

2 MS. HASLINGER: Okay. Mr. Chairman, members
3 of the Committee, thank you for giving me this
4 opportunity. I'm pleased to appear here today to
5 present information about how we've implemented a
6 patient safety system in our healthcare organization.

7 I come before you today to give testimony on
8 what we have found to be successful in making our
9 facility safer for patients. I'd like to provide a
10 summary of the nine initiatives which have assisted
11 and supported our patient safety journey and hopefully
12 this can be processed in other hospitals, these
13 recommendations.

14 I'd like to start first with the patient
15 safety needs to be an organizational goal. Patient
16 safety is not just a priority but it's a value, and
17 patient safety needs to be part of our strategic plan.
18 We currently have it as part of the strategic plan.
19 It's identified at the highest level in the
20 organization.

21 The patient safety goals that give direction
22 for the leaders need to be measurable to be able to
23 hold the leadership group accountable.

24 Some of the measures we've used are increased
25 occurrence reporting by 50 percent, decreased adverse

1 drug events by 75 percent, increased near miss
2 reporting by 50 percent. Everyone knows what needs to
3 be done and knows what the measures are that will say
4 if you're successful.

5 Leadership is the key for the organization to
6 move towards a culture of safety. The direction for
7 the patient safety begins with the board and begins
8 with the president, the CEO, the COO, and the top
9 leadership group.

10 All levels of leadership have to be held
11 accountable and have to ensure that the patient safety
12 goals are met. One person, one department, cannot
13 drive this through an organization.

14 Our president, our CEOs, do executive
15 walkabouts in which they walk around the units in the
16 clinical areas and ask the staff what doesn't work.
17 What would you be concerned about if a loved one was
18 admitted here on the midnight shift?

19 We can then take that data and collate it and

20 say where do we need to put resources, how can we
21 improve. The president needs to be the leader of the
22 Patient Safety Committee. This gives the organization
23 the message that patient safety is the number one
24 priority.
25 Organizations need to develop a culture of

11

1 safety. We have a tool that we've used with the
2 Institute for Healthcare Improvement to measure our
3 culture, and we do it annually. This gives our
4 employees an opportunity to tell us what needs to be
5 improved in both our environment and our processes to
6 improve patient safety.

7 We measure it annually, and we often compare
8 ourselves to 50 other hospitals to make sure that
9 those hospitals and our hospitals can share
10 information on how we can get to a hundred percent.
11 We have just completed our second measurement and have
12 a baseline to compare it to.

13 Part of this culture is a nonpunitive
14 culture. That means that employees can report without
15 having any penalties. They don't have to be fearful
16 for their jobs, for themselves, or for their peers.
17 It promotes reporting, and we usually find in our
18 organization that this has truly increased those
19 occurrence reporting and those near misses. This
20 allows us to put our emphasis on systems and on
21 processes and not on people.

22 Reporting is key. You need the data to give
23 direction to see how you're doing. We currently have
24 implemented an online occurrence reporting system. If
25 it's not easy, people don't do it. If nurses have to

12

1 find forms or they have to go back to the nurse's area
2 to write up an occurrence, they often don't have the
3 time to do it. Having it online is very helpful for
4 them as well as the rest of the organization.

5 We need to report near misses. Employees
6 need to know what a near miss is, and not only do we
7 need to know what the near miss is but we need to give
8 it a severity level. If we could have harmed a
9 patient with a near miss, we need to do a root cause
10 analysis just as if it were occurrence. We can then
11 truly look at the processes that need to be improved,

12 and we have currently identified two or three that we
13 have already done, and it's been very helpful in
14 looking at those processes.

15 We may not have addressed those processes if
16 we hadn't done severity level on the near misses. We
17 learn from our errors.

18 An active Patient Safety Committee can be the
19 pulse for the organization for patient safety success.
20 We have employees and managers at all levels in the
21 organization as part of our Patient Safety Committee,
22 which is led by the president. Data and measurement
23 drive the agenda. They have reviewed the occurrences,
24 they look at near misses, they look at the actions,
25 and they make recommendations.

