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**FINAL MINUTES**

**MEETING OF:  
PATIENT SAFETY AUTHORITY**

ONE HACC DRIVE  
WILDWOOD CONFERENCE CENTER  
HARRISBURG, PA

TIME: 10:42 a.m.

DATE: August 8, 2006

**Agenda**

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5 I. Call to Order  
6  
7 II. Approval of June 13, 2006 Meeting Minutes  
8  
9 III. Report of the Board Chair  
10 -Introduction of Barbara Holland, Esq., as  
11 Authority counsel  
12  
13 IV. Report of the Board Administrator  
14  
15 V. PA-PSRS Update  
16 -Report from Dr. Clarke on Suggested  
17 Objective Measures for Patient Safety  
18  
19 VII. Committee Reports  
20  
21 VIII. Old Business  
22  
23 IX. New Business  
24 -Presentation of a regional collaborative  
25 initiative to clarify the use of  
26 color-coded wristbands: Bonnie Haluska,  
27 Associate Vice President of Allied  
28 Health Services, and representatives of  
29 other healthcare facilities in Northeast  
30 Pennsylvania that formed the "Color of  
31 Safety Committee"  
32  
33 X. Public Comments  
34  
35 XI. Adjournment

1 Patient Safety Authority

2 August 8, 2006

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4 **Board Members:**

5 Anita Fuhrman, RN, BS  
6 Joan M. Garzarelli, RN, MSN  
7 William F. Goodrich, Esquire  
8 Roosevelt Hairston, Esquire  
9 Lorina L. Marshall-Blake  
10 Ana Pujols-McKee, M.D., Chair  
11 Gary A. Merica, R.Ph.  
12 Cliff Rieders, Esquire (phone)  
13 Stanton Smullens, M.D.  
14 Marshall W. Webster, M.D. (phone)

15

16 **PSA Personnel:**

17 Alan B.K. Rabinowitz, Board Administrator  
18 Sharon L. Hutton, Administrative Assistant

19

20 Also Present:

21

22 John Clarke, M.D., PA-PSRS Clinical Director, ECRI  
23 Bonnie Haluska, Chairperson, "The Color of Safety  
24 Committee"  
25 Members of "The Color of Safety Committee"

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## PATIENT SAFETY AUTHORITY

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The regularly scheduled meeting of the Patient Safety Authority was held on Tuesday, August 8, 2006. Ana Pujols-McKee, M.D., Chairperson, called the meeting to order at 10:42 a.m.

Approval of Minutes of previous meeting.

DR. MCKEE:

Good morning. We will start by approval and review of the minutes which is in tab two.

DR. SMULLENS:

So moved.

MS. MARSHALL-BLAKE:

Second.

DR. MCKEE:

The minutes are approved.

[The motion carried unanimously.]

Old Business

DR. MCKEE:

The second item on the agenda is a discussion on the Authority counsel. And we have -- we are ready to proceed with an interim counsel, Barbara Holland. She is

1 not able to join us today. And, we have a  
2 resolution of the Board that needs to be  
3 addressed in order to proceed with this.  
4 Barbara Holland is agreeable to begin as  
5 counsel on a temporary basis beginning  
6 September 1, 2006 and that would mean that  
7 we would come up with a new draft Memorandum  
8 of Understanding that would retain her on a  
9 30-day renewal basis, and that memorandum  
10 will be available to us for review on or  
11 around the 1<sup>st</sup> of September. What the Board  
12 needs to address in terms of a resolution is  
13 whether or not we had agreed and made a  
14 resolution that we would put out a RFP for  
15 counsel. And, this would -- our choices  
16 are, basically, that we would postpone the  
17 release or the issuance of an RFP until a  
18 three-month or a two-month trial with  
19 Barbara Holland. At that time we would have  
20 a choice of either an RFP or retaining her  
21 on a permanent basis. And, so, we would  
22 have to go back and readdress the resolution  
23 that basically the Board had made that they  
24 would issue an RFP from this point on. And,  
25 so, does anyone want to make a motion or any

1 discussion on that?

2 MR. RIEDERS:

3 This is Cliff Rieders. Thank you for  
4 accommodating me by telephone. I would make  
5 that motion that we defer the issue of an  
6 RFP for 90 days in order to give an  
7 opportunity for Barbara Holland to serve as  
8 our counsel.

