

My name is Sandra Jones, and I am a Registered Nurse with over 30 years of experience, mostly in Emergency Nursing. My current position is Clinical Safety Manager at Providence Hospital and Medical Centers located in Southfield, Michigan, which is part of the St. John Health System. I appreciate the opportunity to provide testimony to the State Commission.

I attended a portion of the November 17 State Commission on Patient Safety's public hearings, and listened to a half dozen speakers submit testimony on several aspects of patient safety. I will argue in my testimony that developing a "culture of safety" in hospitals, state regulatory agencies, third-party payers, and our legal system can help to reduce medical errors better in the long term, and that there are many drawbacks to the punitive medico-legal environment pervasive in the current system.

In the five years since the Institute of Medicine's (IOM) report brought the topic of patient safety and medical errors to the attention of healthcare organizations and the public, healthcare organizations have implemented initiatives to address safety concerns. Most hospitals have teams that review and track medication errors.

Hospital regulatory and accreditation agencies, like the Joint Commission on Accreditation of Health Care Organizations (JCAHO) have adopted a more aggressive focus on patient safety since 1998. Initially, JCAHO periodically distributed "Sentinel Event (SE) Alerts" on topics that were represented in serious adverse events reported to them by health care organizations. Examples of these included preventing wrong side/site surgical errors, infant abduction, and blood transfusion reactions. In 2003, all JCAHO accredited organizations were required to comply with National Patient Safety Goals based on the SE Alerts, including specific actions to improve communication between health care workers, which was an underlying factor in many serious events. The "time out" before invasive procedures, to allow the team to confirm the correct patient, side/site, and procedure, was one requirement. An additional goal was included for 2004 aimed at preventing hospital-acquired infections. 2005 goals include all the previous ones, plus new ones, including the reconciliation of medication at each change of treatment location. JCAHO has been able to use its power of accreditation (with its deemed status for Medicare certification and hence payment for services rendered to Medicare patients) to force organizations to adopt better and safer practices. This is one of the many driving forces that are contributing to the development of a culture of safety.

The Veterans Administration Hospital system has successfully implemented a bar-coding system for medication administration. The question is: "Is healthcare safer now?"

Although not comprehensive, I will provide a brief review of some of the current literature regarding patient safety, prior to sharing my testimony and personal experiences.

During an audio-conference sponsored by the Institute for Healthcare Improvement (IHI) <sup>1</sup>on November 12, 2004, a panel of patient safety experts discussed changes that have occurred since the 1999 IOM report. The panel included Don Berwick, Lucian Leape, Peter Pronovost, and Sorrell King (mother of Josie King, the 18-month old child who died as a result of medical errors). The consensus of the panel was that although progress has been made, we haven't made as much progress as we had hoped.

Two surveys were also released during the week of November 15<sup>th</sup> in response to the five-year anniversary of the IOM report. On November 16, 2004, the Leapfrog

Group released their annual “Leapfrog Hospital Quality and Safety Survey”.<sup>2</sup> The survey asked over 1000 hospitals about their awareness, accountability, and action taken regarding 27 of the safety practices recommended by the National Quality Forum (NQF). Some of the results of the survey were:

1. Only 4% of responding hospitals have fully implemented computer physician order entry.
2. 80% of respondents have implemented procedures to avoid wrong-site surgeries
3. 70% of responding hospital require a pharmacist to review all medication orders before the medication is given to the patient

The results of this survey concurred with the IHI panel’s perceptions.

The day after the Leapfrog Group released their survey, the Kaiser Family Foundation, the Agency for Healthcare Research and Quality (AHRQ), and the Harvard School of Public Health released the results of their “National Survey on Consumers’ Experience with Patient Safety and Quality Information”<sup>3</sup>. Over 2000 adults were surveyed by telephone to assess their perception of the quality and safety of their healthcare. The results of this survey illustrated the disparity between the public and healthcare organization’s perceptions of medical errors. Some of the key findings of this survey include:

1. 48% of the respondents said they were very or somewhat worried about the safety of their health care.
2. 57% said they had never heard the term “medical error,” or had heard the term, but didn’t know what it meant.
3. 52% stated that mistakes made by individual health professionals are a more important case of preventable medical errors than mistakes made by the institutions where they work (36%).

