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Patient Safety Reporting Program
2023 Progress Report

Oregon's Program for Shared Learning

The Oregon Patient Safety Commission (OPSC) serves as a hub for shared learning to improve how Oregon's healthcare system responds to and learns from adverse events. OPSC administers the **Patient Safety Reporting Program (PSRP)**, a state-level program to collect and analyze adverse event information from healthcare facilities. OPSC broadly shares lessons learned from PSRP to reduce the risk of patient harm.

In this report, we illustrate:

- Why a **collective effort** is necessary to reduce preventable harm in healthcare
- Why **modernizing PSRP** is a critical step in providing better support for the rapidly changing healthcare environment
- What OPSC is doing to **integrate equity** into all our work
- How **data modernization** will better support current patient safety knowledge and practice
- How OPSC will gain a **better understanding of Oregon's capacity** for responding to and learning from harm
- The ways in which OPSC is **improving shared learning**

The Oregon Patient Safety Commission is committed to helping transform Oregon's healthcare system. We have identified priorities for the coming year, and we look forward to working to advance this important effort.

A Collective Effort Is Needed for Progress

The work of improving patient safety should not be done in isolation, and we all have a role to play. The full benefits of PSRP can only be realized when healthcare organizations:

- **Adopt** a systems-based approach to proactively respond to and learn from patient harm
- **Contribute** what they learn to PSRP

As Oregon's hub for shared learning, we are committed to building a culture that supports collaboration and learning across Oregon's healthcare system. We know that to effectively support an industry that is constantly evolving, often in unpredictable ways, we must continuously incorporate new knowledge and insights to meet changing needs.

In June of 2024, the OPSC Board of Directors prioritized efforts to support coordination and collaboration with Oregon's healthcare community in its strategic plan, focusing on how OPSC can help support healthcare organizations in their patient safety work. In this plan, OPSC committed to:

- **Continue** to modernize PSRP to align with current technology and constantly changing patient safety needs
- **Support** capacity building for responding to and learning from harm events

Through PSRP, OPSC can build on the work organizations are already doing and provide meaningful shared learning so that we can all make progress *together*.

The Essential Role of a State Reporting Program

We conducted an analysis to understand the unique and interdependent roles of state- and organization-level reporting programs in making progress to reduce patient harm. We learned that the role of a state program like PSRP is to:

- **Build on** organization-level efforts without duplication
- **Share** information to inform safety and quality improvement work
- **Facilitate** work on problems that can't be solved in isolation
- **Provide** meaningful public accountability
- **Encourage** practices and improvement efforts that advance equity

In this progress report, we'll share the steps we've taken thus far to ensure we can play our part in making Oregon's healthcare system safer for every patient.

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Making a More Direct Connection to Learning

The key to state-level adverse event reporting programs is to broadly share lessons learned from healthcare organizations. The current structure of the PSRP reporting form focuses on a detailed description of the adverse event itself and can make what was learned from the investigation a secondary priority. This means that it isn't always clear what the organization learned and sometimes requires additional follow-up from OPSC. To more effectively tap into organizational expertise and lessons learned… **why not just ask organizations directly?**

As our first small but crucial step in updating PSRP, we'll embark on an initiative to ask facilities what they learned from their event investigation and analysis, as well as what key lessons they want others to learn from their work.

Progress Report: Modernizing PSRP

While healthcare has been in a constant state of change since PSRP was created in 2003, the program, its statute (ORS 442.819 to 442.851), and its administrative rules (OAR 325-001-0000 to OAR-035-0045) remained largely unchanged. In 2021, we sought input from members of Oregon's healthcare community to understand their patient safety priorities and practices. Their input, in conjunction with a literature review of advances in patient safety, shaped proposed revisions to the PSRP statute to strengthen the reporting program without creating new mandates or additional reporting burden. The passage of Senate Bill 229 in the 2023 Legislative Session was an important milestone in the process to modernize PSRP. The revisions:

- Revised overly specific or outdated language, allowing the statute to remain relevant
- Updated elements of the reporting program to support current patient safety knowledge and practice
- Codified health equity as an essential part of reporting program data collection and analysis because we know that inequitable care cannot be safe care

With these important statutory updates complete, OPSC also revised the related Oregon Administrate Rules using a collaborative process. Our primary focus was on increasing the flexibility of PSRP to align with modern patient safety practice, which will strengthen OPSC's ability to share learning.