9 DR. MCKEE:

10 Any discussion? All in favor? Voice vote,  
11 okay.

12

13 Anita Fuhrman, RN, BS, aye; Joan M.  
14 Garzarelli, RN, MSN, aye; William F.  
15 Goodrich, Esquire, aye; Lorina L. Marshall-  
16 Blake, aye; Gary A. Merica, R.Ph., aye;  
17 Cliff Rieders, Esquire, aye; Stanton  
18 Smullens, M.D., aye; Marshall W. Webster,  
19 M.S., aye.

20 [The motion carried unanimously.]

21 \*\*\*

22 Report of Board Administrator

23 [Mr. Rabinowitz reported that the financial statements  
24 were received from the comptroller's office and that  
25 all but two of the facilities had submitted their

1 assessments. He discussed several articles from the  
2 June Patient Safety Advisory. He stated the verbal  
3 orders article included a series of documents that has  
4 been labeled as a toolkit. Included in the toolkit is  
5 an audio PowerPoint. A PowerPoint presentation was  
6 given to demonstrate what is available on the website  
7 for downloading for educational purposes that  
8 facilities can use for training. Mr. Rabinowitz  
9 reported that no article, except the color-coded  
10 wristband, has generated as much response from people  
11 around the country as this verbal order toolkit, and  
12 that it has really helped spread the word about the  
13 data collection and analysis function. Mr. Rabinowitz  
14 reported on evaluations from the root cause analysis  
15 course. He stated that 100 percent of the respondents  
16 rated their instructors as excellent or good in four  
17 or five categories, and 98 percent excellent or good  
18 in the fifth category, 100 percent of the root cause  
19 analysis course attendees said the training prepared  
20 them to participate in an RCA investigation, 90  
21 percent said that training prepared them to lead a  
22 root cause analysis team, and 82 percent felt that the  
23 two-day course had prepared them to train others on  
24 root cause analysis. He stated that the possibility  
25 of doing some focus groups of patient safety officers

1 at various facilities is being considered to solicit  
2 some more direct feedback about their use of PA-PSRS  
3 and what they might expect of the Authority that might  
4 better help define some planning for the immediate  
5 future, and some kind of options that the Board may  
6 want to move forward on. Mr. Rabinowitz reported a  
7 meeting was held with the Department of Health. The  
8 only real item on that agenda was implementation of  
9 House Bill 1591, Act 30 of 2006, which added certain  
10 abortion facilities to Act 13 reporting requirements,  
11 and the logistics of adding those facilities was  
12 discussed at the meeting. They would not be subject  
13 to mandatory reporting until after January 1, 2007.  
14 Regarding the PA-PSRS report, Mr. Rabinowitz stated as  
15 of the prior week 355,000 reports had been received of  
16 Serious Events and Incidents and that is in about a  
17 25-month period. He reported an analytical tool has  
18 been added to the PA-PSRS program which will aggregate  
19 all reports that a facility has submitted according to  
20 specific JCAHO's National Patient Safety Goal  
21 objectives so a facility can produce a management  
22 report just to track the reporting of adverse events  
23 or near misses that are related to the individual  
24 JCAHO's National Patient Safety Goals. Lastly, Mr.  
25 Rabinowitz stated that regarding an Anonymous Report

1 that the Board had requested that the facility send an  
2 evaluation of their root cause analysis or  
3 developments related to the issues affected by that  
4 Anonymous Report and the Serious Event that ensued.  
5 He stated they do seem to have complied with internal  
6 improvements and enhancements to prevent a  
7 reoccurrence of a similar event.]

