2025

Vermont Patient Safety Surveillance and Improvement System Annual Report

April 2026

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Vermont Program for Quality in Health Care, Inc.

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2025

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Vermont Patient Safety Surveillance & Improvement System (PSSIS) Event Reporting

This annual report provides Serious Reportable Event (SRE) patient safety data reported through the PSSIS in 2025 and an overview of opportunities and strategies for continuing to improve safety across Vermont's Hospitals and Ambulatory Surgery Centers (ASC) in 2026. The report highlights efforts by reporting entities to inspire and sustain a culture of safety, and a commitment to applying high-reliability principles in daily interactions with leadership and staff. The **Vermont Program for Quality in Health Care (VPQHC)** has long served as a trusted convener, educator, and partner in statewide quality improvement and administers the PSSIS on behalf of the Vermont Department of Health (VDH).

The **PSSIS** strengthens Vermont's ability to detect harm trends, analyze events, and disseminate statewide learning. Ensuring patient safety is a fundamental priority in healthcare. The PSSIS provides a structured framework for hospitals to analyze adverse events and improve patient care. An SRE is an adverse event or safety issue in a healthcare setting. These events are usually preventable, may cause serious harm and offer an opportunity to examine the root causes and system wide prevention solutions. **SREs are defined by the National Quality Forum (NQF).**

Patient safety is "a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce impact of harm when it does occur." - WHO

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Patient Safety Surveillance in Vermont

VPQHC Key Contributions Through the Vermont PSSIS

- Centralized Serious Reportable Event (SRE) learning is supported by:
  - aggregating SRE data from Vermont Hospitals and Ambulatory Surgery Centers and informing a statewide perspective on safety trends.
  - utilizing the 18 V.S.A Chapter 43A, peer-protected environment, allowing organizations to confidentially share event details, and corrective action plans associated with lessons learned and best practices.
  - conducting routine patient safety program site visits, offering quality and safety improvement webinars, toolkits, and training to support organizations to optimize safety improvements.
  - collaborating with the Vermont Department of Health, to inform statewide safety priorities, guide policy recommendations, and demonstrate compliance with reporting requirements, creating alignment between frontline practice and state-level oversight.
  - facilitating compliance with the **statutorily mandated** (18 V.S.A 43A) program, Vermont hospitals and Ambulatory Surgery Centers (ASCs) to ensure:
    - reporting of Serious Reportable Events (SREs) within 7 days of discovery.
    - submission of causal analysis and corrective action plans within 60 days.
    - reporting of Intentional Unsafe Acts within 7 days of discovery.
    - participation in periodic on-site monitoring visits.

How many hospitals and ambulatory surgery centers were required to report into the PSSIS in 2025? **18**

Sustaining a Culture of Safety

A culture of safety in healthcare is an organizational mindset, defined as a set of values, beliefs and behaviors that prioritize patient safety above all else and is embedded in every action, decision, and interaction. A culture of safety is not just about preventing errors. It is about creating an environment where people can reliably detect and report adverse events and learn 1) what happened, 2) why it happened, and 3) ways to prevent it from happening again.

Patients and their care partners, as members of the healthcare and safety team, play a critical role in recognizing what information is needed to feel safe during hospitalization and post discharge. Voicing preferences and concerns is essential to foster trust and collaborative decision making through bidirectional communication with doctors, nurses, care managers, physical therapists, pharmacists, and other health care providers. Proactive behaviors such as asking questions to understand medical terminology, treatment, medication plans, and options are ways that patients and care partners can support a culture of safety.

Psychological safety and workforce wellbeing are essential for health care workers to feel safe speaking up about actual or potential safety risks. When psychological safety is high, staff are more likely to intercept errors before they reach the patient. Psychological safety ensures reporting mechanisms lead to system improvement balancing accountability with learning rather than blame.

High reliability principles as they relate to Serious Reportable Events (SREs) have been adopted by Vermont hospitals and Ambulatory Surgery Centers including:

- an assumption that failure is possible and vigilant detection mechanisms must be maintained.
- a commitment to explore multiple contributing factors and action plans through causal analysis methods.
- channels to escalate concerns and cross departmental situational awareness to improve communication.
- a commitment to anticipate and adapt quickly.
- a collaborative environment to welcome expertise.