Now PSRP is positioned to better support the rapidly changing healthcare environment, build on the work organizations are already doing, and provide meaningful shared learning. As we move forward with this work, we will focus on how OPSC can best support Oregon healthcare organizations at the state level.

Progress Report: Integrating Equity

One of OPSC's strategic goals is to ensure that we are integrating equity into all we do, including program operations and activities. As a part of our PSRP modernization effort, OPSC has codified health equity as an essential part of reporting program data collection and analysis through statutory revision.

Acknowledging the State of Equity in Healthcare

We know that inequitable care cannot be safe care and that patient safety and health inequity are undeniably linked. Health inequities are the differences in health outcomes that are systematic, avoidable, and unjust.[1, 2, 3, 4] Structural racism and systemic discrimination based on factors such as race, sex, language, and socioeconomic class are codified in the policies and practices of the U.S. healthcare system.[5, 6]

Understanding the root causes of inequity in patient safety is essential to inform strategies to address those inequities—but there's limited information about how healthcare organizations seek to understand the role of health equity in adverse events.

So, what can OPSC do? We can encourage practices and improvement efforts that advance equity. OPSC's role is to work with organizations across the healthcare system to support learning and collaboration. We offer insight into the efficacy of the processes and systems organizations use to make care safer following patient harm events.

Progress Report: Data Modernization

One aspect of our modernization effort is to revise elements of the reporting program to support current patient safety knowledge and practice, as well as to fulfill the shared learning goal of the program.

To do this, we need to rethink our approach. Instead of taking a narrow view that centers on the specifics of an individual adverse event, we will focus on:

- The systems organizations have in place to respond to and learn from adverse events
- What organizations learned from those events that can benefit others

With this in mind, we are looking at how we can improve our current approach to data collection. Table 1 provides a summary of where we are today, and where we want to go, with PSRP data collection.

