Prometheus, a Titan in Greek mythology, was tasked by Zeus to craft humankind out of clay. Being mortal, man was not allowed to ascend Mount Olympus and enjoy its riches and splendor. Instead humans were forced to remain on earth, foraging for food and shivering in the cold, dark night. Fire was a luxury of the gods and deemed ill-suited for such savage creatures.

This infuriated Prometheus, who had become attached to his creations, and he vowed to steal for them this precious gift. One night, he snuck down to where they had gathered for the evening, and with a single spark, lit a fire. He taught man how to harness his gift for protection from beasts and to keep warm when the sun set.

Prometheus knew man’s life would change forever. People would no longer be at the complete mercy of their environment.

They could forge great cities, build ships to explore the seas, and tame the wilderness. Prometheus knew the power of a single spark.

Like Prometheus, we understand this power. We have created a learning system which provides the spark necessary to ignite the fires of improvement in Pennsylvania, across our country, and around the world. With more than two centuries’ worth of combined healthcare experience, the incredible knowledge gained through the Pennsylvania Patient Safety Reporting System, and a passion to make healthcare safe for all patients, we have the spark.

Together we can take that spark and set the world on fire.
Patient Safety Authority

Board of Directors

Stanton N. Smullens, MD (Chair)
Physician Appointed by the Governor

Daniel Glunk, MD, MHCDS (Vice Chair)
Appointee of the President Pro Tempore of the Senate

John Bulger, DO, MBA (Secretary/Treasurer)
Healthcare Worker Appointed by the Governor

Radheshyam Agrawal, MD
Healthcare Worker Appointed by the Governor

Kathleen Law, MS, RN
Healthcare Worker Appointed by the Governor

Jan Boswinkel, MD
Healthcare Worker Appointed by the Governor

Denelle Weller, RN
Healthcare Worker Appointed by the Governor

Arleen Kessler, PharmD, MBA, RPh
Pharmacist Appointee of the Governor

Mary Ellen Mannix, MRPE
Non-Healthcare Worker Appointed by the Governor

Veronica Richards, Esq.
Appointee of the Minority Leader of the Senate

Linda Waddell, MSN, RN
Nurse Appointee of the Governor

Eric Weitz, Esq.
Appointee of the Minority Leader of House

Leadership

Regina M. Hoffman, MBA, RN
Executive Director

Howard Newstadt, JD, MBA
Sr. Director, Finance & Business Operations/CIO/CISO

Michelle Bell, BSN, RN
Director, Outreach & Education

Rebecca Jones, MBA, RN
Director, Data Science & Research

Caitlyn Allen, MPH
Manager, Communications & Publications

Staff

JoAnn Adkins, BSN, RN
Senior Infection Preventionist

Jeffrey Bomboy, BS, RN
Senior Patient Safety Liaison

Kelly R. Gipson, BSN, RN
Project Manager

Lynette Hathaway, MSN, RN
Infection Prevention Analyst

Richard Kundra, BS
Patient Safety Liaison

Christopher Mamrol, BSN, RN
Patient Safety Liaison

Karen McKinnon-Lipsett
Administrative Specialist

Shelly M. Mixell
Communications Specialist

Melanie A. Motts, MEd, RN
Senior Patient Safety Liaison

Eugene Myers, BA
Associate Editor, Communications & Publications

Teresa Plesce
Office Manager/HR Liaison

Catherine M. Reynolds, DL, MJ, RN
Patient Safety Liaison

Terri Lee Roberts, BSN, RN
Senior Infection Preventionist

Megan Shetterly, MS, RN
Senior Patient Safety Liaison

Alex Ulsh, BSC
Systems Administrator/Deputy CISO

Katie Vivian, BSN, RN
Infection Prevention Analyst

Susan Wallace, MPH
Patient Safety Liaison

Robert Yonash, BSN, RN
Senior Patient Safety Liaison

Contractors

Theresa V. Arnold, DPM
Julia Barndt, MA
Sharon Bradley, RN
Phyllis Bray
James Davis, MSN, RN
Eloise DeHaan
Cynthia Field, BSN, RN
Edward Finley, BS
Michael J. Gaunt, PharmD
Suzanne R. Gehris
Matthew Grissinger, BS, RPh
Arounsavanh Khemdy
Shawn Kincaid
Tara Kolb
Susan Lafferty
Kim Liberatore, MSN, RN
Donna Lockette
Mary C. Magee, MSN, RN
William Marella, MBA, MMI
Christina Michalek, Bsc Pharm, RPh
Jesse Munn, MBA
Benjamin Pauldine, MS
Badal Sanghvi, MBA
Carly Sterner
Dawn Thomas

Dates for All Public Board Meetings in 2018

- January 25, 2018
- March 12, 2018
- April 26, 2018
- June 18, 2018
- September 18, 2018
- October 31, 2018
- December 13, 2018

Find summary minutes of public board meetings online at patientsafety.pa.gov.

Contact Information

333 Market Street - Lobby Level
Harrisburg, PA 17101
patientsafety.pa.gov
patientsafetyauthority@pa.gov
717.346.0469

Annual Report Production Staff

Stanton N. Smullens
Daniel Glunk
Eric Weitz
Regina Hoffman
Caitlyn Allen
Eugene Myers
Katie Vivian
Shelly M. Mixell
Edward Finley
In 1846, Dr. Ignaz Semmelweiss began researching why so many women in a maternity ward at the General Hospital in Vienna were dying of childbed fever. Theorizing that doctors who had performed autopsies carried “cadaverous particles” on their hands that infected women during delivery, he proposed that clinical staff wash their hands with a chlorine solution as well as soap.

Although this change resulted in a dramatic decrease in deaths, the new procedure wasn’t embraced immediately. No one would accept that a doctor could cause harm. Though surgical scrubbing techniques were already in place, the first national hand hygiene guidelines weren’t introduced in the United States until the 1980s.

Despite a clear benefit to patient safety, Semmelweiss’ controversial recommendations didn’t become a new standard of healthcare for more than a century. However, without early pioneers like him who provided the spark that inspired others to continue and champion their work, medicine might still be stuck in the Dark Ages.

Seventeen years ago, the Patient Safety Authority lit a spark with our vision of safe healthcare for all patients. Since then we have been illuminating the field with careful research, thoughtful solutions, and comprehensive education.

In the following pages you will read stories about many others who have not only joined us in our efforts, but also advanced and expanded on them. These are the people, facilities, and organizations who are fanning that spark—and adding their own—into a blaze of innovation that will change healthcare, patients’ lives, and the world for the better.

We aren’t there yet, and it may take some time, but we need such lights to show the path forward and chase away the dark.

Stanton N. Smullens, MD
Chair, Board of Directors, Patient Safety Authority

Regina Hoffman, MBA, RN
Executive Director, Patient Safety Authority
Definitions

**ABORTION FACILITY**

Act 30 of 2006 extended the reporting requirements in the Medical Care Availability and Reduction of Error (MCARE) Act to abortion facilities that perform more than 100 procedures per year. At the end of 2018, Pennsylvania had 17 qualifying abortion facilities.

**ADVERSE EVENT**

This term is commonly used when discussing patient safety, but it is not defined in the MCARE Act. The Institute of Medicine Committee on Data Standards for Patient Safety defines an adverse event as “an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.”

The Authority considers this term to be broader than “medical error,” because some adverse events may result from clinical care without necessarily involving an error.

Although PA-PSRS includes reports of events that resulted from errors, the Authority’s focus is on the broader scope of actual and potential adverse events, not only those that result from errors.

**AMBULATORY SURGICAL FACILITY**

The Health Care Facilities Act (HCFA) defines an ambulatory surgical facility (ASF) as “a facility or portion thereof not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment.

“ASF does not include individual or group practice offices of private physicians or dentists, unless such offices have a distinct part used solely for outpatient treatment on a regular and organized basis. ...Outpatient surgical treatment means surgical treatment to patients who do not require hospitalization but who require constant medical supervision following the surgical procedure performed.” At the end of 2018, there were 323 qualifying ASFs in Pennsylvania.

**ANALYST**

The analyst is a member of the Authority team with education and experience in medicine, nursing, pharmacy, product engineering, statistical analysis, and/or risk management. Analysts review events submitted through PA-PSRS and compose the majority of the articles included in the Pennsylvania Patient Safety Advisory.

**BIRTHING CENTER**

The HCFA defines a birthing center as “a facility not part of a hospital which provides maternity care to child-bearing families not requiring hospitalization. A birth[ing] center provides a homelike atmosphere for maternity care, including prenatal labor, delivery, and postpartum care related to medically uncomplicated pregnancies.” At the end of 2018, Pennsylvania had six qualifying birthing centers.

**HOSPITAL**

The HCFA defines a hospital as “an institution having an organized medical staff established for the purpose of providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of persons who are injured, disabled, pregnant, diseased, sick, or mentally ill. ...The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for the mentally ill.” At the end of 2018, Pennsylvania had 237 qualifying hospitals.

**INCIDENT**

An event which either did not reach the patient (“near miss”) or did reach the patient but the level of harm did not require additional healthcare services. The legal definition from the MCARE Act: “an event, occurrence, or situation involving the
clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional healthcare services to the patient. The term does not include a serious event.”

INFRASTRUCTURE FAILURE

A potential patient safety issue associated with the physical plant of a healthcare facility, the availability of clinical services, or criminal activity. The legal definition from the MCARE Act: “an undesirable or unintended event, occurrence, or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.” Infrastructure failures are submitted only to the Pennsylvania Department of Health (DOH) and are not addressed in this report.

MEDICAL ERROR

This term is commonly used when discussing patient safety, but it is not defined in the MCARE Act. The word “error” appears in PA-PSRS and in this report. For example, one category of reports discussed is “medication errors.” The Institute of Medicine Committee on Data Standards for Patient Safety defines an error as the “failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)…. It also includes failure of an unplanned action that should have been completed (omission).”

Within the MCARE Act, the term “medical error” is used in section 102: “Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.” It is also used in defining the scope of chapter 3, “Patient Safety”: “This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.”

NURSING HOME

Act 52 of 2007 revised the MCARE Act to require nursing homes to report healthcare-associated infections (HAIs) to the Authority. Specifically, the act states that “the occurrence of a healthcare-associated infection in a healthcare facility shall be deemed a serious event as defined in section 302.” Reporting from these facilities began in June 2009. For this report, Pennsylvania had 699 qualifying nursing homes at the end of 2018. (See the Infection Prevention section of this report for data received from nursing homes.)

OTHER EVENT TYPE

The Centers for Medicare and Medicaid Services (CMS) requires hospitals to report to DOH any death of patients in restraints or in seclusion, or in which restraints or seclusion were used within 24 hours of death (other than soft wrist restraints). Deaths in which the restraints or seclusion are suspected of or confirmed as having played a role in the death should be reported as serious events. Other deaths in which the restraint or seclusion use was incidental or not suspected should be reported under this “Other” category.

Reports of serious events and incidents are submitted to the Authority for the purposes of learning how the healthcare system can be made safer in Pennsylvania. Reports of serious events and infrastructure failures are submitted to DOH so it can fulfill its role as a regulator of Pennsylvania healthcare facilities.

PATIENT SAFETY LIAISON

The patient safety liaison (PSL) is a unique resource to Pennsylvania MCARE facilities. Serving as the face of the Authority, the PSL provides education and consultation to MCARE facilities and ensures that facilities are aware of the resources available to them through the Authority, such as educational toolkits, presentations, and webinars. The program has eight liaisons located regionally throughout Pennsylvania.

PATIENT SAFETY OFFICER

The MCARE Act requires each medical facility to designate a single individual to serve as that facility’s patient safety officer (PSO). In addition to other duties, the MCARE Act requires the PSO to submit reports to the Authority.

SERIOUS EVENT

The legal definition from the MCARE Act: “an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient. The term does not include an incident.”

