



Patient Safety Authority A Successful Beginning – A Plan to Achieve Strategic Plan Executive Summary May 2007

Background

The Patient Safety Authority (the Authority) is an independent state agency established under Act 13 of 2002, the Medical Care Availability and Reduction of Error (“Mcare”) Act. Under Act 13, all hospitals, birthing centers, ambulatory surgical facilities and certain abortion facilities must report what the Act defines as “Serious Events” (actual adverse events) and “Incidents” (so-called “near-misses”). The Authority analyzes and evaluates those reports so it can learn from the data reported in order to advise facilities and make recommendations for changes in healthcare practices and procedures which may be instituted to reduce the number and severity of Serious Events and Incidents.

Statewide mandatory reporting went into effect in June 2004, making Pennsylvania the first state in the nation to require the reporting of both actual adverse events and near-misses. To date, Pennsylvania healthcare facilities have submitted over 500,000 reports of Serious Events and Incidents through PA-PSRS, with recent average monthly reports over 17,000.

A Successful Beginning – More to Accomplish

The Authority has enjoyed many successes in its first few years of operation. PA-PSRS is one of the largest repositories of patient safety event data in the world. Articles in the Patient Safety Advisory have had an impact on the operations of the reporting facilities. The Authority has garnered the respect of the reporting facilities and is seen as having an impact on patient safety. In recognition of its efforts, the Authority received the national 2006 John M. Eisenberg award for patient safety and quality. The Eisenberg Award, presented jointly by The National Quality Forum (NQF) and the Joint Commission, recognizes major achievements of individuals and organizations in improving patient safety and quality.

To date, the Authority has been focused on the development and implementation of the PA-PSRS (Pennsylvania Patient Safety Reporting System), data collection, analysis, and guidance provided through the Patient Safety Advisory. The Authority is in position to

build on these successes and have a greater impact on patient safety in Pennsylvania over the next several years. Input was solicited from primary stakeholders and national patient safety experts. The Authority received valuable feedback from Pennsylvania healthcare facilities, government entities, patient safety organizations, healthcare membership organizations and national patient safety organizations. Based on this information, the Authority developed a set of objectives and initiatives that have been incorporated into a comprehensive strategic plan that addresses the patient safety needs of Pennsylvania's healthcare community to better protect patients.

It is important to note, the initiatives incorporated in the strategic plan will not replace the current activities of the Authority: data collection, data analysis, and providing guidance through the *Patient Safety Advisory*. They will build upon these successful activities to increase the Authority's role and presence in Pennsylvania patient safety. However, the Board believes the Authority could have a significantly greater impact on patient safety in Pennsylvania by branching out beyond past activities. Therefore, education, training, collaboration, and communication are featured more prominently in the new initiatives.

Strategic Plan Initiatives

Initiative A: Educate Executive Management and Boards of Trustees

Real change stands a better chance if driven from the top down through the organization. The purpose of this initiative is to continue to engage facility Boards and executive management in discussions of patient safety. The program will increase the profile of patient safety and raise the priority of patient safety at the Board level. The Authority will collaborate with other Pennsylvania entities to implement this initiative.

Initiative B: Infection Awareness and Reduction

The reduction and elimination of Healthcare Acquired Infections (HAI) have been identified as a prominent portion of Governor Ed Rendell's health care reform plan. The Governor's Office of Healthcare Reform has asked the Authority to provide regional infection-reduction education and training. This initiative should help lead to the goal of significant infection reduction in Pennsylvania's healthcare facilities.

Initiative C: Patient Safety Knowledge Exchange (PasSKEy)

Guidance provided in the Patient Safety Advisory has been driving change. Last year, Patient Safety Officers reporting to the Authority's annual survey reported over 500 policy and process changes made as a result of Advisory articles. The Authority wants to do more to initiate changes that make the healthcare environment safe for patients. The Patient Safety Knowledge Exchange would provide a formal electronic forum for the exchange of information, ideas, and solutions within the facility patient safety community. This sharing would eliminate redundancy and provide knowledge to patient safety officers that they can use to implement patient safety strategies, policies, and processes within their institutions.

Initiative D: Improve Reporting Consistency and Recommendations

Facility Patient Safety Officers and regional health organizations have been imploring the Authority to make pronouncements that would provide for consistent reporting. In addition, the Authority's attempts at patient safety measurement are severely hampered by inconsistent reporting. Consistent reporting would improve the environment for measurement and reduce or remove differences in facility reporting.

