Patient Safety Authority Testimony to the Legislative Budget and Finance Committee Senate Resolution 2019-20

Prepared and Presented by
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Patient Safety Authority

Patient Safety Authority

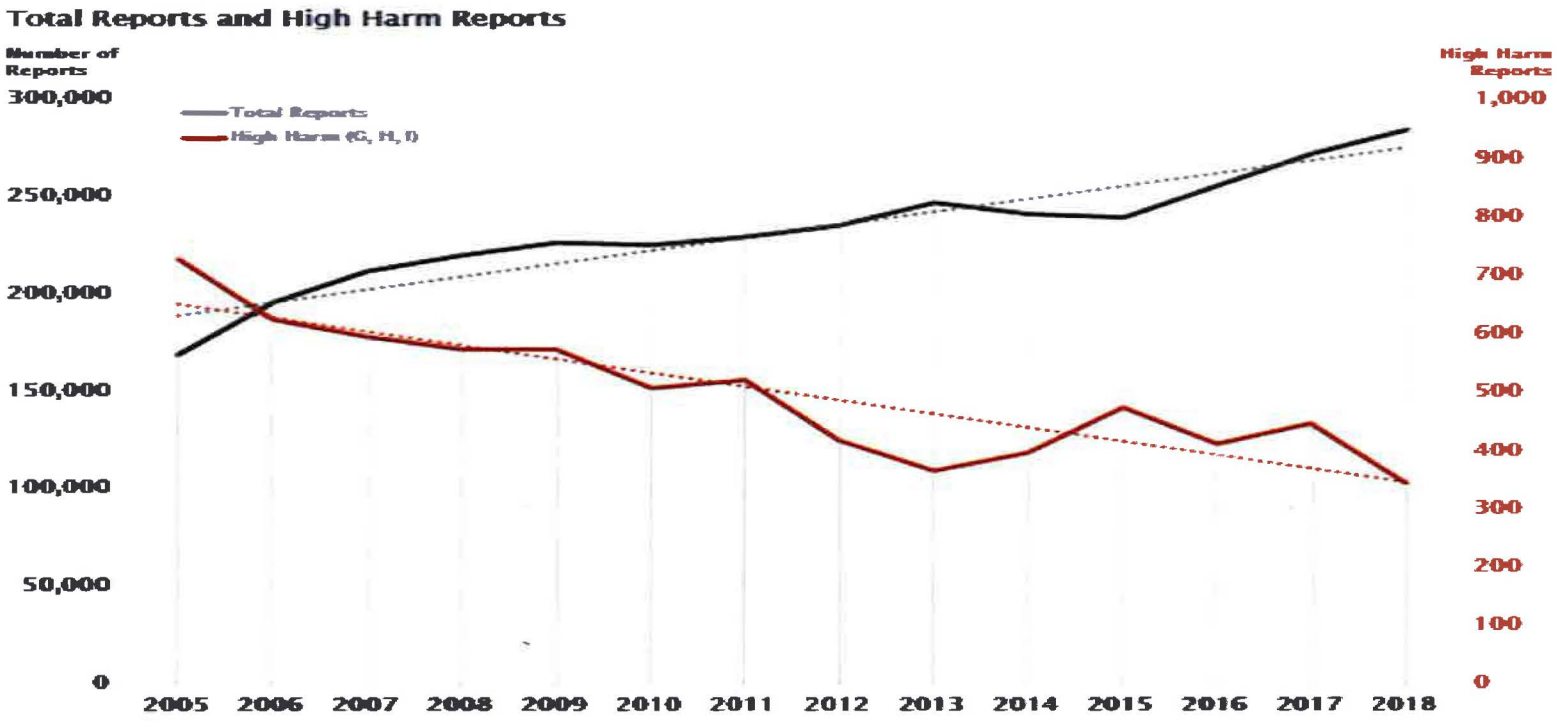
Position

- The Patient Safety Authority neither supports nor opposes a change in venue for medical malpractice cases in Pennsylvania.
- The Patient Safety Authority is interested in providing the committee with facts associated with the data it collects.

Background

- Pursuant to Act 13 of 2002, Pennsylvania acute care facilities are mandated to report patient safety events. Reporting began in June 2004.
- Facilities are required to report both Incidents and Serious Events to the Patient Safety Authority.
- Incidents - an event, occurrence, or 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 the delivery of additional healthcare services to the patient.
- Serious Event - 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 healthcare services to the patient.
- High Harm Event – a subcategory of serious events that result in permanent harm to the patient, immediate threat to life, or death.
- *Note – the term Medical Error does not appear in any of these definitions.*