Table 1: Current vs. Future State

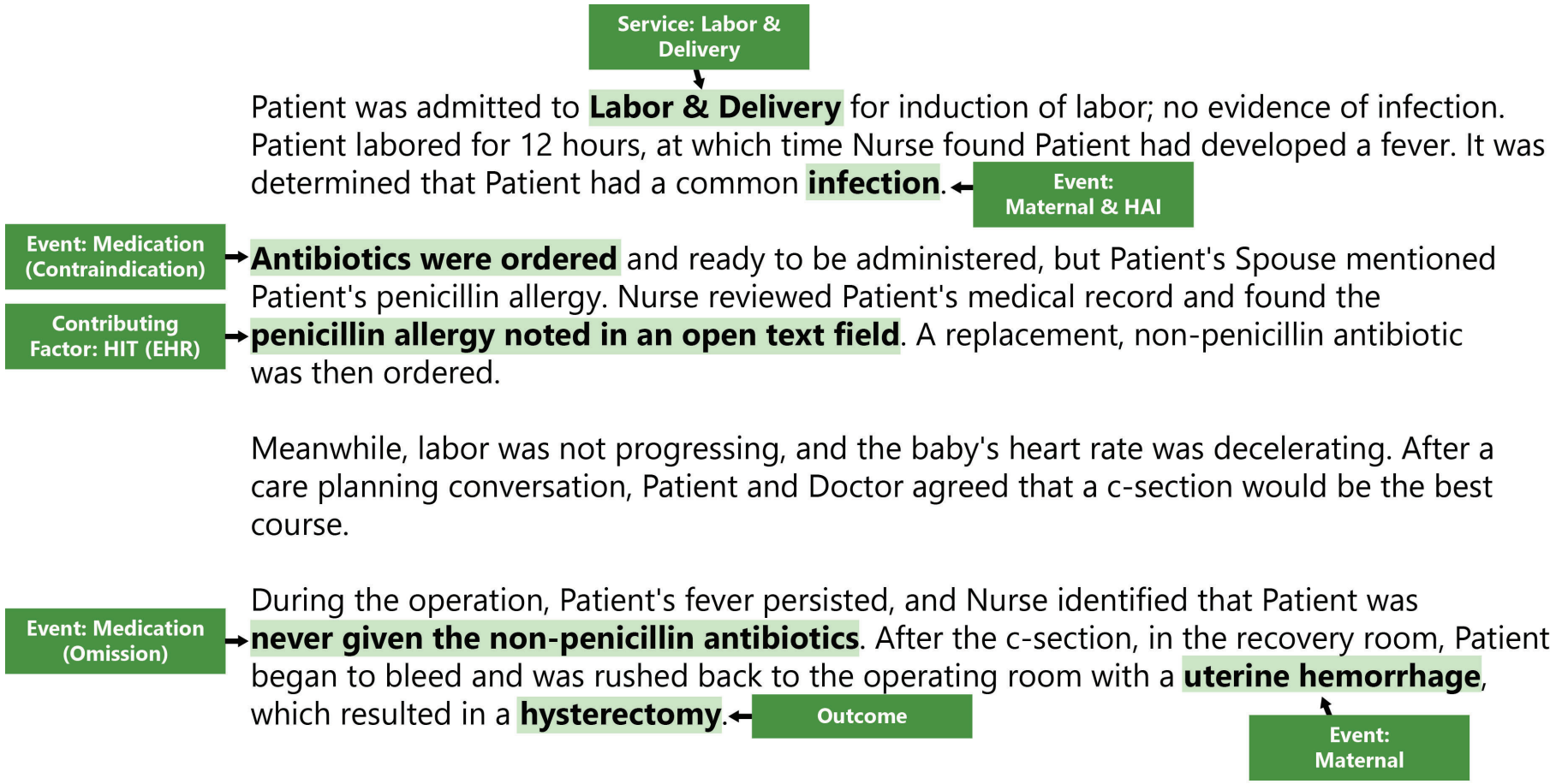
Where We Are Today	Where We Want to Go
Individualized forms: Each eligible facility type—ambulatory surgical centers (ASCs), hospitals, nursing facilities, and pharmacies—has an individualized adverse event reporting form	**Unify data collection:** Transition to a single reporting form for all facility types
Overlap in how events are categorized: There is overlap among event type, harm, patient outcome, type of service, and contributing factors that can be difficult for reporters to parse and correctly attribute in the form (See Figure 1, p.7 for an example event description to illustrate the overlap)	**Evaluate the triggering questions model used by a variety of event investigation and analysis approaches (RCA², CANDOR, and The Joint Commission):** Consider the use of triggering questions to help event investigation teams look into areas that might otherwise be missed
Counting focus vs. learning focus: The focus is on counting adverse events using narrow, specific definitions. This can encourage the selection of a single event type, potentially hiding the complexity of adverse events (See Figure 1, p.7 for an example that highlights this complexity)	**Make a more direct connection to learning:** Keep the focus on what facilities learned, making categorizing event types secondary
Event focus vs. system focus: The focus is on the details of individual adverse events rather than on the systems for responding to the wide range of safety issues that arise	**Assess the systems for responding to and learning from harm in Oregon:** Understand harm response systems and processes that facilities already have in place to inform both our shared learning and how we offer support

Note: Our 2023 data is presented in Appendix I: 2023 PSRP Data.