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2025 Annual Activity Summary

In 2025, the Patient Safety Surveillance and Improvement System (PSSIS) focused on strengthening healthcare quality and patient safety across Vermont through three strategic initiatives:

National Quality Forum Serious Reportable Events Update included:

- participation in NQF request for public comment on the new SRE list.
- communication to hospitals and ASCs for 2025 release of new guidelines timeline.
- consultation to hospitals and ASCs regarding reporting guidelines.

Cross-Institutional Learning Collaborative included:

- distribution of national healthcare quality resources.
- facilitation of CMS Patient Safety Structural Measure networking to share best practices and resources.
- sponsorship of educational series on CMS Star Ratings and patient safety metrics.
- facilitation of patient safety event reporting shared learning statewide.

Leadership Transition Support provided:

- targeted support for hospitals experiencing quality leadership transitions.
- reinforced focus on creating a non-punitive, learning-oriented safety culture.
- 2025 Emergency Care Research Institute Top 10 Patient Safety Concerns and webinar link to hospitals and ASCs to improve the safety, quality, and cost effectiveness of care across all healthcare settings worldwide.
- “Increased Utilization of Overtime and Agency Nurses and Patient Safety” article about nurse staffing.
- registration for IHI Patient Safety Learning Series to all hospitals and ASCs.

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Vermont Patient Safety Landscape 2025

