Patient Safety Surveillance and Improvement Program (PSSIP)

Annual Utah patient safety report
CY 2025

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

Division of Data, Systems, and Evaluation

The Office of Informatics and Data Systems

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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 (preventable harm, 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 preventable patient harm events in Utah.

The PSSIP is governed by Utah Administrative Code R429-1 and R429-2. Per the code, 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 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 medical processes rather than a patient's underlying medical condition.

The data presented in this report is based on events reported by medical facilities according to the administrative rule. This report only includes patient safety events that were reported in REDCap per the administrative code requirements. This report provides insight regarding events and data reported to the PSSIP.

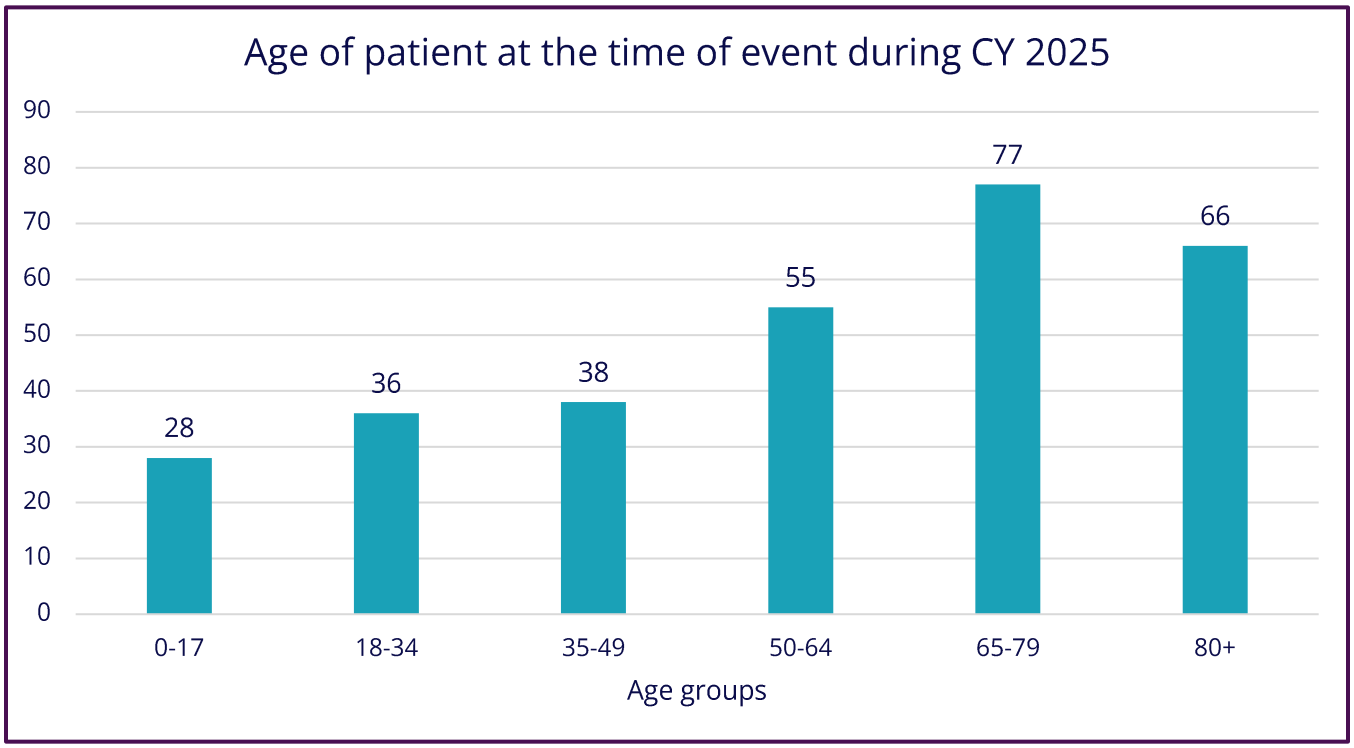
The program saw significant growth in 2025, recording 300 total events in REDCap. This surge was driven by a robust outreach strategy that onboarded more than 130 new users in REDCap and expanded the medical facility reporting network by 43%. These efforts have substantially heightened awareness of reporting requirements for covered Utah medical facilities. Please note: This report includes events occurring in 2025 that were submitted in REDCap by February 1, 2026. Events from 2025 reported after this data are not 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 can be found in the following Utah code references: 26B-1-224: 26B-8-406; 26B-8-407; 26B-1-202; 26B-2-201, 26B-7-202.

