Patient Safety Authority
2020 Annual Report

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

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> **Today is only one day in all the days that will ever be. But what will happen in all the other days that ever come can depend on what you do today.**
>
> ***– Ernest Hemingway***

Though Ernest Hemingway wrote these words more than 80 years ago, they rang as true in 2020 as they did in 1940. Each passing day carried the weight of the entire future. The decisions made each day determined the next day's success and failure.

Contained in these pages are stories from last year. Many of them ours: Patient Safety Authority staff worked around-the-clock supporting "at risk" facilities in their darkest hours to secure personal protective equipment (PPE); stay apprised of the most current, ever-evolving research; and develop facility-specific plans to protect patients and residents.

But many are from healthcare facilities too. Stories of triumph over the invisible menace, such as one hospital who overcame a shortage of isolation rooms by converting an entire floor to negative pressure, as well as of individuals and teams who maintained focus on persisting challenges, such as a nursing unit that achieved the unachievable by preventing falls for an entire year.

Despite the seemingly insurmountable odds, healthcare facilities across the Commonwealth, United States, and abroad rose to the occasion and proved that ingenuity, tenacity, and teamwork can overcome anything.

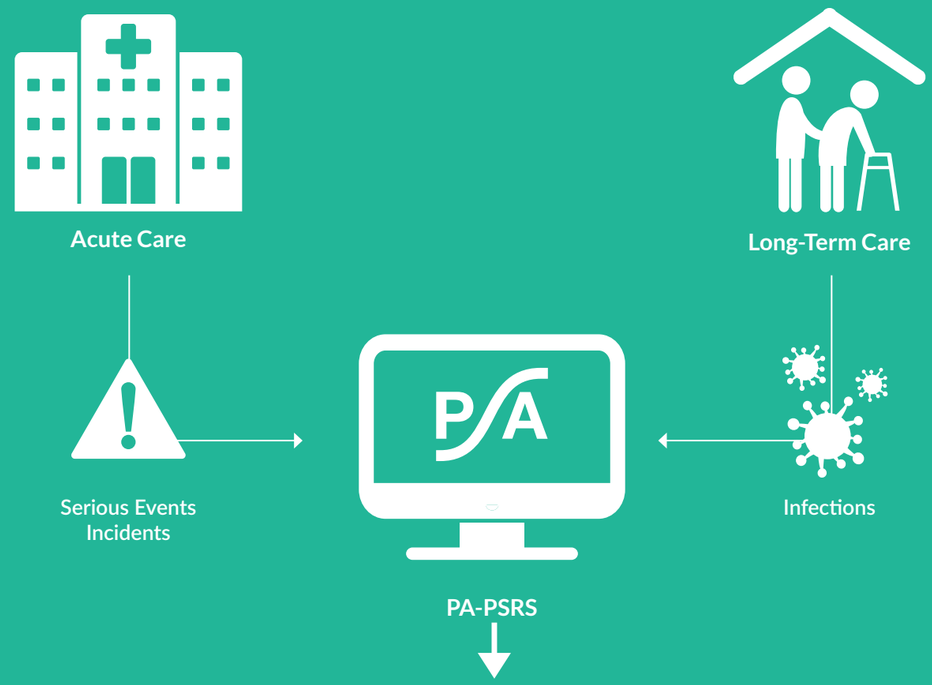
We share these stories as a reminder that what you do today matters.

Thank you to our frontline heroes for their continued bravery and sacrifice.

Fast Facts

The Patient Safety Authority (PSA) is an independent state agency that collects reports of patient safety events from Pennsylvania healthcare facilities. Pennsylvania is the only state that requires acute care facilities to report all incidents of harm (serious events) or potential for harm (incidents). Long-term care facilities report infections into the Pennsylvania Patient Safety Reporting System (PA-PSRS), as outlined by Pennsylvania Act 52 of 2007.

The PSA analyzes those reports to prevent recurrence—either by identifying trends unapparent to a single facility or flagging a single event that has a high likelihood of recurrence—and disseminates that information through multiple channels.



- Founded in 2002 by the Pennsylvania Medical Care Availability and Reduction of Error Act (commonly referred to as "Act 13" or "the MCARE Act")
- Vision: Safe healthcare for all patients
- PA-PSRS is one of the largest patient safety databases in the world, with more than 4 million event reports
- Governed by an 11-member board appointed by the governor and Pennsylvania legislature

Actionable Insights
from across Pennsylvania

To better understand the patient experience during the pandemic, a team at **Pennsylvania Hospital** embraced the idea of "going to the gemba," a lean principle based on the Japanese term gemba, meaning "the actual place." They met patients when they were dropped off and accompanied them to their treatment areas, gaining insights into what they perceived to be safe so they could improve patient safety and trust in the hospital.

Actionable Insight: *Patient involvement builds trust and helps clinicians consider the inconceivable.*

At **Thomas Jefferson University Hospital**, despite the personal risks to them and loved ones, 9 & 10 Thompson staff made the decision each day to aid and heal patients—studying new medications and their complicated administrations and compassionately holding the hands of those who didn't make it. They also helped each other, from donning and doffing personal protective equipment to opening their own homes so staff who could not risk exposing elderly parents or children had a safe place to decompress after a difficult shift.

Actionable Insight: *2020 proved the only path forward is working together.*

During an emergency boil water advisory at **Einstein Endoscopy Center–Blue Bell**, an employee raised the issue of a potential impact on high-level disinfection and the processing of scopes. Collaboration between infection prevention, patient safety, and the scope manufacturer confirmed such an impact, and the facility immediately implemented an alternative plan for appropriately disinfecting the scopes. This employee's quick thinking, communication, and participation in the action plan helped prevent harm to patients under unique circumstances.

Actionable Insight: *Now more than ever, ingenuity and creative thinking are necessities of safe care.*

A registered nurse caring for a patient who had a transmetatarsal amputation at a Pennsylvania hospital noted subtle changes in their mental status assessment as well as a 102-degree fever and heart rate over 100. As providers worked up the patient for sepsis of unknown source, she received permission from the internal medicine provider to remove the patient's postoperative splint and dressing—revealing the incision site and surrounding tissue to be necrotic. The patient returned to surgery for further amputation. The nurse's observational and critical thinking skills led to the discovery of the source of sepsis and more rapid treatment.

Actionable Insight: *The pervasiveness and aggressiveness of infections make source identification a crucial component of combating sepsis.*

Within four hours, the facilities team, the environmental services team, and the emergency management coordinator at **UPMC Lock Haven** created five negative pressure rooms in an isolated hallway to care for COVID-positive patients. This novel unit then received five COVID-positive residents within the next eight hours.

Actionable Insight: *Crises prove the seemingly impossible can be done.*

A respiratory therapist at **UPMC Magee-Womens Hospital** helped avert potential harm to his patient when he noticed something alarming in their chest X-ray and brought it to the attention of the medical team. The team ordered a CT angiography scan, which led to a diagnosis of bilateral pulmonary emboli: blockages in the lung's arteries. Without the respiratory therapist's advocacy for his patient, the problem could have been missed, resulting in delayed treatment or serious complications.

