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Testimony  
Senate Public Health and Welfare Committee Hearing  
“Reducing Infections in Pennsylvania”  
June 6, 2007

Good morning. I am Mike Doering, interim executive director of the Pennsylvania Patient Safety Authority. With me today is Dr. John Clarke, the Pennsylvania Patient Safety Reporting System program’s Clinical Director. Dr. Clarke is a trauma surgeon and a professor of surgery at Drexel University in Philadelphia. He is nationally recognized in the field of patient safety, incident reporting systems and healthcare information technology.

Dr. Clarke and I appreciate the opportunity to be with you today to talk about the Authority and what we have found through our data in regard to healthcare acquired infections, the guidance we have given to facilities to help reduce them and the additional steps we believe must be taken to significantly reduce or eliminate them entirely.

Before I begin to speak about the infection data, I will give a brief background for those of you who may be unfamiliar with the Authority and its patient safety mission. The Patient Safety Authority is an independent state agency established under Act 13 of 2002, the Medical Care Availability and Reduction of Error “Mcare” Act. It is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, birthing centers and most recently certain abortion facilities. Its role is non-regulatory and non-punitive. More than 485 healthcare facilities are currently subject to Act 13 reporting requirements.

Facilities submit reports of Serious Events and Incidents through the Pennsylvania Patient Safety Reporting System (PA-PSRS), a confidential web-based system that was developed for the Authority under contract with ECRI Institute, a Pennsylvania-based independent, non-profit health services research agency, in partnership with EDS, a leading international, information technology firm, and the Institute for Safe Medication Practices (ISMP), also a Pennsylvania-based, non-profit health research organization.

More than 525,000 reports have been submitted through PA-PSRS since the program was initiated in June 2004. Approximately, ninety-six percent of these reports are near-misses, which means no harm was done to the patient, the remainder are actual events. Based on those reports, the Authority issues quarterly and supplementary *Patient Safety Advisories* to give guidance to hospitals, other healthcare facilities and individual providers about steps they can take to reduce

and prevent patient harm. PA-PSRS also provides Patient Safety Officers with sophisticated analytical tools that enable them to evaluate data about their own facilities. They can use this information for internal patient safety, risk management and quality improvement activities.

The Authority's philosophy centers around building "Cultures of Safety" and learning from events to prevent them from happening again, whether it is an adverse event or near-miss. The *Advisories* and educational conferences sponsored by the Authority are important components in providing guidance and making that learning possible.

In a recent survey done by the Authority, Patient Safety Officers indicated that they had made hundreds of changes in their facilities as a direct result of information they obtained from the *Patient Safety Advisories* issued in 2006.

However, the Authority's Board of Directors and staff recognize there is a tremendous amount of work that still must be done to develop cultures of safety within our healthcare institutions that promote full and open disclosure of events; investigations into "why" an event occurred; and improvements and prevention measures to ensure an event does not occur again. These three steps are the foundation for creating an environment that will truly reform patient safety and make healthcare facilities as safe as they can be. More about developing those cultures of safety through our recently approved strategic plan will be discussed in more detail later.

The Authority also recognizes that more work needs to be done in regard to reducing healthcare associated infections which is why we are all here today. In the PA-PSRS system, infections are one of the most frequently reported complications. While the Authority does not receive the same quantity of infection data as the Pennsylvania Healthcare Cost Containment Council due to Act 13 definitions and duplication of reporting, we do receive valuable information about infections that facilities can learn from.

Further, since the Authority added some categories for infections, the PA-PSRS infection data has increased in almost every category since 2005. Significant increases in reporting have been seen with surgical site infections and urinary tract infections. [Display graph] Reporting of hospital acquired infections in each region has also increased. Overall, there has been a 63 percent increase in the number of infections reported to the PA-PSRS system from 2005 to 2006. This number does not mean more infections have occurred, but that the reporting of infections is better.

The Authority has written about some solutions to these problems in *Patient Safety Advisory* articles and has followed closely the achievements of your distinguished guests speaking here today. Some of the PA-PSRS infection reports include: intravascular catheter infections; wound or surgical site infections; and MRSA infections.

One particular infection, *C. diff*, has recently been highlighted in the news and in June 2005 in a *Patient Safety Advisory*. It does not always occur in the hospital, sometimes it occurs when the patient goes home and is required to take antibiotics for several days following an illness or surgery.

Clostridium Difficile [klo-STRID-ee-um dif-uh-SEEL] or C. diff, has been seen in several cases submitted to the Patient Safety Authority as the major contributing factor for causing patient deaths. Most of the patients in the reports (86 percent) were 70 or older. Many patients were treated with antibiotics to guard against infection for an elective surgery. In several cases, the reports show patients developed C. diff in the community after discharge. They failed to return to the healthcare system until the disease had progressed significantly. Unfortunately, the patients most likely did not know their symptoms were serious and did not associate them with the antibiotics taken after their recent surgery.

Our June 2005 Advisory emphasized the importance for the healthcare community to educate the patient on the risks of C. diff upon discharge and the importance of incorporating several strategies to reduce the risk of infection. The treatment and prevention strategies were highlighted in the article and sent to all healthcare facilities reporting to PA-PSRS. The piece was also sent as a stand-alone article to physicians in Pennsylvania through the Pennsylvania Medical Society.

Most recently the Authority issued a "Consumer Tips" piece for the public which you should have received via email and which you have in your packet of information. The piece highlights some of the C. diff cases found in Pennsylvania and gives patients information on the symptoms and actions to take if symptoms develop.

