2024

Vermont Patient Safety Surveillance and Improvement System Annual Report

April 2025

VPQHC
Vermont Program for Quality in Health Care, Inc.

VERMONT
DEPARTMENT OF HEALTH

2024

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Patient Safety Surveillance in Vermont

Patient safety is a fundamental priority in healthcare. The Patient Safety Surveillance and Improvement System (PSSIS), administered by the Vermont Program for Quality in Health Care on behalf of the Vermont Department of Health, provides a structured framework for hospitals to analyze adverse events and improve patient safety.

As part of this state-required program (18 V.S.A. Chapter 43A), Vermont hospitals and ambulatory surgery centers:

- Report Serious Reportable Events (SREs) within 7 days
- Submit a causal analysis and corrective action plan for SREs within 60 days
- Report Intentional Unsafe Acts within 7 days
  - Causal analysis and corrective action plans are not required for intentional unsafe acts
- Participate in periodic on-site monitoring visits

A Serious Reportable Event (SRE) is an adverse event or safety issue in a healthcare setting. These events are usually preventable, can cause serious harm, and indicate problems in the healthcare system's safety measures. Some SREs are completely avoidable and should never occur. SREs are defined by the National Quality Forum's list of serious reportable events (National Quality Forum, 2011).

Intentional Unsafe Acts are defined by Vermont Statute (18 V.S.A. § 1916). They can broadly be defined as an act, or omission, or reckless behavior by staff or providers that was not an accident and cannot be justified with extenuating circumstances.

This annual report aims to help patients, healthcare professionals, and policymakers better understand the state of patient safety in Vermont, promoting transparency and continuous improvement within Vermont's healthcare system.

"Although it is impossible to remove the chances of human error in healthcare delivery, well-designed health systems have operational structures to reduce medical errors."
(Twenter, 2025)

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2024 Annual Activity Summary

In 2024, the Patient Safety Surveillance and Improvement System (PSSIS) focused on strengthening healthcare quality and patient safety across Vermont through three strategic initiatives:

Reporting Enhancements and Stakeholder Support

- Updated reporting forms
- Conducted personalized orientations and one-on-one meetings with new and established quality staff and directors

Professional Development and Education

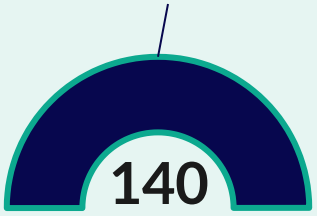
- Hosted two webinars focused on patient safety
- Distributed national healthcare quality resources
- Shared resources on emerging topics like Artificial Intelligence's impact on patient safety

Organizational Resilience and Support

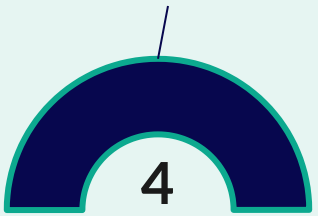
- Targeted support for hospitals experiencing quality leadership transitions
- Provided context on patient safety metrics and CMS star ratings
- Maintained focus on creating a non-punitive, learning-oriented safety culture

In 2024...