Total Events Reported in 2025

Events Reported into the PSSIS

On-Site Monitoring Visits

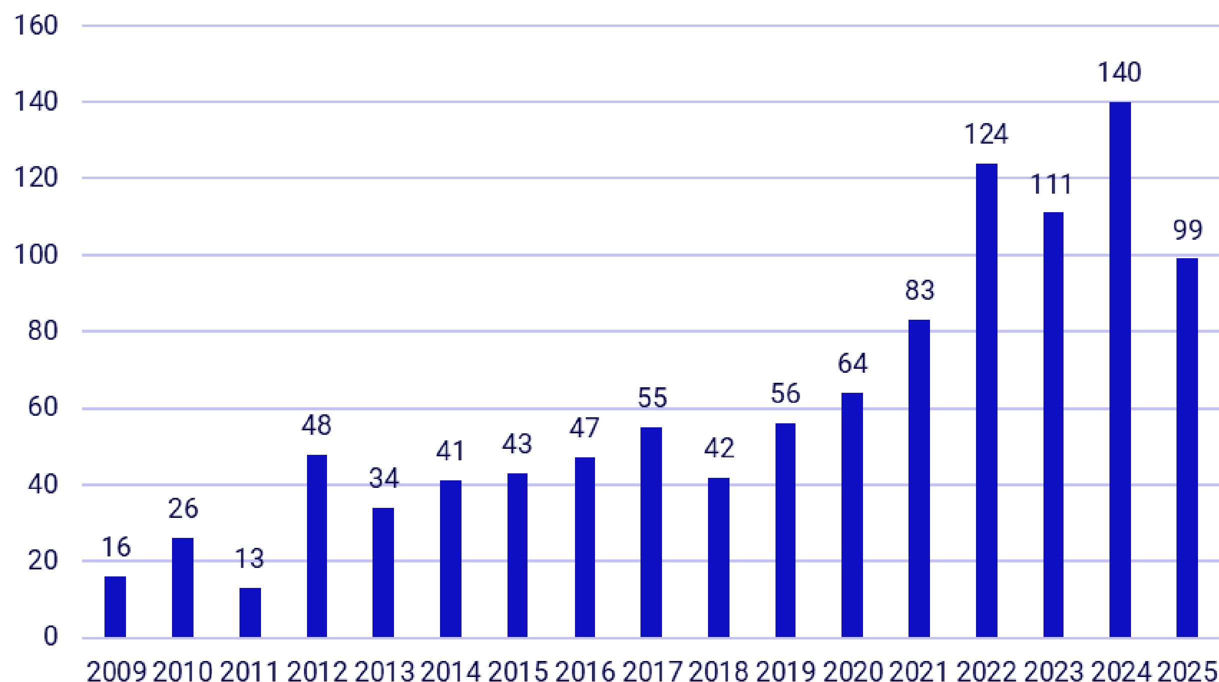

Figure 1 depicts the annual number of events reported to the Patient Safety Surveillance Information System (PSSIS) from 2009 to 2025. It is important to note that reporting has evolved over time, including the 2011 update to Serious Reportable Event (SRE) definitions and the more recent inclusion of ambulatory surgery centers. In 2025, reported events decreased compared to the previous three years. The reasons for this decline are not definitively known and should be interpreted with caution. Potential factors include continued investments in staffing, safety, and quality, as well as application of learnings from prior events. This may also reflect a transition out of pandemic-related conditions, during which the healthcare system experienced significant strain on workforce capacity and care delivery resources.

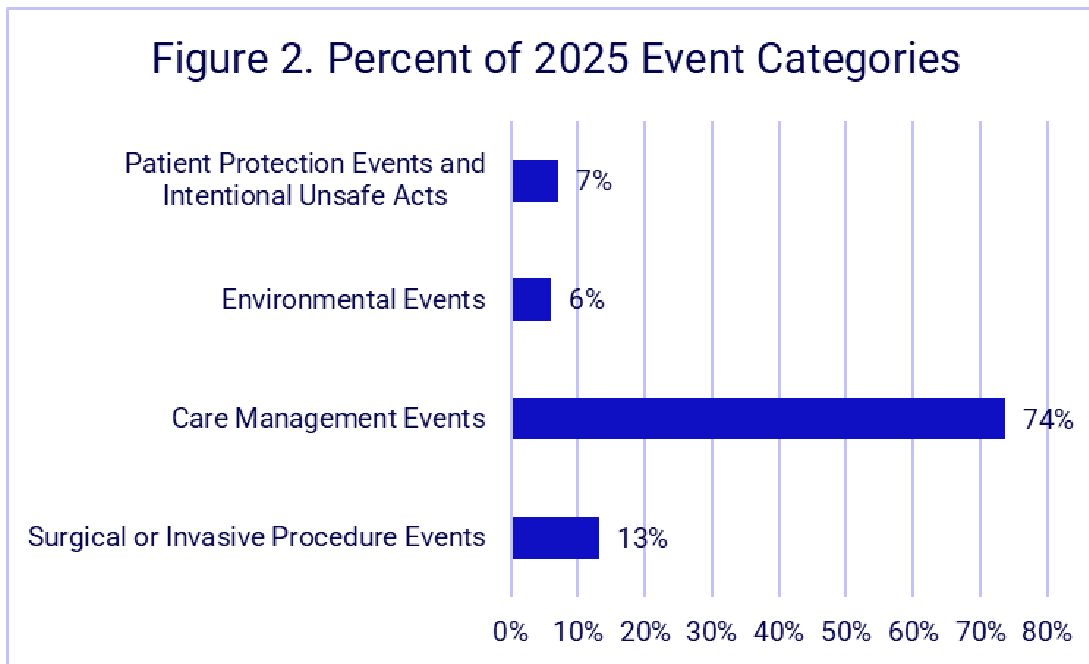

Figure 2 shows the percentage of events by category across all 99 events reported in 2025. Categories with fewer than six reports have been combined for confidentiality.

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 Specific Categories (incomplete list)

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

Surgical
- Wrong procedure
- Retention of foreign object
- Wrong site

Environmental
- Oxygen not available to patient when ordered

Criminal
- Physical Assault (with serious injury or death)

Care Management
- Fall (with serious injury or death)
- Pressure Injury (advanced stage)
- Medication error (with serious injury or death)
- Death or serious injury during labor or delivery

Event Types

Detailed subcategories of events offer greater specificity about the nature of patient safety incidents, enabling more focused prevention strategies.

