> Each one of us can make a difference.
>
> Together, we make change.
>
> Barbara Mikulski

WE MAKE CHANGE TOGETHER

Included in this packet:

- Frequently Asked Questions (FAQs)
- Overview of Pennsylvania Act 13 of 2002, also referred to as the Medical Care Availability and Reduction of Error ("MCARE") Act
- Act 13 link
- Act 52 link
- Common abbreviations and definitions
- PSA "Who We Are" flyer
- Facility Patient Safety Plan
- List of facility PSC members
- Confidentiality agreement

Frequently Asked Questions

Why am I being asked?

Since the passage of MCARE over 20 years ago, PSC community members have demonstrated the importance and value of engaging non-healthcare workers to provide input and insight into the patient's perspective of the provision of care and ways to improve the quality of the care and services being provided.

What type of time commitment is involved with being a PSC community member?

Meeting times vary and from one facility to another. Typically, patient safety committee meetings last between one to two hours. Hospital-based patient safety committees are required to meet monthly while ambulatory surgical facilities and birthing centers are required to meet quarterly.

What do these committees do?

Their main focus is to review patient safety events (like falls or infections) to figure out the cause and how they can be prevented from happening again.

Do I need to have a background or experience in healthcare in order to serve?

No. A background or experience in healthcare is not required. In fact, oftentimes community members ask important questions or share perspectives no one else has thought of.

Are there any legal responsibilities associated with being appointed a Patient Safety Committee community member?

No. The MCARE law states that no person who participates in Patient Safety Committee meetings can be asked to testify about the work of the committee.

What are the expectations of community members?

Don't be afraid to speak up or share your opinion. If there's something you don't understand, ask! Because you are an important member of the team, try to attend as many meetings as you can. And remember, this committee provides a safe space to discuss serious, and sometimes upsetting, things openly and honestly. So never share anything the committee discusses outside of the meetings.

What is the Patient Safety Authority?

The Patient Safety Authority (PSA) is an independent state agency that was created in 2002 under Act 13 to reduce patient harm. PSA works closely with Pennsylvania healthcare facilities to identify problems and recommend solutions.

My Patient Safety Committee

Organization: _____

Patient Safety Officer (PSO): _____

_____

PSO Phone Number: _____

PSO Email: _____

Meeting Day (e.g., 3rd Tuesday of each month):

_____

Meeting Time: _____

Location: _____

_____

Parking Location: _____

_____

Commonly Used Abbreviations & Definitions

PSC members try to limit heavy use of medical language or abbreviations that everyone may not know. But sometimes they can forget, so please speak up if anything is unclear. They will be happy to explain.

Abbreviations

Agencies/ Organizations

Clinical Areas/ Departments

Medical Conditions

General Terms/ Safety Tools

ADE — Adverse Drug Event

AHRQ — Agency for Healthcare Research and Quality

AMA — Against Medical Advice (can also refer to the American Medical Association)

CCU — Coronary Care Unit

CDSS — Clinical Decision Support System

CHF — Congestive Heart Failure

CMS — Centers for Medicare & Medicaid Services

COPD — Chronic Obstructive Pulmonary Disease (emphysema)

CPOE – Computerized Physician Order Entry

CVA — Cerebral Vascular Accident (stroke)

DOH — Department of Health

FMEA — Failure Mode and Effects Analysis

HAP — The Hospital and Healthsystem Association of Pennsylvania

HAI — Healthcare–Associated Infection

HIPAA — Health Insurance Portability and Accountability Act

HRO — High Reliability Organization

HTN — Hypertension (High Blood Pressure)

ICU — Intensive Care Unit

ICN — Intensive Care Nursery

MI — Myocardial Infarction (Heart Attack)

NICU — Neonatal Intensive Care Unit (can also refer to a neuroscience ICU)

OT — Occupational Therapy

PDSA — Plan–Do–Study–Act

PHI — Protected Health Information

PSA — Patient Safety Authority

PSO — Patient Safety Officer

PA-PSRS — Pennsylvania Patient Safety Reporting System (pronounced "PAY-sirs")

PT — Physical Therapy

RCA — Root Cause Analysis

RRT — Rapid Response Team

TIA — Transient Ischemic Attack (mini stroke)

TJC — The Joint Commission

Definitions

Adverse Drug Event (ADE) — An adverse event involving medication use

Adverse Drug Reaction — An adverse effect produced by the use of a medication in a recommended manner

Alert Fatigue — Occurs when clinicians are exposed to a large number of alarms meant to alert them to potentially unsafe conditions, causing them to become desensitized to them. Desensitation may lead to longer response times or missed alarms.