Events Accepted into the PSSIS



On-Site Monitoring Visits



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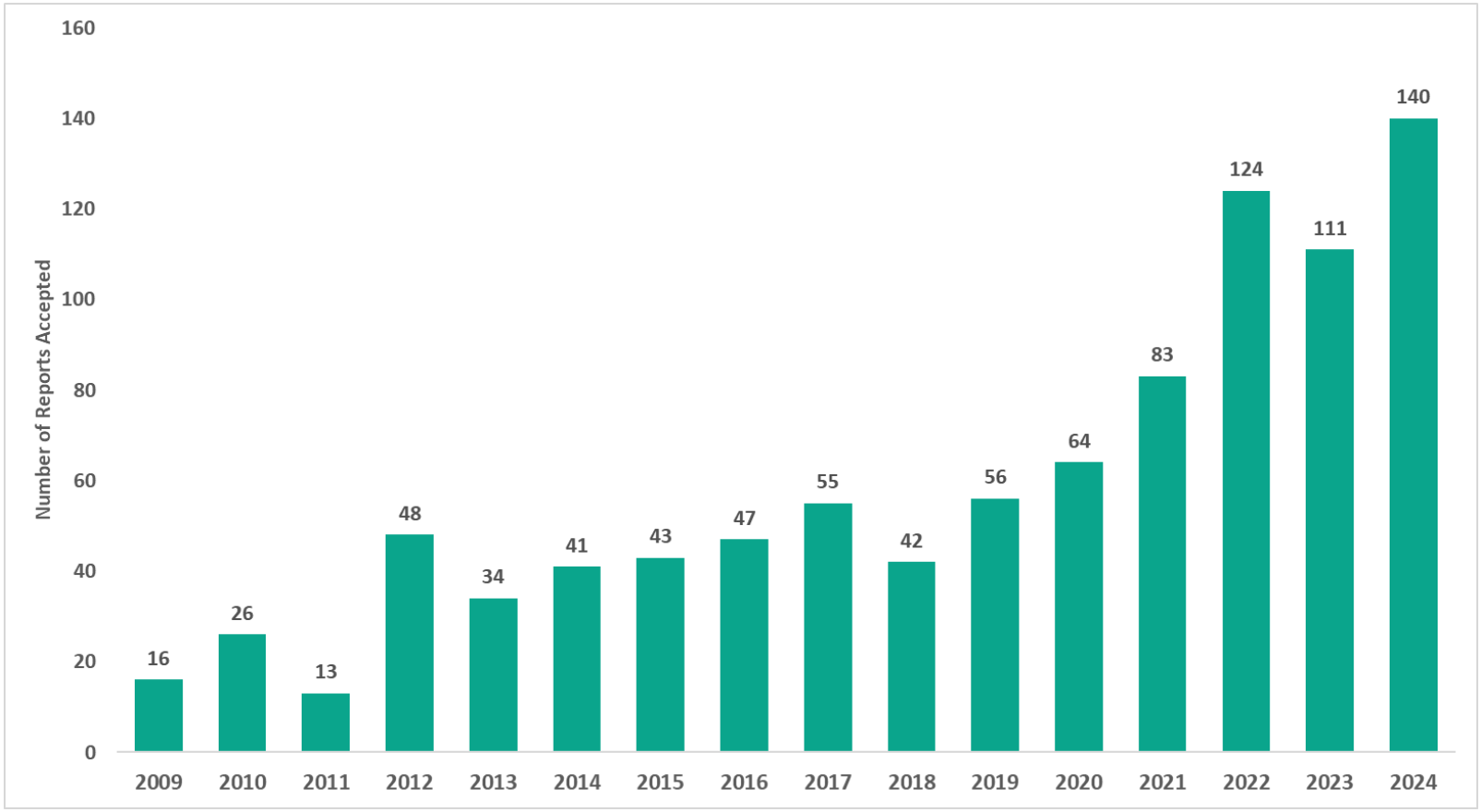
Data Overview

How many hospitals and ambulatory surgery centers were required to report into the PSSIS in 2024?

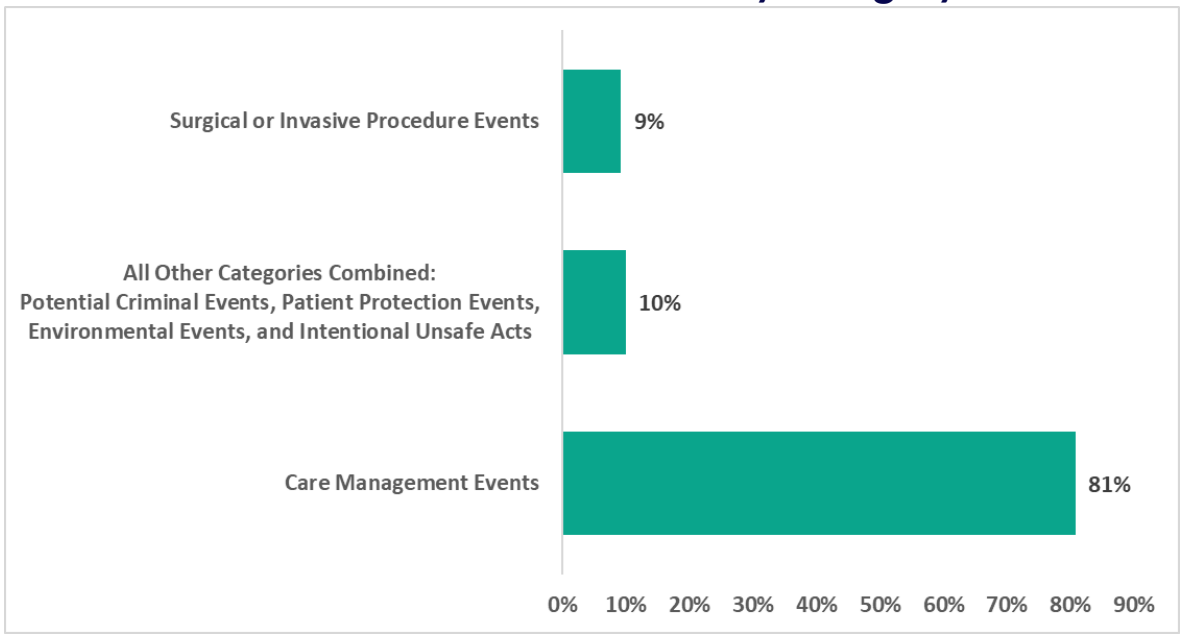
18

PSSIS Event Reports



The annual number of events accepted into the Patient Safety and Surveillance Information System (PSSIS) have increased. While 2024 shows the highest number of events, this increase may be attributed, in part, to national education initiatives (e.g., pressure injuries) and increased institutional awareness of and commitment to safety reporting.

