



P A T I E N T
S A F E T Y
A U T H O R I T Y

Who We Are

The Pennsylvania Patient Safety Authority, a national John Eisenberg Award winner for patient safety, is an independent state agency charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety.

By law, all Pennsylvania hospitals, ambulatory surgery centers, birthing centers and certain abortion facilities must report all adverse events and near misses to the Patient Safety Authority. Pennsylvania nursing homes must also report healthcare-associated infections to the Authority.

The Authority developed the Pennsylvania Patient Safety Reporting System (PA-PSRS), a secure web-based system to collect these reports. In turn, the Authority staff analyzes the reports and makes recommendations about steps providers can take to prevent similar events from happening in the future.

Statewide mandatory reporting was initiated in June 2004, making Pennsylvania the first and only state in the nation to require the reporting of both adverse events and near misses. All information submitted through PA-PSRS is confidential and non-discoverable, and the reports do not contain any patient or provider names. On average, healthcare facilities in Pennsylvania submit about 5,200 reports each week.

The Authority's mission is to help healthcare workers learn from past experiences. The Pennsylvania Patient Safety Advisory is one communication vehicle the Authority uses to inform facilities about what is in their data so they can learn from the events and prevent them from happening again. The Advisory is a quarterly journal containing

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articles about actual events that took place in Pennsylvania health-care facilities. Each article also provides valuable clinical guidance about measures facilities can adopt to improve patient safety. Educational resources such as PowerPoint presentations, videos, posters and resource guides are also available based on Advisory articles for facilities to help educate staff. Consumer tips are also made available for patients so they can help prevent a medical error from occurring to them or a loved one.

Several real-life case studies based on Authority reports are highlighted throughout this pamphlet. They demonstrate, while errors sometimes happen, the best way to promote patient safety is to learn from near misses and past mistakes so we can avoid a recurrence.

More information about the Authority's goals and programs are also highlighted to inform healthcare providers and their patients about what the Authority is doing to help improve patient safety in Pennsylvania.

Analyzing, Educating and Collaborating for Patient Safety

The Pennsylvania Patient Safety Authority has enjoyed many successes in its first few years of operation. Articles in the Patient Safety Advisory have had an impact on procedures of the reporting facilities. The Authority has earned the respect of the reporting facilities and is seen as an educational resource on patient safety. In recognition of its efforts, the Authority received the 2006 John M. Eisenberg award for patient safety and quality. The Eisenberg Award, presented jointly by the National Quality Forum (NQF) and the Joint Commission, recognizes major achievements of individuals and organizations in improving patient safety and quality.

During its first few years, the Authority focused on the development and implementation of the PA-PSRS data collection system and the analysis and guidance provided through the Patient Safety Advisory. The Authority has begun to build on these successes to have a greater impact on patient safety in Pennsylvania. Input was solicited from primary stakeholders and national patient safety experts for the Authority's next steps in building a comprehensive plan to help Pennsylvania's healthcare community improve patient safety in their facilities. Highlights of the plan are featured in this pamphlet with education, training, collaboration and communication featured prominently in the initiatives. For a detailed look at the entire plan, please go to www.patientsafetyauthority.org.

CASE STUDY 1...

Doing the "Right" Things to Correct Wrong-Site Surgery

Problem: Wrong-site surgery data submitted to the Authority shows that every other day in Pennsylvania healthcare facilities, an event causes harm to a patient or nearly causes harm. Further analysis of select hospitals with either high or low incidence of wrong-site surgery shows considerable variation in how protocols are implemented to prevent wrong-site surgery.

Prevention Advice for Healthcare Facilities: There are numerous educational resources healthcare facilities can use for wrong-site surgery prevention protocols. In 2003, the Joint Commission held a summit and its Board of Commissioners adopted a universal protocol for preventing wrong-site, wrong procedure and wrong person surgery. However there is considerable variation among facilities as to how they implement those protocols. The Authority provides several educational tools to help facilities implement protocols to prevent wrong-site surgery.

For more details and information regarding wrong-site surgery go to the complete 2007 June Patient Safety Advisory article "Doing the 'Right' Things to Correct Wrong-Site Surgery." For subsequent update articles, type "wrong-site surgery advisory articles" in the search bar on the Authority's website. For the wrong-site surgery educational toolkit go to the Authority's website and click on "Educational Tools."

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CASE STUDY 2...