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

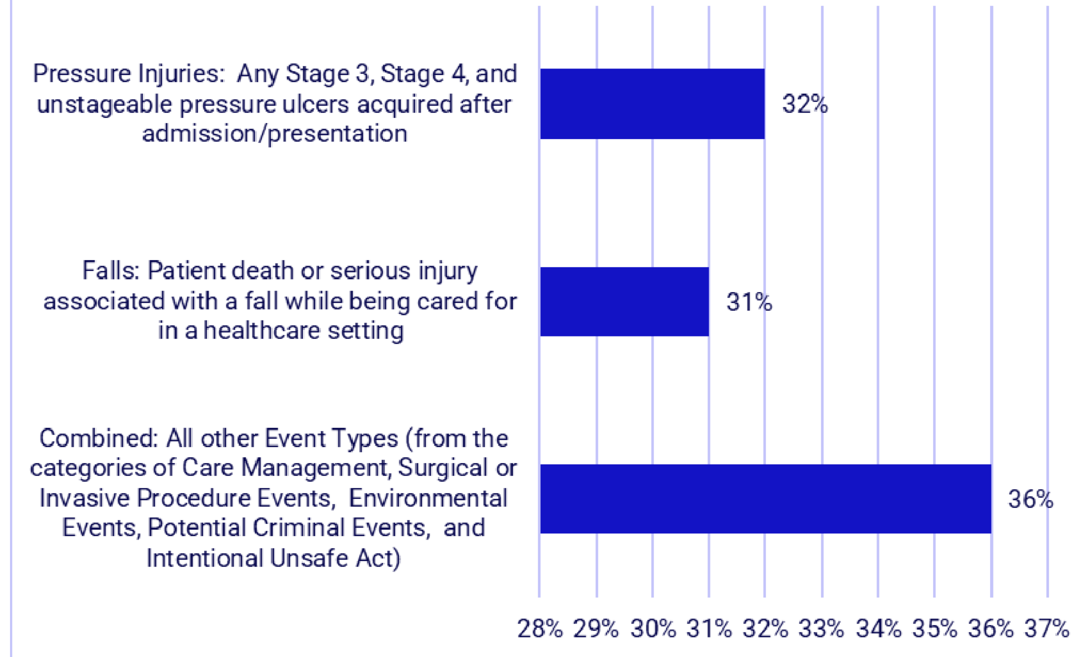

Figure 3 shows the breakdown of specific event types across all 99 events reported in 2025. Falls and pressure injuries collectively represent 63% of all events reported and continue to represent the highest frequency of reported events over the past five years. 2025 demonstrates, however, a lower percentage of pressure injuries from previous year's report. The reduction in pressure injuries reported over the previous year may be an indication that clinical teams are intervening before progression of injury occurs and are enacting more effective injury prevention standards based on learnings from prior years. More injuries are being reported with factors including environmental events in 2025. This may be due to a heightened acuity of patients requiring more oxygen interventions at various levels of care. Multiple systems need to be in place to ensure that portable oxygen is available. Categories with fewer than six reports have been combined for confidentiality.

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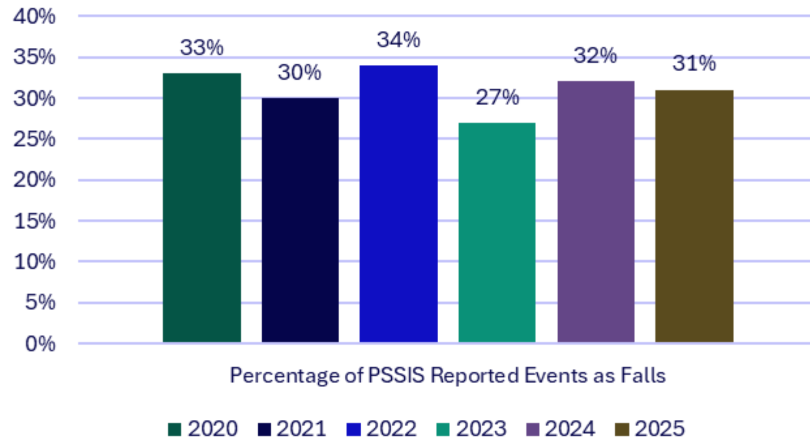
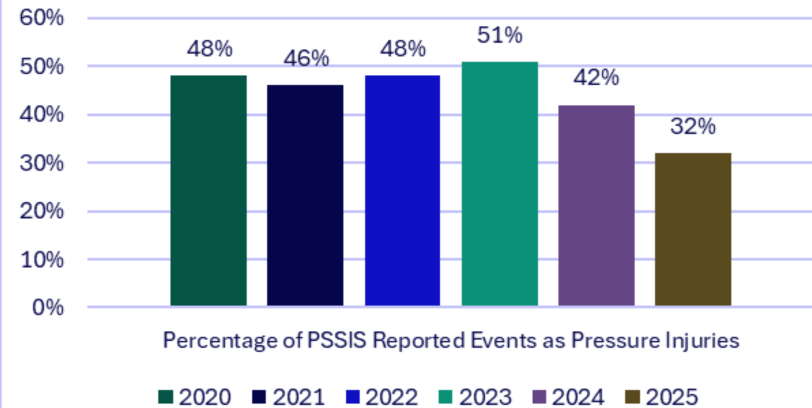
Focused Review: Falls and Pressure Injuries

