

FINAL MINUTES

MEETING OF:

PATIENT SAFETY AUTHORITY

ONE HAAC DRIVE
WILDWOOD CONFERENCE CENTER BUILDING
HARRISBURG, PENNSYLVANIA

TIME: 11:40 A.M.

DATE: DECEMBER 12, 2006

PATIENT SAFETY AUTHORITY
Public Meeting
December 12, 2006

Agenda

- I. Call to Order
- II. Approval of November 14, 2006 Meeting Minutes
- III. Report of the Board Chair
- IV. Report of the Board Administrator
- V. Committee Reports
- VII. PA-PSRS Update
 - Data "Dashboard"
 - Presentation on medication errors and adverse drug reactions (ADRs): Matt Grissinger, R.Ph., PA-PSRS Analyst at ISMP
 - Observations on the International Symposium on Confidential Reporting Systems recently held in London: John Clarke, MD, PA-PSRS Clinical Director
- VIII. Old Business
- IX. New Business
 - Election of Officers
- X. Public Comments
- XI. Adjournment

1 PATIENT SAFETY AUTHORITY

2 DECEMBER 12, 2006

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4 The regularly scheduled meeting of the Patient
5 Safety Authority was held on Tuesday, December 12,
6 2006. Ana Pujols-McKee, Chairperson, called the
7 meeting to order at 11:40 a.m.

8 ***

9 Report from Chair

10 [Everyone was wished a wonderful holiday and reminded
11 they will meet again in January. The November 14,
12 2006 minutes were approved.

13 It was stated that Barbara Holland, Gary Merica
14 and Ana Pujols-McKee attended a half day session held
15 by the Hospital and Healthcare Association of
16 Pennsylvania (HAP) and the Office of Healthcare
17 Reform. The topic was the culture of safety.]

18 [Mr. Merica gave a brief summary of the meeting. The
19 meeting was run by David Marx who over the past decade
20 created a systematic approach to the investigation of
21 medical errors and adverse events and how we treat
22 individuals who are involved in medical errors. The
23 systematic approach that Pennsylvania has chosen to

1 adopt lists medical errors in three separate
2 categories including: simple human error, at-risk
3 behavior, or reckless behavior. Each type of error has
4 a different response and the individual will be
5 treated according to the error committed. Minnesota
6 was one of the first states to adopt this program.
7 Beginning in January 2007, HAP, the Office of
8 Healthcare Reform and other stakeholders who were
9 present will meet on a monthly basis and develop an
10 implementation plan for the state of Pennsylvania by
11 the end of March. Pennsylvania would then have
12 regional training sessions for staff and members of
13 our regulating and governmental agencies as well as
14 providers. Mr. Merica also stated that he took a team
15 from his own health system to Dallas for training at
16 David Marx's headquarters. Mr. Merica spoke briefly
17 at the end of the session. It was mentioned that
18 David Marx is really looking at the approach we're
19 taking as the model for going forward and he thinks
20 we're really getting off on a good foot.]
21 [Dr. McKee announced that she has been appointed to
22 serve on the council for PHC⁴. She sees this as an
23 opportunity for organizations to be able to

1 communicate better and connect more. She also
2 announced that this is Alan Rabinowitz's last meeting
3 and wished Mr. Rabinowitz well on behalf of the board
4 and thanked him again for his service.

5 Report of the Board Administrator

6 [Mr. Rabinowitz stated that Act 30 of 2006 was being
7 implemented and is a mandate that makes certain
8 abortion facilities subject to Act 13 reporting
9 requirements. Under Act 30, providers that perform
10 100 or more abortions in a calendar year are now
11 subject to mandatory reporting. The Department of
12 Health has provided the PSA with a list of 32
13 registered entities. The PSA has attempted to contact
14 all of these entities. A user training session was
15 held recently for a number of the abortion facility
16 providers that chose to attend. Once the Department of
17 Health determines which facilities will be eligible to
18 report, they will be assessed monies depending on the
19 number of procedure rooms, but will not have to pay
20 the assessment before 2008. The abortion facilities
21 will fall under the same assessment protocols as
22 ambulatory surgical facilities and birthing centers.

23 Mr. Rabinowitz also provided an update on the

1 annual facility assessment for 2007-2008. He asked
2 Dick Lee, Deputy Secretary for Quality Assurance in
3 the Department of Health, to keep him apprised of when
4 the Department of Health will make that assessment.

5 Mr. Rabinowitz made the board aware of an email
6 that went out to all hospital PSOs inviting them to
7 participate in a hospital pharmacy assessment survey
8 to determine how accurately their electronic pharmacy
9 systems work. Mr. Rabinowitz stated that Pinnacle
10 Health System and the UPMC Health System are scheduled
11 to begin using the interface. The Jefferson Hospital
12 System is likely to be the next system up and running.
13 Due to the implementation of these large systems, he
14 expects the number of facilities that are able to
15 report Incidents directly through the interface to
16 increase significantly.