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9 PA-PSRS Update

10 [John Clarke, M.D. discussed issues regarding  
11 objective measures for patient safety. Two articles  
12 related to measuring quality and success were  
13 discussed. One of the articles dealt with qualitative  
14 and quantitative measures including rates of harm,  
15 noncompliance with practice, lessons learned and  
16 culture of safety surveys. He stated another  
17 interesting article was dealing with looking at  
18 compliance with best practice. Dr. Clarke discussed  
19 eradicating errors or more specifically harm from  
20 errors. He stated a short list of things to look at  
21 in most all the cases that were being reported and  
22 where the rate really didn't matter because you'd want  
23 to get it to zero included three things, retained  
24 foreign bodies, wrong site surgery, and colonoscopy  
25 perforations. Dr. Clarke stated that in all of these

1 cases there are no clear solutions. Even wrong side  
2 surgery with the universal precautions has not put a  
3 significant dent in the problem of wrong-side surgery.  
4 He stated the best way to start would be to do some  
5 focused, prospective data collection beyond what is  
6 currently done with volunteer institutions whereby you  
7 call up and try to get more detail and that is  
8 currently being done. Dr. Clarke stated colonoscopy  
9 has just started being looked at because the potential  
10 for a high perforation rate has been identified a  
11 while back and the numbers are just now coming in on  
12 that. Dr. Clarke suggested that a study could be  
13 prepared, and he thought it would take a body of  
14 experience to understand the situation which would  
15 probably be on the order of a year for the colonoscopy  
16 and maybe on the order of a year to a year and a half  
17 for some of the others but it is a worthwhile  
18 objective and with enough resources could be  
19 accomplished. He felt that a focused, strategic  
20 program to significantly reduce those events could be  
21 created. Dr. Clarke stated he would form an advisory  
22 board on this issue and would report back on its  
23 progress at a future meeting.]

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1 New Business

2 [Bonnie Haluska, Chairperson of "The Color of Safety"

3 Committee, and members of "The Colors of Safety

4 Committee" gave a presentation on the use of color-

5 coded bands. Ms. Haluska stated that when the

6 patient Advisory was received talking about the color

7 banding at first glance it seemed that no one really

8 has a problem with this color band. Everyone uses

9 their own colors and there really shouldn't be a

10 problem. But, looking at the hospitals within the

11 area in Northeastern Pennsylvania where patients are

12 transferred within their own hospitals for different

13 services, it was felt necessary, perhaps, to come to

14 terms on using specific colors so that there would not

15 be any issues with any patient safety irregularities

16 and to keep the patient safety issue at the forefront.

17 The members of the task force discussed the process

18 they implemented and how successful it has been

19 regarding the color-coded bands and the collaboration

20 among the different facilities. Ms. Haluska stated

21 the idea was to prepare a toolkit and offer this to

22 any hospital that's looking to standardize or join in

23 this effort. She stated that people that do not use

24 color bands are not being told to use them, but people

25 that use color bands were being asked to try and look

1 at what was being doing here and maybe adopt it. The  
2 system that was implemented, the different colors of  
3 bands and what they designated, as well as other  
4 details of the program were discussed. Ms. Haluska  
5 indicated the system has been very successful and well  
6 received by those who were introduced to it.]

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8 MS. MARSHALL-BLAKE:

9 Madam Chair, I was going to ask if it would  
10 be in order that the Board would do a  
11 resolution commending them for what they've  
12 done in line with the comments that Mr.  
13 Goodrich made because it's exciting to  
14 actually see something actually happening.  
15 It's simple enough, I think that everyone  
16 can grasp so you're to be commended that no  
17 matter where you sit that you understand it,  
18 so I would recommend that the Board do a  
19 resolution commending them for the work that  
20 they've done.

21 MR. GOODRICH:

22 Second.

23 DR. MCKEE:

24 All those in favor. Very good. So  
25 resolved. And, we thank you for the first

1 person who took the courage to make the  
2 first phone call, and the second person who  
3 responded, and then everybody else in  
4 between. Thank you, guys. Thank you.

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6 [The meeting adjourned on August 8, 2006.]

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Jason Blymire  
Minute Clerk,  
York Stenographic Services

PATIENT SAFETY AUTHORITY  
BOARD OF DIRECTORS  
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AUGUST 8, 2006

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TIME	AGENDA
10:42	Call to Order, Ana Pujols-McKee, M.D., Chair
10:43	Approval of Minutes of the previous meeting
10:44	Motion on status of MOU
10:46	Report of Board Administrator Alan Rabinowitz
11:09	PA-PSRS Update
11:54	Presentation, Bonnie Haluska, Associate Vice President for Inpatient Services, Allied Health, Members of "Colors of Safety Committee"
12:37	Adjournment