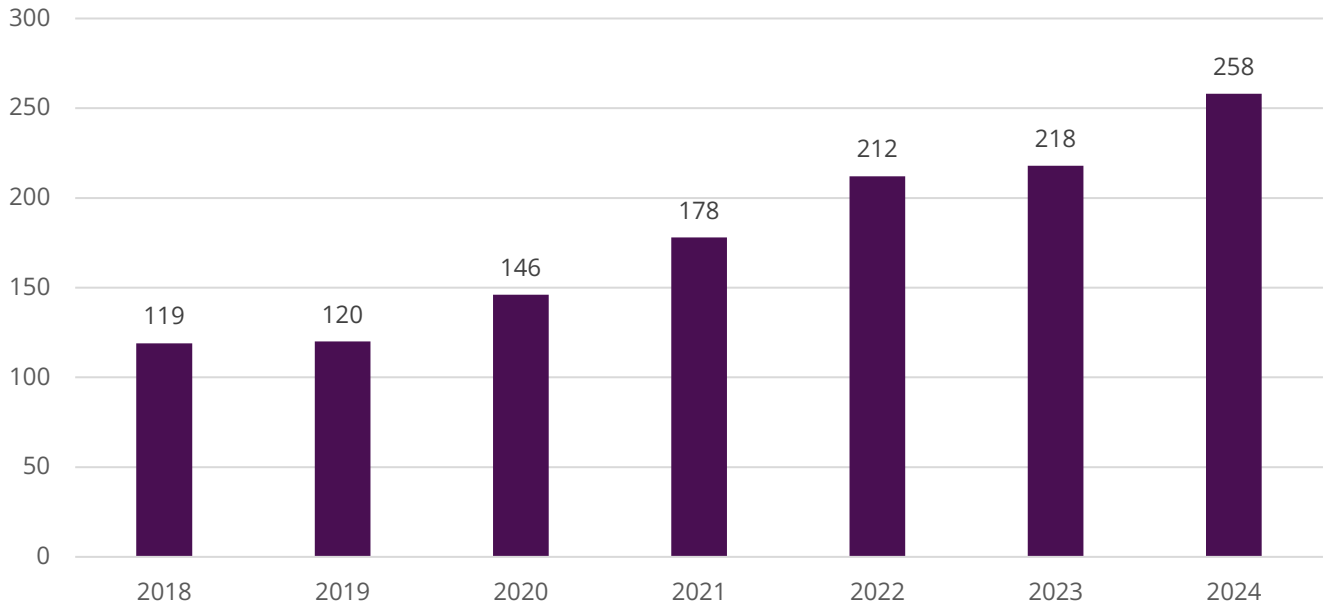




Patient safety meetings

Patient safety meetings are only possible through collaboration with community partners. These meetings provide a time for particpants to share experiences, gather and share resources, and create a community of support. Meeting information can be found on the PSSIP website or by contacting the patient safety email at patientsafety@utah.gov .

Reported events between 2018 and 2024



An increase in reporting patient safety events started in 2019. This does not infer an overall increase in patient safety events but does indicate an improvement in reporting requirements awareness and improved engagement.

Any questions?

Contact Shanna Jaggers at sjaggers@utah.gov

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