17 Mr. Rabinowitz added that a recent mailing of the
18 PSA "Who We Are" brochure recently went out to all
19 CEOs encouraging them to share the brochure with their
20 board of trustees. The brochure is meant to serve as a
21 vehicle for board discussion of patient safety issues.
22 Mr. Rabinowitz ended his report by thanking the Board
23 for the opportunity to serve.]

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[Mr. Rabinowitz was then presented with a plaque from the PSA Board which he read for everyone. "Your hard work and enthusiasm as the first administrator of the Patient Safety Authority have been critical to our success. We are proud of your service and leadership. In grateful appreciation from the Board of the Patient Safety Authority December 2006."]

Dr. McKee noted that Mike Doering will be serving as the interim director and his first meeting will be in January. She then stated that an inventory was done of the current Board committees and that several of them were put on hold until the strategic plan is in full gear. The Education and Communications Committees are two that are on hold. Other board committees and their chairs are as follows: the Strategic Planning Committee will be chaired by Stan Smullens; a Search Committee will be chaired by Cliff Rieders; the ECRI Review Committee will be chaired by Gary Merica and, the Data Review and Update Committee will be chaired

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1 by Joan Garzarelli.]Mr. Merica mentioned that the ECRI
2 Review Committee had one meeting and is in the process
3 of trying to schedule another teleconference call.

4

5 [Mr. Marella, PA-PSRS ECRI Project Manager, gave an
6 update on the data dashboard. One purpose of the
7 dashboard was to try and focus on patient safety
8 issues that might be useful as measures of success.
9 The "measurable" items are ones that are highly
10 observable and therefore easier to track. Mr. Marella
11 added that along with these measurable items, PA-PSRS
12 would like to focus projects aimed at implementing
13 changes in facilities and thereby reducing the number
14 of events. Today the discussion was focused on
15 medication errors. Discussion continued as to how they
16 are being reported, what type of harm score should be
17 given to such events, etc. During the discussion, Dr.
18 McKee questioned the number of medication errors with
19 high harm, noting that there is only one out of over
20 3,500 reports. She wondered if that number was
21 accurate. Mr. Marella said Mr. Grissinger would
22 elaborate on that subject but noted that although
23 medication errors are one of the most frequently

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1 reported events, they are not necessarily the ones
2 that frequently lead to harm. Discussion continued
3 about the categorization of reports and the reasons
4 why various facilities may have different reporting
5 rates. Board members and PSA legal counsel continued
6 to discuss ways that facilities might be able to track
7 events better and in more detail, specifically
8 medication errors and to perhaps pinpoint exactly
9 where the error is taking place (e.g. in the
10 administrative phase or pharmacy dispensing phase).
11 Mr. Marella said tracking reports in that detail is
12 possible and something PA-PSRS staff can look into
13 doing for the top four or five medication errors.

14 Discussion then turned to infections and
15 questions arose from board members and legal counsel
16 as to why infections are not reported more frequently
17 and are not considered a Serious Event by some
18 reporting facilities. Board member Joan Garzarelli
19 stated that many facilities believe their infections
20 are being reported through PHC4. They see PA-PSRS as a
21 duplicate for infections. Mr. Marella acknowledged
22 that the PA-PSRS system is getting a fraction of all
23 of the infections that occur, but in other categories

1 (e.g. falls) he believes PA-PSRS is receiving 80
2 percent or better. Mr. Marella added that facilities
3 also report events differently. He noted that looking
4 at just numbers is misleading. It is better to find
5 the lessons learned through those who prevented an
6 event from occurring and use that information to teach
7 other facilities.

8 Discussion continued as to the harm score and how
9 facilities are interpreting the word "unanticipated."
10 Discussion ended with board members agreeing that the
11 dashboard information is a work in progress that will
12 develop as time goes on. Dr. McKee acknowledged the
13 dashboard will be developed as a tool for the board to
14 use with board member Joan Garzarelli in charge of the
15 Data Committee to work out the details.

16 [Matt Grissinger, a PA-PSRS medication event analyst
17 from ISMP gave a presentation regarding medication
18 errors reported to the PA-PSRS program. He stated that
19 reports were reviewed by the analysts with regard to
20 patterns based on volume and patterns based on
21 individual cases or groups of similar cases. He added
22 that Pennsylvania receives the same types of
23 medication errors as those reported throughout the

1 United States. Mr. Grissinger stated that Pennsylvania
2 receives over 3,600 medication errors per month, and
3 approximately 307 adverse drug reactions per month. He
4 added that medication errors occur as wrong doses,
5 over doses, under doses, wrong drugs, wrong dosage
6 forms and wrong rates. Mr. Grissinger discussed the
7 patterns of the reports based on volume. He stated
8 that in the first Patient Safety Advisory, PA-PSRS
9 found that one in four medication errors involved high
10 alert medications. He added that of that 25 percent,
11 44 percent involved pain medications, 16 percent
12 involved insulin products, 14 percent Heparin and 9
13 percent morphine. Mr. Grissinger said he has reviewed
14 the medication report data recently for high alert
15 medications. He found that three classes of the high
16 alert medications that include anticoagulants,
17 insulins and opiates and narcotics accounted for 20
18 percent of all medication reports. Mr. Grissinger
19 believes this is significant, not so much for the harm
20 reported, but for the potential of harm because
21 another step in the process could have led to a major
22 problem.