13

1 They give the direction to the organization,
2 the people down in the ranks who know what's going on
3 about what needs to be done and what resources need to
4 be provided to the organization.

5 The biggest improvement that's going to be
6 made in patient safety is through technology. Bar
7 coding, electronic medical records, computer order
8 entry are currently out there and organizations need
9 to somehow find the dollars to adopt them.

10 We received a grant for putting a bar coding
11 system in place. I expect that 50 percent of our
12 identification errors, adverse drug events or drug
13 administration errors and blood transfusions will be
14 decreased because of this bar coding.

15 We can only rely on an employee for lots of
16 things but bar coding puts that forcing function in
17 there that we all need to start adopting from other
18 industries.

19 Computer order entry, with all the alarms and
20 the alerts, we're currently spending 5 to \$6 million a
21 year implementing a computer order entry and
22 electronic medical record at Munson over the next few
23 years. I don't know how organizations are going to
24 find this money but it's key that they do this because
25 we really think that it's going to make an

14

1 improvement.

2 Forcing functions, we need to learn about it
3 in healthcare. The free-flow infusion pumps, we need

4 to know that they're going to make it safe for giving
5 IVs to patients.

6 Patients want to be involved. Use them as a
7 resource. We have a patient safety brochure that we
8 provide to patients and we ask them to ask our
9 employees, "Did you wash your hands before you treat
10 me? Did you look at my ID band before you gave me
11 medication? What medication are you giving me?" And
12 if in question, ask. Ask if something doesn't seem
13 right.

14 This brochure has made it somewhat difficult
15 for the staff because patients are becoming involved.
16 And when we didn't think about the alcohol gel, about
17 putting it in the brochure, we had a lot of people
18 asking why they didn't wash their hands. So we know
19 the brochures work and we know patients want to be
20 involved.

21 We need to join and learn with others. Lots
22 of organizations have a lot of good information.
23 We've chosen IHI as part of our benchmarking group.
24 We joined them in 1989 -- or '98 at becoming a part of
25 their collaborative in drug safety and illegible

15

1 handwriting. We have just been part of their 2001
2 Patient Safety Impact Group in which we have been with
3 50 other hospitals looking at how we can make our
4 patients safer.

5 We need to make -- we need to say that the
6 national patient safety goals makes sense. They're
7 not just requirements out there. They make sense. We
8 need to implement them and we need to measure them to
9 make sure that we keep 100 percent on all goals, that
10 they're not just something because a regulatory agent
11 has said we need to apply them.

12 We need to tell our stories. We use
13 story-telling. We talk about "It Happens Here."
14 We've got a video about our stories. We have a
15 monthly brochure that's called, "It Happens Here."

16 Employees don't believe that things happen if
17 they haven't been involved. And so by sharing the
18 stories through story-telling, they understand that,
19 yes, it can happen here and what have we done to
20 prevent it.

21 Finally, I'd like to close with three
22 comments. Nothing changes until we change it. Safety

23 is everyone's responsibility. And as clinicians and
24 people working with patients, the first thing we learn
25 is do no harm.

16

1 Thank you for this opportunity to offer these
2 comments.

3 DR. SIMMER: Thank you. We have some
4 questions.

5 MR. BISSONNETTE: Could you describe a little
6 bit more your reporting system. If I was an employee
7 at your hospital and I was aware of a medical mistake
8 or a near miss, how would I report it?

9 MS. HASLINGER: We have what we call PEERS,
10 it's an online reporting system, occurrence system. I
11 would sign on with my code and select the PEERS, and I
12 could go in and it asks me questions about what -- if
13 it was a fall, if it was medication. It sort of
14 categorizes, and it just leads me through some screens
15 where I can put the input.