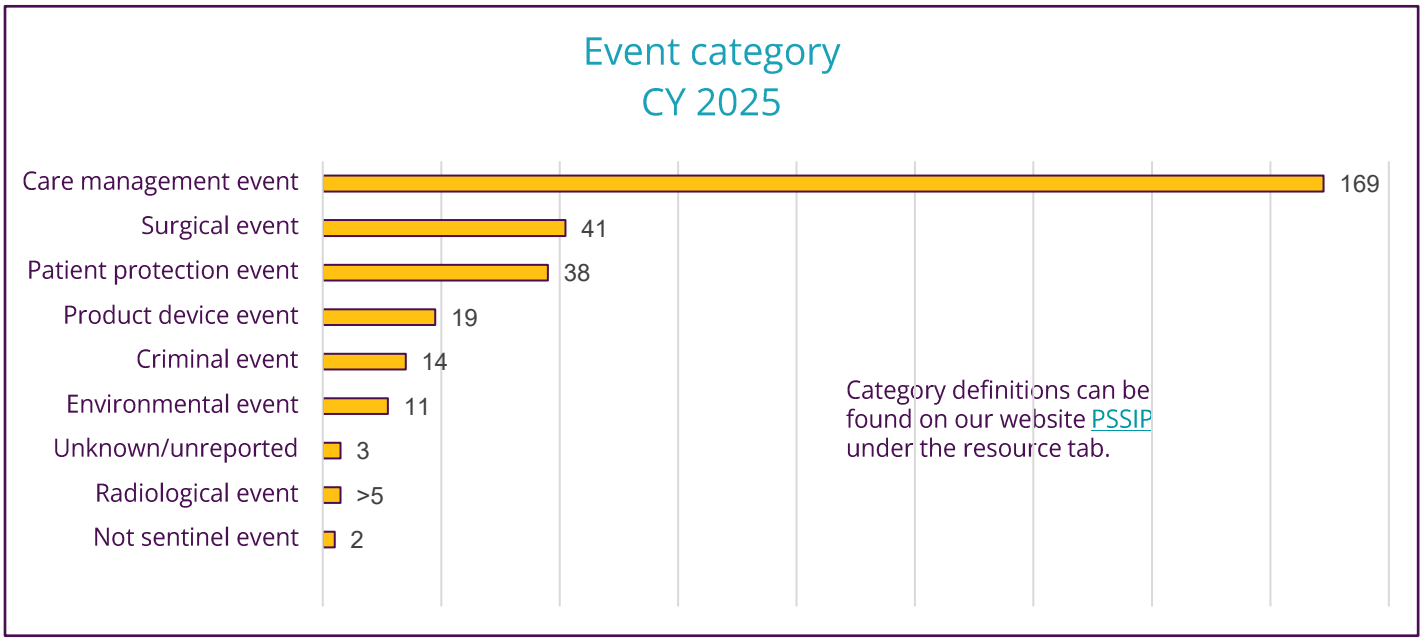
The Patient Safety Surveillance And Improvement Program

Calendar year 2025 At-a-glance

- During 2025, 300 total events were reported via REDCap. This resulted in a 15.8% increase over 2024. The increase does not infer an overall increase but rather shows an increase of awareness in reporting requirements.
- Of the total reports, 22% involved Medicaid patients. This figure excludes three events where the insurance type was not provided.
- 41.7% of the events reported involved men and 58.3% of the events involved women. Compared to 2024, this is a decrease of 20.6% for men and an increase of 23.8% for women.
- There was a 43% increase in the reporting capacity of medical facilities.



What did 2025 look like for patient safety?