STANDARDIZATION

Twenty-eight guiding principles went into effect on April 1, 2015, to improve consistency in event reporting through PA-PSRS. The guidance was developed to help provide consistent standards to acute healthcare facilities in Pennsylvania in determining whether occurrences within facilities meet the statutory definitions of serious events, incidents, and infrastructure failures as defined in section 302 of the MCARE Act.

The Authority, DOH, and healthcare facility staffs have worked together toward a shared understanding of the requirements. The reporting guidelines were identified based on frequently asked questions (FAQs), controversies, and inconsistencies that were evident in the data collected by the Authority and DOH.
In 2018, the Patient Safety Authority significantly raised the bar in raising awareness by enhancing and expanding efforts to realize its vision of safe healthcare for all patients. Pennsylvania’s first conference dedicated to patient safety saw almost 300 attendees; 11,000 individuals received training through an Authority event; and readership for the *Pennsylvania Patient Safety Advisory* expanded by 12%. Another notable success for the Authority was its Antibiotic Stewardship Collaborative, which concluded in November; the project spanned 15 months and 31 long-term care facilities, and ultimately surpassed its goal of a 10% improvement in process and outcome measures related to antibiotic orders for urinary tract infections and asymptomatic bacteriuria.

To further inspire, educate, and empower everyone to take an active role in patient safety, the Authority launched the Center of Excellence for Improving Diagnosis (CoE), which aims to get patients more engaged in their own care and encourage them and healthcare providers to work together to improve the diagnostic process. In conjunction with the brand-new CoE, the Authority published its first special issue of the *Advisory*, entirely focused on improving diagnosis. This special *Advisory* was distributed to a broad and appreciative audience, and was one of the Authority’s most popular issues of all time. Another notable achievement for the Authority was to take the bold but considered step of issuing a statewide notice, “Final Recommendation to Ensure Accurate Patient Weights,” to help reduce weight-related medication and other errors.

Read the highlights below and in the following pages to learn more about the Authority’s many accomplishments in the last year and its blossoming impact and influence on patient safety.

- Regina Hoffman was named to *Becker’s Hospital Review*’s 2018 list of “50 Experts Leading the Field of Patient Safety.”
- Hoffman participated in the *Institute for Healthcare Improvement’s* (IHI) expert panel meeting on patient safety reporting.
- Hoffman was appointed the subcommittee co-chair on learning systems for the IHI/Agency for Healthcare Research and Quality’s (AHRQ) National Steering Committee on Patient Safety.
- Hoffman served on the selection committees for the Health Care Improvement Foundation’s (HCIF) Delaware Valley Patient Safety and Quality Award and the Hospital and Healthsystem Association of Pennsylvania’s (HAP) annual Achievement Award.
- Howard Newstadt oversaw the modernization of the Pennsylvania Patient Safety Reporting System (PA-PSRS), whose code and system design passed the Commonwealth’s IT Security (CA)² process and was approved for release on the web.
- Michelle Bell sat on The Joint Commission Standards Review Panel (SRP) for Pediatric Emergency Equipment and Supplies.
- Bell was invited to participate in the Institute for Safe Medication Practices (ISMP) summit: Optimizing Safe Implementation and Use of Smart Infusion Pumps.
- Becky Jones was a presenter and panel member at the full-day Diagnostic Error Immersion Workshop at the IHI/National Patient Safety Foundation (NPSF) Patient Safety Congress in May 2018.
- In November 2018, Jones and Dr. Timothy Mosher presented at Jefferson Health’s Population Health Forum regarding improving diagnosis.
- Cathy Reynolds was a co-presenter at the Diagnostic Error in Medicine (DEM) conference in November.
- Jeff Bomboy presented on health literacy at the annual conference for the Pennsylvania Society of Radiologic Technologists.
- Lynette Hathaway and Terri Lee Roberts led the Healthcare-Associated Infection (HAI) Advisory Panel. Eighteen members were selected to advise on current infection-related issues and to identify educational opportunities.
- In December, JoAnn Adkins conducted a webinar on infection prevention and performance improvement to almost 300 attendees.
Event Reports since 2004 (Acute Care & HAI)
3,688,381

Event Reports - 2018 (Acute Care)
284,349

Event Reports - 2018 (HAI - Nursing Homes)
30,642

Event Reports by Month

Increase in Reporting
4.6%

Individuals Educated
11,049

National, State & Regional Presentations
324

Advisory Readers Worldwide
4,542

Increase in Readership
12%

Countries Where the Advisory is Read
44
The average day of a nurse begins with a detailed handoff and assessment of current patient needs, followed by verifying and administering medication, conducting tests, participating in rounds, charting patient records, responding to emergencies, addressing families, and answering emails—all before giving a detailed handoff for the next shift. And he or she is only a single member of a large, multidisciplinary care team.

We recognize that caregivers have many competing responsibilities and that the stakes often mean the difference between life or death. Because we’re not directly involved in patient care and can observe emerging trends across the state, we’re able to identify common areas of concern with broad implications. We can then allocate resources and develop actions to effect widespread change.

Such is the basis for our strategic plan—four areas that are of great importance in healthcare:

- Diagnostic excellence – almost every healthcare encounter requires communicating an accurate, timely diagnosis to the patient
- Focus on the patient – patients must be respected as an equal member of their care team
- Long-term care – those in long-term care facilities are some of the most vulnerable patients, with unique needs and challenges
- Event reporting – with the largest event reporting database in the nation, it’s imperative to validate the data and identify opportunities for more in-depth analysis
Diagnostic Excellence

- Launched the Center of Excellence for Improving Diagnosis
- Published a special issue of the Pennsylvania Patient Safety Advisory focused on diagnostic excellence
- Continued partnership with the Health Care Improvement Foundation (HCIF), co-leading the Hospital and Healthsystem Association of Pennsylvania (HAP) Hospital Improvement Innovation Network (HIIN) collaborative demonstration project to decrease the risk of diagnostic error
- Presented at several national conferences, including the Association of American Medical Colleges (AAMC) Integrating Quality Conference, Institute for Healthcare Improvement and National Patient Safety Foundation (IHI/NPSF) Patient Safety Congress, and Society to Improve Diagnosis in Medicine (SIDM) Diagnostic Error in Medicine Conference
- Worked collaboratively as a member of the Coalition to Improve Diagnosis (CID) to create and launch the ACT for Better Diagnosis™ initiative to raise awareness and share practical strategies for improvement
- Convened a panel of national experts to discuss challenges and potential solutions for the problem of diagnostic error

Focus on the Patient

- Developed Safety Tips for Patients, consumer tip sheets for common patient safety concerns
- Expanded the Patient Advisory Panel, a group of patients, parents, and nurses who ensure Authority materials are health literate and relevant
- Surveyed Pennsylvanians about their comfort level addressing common healthcare practices, e.g., whether they felt comfortable asking their physician to wash her hands
- Added a patient representative to the advisory board for the 2019 Pennsylvania Patient Safety Summit
- Participated in 33 health fairs, public events for patients to learn more prevention strategies for common safety concerns, e.g., the importance of vaccinations
- Researched patient attitudes about diagnosis, e.g., do patients follow up with their provider regarding test results?
- In conjunction with HAP and Patient & Family Centered Care Partners (PFCCpartners), developed training for clinicians on how to engage patients and families in their care

Long-Term Care

- Completed an 18-month antibiotic stewardship collaborative program with 26 long-term care facilities and exceeded the goal of a 10% reduction in process and outcome measures overall
- Held educational symposia in four regions throughout the state focused on infection prevention topics and pressure injury prevention in long-term care facilities
- Continued relationships with key strategic partners to enhance offerings for long-term care facilities

Event Reporting

- Conducted a systemic review of the Pennsylvania Patient Safety Reporting System (PA-PSRS) to improve its relevance, function, and contributions to patient safety improvement
- Explored several opportunities to review other data sources to identify future enhancements within PA-PSRS, including court dockets, malpractice claims, and data from the Pennsylvania Insurance Department
- Continued a multiyear project to enhance the reporting system through the Authority’s PA-PSRS modernization project
Recommendation

The MCARE Act calls upon the Authority to issue recommendations to medical facilities on a facility-specific or statewide basis to reduce the number and severity of incidents and serious events. In 2018, the Authority issued formal, statewide recommendations regarding weight-based medication errors.

An analysis conducted in 2016 of medication-related events showed little change from a 2009 analysis of medication-related events. Many medication-event reports included mix-ups between pounds and kilograms, as well as documented weights that differed from the patient’s actual weight.

Consequently, the Authority issued the following recommendations, with approval from the Pennsylvania Department of Health:

- Organizations must have a process in place to weigh each patient as soon as possible on admission; when a patient experiences a change in condition that may lead to significant changes in weight; and during each appropriate* outpatient or emergency department encounter, with the exception of emergency situations. The use of estimated, historical, or stated weight should be avoided.

*Appropriate encounters include all encounters in which the patient is being seen by a licensed independent practitioner, excluding life-threatening situations where the delay caused by weighing the patient could lead to serious harm (e.g., major trauma). It also excludes laboratory and other services that do not prescribe or administer medications.

- Organizations must have a process in place to measure and document a patient’s weight in metric units (e.g., grams or kilograms) only. This would include computer information systems, infusion pumps and other medication devices, printouts, and preprinted order forms that prompt users to record patient weight.

In issuing these recommendations, the Authority took into consideration the expectation of improved quality of care; implementation feasibility and other relevant implementation practices; and cost impact to patients, payors, and medical facilities.

The Authority’s “Final Recommendation to Ensure Accurate Patient Weights” can be found at www.pabulletin.com/secure/data/vol48/48-36/1430.html.

Notes


The Case for Metric Patient Weights

The dosing for many medications is determined based on your weight. So it is critical that your provider has an accurate measurement of how much you weigh before prescribing any medication.

To ensure that you are always receiving the appropriate dose, you should be weighed every time you are admitted to the hospital, arrive at the emergency room, or receive outpatient care, or if there is a change in your condition that may cause a significant change in your weight.

This Could Happen Anywhere: A Real-Life Case of a Weight-Based Error

While we've all heard the phrase “an ounce of prevention is worth a pound of cure,” caregivers should instead be thinking “28.3 grams are worth .45 kilograms of cure.”

Why does it matter? It turns out that clinical metrics should include the metric system when it comes to measuring patient weight and medical doses. A case in point: When one physician recorded a patient’s weight of 160 pounds as 160 kilograms in their electronic health record, they set off a chain of errors that led to a serious event. (If your calculator isn’t handy, 160 kg is the equivalent of 352.7 pounds!)

A pharmacist then used that incorrect weight to mix a 9 mg dose of alteplase, a clot-busting drug commonly used to treat stroke, which two nurses verified—again, according to the incorrect weight—before administering the pill. They also started a drip of 81 mg over an hour.

When the hour was nearly up, someone realized that the medical dosage had been calculated for a person more than twice the patient’s actual weight. They immediately stopped the drip, but the patient had already received approximately 72 mg of it. A pharmacist recalculated the correct dosage based on the patient’s true weight and determined they should have received a 6.5 mg bolus and a 58.9 mg drip.

All told, the patient had been overdosed by about 15.6 mg, and consequently suffered hemorrhaging that filled the pleural cavity between their lungs with blood, which required quick intervention in the form of intubation and chest tube insertion to drain the space.
Education

When studying patient safety events to understand why some medical errors occur, and why others are averted, there is always one common element, no matter the facility or the procedure—people. People are at the root of every aspect of healthcare, from the patients receiving care to those delivering it, from designers of software to those who use it. At a basic level, humans are part of the problem. But humans are also the solution.

“If you want to sum up patient safety, you have to start by recognizing that humans make mistakes, and we’re not going to change that,” says Christopher Mamrol, patient safety liaison (PSL) with the Authority.

To make the process better and safer, we need to improve the systems. And human factors is a way to find out what’s wrong with the system.