16 When I send it, it automatically prints in
17 Risk Management. Risk Management then screens all of
18 the errors and categorizes them and then sends the
19 information electronically to the manager or the
20 department where the error happened and anyone that
21 might be involved in it. Those people then respond
22 within 24 to 48 hours and report back to Risk
23 Management about what is going on.

24 We can then track and trend those errors
25 through the PEERS system and we can also -- this is

17

1 part of the Trinity system that we're working with.
2 We can also benchmark all our errors with the Trinity
3 Association to find out where our errors are and where
4 theirs might be and how we can help each other.

5 MR. BISSONNETTE: Could I do that report
6 anonymously?

7 MS. HASLINGER: Yes. You can do it
8 anonymously. You have the choice of putting your name
9 in or not putting your name in. Almost all our
10 reporting is anonymous.

11 MR. PARADIS: You referred to IHI. Could you
12 explain that in a little more detail?

13 MS. HASLINGER: The Institute for Healthcare
14 Improvement, Don Berwick out of Boston. He, in my

15 opinion, is the Dr. Dimling [phonetic] of quality in
16 this generation, and I'm one of his biggest fans. I
17 think his organization has top notch information
18 resources. If you just take what they tell you and
19 apply it, your organization is going to be safer.
20 They have all the tools that you need. They've done
21 all the work.

22 MS. McDONALD: You noted that you have a
23 pretty active Patient Safety Committee, quality.

24 MS. HASLINGER: I do.

25 MS. McDONALD: Are there any patients on that

18

1 committee? I mean, you talked about all the people
2 who are on there.

3 MS. HASLINGER: We invite patients at certain
4 times to the Patient Safety Committee if there are
5 issues that we need patient input, or we will have --
6 we have a member of our corporate communications, and
7 we usually will ask them to get a focus group of
8 patients together when an item comes up, and a couple
9 members of the Patient Safety Committee will then meet
10 with the focus group of patients to get input from
11 them. I think we've only had a patient twice to the
12 Patient Safety Committee in the last year.

13 DR. SIMMER: Thank you very much.

9

2 MS. HASLINGER: Okay. Mr. Chairman, members
3 of the Committee, thank you for giving me this
4 opportunity. I'm pleased to appear here today to
5 present information about how we've implemented a
6 patient safety system in our healthcare organization.

7 I come before you today to give testimony on
8 what we have found to be successful in making our
9 facility safer for patients. I'd like to provide a
10 summary of the nine initiatives which have assisted
11 and supported our patient safety journey and hopefully
12 this can be processed in other hospitals, these
13 recommendations.

14 I'd like to start first with the patient
15 safety needs to be an organizational goal. Patient
16 safety is not just a priority but it's a value, and
17 patient safety needs to be part of our strategic plan.
18 We currently have it as part of the strategic plan.
19 It's identified at the highest level in the
20 organization.

21 The patient safety goals that give direction
22 for the leaders need to be measurable to be able to
23 hold the leadership group accountable.
24 Some of the measures we've used are increased
25 occurrence reporting by 50 percent, decreased adverse

10

1 drug events by 75 percent, increased near miss
2 reporting by 50 percent. Everyone knows what needs to
3 be done and knows what the measures are that will say
4 if you're successful.

5 Leadership is the key for the organization to
6 move towards a culture of safety. The direction for
7 the patient safety begins with the board and begins
8 with the president, the CEO, the COO, and the top
9 leadership group.

10 All levels of leadership have to be held
11 accountable and have to ensure that the patient safety
12 goals are met. One person, one department, cannot
13 drive this through an organization.

14 Our president, our CEOs, do executive
15 walkabouts in which they walk around the units in the
16 clinical areas and ask the staff what doesn't work.
17 What would you be concerned about if a loved one was
18 admitted here on the midnight shift?

19 We can then take that data and collate it and
20 say where do we need to put resources, how can we
21 improve. The president needs to be the leader of the
22 Patient Safety Committee. This gives the organization
23 the message that patient safety is the number one
24 priority.

