Promoting Patient Safety Through Data Collection, Analysis and Guidance

Michael C. Doering
Executive Director, Patient Safety Authority

Hedy Cohen
Vice President, Institute of Safe Medication Practices

Pennsylvania Association of Nurse Anesthetists
Pittsburgh, PA

October 4, 2008
Patient Safety Authority Background

Act 13 (March 2002)

- 11-member Board appointed by the Governor and General Assembly
- Independent Agency
- Non-regulatory
- Dedicated Funding Stream
- Contract with outside entity to collect, analyze and evaluate reports of Serious Events and Incidents and identify trends
- Advise and issue recommendations for changes and improvements in healthcare practices (Advisories)
- Focused education, research and collaboratives
### PA - Reporting Components

<table>
<thead>
<tr>
<th>Who Reports</th>
<th>Types of Events</th>
<th>Other Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>Near-Misses (&quot;Incidents&quot;)</td>
<td>Mandatory</td>
</tr>
<tr>
<td>Ambulatory Surgical Facilities</td>
<td>Adverse Events (&quot;Serious Events&quot;)</td>
<td>No Individual Identifying Data</td>
</tr>
<tr>
<td>Birthing Centers</td>
<td>Infrastructure Failures</td>
<td>Confidentiality Provisions</td>
</tr>
<tr>
<td>Certain Abortion Facilities</td>
<td></td>
<td>Non-discloseable</td>
</tr>
<tr>
<td>Nursing Homes (Early 2009)</td>
<td></td>
<td>Whistleblower Protections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facility assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Written Patient Notification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anonymous Reports</td>
</tr>
</tbody>
</table>
## 2007 PA-PSRS Reports by Event Type and Serious Events

<table>
<thead>
<tr>
<th>Event Type</th>
<th>% PA-PSRS Reports</th>
<th># of PA-PSRS Reports</th>
<th>% Serious Events</th>
<th># of Serious Events</th>
<th>% Incidents</th>
<th># of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Errors</td>
<td>22%</td>
<td>47,492</td>
<td>4%</td>
<td>262</td>
<td>23%</td>
<td>47,230</td>
</tr>
<tr>
<td>Adverse Drug Reactions</td>
<td>2%</td>
<td>5,051</td>
<td>4%</td>
<td>258</td>
<td>2%</td>
<td>4,793</td>
</tr>
<tr>
<td>Equip./Supp/Devices</td>
<td>1%</td>
<td>3,160</td>
<td>1%</td>
<td>62</td>
<td>1%</td>
<td>3,098</td>
</tr>
<tr>
<td>Falls</td>
<td>17%</td>
<td>35,033</td>
<td>17%</td>
<td>1,240</td>
<td>17%</td>
<td>33,793</td>
</tr>
<tr>
<td>Errors of P/T/T</td>
<td>23%</td>
<td>49,057</td>
<td>8%</td>
<td>596</td>
<td>24%</td>
<td>48,461</td>
</tr>
<tr>
<td>Complications of P/T/T</td>
<td>16%</td>
<td>31,416</td>
<td>45%</td>
<td>3,283</td>
<td>14%</td>
<td>28,133</td>
</tr>
<tr>
<td>Transfusion</td>
<td>1%</td>
<td>2,310</td>
<td>0%</td>
<td>20</td>
<td>1%</td>
<td>2,290</td>
</tr>
<tr>
<td>Skin Integrity</td>
<td>11%</td>
<td>23,567</td>
<td>10%</td>
<td>750</td>
<td>11%</td>
<td>22,817</td>
</tr>
<tr>
<td>Other/Miscellaneous</td>
<td>7%</td>
<td>14,897</td>
<td>11%</td>
<td>806</td>
<td>7%</td>
<td>14,091</td>
</tr>
</tbody>
</table>
Reports Submitted by Hospitals per 1,000 Patient Days (2004*- 2007)

*PA-PSRS Began Collecting Reports June 28, 2004; these figures reflect the second half of 2004.
Serious Event and Incident Reports since 2004

Number of Serious Event and Incident Reports since Inception of PA-PSRS
Reports Submitted by Individual Hospitals Per 1,000 Patient Days (Highest to Lowest)
Patient Safety Authority Contract Partners

ECRI  
A NONPROFIT AGENCY

Institute for Safe Medication Practices

EDS
PA-PSRS: Clinical Analysis

Incoming Reports → Triage → Analytics

Program Outputs:
- PSA Annual Report
- Public Advisories and Recommendations
- Contact with Individual Facilities

Patient Safety Review Meeting
Data Output:

- Real time feedback to facilities
- Patient Safety Advisories
- Annual Report
- Integrated Facility – specific Analysis

Other Patient Safety Activities:

- Education and Training Programs
- Research
- Promotion of Culture of Safety
- Encourage Full and Open Disclosure
Where We Are

Safe Patient Experiences

- Over one half million reports reviewed
- Patient Safety Advisories
- RCA and new user training
- Special Projects

PA-PSRS
Where We Are Going

Safe Patient Experiences

- Education
  - FMEA
  - Healthcare acquired infection
  - Board of Trustees
  - Root cause analysis
  - Health care training grounds
  - Nursing homes

- Data Collection
  - Over one half million reports reviewed
  - Patient Safety Advisories
  - RCA and new user training
  - Special Projects

- Analysis

- Guidance

- Collaboration
  - PaSsKEy
  - Board of Trustees
  - Extended local presence
  - State Agencies
  - HAP, IHI, HCIF, others
Where We Are Going

Safe Patient Experiences

- Over one half million reports reviewed
- Patient Safety Advisories
- RCA and new user training
- Special Projects
- Recommendations
- Reporting consistency

Education
- FMEA
- Healthcare acquired infection
- Board of Trustees
- Root cause analysis
- Health care training grounds
- Nursing homes

PA-PSRS

Data Collection
Analysis
Guidance

Collaboration
- PaSsKEy
- Board of Trustees
- Extended local presence
- State Agencies
- HAP, IHI, HCIF, others
Strategic Plan Initiatives

- A: Educate Executive Management and Boards of Trustees
- B: Infection Awareness and Reduction
- C: Patient Safety Knowledge Exchange (PaSSkEy)
- D: Improve Reporting Consistency and Recommendations
- E: Increase Effectiveness through Extended Presence
- F: Governor’s Office of Healthcare Reform (GOHCR) Collaboration
- G: Data Collaboration
- H: Patient Safety Methods Training
- I: Nursing Home Data Analysis
- J: PA-PSRS System Enhancements
- K: Maintain Success of Patient Safety Advisory
PA Patient Safety Authority

www.psa.state.pa.us

c-mdoering@state.pa.us