In May 2018, the Authority debuted a brand-new workshop to address this important topic, “Utilizing Human Factors to Improve Patient Safety.” Mamrol, who helped develop and co-led that training, defines human factors as “the relationship between people and their environment and the tools and equipment they use.” Although human factors is currently a hot topic in patient safety, the Authority has been teaching about it for many years. However, after Mamrol attended a two-day human factors workshop at Johns Hopkins Medicine last year with fellow PSLs Melanie Motts and Rick Kundravi, the group returned with new ideas.

“We came back refreshed in human factors and felt that we could update our training to share the information with our facilities,” Motts says. She worked with Mamrol and another PSL, Catherine Reynolds, to adapt the Authority’s previous human factors training and incorporate what they had learned at Hopkins into a new program that reflects current thinking on the subject.

Reynolds, who co-led the first workshop with Mamrol, stresses, “As human factors science has evolved, so has our understanding of how important that relationship is. It was a natural step to put a brighter focus on it again, bring it around with a more updated perspective of what is the best understanding of human factors, and keep the Authority on the leading edge of patient safety.”

Following the favorable response to the first workshop, other sessions are now being delivered throughout the state. Mamrol says the next step is to “do a deeper dive into some of the specifics,” perhaps in individual workshops focused on subtopics of human factors such as process mapping and proactive risk management.
11,049
Total Individuals Trained by the Authority in 2018

17,032
Total Contact Hours

324
Total Events

34
Individuals per Event

344
Attendees: Most Popular Event

8
Presentations at National Conferences

HAP HiIN: Growing a Positive Safety Culture in Healthcare
Pennsylvania Patient Safety Summit

One of the most powerful motivators for spurring action is to gather a group of passionate, similarly motivated individuals and provide them detailed road maps for change. Such was the basis for the first annual Pennsylvania conference dedicated to patient safety.

The Pennsylvania Patient Safety Summit (P2S2) provided a forum for almost 300 healthcare professionals, frontline staff, and patients to discuss current challenges and to learn from those who have implemented tested improvement strategies.

The keynote speaker was Dr. John Kenagy, a vascular surgeon, visiting scholar to Harvard Business School, and professor at the University of Washington, who was dubbed by Forbes magazine as “the man who would save healthcare.”

Attendees chose from four educational tracks: infection prevention, responding to error, medication safety, and diagnostic excellence.

The closing panel looked at patient safety on a macro level and featured four speakers who were on the scene during the May 2015 Amtrak derailment in Philadelphia. Panelists shared the critical lessons learned when systems were tested under the most devastating conditions.

The Authority chose “chain reaction” as the conference’s theme to remind attendees that a single event can have extraordinary results when put into motion. Everyone was encouraged to think of just one thing they could do to make a difference and to start their own chain reaction.

277 Attendees

142 Organizations
Eileen Wan, MS, RN  
PSO and Director, Quality and Risk  
St. Luke’s Anderson Campus

Jane Whitney, BSHA, RN  
Regional Manager Clinical Risk and Patient Safety, PSO  
Geisinger Holy Spirit

Donna Hamilton  
PSO, Allegheny Valley Hospital

Mary E. Doutt, RN  
Director, East Side Surgery Center

Nicole Alerding, MSN, RN  
Performance Improvement Director, PSO  
Roxborough Memorial Hospital

I feel fortunate to have the Authority and the liaisons as advocates for us and our patients.

Jane Whitney, BSHA, RN  
Regional Manager Clinical Risk and Patient Safety, PSO  
Geisinger Holy Spirit

I am thankful for Rick and am certain that it directly relates to the exceptional care that our hospital provides.

Donna Hamilton  
PSO, Allegheny Valley Hospital

The ongoing education Susan provides is amazing—always pertinent, timely, and convenient.

Susan  
PSO, Allegheny Valley Hospital

I feel fortunate to have the Authority and the liaisons as advocates for us and our patients.

Mary E. Doutt, RN  
Director, East Side Surgery Center

Mel has helped us increase reporting awareness and avoid recurrences of reported events.

Mel Alerding, MSN, RN  
Performance Improvement Director, PSO  
Roxborough Memorial Hospital

Susan  
PSO, Allegheny Valley Hospital

The ongoing education Susan provides is amazing—always pertinent, timely, and convenient.

Susan  
PSO, Allegheny Valley Hospital

I feel fortunate to have the Authority and the liaisons as advocates for us and our patients.
Patient Safety Liaisons - 10 Years Strong

Like most great ideas that make a large impact, the Patient Safety Liaison program started small, albeit far from simple. The Authority’s first patient safety liaison (PSL), Megan Shetterly, came to work in August 2008 without any model for how to go about her work—because no one had ever done anything like it before. Just as the Authority itself was unprecedented anywhere else in the country, Shetterly was venturing into unexplored territory, territory which spanned Northeast Pennsylvania, encompassing 71 healthcare facilities.

One of only five people in the Authority at the time, on her first day Shetterly received spreadsheets of data, a list of facilities, thick binders, a map, push pins—and coffee. Her initial goal: to visit 10 hospitals, two ambulatory surgery centers, and one rehab facility. Without quite knowing where to start, she began by picking up the phone and calling the patient safety officer (PSO) at Sacred Heart Hospital to schedule a visit.

Such visits were the vision behind the PSL program, to meet the growing need for one-on-one guidance and education from the Authority and staff to serve as liaisons with and among facilities. Shetterly’s first visit went well, and the next, and the next... The pilot program was a success! The Authority’s second PSL, Rick Kundravi, was hired nine months later—and the program has continued to grow since in staff, scope, visits, educational programs, and outreach activities. By 2009, the Authority had six PSLs covering regions throughout the state, and now, as it celebrates its tenth year in practice, the program numbers eight patient safety experts who demonstrate every day their hard work and dedication to helping facilities reduce harm.
Winners

2019

- Ambulatory Care/Surgery
  - Einstein Medical Center Elkins Park
- Best Use of Authority Resources
  - Phoenixville Hospital
- Focus on the Patient
  - Saint Clair Memorial Hospital
- Improving Diagnosis
  - St. Luke's University Hospital - Bethlehem
- Individual Impact
  - Shriners Hospitals for Children - Erie ASC
- Innovation
  - Einstein Medical Center Philadelphia
- Long-Term Care
  - South Mountain Restoration Center
- Safety Story (Near Miss or Close Call)
  - St. Christopher's Hospital for Children
- Transparency and Safety in Healthcare
  - UPMC Children's Hospital of Pittsburgh
- Video
  - Pennsylvania Hospital (Penn Medicine)
Healthcare demands excellence. Even minor decisions can have life-altering consequences, and every member of the care team must work cohesively to return as much normalcy to their patient’s lives as possible. When the bar is set this high, it can be difficult to distinguish yourself. But that is exactly what this year’s I AM Patient Safety winners were able to do.

Recipients were selected from across the Commonwealth—from small rural facilities to large urban academic medical centers—for their dedication to their craft, innovative solutions to chronic challenges, and ability to provide patients hope.

Each year, selecting winners becomes more difficult. Each year, Pennsylvania caregivers keep raising the bar, turning last year’s excellence into this year’s standard. This year was no exception. We received 153 stories that in any other year would have won. Stories of a nurse who diagnosed an undetected fatal condition, an intensive care unit (ICU) that overcame alarm fatigue with a redesigned call bell system, and home health aides who saved their patient from a house fire.

We share these stories to inspire others to match their successes. If just one person is motivated to give an extra inch, that could be a life saved or devastating harm prevented. We thank everyone for their continued dedication and look forward to hearing how you’re reinforcing why Pennsylvania is the national leader in patient safety.
Einstein Medical Center Elkins Park showed they put patient safety first when they created a Surgical Unit Safety Practice (SUSP) team to address a higher-than-average number of surgical site infections (SSI). Their multidisciplinary, collaborative efforts resulted in a bundle that dramatically decreased SSI from 2.8% to 0% over three years.

Phoenixville Hospital

After reviewing an Advisory article about the importance of good catch reporting, Phoenixville Hospital’s Patient Safety Committee developed and implemented a program to educate staff about good catch reporting and its benefits, which reinforced a culture of safety and resulted in an improved ratio of good catches to serious events.

St. Luke’s University Hospital – Bethlehem

Dr. Robert Gayner not only supported the hospital’s efforts to improve acute kidney injury (AKI) diagnoses in its patients, but also led initiatives to educate staff and improve processes networkwide to ensure patients are correctly identified on admission and their care is managed effectively before and during surgery—and even after discharge.

Shriners Hospital for Children – Erie ASC

As a nurse anesthetist, Stephanie LaJohn shows extraordinary compassion for her patients, taking the time to make them more relaxed, comfortable, and prepared for anesthesia and surgery. She turns a scary event into a fun game, and ensures they know what’s about to happen—and that she will be with them every step of the way.

Einstein Medical Center Philadelphia

Recognizing the risks posed by contrast extrasavation, as well as an increase in events at their facility, Rose Hall, Lisa Griffin, and Dr. Ryan Lee devised a solution: power-injected injections, which produce less variation than hand injections between administering the test saline bolus and the iodinated contrast for computerized tomography (CT) scans.
Long-Term Care

South Mountain Restoration Center

Every day, the Environmental Services team makes a direct and indirect impact on the overall quality of care and safety of residents. They consistently take the initiative in leading new procedures and programs—assuming greater responsibilities beyond their baseline responsibilities—to help staff prevent and control the spread of disease at the facility.

Focus on the Patient

Saint Clair Memorial Hospital

Don Warnick and Peggy (Karish) Leschak recognized the need to ensure the safety of patients with a history of self-harm and quickly developed a new triage process that data mines patients’ electronic medical records at registration and identifies those who may be at risk for suicide—allowing clinical caregivers to observe them, assess their risk, and provide interventions.

Safety Story

St. Christopher’s Hospital for Children

Stacy Green heard a strange sound in a patient’s room and discovered a dangerous situation: the bed’s power cord was frayed and sparking. The bed was quickly replaced, and her timely reporting prompted an inspection of every patient bed—three more were removed from service—and a new procedure to check electrical cords when rooms are cleaned after patient discharge.

Transparency & Safety

UPMC Children’s Hospital of Pittsburgh

At the UPMC Children’s Hospital of Pittsburgh, the Patient Safety and Quality Department is dedicated to creating a culture that supports transparency by using process improvement to minimize errors and near-misses and ultimately decrease patient harm. The organization also adopted a “Just Culture” that embraces learning from mistakes.

Video

Penn Medicine Pennsylvania Hospital

Penn Medicine Pennsylvania Hospital; Kathryn Farrell; George Shafer; and the Therapeutic, Intervention, Presence, and Sanctuary (T.I.P.S.) Team created a video to educate the organization about their cohesive and consistent approach to patient care. The 10-minute video highlights patient and employee experiences with T.I.P.S.

Executive Director’s Choice

UPMC Hamot

Twenty-four hours a day, every day, the 33 transporters at UPMC Hamot move patients from test to test, around 400 times daily. From responding to emergency situations to making good catches, they always put patients first—striving to provide the best experience possible, with a focus on safety and efficiency.
Process Measure Survey

The Authority conducted a Process Measures Survey of acute facilities in November and December 2018, as a follow-up to the first one conducted a decade earlier. The 2018 survey was similar to the original in purpose, questions, and answer choices; however, the Authority revised some questions to reflect updated indicators of a mature safety culture.

The survey’s 48 questions covered ten areas: Leadership, Infection Prevention and Control, Behavioral Health, Diagnostic Excellence, Falls, Health Information Technology, Medication Safety, Transition of Care, Safe Surgery, and Obstetrics. In each question, respondents were instructed to report the degree to which a specific safety practice has been implemented at their facility.

The Authority received and analyzed 158 unique responses from facilities with at least 30% completion. The domains with the most completed questions were Safe Surgery, Infection Prevention and Control, and Obstetrics. The domains with the least completed questions were Behavioral Health, Medication Safety, and Diagnostic Excellence.