Progress Report: Data Modernization (continued)

Figure 1 is a fictional example of an adverse event description that is representative of those submitted to PSRP. This example highlights the overlap between event type and other event elements, as well as the complexity of adverse events. Even though it's short, it contains multiple potential event types, a service, a contributing factor, and a patient outcome.

Figure 1: Example event description



Progress Report: Capacity Building

Our ongoing work to modernize PSRP is foundational to ensuring that the program can continue to evolve along with, and meet the needs of, our changing healthcare system. As we continue this work, we also want to better understand Oregon's capacity for responding to and learning from adverse events. We want to ensure that we offer meaningful program engagement activities and shared learning.

Guided by current patient safety best practice,[7] **we want to learn about the harm response systems healthcare organizations have in place**. When healthcare organizations use a systems-based approach to respond to and learn from adverse events, and submit what they learn to PSRP, they also contribute to Oregon's collective statewide learning system.

Fortunately, a promising best practice model provides a road map for Oregon healthcare organizations. The communication and resolution program (CRP) model provides a systems-based approach that emphasizes a comprehensive, consistent, and systematic response to every patient harm event. This includes an inquiry into what happened, on-going communication with the patient and family, support for involved healthcare providers, and restitution when the standard of care was not met. One of the most widely used CRPs is the Agency for Healthcare Research and Quality's (AHRQ's) model, Communication and Optimal Resolution (CANDOR).[8]

Stronger Together

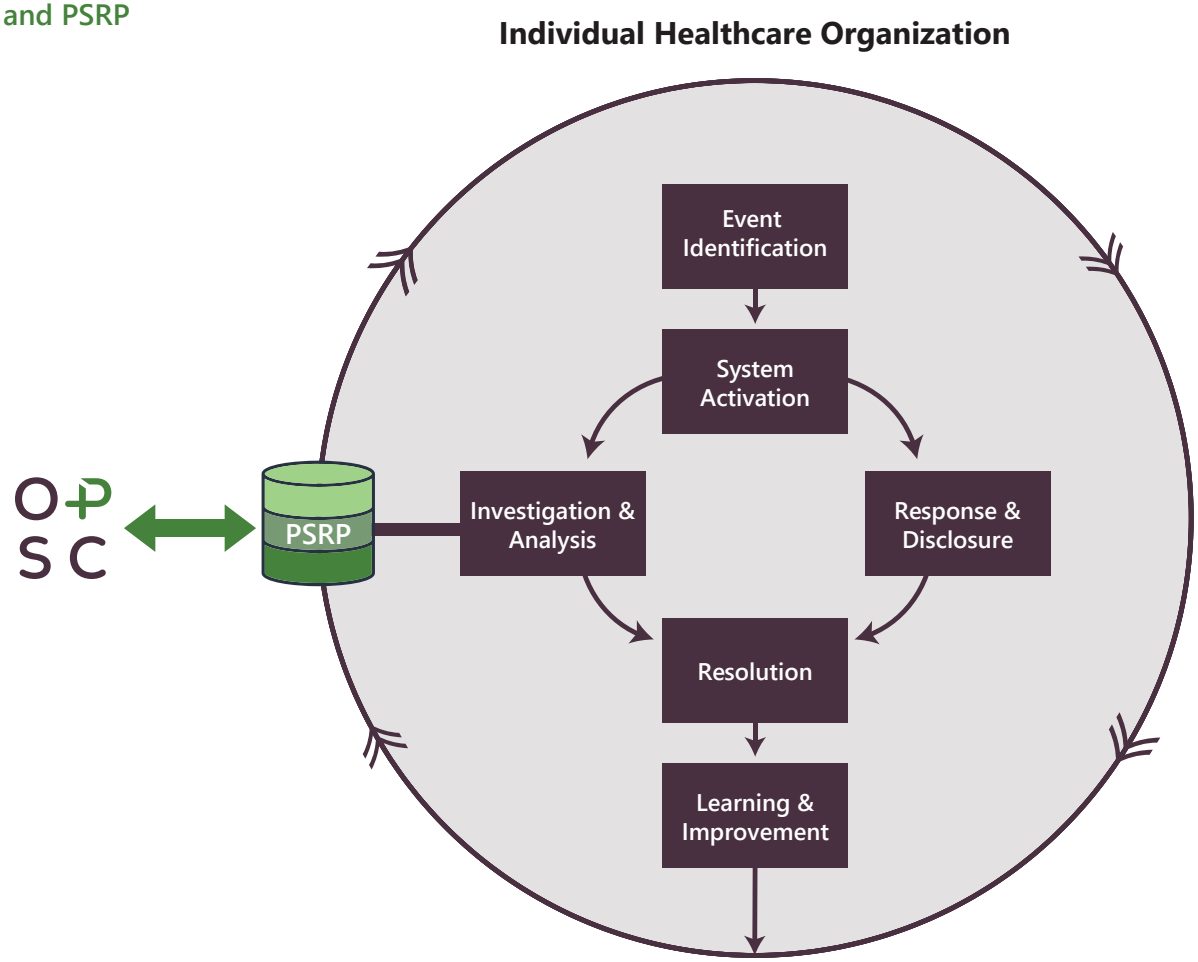
The stronger individual healthcare organizations are, the stronger we are as a state. This is why we are actively looking for opportunities to support healthcare organizations to build capacity for responding to and learning from adverse events; partnerships are key to this work. We are currently partnering with:

- **Pathway to Accountability, Compassion, and Transparency (PACT):** This partnership offers Oregon healthcare organizations access to PACT's expertise to strengthen harm response programs using best practice, systems-based models like CRP and CANDOR (See Figure 2, p 9).
- **Washington Patient Safety Coalition and Health Quality BC:** This regional collaboration brings together hundreds of healthcare professionals, providers, students, patients, families, and caregivers from all care settings for the Annual Northwest Patient Safety Conference. In addition, this collaboration works to share resources and ensure consistent patient safety education across the region.

To bolster our engagement efforts, we will seek additional partnerships to support Oregon healthcare organizations.

A Statewide Learning System: How it Works

Figure 2: A systems-based response to harm events using Communication & Optimal Resolution (CANDOR) and PSRP



The Patient Safety Reporting Program (PSRP) connects to systems for event investigation and analysis and offers a safe space where learning and improvement can occur.

The Oregon Patient Safety Commission (OPSC) shares aggregated learning from PSRP to help organizations from around the state and across the continuum of care make progress together.

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Improving How We Share What We Learn

In our quest to share what we learn in the most engaging and effective ways possible, we are committed to adhering to the latest communication best practices. We know how busy healthcare professionals are, and we understand that short, bite-sized communications are more effective in sharing actionable information.

With that, here are some of the things we shared in 2023, capturing both learnings from our programs and best-practice patient safety resources. We use an integrated campaign model for each of our communications, including email, social media, and website engagement:

- Addressing Medical Gaslighting to Improve Maternal Health—Together
- Improving Diagnostic Safety Practices with the Safer Dx Checklist
- Join AHRQ's National Action Alliance to Advance Patient Safety Webinar Series
- Patient & Family Engagement: A Patient Safety Priority
- World Patient Safety Day (Patient and Family Engagement, Connection to National Action Alliance)
- Health Equity Tools: Advancing Equity through Quality and Safety Peer Network Series
- New Patient Safety Podcast: "More Hospitals Move to Confront Medical Errors Head On"
- 2023 EDR Annual Report

What's Next?

At OPSC, we are committed to continuing the work necessary to ensure PSRP evolves along with the healthcare system it was created to support.