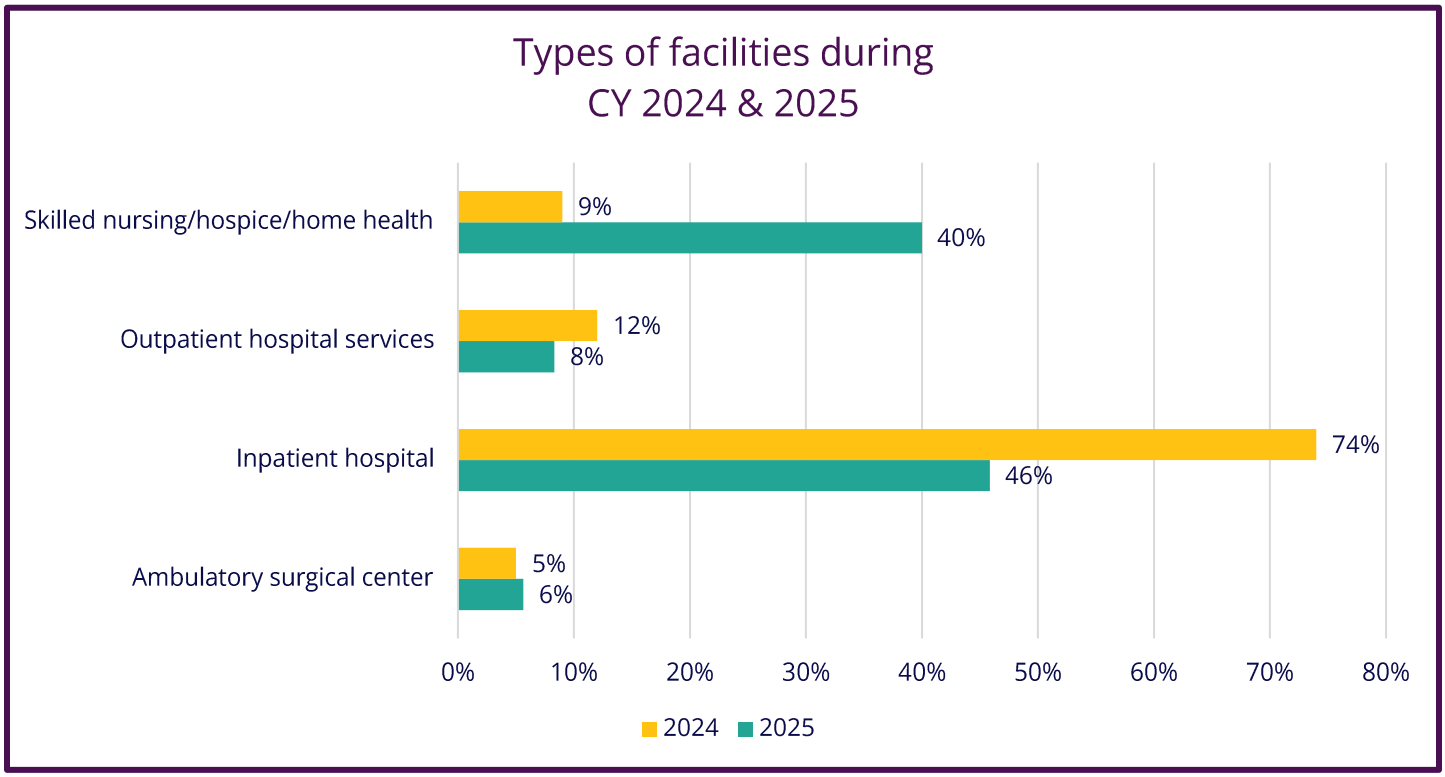
Event category descriptions

- The care management category includes 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 includes 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.

