1. The Commonwealth Fund. (2007). Pennsylvania's Public Reporting of Hospital-Acquired Infections: How Are Hospitals Addressing the Issue? Retrieved October 12, 2020, from <https://www.commonwealthfund.org/publications/newsletter-article/pennsylvanias-public-reporting-hospital-acquired-infections-how-are>

* Pennsylvania was the first state to publically report the volume and cost of hospital-acquired infections. The report was released by the Pennsylvania Health Care Cost Containment Council (PHC4) in 2006 (for 2005 calendar year)
  + Infection rate of 12.2/1000 cases
  + 394,000 infection-related hospital days
  + $3.5B in hospital charges
* For an average commercially-insured patient, the cost of a hospital stay increases from $8,000 to $54,000 if an infection is acquired.
* Public reporting led to national discussion, as well as regionally and nationally-based improvement initiatives to promote safe practices and set infection-prevention goals
* UPenn has approximately 70,000 central line patient days annually, reduced the associated infection rate by 30% form 2005 to 2006

1. Kohn L T, Corrigan J M, Donaldson MS (2000) To err is human: building a safer health system. Washington, DC: National Academy Press. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2464859/#ref4>

* Institute of Medicine report of 1999
* Medical errors occurring in hospitals cause between 44,000 and 98,000 deaths of Americans each year.

1. Kuo, Y., Lee, T., Mills, M. E., & Lin, K. (2012). The Evaluation of a Web-Based Incident Reporting System. *CIN: Computers, Informatics, Nursing,* *30*(7), 386-394. doi:10.1097/nxn.0b013e31825106ea

* Non-U.S. study found that simplicity and anonymity of reporting significantly improve rates of reporting safety events.
* adverse event (injury caused by healthcare professionals), near-miss (potential adverse event identified before it caused harm to patients), and medical errors (a mistake that did not affect the patient's health).

1. Lamb, R., & Golann, D. (2003, March/April). Hospital Disclosure Practices: Results Of A National Survey. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.22.2.73

* National study including for-profit and non-profit hospitals, selected by stratified random sampling (by faculty size and geographic region) of hospitals with 200 or more beds.
* Only one in three responding hospitals had board-approved disclosure policies. However 80% (in 2003) had polies in place or under development. Disclosures were described and classified by the following elements:
  + Explanation
  + Undertaking to investigate the incident
  + Apology
  + Achnkowledgement of harm
  + Declaration of responsibility
  + Promise to share investigation results with patients/families
* 17% of hospitals routinely released disclosures with all six of the above elements
* Hospitals, especially those with major concerns for malpractice implications, were less likely to disclose preventable harm outcomes, compared to non-preventable outcomes of comparable severity.

1. Leape, L. L., & Berwick, D. M. (2005). Five Years After To Err Is Human. *Jama,* *293*(19), 2384. doi:10.1001/jama.293.19.2384
   * Motivated hospitals to adopt move safety practices, and placed an emphasis on patient safety [such as creating roles like Chief Safety Officer]. Slower rate than called for by IOM report
2. MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, Pennsylvania General Assembly (2007) Retrieved from: <https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2007&sessInd=0&act=52#>
3. Pennsylvania Patient Safety Authority. (2007, July). Act 52: Governance. Retrieved from http://patientsafety.pa.gov/PatientSafetyAuthority/Governance/Pages/Act52.aspx

**ACT 52 - MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT - Reduction and Prevention of Health Care-Associated Infection and Long-Term Care Nursing Facilities**

Act 52 of 2007 requires certain healthcare facilities in Pennsylvania to report healthcare-associated infections to the Pennsylvania Department of Health, the Pennsylvania Healthcare Cost Containment Council and the Pennsylvania Patient Safety Authority through the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) for hospitals Pennsylvania Patient Safety Reporting System (PA-PSRS) an electronic reporting system for nursing homes. The Act is part of the Governor's "Prescription for Pennsylvania" plan to reduce and eliminate healthcare associated infections.

1. PHC4. (2012, February). The Impact of Healthcare-associated Infections in Pennsylvania 2010. Retrieved from <http://www.phc4.org/reports/hai/10/nr022412.htm>

* Released in 2012 (for 2010 calendar year)
  + 1. Infection rate of 11.3/1000 cases
    2. Mortality rate with HAI was 9.1% (compared to 1.7% without an HAI)
    3. ALOS with 21.9 days with HAI (compared to 5.0 days without)
    4. 41.9% of patients with an HAI has a readmission within 30 days (16.3% readmissions rate without)

1. Pronovost, P. (2008, August). Improving the Value of Patient Safety Reporting Systems. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK43621/>

* Evaluation of web-based patient safety reporting system (PSRS)
* Reporting via PSRS leads to analysis (crucial step), leads to root cause analysis, leads to imrpovements in procedures and reduced future harm
* Example: For example, one hospital identified insufficient staff knowledge as the main cause of events related to the use of intracranial pressure monitoring devices. This recognition led to an improved staff training program.
* Collection within a hospital of system can identify site-specific imrpovements; public reporting can pool common causes of harm for widespread awareness and policy change

1. Shi, L., & Singh, D. A. (2019). *Essentials of the U.S. Health Care System* (Fifth ed.). Burlington, MA: Jones & Bartlett Learning.

* Potential topic: fear of litigation in disclosing preventable harm (Lamb et al., 2003)
  + Malpractice claims were due to (in order of frequency) diagnostic errors, medication errors, improper performance, failure to communicate with patients, and failure in referral
* In a healthcare setting, safety emphasizes the absence of medical errors, specifically errors that could negatively affect clinical and health outcomes.
* A safety event is “any process, act of omission, or commissions that causes hazardous health care conditions or unintended harm to the patient.”
* In a 2005 analysis, harm was found to be most associated with therapeutic intent of an activity, language barriers, errors of judgement, communication from another office, mistiming of procedure, and medication errors.
* **Reporting patient safety events appears to be an effective approach for improving patient safety**.
* In healthcare, reporting is promoted through anonymous reporting, meaningful feedback, and greater ease to report
* By reporting adverse events and near misses
  + Enables safety specializes to investigate, identify underlying factors, and mitigate risks
* Significant relationship between safety culture and nursing-sensitive patient outcomes (e.g. fewer medication errors, patient falls)