



occurred. From that analysis, a movement began in Northeast Pennsylvania to standardize the color-coded wristbands.

Today, almost 40 states and the U.S. military have standardized their color-coded wristbands and all refer to the Authority's analysis of this near-miss situation for spurring the movement to standardize.

Pennsylvania Patient Safety Advisory, Education Sessions and Collaborations

Since the first *Advisory* was published in March 2004, the Authority has worked to ensure data submitted from facilities is used to help them learn from events and identify changes that prevent them from happening again. To date, hundreds of articles on a variety of topics have been published enabling Pennsylvania healthcare facilities to make thousands of process changes within their institutions to improve patient safety.

Along with the *Advisory*, the Authority offers free educational programs and collaborations to help healthcare providers. Many of the topics are data driven and include: wrong-site surgery prevention, medication error prevention, falls prevention, human factors science, Just Culture™, teamwork, data analysis, root-cause analysis, and reliable design. The Authority also seeks ideas and feedback from Pennsylvania healthcare facilities on what they need specifically within their organization to improve patient safety.

Reporting Serious Events and Incidents or near-misses in your facility is an important step you can take to improve patient safety in your facility. Make a personal commitment to patient safety and report events to your Patient Safety Officer or supervisor.



P A T I E N T S A F E T Y A U T H O R I T Y

An independent agency of the Commonwealth of Pennsylvania

Phone | 717-346-0469

Fax | 717-346-1090

E-mail | patientsafetyauthority@pa.gov

Web site | www.patientsafetyauthority.org

Address

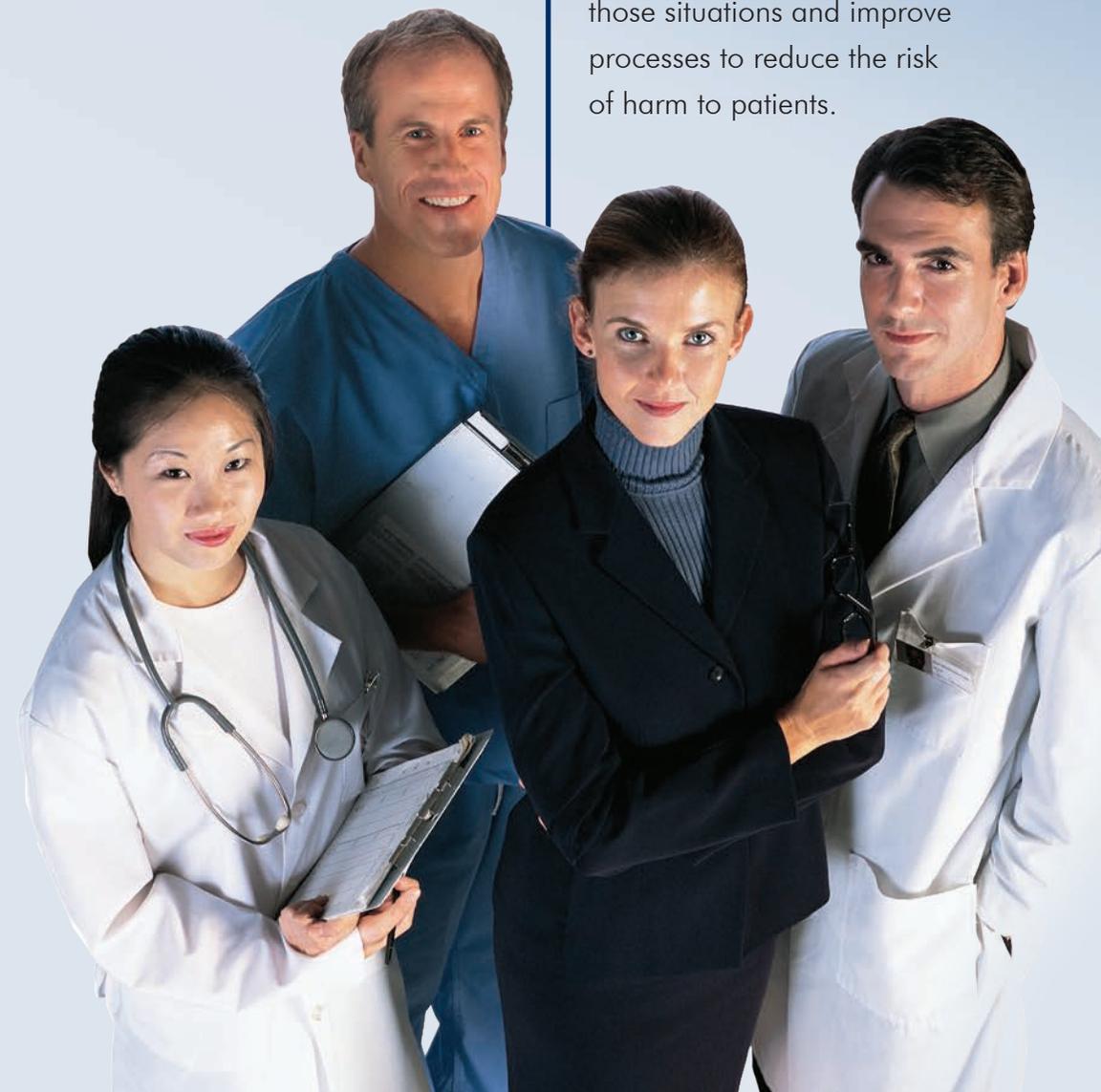
333 Market Street

Lobby Level

Harrisburg, PA 17120

Why Reporting Matters

Reporting patient safety events makes it possible to learn from those situations and improve processes to reduce the risk of harm to patients.



The Pennsylvania Patient Safety Authority