Benchmark — Standard for providers to achieve derived from outcome data

Checklist — An orderly listing of actions to follow

Clinical Decision Support System (CDSS) — Any system designed to help clinicians make decisions, such as the preselection of a certain antibiotic for a specific type of infection

Close Call — An event or situation that did not produce patient injury, but only because of chance; also referred to as a near miss

Computerized Physician Order Entry (CPOE) — Any system in which physicians place orders electronically (using a computer)

Confirmation Bias — The tendency to search for information to support a prior belief or explanation

Crew Resource Management — The training of groups to function as teams rather than a collection of individuals

Diagnostic Error — Any mistake or failure in the diagnosis process leading to a misdiagnosis, missed diagnosis, or a delayed diagnosis.

Disclosure — Communication of a medical error or adverse event

Error — An act of commission (doing something wrong) or omission (failing to do the correct thing) that leads to an undesirable (negative) outcome or the significant potential for such an outcome

Evidence–based — The idea that practice should be based on proven scientific research

Failure Mode — One possible way a system can fail

"Five Rights" of Medication — Administering the right **medication** in the right **dose** at the right **time** by the right **route** to the right **patient**

Forcing Function — A part of a design that prevents a certain action from being performed

Hand-off — The process of one healthcare professional updating/communicating with another on the status of one or more patients to provide care to that patient or to patients

Healthcare–Associated Infection (HAI) — An infection occurring in a patient during the process of care in a hospital or other healthcare facility

Health Insurance Portability and Accountability Act (HIPPA) — Federal regulation meant to increase the privacy and security of patient information during the transmission or communication of protected health information (PHI)

Health Literacy — A person's ability to locate, process, and understand the basic information necessary to act on medical instructions and make decisions about their health

High Reliability Organizations (HROs) — Groups or systems that operate in hazardous conditions but have fewer than their share of adverse events (accidents)

Hindsight Bias — The tendency to overestimate your ability to have predicted an outcome that could not have possibly been predicted

Human Factors — An area of study that attempts to identify and address safety problems that are due to the interaction between people, technology, and the work environment

Informed Consent — When a physician tells a patient about the risks and benefits of a proposed procedure or test, as well as any reasonable alternatives, to allow them to decide whether they want to proceed

Just Culture — Program that promotes system improvements over individual punishment

Latent Errors — Underlying problems within a system that may contribute to an error

Medication Reconciliation — A process of creating the most accurate list possible of all medications a patient is taking—including drug name, dosage, frequency, and route—and comparing that list against the physician's admission, transfer, and/or discharge orders, to provide correct medications to the patient throughout their hospital stay

Near Miss — An event or situation that did not produce patient injury, but only because of chance; also referred to as a close call

Never Event — An occurrence that should "never" happen if proper safety procedures are followed, like surgery on the wrong body part

Normalization of Deviance — The gradual shift in what is regarded as normal after repeated exposure to behavior that strays from correct or safe operating procedure

Patient Safety — Freedom from accidental or preventable injury during the provision of care

Plan–Do–Study–Act (PDSA) — Cycle of activities for achieving process or system improvement

Rapid Response Team (RRT) — Group of providers summoned to a patient to immediately assess and treat the patient with the goal of preventing an adverse clinical outcome

Readback — Verbally repeating what is verbally communicated by another individual; also referred to as teach-back

Root Cause Analysis (RCA) — A process to identify the main cause(s) of a problem or error

Run Chart — Type of graph that uses a statistical analysis to study how a process changes over time

Safety Culture — An environment that consistently minimizes adverse events and maintains a commitment to safety at all levels of the organization

Sentinel Event — Term used by The Joint Commission to describe an adverse event in which death or serious harm to a patient occurred

Situational Awareness — The degree to which one's perception of a situation matches reality

Slips — Failures in behavior or in concentration in the performance of routine tasks due to lapses in memory

Swiss Cheese Model — An illustration of how errors can occur: Imagine each prevention measure as a slice of Swiss cheese; when you stack them beside each other, if holes on the slices line up, an error can still slip through the layers

Time-outs — Planned periods of interdisciplinary discussion to ensure important details have been addressed, such as the surgical team confirming which body part they are operating on before beginning the procedure

Triggers — Signals for detecting likely adverse events

Workaround — A consistent pattern of work or ways of bypassing safety features

For a more complete list, visit: AHRQ.org

COMMUNITY MEMBER

PATIENT SAFETY

Patient Safety Committee Community Member

Recruitment and Onboarding – Patient Safety Officer (PSO) Checklist

Act 13 of 2002 (MCARE) states community members are:
"....residents of the community served by the medical facility who are not agents, employees or contractors of the medical facility."