In the coming year, we will:

- **Continue** to modernize PSRP to align with current technology and constantly changing patient safety needs
- **Use** PSRP to encourage practices and improvement efforts that advance equity
- **Modernize** the PSRP data strategy to focus on organizational harm response systems and key learnings from adverse events
- **Seek** opportunities to help healthcare organizations build capacity for responding to and learning from adverse events

Through PSRP, OPSC will build on the work organizations are already doing and provide meaningful shared learning so that we can build a culture of safer care—together.

Our Thanks

We appreciate the time, energy, and expertise of those who have partnered with us and supported the vision of PSRP over the last year. From the OPSC Board of Directors who were instrumental in the creation of the OPSC Strategic Plan, to the members of the healthcare community who helped inform our administrative rules, it has taken a group of dedicated, mission-driven people to continue to move this work forward. A special thanks to the Oregon Legislature for their support in the passing of Senate Bill 229, which was integral to ensuring we can modernize PSRP.

Appendix A. 2023 PSRP Data

Event Types Reported in 2023

Table 2 provides a list of the types of adverse events that Oregon healthcare facilities contributed to PSRP in 2023: 42 reports were from ASCs, 154 were from hospitals, 0 were from nursing facilities and pharmacies. Table cells are grayed out if the event type is not available for that facility type. There are 35 total event types across all four reporting segments.*

Table 2. Event Types by Segment, 2023

Event Type	ASC		Hospital		Nursing Facility		Pharmacy		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Fall	5	12%	31	20%					36	18%
Surgical or other invasive procedure	18	43%	12	8%					30	15%
Care delay (inc. delay in treatment, diag.)			27	18%					27	14%
Medication or other substance	6	14%	14	9%					20	10%
Pressure injury			18	12%					18	9%
Maternal			12	8%					12	6%
Retained object	1	2%	10	6%					11	6%
Device or supply			10	6%					10	5%
Aspiration	8	19%	1	1%					9	5%
Suicide or attempted suicide			7	5%					7	4%
Other	1	2%	5	3%					6	3%
Healthcare-associated infection (HAI)	3	7%							3	2%
Anesthesia	1	2%	1	1%					2	1%
Electric shock			2	1%					2	1%
Failure to follow up test results			2	1%					2	1%
Perinatal			2	1%					2	1%
Blood or blood product			1	1%					1	1%
Deep vein thrombosis	1	2%							1	1%
Irretrievable loss of irreplaceable specimen			1	1%					1	1%
Total Reports	42		154		0		0		196	

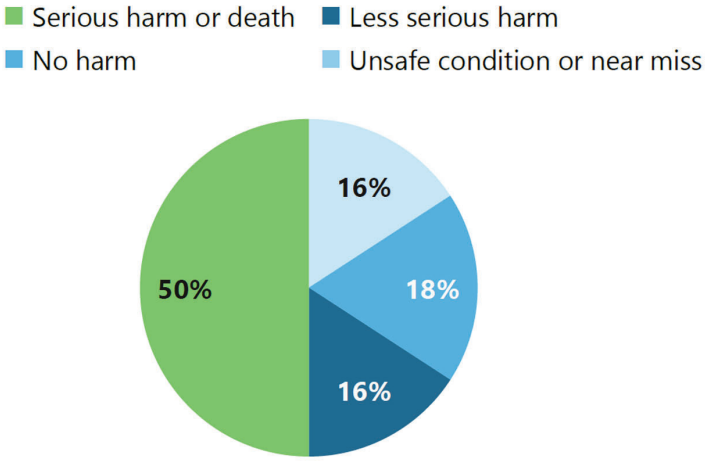
* Note: Event types that were not included in 2023 reports are not represented in the table above.

Appendix A. 2023 PSRP Data (continued)

Harm Categories Count

OPSC has adapted the National Coordinating Council for Medication Error Reporting and Prevention's (NCC MERP's) Medication Error Index (2001) to classify adverse events reported to PSRP according to the severity of the outcome. PSRP participants are required to report serious adverse events. Participants are also encouraged to report less serious harm events, no harm events, and near misses, because all events, regardless of harm, are prime opportunities to learn and improve systems of care. As expected from the program's emphasis on serious adverse events, half of the reports submitted to PSRP in 2023 (50%) resulted in serious harm or death (Figure 3).