Reports 2005-2018



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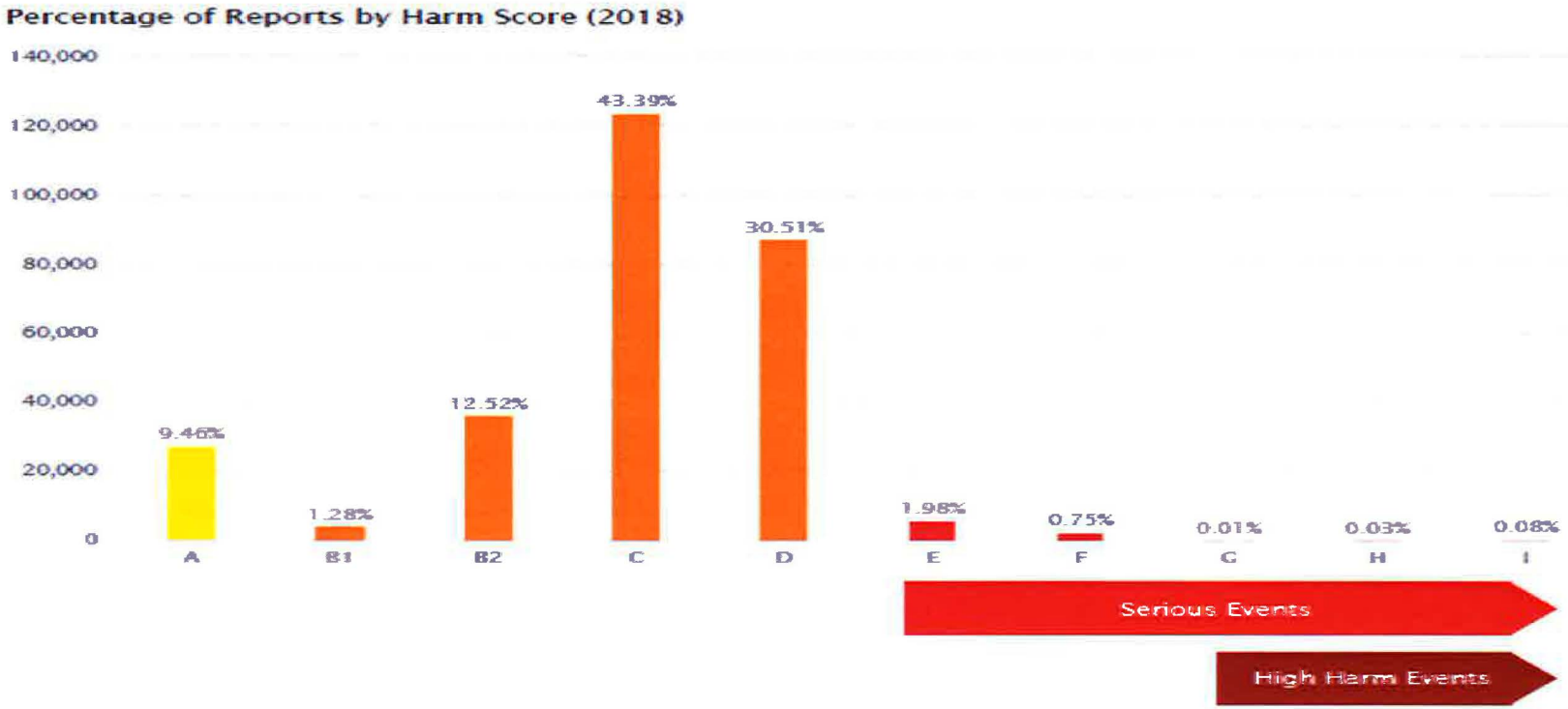
Reports by Harm Score (2018)



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Conclusions

- Fact – The number of total *reports* has increased since 2005.
- Fact – The number of high harm *reports* has decreased since 2005.
- Fact – Pennsylvania has the largest number of patient safety events reported across the country because the legislature had the foresight to include all events, including non-harm events in its mandatory reporting requirements.
- Fact – There are limitations to Patient Safety Authority data. Even with mandatory reporting requirements, not all events are captured or submitted. Therefore, our numbers do not represent 100% of patient safety events.
- Fact – Low numbers of reports does not mean care is safer, in fact, low numbers of reports is generally viewed as a patient safety concern in the industry.
- Fact – While the total number of *reports* has increased, we cannot conclude that the total number of actual *events* has increased. We also cannot conclude with certainty that because the number of high harm reports decreased that the actual number of patient events decreased.
- Our opinion - The Patient Safety Authority views an increase in the total number of events and a decrease in high harm events as a positive signal for the people of Pennsylvania. We expected the total number of reports to increase over time due to education related to the requirements, regulatory pressure and culture change. When organizational culture supports reporting, more opportunities are uncovered to improve care and processes before harm occurs, so one would expect that when reports of non-harm go up and organizations address the underlying issues, that reports of actual harm should go down.

What questions do you have?

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Thank You!

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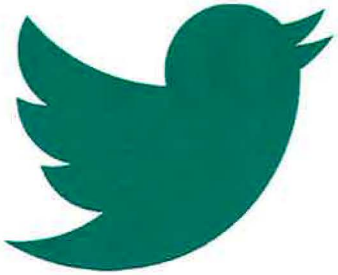

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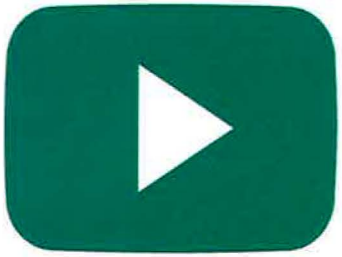

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