Percent of 2024 Events by Category



The percentage of events by category across all 140 events reported in 2024 shows the majority of reports are from the Care Management category. Categories with fewer than six reports have been combined for confidentiality.

Categories of Events

Understanding the major categories of patient safety incidents helps healthcare facilities target quality improvement initiatives toward the most important safety concerns.

Examples of Events Within Categories *(incomplete list)*

Some events require a certain level of harm to qualify.

Surgical
- Wrong patient
- Wrong site
- Retained object

Product or Device
- Device malfunction
- Contaminated drugs

Patient Protection
- Elopement
- Suicide

Care Management
- Fall
- Pressure Injury
- Medication error

Environmental
- Electric shock
- Burn

Criminal
- Physical Assault
- Sexual Assault
- Abduction
- Impersonation

To see the complete list of events, see the National Quality Forum's 2011 list of Serious Reportable Events.

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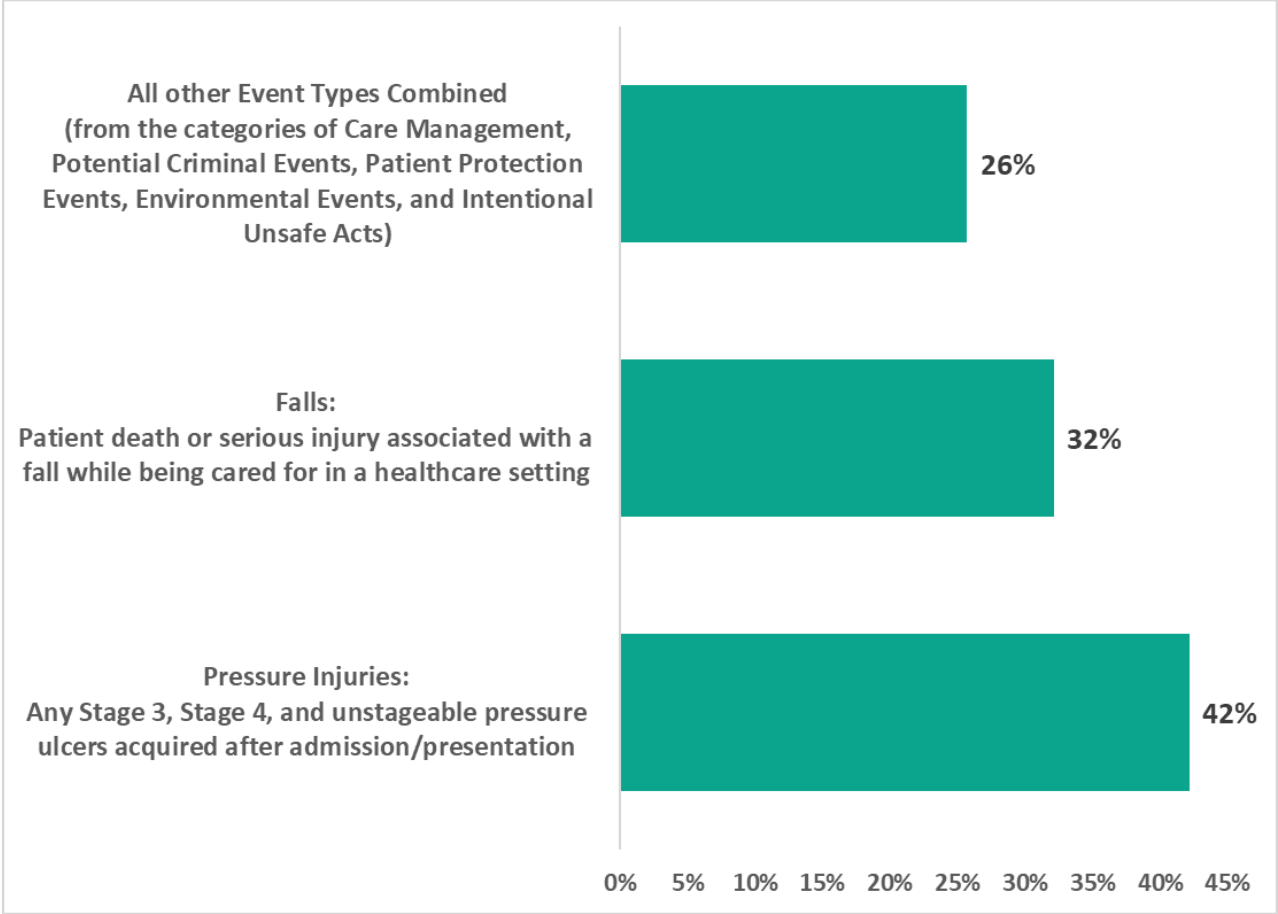
Event Types