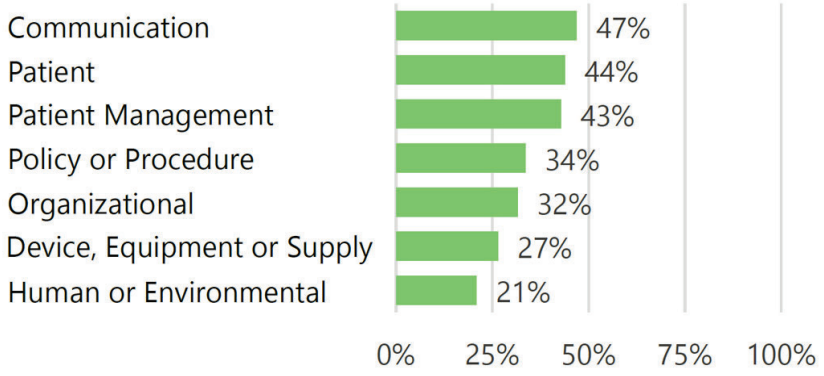
Figure 3. Harm Categories for All Segments, 2023



Contributing Factor Category Count

Contributing factors shed light on the circumstances or conditions that increased the likelihood of an event. By identifying system-level factors, such as communication and patient management, organizations have a solid starting point to uncover deeper, system-level causes that can be addressed to prevent event recurrence. Almost half of the reports submitted to PSRP in 2023 identified one or more communication factors (Figure 4).

Figure 4. Contributing Factor Categories, 2023



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Appendix A. 2023 PSRP Data (continued)

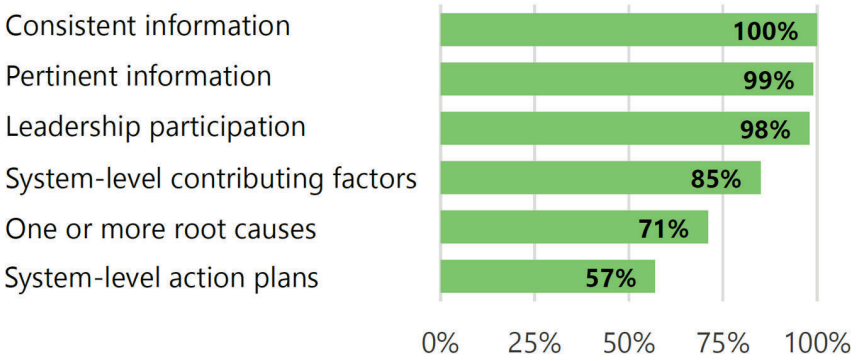
Quality Review Data: Strong Action Plans and Root Causes

Event reports submitted to PSRP in 2023 provide a window into an organization's event review and analysis process but do not provide the full picture of the systems and procedures facilities have in place. Collecting facility-level information about said systems and procedures in the future will give a more complete picture of how Oregon's facilities respond to and learn from adverse events.

OPSC reviews reports based on a set of quality components, which serve as indicators of a strong event review and analysis process that can prevent future events. The two most frequently missing quality components were:

- One or more system-level action plans designed to minimize risk
- One or more root causes

Figure 5. Percent of Reports Receiving Each Quality Component, 2023



Quality Review Data: Acceptable Quality

Just over half of submitted reports (55%) included all six elements necessary for acceptable quality. Less than 20% of ambulatory surgery center (ASC) reports were acceptable quality (Table 3).

Table 3. Acceptable Quality by Segment (2023)

Segment	Number	Percent
ASC (n=42)	7	17%
Hospital (n=154)	101	66%
All Segments (n=196)	108	55%

Note: Nursing facilities & pharmacies did not submit any reports in 2023.

