

Testimony to the State Commission on Patient Safety
Traverse City, Michigan
November 30th, 21004
From: Jim Fischer

Mr. Chairman and members of the State Commission on Patient Safety, My name is Jim Fischer and I am a registered nurse and the Vice President of Patient Care Services at Munson Medical Center here in Traverse City. I have been a registered nurse for 26 years and in my current position of vice president for the past five years. I am here to share with you my thoughts on patient safety from a nursing perspective, which is largely a “front line” and “in the trenches” view point.

The nursing staff, along with other care providers at Munson Medical Center, has been explicitly focused on patient safety in an intense manner for several years. We are not perfect, but we have made significant strides in making the environment a safer one for patients, their family members, and staff. I am going to share with you what we have experienced in our microcosm at Munson because I believe that it could serve as the source for other initiatives, that if implemented at the macro or State level, would result in fewer deaths and less harm to patients in the State of Michigan.

To begin, it is clear that what is needed first and foremost is **leadership**. The top leadership in the organization must recognize the importance of patient safety, make it a top priority and dedicate resources to it. This top leadership is followed by front-line leadership, which must reinforce the importance of patient safety and tailor it to the unique needs of each clinical setting and patient population being cared for. Without this leadership patient safety efforts will surely fall flat on its face.

The next major ingredient for improving patient safety is to create a learning environment around the errors that are committed. This can also be thought of as creating a **culture of patient safety**. This involves non-punitive reporting, following up on errors as soon as they occur, learning why errors happen, and taking the necessary steps to make system changes so the errors are not repeated. We are taking those necessary steps at Munson so that we have a safer environment for our patients. Experiencing early successes is critical here. Staff need to know that it is typically “systems” that set people up to make mistakes and we need to know about mistakes so that we can make corrections to our systems of providing care to patients.

Within nursing at Munson, we have been able to bring about **significant decreases in the incidence of patient falls and nosocomial skin breakdown, as well as the rate of medication errors**. We have accomplished this by providing the necessary leadership on patient safety, implementing a non-punitive reporting system, emphasizing to staff the expectation that errors are reported because we want to fix systems that are causing them, benchmarking our results to best practices found in the literature, and then engaging staff in general assessment, planning and implementation of solutions to fix our systems of care.

Here’s a small, but simple example of how we are **reducing patient falls**. We have formed a task force of expert nurses to review the literature, including research, on how to reduce patient

falls. Their work has prompted changes in data collection that has given us additional information on patient fall occurrences. That has led to us implementing a “falling star” effort, which is code for a specific patient needing to have additional interventions because of being at high risk for falls. This includes having all members on the health care team being aware of that heightened risk and keeping a closer eye on the patient. In addition, we have found that the majority of the time falls occurred was related to patients getting up to the bathroom. We now proactively help the patient to the bathroom every two hours while they are awake to keep their bladders empty and therefore, decreasing the likelihood of having a fall happen. Because of these measures, we are experiencing 1/3 fewer falls at Munson. We aren’t where we want to be yet, but we are heading in the right direction.

Sometimes it is the seemingly simple efforts that can make big improvements and other times complex efforts are needed. Implementing an **electronic medical record** is one of these complex (sometimes I call it Herculean) efforts that can reduce harm and decrease patient morbidity and mortality. Health care is incredibly complex. Providing health care across the continuum of care and involving a multitude of providers is a daunting challenge to say the least. Patients present to the Emergency Room not knowing the medications they are on, other than “a little blue pill for my heart and a yellow pill for my blood pressure.” To address these challenges and the gaps that come with complexity, Munson is assuming a lead role in creating a community electronic medical record, which is designed to provide relevant clinical information in a shared network from physician offices, outpatient clinics, and hospitals. The goal is to have specific health information on patients as soon as it is needed, making for better, safer, and hopefully more efficient care. To do this, Munson has invested millions of capital dollars in information technology. We are at the cutting edge by implementing these systems but resources are very limited during these tight economic times. The electronic medical record holds great promise, and hospitals need help in funding those efforts.

Another area of patient safety that is of great interest to nursing is the **nurse to patient ratios** that are in place. If a nurse is stretched too far and has too many things to do, they will be more likely to make errors of omission or commission. There is a growing body of evidence and research that hospitals that have better RN to patient staffing ratios also have better patient outcomes. At Munson we watch our staffing ratios very carefully, trying to find that right balance of safe, quality nursing care while at the same time being good stewards of resources. A recent study showed that registered nurses catch 86% of potential errors. We must recognize that patients in the hospital today are sicker and more in need of nursing care than they were even just several years ago. There are adverse patient outcomes that are particularly sensitive to low numbers of registered nurses including: urinary track infections, pneumonia, shock, upper gastrointestinal bleeding, longer hospital stays, failure to rescue, and 30 day mortality rates. All of these adverse outcomes are higher when fewer nurses are caring for more patients. Hospitals must assure that the level of nurse staffing is appropriate to meet the intensity of care required by their patients. This will lead to less harm and lower patient mortality.