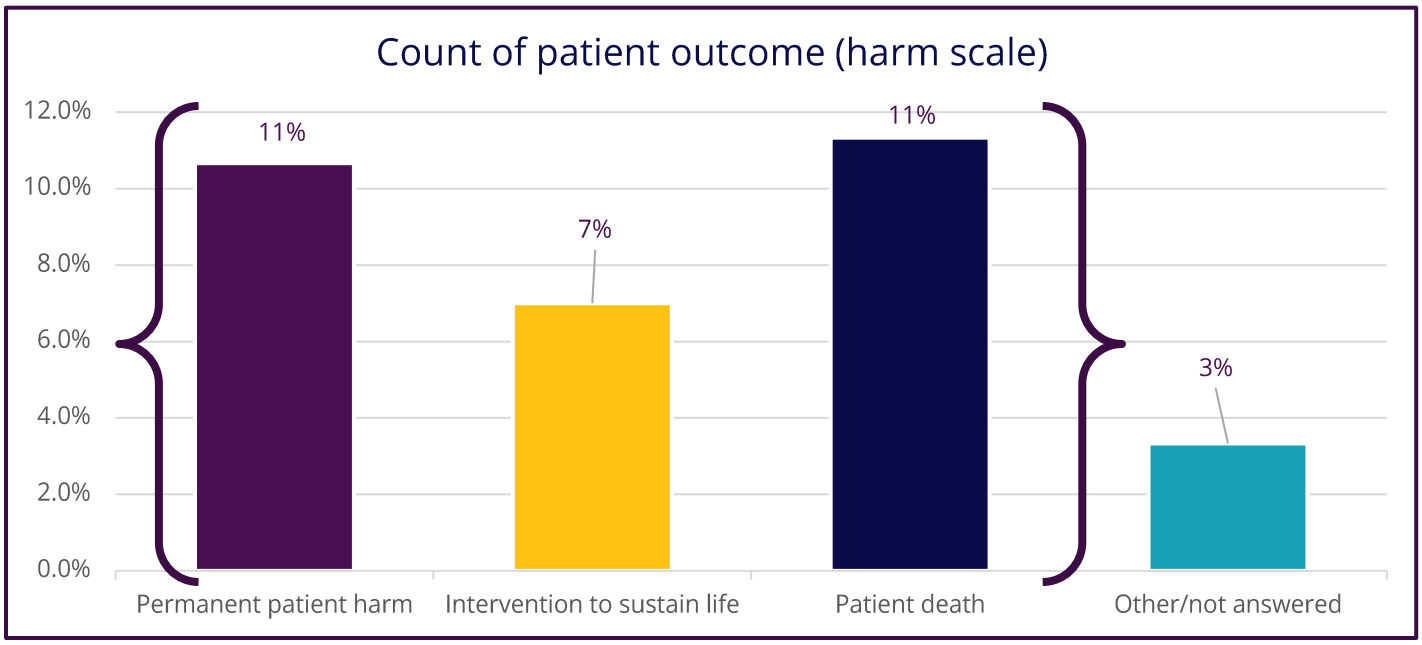
What did 2025 look like for patient safety facility type?

There was a marked rise in reports from skilled nursing, hospice, and home health facilities compared to 2024, reflecting strengthened reporting awareness. The state organized meetings to make sure healthcare facilities understood reporting requirements and procedures. These real-time dialogues included:

- **Navigating complexity:** Skilled nursing and hospice care often involve complex, end-of-life scenarios where "what counts as a reportable event" can be difficult to define. Through review of the administrative code and emerging research, healthcare facilities provided clarification and support in reporting.
- **Culture shifting:** Moving from a punitive 'compliance' mindset to a proactive 'safety-first' culture that prioritizes patient well-being over fear of scrutiny.
- **Strategic partnership:** Reaffirming facilities as vital contributors to patient safety science rather than mere data points.
- **Local impact:** Demonstrating how Utah-specific data directly informs and improves regional care standards.



What did 2025 look like for patient outcomes?

