WE CAN DO BETTER WHEN WE KNOW BETTER

What we've done with what we know so far

2,800

ESTIMATED LIVES SAVED

$160 Million

ESTIMATED DOLLARS SAVED

60,000

HEALTHCARE PROFESSIONALS EDUCATED

3 Million

TOTAL REPORTS ENTERED INTO PA-PSRS

Patient Safety Authority

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Why Reporting Matters

One person can ~~only~~ do so much.

THE POWER OF ONE

How one person in Pennsylvania sparked a national movement

Someone at a Pennsylvania hospital reported that staff nearly failed to rescue a patient who had a heart attack because the patient had been mistakenly designated as "DNR" (do not resuscitate).

The source of confusion was that a nurse had placed a yellow wristband on the patient, thinking that it signified "restricted extremity" (i.e., the arm should not be used for drawing blood or obtaining IV access), because that's what yellow wristbands indicated at another facility where she worked.

Fortunately, another clinician identified the mistake and rescued the patient. Even though no one was injured in this event, analysis revealed the need for a standardized system.

One PA hospital reported confusion over the color of a patient wrist band.

PA hospitals adopted a standardized system for color-coded wrist bands.

41 states and the US military have adopted the standardized colors.

The Patient Safety Authority is an independent state agency that was created to improve the quality of healthcare in Pennsylvania. Medical facilities across the commonwealth are required to report not just events that harm a patient, but also near misses and events that don't cause harm, which occur much more frequently.

The Authority analyzes those reports and provides facilities resources to minimize the risk of error and prevent harm from recurring.

While the Authority boasts the most robust reporting system in the nation, some research suggests only three percent of patient safety events are reported. Many are unaware of this discrepancy or its significance.

STRENGTH IN NUMBERS

How a broader perspective identifies wide-spread issues

A hospital may experience one or two newborn falls each year. However, reviewing the reports in aggregate indicates a more serious issue, which the Authority can bring to facilities' attention.

During a specialized eye surgery, a patient was injured when a piece of equipment became dislodged mid-procedure. The apparent cause was user error, but after reviewing reports from across the state, it emerged this instrument had a significant manufacturing defect that has since been corrected.

We provide **free** resources, consultation, and education for PA healthcare facilities.

Education
Receive on-site training or attend a webinar or regional event

Event Reporting
Understand the elements of Act 13 (MCARE Act)

Collaboration
Develop partnerships, learning opportunities, and strategies to prevent patient harm

Consultations
Discuss your facility needs, e.g., review current processes, analyze events

Peer-reviewed Journal
Read articles based on data from Pennsylvania healthcare facilities

Facility Visits
Discuss keystone projects, hot topics, and open questions

Funding for Patient Safety Authority resources is provided by PA healthcare facilities, as outlined in Pennsylvania Act 13 of 2002, the Medical Care Availability and Reduction of Error (MCARE) Act.