Welcome to Patient Safety I. This program is designed to inform you of the MCARE Act and Act 13 Pennsylvania legislation.
Upon completion of this course, you should be able to identify the requirements of Pennsylvania’s MCARE/ACT 13 legislation.
What is patient safety? Patient safety is the avoidance, prevention and reduction of adverse outcomes or injuries resulting from the processes involved in a patient’s care and treatment. Patient safety is a key part of the LVHN Quality Improvement Program mission and values. LVHN strives to promote a culture of patient safety by empowering staff to identify potential patient safety concerns and to prevent harm to patients.

Regulatory and accreditation requirements addressing patient safety have been placed on hospitals and other types of healthcare organizations for the past several years. These requirements mandate several items, including:

- Patient safety risk assessments,
- Reporting of specific types of patient events, and
- Implementation of specific practices to improve the patient safety and decrease the opportunity for medical errors.
MCARE was signed into law in March 2002. The primary goal of the act is to ensure that all Pennsylvania healthcare organizations make every effort to reduce and eliminate medical errors. The effort can be accomplished through the identification of problems and implementation of solutions that improve patient safety.
MCARE/Act 13 addresses several issues. The patient safety section requires Pennsylvania healthcare organizations to do four things:

- Develop a patient safety plan,
- Designate a patient safety officer,
- Notify the patient safety officer about defined serious events, and
- Notify the patient and/or the family of the serious event and provide a written verification of the event itself.
Lehigh Valley Health Network has developed a Patient Safety plan to improve the health and safety of our patients. The Pennsylvania Department of Health has approved our plan, which is located in the LVHN Administrative Policy Manual.

The Patient Safety Plan can be found on the LVHN Intranet. On the LVHN Intranet Home Page, select the Resources menu. Next, select Employee, then Manuals. On the Manuals and Policies page, click the Administrative Policy Manual. Locate and click the Patient Safety Plan link to view the plan.
Lehigh Valley Health Network promotes a culture that supports accountability for patient safety as an approach to patient safety reporting.
Kristie Lowery is the Patient Safety Officer for Lehigh Valley Health Network. The Patient Safety Officer’s responsibilities are to:
• Ensure serious events are promptly investigated,
• Act upon investigation facts immediately,
• Provide reports about actions taken to improve patient safety to the Patient Safety Council and the Board, and
• Ensure serious events are reported to the state (DOH) within 24 hours of the event.
An event is something that happens that is not consistent with routine operations of LVHN. MCARE / Act 13 defines a serious event as an event, occurrence or situation involving a patient’s clinical care in a medical facility that results in death of the patient or compromises the patient’s safety and results in an unanticipated injury that requires additional clinical care for the patient.

Examples of serious events include removing the wrong kidney, or giving a patient the wrong medication which causes heartbeat to stop.
Act 52, implemented in February, 2008, amended Act 13 and required all healthcare acquired infections (HAI’s) to be considered a serious event. Patients must be informed of a healthcare acquired infection and the plan for treatment. Infection Control staff will inform the physician of the infections that meet the criteria to be considered a serious event by placing of a sticker on the progress notes. The Patient Safety Officer will provide written notification to the patient through a letter within seven days of confirmation of the healthcare acquired infection.
A nurse mistakenly gives a patient a bolus of the fentanyl drip that was hanging instead of the plain NSS IV fluid. The patient experiences a sudden drop in blood pressure and goes into cardiac arrest. The patient responded to resuscitative efforts, was intubated, connected to a ventilator and transferred to ICU. Is this considered a serious event?
Yes this is considered a serious event because the error compromised the patient’s safety and resulted in additional care.
Yes this is considered a serious event because the error compromised the patient’s safety and resulted in additional care.
If you think you have been involved in, or discovered, a serious event, you should immediately report the event to one of the following:

• The Patient Safety Officer at 610-402-3000,
• The Risk Manager on call through the page operator at 610-402-8999, or
• The Patient Safety Hotline at 610-402-2830.

All serious events must be reported immediately, or as soon as possible after the event occurs. The event should be reported no more than 24 hours after the event occurred or was discovered.
The Patient Safety Hotline is available for everyone to use in order to encourage open, honest and prompt reporting of serious events.

If you call the hotline, you are not required to leave your name. However, you must provide the following information:
• Patient’s name
• Patient’s location
• Nature of the medical error or safety issue and
• Person involved in the medical error
Failing to report a serious event may lead to disciplinary action. Licensed healthcare providers may also receive sanctions by their respective licensing bodies.

If an employee or physician fails to report a serious event to the Patient Safety Officer, he or she may receive disciplinary action according to LVHN Human Resources policies and or Medical Staff bylaws.

Licensed healthcare providers, such as RNs, RPhs or MDs, may also receive sanctions by their respective licensing bodies for failing to report a serious event.
No one may retaliate against you for reporting a serious event. The federal “Whistleblower law”, the LVHN Patient Safety Program and the Joint Commission accreditation participation requirement provide this protection to you.

The Whistleblower law was set forth on December 12, 1986 and states that no retaliatory action will be taken against a healthcare worker for reporting a serious event.

Patient Safety Reporting is the right thing to do!
MCARE / Act 13 requires written notification be provided to the patient, or a person authorized to receive such information, within seven days of the occurrence of discovery of the serious event. If the patient is a child, and is not an emancipated minor, the written notification is given to the child’s parent or legal guardian.

The Patient Safety Officer will determine if the event meets the state’s definition of a “serious event”. The written notice will be prepared by the PSO in order to ensure that the MCARE/Act 13 requirements are completely met.
Notification will be provided to a patient's family under either of the following situations:
• If a patient gives consent, the written notification may be given to an available family member or designee.
• If the physician and Patient Safety Officer determine that the patient lacks the capacity to understand the events that occurred, then a discussion, followed by the written notification, will be given to the patient's family.