In March 2002, the Medical Care Availability and Reduction of Error (MCARE) Act was signed into law creating the Pennsylvania Patient Safety Authority (Authority). All Pennsylvania hospitals, ambulatory surgical facilities, birthing centers and abortion facilities are required to report all Serious Events (events that harm the patient) and Incidents or near-misses (events that do not harm the patient) to the Authority for analysis. Serious Events and Infrastructure Failures (e.g., power outages, criminal activity) are also transmitted through the electronic reporting system at the same time to the Pennsylvania Department of Health (DOH) for regulatory oversight. Facilities began reporting in June 2004 through the Pennsylvania Patient Safety Reporting System (PA-PSRS), a secure, password protected, web-based system. In 2009, nursing homes began reporting healthcare-associated infections (HAI) to the Authority and DOH. The Authority’s purpose is to provide analysis and recommendations to Pennsylvania’s healthcare facilities about what can be done to minimize the risk of error and prevent events from happening.

Serious Event

An event, occurrence, or current situation involving the clinical care of a patient at a medical facility that results in death, or compromises patient safety AND results in an unanticipated injury requiring the delivery of additional health care services to the patient.

Incident (near-miss)

An event, occurrence, or current 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 health care services to the patient.

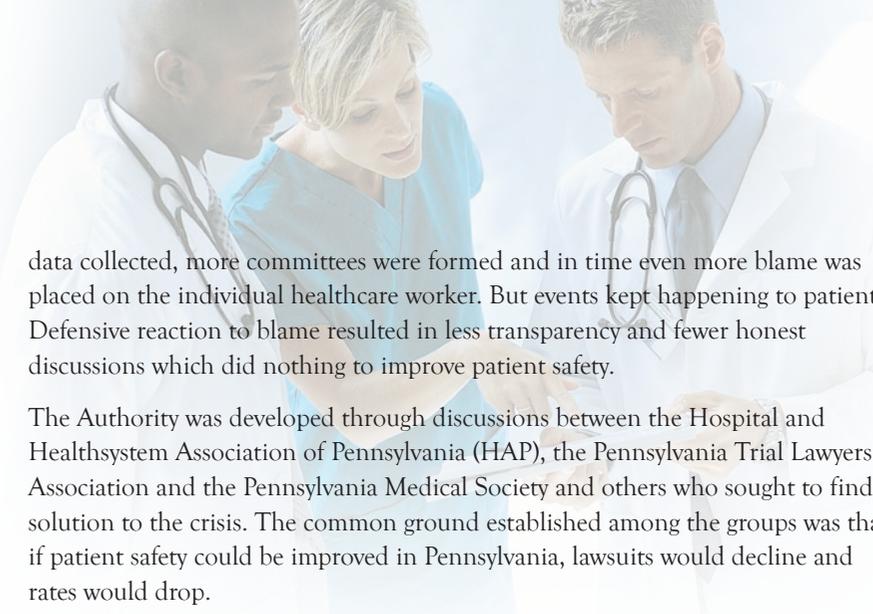
Infrastructure Failure

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.

Background: Why the Pennsylvania Patient Safety Authority Was Created

Prior to enactment of the MCARE Act, a crisis was developing for Pennsylvania’s healthcare providers. Medical malpractice insurance rates were climbing due to large numbers of medical malpractice lawsuits. Rising insurance rates drove some to leave the state and others to struggle to pay premiums. At about the same time, a national report was published by the Institute of Medicine (IOM) titled “To Err is Human” that showed between 44,000 and 98,000 preventable deaths from medical errors were occurring each year in the United States.