Actionable Insight: *Any member of the care team may be the first to identify a critical change in status or clinical finding.*

A nurse at **Forbes Hospital – Allegheny Health Network** discovered the operating room schedule and electronic health record indicated a surgery to be performed on the patient's left side, but the right side was marked and consent forms named the right. They notified the surgeon and determined it was a scheduling error; after verifying the right side with two nurses, a certified registered nurse anesthetist, the surgeon, and the patient, the surgery was done on the correct side. This preprocedure assessment improves patient safety with verification every time of right patient, right procedure, and right area for surgery.

Actionable Insight: *Multiple checks and redundancies are required to prevent wrong-site surgery.*

A team at **Allegheny Valley Hospital, part of the Allegheny Health Network**—consisting of the perioperative manager, the director of perioperative education, the chief of surgery, and the entire surgical team, with leadership support—created an orientation video for new perioperative employees about the recently established Hard Stop policy, which empowers staff to advocate and "stop the line" when anyone feels that patient safety is in jeopardy.

Actionable Insight: *Safety increases when each member of the care team is empowered—and encouraged—to speak up.*

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 2020, Pennsylvania had 18 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 PSA considers this term to be broader than "medical error," because some adverse events may result from clinical care without necessarily involving an error. And not all adverse events are preventable.

Although PA-PSRS includes reports of events that resulted from errors, the PSA'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 2020, there were 337 qualifying ASFs in Pennsylvania.

ANALYST

The analyst is a member of the PSA 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 PSA's quarterly, peer-reviewed journal, *Patient Safety*.

BIRTHING CENTER

The HCFA defines a birthing center as "a facility not part of a hospital which provides maternity care to childbearing 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 2020, Pennsylvania had five 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, or rehabilitation services for the rehabilitation 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 2020, Pennsylvania had 235 qualifying hospitals.

INCIDENT

A "potential adverse event": 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 event 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

A "preventable adverse event": 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 PSA. 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 701 qualifying nursing homes at the end of 2020.

OTHER EVENT TYPE

The Centers for Medicare & 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 PSA 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 EVENT

An event, occurence, or condition that could have resulted or did result in harm to a patient and can be but is not necessarily the result of a defective system or process design, a system breakdown, equipment failure or human error. They can also include adverse events, no-harm events, near misses, and hazardous conditions.

PATIENT SAFETY LIAISON

The patient safety liaison (PSL) is a unique resource to Pennsylvania MCARE facilities. Serving as the face of the PSA, the PSL provides education and consultation to MCARE facilities and ensures that facilities are aware of the resources available to them through the PSA, 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 someone 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 PSA.

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 PSA, 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 PSA and DOH.

Executive Summary

Like everyone, much of the PSA's efforts in 2020 focused on COVID-19. Once news of the pandemic hit, the field staff, led by our team of infection preventionists, began providing virtual consultations for healthcare facilities across Pennsylvania covering everything from cleaning protocols to obtaining additional personal protective equipment. Sometimes the team just provided emotional support for frontline staff during their darkest hours.

Our Data Science and Research team analyzed Pennsylvania Patient Safety Reporting System (PA-PSRS) reports to identify trends related to COVID-19, as well as its correlation with established causes of harm like falls, medication errors, or surgical complications.

In 2020, *Patient Safety* celebrated its first full calendar year of existence, its sixth issue, and more than 60 published manuscripts, including an in-depth look at prone positioning and patients with acute respiratory distress syndrome; an analysis of wrong-site surgery in Pennsylvania healthcare facilities; interviews with industry experts on pandemic-induced clinician burnout, sepsis, and patient advocacy; and four patient commentaries.

Highlights from 2020 include:

- PSA infection preventionists provided more than 800 consultations to Pennsylvania facilities about the pandemic
- *Patient Safety*, the PSA's quarterly, peer-reviewed journal, won three awards for publication excellence: the MarCom 2020 Platinum Award for "Government Publication," the APEX 2020 Grand Award for "Most Improved Publication," and Ragan's PR Daily Award Finalist for best "Healthcare Digital Publication"
- *Patient Safety* reached 43,000 readers across 163 countries and all 50 states
- The PSA partnered with national experts and Pennsylvania hospitals to develop a video series to improve safety of telemetry monitoring
- Data analyst Elizabeth Kukielka was elected to the Temple University School of Pharmacy Alumni Association board of directors and joined the executive board as secretary
- Kukielka also co-presented at the 2020 Pennsylvania Society of Health-System Pharmacists (PSHP) Emergency Preparedness Management Virtual Summit and the 52nd Annual PSHP Assembly
- Following the PA-PSRS Application Modernization (AMOD) in 2019, PSA decommissioned all previous PA-PSRS servers and associated services at the Commonwealth's enterprise data center in 2020, resulting in savings of $32,000, or 34% from the previous year
- Director of Engagement Caitlyn Allen served on the Communications Committee for the Philadelphia chapter of the American College of Healthcare Executives (ACHE)
- The PSA partnered with Pennsylvania celebrities to raise awareness about influenza vaccination during its *Knock Out the Flu, PA* campaign. Participants included the Philadelphia Phillies; the Philadelphia Union; Karen Rogers of 6abc; CEO of Big Brothers Big Sisters Independence, Marcus Allen; and *Philadelphia Inquirer* food critic, Craig LaBan
- The PSA's 2019 annual report, *Actionable Insights*, received the MarCom 2020 Gold Award for "Government Annual Report"

Long-Term Care

- Provided more than 800 consultations to nursing homes on COVID-19, covering everything from acquiring personal protective equipment and visitor restrictions to protocols for screening personnel
- In conjunction with the Department of Health, completed 68 risk assessments to LTC facilities deemed "at high risk" of having a COVID-19 patient
- Held two Q&A sessions targeted to LTC facilities: *Ask an Infection Preventionist*
- Developed three LTC-focused educational resources, *The Lowdown*, that covered topics ranging from COVID-19 to influenza vaccination

Diagnostic Excellence

- Held focus groups to gain further insight into perspectives and experiences of the diagnostic process and diagnostic improvement work in Pennsylvania
- Continued as an active member of the Coalition to Improve Diagnosis and Center of Excellence for Improving Diagnosis (CoE) team members joined work groups focused on measurement, team collaboration, and education
- Hosted an educational webinar presented by the Children's Hospital of Philadelphia regarding their Cognitive Bias Think Tank, aimed at tackling missed opportunities in diagnosis