23 Mr. Grissinger added that another category PA-

1 PSRS captures is look-alike names, one of the most
2 common errors seen by clinical staff. One of the most
3 common errors in look alike names involved confusion
4 between morphine and hydromorphone. Also, there was
5 confusion between Alprazolam and Lorazepam and Novolog
6 and Novolin. Mr. Grissinger stated that another
7 medication issue is the use of suffixes because many
8 times the suffix gets forgotten which can potentially
9 cause an error. The most common drug names with suffix
10 issues were identified.

11 Mr. Grissinger stated that it is important to
12 look at events that occur even one or twice a year
13 because of the potential harm they can cause to
14 others. He gave examples of such rare occurrences and
15 the benefit of reporting such occurrences, including a
16 Supplementary Advisory published by the Authority
17 concerning confusion with TB and insulin syringes. Mr.
18 Grissinger said since that Supplementary Advisory was
19 published in October 2004, numerous facilities have
20 said they were able to prevent similar errors from
21 occurring at their facilities.

22 Mr. Grissinger then discussed medications and the
23 elderly. His discussion included the Beers Criteria -

1 a special criteria developed by Dr. Mark Beers - that
2 contains a list of medications that should not be used
3 on the elderly (people over 65). He stated the
4 protocols used in long-term care facilities should
5 also be followed in acute care facilities and he is
6 discouraged that they are not followed as well in
7 those facilities. Mr. Grissinger continued his
8 discussion by emphasizing that what happens
9 nationally, could also happen in Pennsylvania so it is
10 important to pay attention to the national medication
11 issues as well. He gave some examples of medication
12 errors that have occurred in other states, which
13 Pennsylvania can learn from. He added that when a
14 topic is chosen for an Advisory article it isn't
15 always chosen because there were a lot of reports on
16 that particular topic, but many times a topic is
17 chosen because of the harm that such an event could
18 cause to a patient if it occurs. He then gave examples
19 to the PSA board about what the PA-PSRS staff is doing
20 with the information they are collecting. Some
21 examples include: a recently released pharmacy survey
22 regarding CPOE usage and more in-depth analysis on
23 anticoagulants.

1 Mr. Grissinger then fielded questions from the
2 PSA board concerning the participants of the survey
3 and the number of CPOE organizations in Pennsylvania
4 and the impact of CPOEs. Discussion continued with
5 board members making suggestions that the PSA track
6 more of what facilities are doing with the Advisories
7 and ensuring that facilities are using them. Some
8 members of the board also expressed an interest in the
9 PSA making recommendations through the PA Department
10 of Health for facilities to follow. The board members
11 discussion continued with more discussion on the
12 anticoagulant project and when the board could expect
13 results from it (early next year).

14 Mr. Grissinger concluded his discussion by
15 stating that unfortunately errors that were occurring
16 30 years ago are still occurring today and
17 Pennsylvania's numbers are not different from numbers
18 they are seeing nationally.

19

20 [Dr. Clarke spoke briefly on the symposium he attended
21 sponsored by the National Patient Safety Agency in
22 London, England, on confidential reporting systems.
23 The symposium covered reporting systems of many

1 organizations, not just those in medicine. Dr. Clarke
2 gave some of the major components of the National
3 Patient Safety Agency which he called the UK's
4 Pennsylvania Patient Safety Reporting System (PA-PSRS)
5 counterpart. Some facts about the National Patient
6 Safety Agency include: began in 2000 or 2001, but
7 began collecting after PSA; they have over one million
8 reports; they receive about 60,000 reports a month; it
9 serves a nation of over 55 million people including
10 all doctors offices; and 42 analysts work for the
11 Agency. He added that the Agency experiences many of
12 the same problems as PA-PSRS including reports are
13 often too short on narratives and compliance when
14 reporting harm scores given for certain events. The
15 only difference Dr. Clarke mentions between the Agency
16 and PA-PSRS is that the Agency analysts do not read
17 all of the reports received and PA-PSRS staff do
18 review all reports received. The barriers in getting
19 US organizations to change their way of thinking in
20 medicine and patient safety are also barriers in the
21 UK. Dr. Clarke suggested to the board that by doing
22 more projects with facilities to implement change, the
23 PSA could get past the barriers by redesigning the

1 system instead of just telling provides to "be more
2 careful." The Board discussed project possibilities
3 with an emphasis on making sure the confidentiality of
4 the facilities is not put at risk. Dr. Clarke ended
5 his presentation after fielding more questions
6 regarding the Agency.

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8 Dr. Pujols-McKee noted that the election of officers
9 will be held at the next meeting. There being no old
10 business, no new business, no public comments, the
11 meeting was adjourned.

12

13 [End of Hearing]

14 cmf