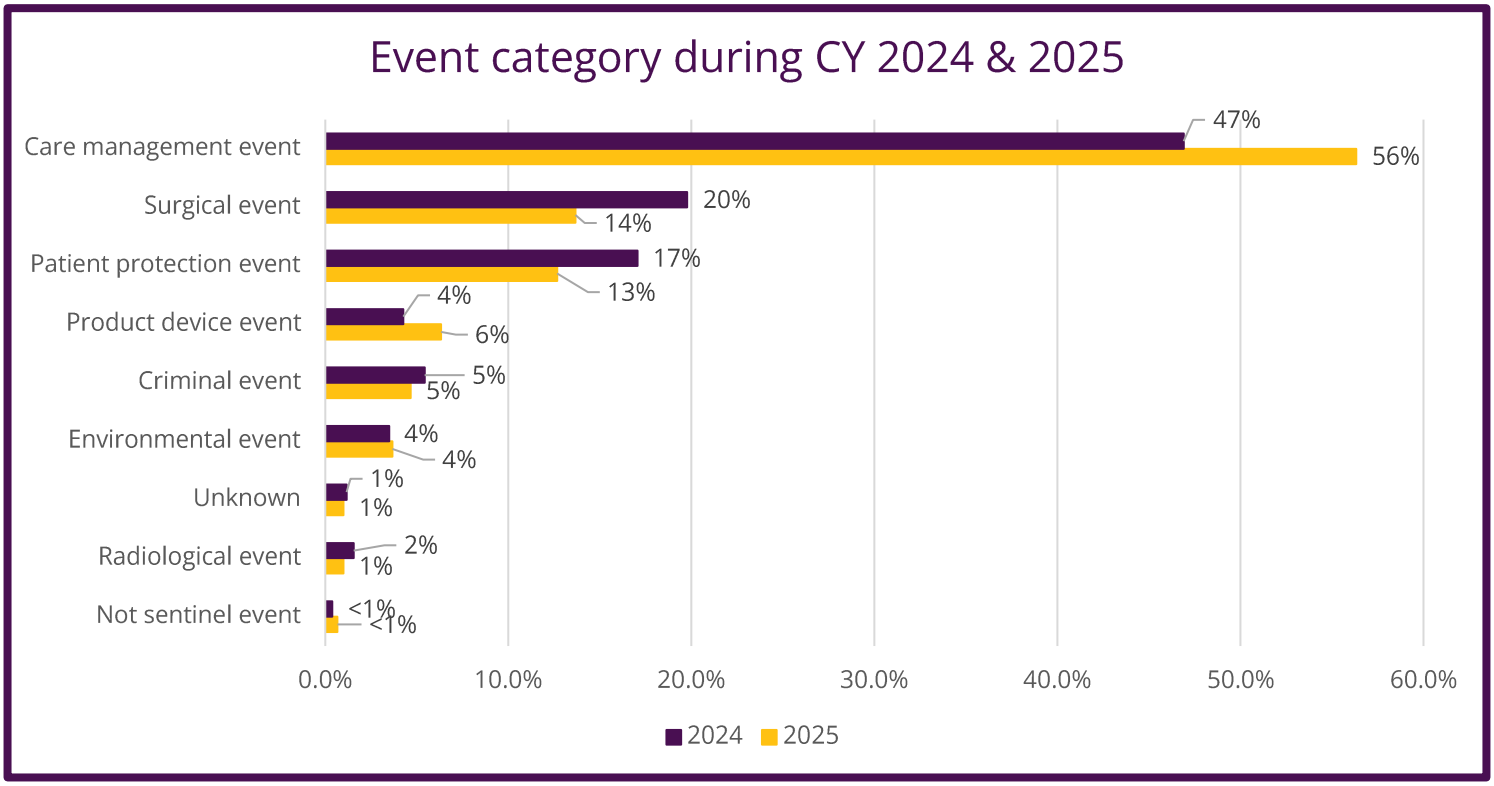


Analysis of 2025 patient safety data reveals that **29% of reported events** resulted in critical outcomes, categorized as permanent harm, life-sustaining intervention, or mortality. While the vast majority of reports provided clear data, **3%** remained incomplete or unknown, highlighting an area for continued data-integrity training. These figures underscore the vital nature of patient safety reporting, which aims to identify and mitigate systemic risks before they escalate into preventable harm during active care.

What did 2025 look like ?

The data shows a significant shift in the landscape of reported healthcare events. While **care management** events saw a substantial increase, **surgical** and **patient protection** events decreased notably.

- **Dominance of care management:** This remains the largest category and saw the most significant growth, rising from **47% in 2024** to **57% in 2025**. These typically include events like medication errors, falls, or failures to follow-up on lab results.
- **Decrease in surgical events:** There was a sharp decline in reported surgical events, dropping from **20%** to **14%**. This may reflect improved surgical protocols or a shift in where these procedures are being performed (e.g., more outpatient settings).
- **Reduction in patient protection:** These events (often involving patient elopement, suicide, or discharge to the wrong person) decreased from **17%** to **13%**.
- **Rise in product/device issues:** While a smaller overall percentage, product/device-related events rose from **4%** to **6%**, a relative increase of nearly **46%**.