Use of Color-Coded Patient Wristbands Creates Unnecessary Risk

Problem: A hospital in Pennsylvania submitted a report describing an event in which healthcare workers nearly failed to rescue a patient who had a heart attack because the patient had been incorrectly designated as DNR (do not resuscitate). A nurse had incorrectly placed a yellow wristband on the patient. In this hospital, the color yellow meant that the patient should not be resuscitated if he had a heart attack or quit breathing. In a nearby hospital, where this nurse also worked, a yellow wristband meant restricted extremity, or do not take blood out of this arm or use this arm for an IV.

Prevention Advice for Healthcare Facilities: Since the Advisory article was published, Pennsylvania facilities in the central and northeastern regions of the state formed the “Color of Patient Safety Task Force” and standardized the colors for color-coded wristbands. The Authority, the Hospital and Health System Association of Pennsylvania (HAP), members of the state legislature and the task force recommended Pennsylvania healthcare facilities to adopt the standard colors presented in the “Colors of Patient Safety” manual. The manual is available on the Authority’s website with protocols and information to help facilities standardize their color-coded wristbands and improve patient safety. This one near miss garnered national attention and prompted several other states to adopt the standardized colors and utilize the task force manual.

For the complete Advisory articles on color-coded wristbands go to the 2005 December and 2006 August supplementary issues of the Patient Safety Advisory.


Educate Executive Management and Boards of Trustees

Patient safety begins from the top, the Authority has collaborated with the Hospital and Health System Association of Pennsylvania (HAP) to educate executive management and boards of trustees in Pennsylvania’s hospitals. It is important for the top leaders of the healthcare facilities reporting the data to understand why the data is reported and what they can use from the data to improve patient safety and ultimately reduce costs. The Authority has sponsored four pilot patient safety training sessions. Once the pilot sessions are evaluated, more sessions will be developed statewide.

Infection Awareness and Reduction

Through Pennsylvania law, the Authority has collaborated with the Governor’s Office of Healthcare Reform, the Pennsylvania Department of Health, the Pennsylvania Healthcare Cost Containment Council and the Centers for Disease Control and Prevention (CDC) to collect healthcare-associated infection data and reduce infections in Pennsylvania’s healthcare facilities and nursing homes. The Authority convened a Healthcare-Associated Infection Advisory Panel representing Pennsylvania’s top leaders in infection control. The panel has been instrumental in helping guide the infection reporting process for hospitals and nursing homes.

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The Patient Safety Authority of the Commonwealth has, since its inception, labored to create a learning community across the state which embraces all those who directly or indirectly affect care at our patient's bedside. Abington Memorial Hospital was most fortunate to have visionary and engaged trustees who believed in and supported our patient safety work and with whom we transparently share our outcomes. The Patient Safety Authority's Advisories such as that on Wrong-site surgery have enlightened all of us from boardroom to bedside. Healthcare is fundamentally a human enterprise and human beings will always make mistakes. Our goal is to eliminate harm and we are pleased to regard the PSA as our partner as we seek to eliminate medically-related harm in the Commonwealth.

*John J. Kelly, MD, FACP
Chief of Staff
Abington Memorial Hospital*

Patient Safety Knowledge Exchange (PassKey)

The Authority's mission is to educate healthcare facilities by providing them with information learned upon analysis of the events happening in their own institutions. Along those lines, the Authority will develop the Patient Safety Knowledge Exchange providing an electronic confidential forum to allow sharing of information, ideas and solutions within the facility patient safety community. Patient Safety Officers throughout Pennsylvania

will be able to communicate with each other openly about what has improved patient safety in their facilities.

The Patient Safety Liaison Program (Extended Presence)

Led by the Director of Educational Programs, the Patient Safety Liaison program ensures hospitals, ambulatory surgery facilities, birthing centers and certain abortion facilities receive direct contact with

Case Study 3...

Fall Prevention Programs Should Include Medication Review

Problem: People who are more at risk for falls may be on medications which may also increase their likelihood of falling. The Authority data shows in 2006, more than 4,000 patients who experienced falls were also taking two or more medications increasing the risk of falls. The total of reported falls in 2006 was 33,882. While 70 percent of the total number of falls reported no injuries to patients, the potential is there for harm.

Prevention Advice for Healthcare Facilities: Risk reduction strategies include recognizing the problem and involving physician, nursing and pharmacy staff in developing fall prevention programs that include medication assessment and reassessment strategies. Reviewing all fall prevention strategies, including medications, and assessment and reassessment is necessary, before and after, a patient falls so realistic and appropriate changes can be made to help minimize the risk of future falls.

