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In Conversation with... Regina Hoffman about Building Capacity for Patient Safety

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Editor's note: Regina Hoffman is the executive director of the Pennsylvania Patient Safety Authority. We spoke to her about her experience in collaborative learning, sharing information across healthcare facilities, and patient safety education.

Sarah Mossburg: Welcome, Regina. Can you please tell us a little about yourself and your current role?

Regina Hoffman: I am a registered nurse. I have worked in a variety of healthcare settings and roles for about 30 years. After nursing school, I worked as a staff nurse in a hospital, then as a director of nursing in a long-term care facility. Eventually, I found myself working in patient safety.

I started working at the Pennsylvania Patient Safety Authority almost 11 years ago as a patient safety liaison (now called patient safety advisor). For the past seven years, I have served as the executive director of the agency. The Patient Safety Authority is an independent, nonregulatory agency in Pennsylvania. We are governed by an independent, 11-member board. Our funding comes from healthcare facilities through an annual assessment based on their bed count or the number of procedure rooms.

The Pennsylvania Patient Safety Authority was established in 2002 as a result of the Medical Care Availability and Reduction of Error Act (MCARE), which was passed to reform medical professional liability in Pennsylvania. One provision in that act states that every effort must be made to reduce and eliminate medical errors by identifying problems and then implementing solutions that promote patient safety. That's where we come in. The Patient Safety Authority is charged with collecting information related to patient safety events across Pennsylvania, analyzing that information, and then advising healthcare facilities on practices that improve safety and prevent patient harm.

Our team of advisors serves a variety of healthcare settings in Pennsylvania. For example, every hospital, surgery center, birthing center, and abortion facility has an advisor from our team assigned to them, who can support the facility in anything related to patient safety. Every long-term care facility also has an infection prevention advisor from our team assigned to them. Our advisors have decades of experience in patient safety and infection prevention and come from varied specialty backgrounds.

Sarah Mossburg: One of the Patient Safety Authority's most prominent functions is managing the Pennsylvania Patient Safety Reporting System (PA-PSRS). Can you tell us more about this system?

Regina Hoffman: PA-PSRS is the largest patient safety database of its kind in the United States and is one of the largest in the world. It houses reports of patient safety events across Pennsylvania. PA-PSRS was developed as a result of MCARE, which requires that hospitals, ambulatory surgery facilities, birthing centers, and abortion facilities report all patient safety events to us. These events and unsafe conditions reported result not only in injury but also in near-misses. A few years later, an amendment was made to the act that required long-term care facilities to report healthcare-acquired infections into the database.

Sarah Mossburg: How are healthcare systems using the PA-PSRS data?

Regina Hoffman: Healthcare facilities use the data in a couple of different ways. Because facilities are required to report patient safety events to us, the entire patient safety team at the facility, and often the leadership team, know that an event occurred in a very timely manner. This information allows them to start taking immediate action after an event occurs and creates an early opportunity to investigate the causes and the contributing factors. That is the microsystem of the learning system in Pennsylvania and what is happening within each hospital and how they use that information.

When we look at the macrosystem or the bigger picture, the Patient Safety Authority looks at events across the entire healthcare system in Pennsylvania—not just one hospital or one health system. Healthcare facilities may share information and lessons learned within their own institutions and system, but usually not outside of their walls. That is where the Patient Safety Authority comes in. We are able to look at that information without disclosing which facility it came from, and then we advise other facilities about potential problems. Sometimes that is based on trends that we are seeing or based on one event.

For example, we had an event a few months ago where a patient's finger was amputated in a wheelchair. While that is a known risk of wheelchair usage, it is not one that staff may often think about or expect to happen. Based on that event, we were able to alert healthcare workers about what happened to bring attention to this risk through our safety alert program and other marketing measures—all without disclosing where it happened.

A safety event may seem like a one-off occurrence within a single hospital, but when we start looking across the whole system, that's when we realize that these are bigger problems than we think. The Patient Safety Authority will take that information and get it back to the healthcare facilities.