Patient Engagement

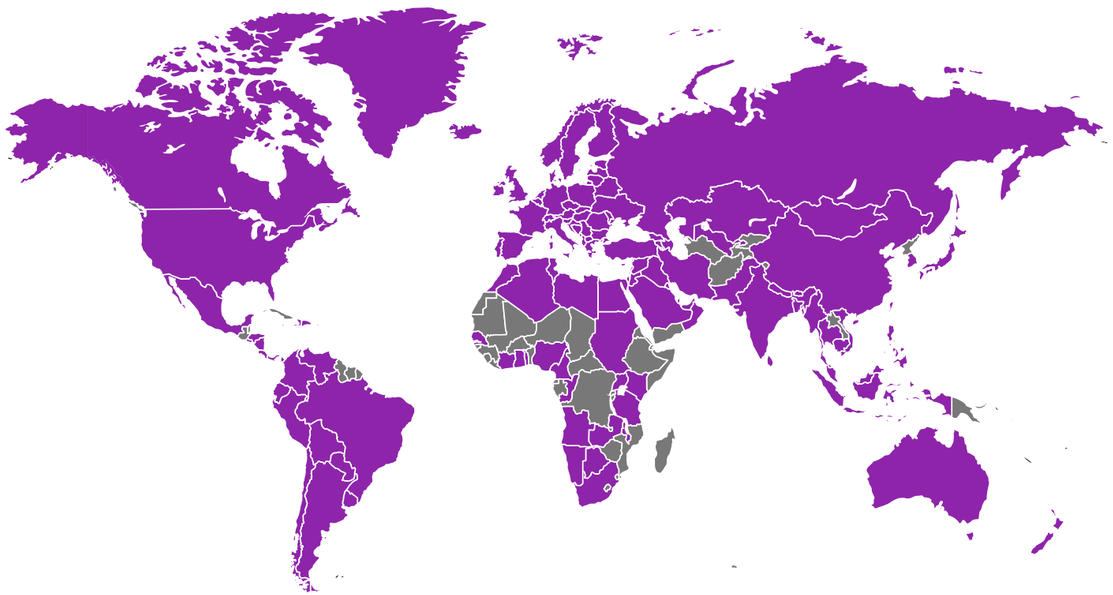
- Developed a virtual escape room where participants raced a clock to diagnose their child's illness
- Participated in several television interviews focused on infection prevention, including handwashing, toxic hand sanitizer, and influenza vaccination
- Implemented the *Knock Out the Flu, PA* campaign to promote flu shots that included two educational videos (more than 12,500 views)
- Continued the *Don't Miss Sepsis* campaign raising awareness about sepsis that included interviews with sepsis survivors and a world-renowned emergency care physician, posters for SEPTA regional rail trains, and social media posts
- Debuted *How to Be Your Own Advocate* series where patients can learn simple but critical tools to feel more empowered
- Featured four patient commentaries in *Patient Safety* with focuses ranging from misdiagnosis and surviving COVID-19 to a lifetime struggle with polio

Event Reporting

- Decommissioned all previous PA-PSRS servers and associated services at the Commonwealth's enterprise data center in 2020 resulting in savings of $32,000, or 34% from the previous year

Patient Safety

The Award-Winning Journal of the PSA



Note: Purple denotes countries with at least 1 reader

2020 marked the first complete calendar year for *Patient Safety*, the PSA's quarterly, peer-reviewed journal. While *Patient Safety* continued to evolve and define its niche in the literature, the journal was recognized with three awards for publication excellence: the MarCom 2020 Platinum Award for "Government Publication," the APEX 2020 Grand Award for "Most Improved Publication," and Ragan's PR Daily Award Finalist for best "Healthcare Digital Publication."

Highlights from 2020 include an analysis of wrong-site surgery, safety hazards associated with intravenous vancomycin, the annual review of Pennsylvania Patient Safety Reporting System (PA-PSRS) event reports, and an interview with Drs. Jeff Brady and Tejal Gandhi on the National Action Plan to Advance Patient Safety.

The mission of *Patient Safety* is to provide timely, original, scientific research that healthcare systems and providers can use to improve patient care and educate frontline staff about safe practices. Its focus is on problems associated with a high combination of frequency, severity, and possibility of solution; novel improvement strategies; and areas in which urgent communication of information could have a significant impact on patient outcomes.

INSIGHT FOR ACTION: While all aspects of a medical journal may not be applicable to everyone, it is possible—and perhaps is even the future of academic publishing—to increase readability among broader audiences.

43K
Readers

4.7K
Cities/
Regions

163
Countries

50
States

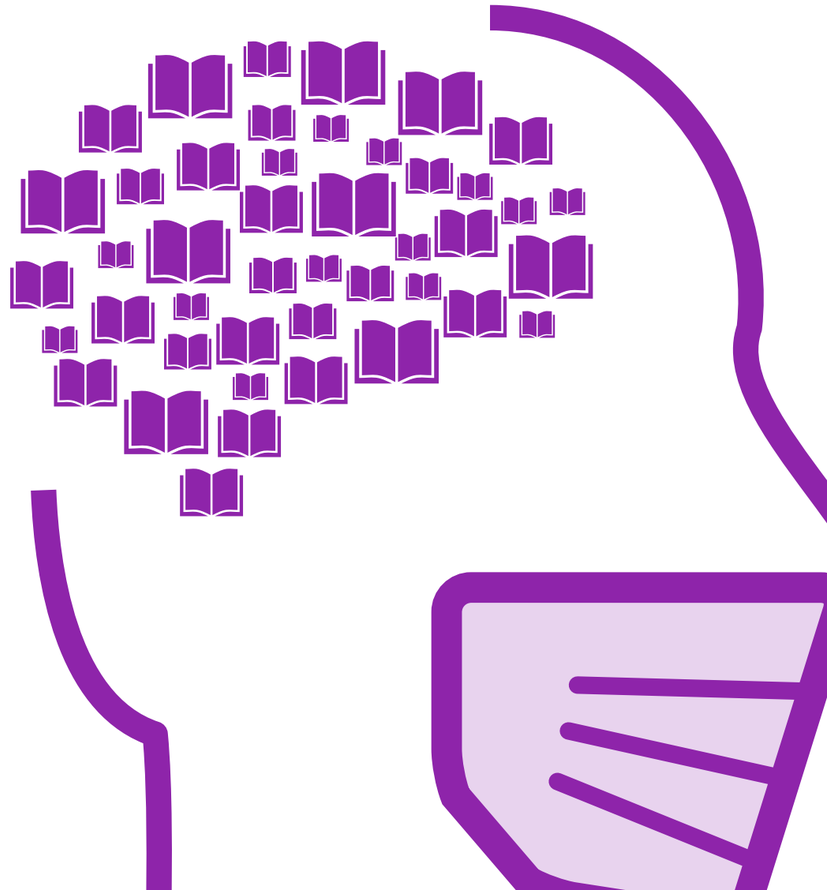
68
Articles
Published

Patient Safety won 3 awards for publication excellence

RAGAN'S PR Daily AWARDS Winner

WINNER 2020 APEX® AWARDS FOR PUBLICATION EXCELLENCE

2020 MARCOM PLATINUM WINNER



I AM Patient Safety
Annual Achievement Award Winners

Executive Director's Choice Award
Fox Chase Cancer Center at Temple University Hospital

Lisa Conrad and Amy Magagna led the 3rd floor surgical oncology nursing team at Fox Chase Cancer Center, Temple Health in implementing comprehensive fall prevention practices—which led to zero patient falls for 365 consecutive days. "People fall every day. They fall in the community, in their homes and in the hospital. 365 days without a fall sounds impossible. This gives us hope that all of the things we are striving for in improving patient safety and reaching zero harm can be achieved," said executive director, Regina Hoffman, on why she selected this team.