For the complete Advisory article "Medication Assessment: One Determinant of Falls Risk" go to the 2008 March Patient Safety Advisory.

the Patient Safety Authority and its wealth of educational resources. In a focus group, Patient Safety Officers requested more of a presence from the Authority. The regional Patient Safety Liaison program will allow facilities the opportunity to discuss patient safety issues with someone who can, in turn, provide the educational resources needed to improve patient safety in their facilities.

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Case Study 4...

Care at Discharge - Incomplete Discharge Processes May Cause Harm to Patients

Problem: According to Authority data, during discharge from hospitals some patients are not given the proper instructions for taking care of themselves at home, which can result in patient harm. Studies show a lack of communication at the time of discharge from a hospital has caused harm to patients. More than 800 reports submitted through PA-PSRS identified a variety of problems occurring at discharge. In about 30 percent of these reports, the patients did not receive verbal or written discharge instructions before leaving the hospital.

Prevention Advice for Healthcare Facilities: Planning and providing for a successful patient discharge from the hospital to the home or to another healthcare facility is a complex process that begins when the patient is admitted to the hospital and ends when the patient receives and understands all the information and services needed to recover or maintain their health after being hospitalized. The Authority provides risk reduction strategies that include a standardized comprehensive approach to discharge planning which may reduce harm to patients and improve quality of care after hospitalization.

For all of the risk reduction strategies, a sample checklist and consumer tips go to the complete 2008 June Advisory article "Care at Discharge – A Critical Juncture for Transition to Posthospital Care."

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Case Study 5...

Data Shows Verbal Orders Are Often Misunderstood

Problem: Patients are at greater risk of medication errors when drugs are ordered verbally or over the telephone, than when orders are written or sent electronically. Interpreting speech is more difficult than writing because of various accents, dialects and pronunciations. In addition, background noise, interruptions and unfamiliar drug names and terminology can make the problem worse. Once received, a verbal order must be written down, which adds to the risk of making a mistake. The person taking the order must rely on memory for an accurate record of the order.

- **Example #1:** A misunderstood verbal order led to a patient's receiving "erythromycin" instead of "azithromycin."
- **Example #2:** A telephone order relayed to pharmacy by a nurse for "Viscerol" was clarified by pharmacy as "Vistaril."
- **Example #3:** A phone order mistaken for "Toradol 50 mg" was administered prior to the pharmacy review, when the intended dose was "Toradol 15 mg."
- **Example #4:** A patient told a doctor she regularly took "five 30 mg Phenobarbital" tablets at bedtime, and the doctor wrote "530 mg of Phenobarbital." When the pharmacist called to clarify, the physician corrected the order to read "150 mg of Phenobarbital."

Prevention Advice for Healthcare Facilities: Verbal orders should be avoided, but when they must be taken, the Authority advocates a read-back procedure in which the person receiving the order writes it down, reads it back, and gets confirmation that they understood the order correctly. In addition, numbers like 15 should be spoken as "one-five," not "fifteen," to avoid confusing the number "15" with the number "50." Similarly, the number "50" should be spoken as "five-zero," not "fifty," to avoid confusing the number "50" with the number "15." Many reports submitted to the Authority include errors that could have been prevented if these procedures were followed.

For the complete article and an educational toolkit about verbal orders, go to the 2006 June Patient Safety Advisory article entitled "Improving the Safety of Telephone or Verbal Orders."

I, as Patient Safety Officer, for Clearfield Hospital, applaud the efforts of the Patient Safety Authority. The transparency of sharing of Incidents has provided an excellent avenue for institutions to improve their processes.

We are grateful to the Authority for regularly providing us with Patient Safety Advisories. We have used that information to improve the care to our patients, such as our assessment of sleep apnea, improved administration of transdermal medications, and the safe use of Phenergan, as several examples.

Your articles are shared with hospital staff and have heightened awareness of MRI hazards and drug labeling, just two more examples of Advisory utilization.

We encourage you to continue your exemplary efforts to improve patient safety.

*James P. Davidson, MD
Patient Safety Officer
Clearfield Hospital*

Collaborations and Educational Conferences (Patient Safety Methods Training)

The Patient Safety Authority collaborates with state and national healthcare organizations by sharing the information contained in nearly one million reports of Serious Events and Incidents submitted by Pennsylvania's healthcare facilities. The partnerships have covered numerous topics including patient falls, wrong-site surgery, pressure ulcers, high-alert medications, central line infections and ventilator-associated pneumonia (VAP). The Authority will continue to work with other healthcare and state organizations to educate healthcare providers through regional conferences covering topics such as disclosure, the philosophy behind reporting adverse events and near misses, and root cause analysis and failure mode and effects analysis (FMEA) training.