The Authority observed two overarching trends among all the domains: high levels of implementation of safety practices to support communication about patient safety with frontline staff, and low levels of implementation of safety practices to support patient engagement in organizational patient safety efforts. These results will inform the Authority’s focus over the next several years.
Domains

- Behavioral Health
- Safe Surgery
- Transition of Care
- Medication Safety
- Obstetrics
- Diagnostic Excellence
- Falls
One of the Authority’s core methods for catalyzing change is through the *Pennsylvania Patient Safety Advisory*, its quarterly, peer-reviewed journal. Articles primarily leverage the *Pennsylvania Patient Safety Reporting System (PA-PSRS)*, the largest event reporting database in the United States, and highlight areas associated with a high combination of frequency, severity, and possibility of solution; novel problems and improvement strategies; and concerns in which urgent communication of information could have a significant impact on patient outcomes.

Facilities are alerted to immediate dangers or unseen chronic conditions and provided with the tools they need to prevent harm and improve safety.

Swallowing medication can be difficult, so to make it easier, it’s common to crush the tablet and mix it with applesauce or water. Sometimes this is perfectly safe. Sometimes this has dire consequences. Some pills are time-release, meaning that a steady dose of medication is given over the course of several hours. Ingesting the crushed pill could deliver the full dose at once and cause severe consequences.

Such was a clear choice for an *Advisory* article—70% of Americans take at least one medication each day, exposing nearly 228 million people to risk. The journal provided a venue through which the Authority could raise attention to this seemingly innocuous practice and share strategies for preventing serious injury.
4.5k Readers → 12% Increase
44 Countries → 33% Increase
48 States → 9% Increase
**HAP HIIN**

Collaboration is one of the most effective tools for change. By working together, organizations can learn from past mistakes and build on successes. The Hospital and Healthsystem Association of Pennsylvania (HAP) Hospital Improvement Innovation Network (HIIN) provided such an opportunity for 92 Pennsylvania facilities to reduce patient harm by 20% and achieve a 12% reduction in 30-day readmissions. The Authority oversaw four focus groups: Adverse Drug Events, Culture of Safety, Diagnostic Errors, and Falls.
Health Literacy

2018 marked the third year of collaboration between the Authority and The Health Care Improvement Foundation (HCIF) to educate healthcare providers about the scope of health literacy and strategies to address it.

HCIF contracted the Authority to provide health literacy resources, including regional and facility-level education and statewide webinars. Twenty events were conducted in 2018 for 640 attendees.

The same principles were behind the Authority’s 15 new Safety Tips for Patients—consumer-focused resources that highlight common concerns from the importance of getting a flu shot to preventing pressure injuries and navigating end of life care.

Antibiotic Stewardship

Infection preventionists from the Authority partnered with long-term care (LTC) facilities across Southeastern and South Central Pennsylvania to develop, implement, and sustain an antibiotic stewardship program. The goal was to improve process and outcome measures related to antibiotic orders for urinary tract infections (UTIs) and asymptomatic bacteriuria (ASB) in LTC facilities by 10%.

From June to August 2017, the Authority worked with facilities to plan the project, which was then implemented from September 2017 to August 2018, followed by a three-month sustainability study. Of the 31 long-term care facilities enrolled in the collaborative, 24 completed all components of the project. The project concluded successfully in November 2018 with an overall 14.24% improvement in process and outcome measures.

In addition, the collaborative saw other successes—which will have a long-term, beneficial impact beyond antibiotic stewardship—including enhanced resident safety; improved team building skills; culture change at facilities through engagement of staff, residents, and families; and increased awareness of Authority resources.
ADVERSE DRUG EVENTS
Adverse drug events include medication errors or unexpected reactions related to anticoagulants, insulin, and opioids. The Authority provided participating organizations with resources to help reduce these events, including:
- Education opportunities such as webinars and coaching calls
- One-to-one consultative phone calls
- Tip sheets developed to reinforce methods for data collection, reporting, and outcome measurement
- Project-specific outcome and process measures worksheet
- Newsletters from the Institute for Safe Medication Practices and relevant journal articles
- Topics/Areas of Focus: Nonopioid analgesia, insulin safety, prevention of opioid-induced respiratory depression, medical cannabis, and inpatients

CULTURE OF SAFETY
A culture of safety is the foundation for reducing harm and improving the quality of care. This collaborative was open to all HAP HIIN enrolled facilities. Resources provided included:
- Collaboration with the Person and Family Engagement focus group for shared learning opportunities, including in-person education session
- Culture of safety resurvey in the composite of Person and Family Engagement
- Topics/Area of Focus: Increasing transparency, shifting from a culture of blame to learning

DIAGNOSTIC ERRORS
As a complex process and one that can lead to devastating outcomes, the diagnostic errors focus group completed the following:
- Metric development
- Facility visits
- Facility networking
- Diagnostic Error in Medicine (DEM) presentation
- Article written for the Advisory special edition
- Topics/Areas of Focus: Best practices shared by Pennsylvania hospitals

FALLS
Falls with injury is one of the most commonly reported serious events by Pennsylvania hospitals. Participants in this focus group received:
- Post-fall investigation tool, self-assessment, subsequent action plan, point prevalence audits
- Networking regional meetings, webinars, coaching calls, on-site consultation
- Data analysis and trend identification
- Facility needs assessment
- Topics/Areas of Focus: Patient and family engagement, post-fall huddles and injury prevention, patient ambulation, literature review, data analysis, and lessons learned

The analyses upon which this publication is based were performed under contract number HHSM-500-2016-00066C, entitled “Partnership for Patients Hospital Improvement Innovation Network Contract, sponsored by the Centers for Medicare & Medicaid Services, Department of Health and Human Services.”
Antibiotic Stewardship

While every facility that participated in the Authority’s LTC Antibiotic Stewardship Collaborative last year was expectancy positive outcomes, for some facilities it was more wildly successful than they had hoped.

No one was more surprised than Mary Pat Frick. As the infection preventionist for Masonic Village in Elizabethtown, overseeing ten neighborhoods, she had participated in a collaborative with the Authority before on catheter-associated urinary tract infections (CAUTIs), which she describes as “an epic fail.”

“It was a horrible disaster because I didn’t have leadership support. I tried to do everything on my own,” she says. So when she signed up again for the antibiotic stewardship program, she was determined to do things differently, and this time she had buy-in from the medical director, other leadership, and providers across the board. “And wow, what a difference it made.”

Another big change was in how she went about educating Masonic Village's 500-person nursing staff and 250–300 other department staff.

“With the catheter collaborative, I threw all this information at staff all at once—boom! Tried to accomplish so many goals at once,” Frick says. “Where here, I started eating the whale one bite at a time.” She specifically focused on introducing new procedures gradually and strategically, explaining the reasoning behind each. She also stayed in constant communication with the medical director, director of nursing, and director of quality, making sure they had a say in what she wanted to tackle next. And all along the way, she had the monthly data from the facility—and benchmarks from other facilities in the collaborative and nationwide—to reinforce and guide their efforts.

The initiative was so successful, LeadingAge recognized the facility for its approach to raising awareness and creating these policies. Following LeadingAge’s recommendation, the Department of Health decided to kick off its Antibiotic Awareness Campaign in July 2018 at Masonic Village—one of only three facilities they selected in the state.

“The PSA collaborative really helped with all the resources that they give you,” Frick says. “You cannot fail if you follow their recommendations.”

She likens it to cooking and following a recipe, in which things turn out the way you expect them to if you follow directions and take things one step at a time. “If we can do it, anyone can,” she says. “I failed, and I’ve seen now what success looks like. It just pumps me: What can we do now? What can we focus on next?”

Beth McMaster, Vice President of Operations and Chief Operating Officer (COO) of United Church of Christ Homes (UCC), echoes Frick’s sentiment, wondering, “Where’s the collaboration going next? Are they going to start looking at skin infections? Upper respiratory infections? We’re excited to see where we head next with JoAnn Adkins and the Collaborative.”

Like Frick and Masonic Village, McMaster and her staff at UCC’s Sarah A. Todd Memorial Home had good buy-in from their leadership and tried to include everyone at the facility as part of the infection team, “educating them on what their specific roles were and how they could help the residents,” she says. The biggest hurdle was convincing families and some medical directors to do things differently—but this challenge also brought them their greatest success.

“We started education right at the time of admission, and then it would continue through, not only for the new residents, but any long-term residents who had been there previously,” McMaster says. At quarterly care plan review meetings with the family, they provided more education about antibiotics and answered their questions. “That was our best point of contact with not only our residents, but also their families, who needed to get the same information and get everyone on the same page.”

Another major approach they took was to educate their nursing staff in reading a urine analysis and understanding antibiograms—and emphasizing watchful waiting for 24 hours before prescribing antibiotics.

Gradually, the culture shifted, and everyone embraced the changes at Sarah Todd, as well as at UCC’s three other facilities that implemented them though they were not officially part of the collaborative.
McMaster says that each of their buildings had some measure of success, with positive outcomes both for residents and a decrease in antibiotic use, and professional growth for nursing staff in education and communication, which will have an impact in other areas of patient care beyond this collaborative.

“The bottom line is improved resident care, and it just drives home the fact there is opportunity to continue to learn and to grow and to become better and better and better,” McMaster says.

The PSA collaborative really helped with all the resources that they give you. You cannot fail if you follow their recommendations.
In 2016, the Authority identified diagnostic excellence as one of its four strategic priorities. As the Authority created an operational plan and started its work, it became clear that effecting meaningful change in this complex area of patient safety requires an enduring commitment and a formal structure. Therefore, the Authority established the Center of Excellence for Improving Diagnosis (CoE) in June 2018, with a team comprised of a director, a physician advisor, a communications/marketing lead, core team leads, and an administrative coordinator.

Since the CoE’s inception, it has focused on exploring ways to identify and classify patient safety events involving diagnostic error and diagnostic process failure and build awareness about the issue. In September, the CoE helped launch ACT for Better Diagnosis™, a Society to Improve Diagnosis in Medicine (SIDM) initiative to raise awareness and share practical strategies for improvement.

In October, the Authority and CoE published a special issue of the Advisory dedicated to improving diagnosis, which included an analysis of events reported through the Pennsylvania Patient Safety Reporting System (PA-PSRS) that involved failures in the diagnostic process, an interview with 10 of the nation’s top experts in the field, and real-life examples of how healthcare facilities have addressed this complex issue. CoE team members also presented at several state and national conferences.

This Could Happen Anywhere: A Real-Life Case of a Diagnostic Error

While the pervasive slogan “If you see something, say something” was intended to make everyone think about public safety, it turns out to be meaningful for those working in healthcare as well, particularly when it comes to patient safety. In one reported case, saying something about a potential medical concern—and more importantly, acting on it immediately—would have led to a very different diagnosis for the patient and been early enough to have dramatically improved their chances for successful treatment.

This patient came in with a urological issue in June 2013 and underwent a computed tomography (CT) scan of the abdomen and pelvis. The scan showed an incidental finding of a noncalcified nodule in the lung which could have indicated a neoplasm—a new, abnormal growth of tissue. The radiologist was concerned it may have been malignant and recommended a chest CT for better characterization of the nodule. Though they saw something and said something, unfortunately, the patient was not informed about the incidental finding, and the chest CT was not ordered.

In fact, the incidental finding was not rediscovered for another four years, when the patient was admitted to the hospital for a gastrointestinal issue. This time, the chest CT scan was ordered—and the “noncalcified nodule” had doubled in size since its first appearance. The unidentified mass had been lung cancer all along, and because no one investigated it further when it was found, it had advanced in stage and metastasized to other parts of the body. The extensive delay in follow-up imaging and treatment resulted in a much-reduced likelihood of the patient’s survival.
Center of Excellence
for Improving Diagnosis

**Action**
Facilitate the development and implementation of novel solutions

**Vision**
Accurate and timely diagnoses communicated to all patients

**Knowledge**
Gather, synthesize, and share information to broaden awareness and understanding

**Connection**
Build partnerships and create new networks to accelerate and scale improvement efforts
Patients Surveyed
about basic safety practices

Patient Engagement
“Patient engagement.” How do you define it? Well, it’s a little different everywhere you go. Patient engagement in a hospital or physician practice may mean the patient being involved in and a part of their own care. At an organization like the Patient Safety Authority, patient engagement means including patients in our work.