Detailed sub-categories of events ("event types") offers greater specificity about the nature of patient safety incidents, enabling more focused prevention strategies.

By monitoring trends in these specific event types over time, healthcare organizations can measure the effectiveness of their safety protocols and make data-driven adjustments.

Percent of 2024 Events by Type



Falls and pressure injuries represent the highest reported event types. Events with fewer than six reports have been combined for confidentiality.

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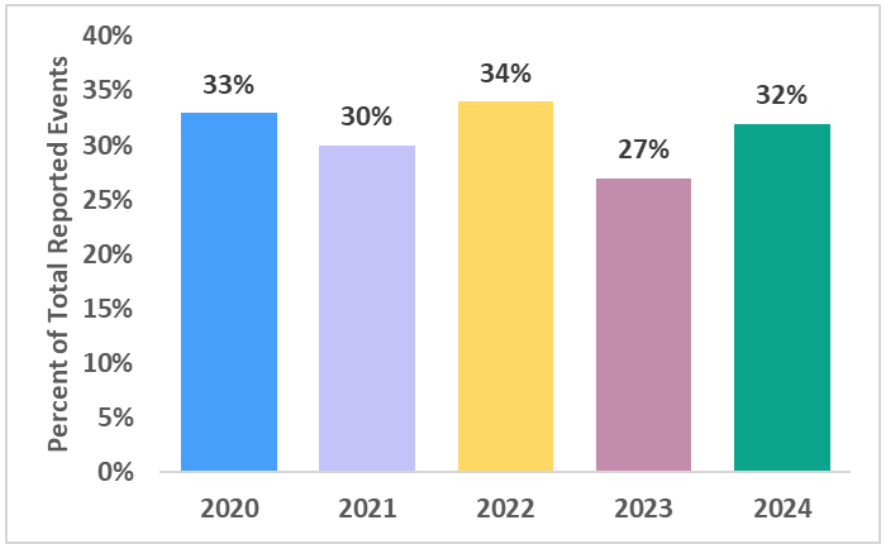
Falls and Pressure Injuries

Falls and pressure injuries continue to represent the highest volume of reported incidents and can lead to extended hospital stays for additional treatment, surgery, and even death.

Collectively in 2024, these two events represent 74% of all events reported, which is similar to the past 5 years.

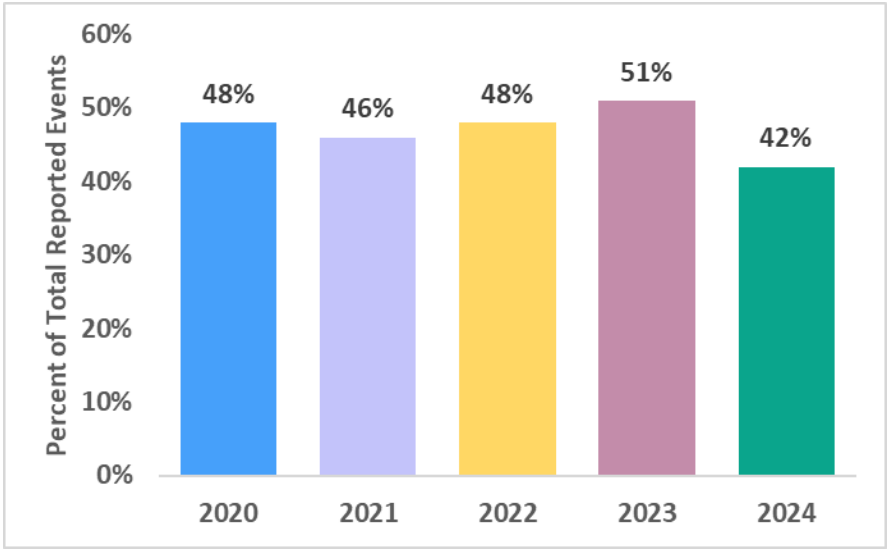
Proportion of Events Attributed to Falls



2024 Length of Stay Fact:
58% of falls occurred within 0-5 days of the admission/ encounter date.

Definition:
"4E. Patient death or serious injury associated with a fall while being cared for in a healthcare setting" (National Quality Forum, 2011).