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Case Study 6...

Hand Hygiene Practices and the Use of Alcohol-Based Sanitizers

Problem: Proper hand hygiene, either through a thorough hand washing with soap and water for at least 15 seconds or the application of 3 to 5 ml of an alcohol-based antiseptic solution, has been reported as the most significant method to reduce healthcare-associated infections (HAIs). The Centers for Disease Control and Prevention (CDC) estimates about 90,000 patients die each year as a result of an HAI. Reports submitted to the Authority show healthcare providers do not follow the proper procedures prior to caring for a patient to prevent infections. Many entered patient rooms, gave care, and left without washing their hands. This included patients who are in contact isolation. For the most part today, the rate of hand hygiene compliance remains at less than 50 percent.

Prevention Advice for Healthcare Facilities: System failures encourage poor compliance by healthcare workers. Healthcare facilities need to design user-friendly, easily accessible, and simple but effective hand hygiene systems. Well-designed systems combined with other important factors (such as buy-in from the top down) will ultimately lead to motivation resulting in individuals taking responsibility for compliance.

For more guidelines and information on proper hand hygiene protocols go to the 2008 September Advisory article "Hand Hygiene Practices and the Use of Alcohol-Based Sanitizers."

Consumer Tips

Although the primary work of the Authority is focused specifically on healthcare facilities, it is obvious patients are the center of all patient safety activities. The Authority is committed to providing consumers of the healthcare industry with information they can use to ensure they receive quality care as a patient. The Authority offers consumer tip sheets containing valuable medical information that is easy to understand. Topics include but are not limited to: medication errors, wrong-site surgery, falls, healthcare-associated infections and the risks associated with color-coded wristbands. These tips and other consumer brochures are based upon the data received by the Authority from Pennsylvania healthcare facilities. The Authority data also shows patients have prevented medical errors by speaking up and participating in their healthcare.

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Case Study 7...

Updating Pressure Ulcer Stages, Reporting and Risk Reduction Strategies

Problem: Reports as of December 2007 show facilities continue to leave out essential information in regard to staging pressure ulcers. Nearly 13 percent of all pressure ulcers were categorized as stage III or IV; more than 26 percent of total reports did not include the pressure ulcer staging information. In 2007, the National Pressure Ulcer Advisory Panel (NPUAP) updated pressure ulcer staging, adding two stages to create a total of six pressure ulcer stages. The goal of this revision was to increase the number of correctly staged pressure ulcers. In October 2008, facility reimbursement changes by the Center for Medicare & Medicaid Services for Stage III or IV pressure ulcer now require admission diagnosis and documentation.

Prevention Advice for Healthcare Facilities: The Authority has updated its reporting system to include the Suspected Deep Tissue Injury and Unstageable Stages to help facilities more accurately diagnose and document pressure ulcers. Risk reduction strategies provided by NPUAP include protocols facilities should consider when developing or updating pressure ulcer protocols, documentation and communication systems. Strategies include: assessment upon admission and regular reassessment, positioning patients, monitoring caloric intake, protecting patient's skin from excessive moisture and educating healthcare providers about admission pressure ulcer assessments, protocols, documentation and communication systems.

For more detailed information about the pressure ulcer risk reduction strategies go to the 2008 December Patient Safety Advisory article "Pressure Ulcers: New Staging, Reporting and Risk Reduction Strategies" and the 2006 September Patient Safety Advisory article "Pressure Ulcers: A Look at Reports to PA-PSRS."





Speakers Bureau and Consumer Awareness Opportunities

For healthcare facilities and organizations, community and consumer groups, the Authority offers a speakers bureau. When appropriate a representative of the Patient Safety Authority will come speak about the current healthcare issues facing healthcare providers and consumers based upon data submitted to the Authority and national trends. The Authority can tailor the information based upon the needs of your organization. The Authority also attends healthcare fairs and other healthcare related events with an informational booth at your request. Please call the Authority at 717-346-0469 for more information about its speakers bureau and informational booth.

Case Study 8...