Our Patient Advisory Panel consists of six volunteers that provide perspective through the eyes of patients. They are involved in education planning, reviewing publications, and sharing their insights to help shape strategic planning. Patients are at the center of patient safety and we believe their voices need to be heard.

Dwight McKay has volunteered in patient safety for nearly 15 years. He says, “The work I do is behind the scenes, not on the front lines, so it isn’t ‘sexy’ like being a paramedic or a nurse or physician in an emergency room. I go to meetings. I go to meetings where patient safety programs are developed, patient safety statistics are analyzed, and adverse event reports are reviewed. But the thing I never forget is that those programs and statistics and event reports relate to situations in the lives of real people. I know what we do makes a difference.” Engaging volunteers, like McKay, keeps the patient at the heart of what we do.
With more than 3.3 million acute care and 300,000 HAI reports, the Pennsylvania Patient Safety Reporting System (PA-PSRS) is the largest event reporting database in the country—and one of the largest in the world. Reporters answer 22 core questions, including patient demographics, level of harm, and event type, and all information is confidential.

This section addresses serious events and incidents reported by acute care facilities. Although PA-PSRS collects information about infrastructure failures and any additional items (other), those reports are submitted only to the Department of Health. (See below.)

Interpreting PA-PSRS Data
Several factors influence the number of reports submitted by a particular facility, of which each facility’s safety and quality are just two. Other factors include facility size, case volume, services provided, patient case mix, severity of illness, understanding of what is reportable, and success in detecting reportable events. The following factors should be considered when reviewing PA-PSRS data:

- PA-PSRS has its own unique definitions for what is reportable. Because it uses a specific taxonomy of event types that may differ from other systems, it may be difficult to draw direct comparisons.
- Data is based on reports submitted through PA-PSRS between January 1, 2018, and December 31, 2018, (unless otherwise noted).
- The data isn’t adjusted to reflect facility openings, closings, or ownership changes. Unless otherwise noted, report counts are “raw numbers” and have not been adjusted for any facility- or patient-related factors.

Submission of PA-PSRS Reports
Acute Care Reports (2018)

284,349

Increase in Reporting
4.6%

Most Frequently Reported Event Type (2018)

Error related to Procedure/Treatment/Test (31%)

Incidents
276,263 (97%)

Serious Events
8,086 (3%)

Acute Care Reports since 2005

3,382,091

Incidents/Month
23,022

Serious Events/Month
674

Acute Care Reports by Quarter (2009–2018)
Control Charts — How Do You Show Change Over Time?

How do you know if changes that occurred over time happened by chance or were expected? One way to measure variation is with control charts—statistical models that take into account all known causes of variability to determine if a true impact occurred.

You take the subway each morning to head to class. Your commute normally lasts 10–15 minutes, depending on how many people enter or exit at each stop.

One day, the engine experiences an electrical problem, and it takes you 26 minutes to get to school. Just because your commute was longer than usual on that one day, there’s no reason to assume that it will continue to be longer in the future.

However, if your subway line is overly crowded and the city plans to build another station on your line, you should expect that this extended travel time will persist.

The same variability can happen with event reporting. By using control charts, we can assess whether the number of event reports increased in a given year because more events occurred, or if, perhaps, the culture of safety is improving and people are more apt to report something than they were before.

Any points that fall outside of the upper or lower control limits indicate that changes occurred outside of what was expected.
Reports by Type

PA-PSRS uses a taxonomy designed to answer the most basic question about an occurrence: “What type of event happened?” The complete event type taxonomy is a three-level, hierarchical taxonomy with 222 distinct event types.

Reports by Type (2018)

Highest Percentage Increase by Event Subtype

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Increase from 2017</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complication - Cardiopulmonary arrest outside of ICU setting</td>
<td>644</td>
<td>36.4%</td>
</tr>
<tr>
<td>Complication - Extravasation of drug or radiologic contrast</td>
<td>459</td>
<td>25.1%</td>
</tr>
<tr>
<td>Error - Referral/consult problem</td>
<td>1,034</td>
<td>23.9%</td>
</tr>
<tr>
<td>Error - Radiology/imaging test problem</td>
<td>1,039</td>
<td>15.9%</td>
</tr>
<tr>
<td>Error - Surgery/invasive procedure problem</td>
<td>2,309</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

Highest Percentage Decrease by Event Subtype

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Decrease from 2017</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall - Found on floor</td>
<td>-347</td>
<td>-4.3%</td>
</tr>
<tr>
<td>Fall - Toileting</td>
<td>-203</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Other/Miscellaneous</td>
<td>-1,037</td>
<td>-6.3%</td>
</tr>
<tr>
<td>Medication error - Wrong patient</td>
<td>-233</td>
<td>-20.2%</td>
</tr>
<tr>
<td>Medication error - Unauthorized drug</td>
<td>-405</td>
<td>-25.0%</td>
</tr>
</tbody>
</table>
# Risk Factors of Reports

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th># of Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance to rise from chair</td>
<td>12,168</td>
</tr>
<tr>
<td>Prior history of falls in past 12 months</td>
<td>8,117</td>
</tr>
<tr>
<td>Altered mental status</td>
<td>5,967</td>
</tr>
<tr>
<td>Altered elimination</td>
<td>5,195</td>
</tr>
<tr>
<td>Dizziness or vertigo</td>
<td>2,751</td>
</tr>
<tr>
<td>Patient depressed</td>
<td>2,696</td>
</tr>
<tr>
<td>Recent history of visual impairment</td>
<td>1,775</td>
</tr>
<tr>
<td>Recent history of hearing impairment</td>
<td>1,277</td>
</tr>
</tbody>
</table>

# Limited Mobility

- 3,940 reports

# Friction and Shear

- 2,314 reports

# Moisture

- 1,989 reports

# Poor Nutrition

- 1,942 reports

# Frail Skin

- 1,887 reports

# Impaired Sensory Function

- 1,634 reports

# Unknown

- 1,305 reports

# Edema

- 862 reports

# Other

- 830 reports

# BMI > 30

- 713 reports

# Dry Skin

- 688 reports

# Head of Bed Angle

- 517 reports

# Non-Compliance with Preventative Measures

- 479 reports

# Terminal Illness

- 412 reports

# Peripheral Vascular Disease

- 353 reports

# Multiple Organ Failure

- 352 reports

# BMI < 20

- 318 reports

# Prolonged Surgical Time

- 230 reports

# Smoking

- 122 reports

"# of Reports" indicates the number of patients who reported or exhibited that risk factor while at the facility in 2018. For example, 17.7% of patients (5,967 out of the total 33,656 patients who experienced falls) displayed signs of an altered mental status, while 24.1% (8,117) had fallen within the past year. Note that multiple risk factors may have been attributed to the patient in each reported event. Also note that additional risk factors for falls—such as hearing impairment, visual impairment, or depression—may have been present and contributed to the event, but were not observed or recorded, as not all facilities screen for them at admission.

"# of Reports" indicates the number of reports in which that risk factor was identified as contributing to the healthcare associated pressure injury (HAPI) in 2018. Note that multiple risk factors may have been identified for each reported HAPI.

Though HAPIs have long been considered the sole responsibility of nurses, the reported risk factors indicate the need to engage a multidisciplinary team for adequate injury prevention.

Physical and occupational therapists (PT/OT) could provide guidance for the management of patients with limited mobility, and a registered dietitian would be able to develop an individualized nutrition plan. Healthcare professionals with expertise in wound care or a designated wound care “champion” could provide guidance for the care of patients at high risk for or with previously acquired pressure injuries in collaboration with healthcare providers, who could review orders and monitor a patient for changes in physical or medical conditions which impact risk for pressure injuries.

**Most Commonly Reported Risk Factors for HAPI**

- Limited Mobility
- Friction & Shear
Most Commonly Reported Risk Factors for Falls

- Assistance to Rise From Chair
- Prior History of Falls
- Altered Mental Status

In-Depth Analysis

Moisture
Serious Events: Medication Errors

In 2018, 190 medication errors were reported as serious events, mentioning 90 unique medications. The most common medications involved in these events were insulin (17.9%), vancomycin (4.2%), and heparin (4.2%).

High-alert medications, drugs that bear a heightened risk of causing significant patient harm when they are used in error, represented about half of serious event reports. Insulin was the most common class of drugs (45% of events involving high-alert medications), followed by anticoagulants [e.g., heparin, enoxaparin (20%)] and adrenergic agonists [e.g., epinephrine, norepinephrine (16%)].

Analysis of the events mentioning insulin reveals a variety of contributing factors, including:

- Two of seven wrong dose/overdosage events mentioning insulin involved 10-fold overdoses (i.e., patient receiving 100 units of insulin instead of 10 units), three involved breakdowns during the medication reconciliation process, and only one involved an insulin infusion.
- Two of five dose omissions mentioning insulin involved the use of a patient’s own insulin pump and two situations in which not ordering insulin for the patient led to harm.
- All four wrong patient errors involved one patient’s insulin pen being administered to another patient.

In response, the Authority published several risk reduction strategies in the Advisory to prevent patient harm with the use of insulin, including:

- Never use an insulin pen for more than one person, even when the needle has been changed. They are designed for single patient use only.
- Clearly label insulin pens with the person’s name or other identifying information to ensure that the correct pen is used exclusively on one individual. Take care to not cover essential product information (e.g., product name) or the dosing window.
- Educate patients and their families or caregivers on medication reconciliation and the important role they play in the process.
- Work with vendors to ensure the medication administration record and prescription label match how medications are to be administered (e.g., 10 units) rather than how they are supplied (e.g., 100 units/mL).
Emergency Department
11.6% of Events
Most Common Drug:
Insulin (23%)

Med./Surg. Unit
11.6% of Events
Most Common Drug:
Insulin (18%)

Telemetry Unit
6.8% of Events
Most Common Drug:
Insulin (31%)

Event Reports by Process Step

Prescribing | Transcription | Preparation | Administration | Monitoring

Note: Reporters could select more than one node.

Event Reports by Type

Monitoring Error | Extra Dose | Dose Omission | Wrong Drug | Other | Overdosage

0 5 10 15 20 25 30 35 40 45
# Reports by Harm Score

<table>
<thead>
<tr>
<th>Harm Level</th>
<th>Harm Score</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsafe Conditions</td>
<td>A</td>
<td>Circumstances that could lead to an adverse event</td>
</tr>
<tr>
<td>Event, No Harm</td>
<td>B1, B2, C, D</td>
<td>Often called a “near miss,” an event that either did not reach the patient or did reach the patient but did not cause harm</td>
</tr>
<tr>
<td>Event, Harm (excluding death)</td>
<td>E, F, G, H</td>
<td>An event that reached the patient and caused temporary or permanent harm</td>
</tr>
<tr>
<td>Event, Death</td>
<td>I</td>
<td>An event that resulted in or contributed to death</td>
</tr>
</tbody>
</table>

### Percentage of Reports by Harm Score (2018)

![Graph showing percentage of reports by harm score.](image)

- **A** (Safe) - 9.46%
- **B1** - 1.28%
- **B2** - 12.52%
- **C** - 43.39%
- **D** - 30.51%
- **E** - 1.98%
- **F** - 0.75%
- **G** - 0.01%
- **H** - 0.03%
- **I** - 0.08%

**Serious Events**

**High Harm Events**
Type of Events Associated With Death (2018)

- **Complication (Proc./Treatment/Test)**: 110 reports
- **Error (Procedure/Treatment/Test)**: 21 reports
- **Self-Harm**: 12 reports
- **Patient Fall**: 8 reports
- **Adverse Drug Reaction**: 5 reports
- **Other**: 58 reports
Represented are the six most common event types for an inpatient setting. "Inpatient" refers to inpatients across all hospital types—psychiatric, children’s, critical access, etc.
59,956 reports