The Authority will continue to make "Consumer Tips" sheets available whenever possible to help spread the word about an important issue. We've done similar campaigns in the past regarding the importance of patient participation in healthcare through a "Speak Up™" brochure with information provided by the Joint Commission and distributed through the Authority. These campaigns are part of a larger educational scope designed to improve the cultures of safety in institutions by encouraging patients to take an active role in their healthcare.

Your information packets also include several other infection control articles published in *Patient Safety Advisories*. Titles include: "A Different Look at Scissors Safety: Infection Control," "Healthcare Industry Representatives: Maximizing Benefits and Reducing Risks," "Bioburden on Surgical Instruments," and "Threat of Cornea Transplant Contamination."

Also in your information packet is the Patient Safety Authority's 2007 *Strategic Plan* which calls for the Authority to work with the Governor's Office of Healthcare Reform, the Pennsylvania Health Care Cost Containment Council (PHC4) and other state healthcare agencies, hospitals and organizations to reduce infections and improve patient safety overall through more educational and training initiatives.

The Authority is currently training facilities in your districts on the importance of conducting Failure Mode and Effects Analysis (F-M-E-A) for potential events in their institutions. The training sessions show facilities how they can improve patient safety by looking proactively, before an event occurs, at system processes with a critical eye and fix any potential gaps in the process that may cause an error. The session in Pittsburgh held recently was well-attended and facilities have given high marks for the usefulness of the material presented. The

Authority is in Gettysburg today and will be in the eastern part of the state next week to finish the training. Also, prior to the start of the sessions in the West and East, the Authority scheduled discussions with Patient Safety Officers on how the Authority can make reporting more consistent and also enhance the analytical tools in the PA-PSRS system to garner more useful information from the data. These ongoing discussions are part of the Authority's plan to engage facilities and provide more venues for them to discuss prevention strategies that work with one another.

Another *Advisory* article gives the perfect example of how the Authority believes you intended Act 13 to work in Pennsylvania. A nurse placed a yellow colored armband on a patient believing the armband meant, "Do not take blood out of this arm," when in fact the armband meant "Do not Resuscitate." The nurse worked in two different facilities that had two different protocols for color-coded wristbands. She put the wrong colored wristband on the patient by mistake. The patient had a heart attack and was almost not resuscitated. Luckily, another healthcare worker found the mistake in time for them to save the patient. The Authority did a survey to determine how many colors and meanings Pennsylvania facilities used for their wristbands. The Authority highlighted the issue in an *Advisory* with a graph showing the numerous colors and various meanings used for wristbands in Pennsylvania. Facilities in northeast Pennsylvania worked together to develop a protocol for standardizing color-coded wristbands shortly thereafter. The protocol developed by the often-competing hospitals has spawned action from not only other Pennsylvania hospitals but across the nation. The efforts of the hospitals and the Authority have most recently been featured in an article in *The Wall Street Journal*. New Jersey and New York have also adopted Pennsylvania's color-coded wristband protocol. Arizona, California, Colorado, New Mexico, Nevada, Oklahoma, Oregon and Utah formed the Western Region Alliance for Patient Safety (WRAPS) after reviewing the Pennsylvania protocol and incorporated major portions of the Pennsylvania initiative. Maryland and Missouri have also used information from Pennsylvania's experience to incorporate a standard for color-coded wristbands. Some articles on what these states have done, the *Advisory* articles and *The Wall Street Journal* article are also included in your packet.

Along with helping facilities work together to solve problems, another component of the Authority's strategic plan is educating hospital boards of trustees on the importance of patient safety in their facilities, not only to provide the best quality care, but also to reduce the costs of prolonged care and errors due to inefficient processes in their institutions.

The Authority believes that the safest healthcare institutions in Pennsylvania are those whose boards of trustees are fully engaged in the patient safety initiatives in their facilities. These facilities also report more Serious Events and Incidents because they know the more they report, the more they know about what's going on in their facilities. The information provides the roadmap for institutions to show their patient safety committees and boards of trustees the tools needed to drive real change in their facilities that improve patient safety.

As part of its plan to reduce infections, the Authority will further study the initiatives that have clearly worked in Pennsylvania. The initiatives established by Dr. Richard Shannon and others at Allegheny General Hospital have been adopted by the national initiatives sponsored by

the Institute for Healthcare Improvement (IHI) for the 100,000 Lives Campaign and more recently the 5 Million Lives Campaign.

The work done by the Pittsburgh Regional Healthcare Institute and the Delaware Valley Healthcare Council will also be considered before the Authority begins its educational initiative to work directly with hospitals to reduce infections and implement evidence-based safety initiatives.

As proven here today, there are strategies that work to reduce infections and other harm to the patient. The key is providing other facilities with the knowledge and resources to combat those infections. The Authority will work with Pennsylvania facilities and other healthcare organizations throughout the state to help eradicate the life-threatening and often deadly hospital acquired infections and other infections within the community by giving the facilities the information and resources they need.

The Authority has already begun a similar process with Pennsylvania facilities to reduce wrong side surgeries. At the end of this month a study will be released on the number of wrong side surgeries and near misses of wrong side surgeries in Pennsylvania. But along with that study will be a project dedicated to determining best practices for reducing and eliminating wrong side surgery that the Authority will take into the facilities and help implement.

We know our work is far from over, but I thank you Senator Erickson and members of the Public Health and Welfare Committee for allowing me this opportunity to discuss the Patient Safety Authority and what it has done thus far to educate facilities on infections and other harmful events occurring in Pennsylvania healthcare facilities.

We will be happy to take any questions you may have at this time.

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