Respondents cited the following as the top 5 likely causes of medical error:

1. Overwork/stress/fatigue of healthcare professionals – 74%
2. Doctors not having enough time with patients – 70%
3. Not enough nurses in hospital – 69%
4. Health professionals not working together or communicating as a team – 68%
5. Poor training of health professionals – 58%

The top 5 possible solutions to prevent medical errors were:

1. Giving doctors more time to spend with patients – 79%
2. Requiring hospitals to develop systems to avoid medical errors – 72%
3. Better training of healthcare professionals – 72%
4. Requiring hospitals to report all serious medical errors to a state agency – 71%
5. Increasing the number of nurses – 67%

Although not in the top five, 54% of the respondents suggested fining and suspending the licenses of healthcare professionals who make a medical error.

Comparison of the three citations above illustrates a disparity between the perceptions of the public and healthcare providers regarding patient safety. There needs to be a shared vision about the type of environment we want in Michigan in order for progress in patient safety to be optimized.

According to Frankel (2004):

“One of the hallmarks of a safety culture is an environment in which accountability for bad events clearly differentiates between individual causation, and environmental or system influence. This perspective is the basis of a “just” culture, in which blame is appropriately focused and doing so increases the likelihood that the system as a whole will work more effectively.” (p. 129)

Historically, the culture of most healthcare organizations has been punitive. If an error was made, the focus was on the individual involved, rather than on the process or system, which often resulted in blame. This attitude encouraged people to hide errors, thus perpetuating them. Michigan’s legal environment has also been punitive, therefore hospitals’ response to errors was to become defensive and withholding. . All one has to do is listen to TV commercials that tell the public if a loved one has been injured to immediately call a lawyer. There’s a commercial currently on TV urging anyone who has taken Vioxx to sue.

You may have heard the term “blame-free” culture used. This is not an appropriate phrase to use, since it implies that there is no accountability. The overwhelming majority of healthcare workers do not come to work to harm or injure a patient. In rare instances, an individual may cause harm to a patient due to gross negligence, or criminal actions. In these cases, blame is appropriate and necessary. However, in the majority of cases, medical errors are not totally due to an individual’s error. There is frequently a system or process component that contributes to the error. The better term to use would be “just” culture, as previously defined above. According to Leonard, Frankel, and Simmonds (2004), “An ever increasing body of evidence indicates that at least 80 percent of medical error is system derived – meaning that system flaws set good people up to fail” (p.5), and that “...only about 5 percent of medical harm is caused by incompetent or poorly intended care.” (p.7) <sup>5</sup>

So then, in order to improve patient safety, we need to promote an environment where healthcare providers feel safe to report actual errors, whether or not harm is caused to patients, in addition to “near misses,” where an error is prevented from reaching the patient. We need to promote an environment in which the first response is not to assign blame, censure, or sue, but to look at how and why an error occurred, and take steps to avoid the error in the future. However, in our current climate, both within healthcare organizations, and in the legal system of Michigan, we have a lot of work to do to get there.

What are some specific actions that can be taken? I can make some recommendations, based on my personal experiences.