Represented are the six most common event types for an outpatient setting. “Outpatient” refers to patients at an ambulatory facility or outpatients at an acute care hospital.
Number and Percentage of Reports by Acute Care Facilities

Acute Care Hospitals · Event Types by Bed Count (2018)

*2004 did not include a full year of data; PA-PSRS accepted reports starting June 28, 2004.
Ambulatory Care Facilities – Most Commonly Reported Event Types

Error (Procedure/Treatment/Test) 35.5%
3,092 reports

- 2,863 were Surgery/Invasive Procedure
  - 73.7%: Procedure canceled
  - 10.8%: Other
  - 3.3%: Procedure not completed
- 116 - Laboratory Test
  - 28.4%: Mislabeled specimen
- 2,037 - Other
  - 450 - Unexpected transfer to higher level of care
  - 14 - Inappropriate Discharge
- 1,287 - Complication Following Surgery
  - 79.6%: Other
  - 15.6%: Unplanned return to the OR
- 493 - Other
  - 202 - Anesthesia
    - 55%: Other
    - 35.6%: Aspiration

Of these reports
- 2,037 - Other
  - 116 - Laboratory Test
  - 450 - Unexpected transfer to higher level of care
  - 14 - Inappropriate Discharge

Complication (Proc./Treatment/Test) 27.9%
2,426 reports

- 932 - Other
  - 444 - Unanticipated Transfer to Higher Level of Care
  - 1 - Inappropriate Discharge

Skin Integrity 2.4%
209 reports

- 60 - Skin Tear
- 60 - Other
- 34 - Abrasion

Psychiatric Hospitals

Patient Self-Harm 29.7%
1,628 reports

- 1,095 - Other Self-Harm
- 487 - Self-Mutilation
- 38 - Ingestion of Foreign Object or Substance
- 492 - Ambulating
- 263 - Found on Floor
- 193 - Other

Patient Fall 25.8%
1,415 reports

- 263 - Found on Floor
- 193 - Other

Other/Miscellaneous 25.1%
1,378 reports

- 372 - Dose Omission
- 112 - Extra Dose
- 74 - Wrong Drug
- 65 - Wrong Dose/Overdose

Medication Error 16.5%
905 reports
**Critical Access Hospitals** – Hospitals Designated by DOH to Provide Care in Rural Areas

**Error (Procedure/Treatment/Test)**
- 19.2% 409 reports

**Other/Miscellaneous**
- 16.9% 361 reports

**Patient Fall**
- 16.4% 349 reports

**Complication (Proc./Treatment/Test)**
- 16.3% 348 reports

---

**Rehabilitation Hospitals**

**Patient Fall**
- 37.8% 1,932 reports

**Skin Integrity**
- 20.5% 1,050 reports

**Medication Error**
- 17.7% 905 reports

**Other/Miscellaneous**
- 11.5% 586 reports

---

- Of these reports
  - 213 - Laboratory Test
    - 21.6%: Other
    - 17.8%: Specimen quality
  - 72 - Surgery/Invasive Procedure
    - 23.6%: Procedure canceled
  - 66 - Radiology/Imaging Test

- Of these reports
  - 322 - Other
  - 34 - Unanticipated Transfer to Higher Level of Care
  - 3 - Inappropriate Discharge

- Of these reports
  - 89 - Found on Floor
  - 53 - Ambulating
  - 45 - Sitting in Chair/Wheelchair

- 81 - Emergency Dept.
  - 55.6%: Unplanned return to ED
  - 42%: Other
  - 2.5%: Discrepancy b/w ED interpretation of X-ray or EKG and final reading
  - 60 - IV Site Complication
  - 51 - Other

- Of these reports
  - 407 - Skin Tear
    - 38.2%: Stage 2
    - 18.8%: Deep Tissue Injury
    - 16%: Unstageable
  - 245 - Other

- Of these reports
  - 287 - Dose Omission
  - 134 - Other
  - 84 - Wrong Time
  - 83 - Wrong Dose/Overdose
  - 70 - Wrong Drug

- 344 - Other
  - 234 - Unanticipated Transfer to Higher Level of Care
  - 7 - Other Unexpected Death

---
Teaching Hospitals – Hospitals Associated With a Medical College That Offers Clinical Training

- **Error (Procedure/Treatment/Test)**
  - 30.7%
  - 35,745 reports
  - Of these reports:
    - 14,631 - Laboratory Test
    - 29.9%: Specimen quality
    - 16.3%: Mislabeled specimen
    - 7,349 - Surgery/Invasive Procedure
      - 15.3%: Other
      - 8.8%: Consent missing/inadequate

- **Complication (Proc./Treatment/Test)**
  - 16.9%
  - 19,723 reports
  - Of these reports:
    - 3,206 - Complication following Surgery
      - 41.3%: Unplanned return to the OR
      - 40.4%: Other
      - 3.5%: Cardiopulmonary event
    - 2,910 - IV Site Complication
    - 2,504 - Other

- **Medication Error**
  - 15.3%
  - 17,835 reports
  - Of these reports:
    - 3,614 - Other
    - 2,569 - Dose Omission
    - 1,733 - Prescription/Refill Delay

- **Patient Fall**
  - 13.4%
  - 15,580 reports
  - Of these reports:
    - 3,990 - Found on Floor
    - 2,564 - Other
    - 2,463 - Ambulating

Long-Term Acute Care Hospitals – Hospitals That Specialize in Patients Requiring Extended Care

- **Medication Error**
  - 25.6%
  - 921 reports
  - Of these reports:
    - 286 - Dose Omission
    - 136 - Other
    - 88 - Wrong Dose/Underdosage
    - 82 - Wrong Drug
    - 61 - Wrong Dose/Overdosage

- **Complication (Proc./Treatment/Test)**
  - 17.2%
  - 620 reports
  - Of these reports:
    - 553 - Catheter/Tube
    - 28 - Complication following Surgery
      - 25 - Removal of tube/other medical device by patient
    - 17 - Other

- **Patient Fall**
  - 16.2%
  - 583 reports
  - Of these reports:
    - 349 - Found on Floor
    - 52 - Assisted Fall
    - 41 - Sitting at Side of Bed

- **Skin Integrity**
  - 15.2%
  - 548 reports
  - Of these reports:
    - 180 - Pressure Injury
    - 75 - Deep tissue injury
    - 36 - Stage 2
    - 32 - Unstageable
    - 140 - Skin Tear
These six regions are based on DOH’s Public Health Districts. The differences in events reported by region may be explained by noting variation of reporting patterns, i.e., more reports may be submitted in regions with larger populations and greater numbers of healthcare facilities. The number of patient days is based on 2017 PHC4 data.
Northwest

42.7 incidents
1,000 pt. days

1.1 serious events
1,000 pt. days

Southwest

30.9 incidents
1,000 pt. days

0.7 serious events
1,000 pt. days
**Northeast**

- Incidents per 1,000 pt. days: 26.7
- Serious events per 1,000 pt. days: 0.7

**Southeast**

- Incidents per 1,000 pt. days: 25.5
- Serious events per 1,000 pt. days: 0.5
<table>
<thead>
<tr>
<th>Region</th>
<th>Incidents (1,000 pt. days)</th>
<th>Serious Events (1,000 pt. days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Central</td>
<td>36.8</td>
<td>1.5</td>
</tr>
<tr>
<td>South Central</td>
<td>40.0</td>
<td>0.9</td>
</tr>
</tbody>
</table>
Of the 699 facilities actively registered into PA-PSRS as of December 31, 2018, analysis of healthcare-associated infections (HAI) could be conducted on 535 (76.5%). 164 facilities were excluded based on the following criteria:

- The long-term care (LTC) facility had one or more months with occupancy above 100% or below 50%. Occupancy is calculated by dividing the number of resident days during that month by the number of beds listed for each facility. The quotient is then divided by the number of days in that month. In 2018, 36 LTC facilities were excluded, compared to 25 in 2017.
- The number of resident days were not reported for one or more months during the year; 121 LTC facilities were excluded from 2018 data analysis, compared to 54 excluded in 2017.
- LTC facilities that did not report resident days at the unit level were excluded from unit level analysis. In 2018, seven LTC facilities were excluded, compared to two in 2017.

Highlights from the year:

- Katie Vivian and Lynette Hathaway were hired as infection prevention analysts.
- JoAnn Adkins and Terri Lee Roberts hosted four LTC infection prevention symposia across the Commonwealth for almost 300 participants.
- Adkins facilitated an antibiotic stewardship collaborative for 24 LTC facilities.
- Roberts presented on the early identification of sepsis in the nursing home setting for Telligen, the Medicare Quality Improvement Organization for Colorado, Iowa, and Illinois.
- Adkins presented at several conferences, including the Pennsylvania Association of Directors of Nursing Administration’s (PADONA) annual conference, the Pennsylvania Health Care Association’s (PHCA) annual conference, and the fifth annual Compliance and Risk Management Conference.
- Roberts presented to several industry leaders, including the Healthcare Council of Western Pennsylvania’s Long-Term Care Quality Committee and the Pennsylvania Coalition of Affiliated Healthcare & Living Communities (PACAH).
- Adkins and Roberts completed Infection Control Assessment and Response (ICAR) assessments for nine LTC facilities.
- Roberts conducted a webinar on safe infection prevention practices for LeadingAge PA.
HAI Reports (2018)

26,935

Most Frequently Reported Infection Types

Pneumonia (19.7%)
Cellulitis (19.6%)
SUTI (15.2%)

Respiratory Tract Infections

10,590

Skin and Soft Tissue Infections

8,448

Urinary Tract Infections

5,203

Gastrointestinal Infections

2,663

Device-Related Bloodstream Infections

31

Total HAI Reports Since 2009

306,290

Reports by Infection Type (2018)
Infection Rates by Unit Type

Central Line-Associated Bloodstream Infections (CLABSI)
- CLABSI Dialysis
- CLABSI Permanent Line
- CLABSI Temporary Line

Gastrointestinal Infections
- Bacterial Gastroenteritis
- *Clostridioides difficile* (C. diff)
  - Kaplan
  - Norovirus

Respiratory Tract Infections
- Influenza
- Influenza-Like Illness (ILI)
- Lower Resp. Tract Infection (LRTI)
- Pneumonia

Skin and Soft Tissue Infections
- Cellulitis
- Conjunctivitis
- Scabies

Urinary Tract Infections (UTI)
- Asymptomatic Bacteremic UTI
- Catheter-Associated UTI
- Device-Related ABUTI
- Symptomatic UTI
**Dementia Units** – Units That Provide Care for Residents With Dementia or Related Conditions

### Infection Rates per 10,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUTI</td>
<td>0.07</td>
<td>0.02</td>
</tr>
<tr>
<td>CAUTI</td>
<td>7.09</td>
<td>8.53</td>
</tr>
<tr>
<td>DR-ABUTI</td>
<td>0.57</td>
<td>0.32</td>
</tr>
<tr>
<td>SUTI</td>
<td>1.17</td>
<td>1.26</td>
</tr>
<tr>
<td>Influenza</td>
<td>0.51</td>
<td>0.76</td>
</tr>
<tr>
<td>ILI</td>
<td>0.07</td>
<td>0.1</td>
</tr>
<tr>
<td>LRTI</td>
<td>1.26</td>
<td>1.3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1.79</td>
<td>1.77</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>1.58</td>
<td>1.87</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>1.51</td>
<td>1.38</td>
</tr>
<tr>
<td>Scabies</td>
<td>0.21</td>
<td>0.14</td>
</tr>
</tbody>
</table>

### Infection Rates per 100,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.24</td>
<td>0</td>
</tr>
<tr>
<td>C. diff</td>
<td>2.53</td>
<td>2.61</td>
</tr>
<tr>
<td>Kaplan</td>
<td>7.06</td>
<td>10.2</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.67</td>
<td>0.28</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>18.74</td>
<td>0</td>
</tr>
</tbody>
</table>