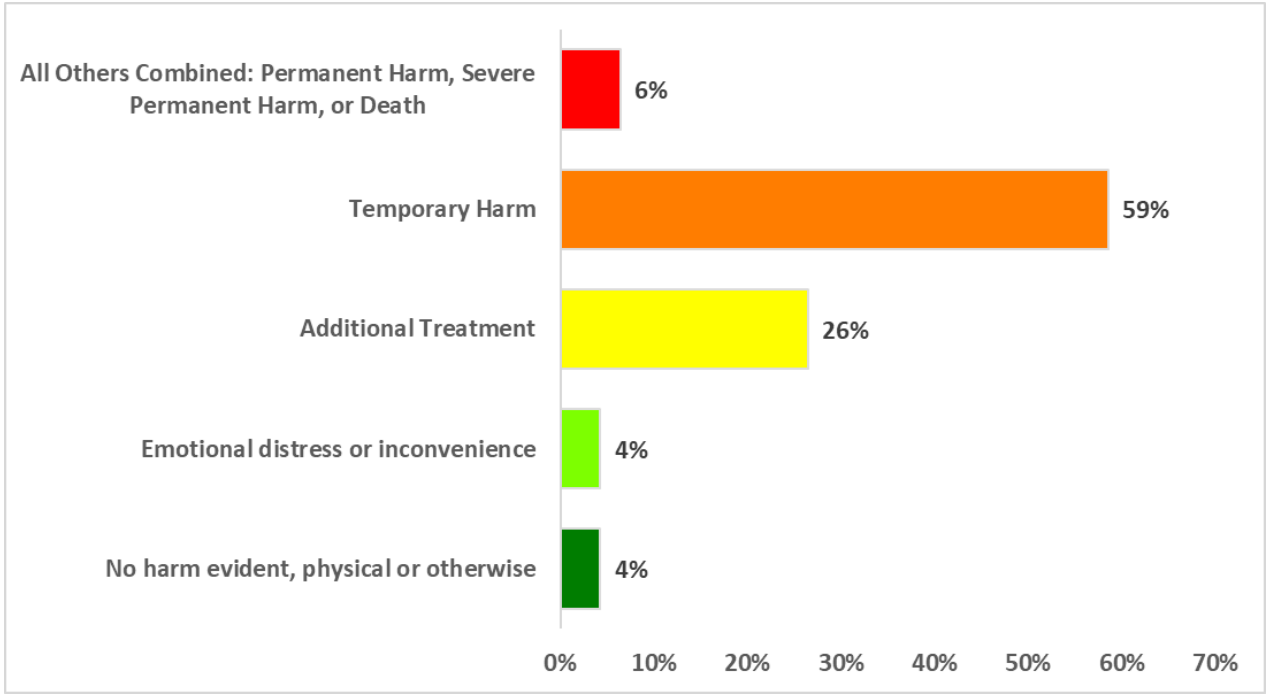
Proportion of Events Attributed to Pressure Injuries



2024 Length of Stay Fact:
Patients with a reported pressure injury had been admitted for an average of 22 days when the injury was identified.

Definition:
"4F. Any Stage 3, Stage 4, and unstageable pressure ulcers (injuries) acquired after admission/presentation to a healthcare setting" (National Quality Forum, 2011).

Percent of Events by Harm Severity



The distribution of 2024 event harm severity shows only 6% of reported events resulted in the most severe categories of permanent harm, severe permanent harm, or death. Categories with fewer than six reports have been combined for confidentiality.

Severity of Events
(Level of Harm)

Measuring the degree of harm caused by patient safety incidents helps prioritize improvement efforts toward preventing the most serious outcomes. Higher harm levels prompt more extensive reviews, broader corrective actions, and longer monitoring, allowing healthcare providers to focus resources on reducing the most impactful incidents.

In Vermont, events can qualify as a Serious Reportable Event or Intentional Unsafe Act even if no harm occurs, depending on the event type.

No harm evident, physical or otherwise
Event reached patient but no harm was evident.

Emotional distress or inconvenience
Event reached patient; mild anxiety, pain, or discomfort; no treatment beyond monitoring.

Additional Treatment
Injury limited to additional intervention during encounter and/or increased length of stay, but not other injury.

Temporary Harm
Bodily or psychological injury, but likely not permanent.

Permanent Harm
Lifelong bodily or psychological injury or increased susceptibility to disease.

Severe Permanent Harm
Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life.

Death

Severity levels are defined in the Vermont Department of Health (2024) Causal analysis and corrective action report form.

