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Autism Spectrum Disorder (ASD) Reports Highlighted in Pennsylvania Patient Safety Advisory

The Pennsylvania Patient Safety Authority received 138 reports involving ASD patients with 13 resulting in harm to the patient

HARRISBURG: In 138 events reported to the Pennsylvania Patient Safety Authority involving patients with autism spectrum disorder (ASD), patient safety concerns were identified including injury to self, lack of cooperation with care and aggressive behavior or injury to others. Further analysis is provided in the 2014 December Pennsylvania Patient Safety Advisory released today.

The Authority received the ASD patient event reports from July 2004 through August 2014. Further analysis of event report narratives showed 12 patient safety concern themes, involving patients with ASD.

“Injury to self or potential injury to self was identified as the most frequently reported concern,” Michelle Feil, MSN, RN, CPPS, senior patient safety analyst from the Pennsylvania Patient Safety Authority said. “Interference or lack of cooperation with care followed with other concerns including aggressive behavior and /or injury to others, use of chemical or physical restraints, patient communication difficulties and/or consent issues.”

The majority of the events were reported for patients under the age of 20 (60.9%, n=84), with most of these events reported for patients under age 10 (n=52), Feil added.

“Although acute care and children’s hospitals reported the majority of events [82.6%], events have been reported for individuals with ASD at each facility type,” Feil said. “The majority of the events were reported as Incidents with no harm to the patient; however, 13 of the events were reported as Serious Events that resulted in harm to the patient.”

Of the 13 events reported to have harmed the patient, 10 were reported as resulting in temporary harm and three were reported as resulting in permanent harm, up to and including death, Feil said.
“Though the number of reports submitted to the Authority involving patients with ASD may be small, thirteen harmed the patient, which represents nine percent of the total number reported,” Feil said. “In comparison, only three percent of all events [246,606] reported to the Authority in 2013 harmed the patient.”

Feil added that the majority of the research for individuals with ASD has been focused on frequency of the disorder, potential causes of ASD, early identification strategies and interventions aimed at reducing associated symptoms, building adaptive skills and maximizing the quality of life for children with ASD.

“Two areas in need of further research, are improving care of the patient with ASD in the acute care environment and specifying the needs of adults with ASD in all care settings, Feil said. “In the absence of robust literature and clinical guidelines specific to the care of patients with ASD in the acute care setting, the Authority reached out to professionals and organizations with a vested interest in improving this care.”

Feil said some of the challenges highlighted in the conversations include: lack of knowledge by healthcare providers; time pressures associated with the fast-paced healthcare system; delays in care; communication with caregivers; communication with patients; and de-escalation techniques if a patient with ASD becomes anxious.

“Education for healthcare providers, particularly those who work in the emergency departments, is also needed,” Feil said. “There are groups within Pennsylvania who are experts in the field that can help facilities educate their employees.

“The Authority also provides risk reduction strategies suggested for healthcare facilities to improve the quality of care for patients with ASD and consumer tips for patients,” Feil added.

For more information about risk reduction strategies and educational resources for patients with ASD go to the December Pennsylvania Patient Safety Advisory article, “Improving the Care for Patients with Autism Spectrum Disorder in the Acute Care Setting,” at www.patientsafetyauthority.org.

The Authority’s 2014 December Advisory contains other clinical articles and toolkits for the healthcare provider to improve patient safety. Highlights of the 2014 December Advisory include:

- **Omission of High-Alert Medications: A Hidden Danger:** A drug omission occurs when a patient does not receive a medication that has been ordered or when a medication has not been ordered despite being appropriate for an underlying condition. Over 2,700 medication errors categorized as drug omissions involving more than 500 different medications were reported to the Authority from January 1, 2013 through April 30, 2013. This article will discuss the most common drugs omitted and provide risk reduction strategies.

- **Decision Tree Helps Standardize Reporting of Falls Event Types:** Falls event reporting through the Pennsylvania Patient Safety Reporting System (PA-PSRS) requires entry of a single falls event category selected from a list of 13 choices. To standardize and improve the reliability and validity of reporting the type of patient fall, a PA-PSRS falls event type decision tree was developed and released in 2012 in collaboration with the PA-PSRS falls
reporting program. This article will discuss the two-year analysis of hospital Serious Event falls reports submitted by hospitals enrolled in the PA-PSRS falls reporting program before and after release of the decision tree which showed a 5.7% increase in reports of toileting-related falls. An educational toolkit is available with this article.

- **A Systems and Behavioral Approach to Improve Hand Hygiene Practice:** Despite convincing evidence since the 1840s that improved hand hygiene reduces infection rates, studies show that healthcare worker compliance with hand hygiene is consistently suboptimal in many healthcare settings. Pennsylvania hospitals and nursing homes have reported a slow but steady decline in healthcare-associated infections (HAIs) through the National Healthcare Safety Network and PA-PSRS. Healthcare facilities may improve hand hygiene practice by applying a multimodal framework of system and behavioral strategies to investigate, understand and mitigate gaps in infrastructure and behavioral components of hand hygiene. An educational toolkit is available with this article.

- **Assessment Tools Help Diagnose Obstructive Sleep Apnea:** Obstructive sleep apnea (OSA) is a common sleep disorder that may first be diagnosed when a surgical patient presents for preadmission testing. Analysis of reports submitted to the Authority over five years identified 99 OSA-related events. Thirty-three reports were classified as Serious Events associated with patient harm. In September 2007 the Authority issued an *Advisory* with an OSA screening tool to use during preoperative evaluation. Since 2007, additional assessment tools, such as the STOP-Bang questionnaire, have become available to help facilities identify and manage patients at high risk for this condition. An educational toolkit is available with this article.

- **Wrong-Site Surgery Update:** There were eight event reports of wrong-site surgery in Pennsylvania operating rooms (ORs) during the third quarter of 2014 and two reports belatedly confirmed from a prior quarter. The eight reports matched those of the second-lowest quarter ever and were the lowest number of reports for the beginning of an academic year (July through September). This article will discuss the trends in the data that conclude that wrong-site errors due to incorrect information in the patient’s record or the incorrect patient’s record are possible with both paper and electronic records. An educational toolkit is available with this article.


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