Falls and pressure injuries continue to account for the highest volume of reported incidents and are associated with extended hospital stays, additional treatment, and, in some cases, surgery. These risks are closely monitored throughout hospitalization and increase with longer inpatient stays.



58% of falls occurred within 0-5 days of the admission/ encounter date.



Patients with a reported pressure injury had been admitted for an average of 33 days when the injury was identified.

Figure 4 and **Figure 5** show five-year trends of the percentage of PSSIS-reported events that are falls and pressure injuries. In 2025, these two event types collectively represent 63% of all reported events.

Figure 4: Of note, falls predominantly occur earlier in a hospital stay. Patients and care partners can effectively help healthcare workers prevent these injuries early on in a hospital stay by collaborating on patient mobility, limitations, and patient needs. The unfamiliarity with the hospital environment puts someone at much higher risk for confusion and falling.

Figure 5: The average length of stay prior to the onset of a pressure injury has increased from 22 days to 33 days which is indicative of better prevention and surveillance being adopted.

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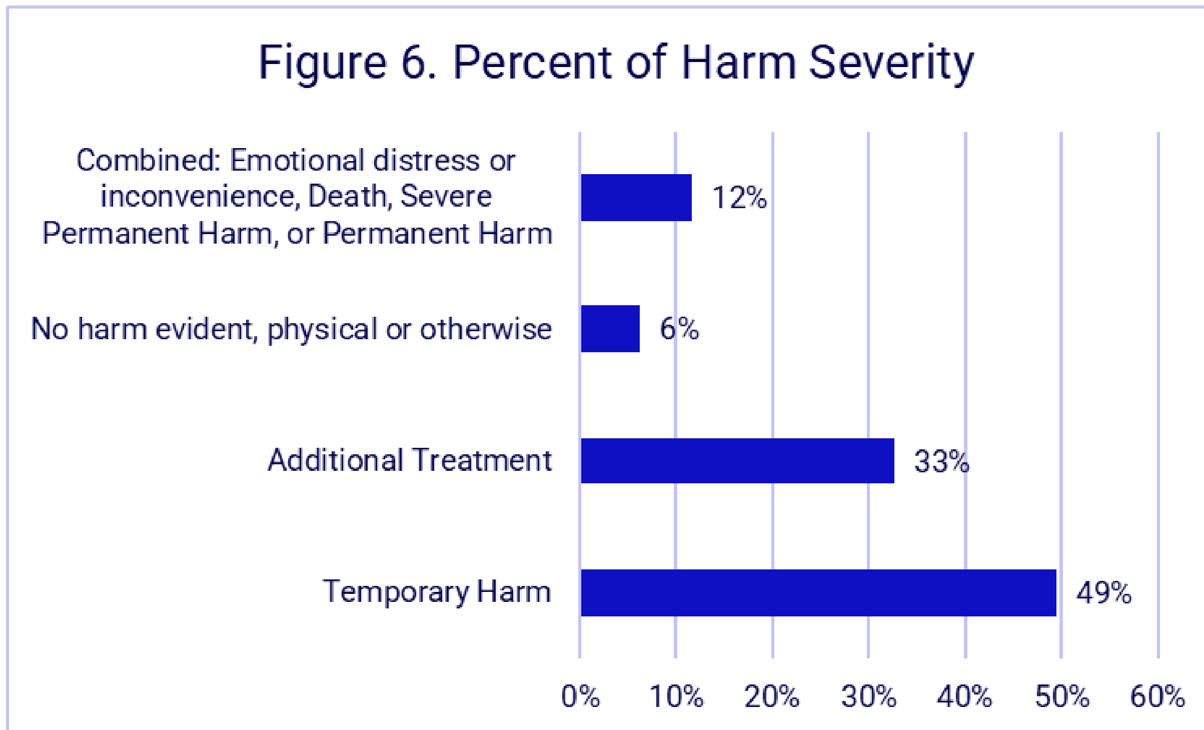