### Infection Rates per 100,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.24</td>
<td>0</td>
</tr>
<tr>
<td>C. diff</td>
<td>2.53</td>
<td>2.61</td>
</tr>
<tr>
<td>Kaplan</td>
<td>7.06</td>
<td>10.2</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.67</td>
<td>0.28</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>18.74</td>
<td>0</td>
</tr>
</tbody>
</table>
**Mixed Units** – Units Where Fewer Than 80% of Residents Are of the Same Type/Acuity

**Infection Rates per 10,000 Resident/Device Days**

![Infection Rates Chart]

**Infection Rates per 10,000 Resident/Device Days**

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUTI</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>CAUTI</td>
<td>10.52</td>
<td>9.4</td>
</tr>
<tr>
<td>DR-ABUTI</td>
<td>0.49</td>
<td>0.48</td>
</tr>
<tr>
<td>SUTI</td>
<td>1.89</td>
<td>1.95</td>
</tr>
<tr>
<td>Influenza</td>
<td>0.76</td>
<td>0.97</td>
</tr>
<tr>
<td>ILI</td>
<td>0.12</td>
<td>0.11</td>
</tr>
<tr>
<td>LRTI</td>
<td>1.27</td>
<td>1.27</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2.39</td>
<td>2.46</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>2.09</td>
<td>2.37</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>1.37</td>
<td>1.28</td>
</tr>
<tr>
<td>Scabies</td>
<td>0.1</td>
<td>0.06</td>
</tr>
</tbody>
</table>

**Infection Rates per 100,000 Resident/Device Days**

<table>
<thead>
<tr>
<th>Infection Rates</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.14</td>
<td>0.03</td>
</tr>
<tr>
<td>C. diff</td>
<td>6.39</td>
<td>5.45</td>
</tr>
<tr>
<td>Kaplan</td>
<td>5.11</td>
<td>4.9</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.3</td>
<td>0.26</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>5.15</td>
<td>4.61</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0.86</td>
<td>1.84</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>6.86</td>
<td>4.61</td>
</tr>
</tbody>
</table>

![Infection Rates Chart]

**Infection Rates per 100,000 Resident/Device Days**

<table>
<thead>
<tr>
<th>Infection Rates</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.14</td>
<td>0.03</td>
</tr>
<tr>
<td>C. diff</td>
<td>6.39</td>
<td>5.45</td>
</tr>
<tr>
<td>Kaplan</td>
<td>5.11</td>
<td>4.9</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.3</td>
<td>0.26</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>5.15</td>
<td>4.61</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0.86</td>
<td>1.84</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>6.86</td>
<td>4.61</td>
</tr>
</tbody>
</table>
Nursing Units – Units That Provide General Nursing Care

Infection Rates per 10,000 Resident/Device Days

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUTI</td>
<td>0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>CAUTI</td>
<td>7.85</td>
<td>7.76</td>
</tr>
<tr>
<td>DR-ABUTI</td>
<td>0.45</td>
<td>0.35</td>
</tr>
<tr>
<td>SUTI</td>
<td>1.41</td>
<td>1.62</td>
</tr>
<tr>
<td>Influenza</td>
<td>0.65</td>
<td>0.88</td>
</tr>
<tr>
<td>ILI</td>
<td>0.05</td>
<td>0.14</td>
</tr>
<tr>
<td>LRTI</td>
<td>1.12</td>
<td>1.21</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2.08</td>
<td>2.25</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>1.93</td>
<td>2.28</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>1.36</td>
<td>1.37</td>
</tr>
<tr>
<td>Scabies</td>
<td>0.06</td>
<td>0.09</td>
</tr>
</tbody>
</table>

Infection Rates per 100,000 Resident/Device Days

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.06</td>
<td>0.04</td>
</tr>
<tr>
<td>C. diff</td>
<td>4.97</td>
<td>5.31</td>
</tr>
<tr>
<td>Kaplan</td>
<td>4.24</td>
<td>6.39</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.54</td>
<td>0.54</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>4.02</td>
<td>8.17</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>2.01</td>
<td>4.67</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>1.07</td>
<td>1.17</td>
</tr>
</tbody>
</table>
Skilled Nursing/Short-Term Rehabilitation Units – Units That Provide Skilled Nursing Care and/or Rehabilitation

Infection Rates per 10,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUTI</td>
<td>0.59</td>
<td>0.1</td>
</tr>
<tr>
<td>CAUTI</td>
<td>8.62</td>
<td>9.88</td>
</tr>
<tr>
<td>SUTI</td>
<td>0.66</td>
<td>0.57</td>
</tr>
<tr>
<td>Influenza</td>
<td>1.87</td>
<td>2.03</td>
</tr>
<tr>
<td>ILI</td>
<td>0.68</td>
<td>1.19</td>
</tr>
<tr>
<td>LRTI</td>
<td>0.07</td>
<td>0.12</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1.3</td>
<td>1.29</td>
</tr>
<tr>
<td>Bacterial Gastro</td>
<td>2.41</td>
<td>2.48</td>
</tr>
<tr>
<td>C. diff</td>
<td>2.28</td>
<td>2.51</td>
</tr>
<tr>
<td>Kaplan</td>
<td>1.28</td>
<td>1.38</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.07</td>
<td>0.06</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>0.11</td>
<td>0.06</td>
</tr>
</tbody>
</table>

Infection Rates per 100,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0.14</td>
<td>0.06</td>
</tr>
<tr>
<td>C. diff</td>
<td>10.67</td>
<td>8.35</td>
</tr>
<tr>
<td>Kaplan</td>
<td>6.38</td>
<td>3.65</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0.37</td>
<td>0.28</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>5.37</td>
<td>3.35</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>4.84</td>
<td>0.67</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>4.84</td>
<td>0.67</td>
</tr>
</tbody>
</table>
Ventilator Units - Units That Provide Care for Residents Who Require Mechanical Ventilation

Infection Rates per 10,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABUTI</td>
<td>0.16</td>
<td>0</td>
</tr>
<tr>
<td>CAUTI</td>
<td>11.3</td>
<td>3.98</td>
</tr>
<tr>
<td>DR-ABUTI</td>
<td>1.26</td>
<td>0</td>
</tr>
<tr>
<td>SUTI</td>
<td>0.56</td>
<td>2.04</td>
</tr>
<tr>
<td>Influenza</td>
<td>0.08</td>
<td>0.54</td>
</tr>
<tr>
<td>ILI</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LRTI</td>
<td>2.79</td>
<td>0.41</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>7.34</td>
<td>6.66</td>
</tr>
<tr>
<td>Bacterial Gastro</td>
<td>2.39</td>
<td>3.4</td>
</tr>
<tr>
<td>C. diff</td>
<td>0.56</td>
<td>0</td>
</tr>
<tr>
<td>Kaplan</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Norovirus</td>
<td>9.69</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>0</td>
<td>9.69</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>2.23</td>
<td>2.04</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Scabies</td>
<td>0.08</td>
<td>0</td>
</tr>
</tbody>
</table>

Infection Rates per 100,000 Resident/Device Days

<table>
<thead>
<tr>
<th>Infection Type</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial Gastro</td>
<td>0</td>
<td>1.36</td>
</tr>
<tr>
<td>C. diff</td>
<td>26.32</td>
<td>16.31</td>
</tr>
<tr>
<td>Kaplan</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Norovirus</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Dialysis</td>
<td>9.69</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Perm Line</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CLABSI Temp Line</td>
<td>9.69</td>
<td>0</td>
</tr>
</tbody>
</table>

65
66
The Authority’s FY18–19 budget totals $8.60 million. Of this amount, approximately $7.40 million is budgeted for acute-care related expenditures, funded in part by the DOH. The FY18–19 acute-care assessment total and is 7.2% less than the maximum annual amount that could have been assessed for the fiscal-year pursuant to Section 305(d) of the MCARE Act. In FY18–19, the Authority Board authorized the use of the Northeast medical care services CPI to calculate maximum allowable assessments.

At the time of the FY18–19 acute-care assessment recommendation, the Authority Board considered several points, including the following:

- The Authority’s FY18–19 budget totals $8.60 million. Of this amount, approximately $7.40 million is budgeted for acute-care related expenditures, funded in part by the DOH.
- The Board maintained the Authority’s FY18–19 budget of $8.60 million at the same total as the FY17–18 budget.
- The FY18–19 acute-care assessment of $6.86 million has increased by $1.86 million since the Authority’s initial FY02–03 acute-care assessment of $5.0 million, an average increase of 2.32% per year.

While the Authority experienced a small increase in staff size and increases in Commonwealth of Pennsylvania–mandated burdened benefit rates in 2018, the FY18–19 budget and assessments were maintained at FY17–18 levels, owing to the Authority’s control of FY17–18 expenditures and continued supplementation of nonassessment revenue receipts.

### Funding From Nursing Homes

Act 52 of 2007, amending the MCARE Act, allows the DOH to assess Pennsylvania nursing homes up to an aggregate amount of $1 million per year for any one year, beginning in 2008, plus an annual increase based on the CPI for each subsequent year. In 2008, following the Authority’s suggestion, the DOH assessed 725 nursing home facilities a total of $1,000,000 and transferred $1,000,782 to the Fund for FY08–09. This money could be spent only on activities related to HAI and implementation and maintenance of Chapter 4 of the MCARE Act. For FY18–19, the Act 52 maximum allowable assessment is $1,193,677, against the Authority Board’s approved aggregate assessment of $1,140,000.

On December 13, 2018, the Board authorized a recommendation to the DOH for FY18–19 nursing home assessment surcharges totaling $6.86 million. This amount is equal to and maintains the FY17–18 acute-care assessment total and is 4.5% under the maximum annual amount that could have been assessed for the fiscal-year pursuant to Section 409(b) of the MCARE Act. In FY18–19, the Authority Board authorized the use of the Northeast medical care services CPI to calculate maximum allowable assessments.

### Financials & Contracts

The MCARE Act established the Patient Safety Trust Fund (Trust) as a separate account in the Pennsylvania Treasury. Under the MCARE Act, the Authority determines how those funds are used to effectuate the patient safety provisions of the Act and administers funds in the Trust. Funds mainly come from assessment surcharges made by the Department of Health (DOH) on certain medical facilities.

The Authority recognizes that Pennsylvania hospitals, birthing centers, ambulatory surgical facilities, abortion facilities, and nursing homes bear financial responsibility for costs associated with complying with mandatory reporting requirements. Accordingly, the Authority has focused on two fiscal goals: (1) to be prudent in the use of money contributed by the healthcare industry and (2) to assure that healthcare facilities paying for the Pennsylvania Patient Safety Reporting System (PA-PSRS) receive direct benefits from the system and from Authority programs in return.

Pursuant to Section 304(a)(4) of the MCARE Act, as a general rule, the Authority is authorized to receive funds from any source consistent with the Authority’s purposes under the Act. Consistent with this mandate, the Authority at times contracts with and receives funding from other healthcare-related entities to reduce medical errors and promote patient safety in the Commonwealth.

These contracts in 2018 are described in the section “Contracts Under Which the Authority Received Revenue in 2018 as a Contractor,” which lists contracts with The Hospital and Health System Association of Pennsylvania (HAP) and The Health Care Improvement Foundation (HCIF).

Within the design of PA-PSRS, the Authority includes a variety of integral and analytical tools that provide immediate, real-time feedback to facilities on their own adverse event and near-miss reports and activities. In 2018, the Authority continued to enhance its newly designed public website, patientsafety.pa.gov, providing expanded access to the Authority’s educational materials and programs, as well as mobile accessibility. The Authority also recently released a Pressure Injury module within PA-PSRS, culminating months of design, development, and testing. In 2018, the Authority continued development of the PA-PSRS Application Modernization (AMOD). The AMOD project entails a complete redesign of the PA-PSRS application, with a planned spring 2019 release to facilities.

### Funding From Hospitals, Birthing Centers, ASFs, and Abortion Facilities

The MCARE Act set an initial limit of $5 million on the total aggregate assessment on acute-care facilities for any one year, beginning in 2002, plus an increase based on the consumer price index (CPI) for each subsequent year. For fiscal year 2018–2019 (FY18–19), the maximum allowable acute-care assessment is $7,393,707, against the Authority Board’s approved aggregate acute-care assessment of $6,860,000.