Ambulatory Surgery Facility
Allegheny Health Network – Ambulatory Surgery Center Division

The nurses at Allegheny Health Network – Ambulatory Surgery Center Division went above and beyond during the pandemic by staffing COVID-19 test tents, operating the employee health line, and picking up shifts in the hospitals—even when paid to stay at home.

Conquering COVID-19
Temple University Hospital COVID-19 Team

In the early days of the pandemic, the COVID-19 team at Temple University Hospital admitted more COVID-19 patients than any other regional hospital. Their comprehensive response included continuous statewide communication, participation in clinical trials, and volunteer efforts such as donating PPE, conducting fundraisers, and more.

Focus on the Patient
UPMC Carlisle Intensive Care Unit

In 2019, UPMC Carlisle's ICU had a problem: They had 25 unit-acquired pressure injuries (PIs) in a 12-month period, approximately 50% of which were device-related. The entire multidisciplinary team made a commitment to change and protect their most vulnerable patients. A year later, their collective efforts led to a >50% reduction in pressure injuries.

Improving Diagnosis
Women's Health Department, Pennsylvania Hospital

Postpartum hemorrhage is a leading cause of maternal mortality in the United States. As one of the largest delivery services in the Commonwealth, Pennsylvania Hospital understood the importance of implementing the latest evidence-based practices to ensure patients receive the highest level of care. As such, the Women's Health team created a hemorrhage-specific interprofessional response team in 2020. This team along with additional standard protocols for hemorrhage management have allowed them to improve morbidity markers for obstetric patients.

Individual Impact
Kelly Romano

Since becoming the patient safety officer at Einstein Medical Center Montgomery five years ago, Kelly Romano, director of Infection Control and Patient Safety, has initiated a number of changes—including a daily patient safety leadership call and a Good Catch program—that have had a profound, lasting impact on the organization.

Long-Term Care Facility
Donna Gerofsky

Donna Gerofsky was recognized for her commitment to infection prevention excellence, which kept residents at Moravian Manor Communities COVID-free during much of the pandemic and helped educate staff on how to prevent spread of the virus through the facility.

Nationwide Warriors
Veterans Administration Pittsburgh Health System

Michael Boland, David Julian, Amanda Beckstead, and William Pileggi of the Veterans Administration, Pittsburgh Health System recognized that combat veterans suffering with post-traumatic stress disorder (PTSD) are at a higher risk of experiencing emergence delirium post-surgery. It's a response characterized by agitation, confusion, and violent behavior. The team designed specialized mandatory training for the VA staff to recognizing trauma exposure in patients so they can plan care appropriately. The training holds promise for all victims of trauma with PTSD.

Physician Offices
Alyssa Parker

Medical Assistant Alyssa Parker of Lehigh Valley Physicians Group, LHVN ExpressCARE–Fogelsville is recognized for saving a patient's life by recognizing abnormalities on their EKG tracing and communicating them to the provider, resulting in diagnosis of a heart attack that required immediate intervention.

Safety Story (Near Miss/Close Call)
Brianna Thompson

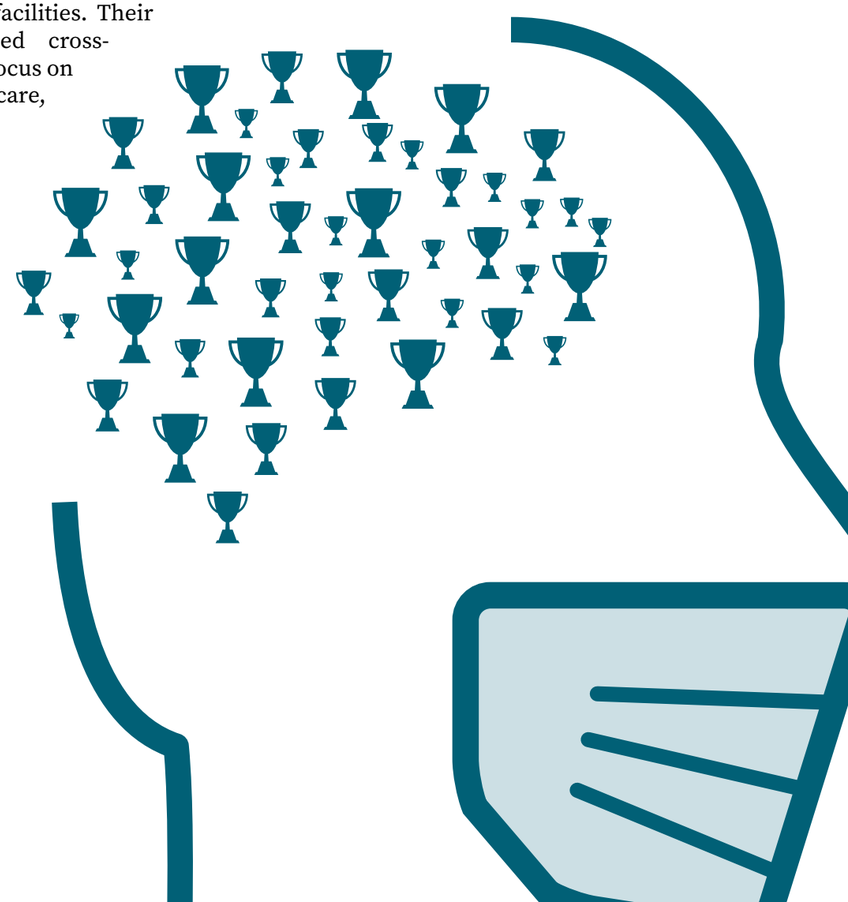
Good catches by Brianna Thompson of UPMC St. Margaret ensured that appropriate care plans were put in place for patients. Her reports and interventions have led to lasting process changes to protect future patients.

Transparency and Safety
WellSpan Health Continuing Care Services Team

The Continuing Care Services Team at WellSpan Health developed a safety reporting system that captures events for patients across multiple settings, including during care transitions between WellSpan and partnering skilled nursing facilities. Their effort established an enhanced cross-continuum safety culture with a focus on transparency, patient-centered care, and a blame-free philosophy.

173
Nominations

79
Facilities



COVID-19 Response

Infection preventionists (IPs) supported the Pennsylvania Department of Health (DOH) Bureau of Epidemiology by reaching out to long-term care (LTC) facilities deemed "at high risk" of having a COVID-19 patient. These telephone risk assessments address visitor restrictions, education, monitoring and screening of personnel, education, monitoring and screening of residents, availability of personal protective equipment (PPE), infection, infection control practices, and communication.

LTC staff were offered resources and individualized support to address specific facility needs or questions identified during the call, the most prevalent of which related to PPE. Those requests were then relayed to DOH for follow-up.

Our IPs also conducted several television interviews, with topics ranging from the importance of hand hygiene and coughing etiquette to how to prevent droplet transmission and the urgency of getting a flu shot.