1. As in most hospitals, Providence has a process in place, where all serious errors are reviewed. The focus of this team is not to place blame, but to look at all factors to discover the “root causes” of the error. The leader of this team begins by explaining this to the involved individuals, to encourage their participation and honest sharing of information. **This attitude needs to be adopted across the state.**
2. We have various multidisciplinary patient safety committees that I facilitate, or participate in. During these meetings, we review all errors, and near misses related to medication use, and patient identification. We identify trends, and develop action plans to deal with them, and the information is filtered up to our governing board. **All healthcare organizations need to share this kind of information with their governing boards. Additionally, the fact that these processes exist needs to be shared with the public.**
3. We implemented an on-line occurrence reporting system to help us more accurately track these trends. We are looking at instituting an Electronic Medical Record, and other technology to assist in reducing errors. This will be very expensive. **Increased use of technology needs to be encouraged, and some means of financial support needs to be provided, to encourage and assist healthcare organizations to implement this technology.**
4. We are in the process of further integrating the concept of a “just” culture in all we do at Providence. Within the entire St. John Health System, training on the concept of a “just” culture is being developed to assist managers to appropriately address errors on their units. **Healthcare organizations need to continue to focus on developing “just” cultures, and do a better job of communicating and educating the public.**
5. In the near future, we will be implementing a recognition program to encourage reporting of errors. Only if people feel safe to report, can we identify issues that may be occurring system-wide, and approach it from that standpoint. **Changes need to be made in our legal and licensing systems, so that healthcare providers are held accountable, but not punished unless there is criminal activity or gross negligence.**
6. St. John Health is implementing a training program for physicians about disclosure of unanticipated outcomes. We believe that full disclosure is the right thing. Partnering with our patients by fully disclosing errors, apologizing, offering fair compensation when appropriate, and sharing ways to improve processes so that the error will not occur again, should decrease the litigious environment in Michigan. **The State Commission on Patient Safety should support changes to facilitate the changes in our legal and licensing systems.**

7. Performance improvement (PI) processes such as Six Sigma, LEAN, Failure Mode Effects Analysis (FMEA), and traditional PI tools are being integrated throughout the organization. We are seeing positive results from the use of these processes, and are beginning to see a change in our culture. **Encourage healthcare organizations to integrate business improvement strategies that have proven successful in other businesses.**
8. As a member of Ascension Health, Providence participated in an organization-wide safety climate survey, to assess the perceptions of safety and teamwork climates across the spectrum of healthcare providers. According to Sexton (2004), in order to develop characteristics of a safety culture, “it is important to assess the current state of the environment, and determine a baseline to see what changes are necessary.”(p.115) <sup>6</sup> **Encourage all healthcare organizations to assess their baseline culture to identify what changes are necessary.**

Effective change is never easy, and in order to continue to provide safer care to the patients we serve, we need to cultivate a “just” culture across our state. The patient safety issues facing healthcare organizations are serious, and the tasks needed to provide safe care seem daunting. (Simmonds and Leonard, 2004).<sup>7</sup> My hope is that the State Commission on Patient Safety will work to remove barriers, so that healthcare in Michigan will be safer and a model for other states to follow.

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<sup>1</sup> Institute for Healthcare Improvement, Teleconference, “To Err is Human” 5 Years Later. November 12, 2004.

<sup>2</sup> Leapfrog Group, “Leapfrog Hospital Quality and Safety Survey”: AHA News Now, November 16, 2004.

<sup>3</sup> Kaiser Family Foundation, the Agency for Healthcare Research and Quality, and the Harvard School of Public Health, “The National Survey on Consumers’ Experiences With Patient Safety and Quality Information”; Public Opinion and Research Program, November 17, 2004.

<sup>4</sup> Frankel, A. (2004). Accountability: Defining the Rules. In M. Leonard, A. Frankel, T. Simmonds, & K. Vega (Eds.), *Achieving Safe and Reliable Healthcare – strategies and solutions* (pp. 129-138). Chicago, IL: Health Administration Press.

<sup>5</sup> Leonard, M., Frankel, A., & Simmonds, T. (2004). Introduction. In M. Leonard, A. Frankel, T. Simmonds, & K. Vega (Eds.), *Achieving Safe and Reliable Healthcare – strategies and solutions* (pp. 3-14). Chicago, IL: Health Administration Press.

<sup>6</sup> Sexton, B. and Thomas, E. (2004). Measurement: Assessing a Safety Culture. In M. Leonard, A. Frankel, T. Simmonds, & K. Vega (Eds.), *Achieving Safe and Reliable Healthcare – strategies and solutions* (pp. 115-127). Chicago, IL: Health Administration Press.

<sup>7</sup> Simmonds, T. & Leonard, M. (2004). Conducting a Patient Safety Project. In M. Leonard, A. Frankel, T. Simmonds, & K. Vega (Eds.), *Achieving Safe and Reliable Healthcare – strategies and solutions* (pp. 189-202). Chicago, IL: Health Administration Press.