Per PA Act 13 of 2002 (MCARE) law:

- ✓ Hospitals are required to have at least **two** community members on their Patient Safety Committee (PSC)
- ✓ Ambulatory surgical facilities, birthing centers, and abortion facilities are required to have at least **one** community member

*The MCARE law requires the minimum number of sitting community members on the PSC per facility type. Some facilities choose to recruit additional community members to allow scheduling flexibility and to ensure community member presence at PSC meetings.

Recruitment	Date

Identify sources to locate potential recruits. Suggestions include but are *not limited to*:

- ✓ Family members or neighbors of staff from the local community
- ✓ Facility volunteer departments
- ✓ Retired employees
- ✓ Local community groups – organizations may have a community relations department that could be helpful to identify potential recruits
- ✓ Local business owners
- ✓ Local faith–based organizations
- ✓ Local assisted living or nursing home residents interested in volunteer opportunities

PSO initial outreach to a potential new community member

At this point, you may only be exploring their interest. Give a high level overview of the role, recognizing additional information can be provided during their orientation if they accept an appointment.

- ❑ Introduce yourself and your role within the organization.
- ❑ Give an overview of the purpose of community members and their key functions.
- ❑ Explain why your organization values patient involvement and the role of the PSC within your patient safety plan.
- ❑ Outline the requirements of Act 13.
- ❑ Describe the typical time commitment and provide meeting logistics (e.g., date, time, and location).
- ❑ Discuss any potential confidentiality requirements.

If the potential candidate agrees to join your committee, begin the onboarding process.

Onboarding	Date

- ❑ Your organization should determine ahead of time if they will offer any reimbursement/stipend for expenses such as travel, time, and/or parking, e.g., providing a voucher or parking pass.

Gather key contact information:

- ❑ Mailing address
- ❑ Email
- ❑ Phone number(s)
- ❑ Brief bio (for introductions later to full committee)

Determine preferred contact methods:

- ❑ Discuss how content materials will be shared and handled

Discuss meeting logistics:

- ❑ Scheduling for recurring committee (day/time)
- ❑ Location
- ❑ Parking: discuss where they should park and if there is a charge

Orientation	Date
❑ Discuss and obtain signature on any Confidentiality Agreements, if applicable. **Gather Community Member Resources (Disseminate based on their preference of electronic/hard copy):** ❑ Community Member "A Call to Serve" Handout ❑ MCARE Primer ❑ Act 13 (MCARE) ❑ Act 52 ❑ Patient Safety Authority Flyer: "Who We Are" (One-Page) ❑ Patient Safety Authority Website – examples of consumer tips ❑ Sample Patient Safety Committee Meeting Agenda with Recurring Reports ❑ Sample Confidentiality Agreements ❑ List of current committee members with title and role ❑ Consider providing a folder or binder with these resources that your new community member can bring to meetings.	

Initial Meeting	Date
❑ Agree on a location where you or your delegate will meet your community member and escort them to the meeting space. ❑ Introduce the new community member at the beginning of the meeting. ❑ Ask the committee members to each introduce themselves and their role. ❑ Plan to spend some time immediately after the meeting to debrief: ✓ How was their first meeting experience? ✓ Was there anything confusing or difficult? ✓ Do they have any additional questions? ❑ **Thank them for coming!** ❑ Make sure they are comfortable finding their way to the exit or have them escorted.	

Follow-up	Date
❑ Schedule a call or in-person meeting with new community member after the third meeting they have attended: ✓ How has their experience been after several meetings? ✓ Has the experienced been generally what they expected? ✓ What challenges do they continue to have? ✓ Has anything surprised them? ✓ Do they feel comfortable speaking up and asking questions? ✓ Is there anything you can do to assist them further? ❑ **Thank them again for joining your committee!**	