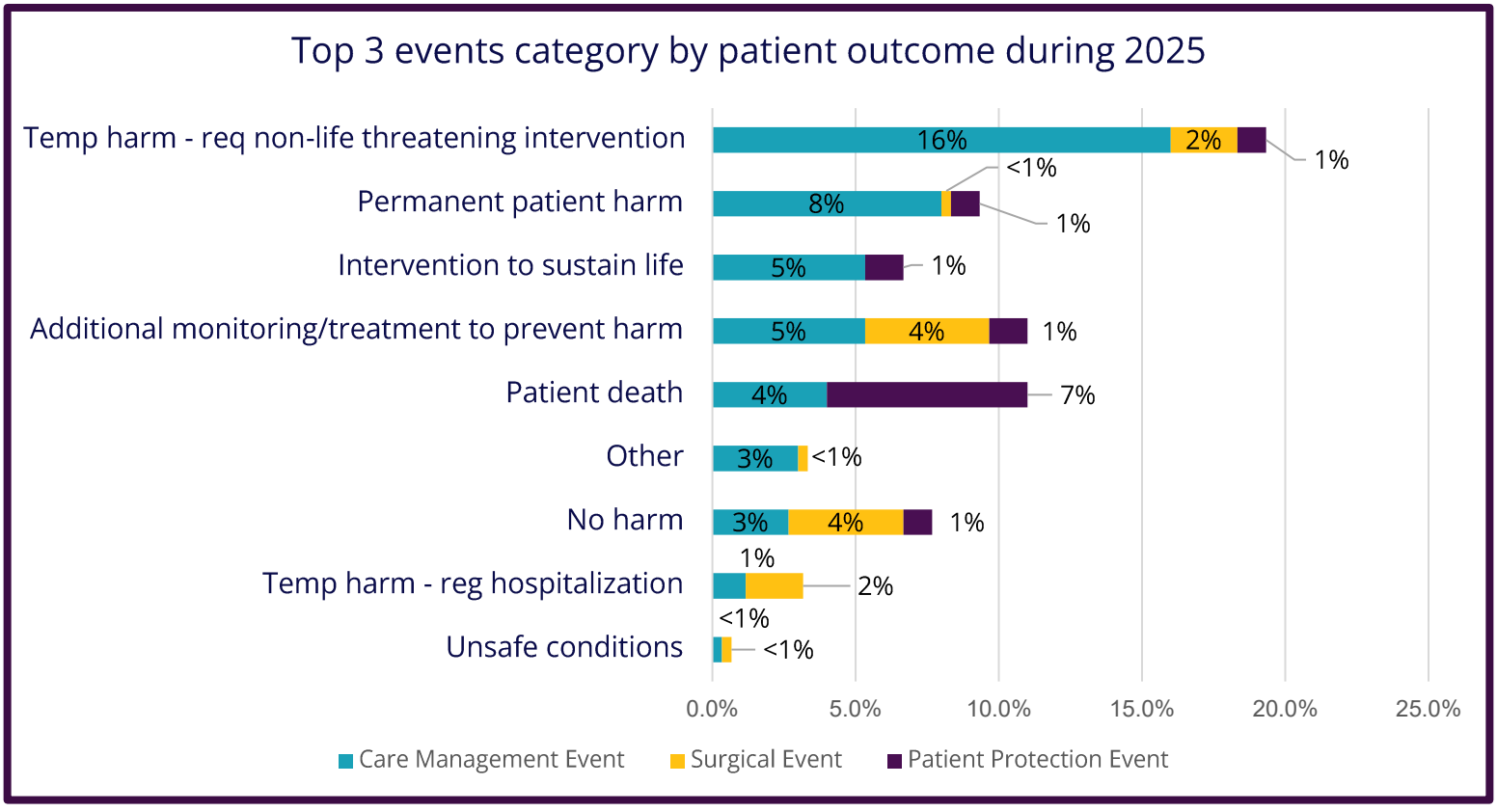


What did 2025 look like for event category by patient outcomes?

The chart breaks down the severity of outcomes for the three most frequent event types: **care management**, **surgical**, and **patient protection**.