Additionally, the Data Science and Research team developed Pennsylvania Patient Safety Reporting System (PA-PSRS) dashboards to track COVID-19-related event reports, and the Engagement team synthesized and disseminated critical information to Pennsylvania facilities.

13K

Views of COVID-19 and Childcare Webinar

10

Television Interviews: Fox56, NBC10 Good Day PA, WFMZ, and WBRE

Infection Preventionists and Patient Safety Liaisons

Infection preventionists provide support for healthcare facilities, primarily nursing homes. They work with these facilities to prevent germs from spreading, look for patterns of infection within the facility, assist in educating the staff, and help to develop policies and procedures that will improve patient care within the facility.

Even though COVID-19 was a hot topic for 2020, the PSA's infection preventionists continued to provide resources on the importance of influenza vaccination to assist in preparation for flu season, with a focus on vaccine basics, how they work, types of vaccines, and the impact vaccines have had on history.

Patient safety liaisons (PSLs) provide consultations and education to acute care facilities across the Commonwealth. Pennsylvania is divided into eight geographic regions with each PSL supporting 80 facilities. This group of experts—with decades of collective experience in nursing, behavioral health, emergency services, intensive care, and patient safety—train new patient safety officers, educate frontline clinicians and administrators, assist with policy development, and consult about facility-specific needs.

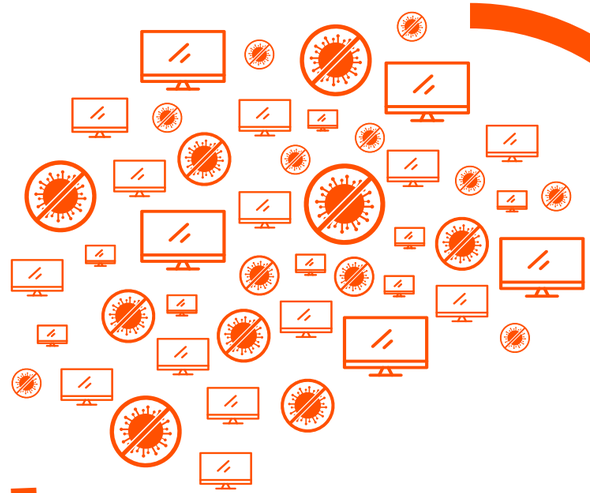
Facility contacts increased by 462 in 2020. These numbers include phone calls, email, video calls, and several in-person visits prior to the shutdown.

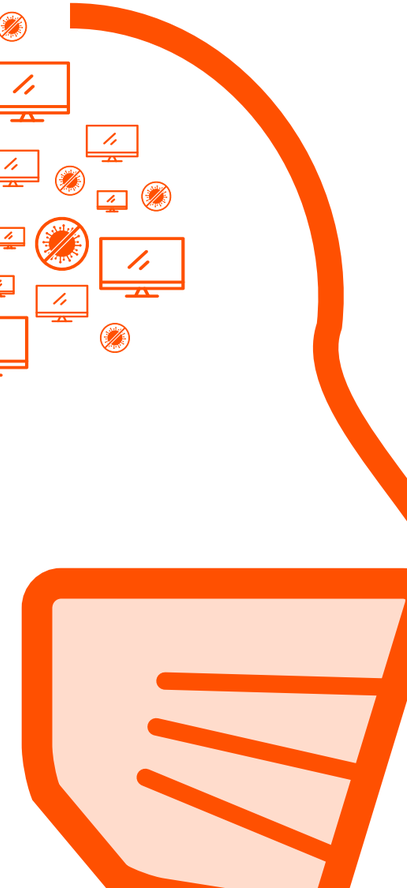
3,324

Facility Contacts

205

New Patient Safety Officer Orientation Sessions





Patient Engagement

Like everyone else, we had plans for 2020, and then 2020 happened. We put projects on hold, postponed or canceled public events, and found creative new ways to engage patients safely (and at a distance).

Because empowering patients is crucial to improving care and reducing harm, we adapted. In the spring, as we came to grips with the emerging pandemic, we worked around the clock updating and disseminating important information about the COVID-19 virus.

Over the summer, as the initial adrenaline rush began to fade and the weight of the pandemic continued to mount, we developed a COVID-specific series on burnout among clinicians and disseminated tips for their family members on caring for the caregivers.

We also developed a new series, *How to Be Your Own Advocate*, from which patients can learn basic, but vital, tricks to feel more in control of their health. The first, a guide on taking one's own heart rate, debuted in the December issue of *Patient Safety*.

INSIGHT FOR ACTION: While making lemonade from lemons is a tired cliché, 2020 provided a serendipitous incentive to develop more versatile and diverse tools that can have a lasting effect on patient safety for years to come.

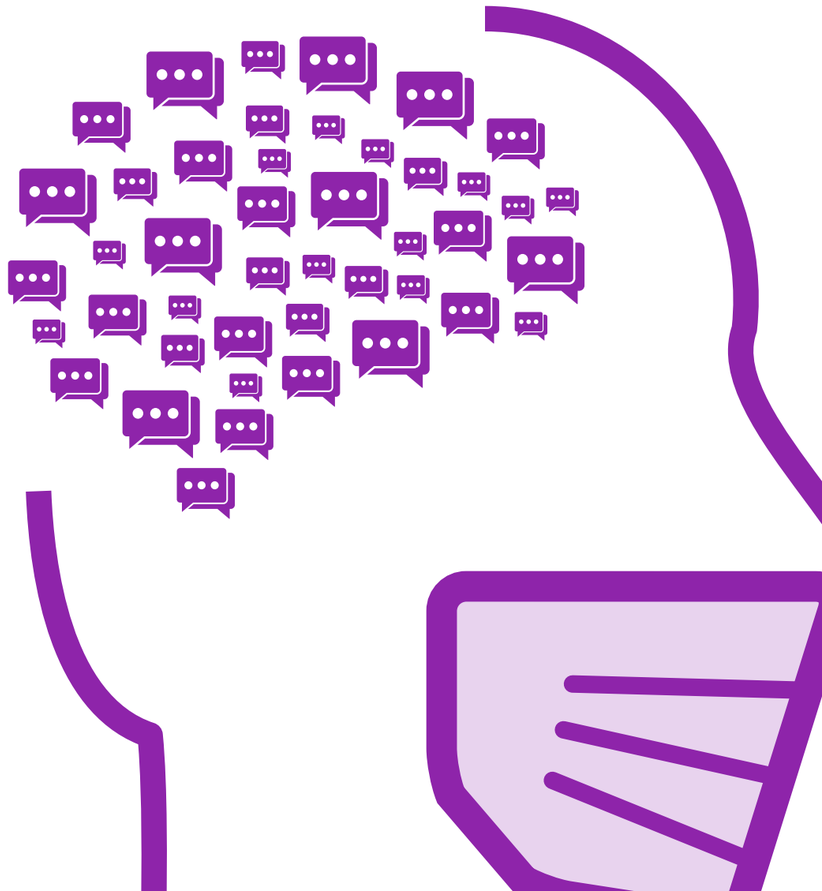
13K
Views of Flu Shot Video

11
Patient-Reviewed Manuscripts

10
Television Interviews

7
Patient Advisory Council Members

> **"Education is the most powerful weapon which you can use to change the world."**
> ***-Nelson Mandela***



Data Science and Research

During a year when the world was looking for answers, the Patient Safety Authority's (PSA) Data Science and Research (DS&R) team continued to inform patients and the healthcare community about important patient safety issues. The DS&R team brings awareness, identifies trends, and provides recommendations using a data-driven approach that analyzes patient safety and healthcare-associated infection data in event reports entered by healthcare facilities into the Pennsylvania Patient Safety Reporting System (PA-PSRS).

