

How Do I Know What to Report?

When in doubt, report any event you feel compromises patient safety to your supervisor and/or Patient Safety Officer.

Definitions of a Serious Event, Incident and Infrastructure Failure are as follows:

Serious Event

(Causes harm to patient)

An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.

Incident or Near Miss

(Does not cause harm to the patient)

An event, occurrence situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require delivery of additional health care services to the patient.

Infrastructure Failure

An undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

What if my supervisor or the Patient Safety Officer does not think a Serious Event has occurred, but I do?

Please try to resolve the issue with your supervisor and/or Patient Safety Officer; however you can file an Anonymous Report with the Authority if you feel a Serious Event has occurred and it has not been addressed appropriately. Go to www.patientsafetyauthority.org and click on "Patients and Consumers," then brochures. The Anonymous Report brochure is for healthcare workers only.

Why Should Healthcare Workers Report Events?

Healthcare workers should report events so that everyone can learn from them and ensure the correct steps are taken to prevent the same event from occurring again. Often a Serious Event or Incident (near miss) occurs because of a breakdown in the healthcare system. By reporting a Serious Event you can take the first step in preventing another patient from being harmed in the same way. By reporting an Incident or near miss, you can provide valuable information so processes can be examined to correct any problem and prevent a patient from being harmed.

To see how reports are being turned into learning opportunities through Patient Safety Advisory articles, go to:
www.patientsafetyauthority.org.
Pennsylvania Patient Safety Authority
333 Market Street, Lobby Level
Harrisburg, PA 17120
717-346-0469



P A T I E N T
S A F E T Y
A U T H O R I T Y



The Facts . . .
Analyzing
Educating &
Collaborating
For Patient Safety

What is the Pennsylvania Patient Safety Authority?

The Pennsylvania Patient Safety Authority is a non-regulatory independent state agency created through legislation (Medical Care Availability and Reduction of Error, "MCare Act") to help reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety.

Who Reports to the Authority?

Under the MCare Act, all Pennsylvania-licensed hospitals, ambulatory surgical centers (outpatient surgery centers) and birthing centers report to the Authority. The Act was amended in 2006 to include abortion facilities that perform more than 100 procedures yearly. In 2007, under legislation (Act 52) nursing homes began reporting healthcare-associated infections (HAIs) to the Authority through the Authority's Pennsylvania Patient Safety Reporting System (PA-PSRS).

What Must Be Reported?

All facilities under the MCare Act (hospitals, ambulatory surgical centers, birthing centers and certain abortion facilities) must report all Serious Events (events that cause harm to the patient) and Incidents or near misses (events that do not cause harm to the patient) to the Authority for analysis and educational purposes. Nursing homes must report HAI's through PA-PSRS for the Authority's educational purposes.

Who Submits Reports for My Facility?

Under the MCare Act all healthcare facilities must designate a Patient Safety Officer (PSO) to collect Serious Events, Incidents and Infrastructure Failures. PSOs also serve on the hospital's Patient Safety Committee, ensure the investigation of Serious Events and Incidents and take the necessary action to ensure the event does not occur again.

Who Should Report?

Everyone in the healthcare facility, including non-clinical workers like housekeeping staff, should report any patient safety concerns to their supervisor and/or Patient Safety Officer.

Will My Name Be Mentioned in the Report?

All information contained in the report is de-identified and confidential. By law, the Authority is not allowed to have any names or identifying

information contained in the reports. This information includes patient names as well as any healthcare worker involved in the event.

Is the Authority part of the Pennsylvania Department of Health (DOH)?

No. While the Authority will work with the DOH to educate facilities, the Patient Safety Authority is an independent agency. The Authority's mission is to educate healthcare facilities from the data collected by implementing guidance based upon research. The Pennsylvania Department of Health receives Serious Events for its regulatory purposes. The DOH does not receive Incidents. However, the DOH does receive Infrastructure Failures for its regulatory purposes. The Authority does not receive Infrastructure Failures. (see graphic in center panel)

What Does the Authority Do with the Reports?

The Authority analyzes the data and distributes the Pennsylvania Patient Safety Advisory which is published in March, June, September and December. Sometimes if there is more information on a specific topic or a case that warrants special attention (i.e. Color-coded wristband Incident), the Authority will develop a supplementary Advisory. The award-winning Patient Safety Advisory has gained worldwide recognition and is utilized by healthcare professionals around the country. To receive the Advisory via email contact the Patient Safety Authority at www.patientsafetyauthority.org. The Authority also collaborates with other healthcare organizations using the data as a starting point for improving patient safety. Also, educational courses are offered and presentations are given using the data to focus on specific areas for improvement.

