The Patient Safety Act
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By now most of our readers have become well acquainted with the Patient Protection and Affordable Care Act (PPACA), which Congress passed in March 2010. No doubt your institution is working hard to grapple with the implications of these changes. Somehow lost in the background noise of the PPACA was the earlier passage of the federal Patient Safety and Quality Improvement Act (the Patient Safety Act) in July 2005.

What is its significance to P&T committee members?

The core goals of this unheralded piece of important legislation are (1) to encourage health care professionals to improve the safety and quality of health care, (2) to understand the underlying causes of hazards in the delivery of health care, and (3) to share those results in all states within a protected legal environment, thereby minimizing any risks related to patient care.1 In short, the legislation is designed to provide an environment in which health care practitioners can voluntarily and anonymously report safety problems, with the idea that conveying these messages will lead to improved care.

The Patient Safety Act was intended to strike a balance between maintaining confidentiality and legal protections in reporting safety information and maintaining patients’ rights. The Act was not intended to mandate participation in any specific patient safety organization (PSO). It is not an error-reporting system per se and does not provide any federal funding for PSOs. Further, it does not pre-empt stronger state legal privileges or other protections of confidentiality.

Under the auspices of the Patient Safety Act, organizations that are eligible to create a PSO include public or private entities, profit or nonprofit entities, and providers such as hospital chains that establish special components to seek to serve as PSOs. The Act offers protections of confidentiality that enable health care providers, hospitals, and PSOs to gather and analyze data on the quality of patient care to reduce any associated safety events.

The Patient Safety Act also outlines the requirements that entities must meet in order to become a PSO. Basically, all PSOs must meet 15 statutory requirements, and component organizations must satisfy the three statutory criteria; other listing requirements must also be met. Thus, all health care providers are now obligated to report data to a PSO.

Perhaps even your own institution is qualified to become a PSO. This is an important part of all P&T committee deliberations, which clearly relate to medication safety data that the committees should be routinely reviewing.

As you learn more about PSOs, you may come across the Patient Safety Evaluation System (PSES). The PSES is involved in collecting, managing, and analyzing information that would be reported to a PSO.1 The Patient Safety Work Product (PSWP) consists of information based on medical records, reports, memos, analyses, and written or oral statements that a reporter would collect or develop for a PSO that could improve patient safety, health care quality, and outcomes.1

I hope that our readers will take the time to understand the main message of the Patient Safety Act and the importance of continued participation by health care providers in reporting safety concerns. In my view, the only way we will improve patient safety is by a professional commitment to public reporting by all clinicians, including physicians, pharmacists, nurses, and others.

Anyone who comes into contact with and cares for a patient should become familiar with the basic concepts of PSOs, should be prepared to report any safety problems—and should be assured that such reports will remain strictly confidential.

As always, I’m very interested in your views. You can reach me at david.nash@jefferson.edu. Please also visit my blog at http://nashhealthpolicy.blogspot.com, which I constantly update.

REFERENCE