Given the magnitude of the COVID-19 pandemic, the DS&R team devoted a considerable amount of time to uncovering new and developing patient safety trends across the Commonwealth. The clinical analysts routinely reviewed a dashboard created by the team's data analyst targeting events that referenced COVID-19. The team also published a data analysis on the early insights regarding patient safety concerns in COVID-19-related events in the June 2020 issue of *Patient Safety*.

Along with the COVID-19-specific dashboard, the team monitored the effect of the pandemic on event reporting across the state. PSA also implemented supportive services for long-term care (LTC) facilities. The DS&R team's infection prevention analyst joined the PSA's field infection preventionists in helping LTC facilities through PA-PSRS Help Desk calls and assisting the Department of Health Bureau of Epidemiology by reaching out to LTC facilities deemed as high risk. These telephone risk assessments addressed visitor restrictions, education, screening of personnel and residents, availability of personal protective equipment, infection control practices, and communication. The team also identified facilities at risk for infection prevention staff turnover and staff new to the role and offered additional support and resources.

In addition to the work around COVID-19, the team explored and analyzed other important patient safety topics and published 12 articles in *Patient Safety* shedding light on new or ongoing trends.

One of the team's patient safety analysts also provided medication safety education by presenting at both the Pennsylvania Society of Health-System Pharmacists' Emergency Preparedness Management Virtual Summit and its 52nd Annual Assembly.

Another important undertaking for the DS&R team this year included creating user-friendly Tableau dashboards for internal use to visualize, trend, and explain data coming into PA-PSRS. This allows the analysts to identify topics of interest for further research and provides the field staff with aggregate reports that can be shared with facilities across Pennsylvania during their visits and consults.

Throughout the year, the team also worked to improve the user experience in PA-PSRS by updating search/export functionality, creating more automated alerts when data are missing, and extending the event details word count to a 4000-character limit. The team is working on further enhancements that will make it easier for facilities to enter reports in PA-PSRS and improve the quality of data being captured, which will lead to better insights and a greater impact.

In 2020, PSA also continued to work with its contractor MedStar Health Research Institute (MHRI). The MHRI team encompasses a wide range of expertise and complements PSA's work by providing clinical analysis and in-depth research articles and developing recommendations and tools to support patient safety best practices.

INSIGHT FOR ACTION: The team's analysis of patient safety concerns in COVID-19-related events identified a considerable number of reports related to laboratory testing with primary outcomes of potential exposure to COVID-19 and missed or delayed test results. These findings were shared in a June 2020 article in *Patient Safety*, which provided healthcare facilities with timely information about the predominant patient safety risks identified in PA-PSRS reports in the early days of the pandemic.

Visit **patientsafetyj.com** to see the full analysis of PA-PSRS data from 2020.

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.

Region	All Reports	Incidents	Serious Events
North Central	18,271	17,486	785
Northeast	27,612	26,615	997
Northwest	20,970	20,350	620
South Central	52,074	50,439	1,635
Southeast	95,704	93,263	2,441
Southwest	63,917	62,027	1,890
Total	**278,548**	**270,180**	**8,368**

279K
Acute Care Reports 2020

270K
Incidents

8.4K
Serious Events

Collaboratives

In today's healthcare system, teamwork and shared experiences have become crucial to patient safety. Working together to problem solve and share responsibility for the patient is a way to gain knowledge and improve care.

Falls

Through a partnership with the Hospital and Healthsystem Association of Pennsylvania (HAP), we continued our Hospital Improvement Innovation Network (HIIN) collaborative through the beginning of 2020.

Our focus was on fall prevention, which focused on increasing awareness through communication and education of key principles, tools, and resources. Evidence-based fall prevention strategies were shared with hospitals through consultation, webinars, coaching calls, and monthly status updates.

Culture of Safety

In 2020, the project continued to foster collaborative work with a core group of participating hospitals. Efforts were focused on identifying and addressing facility-specific opportunities for improvement in response to year 2019 Culture of Safety (COS) survey findings.

Highlights included:

- Provision of COS tools and resources
- Observation of revised workflows and conversations with frontline staff
- On-site consultation to review and provide feedback of implementation measures
- Follow-up communication and discussion regarding resurvey activities

INSIGHT FOR ACTION: Collaboratives provide an important opportunity to pool resources and share knowledge to effect change on a broad scale.

"Ultimately, the HIIN Project gives facilities access to professional resources and organizations, and to share best practices designed to improve the quality and outcomes for the patients we serve.

Chris Banish, MSW, RSP
Safety Risk Manager
Monongahela Valley Hospital, Inc.

"EMHS' commitment to patient safety was strengthened through our facility's Culture of Safety Project. The project involved the entire management team and staff. Information sharing and process changes were championed by the leadership team and patient safety officer.

Loren Stone, MHA
Chief Executive Officer
Endless Mountains Health Systems

"When we began Care Transition Rounds we knew that we had a great deal of work to do in bettering our culture. Throughout the journey of this project, we needed to be open and willing to make changes as we experienced a shift in our culture, and a favorable one at that. With this positive shift, we started to see more involvement from our service partners with increased feedback and openness to change. The culture shift helped to drive a higher-quality, safer plan of care and discharge process for our patients. Care Transition Rounds are now an essential part of what we do every day. Our service partners drive them, our patients love them, and support persons rely on them. Patients' preferences are accounted for and support persons' feedback are considered in creating the safest of discharge plans, from the day they arrive until they are discharged.

Andrea Reed, MSN, RN
Director of Nursing and Patient Safety Officer
UPMC Susquehanna Muncy

Fiscal Statements and Contracts

The Medical Care Availability and Reduction of Error (MCARE) Act[1] establishes the Patient Safety Trust Fund as a separate account in the Pennsylvania Treasury. Under the MCARE Act, the Patient Safety Authority (PSA) determines how those funds are used to effectuate the patient safety provisions of the MCARE Act and administers funds in the Patient Safety Trust Fund. Funds come primarily from assessment surcharges made by the Department of Health (DOH) on certain medical facilities.

The PSA 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 PSA has focused on two fiscal goals: to be prudent in the use of moneys contributed by the healthcare industry, and to assure that healthcare facilities paying for the Pennsylvania Patient Safety Reporting System (PA-PSRS) receive direct benefits from the system and from PSA programs in return. Pursuant to Section 304(a)(4) of the MCARE Act, as a general rule, the PSA is authorized to receive funds from any source consistent with the PSA's purposes under the Act.

