Welcome to the first of our quarterly special editions, which feature articles, stories, interviews, and more from our new journal, Patient Safety. In this issue you will find out how Pennsylvania is fighting the opioid crisis, learn why health literacy is important to patient safety, and arm yourself with evidence-based research and data analyses that will help you prevent harm and improve patient safety.

Pennsylvania Takes on the Opioid Crisis

Dr. Rachel Levine, secretary of health for the Commonwealth of Pennsylvania, recently sat with Susan Wallace, MPH, senior patient safety liaison at the Patient Safety Authority, to discuss Pennsylvania’s efforts to combat the national opioid crisis, Governor Tom Wolf’s multistep plan, and what she would like to see next for the Department of Health. “We want to save people’s lives,” Levine said. “I reject completely the idea that someone suffering from opioid use disorder or heroin addiction is not worth saving. Everybody deserves a chance at life and recovery.”
Patient Perspective — How Health Literate Are You?

Retiree Dwight McKay never used to think much about patient safety, until he had an experience as a patient himself that opened his eyes. After nearly twenty years of misdiagnoses and ineffective treatments for recurring leg pain, an ultrasound finally revealed the truth—and his right leg had to be amputated. Dwight gained incredible insights into the importance of health literacy throughout his journey; in this patient commentary he shares his story and why he believes “patient safety is everyone’s responsibility.”

Commentary — A Look Behind the Curtain

In today’s world data is everything, but there’s often more to the story than just a bunch of numbers, and it’s all too easy to draw the wrong conclusions from barebone statistics. The number of reported occurrences of harm or potential harm to patients in Pennsylvania has increased from 2004 to 2018, but what does that mean? Patient Safety Authority Executive Director Regina Hoffman, MBA, RN, explains just what data from the nation’s largest event reporting database really says—and doesn’t say—about patient safety in the Commonwealth, and why increased reporting could actually be a good thing.

Infection Prevention — Don’t Miss Sepsis!

Forty percent of Americans have never heard of sepsis—a condition that kills more people than breast cancer, stroke, AIDS, and opioid overdoses combined. Sepsis, put simply, occurs when the body’s immune system goes into overdrive, backfires, and attacks its own organs, and it takes the lives of 270,000 Americans each year. But the good news is sepsis can sometimes be prevented if people know what it looks like. To help teach them the signs, this September, Sepsis Awareness Month, the Patient Safety Authority introduced Miss Sepsis: a fictional girl who scraped her knee and got sepsis because her parents didn’t know about it. When you see her smiling face online and in ads on SEPTA trains, remember: Don’t Miss Sepsis!

SUDDENLY FEELING AWFUL AND DON’T KNOW WHY?

Hi! I’m Miss Sepsis.
One day, I was playing at the park and I scraped my knee. Then I got really sick.

My parents didn’t know you can get sepsis outside the hospital—even from a scratch or splinter! I was lucky because I got better, but lots of people don’t.

Don’t get sick like me. If you’re feeling awful, think sepsis!
Learn the signs.
DON’T MISS SEPSIS
Improving Diagnosis — Putting *C. Diff* Testing to the Test

Sherry, an active 68-year-old grandmother, was admitted to the hospital after a fall, and ultimately transferred to a long-term care facility for rehabilitation. She never left. After she tested positive for *Clostridioides difficile* (*C. diff*)—a bacteria which can lead to diarrhea, colitis, and even death—she was put in isolation, where her condition worsened from depression and a lack of activity, engagement, and interaction with others. Weakened, she fell again. This time she hit her head and then passed away. A later analysis determined she may not have had *C. diff* at all, and all that could have been avoided.

Sherry wasn’t a real patient, but she epitomizes what sometimes does happen to patients who are incorrectly diagnosed with *C. diff*. Testing for the bacteria is a challenge, but the solution may lie in better policies and procedures around it; this article shares recommended guidelines for appropriate testing for *C. diff*, as well as a helpful algorithm.

Research — The Pressure’s on for Pressure Injury Education

A pressure injury (PI), defined as “localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical device,” is largely preventable. To discover and implement more PI interventions, it’s important for clinical staff to identify PIs accurately when they occur and document their progression. In response to a recognized gap in bedside nurses’ knowledge surrounding PIs, a recent study introduced PI education programs in a facility’s nursing unit, which demonstrated improvement in nurses’ knowledge of PI assessment, staging, and documentation, and points the way to finding other ways to improve training on PIs.

Data Analysis — In Search of a Cure for Drug Allergy Errors

Medication allergies cause patient harm, but it’s no simple matter to manage a patient’s allergy, particularly when the patient doesn’t know about it or doesn’t share the information, or the allergy hasn’t been documented in their electronic medical record. A recent study looked at reports of medical errors related to drug allergies and identified points of failure in documenting and using allergy information, and provides actionable strategies for reducing the risk of them occurring.

Risky Business

While some health facilities are looking to peripheral venous catheters (PVCs) as a safer alternative to central venous catheters (CVC), in order to reduce the number of central line-associated bloodstream infections (CLAB-SIs), they may be wondering if events related to PVCs are going up as a result. A recent study shows that while there may not be a association between decreased CVC days and increased PVC complications, PVCs have their own risks that providers need to recognize.
Anecdotally, it seems that patient safety has been improving, but looking at the data isn’t always the best or only measurement of progress. So the Patient Safety Authority decided to ask the facilities themselves about how they’re doing, to see whether their organizational structures and processes are aligning with a culture of safety. In November and December 2018, the PSA conducted a process measures survey of acute care facilities—and here are the results of those comprehensive questionnaires, use them to identify gaps in your own facility and individual practice.

Batteries Gone Bad

Many people know the anxiety of watching the low battery indicator on a smartphone until it dies, caught without a charger or a handy outlet. In most cases, the worst that happens is being disconnected from Facebook or missing some calls for a while, but if the battery on a medical device—such as a hearing aid, telemetry pack, or pacemaker—gives out, the outcome for a patient can be much more serious. To explore the scope of the problem for various devices and battery types, analysts queried the Pennsylvania Patient Safety Reporting System (PA-PSRS) for events related to battery failure in 2018, which revealed that although 98% of them did not cause patient harm, four events were Serious Events.