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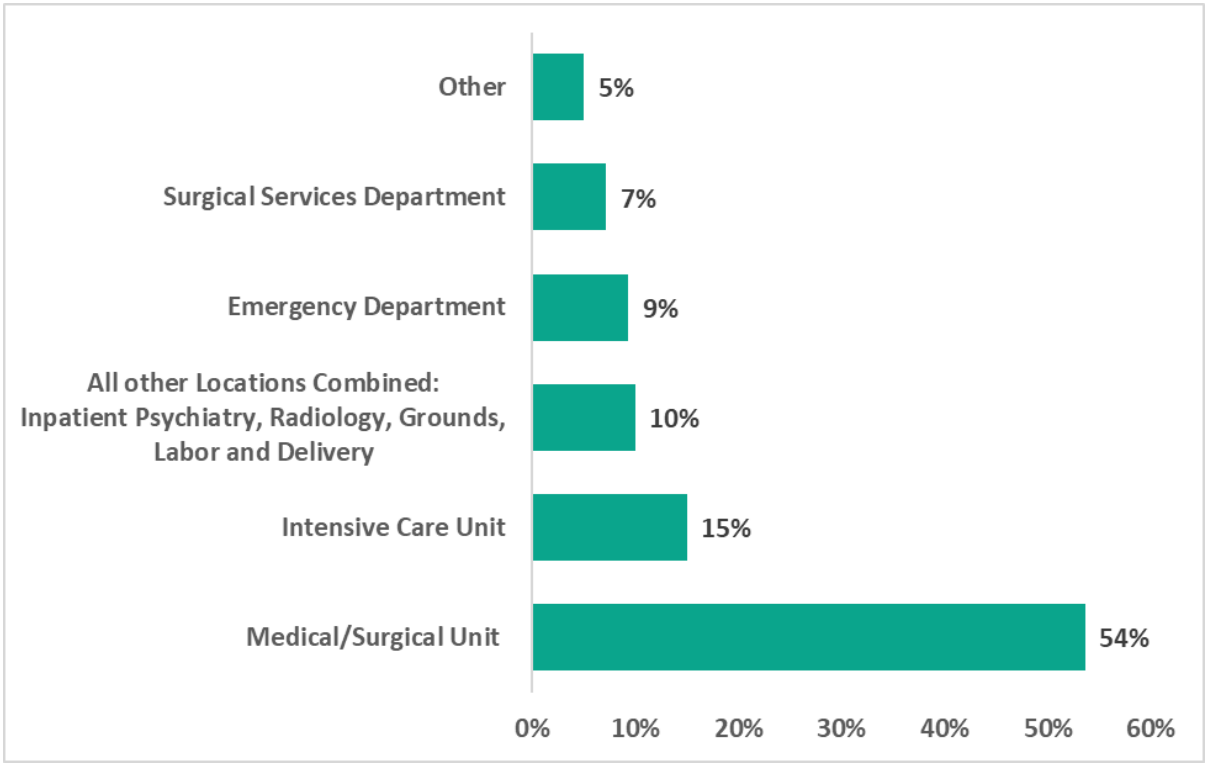
Locations Where Events Occurred

Identifying specific locations where incidents occur enables targeted safety interventions in high-risk areas. Capturing this information helps organizations understand reporting trends across different care settings.

Medical/surgical units typically have the highest patient volume and longest patient stays in hospitals, creating more opportunities for safety events to occur.

Event Distribution by Location



The majority of 2024 events occurred in medical-surgical units (54%), followed by the Intensive Care Unit (15%) and other areas. Categories with fewer than six reports have been combined for confidentiality.

? What's the difference between a **Surgical Services Department** and **Medical/Surgical Unit**?