Several years ago, a researcher at the Patient Safety Authority was reviewing newborn-related safety events and discovered a newborn fall that seemed odd given that newborns are not walking around. After digging deeper into the data, she found that this type of event was not as uncommon as people think. A newborn fall often means the baby was dropped, likely by exhausted parents who fall asleep holding their babies after giving birth. This turned into an awareness campaign, not only for healthcare workers but also for the general public.

Sarah Mossburg: It sounds like the database is used commonly as a signal for events that should be shared out more broadly. Are there other ways that the Patient Safety Authority uses that data?

Regina Hoffman: Once the information is entered into PA-PSRS, it is reviewed by our clinical team in a variety of ways. One way is by reviewing events of high harm, meaning a patient died or experienced a permanent or life-threatening injury, every week as a team. This allows us to gather additional information if needed, bring critical issues to the attention of healthcare facilities through a safety alert, and identify areas for further study.

We recently had a report where a patient with hypersensitivity to milk had an anaphylactic reaction after receiving a dose of solumedrol. When we reviewed the event, we noted there is a warning on the package insert that a reaction could happen. It does not happen often, and most people don't make that association. We were able to really bring it to the attention of healthcare workers fairly quickly.

Other than the quick turnaround, our data science and research teams conduct analyses on the information that we receive to better understand the types of events as they are happening. It could be how frequently something is happening, potential contributing factors to those events, or what the risk reduction strategies have been to prevent future events from happening. We advise hospitals through publication. Most of these manuscripts are published through our quarterly journal, *Patient Safety*.

We began our journal, *Patient Safety*, in September 2019 and have published more than 50 original articles based on our PA-PSRS data. Prior to 2019, we had a separate publication called the Patient Safety Advisory. We have been sharing information through publications for nearly 20 years.

We also have a formal education program. We have had more than 90,000 attendees to date at our local, regional, statewide, and virtual education programs. Our advisors conduct on-site education for leadership teams, patient safety teams, and frontline clinicians. Our education programs are developed as a result of the information we see in our database and other current events in patient safety.

Our education program includes an online learning system that is open to anyone, anywhere and is offered at no cost. We have about 20 courses and are building more. Our data continually inform us of what is going on across Pennsylvania, and then we can tailor our feedback to inform facilities on how to make improvements.

Sarah Mossburg: These are pretty clear ways that the Pennsylvania Patient Safety Authority is engaged in helping build safety capacity throughout Pennsylvania in terms of workforce education and getting safety event and risk information back to health systems in order to impact hospital processes related to that information.

Regina Hoffman: Absolutely. We are building the workforce's capacity for safety, primarily through education, whether it is in-person education, reading an article, or education online. We are also increasing the awareness of safety risks and providing knowledge on how those risks might be mitigated, especially to frontline staff who need to be more conscious of the risks that their patients are exposed to and better equipped to prevent them.

Sarah Mossburg: Outside of the Pennsylvania Patient Safety Authority, you played a large role on the National Steering Committee for Patient Safety as the co-lead for the Learning Systems subcommittee. Can tell us a little bit more about the subcommittee and its goals?

Regina Hoffman: Yes, I led the subcommittee on Learning Systems along with Dr. Stephen Muething. We worked with a very committed and diverse group of 16 individuals that were subject matter experts, clinicians, and patients. The overall vision that the National Steering Committee had was to ensure that healthcare is safe, reliable, and free from harm. There was a significant focus on total system safety as opposed to working on specific patient safety issues. We were working not on falls or adverse drug reactions, but on the overarching issues that could make the whole system better. As the subcommittee that was focused on learning systems, we were charged with developing an aim and clear direction on how learning systems are in line with that vision.

We had guiding principles that we followed to make sure our actions were person-centered, and our direction could span the continuum of care to address all the ways that healthcare touches our lives. We also needed to be able to recognize the relationship between patient safety and health equity.

It was a lot of work, but having that group of people to work with was amazing because of the diverse perspectives. It was a great experience.

