

Volunteering as a Patient Safety Committee Community Member



**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 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 members?

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 discuss anything that happens 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. The 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 and 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 Effects Analysis

HAP – Hospital and Healthsystem Association of Pennsylvania

HAI – Healthcare-Associated Infection

HIPAA – Health Insurance Portability and Accountability Act

HRO – Highly Reliable 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. Desensitization 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 — Also referred to as a near miss. An event or situation that did not produce patient injury but only because of chance

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

Handoff — 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

Highly Reliable 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 — Also referred to as a close call. An event or situation that did not result in patient injury but only by chance

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

Read-back — Also referred to as “teach back”. Verbally repeating what is verbally communicated by another individual

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 is a piece of Swiss cheese lined up next to each other. If a hole on each piece of cheese happens to be aligned, an error can still slip through.

Time Outs — Planned periods of interdisciplinary discussion to ensure important details have been addressed, such as the surgical team confirming which body part before beginning the operation

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](https://www.ahrq.org)