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The Patient Safety Organization Program: Key Barriers Impeding Nationwide Progress Toward Reducing Patient Harm in Hospitals

Why OIG Did This Review

Despite nationwide efforts to improve patient safety, patient harm events in hospitals remain a serious concern. Over nearly 20 years, OIG has identified persistently high patient harm rates nationwide in hospitals, nursing homes, and other health care settings.¹ The Patient Safety Organization (PSO) program is overseen by [AHRQ](#) and was the key provision of the Patient Safety and Quality Improvement Act of 2005 to improve patient safety on a national scale.

What OIG Found

The PSO program has fallen short in facilitating patient safety learning and improvement on a national scale. Although PSOs have helped some hospitals and health systems improve, OIG identified key challenges that hold the program back from achieving the progress envisioned in the Patient Safety and Quality Improvement Act of 2005.



Limited Alignment with Other Patient Safety Efforts: The PSO program could be better aligned with other efforts to improve patient safety, including research. Patient harm definitions vary widely, making it difficult to aggregate events and to analyze nationwide trends.



Uncertainty About Legal Protections for Hospitals That Work with PSOs: Continued uncertainty around legal protections (e.g., confidentiality) for patient safety data makes some hospitals reluctant to share these data for national learning and improvement.



Lack of Patient and Family Involvement: Under the PSO program, PSOs and hospitals have not meaningfully worked with patients and families, who can be valuable partners in patient safety.



Missed Opportunities to Leverage Newer Technologies: The PSO program has not fully harnessed newer technologies, such as artificial intelligence that could help overcome barriers that impede the effectiveness of the PSO program's Network of Patient Safety Databases (NPSD).

What OIG Recommends

1. Increase alignment of the PSO program with other HHS patient safety efforts
2. Promote opportunities to involve patients and families in PSO activities
3. Clarify cybersecurity protections and data use limitations for patient safety work product submitted to the NPSD
4. Take steps to harness technologies and new data sources that could help address barriers facing the NPSD

AHRQ concurred with all four of our recommendations.