Sarah Mossburg: Part of what we are interested in talking to you about today is building organizational capacity for safety. We already talked about how the Pennsylvania Patient Safety Authority helps build healthcare worker capacity in terms of education. One recommendation from the National Steering Committee's National Action Plan to Advance Patient Safety focuses on collaborative learning organizations. Can you speak more about building organizational capacity for safety through learning health systems? What are the implementation tactics to facilitate intraorganizational learning?

Regina Hoffman: Collaborative learning is a foundational piece of our organization and many other organizations dedicated to patient safety. In terms of intraorganizational learning, or learning within a single facility or organization, there are several key pieces. Organizations must have an infrastructure in place to collect information from various sources, whether that is from patients or providers. The system must be easy to use because you're depending on people taking the time to use them.

The more difficult part of organizational learning becomes building that culture where staff is comfortable reporting and knows what the expectations are. Building that culture starts with leadership and it needs to reach the frontline. It's often not people purposefully avoiding reporting events; sometimes, they just do not know what they are supposed to report. That's where expectation setting comes in. Leadership also needs to remove the fears related to reporting. This includes the fear of negative consequences related to reporting.

Intra-organizationally, there must be mechanisms to review the information that is coming in. No one wants to take time to report if nothing happens with the report data. You must begin to build a culture to encourage reporting where people know that reporting is worth their time. You need a feedback loop built into the system to share what happened and what the organization is doing about it. What actions are you taking as an organization to make sure that this does not happen again? This feedback loop should outline the actions individual people can take as well.

Sarah Mossburg: What could that feedback loop look like?

Regina Hoffman: Every organization is different. Feedback loops do not need to be big, elaborate systems. It could be a simple process where information is entered, there is an investigation, and a lesson learned that is shared at a staff meeting. Being able to take what happened and share those stories across different settings is helpful.

Another important piece to intraorganizational learning is to let people know if you are making system changes based on their experiences. It is important to know that something was done about a safety event and that the organization acted or took ownership. Patient safety is a shared responsibility, especially for system problems. Staff wants to know that the care for the next patient is safer because they spoke up and said something. If you have been involved in an error and are already taking ownership of it, then you want to know that the systems that contributed to an error are also being changed.

Sarah Mossburg: Can you speak about collaborative learning beyond one hospital system and across different organizations?

Regina Hoffman: Interorganizational learning is where there is more difficulty. While some healthcare leaders and risk managers will share lessons learned and action steps internally, they are often reluctant to share externally. It can still be viewed as airing dirty laundry, instead of sharing adverse events so similar events do not happen at another organization. While many hospitals and health systems are very transparent, many lessons learned remain behind closed doors.

That is where our challenge really is going forward. How do we continue to break down those barriers?

Sarah Mossburg: Are there any ways that the Patient Safety Authority is able to support interorganizational learning in Pennsylvania?

Regina Hoffman: That is our primary reason for existence—to support interorganizational learning. We are able to take the information that we receive and turn that around into actionable feedback for healthcare facilities. Where our constraint comes in is in the quality of the data that we receive and the depth of that information.

We receive 300,000 reports a year but do not often get information on why something happened or how it happened. This makes is difficult to make appropriate advisement on how to prevent these events from happening in the future.

People are very reluctant to share. In my experience, that reluctance often comes from the real or perceived fear of discoverability in medical malpractice suits. The information we receive from healthcare facilities is intended to be protected under MCARE. The information that Patient Safety Organizations (PSOs) receive is intended to be protected under the Patient Safety and Quality Improvement Act of 2005 Statute and Rule. Other individual state statutes protect peer review and other quality improvement activities. While the intent is good, unfortunately they sometimes create conflicts that end up restricting the sharing of incredibly useful information.

Sarah Mossburg: You mentioned PSOs. How is the Patient Safety Authority different from PSOs and how is it similar?

Regina Hoffman: Sure, we can start with how we are similar. Our end games are the same: to keep patients safe, right? That is the most important thing to remember. We all collect information from hospitals and other healthcare facilities related to patient safety events. What happens at that point varies because there are many PSOs and not all of them function in exactly the same way. There is some level of taking that information and using it to inform healthcare organizations of ways to improve patient safety.