As tension mounted in the healthcare industry in the 1990s, so did the tendency to find someone to blame. In that blame-oriented culture, the focus was on individual performance and who did or didn’t perform as expected. For example, fingers were pointed at the surgeon who operated on the wrong knee, the nurse who gave wrong medications and the hospital that hired staff who weren’t competent. The result of asking “who did this?” resulted in still more lawsuits, more tests were ordered, more



data collected, more committees were formed and in time even more blame was placed on the individual healthcare worker. But events kept happening to patients. Defensive reaction to blame resulted in less transparency and fewer honest discussions which did nothing to improve patient safety.

The Authority was developed through discussions between the Hospital and Healthsystem Association of Pennsylvania (HAP), the Pennsylvania Trial Lawyers Association and the Pennsylvania Medical Society and others who sought to find a solution to the crisis. The common ground established among the groups was that if patient safety could be improved in Pennsylvania, lawsuits would decline and rates would drop.

Learning Culture vs. Blame Culture

*“A critical component of a comprehensive strategy to improve patient safety is to create an environment that encourages organizations to **identify errors, evaluate causes and take appropriate actions** to improve performance in the future.”*

—To Err Is Human
(Institute of Medicine Report, 1999)

When healthcare facilities shift their focus from blame to reporting errors and near misses and discovering the reasons why they occur, they are set to learn from their own mistakes. Learning from mistakes is a hallmark of organizations committed to safety. In a culture of safety all employees from housekeeping staff to the CEO should feel comfortable voicing concerns if they see something that could harm a patient.

A learning culture is one that begins with investigating *why* an event happened, not who was involved. By analyzing underlying processes and systems involved in the event and pinpointing the reason the process or system failed, improvements can be made that will decrease the likelihood of that type of event from happening again. The focus has changed from reactive to proactive, from blame to learning.

Root cause analysis (RCA) and Failure Mode and Effects Analysis (FMEA) are methods of problem solving used to help determine the “why” of an event so that steps can be taken to decrease the likelihood of the event happening again and reduce harm to a patient.

However, the path to learning from an event and prevention begins with reporting the event. In essence, it begins with you.

Why Reporting Matters

While there has been a lot of progress in improving patient safety in Pennsylvania, there’s still a lot of work to be done. Some research shows that only two to three percent of errors are reported. Many hospitals are unaware of the extent of errors occurring and the importance of reporting. Many healthcare workers would report only what they could not hide. Errors were perceived by healthcare providers, and the public, as indicators of carelessness. Often staff avoided reporting out of fear of embarrassment, discipline, intimidation, or the sense of futility. All too often the excuse for not reporting is that it takes too much time.

The Authority works to demonstrate to Pennsylvania healthcare facilities that reporting is valuable and worth the time and effort by using the events reported into the PA-PSRS system as a rich source of data and information. Analysis of the data submitted provides insight into the causes of a wide range of event types. Research into those causes results in recommendations to avoid recurrence. In this way, Pennsylvania healthcare facilities learn not only from their own events but from the other healthcare organizations in the state. The research and recommendations are presented in the *Pennsylvania Patient Safety Advisory*, an award-winning journal. Healthcare professionals throughout Pennsylvania receive the *Advisory*, which is distributed quarterly via email at no cost.

In Pennsylvania, it is mandatory to report not only Serious Events, but also the Incidents or near-misses in which no patient harm occurred. Like the Institute of Medicine, the Authority believes these events are important because they can often point to the cause of a Serious Event before it occurs. Collecting near-miss reports and acting on them enables facilities to be proactive instead of reactive. Near-misses offer the opportunity to learn where systems and processes are weak so that action can be taken before injury occurs. Just one report can generate a movement.

Color-Coded Wristband Near-Miss

Early on in the analysis of events reported by Pennsylvania facilities, it became evident how important reporting just one near-miss or one event could be.

A hospital in Pennsylvania submitted a report to PA-PSRS describing an event in which clinicians nearly failed to rescue a patient who had a heart attack because the patient had been incorrectly designated as “DNR” (do not resuscitate). The source of confusion was that a nurse had incorrectly placed a yellow wristband on the patient. In this hospital, the color yellow signified that the patient should not be resuscitated. In a nearby hospital, in which this nurse also worked, yellow signified the patient’s “restricted extremity,” meaning that this arm should not be used for drawing blood or obtaining IV access. Fortunately, in this case, another clinician identified the mistake, and the patient was resuscitated. However, this one near-miss generated further analysis by the Authority at the request of the facility where the near-miss