Pennsylvania has become a leader in patient safety excellence in large measure due to the vision and work of the Patient Safety Authority (the Authority), an independent state agency dedicated to reducing and eliminating medical errors through a variety of solutions. Michael C. Doering, Executive Director, discussed the programs and work of the Authority at a recent Health Policy Forum.

The Authority’s primary focus is to help healthcare workers learn from past experiences. It functions as a vehicle for communication, education, and problem-solving. One of its most significant initiatives was the implementation of statewide mandatory reporting in 2004. At the time, Pennsylvania was the first and only state in the US to require reporting of near misses, adverse events, and infrastructure failure. Reporting is required of hospitals, ambulatory surgical facilities, birthing centers, and certain abortion facilities. Starting in June 2009, nursing homes were also required to report Healthcare Associated Infections (HAIs) through the Authority’s Patient Safety Reporting System (PA-PSRS).

In 2008, almost 220,000 reports were submitted through PA-PSRS. Upon entry, reports are electronically triaged into a variety of categories and evaluated by patient safety analysts from many medical disciplines. While approximately 8,500 reports resulted in some degree of patient harm, over 96% of the reports describe patient safety events that either did not reach the patient or reached the patient, but caused no harm. The Authority believes every type of report is important as they all point to some type of systemic break down in the processes used to provide care.

The purpose of collecting this data is to effect change and educate. For example, one reported incident related to a misunderstood colored wristband. A patient was incorrectly considered to be DNR due to the misunderstanding. In this case, the error was noticed and there was no harm to the patient. However, the resulting near miss report pointed to a potentially devastating issue. The Authority wanted to capture and correct this problem, and conducted a wrist band survey through Pennsylvania’s facility Patient Safety Officers. They were able to identify the variety of colors used for different conditions at different institutions. This obviously creates major concerns as staff move around through different systems. As a result of reporting this error and conducting a survey, the Authority was able to identify a need for action. A group of Pennsylvania facilities took on the challenge and developed a set of standardized colors and attendant policies and procedures. These standards, or slight variations, are now being implemented to varying degrees in 30 states and in the Armed Services.

The Authority has many important educational initiatives. One program, in collaboration with the Hospital and Health System Association of Pennsylvania (HAP), seeks to modify an American Hospital Association program on patient safety education for executive management and hospital board members for use in Pennsylvania. In addition, the Authority has begun a program to assign regional patient safety liaisons to different facilities. The role of the patient safety liaison is to be a resource to facility patient safety officers, provide education, facilitate process and improvement sharing, and conduct regional improvement collaborations. The Authority also offers educational resources for providers and consumers; patient safety method training; and a speaker’s bureau.

In the future, the Authority plans to increase collaborative activities at the regional level and with other statewide patient safety-centric organizations. It is also developing the Patient Safety Knowledge Exchange (PasSKEy). PasSKEy is an online community where patient safety professionals can discuss issues, access a library of resources, and share ideas, successful processes and practices.

For more information about the Patient Safety Authority visit: www.patientsafetyauthority.org