Appendix A. 2023 PSRP Data (continued)

Demographic Data

Understanding the root causes of inequity in patient safety is essential to informing strategies to addressing those inequities—but there's limited information about how healthcare organizations seek to understand the role of health equity in adverse events. In Oregon, even basic data on race and ethnicity are either not collected during a facility's event investigations or are simply not included in event reports submitted to PSRP (Figures 6-9).

Figure 6. Patient Race, 2023

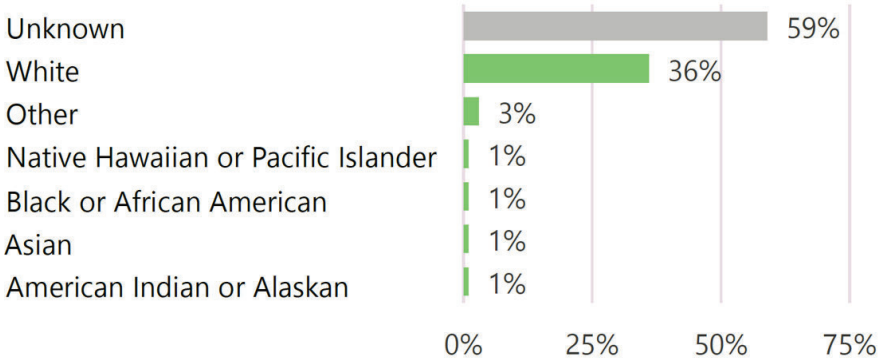


Figure 7. Patient Ethnicity, 2023

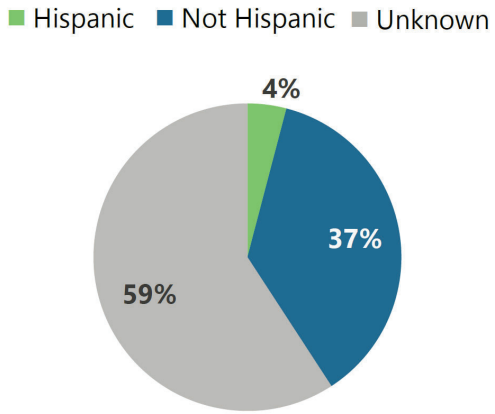


Figure 8. Patient Age Group, 2023

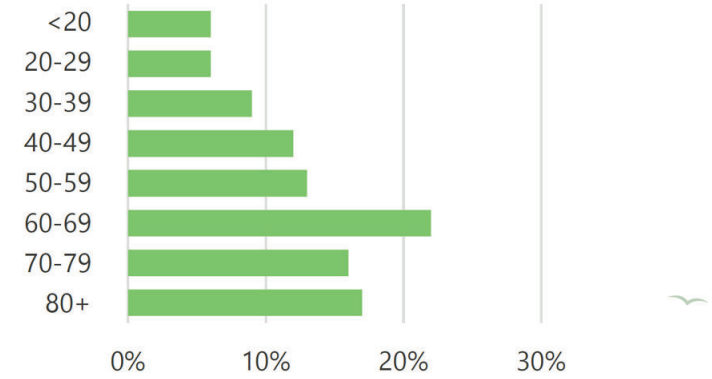
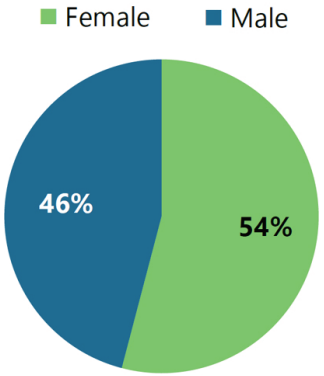


Figure 9. Patient Gender, 2023



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The Oregon Patient Safety Commission (OPSC) is a semi-independent state agency that supports healthcare facilities and providers in improving patient safety.

We encourage broad information sharing, ongoing education, and open conversations to cultivate a more trusted healthcare system.

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