Consistent with this mandate, the PSA 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 2020 are described in the section, "Contracts under which the PSA Received Revenue in 2020 as a Contractor," which lists contracts with the Hospital and Healthsystem Association of Pennsylvania (HAP) and the Health Care Improvement Foundation (HCIF).

Within the design of PA-PSRS, the PSA 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 2020, the PSA continued to enhance its newly designed public website patientsafety.pa.gov, providing expanded access to the PSA's educational materials and programs, as well as mobile accessibility. The PSA continues to update its PA-PSRS Application Modernization (AMOD), with both function and design upgrades introduced in 2020. The AMOD project entailed a complete redesign of the PA-PSRS application with AMOD's release to acute care facilities in June 2019 and to nursing homes in December 2019.

The PSA provides numerous training and education programs, including programs related to reporting, investigating, and analyzing patient safety events, risk assessment, and patient safety topic–specific education. In 2020, the PSA expanded its Data Science and Research team, adding a patient safety analyst and an infection preventionist to the staff. Also, in 2020, the PSA added a graphic designer to the Engagement and Communications team.

Throughout the 2020 COVID-19 pandemic, the PSA's Outreach and Education program's patient safety liaisons and infection preventionists continued to provide expert patient safety support and education to the Commonwealth's 1,200 licensed MCARE facilities. Additionally, in 2020, the Outreach program initiated development of a new internet-based Patient Safety Learning Management System (LMS) to ensure timely education is available to all facilities. The LMS system will be released in 2021.

All these programs are offered at no additional cost to the facilities. The PSA continues to expand its services by organizing and maintaining research collaborations with reporting facilities and other patient-safety-centric organizations. In addition, the PSA offers continuing medical education and patient safety curriculum development, and continues to offer the Patient Safety Authority speakers bureau. By directly providing clinical guidance, feedback, and educational programs to facilities and professionals based on actual events occurring in Pennsylvania, the PSA provides measurable value back to the healthcare industry that substantially funds this program.

Funding Received From Hospitals, Ambulatory Surgical Facilities, Birthing Centers, and Abortion Facilities

The MCARE Act[1] set an initial limit of $5 million on the total aggregate assessment for acute care facilities in the first year of the MCARE Act beginning in 2002, plus an annual increase based on the consumer price index (CPI) in each subsequent year. For fiscal year 2020–2021 (FY 20–21), the maximum allowable acute care assessment is $8,249,916, against the PSA Board's approved aggregate acute care assessment of $6,360,000.

On January 14, 2021, the PSA Board authorized a recommendation to the Department of Health for FY 20–21 acute care assessment surcharges totaling $6.36 million, maintaining the level of the FY 19–20 acute care assessment total and 22.9% less than the maximum annual amount that could have been assessed for the fiscal year pursuant to Section 305(d) of the MCARE Act. The PSA utilizes the Northeast medical care services CPI to calculate maximum allowable assessments.

At the time of the FY 20–21 acute care assessment recommendation, the PSA Board considered several points, including the following:

- The PSA's FY 20–21 budget totals $7.375 million. Of this amount, approximately $6.219 million is budgeted for acute care-related expenditures and funded by the $6.36 million in FY 20–21 acute care assessments. The acute care assessments also fund certain healthcare-acquired infections (HAI) infection prevention activities with the acute care facilities; these are separate from Act 52 nursing home HAI assessment–funded activities.
- The PSA's FY 20–21 budget of $7.375 million is a $125 thousand reduction from FY 19–20 budget of $7.5 million, and a $1.225 million reduction from the FY18–19 budget. These budget reductions were enabled by decreasing dependence on outside consultants; bringing more research, analysis, and publishing functions in-house; and other cost-cutting measures.
- The FY 20–21 acute care assessment of $6.36 million has increased by $1.36 million since the PSA's initial FY 02–03 acute care assessment of $5.0 million, a 1.5% per year average increase.
- The suggested FY 20–21 assessment levels provide the PSA with liquidity and planning flexibility into FY 21–22.

Table 1 shows the number of acute care facilities assessed, approved assessments, and assessments received for each fiscal year.

Funding Received From Nursing Homes

Act 52[2] of the MCARE Act allows the DOH to assess Pennsylvania nursing homes through license surcharges 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 PSA's suggestion, the DOH assessed 725 nursing home facilities a total of $1,000,000 and transferred $1,000,782 to the Patient Safety Trust Fund for FY 08–09. This money could be spent only on activities related to HAI and implementation and maintenance of Chapter 4 of the MCARE Act. For FY 20-21, the Act 52 maximum allowable assessment is $1,331,907, against the PSA Board's approved aggregate assessment of $1,140,000.

On January 14, 2021, the PSA Board authorized a recommendation to the DOH for FY 20–21 nursing home assessment surcharges of $1.14 million. This amount is equal to and maintains the FY 19–20 nursing-home assessment total and is 14.4% under the maximum annual amount that could have been assessed for the fiscal year pursuant to Section 409(b) of the MCARE Act. The PSA utilizes the Northeast medical care services CPI to calculate maximum allowable assessments.

Table 2 shows the number of nursing homes assessed, approved assessments, and assessments amounts received for each fiscal year.

Annual Expenditures and Non-Assessment Revenue Receipts

During calendar year 2020, the PSA spent about $6,692,818 million (**Table 3a**), and received contract- and service- related receipts of $46,173 and investment income of $57,920 (**Table 3b**).

Table 1. Acute Care Facility Assessments

FISCAL YEAR	NUMBER OF FACILITIES ASSESSED BY DOH[a]	APPROVED ASSESSMENTS	TOTAL ASSESSMENTS RECEIVED BY DOH[b]
2002–03	356	$5,000,000	$4,663,000
2003–04	377	$2,500,000	$2,542,316
2004–05	414	$2,500,000	$2,508,787
2005–06	450	$2,500,000	$2,500,149
2006–07	453	$2,500,000	$2,500,034
2007–08	526	$5,400,000	$5,391,583
2008–09	524	$4,000,000	$3,972,677
2009–10	519	$5,000,000	$4,989,781
2010–11	542	$5,000,000	$4,981,443
2011–12	550	$5,100,000	$5,063,723
2012–13	545	$5,500,000	$5,504,549
2013–14	556	$5,500,000	$5,492,002
2014–15	564	$6,200,000	$6,209,459
2015–16	569	$6,500,000	$6,494,845
2016–17	575	$6,675,000	$6,656,359
2017–18	583	$6,860,000	$6,860,164
2018–19	585	$6,860,000	$6,834,611
2019–20	558	$6,360,000	$6,300,845[c]
2020–21[d]	557	$6,360,000	-
Total			**$89,491,715**

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. FY 2019–20 Acute Care Assessment receipts include $66,301.70 transferred to Patient Safety Trust Fund in CY2021.

d. 2020–21 missing figures were unavailable at the time of publication and will appear in next year's annual report.

