Patient Safety: No Harm, No Foul?

Author
Ellen S. Deutsch, MD, MS, FACS, FAAP, CPPS
Editor, Pennsylvania Patient Safety Advisory
Medical Director, Pennsylvania Patient Safety Authority

Introduction

As we work together to improve patient safety, should we focus on provider error or patient harm?

In 2006, the Pennsylvania Patient Safety Authority published a report of six intraoperative cardiac arrests (http://patientsafety.pa.gov/ADVISORIES/Pages/200612_01b.aspx) that occurred during hip arthroplasties using bone cement to implant prostheses; five of those events were fatal. At that time, there were few similar reports in the literature, and what is now known as "bone cement implantation syndrome" was not well understood. Reporting these rare events through Pennsylvania's statewide reporting system allowed recognition of a pattern that might not have been evident at individual facilities. Considering the knowledge generally available at that time, providers may not have thought that there were any errors in these patient-care events, but they reported the events in compliance with Pennsylvania's reporting criteria of unanticipated patient harm and thereby contributed to enhancing future patient safety.

Pennsylvania's Proactive Perspective

Pennsylvania's leadership has been ahead of the curve in establishing a reporting system based on unanticipated patient harm, as well as in recognizing the value of aggregating and reporting healthcare safety data. Healthcare providers are required to submit Incident and Serious Event reports to the Authority through the Pennsylvania Patient Safety Reporting System (PA-PSRS), which allows healthcare safety data to be accumulated at a statewide level. The Authority analyzes PA-PSRS reports and publishes aggregate data and related information in the Pennsylvania Patient Safety Advisory. The Authority, established by the Medical Care Availability and Reduction of Error (MCARE) Act of 2002, fulfills its mission to improve the quality of healthcare in Pennsylvania by collecting and analyzing patient safety information, developing solutions to patient safety issues, and sharing this information through education and collaboration.

It is tempting to place the greatest value on analyzing reports that describe events in which patients were harmed, because these events are often heartbreaking for both patients (and families) and care providers. It is also tempting to look for any errors that may have contributed to the harm. Errors may involve slips, lapses, or mistakes, or they may involve not following policies, protocols, or generally accepted standards. Errors may be attributed to actions or
decisions by direct care providers (at the "sharp end" of patient care), or they may be attributed to actions or
decisions that occurred in other parts of the complex adaptive systems that are enmeshed in healthcare delivery,
such as purchasing, training, staffing, or strategic planning decisions.

In our quest to provide the safest healthcare for Pennsylvanians, learning about events involving errors is important,
but insufficient. The consequences of some errors may be unimportant. The consequences of other errors may be
effectively mitigated to prevent harm, depending on complex interactions between recognition and reversibility of the
error and the resilience of the patient, the providers, and the systems they work within. Conversely, we know that
patients may be harmed even if no error occurred, as in the bone cement implantation syndrome events described
earlier in this article. And we should not wait for harm to occur if we can identify unsafe conditions before they
contribute to harm.

Pennsylvania's Radical Approach

In Pennsylvania, we are uniquely fortunate to benefit from a visionary perspective. PA-PSRS not only collects
information about healthcare events in which patients were harmed, but also information about healthcare events in
which harm could have occurred, but the event did not reach the patient (e.g., a "near miss"). Further, PA-PSRS
collects reports about unsafe conditions, which might not yet affect a specific patient, but which are latent safety
threats. Understanding these concepts helps care providers recognize, mitigate, and learn from hazardous
conditions, even before patients are harmed. The construct of PA-PSRS may seem radical, but it has many benefits.
Reporting without preconditions of harm or error should remove much of the defensiveness and even shame that
may accompany and inhibit event reporting.

Although PA-PSRS is one of the earliest and broadest statewide acute-care patient safety event reporting systems in
the country, many providers in Pennsylvania, including those in leadership positions, do not understand the
following: how the Authority uses information from Serious Event and Incident reports for educational purposes; that
(beyond the facility's internal reporting system) Incident reports are only seen by the Authority; and that the Authority
and the Department of Health have different roles and responsibilities with respect to PA-PSRS data.

Online education about the value, importance, and obligation of reporting patient safety events in acute healthcare
facilities in Pennsylvania is available at http://ecrilearning.ecri.org/PAPSRS_Acute
(http://ecrilearning.ecri.org/PAPSRS_Acute); select "2016_06 Pennsylvania Patient Safety Reporting."

Summary

Collecting data based on patient outcomes has value. Limiting data collection and analysis to those events that
involve provider error will reinforce negative constructs of patient safety, even if that is not the intention. Collecting
data based on patient harm will bring us closer to the goal of safe patient care. Enlarging that perspective to include
events in which hazards were recognized, harm was avoided, and patient care was improved will help us achieve the
safest patient care. Submitting rich, informative details in PA-PSRS reports will help the Authority better illuminate
hazards that are particularly serious, common, or otherwise of educational value to facilities and to share solutions
from facilities and the literature. The unusual breadth of PA-PSRS data collection offers important and unique
opportunities to inform our collaborative efforts to make healthcare safer.

Notes
1. Bone cement implantation syndrome. Pa Patient Saf Advis. 2006 Dec;3(4):1, 4-9. Also available:
http://patientsafety.pa.gov/ADVISORIES/Pages/200612_01b.aspx


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