Figure 6 shows the distribution of event harm severity in 2025. Across the combined harm categories, 7% of PSSIS-reported events resulted in the most severe outcomes: permanent harm, severe permanent harm, or death. Categories with fewer than six reports have been combined to protect confidentiality.

Severity of Events

(Level of Harm)

Measuring the degree of harm caused by patient safety incidents helps prioritize improvement efforts on preventing the most serious outcomes. This classification allows healthcare providers to focus resources on reducing incidents with the greatest impact on patient wellbeing.

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

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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.

Event locations may vary by hospital from year to year, and insights across hospitals can be integrated into strategies to reduce patient harm statewide.

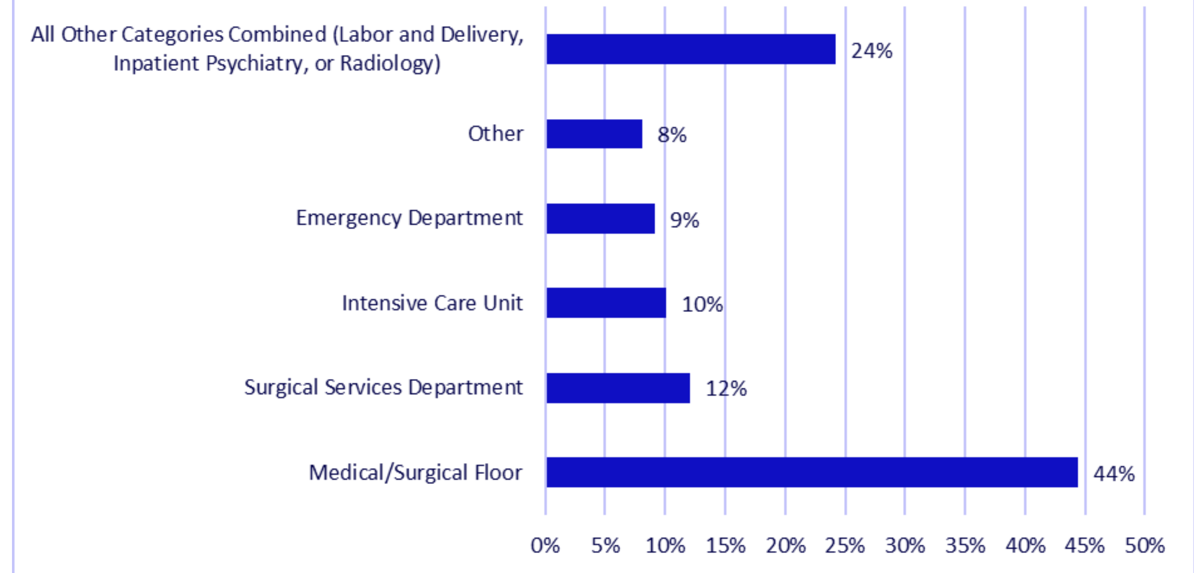

Figure 7: The majority of 2025 events occurred in medical-surgical floor (44%), followed by other areas (24%), and surgical services departments (12%). Categories with fewer than six reports have been combined for confidentiality.

