# Patient Safety in Pennsylvania

Pennsylvania's Patient Safety Authority ("PSA") has completed its Annual Report to the Legislature, as required by law. When I helped to fashion the Pennsylvania Patient Safety Authority in 2001 as part of the Mcare Act, hardly could it have been imagined that the Authority would grow to an entity of national, and even international, recognition.

Under the leadership of Rachel Levine, M.D., Physician General of the Commonwealth of Pennsylvania, the Pennsylvania Patient Safety Authority has continued to professionalize and grow. However, growth should not necessarily be equated with excellence. The two may go together, but not always.

Fortunately, the Authority's 2017-2020 strategic plan is to focus on: (1) improving diagnosis; (2) the patient; (3) long-term care; and (4) evaluating the reporting system. At the first retreat of the Patient Safety Authority, the Board members were asked what were the most important components of the Patient Safety Authority. No one else volunteered, "the patient." Now, at least the Authority recognizes that the patient must be the central focus of safety in the delivery of healthcare. Focus on the patient is relatively new for the Patient Safety Authority. It will include: (1) expanding the inclusion of patient perspective; (2) identifying key topics; (3) educating patients on safe healthcare; and (4) improving awareness of and access to resources.

The Patient Safety Authority is an independent state agency established under the Medical Care Availability and Reduction of Error Act of 2002. Much of the work of the Authority is to collect information. Unfortunately, there has always been great resistance among hospitals and healthcare providers to supplying "serious event" reports. The reason for this reluctance is that under the law, serious events must also be reported to the Pennsylvania Department of Health and patients! The reporting to patients has been a sticking point for many professionals. The likelihood of serious event reporting will be diminished by the Authority's emphasis on not requiring serious event reports if a patient has been told that they may suffer a particular harm, so-called informed consent. In the law of torts, informed consent is required for surgical and certain invasive procedures set forth by the Mcare Act. By importing the concept of informed consent to all medical care, hospitals may think they do not have to file serious event reports with the Patient Safety Authority or the Pennsylvania Department of Health. That also means that patients will not be informed of "serious events" in hospitals.

In spite of the challenges, Pennsylvania is receiving "incident reports". An incident is an action that did not cause harm to the patient but had a potential for causing a problem. These so-called "near misses," borrowing from the language of the Federal Aviation Authority, is also a way to nip medical errors in the bud.

While the Patient Safety Authority does not mention it, **preventable** medical errors are a leading cause of death in the United States. Some would say that it is the third, fourth or fifth leading cause of death. This would never be tolerated in any other industry.

My role on the Patient Safety Authority has been to work in a cooperative spirit to reduce preventable medical errors and to make sure patients and their families receive reports of serious events. Reduction of medical errors can be accomplished not only through the tort system which demands accountability, but also through cooperative and educational agencies such as the PSA.

One of the big problems in hospitals and nursing homes are hospital-acquired infections. Pennsylvania passed Act 52, intended to get a handle on the catastrophe of harm caused by preventable infections in Pennsylvania hospitals and nursing homes. The PSA is taking up the standard, once it was given the legislative authority, to try to get its arms around infections.

The state is filled with Patient Safety Liaisons who are employed by the Patient Safety Authority and go around to hospitals in order to assist in the collaboration between the PSA and hospitals. All too many patients and hospital employees, including doctors, know nothing about the PSA, its work, or the role of the PSA liaisons.

The Patient Safety Authority report to the legislature is filled with data, lots of numbers and interesting charts. The PSA has always been challenged by the question as to whether it has made a difference in patient care. The reporting system for medical errors in Pennsylvania is "mandatory," but it is only as good as the honesty of those who do the reporting. The number of submitted reports has increased steadily each year. The PSA will say that does not mean there are more medical errors, but rather that healthcare providers now buy into the system of reporting errors, as they should. That is one possible conclusion, but certainly not the only one. Likewise, when there is a drop in a particular problem that does not necessarily mean that the PSA is responsible for it. So-called harm reports and number of death event reports have dropped consistently, although there was a spike in number of death reports in 2015 and 2016. The last two years of increase in number of events associated with patient deaths is troublesome and is not adequately explained in the report.

Every government agency, whether independent or not, should justify its budget based upon results. I have pushed this agenda aggressively, especially as I have seen the budget of the PSA expand with each passing year. Without doubt, I am the only Board member who has ever voted against budgetary increases when I thought they were unnecessary.

One of the positive components of the Patient Safety Authority is the great respect shown by and between the Board members and the professional staff. When I speak out vociferously for patients, whistleblowers, and the need to improve what we do, I feel as though I am being taken seriously. That was not always the case, and the change in attitude is reassuring.

The public should be familiar with the work of the Patient Safety Authority. Patients should understand that every hospital is required to have a Patient Safety Officer, and that liaisons will visit the hospital throughout the year from the Patient Safety Authority.

If you or a loved one has suffered unanticipated hard in a hospital, not related to one's physical condition or deterioration, make sure that you ask the hospital for a "serious event" letter. You are entitled to it, and you are entitled to give your feedback to the patient safety liaison, demanding answers to appropriate questions.

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