When Patients Speak – Collaboration in Patient Safety

Problem: A nurse was providing education to a patient and a spouse before cleaning a PICC line, which is similar to an IV. When the nurse mentioned she was going to use the drug Heparin to clear the line, the patient's spouse spoke up and said the patient was allergic to Heparin. The nurse reviewed the chart and did not find any reference to a Heparin allergy. It turns out the allergy had been written on the patient's transfer record but had not been copied onto the chart. Fortunately, this potential error was caught before there was any harm, new care orders were written noting the Heparin allergy and requiring an alternative cleaning agent, in this case saline.

Prevention Advice to Healthcare Facilities: Among other tips, providers are encouraged to listen and improve communication with their patients. The key to creating effective provider-patient relationships is communication. Improving communication skills of healthcare providers to encourage patient sharing of information improves the accuracy and quality of the information received, thus reducing the potential for medical error, missed diagnosis and forgotten patient history information. In addition, clinicians who learn communication and information-sharing skills are better prepared to interact with empowered patients.

For more information and real-life case studies of patients preventing medical errors by speaking up go to the 2005 March Patient Safety Advisory article "When Patients Speak—Collaboration in Patient Safety."

Among other tips, providers are encouraged to listen and improve communication with their patients. The key to creating effective provider-patient relationships is communication.



New Website and Design

The Authority launched a new website and design featuring an enhanced search engine with improved navigation and features allowing users to share patient safety information more easily. A vast collection of educational tools and resources are available to healthcare providers. Features also allow them to browse by topic and discipline hundreds of Patient Safety Advisory articles.

Consumers also can find valuable patient safety information at www.patientsafetyauthority.org

The Authority has been a tremendous help to me personally as a Patient Safety Officer, providing valuable resources to assist me in educating my staff about the root causes of patient safety events and the proven efforts to prevent them. What a plus to have the Authority here in PA! Our institution has access to, not only its written resources (i.e., the Advisory), but also access to its local Board Chair, Dr. Ana McKee, who has visited our institution and spoken to our board. This valuable experience allowed our board members to hear first hand about the Authority and to receive confirmation that they are on the right track. In the oncology setting, infection control and prevention has always been a priority at Fox Chase Cancer Center. Now with the increase in attention given to this topic on the national, regional, and local levels, efforts to build the business case for any initiatives for reducing and eliminating infections in healthcare facilities are strengthened. Partnering with the Authority to gain access to local benchmarks through the CDC's NHSN program will hopefully prove to be beneficial.

*Delinda Pendleton
Director Quality/Risk Management & Infection
Hospital of Fox Chase Cancer Center*

Patient Safety Authority

Board of Directors

Ana Pujols-McKee, MD, Board Chair

Chief Medical Officer and Associate Executive Director, Penn Presbyterian Medical Center

Residence: Philadelphia County (Appointed by the Governor to fill the position designated for a physician and named by the Governor to serve as board chair.)

Anita Fuhrman, RN, BS

Consultant/Accreditation Association for Ambulatory Health Care (AAAHC) Surveyor

Residence: Lebanon County (Appointed by the Governor to fill the position designated for a nurse)

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Director of Quality Management, LifeCare Hospitals of Pittsburgh

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Roosevelt Hairston, Esq.

Vice President for Government Affairs, Children's Hospital of Philadelphia

Residence: Chester County (Appointed by the Governor to fill the position designated for a hospital employee)

Terry Hyman, Esq.

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Residence: Cumberland County (Appointed of the Majority Leader of the House)

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Vice President, Independence Blue Cross

Residence: Philadelphia County (Appointed by the Governor to fill the position designated for a non-healthcare worker)

Gary A. Merica, PRh, MBA/HCM
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Residence: York County (Appointed by the Governor to fill the position designated for a pharmacist)

Cliff Rieders, Esq.

Rieders, Travis, Humphrey, Harris, Waters & Waffenschmidt

Residence: Lycoming County (Appointee of the Minority Leader of the Senate)

Stanton Smullens, MD

Chief Medical Officer, Jefferson Health System

Residence: Philadelphia County (Appointee of the Speaker of the House)

Marshall W. Webster, MD

President/CEO, University of Pittsburgh Physicians

Residence: Allegheny County (Appointee of the President pro tempore of the Senate)

NOTE: Job titles included for identification purposes only

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John Eisenberg Award Winner

The Pennsylvania Patient Safety Authority received the 2006 John M. Eisenberg Award for advancing patient safety and quality in the Commonwealth. Presented jointly by the Joint Commission and the National Quality Forum (NQF), the award recognizes the Authority's efforts to educate the healthcare community through data received through the Pennsylvania Patient Safety Reporting System (PA-PSRS) and published in the quarterly Patient Safety Advisory.