25 Organizations need to develop a culture of

11

1 safety. We have a tool that we've used with the
2 Institute for Healthcare Improvement to measure our
3 culture, and we do it annually. This gives our
4 employees an opportunity to tell us what needs to be
5 improved in both our environment and our processes to
6 improve patient safety.

7 We measure it annually, and we often compare
8 ourselves to 50 other hospitals to make sure that
9 those hospitals and our hospitals can share
10 information on how we can get to a hundred percent.
11 We have just completed our second measurement and have
12 a baseline to compare it to.

13 Part of this culture is a nonpunitive
14 culture. That means that employees can report without
15 having any penalties. They don't have to be fearful
16 for their jobs, for themselves, or for their peers.
17 It promotes reporting, and we usually find in our
18 organization that this has truly increased those
19 occurrence reporting and those near misses. This
20 allows us to put our emphasis on systems and on
21 processes and not on people.

22 Reporting is key. You need the data to give
23 direction to see how you're doing. We currently have
24 implemented an online occurrence reporting system. If
25 it's not easy, people don't do it. If nurses have to

12

1 find forms or they have to go back to the nurse's area
2 to write up an occurrence, they often don't have the
3 time to do it. Having it online is very helpful for
4 them as well as the rest of the organization.

5 We need to report near misses. Employees
6 need to know what a near miss is, and not only do we
7 need to know what the near miss is but we need to give
8 it a severity level. If we could have harmed a
9 patient with a near miss, we need to do a root cause
10 analysis just as if it were occurrence. We can then
11 truly look at the processes that need to be improved,
12 and we have currently identified two or three that we
13 have already done, and it's been very helpful in
14 looking at those processes.

15 We may not have addressed those processes if
16 we hadn't done severity level on the near misses. We
17 learn from our errors.

18 An active Patient Safety Committee can be the
19 pulse for the organization for patient safety success.
20 We have employees and managers at all levels in the
21 organization as part of our Patient Safety Committee,
22 which is led by the president. Data and measurement
23 drive the agenda. They have reviewed the occurrences,
24 they look at near misses, they look at the actions,
25 and they make recommendations.

13

1 They give the direction to the organization,
2 the people down in the ranks who know what's going on
3 about what needs to be done and what resources need to
4 be provided to the organization.

5 The biggest improvement that's going to be
6 made in patient safety is through technology. Bar
7 coding, electronic medical records, computer order
8 entry are currently out there and organizations need
9 to somehow find the dollars to adopt them.

10 We received a grant for putting a bar coding
11 system in place. I expect that 50 percent of our
12 identification errors, adverse drug events or drug
13 administration errors and blood transfusions will be
14 decreased because of this bar coding.

15 We can only rely on an employee for lots of
16 things but bar coding puts that forcing function in
17 there that we all need to start adopting from other
18 industries.

19 Computer order entry, with all the alarms and
20 the alerts, we're currently spending 5 to \$6 million a
21 year implementing a computer order entry and
22 electronic medical record at Munson over the next few
23 years. I don't know how organizations are going to
24 find this money but it's key that they do this because
25 we really think that it's going to make an

14

1 improvement.

2 Forcing functions, we need to learn about it
3 in healthcare. The free-flow infusion pumps, we need
4 to know that they're going to make it safe for giving
5 IVs to patients.

6 Patients want to be involved. Use them as a
7 resource. We have a patient safety brochure that we
8 provide to patients and we ask them to ask our
9 employees, "Did you wash your hands before you treat
10 me? Did you look at my ID band before you gave me
11 medication? What medication are you giving me?" And
12 if in question, ask. Ask if something doesn't seem
13 right.

14 This brochure has made it somewhat difficult
15 for the staff because patients are becoming involved.
16 And when we didn't think about the alcohol gel, about
17 putting it in the brochure, we had a lot of people
18 asking why they didn't wash their hands. So we know
19 the brochures work and we know patients want to be
20 involved.