Table 2. Nursing Home Assessments

FISCAL YEAR	NUMBER OF FACILITIES ASSESSED BY DOH	APPROVED ASSESSMENTS	TOTAL ASSESSMENTS RECEIVED FROM DOH
2008–09	725	$1,000,000	$1,000,782
2009–10	711	$800,000	$799,382
2010–11	707	$800,000	$799,829
2011–12	707	$800,000	$804,473
2012–13	711	$900,000	$913,315
2013–14	698	$1,000,000	$998,751
2014–15	703	$1,050,000	$1,049,842
2015–16	702	$1,080,000	$1,079,505
2016–17	704	$1,111,000	$1,110,185
2017–18	699	$1,140,000	$1,139,483
2018–19	699	$1,140,000	$1,139,645
2019–20	695	$1,140,000	$1,137,933
2020–21[a]	693	$1,140,000	-
Total			**$11,973,996**

a. FY 2020–21 missing figures were unavailable at the time of publication and will appear in the next year's annual report.

Table 3a. 2020 Expenditures

CONTROL LEVEL	AMOUNT
61: Personnel	$4,377,962
63: Operating	$2,314,856
Total 2020 Expenditures	**$6,692,818**

Table 3b. 2020 Revenue Receipts

REVENUE RECEIPTS	AMOUNT
Acute Care Assessments	$6,234,544
Nursing Home Assessments	$1,137,933
Non-Assessment Revenue	$46,173
Investment Income	$57,920
Total 2020 Revenue Receipts	**$7,476,570**

Patient Safety Authority Contracts

The MCARE Act requires the PSA to identify a list of contracts entered into pursuant to the Act, including the amounts awarded to each contractor.

During calendar year 2020, the PSA received services under the following contracts (FC or funds commitment; PO or purchase order):

DXC Technology Services, LLC and DXC MS, LLC, FC # 4000022708

- Five-year contract (including two option years) for Pennsylvania Patient Safety Reporting System (PA-PSRS) software development and maintenance, and other IT services. DXC MS, LLC spun-off from DXC Technology Services, LLC in 2020 as the result of merger and assignment of the contract. In 2021, DXC MS, LLC will be invoiced as Gainwell Technologies, LLC.
- July 1, 2019, through June 30, 2024
- Total Contract Amount: $7,071,540 over 5 years
- Amount invoiced for 2020 (12 months, Jan–Dec): $1,234,628

MedStar Health Research Institute,
FC # 4000022717

- Five-year contract (including two option years) for analyzing and evaluating patient safety data.
- July 1, 2019, through June 30, 2024
- Total Contract Amount: $3,419,185.85 over 5 years
- Amount invoiced for 2020 (12 months, Jan–Dec): $508,999

Ricoh USA, Inc.

- Ricoh Color MFD lease, PO # 4500841111
- September 1, 2017, to August 31, 2021 @ $328.17/month
- 12-month Ricoh lease expense (Jan–Dec) paid in 2020: $3,938.04

Xerox Corp.

- Xerox color MFD lease, PO # 4600015253
- October 1, 2017, to September 30, 2021 @ $315.41/month
- 12-month Xerox lease expense (Jan–Dec) paid in 2020: $3,784.92

Contracts Under Which the PSA Received Revenue in 2020 as a Contractor:

HCIF (Health Care Improvement Foundation)

- Agreement #3 (completed) – Health Literacy Projects
- HCIF 3 Total Receipts in 2020: $2,273.67

HAP/Centers for Medicare & Medicaid Services subcontract agreement – Hospital Innovation Improvement Networks (HIIN)

- Total Receipts in 2020: $43,700.00

Patient Safety Authority Balance Sheet

Table 4, Balance Sheet reflects the status of the Patient Safety Trust Fund as of December 31, 2020.

(Unaudited) as of December 31, 2020

Source: Office of Comptroller Operations, Commonwealth Bureau of Accounting and Financial Management. Calendar Year 2020 (CY20) methodology includes an accrual of Board-approved FY 20–21 Assessment Revenue.

Table 4. Patient Safety Trust Balance Sheet

ASSETS	
Temporary Investments	$8,207,200
Receivables, net:	
Assessment Revenue	7,500,000
TOTAL ASSETS	**$15,707,200**
LIABILITIES AND FUND BALANCE	
Accounts Payable and Accrued Liabilities	$1,355,970
Invoices Payable	92,563
TOTAL LIABILITIES	**1,448,533**
Deferred Assessment Revenue	7,500,000
TOTAL DEFERRED INFLOW OF RESOURCES	**7,500,000**
Restricted	6,758,667
TOTAL FUND BALANCE	**6,758,667**
TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND FUND BALANCE	**$15,707,200**

NOTES

1. Medical Care Availability and Reduction of Error (MCARE) Act of March 20, 2002, P.L. 154, No 13 40. Available: http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2002&sessInd=0&act=13.

2. Medical Care Availability and Reduction of Error (MCARE) Act - Reduction and Prevention of Health Care-Associated Infection and Long-Term Care Nursing Facilities Act of July 20, 2007, P.L. 331, No.52, Cl.40. http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2007&sessInd=0&act=52.

Anonymous Reports/Referrals

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 PSA's website and through the PA-PSRS. The PSA 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.

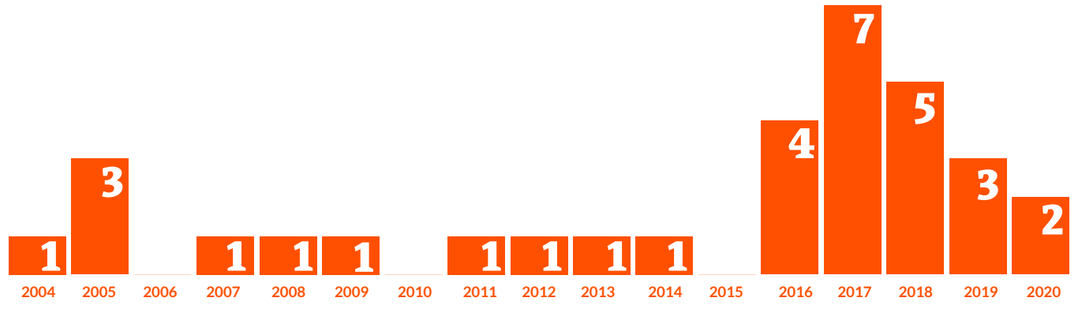
PSLs also review the anonymous reporting process with new patient safety officers as part of their onboarding program. Individuals completing the form do not need to identify themselves, and the PSA assigns professional clinical staff to conduct any subsequent investigations. In 2020, the PSA received two anonymous reports that complied with MCARE Act requirements.

Referrals to Licensure Boards

The MCARE Act requires that the PSA 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 PSA last year. However, the PSA 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 (2004–2020)



THANK YOU!

Thank you to the members of our Healthcare-Associated Infection Advisory Panel and Patient Advisory Panel for your service and expertise!

Your insights help us take action.

Panels

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Patient Safety Authority

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