The Authority has been providing guidance to facilities through Patient Safety Advisories and directly. However, Act 13 calls for the Authority to make patient safety recommendations to DOH. If DOH approves these recommendations, the Authority would communicate them to reporting facilities. These recommendations would not be binding on facilities.

Initiative E: Increase Effectiveness through Extended Presence

The Authority has had limited direct interaction with the reporting facilities. During recent focus group sessions with patient safety officers (PSOs), the PSOs repeatedly said it would be very helpful for them to have an increased Authority presence in their locations. This initiative would establish the roll of a Patient Safety Liaison (PSL). The PSL would promote patient safety activities within a designated region. Activities would include advancing the use of the patient safety knowledge exchange, scheduling training, and working with PSOs and organizing and supporting PSO work groups. In addition, the PSL could work with regional patient safety entities to promote collaboration with the Authority.

Initiative F: Governor's Office of Healthcare Reform (GOHCR) Collaboration

The Governor's Office of Healthcare Reform has asked the Authority to consider implementing several activities identified in the Governor's health reform plan. These activities include the education of facility boards, infection education, and analyzing nursing home events. The activities are addressed through other initiatives identified in this plan. In addition, GOHCR is attempting to bring DOH, PHC4, and the Authority into alignment regarding their work and objectives. Working together, these agencies should be more effective in implementing programs that result in lasting change. The Authority views itself as the education and training component of this group.

Initiative G: Data Collaboration

The data contained in PA-PSRS provides a rich repository of information. The Authority is seeking additional ways to use this information to support patient safety improvement activities. The Authority is beginning to work with other national and Pennsylvania patient safety interests to use PA-PSRS data to support various patient safety initiatives. The Authority can utilize its PA-PSRS information to support patient safety activity prioritization, activity tracking, and other activities. The Authority is currently discussing activities of this nature with HAP regarding IHI implementation activities and HCIF

regarding patient safety objectives. These activities will solidify the effectiveness of PA-PSRS and support others in making Pennsylvania safer for patients.

Initiative H: Patient Safety Methods Training

This initiative is an expansion of current Authority activities. The Authority has provided root cause analysis training and as part of this initiative, will be giving Failure Mode and Effects Analysis (FMEA) training in May 2007. This initiative extends these training activities. In addition, this initiative will identify additional education and training courses with specific focus on health care training grounds such as medical and nursing schools.

Initiative I: Nursing Home Data Analysis

The health care measure recently introduced by Governor Ed Rendell requires the Authority to analyze data supplied by Pennsylvania's nursing homes to the Department of Health. The Authority will be required to provide feedback and make recommendations based on this information.

Initiative J: PA-PSRS System Enhancements

Since PA-PSRS reporting began in June 2004, approximately 300 system enhancements have been implemented. In 2007, the Authority is trying to limit future enhancements because as PA-PSRS becomes more complex, any change has significantly more impact. Also, the federal government is currently considering the implementation of a national patient safety database. It would be premature to make any significant changes prior to knowing what the federal government is going to recommend. Federal patient safety activities may require the Authority to make significant changes to the PA-PSRS system.

Simple enhancements will continue to be made under the current data collection and analysis contract. Also, the Authority will continue to assist facilities with conversion to all-electronic submission of Incidents through the PA-PSRS Interface. It is estimated that approximately 30% of Incidents are being submitted through the interface. The Authority will continue to support interface use by the reporting facilities.

PA-PSRS provides all facilities with access to their own data. However, Patient Safety Officers have asked that the analytical reports available to them be evaluated for efficiency and effectiveness. In response, the Authority will develop an analytical report user group to determine potential solutions.

Initiative K: Maintain Success of Patient Safety Advisory

The *Patient Safety Advisory* has been the Authority's signature product. It is one of the primary reasons the Authority was awarded the John M. Eisenberg Award for patient safety. Last year, the *Advisory* was enhanced through the use of companion toolkits and availability of single articles on the Authority's website. Patient Safety Officers have also

reported a significant number of changes made in their facilities due to the Advisory articles. The continued success of the *Advisory* is important for the credibility of the Authority and to continue facility improvements. The Authority will focus on increasing the distribution of *Advisory* articles within facilities.