The biggest difference is that hospitals are not required to belong to a PSO. If they belong to a PSO, they are not required to submit information to them; it is voluntary. Pennsylvania hospitals are required by law to submit information to the Patient Safety Authority.

Sarah Mossburg: Switching gears, another recommendation of the National Action Plan was facilitating interprofessional education and training on patient safety. Can you tell us more about that recommendation?

Regina Hoffman: Yes. There is an emphasis in the National Action Plan on how to improve safety training for clinical and administrative staff. We need to look at best practices on how high-risk industries train for safety. There is a lot of simulation, for example. As we move forward in healthcare and in patient safety, I think we need to start moving away from a didactic learning model, which is only based on me teaching you something, and start to change that to a learner-based model. That way knowledge gained is more easily turned into practical use.

There is an emphasis on creating standards around patient safety education in both initial training and continuing education. This is critically important. But beyond initial training and continuing education, every single thing that a person learns that involves patient care should be approached from the perspective of safety. It is important to make sure healthcare workers have the important skills that cross every area, like communication skills and specific job skills. Patient safety skills should also be included so that healthcare workers know what could go wrong when learning a new skill or procedure and how to avoid it.

Ongoing training is important, and there should be standards around it. There should be standards making sure that safety is built into education. For example, for nurses, safety training should start from the first day of nursing school and last until retirement.

At some point, we have to move to a point where patient safety is not a separate training. We should integrate patient safety concepts into everything that we are already learning. In a perfect world, there would not need to be patient safety education because it would already be built into all education. For example, if someone is developing a curriculum for a medical student or a pharmacy student, patient safety concepts are already included. There is not a separate course for it.

Sarah Mossburg: What standards could be implemented related to safety education training?

Regina Hoffman: All clinical staff should be able to understand and demonstrate basic patient safety practices specific to the patients they are caring for as well as general safety practices that cross all care areas. Staff should know how their own biases can affect the type and quality of care their patients receive. And all staff must know what to do when they see something that is unsafe and feel empowered to act upon it.

When we move into administrative staff and leadership teams, at a minimum they need to understand basic patient safety concepts, such as culture of safety and high reliability. We also need to move beyond that. Patient safety training at the leadership level should be about driving innovation and system change to improve safety, both for patients and the workforce. We need leaders to move beyond knowing what needs to be done to actually taking action.

Healthcare leaders need to understand what patient safety and workforce safety looks like in 2023. For example, system design, or designing new processes, should be interdisciplinary. In the past, the interdisciplinary approach included managers, frontline staff, and a patient. Today, system design might also include human factors engineers, system design engineers, psychologists, and social workers, it takes a true interdisciplinary team to overhaul a system to make it work better for clinicians and patients. It is still important to get frontline staff and patient input, but we need to start taking advantage of additional expertise. Leadership education about how to engage these safety experts is important.

Sarah Mossburg: A learning organization seems like an ideal way to respond to the constantly changing world that we live in because it allows health systems to take in information and adapt based on what they're learning. What are the next steps for this work?

Regina Hoffman: One of the biggest opportunities continues to be bringing all of the pieces of the National Action Plan together for the greater good. It would be great to see a cohesive approach to patient safety learning, not only in Pennsylvania, but across the country. I would like to find ways to break down the barriers that are keeping people from truly being transparent and sharing meaningful information that could make a positive difference in safety. We have all of these individual learning systems, and we need them to come together. We need them to be transparent, but there still is not a mechanism to do that well.

We have had other states reach out to us and ask what patient safety looks like and what legislation looks like in Pennsylvania. Our system is not perfect by any means, but it is robust and farther along than most. If we could take our model, make some tweaks to it, and replicate it, there would be a way for agencies like ours in every state to come together and start to work on common goals and share freely.

Sarah Mossburg: That's a great message to end on. Thank you for this conversation.