On December 13, 2018, the Board authorized a recommendation to DOH for FY18–19 acute-care assessment surcharges totaling $6.86 million. This amount is equal to and maintains the FY17–18 acute-care assessment total and is 7.2% less than the maximum annual amount that could have been assessed for the fiscal-year pursuant to Section 305(d) of the MCARE Act. In FY18–19, the Authority Board authorized the use of the Northeast medical care services CPI to calculate maximum allowable assessments.
Table 1. Acute-Care Facility Assessments

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>NUMBER OF FACILITIES ASSESSED BY DOH</th>
<th>APPROVED ASSESSMENTS</th>
<th>TOTAL ASSESSMENTS RECEIVED BY DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002-03</td>
<td>356</td>
<td>$5,000,000</td>
<td>$4,663,000</td>
</tr>
<tr>
<td>2003-04</td>
<td>377</td>
<td>$2,500,000</td>
<td>$2,542,316</td>
</tr>
<tr>
<td>2004-05</td>
<td>414</td>
<td>$2,500,000</td>
<td>$2,508,787</td>
</tr>
<tr>
<td>2005-06</td>
<td>450</td>
<td>$2,500,000</td>
<td>$2,501,149</td>
</tr>
<tr>
<td>2006-07</td>
<td>453</td>
<td>$2,500,000</td>
<td>$2,500,034</td>
</tr>
<tr>
<td>2007-08</td>
<td>526</td>
<td>$5,400,000</td>
<td>$5,391,583</td>
</tr>
<tr>
<td>2008-09</td>
<td>524</td>
<td>$4,000,000</td>
<td>$3,972,677</td>
</tr>
<tr>
<td>2009-10</td>
<td>519</td>
<td>$5,000,000</td>
<td>$4,989,781</td>
</tr>
<tr>
<td>2010-11</td>
<td>542</td>
<td>$5,000,000</td>
<td>$4,981,443</td>
</tr>
<tr>
<td>2011-12</td>
<td>550</td>
<td>$5,100,000</td>
<td>$5,063,723</td>
</tr>
<tr>
<td>2012-13</td>
<td>545</td>
<td>$5,500,000</td>
<td>$5,504,549</td>
</tr>
<tr>
<td>2013-14</td>
<td>556</td>
<td>$5,500,000</td>
<td>$5,492,002</td>
</tr>
<tr>
<td>2014-15</td>
<td>564</td>
<td>$6,200,000</td>
<td>$6,209,459</td>
</tr>
<tr>
<td>2015-16</td>
<td>569</td>
<td>$6,500,000</td>
<td>$6,494,845</td>
</tr>
<tr>
<td>2016-17</td>
<td>575</td>
<td>$6,675,000</td>
<td>$6,656,359</td>
</tr>
<tr>
<td>2017-18</td>
<td>583</td>
<td>$6,860,000</td>
<td>$6,860,164</td>
</tr>
<tr>
<td>2018-19c</td>
<td></td>
<td>$6,860,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$76,330,871</strong></td>
</tr>
</tbody>
</table>

a. The number of facilities assessed by the Department of Health differs from the number of the Medical Care Availability and Reduction of Error (MCARE) Act’s facilities cited elsewhere in this report because of differences in the dates chosen to calculate the number of facilities for these two different purposes.

b. Amounts assessed and amounts received differ because a few facilities may have closed in the interim or are in bankruptcy. In a few cases, the Department of Health has pursued action to enforce facility compliance with the MCARE Act’s assessment requirement.

c. 2018-19 missing figures were unavailable at the time of publication and will appear in next year’s annual report.

Table 2. Nursing Home Assessments

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>NUMBER OF FACILITIES ASSESSED BY DOH</th>
<th>APPROVED ASSESSMENTS</th>
<th>TOTAL ASSESSMENTS RECEIVED BY DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>725</td>
<td>$1,000,000</td>
<td>$1,000,782</td>
</tr>
<tr>
<td>2009-10</td>
<td>711</td>
<td>$800,000</td>
<td>$799,382</td>
</tr>
<tr>
<td>2010-11</td>
<td>707</td>
<td>$800,000</td>
<td>$799,829</td>
</tr>
<tr>
<td>2011-12</td>
<td>707</td>
<td>$800,000</td>
<td>$804,473</td>
</tr>
<tr>
<td>2012-13</td>
<td>711</td>
<td>$900,000</td>
<td>$913,315</td>
</tr>
<tr>
<td>2013-14</td>
<td>698</td>
<td>$1,000,000</td>
<td>$998,751</td>
</tr>
<tr>
<td>2014-15</td>
<td>703</td>
<td>$1,050,000</td>
<td>$1,049,842</td>
</tr>
<tr>
<td>2015-16</td>
<td>702</td>
<td>$1,080,000</td>
<td>$1,079,505</td>
</tr>
<tr>
<td>2016-17</td>
<td>704</td>
<td>$1,111,000</td>
<td>$1,110,185</td>
</tr>
<tr>
<td>2017-18</td>
<td>699</td>
<td>$1,140,000</td>
<td>$1,139,483</td>
</tr>
<tr>
<td>2018-19a</td>
<td>699</td>
<td>$1,140,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$9,695,547</strong></td>
</tr>
</tbody>
</table>

a. FY 2018-2019 missing figures were unavailable at the time of publication and will appear in the next year’s annual report.
Annual Expenditures & Revenue
Table 3a. 2018 Expenditures

<table>
<thead>
<tr>
<th></th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>$3,116,104</td>
</tr>
<tr>
<td>Operating</td>
<td>$4,328,541</td>
</tr>
<tr>
<td><strong>Total 2018 Expenditures</strong></td>
<td><strong>$7,444,645</strong></td>
</tr>
</tbody>
</table>

Table 3b. 2018 Revenue Receipts

<table>
<thead>
<tr>
<th></th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Assessments</td>
<td>$6,860,164</td>
</tr>
<tr>
<td>Nursing Home Assessments</td>
<td>$1,139,484</td>
</tr>
<tr>
<td>Non-Assessment Revenue</td>
<td>$595,521</td>
</tr>
<tr>
<td><strong>Total 2018 Revenue Receipts</strong></td>
<td><strong>$8,595,169</strong></td>
</tr>
</tbody>
</table>

Patient Safety Authority Contracts

During calendar year 2018, the Authority received services under the following contracts (FC, or funds commitment; PO, or purchase order).

**ECRI Institute, FC # 4000018888**
Four-year, nine-month (October 1, 2014, through June 30, 2019) contract for program administration, clinical analysis, training and data collection, and reporting infrastructure services.
Total contract amount: $24,227,233 over four years and nine months
Amount invoiced for 2014 (October through December): $1,135,983.79
Amount invoiced for CY2015: $4,824,833.20
Amount invoiced for CY2016: $4,947,215.02
Amount invoiced for CY2017: $4,757,501.80
Amount invoiced for CY2018: $3,931,143.41

**Ricoh USA, Inc.**
Ricoh Color MFD lease, PO # 4500841111
September 1, 2017, to August 31, 2021, at $328.17/month
Total 12-month Ricoh lease expense paid in CY2018: $3,938.04

**XEROX Corp.**
Xerox color MFD lease, PO # 4600015253
October 1, 2017, to September 30, 2021, at $315.41/month
Total 12-month Xerox lease expense paid in CY2018: $3,784.92

Contracts Under Which the Authority Received Revenue in 2018 as a Contractor:

**HCIF (Health Care Improvement Foundation)**
Agreement #2 (Completed), and #3 (Ongoing) – Health Literacy
HCIF 2 Total Receipts in 2018: $9,615.63
HCIF 3 Total Receipts in 2018: $1,567.92

**HAP/CMS Subcontract Agreement – Hospital Innovation Improvement Networks (HIIN)**
Total Receipts in 2018: $541,097.54

**HAP HAI Infection Prevention Agreement**
Total Receipts in 2018: $32,000.00

Other Contracts Under Which the Authority Received Revenue in 2018:

**Eventbrite – Online Conference Registration and Payment Processing**
Net Registration Receipts From 2018 Pennsylvania Patient Safety Symposium (P2S2): $10,939.80

Patient Safety Authority Balance Sheet

<table>
<thead>
<tr>
<th>ASSETS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Investments</td>
<td>$6,979,999</td>
</tr>
<tr>
<td>Receivables, net:</td>
<td></td>
</tr>
<tr>
<td>Assessment Revenue</td>
<td>$8,000,000</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$14,979,999</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES AND FUND BALANCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable and Accrued Liabilities</td>
<td>$0</td>
</tr>
<tr>
<td>Invoices Payable</td>
<td>$851,899</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td><strong>$851,899</strong></td>
</tr>
<tr>
<td>Deferred Assessment Revenue</td>
<td>$8,000,000</td>
</tr>
<tr>
<td><strong>TOTAL DEFERRED INFLOW OF RESOURCES</strong></td>
<td><strong>$8,000,000</strong></td>
</tr>
<tr>
<td>Restricted</td>
<td>$6,116,100</td>
</tr>
<tr>
<td><strong>TOTAL FUND BALANCE</strong></td>
<td><strong>$6,116,100</strong></td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND FUND BALANCE</strong></td>
<td><strong>$14,967,999</strong></td>
</tr>
</tbody>
</table>

Referrals & Anonymous Reports

Referrals to Licensure Boards
The MCARE Act requires that the Authority identify referrals to licensure boards for failure to submit reports under the Act’s reporting requirements. MCARE specifies that it is the medical facility’s responsibility to notify the licensee’s licensing board of failure to report.

No such situations were reported to the Authority during 2018. However, the Authority is unlikely to receive information related to a referral to licensure board because PA-PSRS reports do not include the names of individual licensed practitioners.

Anonymous Reports
The MCARE Act allows healthcare workers to submit an “anonymous report.” Under the provision, a healthcare worker who has complied with section 308(a) of the act may file an anonymous report regarding a serious event. The form is available on the Authority’s website and through the PA-PSRS system. The Authority developed an “Anonymous Reporting” guide to ensure healthcare workers are aware of their option to submit an anonymous report and encourages them to do so when they believe their facility is not appropriately reporting or responding to a serious event.

Liaisons also review the anonymous reporting process with new PSOs as part of their onboarding program. Individuals completing the form do not need to identify themselves, and the Authority assigns professional clinical staff to conduct any subsequent investigations. In 2018, the Authority received five anonymous reports that complied with MCARE Act requirements.
Thanks to the members of our Patient Advisory Panel and Healthcare-Associated Infection Advisory Panel for their service and expertise! We appreciate what you do to be a spark and set the world on fire.
Thank You!

Patient Advisory Panel
- Lucas Wickard
- Dwight D. McKay
- Jennifer Hamm
- Danielle Jurgill
- Lisa Rodebaugh
- Mohammad H. Yassin, MD, PhD
- Bettina Dixon, DNP, CRNA
- Patricia Hennessey, MSN, RN
- James Hollingsworth, MSN, RN
- Darryl Jackson, MD
- Tricia Kradel, PhD, MPH
- Chris Marshall, PharmD, MBA
- Shane Walker
- Paige Van Wirth, MD
- Jason Raines, MPA, MBA
- Dony Frain

HAI Advisory Panel
- Dorothy, D. Horton, RN
- Kenneth J. Brubaker, MD
- Susan E. Coffin, MD, MPH
- David A. Nace, MD, MPH
- Emily G. Shears, MPH
- Mohamed H. Yassin, MD, PhD
- Bettina Dixon, DNP, CRNA
- Particia Hennessey, MSN, RN
- James Hollingsworth, MSN, RN
- Darryl Jackson, MD
- Tricia Kradel, PhD, MPH
- Chris Marshall, PharmD, MBA
- Shane Walker
- Paige Van Wirth, MD
- Jason Raines, MPA, MBA
- Dony Frain