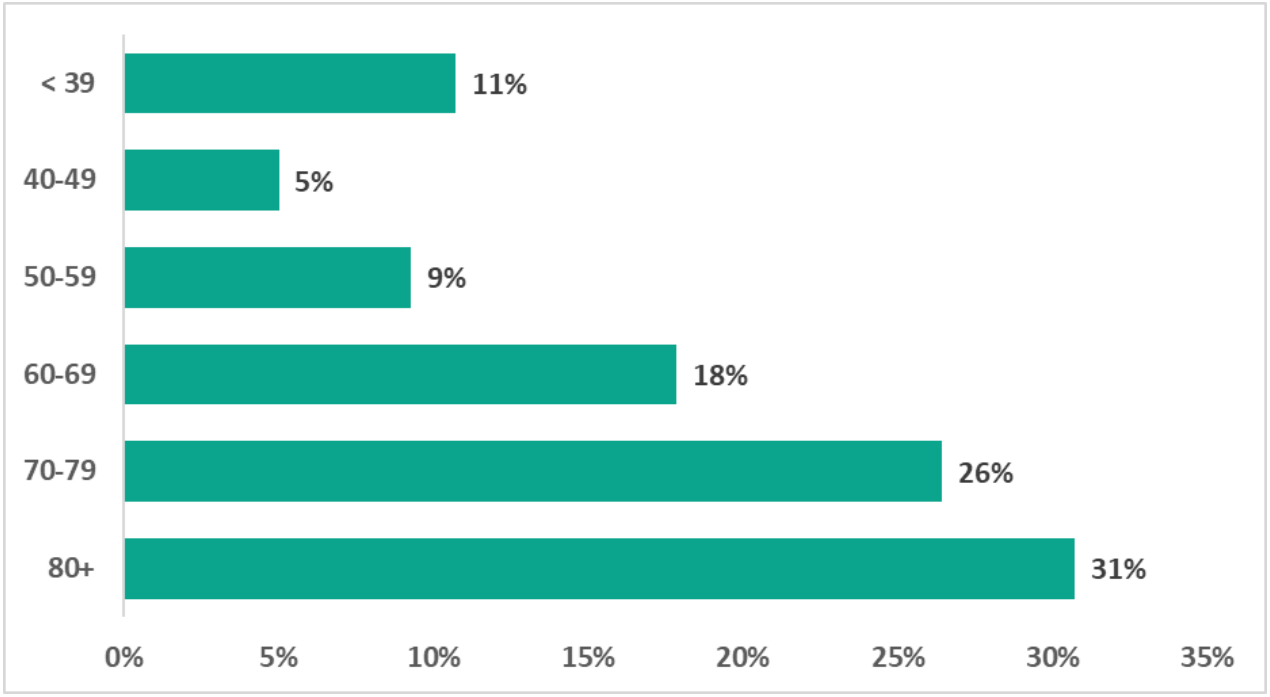
Surgical Services Department:

If you're having surgery, you'll start and end here on the day of your procedure.

Medical/Surgical Unit:

If you need general inpatient care, or longer recovery after surgery, you may stay here.

Percent of Events by Age Group



57% of PSSIS events in 2024 affected patients over age 70.

Patient Demographics

Collecting demographic data helps identify potential disparities in patient safety incidents. Understanding these factors is essential for ensuring equitable care and designing interventions that address diverse patient needs. This is the first full year where Vermont's PSSIS has collected these specific demographic data elements.

Analysis of 2024 reported events found no notable differences based on sex at birth, with male and female evenly represented among the 140 reported events.

For disability status – defined as receiving Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) – 76% of reports fell into the 'Unable to determine/Unknown' category.

Due to small numbers, gender identity, race, ethnicity, disability status, and preferred language could not be meaningfully analyzed.

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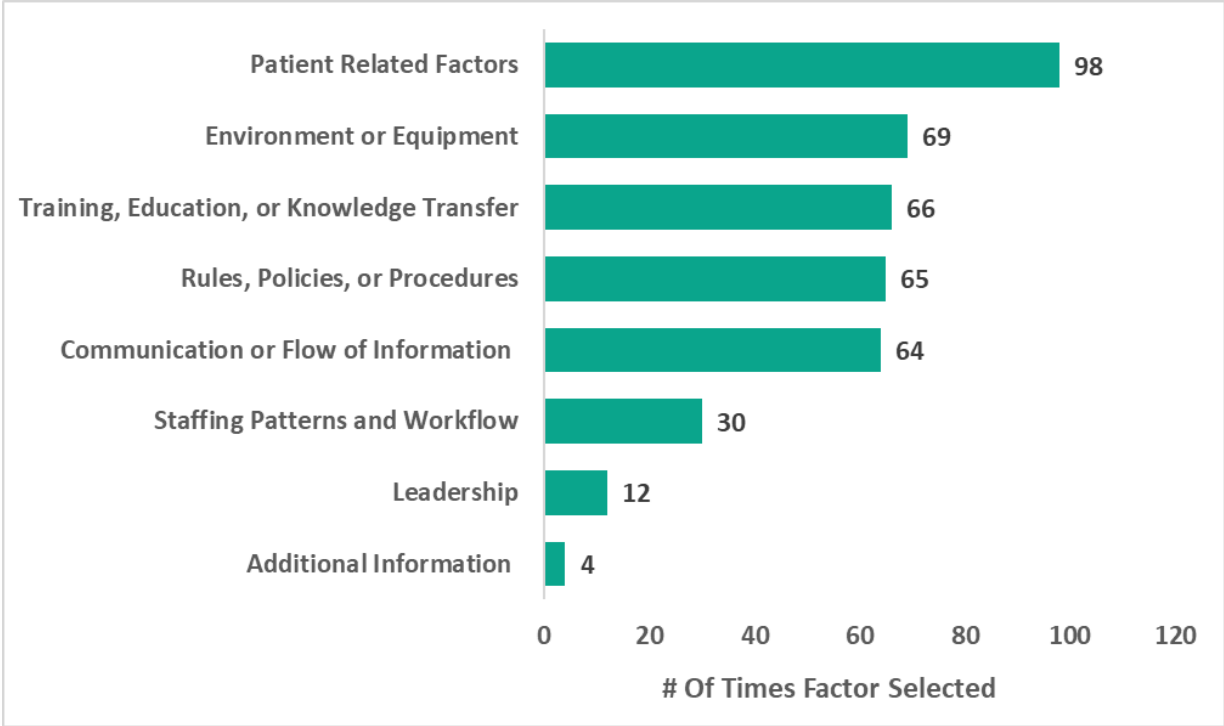
Factors Contributing to Events