As noted in earlier in the report, 29% of reports involve critical outcomes. The data shows exactly where these occur:

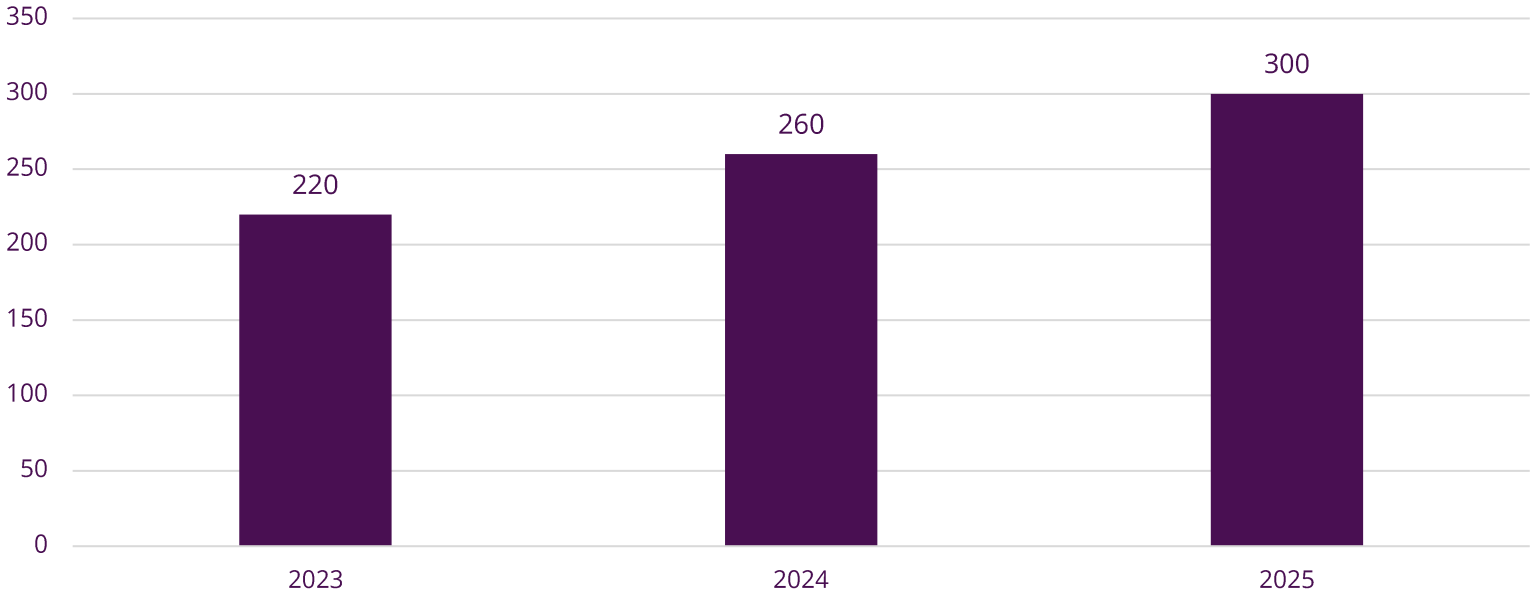
- **Patient death:** Interestingly, while **patient protection events** make up a smaller total volume, they represent the highest percentage of reported deaths at **7%**, compared to **4%** for care management.
- **Permanent patient harm: care management** is the leading contributor here at **8%**, followed by surgical and patient protection events at **<1%** and **1%** respectively.
- **Intervention to sustain life: care management** also dominates this high-severity outcome at **5%**.
- **Temporary harm:** The most common outcome for all three categories is “temporary harm requiring non-life-threatening intervention," led by **care management at 16%**.
- **Near misses/preventions: 5% of care management reports** and **4% of surgical reports** resulted in “additional monitoring/treatment to prevent harm," demonstrating that reporting is successfully identifying risks before they become catastrophic.



Patient safety meetings

Patient safety is a shared responsibility. Through our partnerships with organizations like **Intermountain Health, U of U Health, and the Utah Health Care Association**, we facilitate a community of practice dedicated to mutual support. These meetings serve as a vital hub for gathering resources and sharing safety insights that improve care across the state. Meeting schedules and details are available on the **PSSIP website** or via **patientsafety@utah.gov.**

Reported events between 2023 and 2025



Patient safety event reporting has trended upward since 2019. This growth does not **imply** an increase in actual incidents but rather reflects **strengthened awareness** of reporting requirements and improved facility engagement.

Any questions?

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