21 We need to join and learn with others. Lots
22 of organizations have a lot of good information.
23 We've chosen IHI as part of our benchmarking group.

24 We joined them in 1989 -- or '98 at becoming a part of
25 their collaborative in drug safety and illegible

15

1 handwriting. We have just been part of their 2001
2 Patient Safety Impact Group in which we have been with
3 50 other hospitals looking at how we can make our
4 patients safer.

5 We need to make -- we need to say that the
6 national patient safety goals makes sense. They're
7 not just requirements out there. They make sense. We
8 need to implement them and we need to measure them to
9 make sure that we keep 100 percent on all goals, that
10 they're not just something because a regulatory agent
11 has said we need to apply them.

12 We need to tell our stories. We use
13 story-telling. We talk about "It Happens Here."
14 We've got a video about our stories. We have a
15 monthly brochure that's called, "It Happens Here."

16 Employees don't believe that things happen if
17 they haven't been involved. And so by sharing the
18 stories through story-telling, they understand that,
19 yes, it can happen here and what have we done to
20 prevent it.

21 Finally, I'd like to close with three
22 comments. Nothing changes until we change it. Safety
23 is everyone's responsibility. And as clinicians and
24 people working with patients, the first thing we learn
25 is do no harm.

16

1 Thank you for this opportunity to offer these
2 comments.

3 DR. SIMMER: Thank you. We have some
4 questions.

5 MR. BISSONNETTE: Could you describe a little
6 bit more your reporting system. If I was an employee
7 at your hospital and I was aware of a medical mistake
8 or a near miss, how would I report it?

9 MS. HASLINGER: We have what we call PEERS,
10 it's an online reporting system, occurrence system. I
11 would sign on with my code and select the PEERS, and I
12 could go in and it asks me questions about what -- if
13 it was a fall, if it was medication. It sort of
14 categorizes, and it just leads me through some screens
15 where I can put the input.

16 When I send it, it automatically prints in
17 Risk Management. Risk Management then screens all of
18 the errors and categorizes them and then sends the
19 information electronically to the manager or the
20 department where the error happened and anyone that
21 might be involved in it. Those people then respond
22 within 24 to 48 hours and report back to Risk
23 Management about what is going on.
24 We can then track and trend those errors
25 through the PEERS system and we can also -- this is

17

1 part of the Trinity system that we're working with.
2 We can also benchmark all our errors with the Trinity
3 Association to find out where our errors are and where
4 theirs might be and how we can help each other.
5 MR. BISSONNETTE: Could I do that report
6 anonymously?
7 MS. HASLINGER: Yes. You can do it
8 anonymously. You have the choice of putting your name
9 in or not putting your name in. Almost all our
10 reporting is anonymous.
11 MR. PARADIS: You referred to IHI. Could you
12 explain that in a little more detail?
13 MS. HASLINGER: The Institute for Healthcare
14 Improvement, Don Berwick out of Boston. He, in my
15 opinion, is the Dr. Dimling [phonetic] of quality in
16 this generation, and I'm one of his biggest fans. I
17 think his organization has top notch information
18 resources. If you just take what they tell you and
19 apply it, your organization is going to be safer.
20 They have all the tools that you need. They've done
21 all the work.
22 MS. McDONALD: You noted that you have a
23 pretty active Patient Safety Committee, quality.
24 MS. HASLINGER: I do.
25 MS. McDONALD: Are there any patients on that

18

1 committee? I mean, you talked about all the people
2 who are on there.
3 MS. HASLINGER: We invite patients at certain
4 times to the Patient Safety Committee if there are
5 issues that we need patient input, or we will have --
6 we have a member of our corporate communications, and
7 we usually will ask them to get a focus group of

8 patients together when an item comes up, and a couple
9 members of the Patient Safety Committee will then meet
10 with the focus group of patients to get input from
11 them. I think we've only had a patient twice to the
12 Patient Safety Committee in the last year.
13 DR. SIMMER: Thank you very much.