Understanding patient safety incidents is key to prevention. Analyzing system interactions – such as communication and policies – helps organizations identify causes and implement targeted prevention measures. Ensuring safety goes beyond individual performance, as human error is inevitable in complex healthcare settings.

Count of Identified Contributing Factors



The 2024 distribution of contributing factors shows that "Patient Related Factors" were the most frequently identified, followed by issues related to equipment, training, policies and communication. Multiple factors may be selected for a single event.

Patient Related Factors

Physical assessment, comorbid conditions, and/or the patient's understanding and engagement in the plan of care.

Environment or Equipment

Complications or failures in appropriate use of equipment. Environment refers to conditions in the environment that present a risk.

Training, Education or Knowledge Transfer

Insufficiencies in training and/or inconsistent or inadequate education.

Rules, Policies, or Procedures

Failures in processes that can be traced to non-existent or inadequate protocols and procedures. Failure to follow established protocols or procedures.

Communication or Flow of Information

Availability of critical information (verbal, written or electronic) between any members of the healthcare team.

Staffing Patterns and Workflow

Inadequate staffing leading to situations where there is greater risk for patient safety events.

Leadership

Refers to the safety culture principles and behaviors of the organization.

Additional Information

Allows an open explanation by the reporting facility.

Factors contributing are defined in the Vermont Department of Health (2024) Causal analysis and corrective action report form.

Strategic Priorities for 2025

Hospitals, ambulatory surgery centers, the Vermont Program for Quality in Health Care, and the Vermont Department of Health will continue to partner to improve patient safety, to decrease serious adverse events, and to facilitate quality improvement efforts.

National Quality Forum Serious Reportable Events Update

The National Quality Forum (NQF) is in the process of revising the Serious Reportable Events list, which has remained unchanged since 2011. VPQHC will proactively prepare for a potential 2025 release by monitoring the revision process and rapidly communicating any changes to all affected facilities.

Cross-Institutional Learning Collaborative

Explore a structured patient safety learning network that facilitates systematic knowledge sharing about adverse event analyses, successful interventions, and lessons learned. This effort aims to promote shared learning and accelerate safety improvements by highlighting system-level patterns and solutions.

Leadership Transition Support

Develop an onboarding program for new Quality Department staff. This could include a standardized orientation package and mentorship opportunities, pairing experienced quality leaders with newcomers. Supporting leaders early in their roles can help sustain a strong safety culture during times of change.

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Technical Notes

Data Source: Reports accepted into the Vermont Patient Safety Surveillance and Improvement System (18 V.S.A Chapter 43A) from January 1, 2024, to December 31, 2024.
Reporting Entities: Vermont hospitals and ambulatory surgery centers (defined by 18 V.S.A. § 1902).
Event Criteria: Includes serious reportable events as defined by the National Quality Forum (National Quality Forum, 2011) and intentional unsafe acts (18 V.S.A. § 1916).
Exclusions: Events retracted by the reporting facility or rejected for not meeting criteria have been removed from the dataset.
Confidentiality: To protect confidentiality, event categories with fewer than six reports have been combined.

References

National Quality Forum. (2011). Serious Reportable Events in Healthcare – 2011 Update: A Consensus Report. https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

Twenter, P. (2025, March 14). Healthcare quality trends: 45 key stats. Becker's Clinical Leadership. https://www.beckershospitalreview.com/quality/healthcare-quality-trends-45-key-stats.html?origin=BHRSUN&utm_source=BHRSUN&utm_medium=email&utm_content=newsletter&oly_enc_id=4878A5009034H5Y

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Vermont Statutes. 18 V.S.A. Chapter 43a: Patient Safety Surveillance and Improvement System, including 18 V.S.A. § 1916. Retrieved from https://legislature.vermont.gov/statutes/chapter/18/043a

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