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

Surgical Services Department:

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

Medical/Surgical Floor:

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

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Patient Demographics

Collecting demographic data helps identify potential disparities in patient safety incidents. Noted is the highest incidence of reported events for populations over 60 (55%) with particular notice in patients over 70 years of age (42%). Understanding these factors is essential for ensuring equitable care and designing interventions that address diverse patient needs. This represents the second full year that Vermont's PSSIS has collected demographic data.

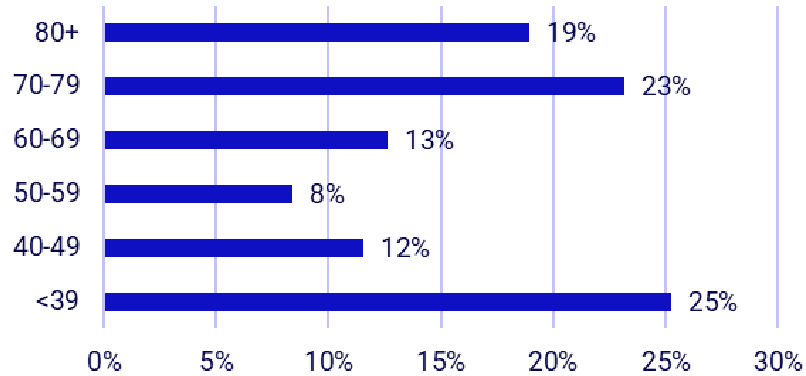

Figure 8 illustrates the distribution of patient age groups for reported events.

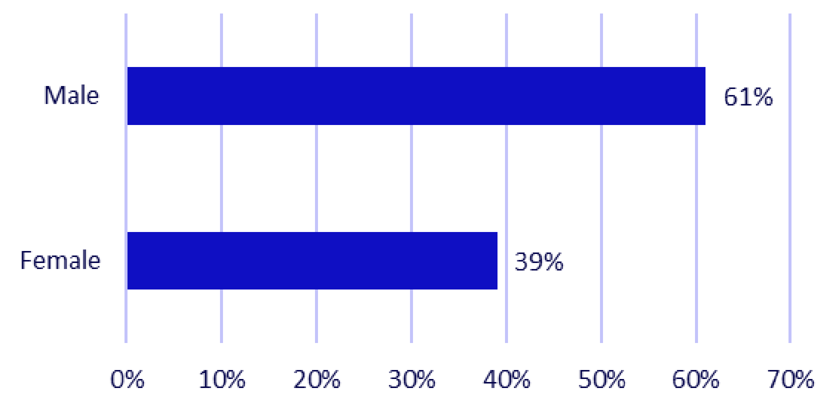

Figure 9 illustrates the distribution of patient sex at birth for reported events.

Analysis of reported events found a higher incidence of events for male patients in 2025 (of those males, 42% were ages 70 years or older). Of the 99 total cases reported, one-quarter of the 25% of reported events < 39 years of age included neonates and children. This highlights the need for continued attention to patient safety across age groups, including older adults and younger populations.

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

For disability status – defined as receiving Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) – 82% of reports fell into the 'Unable to determine/Unknown' category. This is due to this information not being accessible to the teams that are exploring the events and performing the root cause analysis because access to billing or disability status information is not housed in the same place of a patient chart.

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Factors Contributing to Events

Understanding patient safety incidents is key to prevention. The field of patient safety distinguishes between two types of errors: **active errors**, which typically involve frontline workers and happen at the moment they interact with a part of the larger system (such as the medical record or a medical device), and **latent errors**, which are hidden problems in the system – like environmental design or policies – that make active errors more likely to cause harm (Agency for Healthcare Research and Quality, 2019/2024).