Another area that bears close attention is the movement of hospitals to become recognized as “**Magnet facilities**.” There is a body of research that now supports organizations achieving a high level of nursing excellence in the care provided to their patients and are recognized as Magnet hospitals have better outcomes. Currently there are approximately 130 facilities in the

country that have been recognized for their high level of excellent nursing care and are Magnet hospitals. Munson is now in the process of being so recognized.

Another issue of concern to nursing is the growing **shortage of nurses** in this country including in the State of Michigan. We need to address this shortage if we are to make significant headway in achieving a safer environment for patients. The nursing population is aging and there is an increasing unwillingness of young people to consider nursing as a profession. However, locally we have a model of partnership between our community college, Northwestern Michigan College and Munson Medical Center to increase the overall number of individuals choosing nursing as a profession and increasing the numbers of students in their nursing program. I am pleased to announce that due to this partnership we are now in a position to meet the future need for nurses in our community. This is the result of the local college and hospital working together to meet the growing demand for nurses. We have jointly promoted nursing as a positive career choice, strengthened the clinical experiences for students, created joint appointments for clinical instructors, provided new roles for nursing students and supported tuition needs. Because of this Munson has been having better success at filling our nursing vacancies than what has been experienced around the State and nation. Our current vacancy rate is about 2% and approaching zero, whereas; the rate across the country is about 13%. Having an appropriate number of new registered nurses graduating from nursing programs is critical to providing a safe environment for patients.

Let me suggest some **recommendations for improvements** in the areas that I have mentioned here:

Leadership – The State of Michigan must assign leadership to the a body aimed at improving patient safety and reducing medical errors. The Michigan Health and Safety Coalition is a good starting point. This leadership needs to stress accountability to hospitals and health care providers for implementing systems to make it safer for our patients. Be bold and don't hold back. All patients deserve a safe environment.

Mandatory, non-punitive reporting systems – This should be instituted for errors occurring in health care. We must create a learning environment so that care providers are not operating in a vacuum unaware of errors their colleagues are making. The data elements must have easily understood definitions that can be operationalized in a consistent manner across settings. In time, results should be publicly made available by organization so that informed decisions can be made as to where the people want to receive their health care. We should be able to benchmark our results on a multitude of measures including: patient falls, nosocomial skin breakdown, medication errors causing harm, pneumonia and shock rates, and general patient satisfaction with pain control to name a few. If we measure it, we can better understand it and then implement solutions to improve it.

Funding - We need support in funding the electronic medical record. It cannot be understated that it takes millions of dollars to move forward with these systems. Let's call a spade a spade. Medicaid funding is pitiful. Munson and other hospitals across the State lose millions of dollars every year caring for the Medicaid population. It is the State of Michigan's moral responsibility to adequately fund the care needed by this population.

Nurse staffing and nursing vacancy – We need to create partnerships between hospitals and colleges and universities to increase the number of young men and women entering the nursing profession. This will require increased funding for schools and scholarships. In addition, expecting and supporting hospitals to create positive working environments, consistent with Magnet standards, will go a long way in both attracting and keeping smart, bright nurses at the bedside as well as improving patient outcomes and decreasing harm and mortalities.

Thank you for the opportunity to share my views with you today.

The references used in this report can be found in:
www.ahrq.gov/research/nursestaffing/nursestaff.htm

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Executive Summary

Leadership is needed first and foremost to create environments where patient safety is a top priority.

Creating a culture of patient safety is needed. This involves:

- Non-punitive error reporting
- Follow-up on errors when they happen
- Making system changes so errors are not repeated

Lower levels of hospital nurse staffing are associated with more adverse outcomes. Conversely, better patient outcomes are associated with improved RN staffing. Specifically: with expert registered nurses involved in careful planning and implementation of solutions lower incidence of patient falls, nosocomial skin breakdown, and medication errors can occur

Adequate nurse to patient ratios are critical to improving patient safety. Lower numbers of registered nurses with higher numbers of patients are associated with more adverse outcomes including: higher rates of pneumonia, shock, upper gastrointestinal bleeding, longer hospital stays and higher mortality rates.

Implementing an electronic medical record can produce better, safer, and more efficient care.

Hospitals providing excellent nursing care are being recognized as “Magnet facilities.” These facilities are associated with better patient outcomes.

The State of Michigan and the country is experiencing a shortage of registered nurses

Recommendations:

- The State of Michigan should be assuming a lead role in creating a safer environment for patients
- We must create a mandatory, non-punitive reporting system for errors
- Increased funding is needed to support development of the electronic medical record
- Incentives should be created for hospitals to achieve Magnet recognition.
- Partnerships must be promoted between hospitals and schools of nursing to increase the number of young women and men choosing nursing as a profession