The Patient Safety Authority

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Many states have enacted legislation to mandate the reporting of medical errors and to require a form of public disclosure. It is thought that via public transparency, we can compare process-improvement strategies, thereby lowering the rate of medication errors and improving the quality and safety of health care. Among these state agencies, one has been hailed as a bellwether for the rest of the nation, namely the Patient Safety Authority (PSA) in the Commonwealth of Pennsylvania. I would like to review the early history and progress of this agency, with an emphasis on its efforts to reduce medication errors.

The agency’s annual report from 2006 considered the authority to be an independent state agency established under the Medical Care Availability and Reduction of Error Act (the MCARE Act), or Act 13 of 2002. The purpose of Act 13 is 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, some abortion centers. The agency’s role is nonregulatory and nonpunitive.

By the end of 2006, the agency had collected more than 436,000 reports, with the PSA possessing one of the largest databases of its kind in the world. The PSA has garnered prominent national press and interest from the international community as well. Its core mission is to analyze reports of serious adverse events and incidents through the Pennsylvania Patient Safety Reporting System (PSRS), a secure Web-based data collection and analysis system.

During the calendar year for 2006, the 460 hospitals, ambulatory surgical facilities, and birthing centers in Pennsylvania submitted almost 196,000 reports that included about 7,000 serious events and approximately 189,000 incidents (near-misses). Fortunately, although 90% of the adverse events were classified this way, we can learn much from the size and scope of this publicly reported data set.

For regular readers of P&T, it should come as no surprise that medication errors accounted for nearly 25% of all reports submitted in 2006. The next largest category consisted of errors related to procedures, diagnostic tests, and patient falls.

It is interesting that patterns and trends were evaluated according to the “recovery rate”—the percentage of reports that did not involve harm to patients (incidents), compared with all reports. The desired result is an increase in the recovery rate. Such an increase is possible if the number of serious events reports decreases. Patient safety experts also consider an increase in the number of reports of detected events that do not harm patients to be desirable.

In a nutshell, then, the recovery rate has begun to increase throughout Pennsylvania since the PSRS came into existence. It appears as though hospitals are “getting it,” at least with the need to report near-misses and related medication misadventures.

The question remains: does improved reporting lead to better quality and safety of the health care delivered?

This is a key policy question that concerns all current and proposed statewide reporting systems. The professional staff of clinical analysts at the PSA evaluates all reports of serious events and incidents. This research is published in a quarterly publication, Patient Safety Advisory, which is directed primarily to health care professionals and facility administrators.

The Advisory provides clinical guidance about improvements in procedures that facilities can adopt to improve patient safety and reduce potential harm to patients. With this publication, therefore, a statewide ongoing type of benchmarking system is in place. Of course, to actually improve care, we must ensure that people read, understand, and implement the advice they are getting in the Advisory. This is no small feat.

The PSA notes that more than 100 peer-reviewed articles have been published about specific events submitted through its data set. Various task forces have also been developed with leaders from across the state based on recommendations appearing in the Advisory. From the perspective of medication safety, the Advisory has distributed major findings, with a special emphasis on the risk of using verbal orders for medications and insisting on a “read-back” procedure. An educational toolkit, a slide show, and sample policy procedures have also been posted to help hospitals implement steps to promote medication safety.

The PSA admits that the reporting of adverse events is a first step in addressing quality and safety:

The action of submitting a report is an acknowledgement that something actually or almost happened, but the next steps are important—learning why it happened and implementing steps to prevent it from happening again. The Authority recognizes [that] this is no easy task, but it’s a challenge that everyone from hospital CEOs to the maintenance workers in every facility should accept.

I can only add to this admonishment—Amen!

I am proud of the work that the PSA has done in Pennsylvania. It is not easy for us to be in the forefront of such a control...
versial area. I know that Jefferson Medical College has struggled with the liability issues swirling around public reporting. I think we are marching in the right direction, and I challenge other states to participate in comparable activities.

What is your P&T committee doing to grapple with the public reporting of medication errors? What statewide, local, or national medication error rates and recovery rates are you using as benchmarks in your hospital or managed care system?

More information is available about the Patient Safety Authority in Pennsylvania at its Web site (www.psa.state.pa.us), or you can call Laurene M. Baker at 717-346-1092.

As always, I am interested in your views. You can reach me at my e-mail address, david.nash@jefferson.edu.

REFERENCE

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