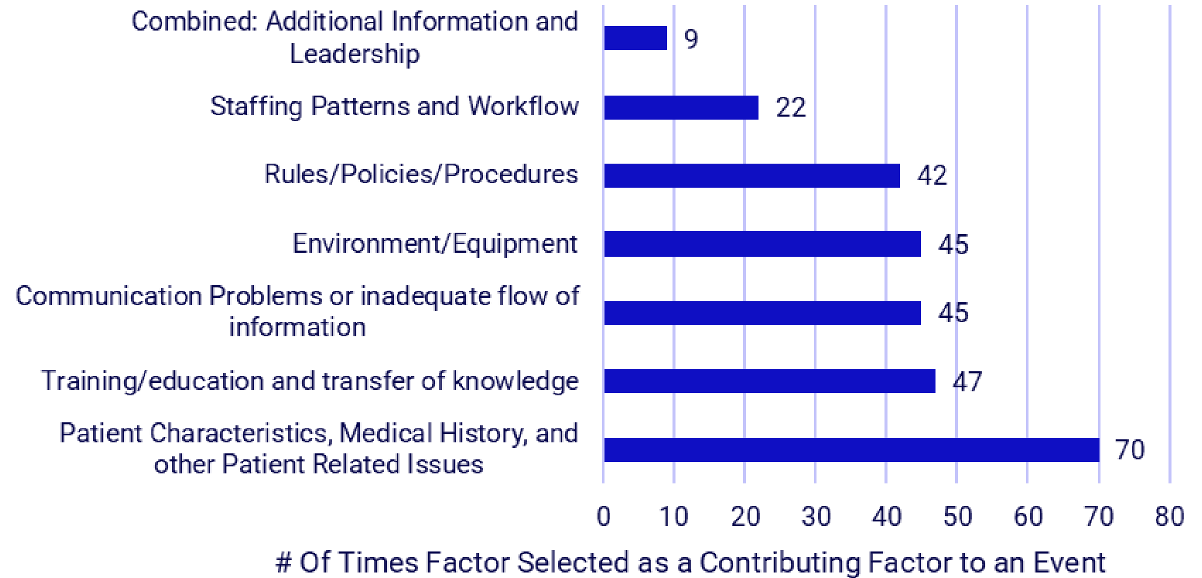

Figure 10 shows the distribution of factors identified as contributing to a Serious Reportable Event. Multiple factors may be selected for a single event. “Patient-related factors” were most frequently identified; these include medical status, functional status, cognitive status, and overall condition. While these factors contribute to events, they may not be readily modifiable and should be considered when designing strategies to address patient needs.

Analyzing system interactions and their contributions to events such as communication, processes, and policies help organizations identify causes and implement targeted prevention measures. Ensuring safety goes beyond individual performance, as human error is inevitable. Healthcare systems can include “forcing functions” - built-in safeguards that require the correct steps before care proceeds - to prevent errors and improve patient safety.

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Strategic Priorities for 2025

National Quality Forum Serious Reportable Events Update

The National Quality Forum (NQF) has revised the Serious Reportable Events list, which has remained unchanged since 2011. VPQHC will draft a summary document for ease of use for affected facilities, host an educational webinar and guide new submission forms and processes to optimize the transition from the 2011 guidance to the 2025 guidance by July 2026.

This will alter the next annual report, as the new SRE definitions take effect mid-year. The goals of the updated events from NQF are to simplify inclusion criteria and focus on patient physical and emotional harm. Work will continue to maintain Vermont's statute to be consistent with national standards and facilitate meaningful work through data analysis and reporting.

Cross-Institutional Learning Collaborative

VPQHC will incorporate patient safety learning into the Quality Directors Network quarterly meeting that facilitates systematic knowledge sharing. The aging population in Vermont, with 1 in 4 residents > 60 years old and the principal population with SREs (55%), dictates great opportunity moving forward to address the specific gaps that exist for this vulnerable population. Exploring age friendly care, mobility and consistent assessment tools as strategies for fall and pressure injury prevention will be presented and discussed as potential preventative approaches.

The healthcare environment at state and federal levels is supporting the work of moving from compliance and reporting towards measurable harm reduction by emphasizing quality indicators. VPQHC will bring attention to the healthcare entities for action and will highlight these themes throughout all planned educational events with opportunities to learn from one another and grow as a state in our systems of patient safety

Leadership Transition Support

Develop an onboarding program for new Quality Department and Patient Safety 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 submitted to the Vermont Patient Safety Surveillance and Improvement System (18 V.S.A Chapter 43A) from January 1, 2025, to December 31, 2025.
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.

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