



PATIENT SAFETY/MEDICAL ERRORS/General

The Issue

To Err Is Human: Building a Safer Health System is a report released in 1999 by the Institute of Medicine (IOM) that alerted the American public to an overwhelming number of deaths related to hospital care. Since that time, IOM and other national organizations, such as the Joint Commission Accreditation of Healthcare Organizations (JCAHO) and the National Quality Forum, have established patient safety goals and metrics to track the adverse events. Legislation at the state level has addressed the need for each hospital to have a patient safety officer and a patient safety program. This legislative activity is expected to increase as the public becomes more aware of the potential dangers in our health care system and seeks greater oversight and increased efforts regarding patient safety.

While national organizations and federal and state governments are pushing for greater controls and reporting, the hospital industry is working with health care professional organizations to create greater safety for their patients and families. This is being accomplished through improved reporting; clinical process improvements to reduce the potential for system and human errors, and change in at-risk behaviors for all clinicians with greater awareness of hazards and potential outcomes.

The CHRISTUS Health Position: Protect patient safety without penalizing providers.

This Catholic health ministry's approach to addressing the issue of patient safety is shaped by fundamental values and a commitment to extend the healing ministry of Jesus Christ. By promoting and building quality into the organizational structure and processes, CHRISTUS Health is dedicated to providing care that is safe, effective, patient-centered, timely, efficient, and equitable. This is being accomplished through a variety of programs, training of associates, and patient safety-specific initiatives. In addition to the work in the clinical setting, a set of patient safety indicators is reported quarterly to the Board of Directors along with financial, service, and clinical quality indicators on a Balanced Scorecard Report.

Because we live our Core Values of Dignity, Integrity, Excellence, Compassion, and Stewardship, each patient entrusted to our care deserves open and honest communication and the safest environment possible. This transparency in communication and dealing with persons involved with any substandard activity supports an atmosphere of trust between the patients and care givers. CHRISTUS Health has taken the issue of transparency one step further than most

health care organizations by publishing our quality outcomes on our web site. This transparency demonstrates our commitment to patient safety and the highest quality health care.

CHRISTUS Health agrees with the Catholic Health Association position that supports medical errors reduction, including a national and uniform mandatory reporting system, on the condition that the following stipulations are met:

1. The primary and demonstrable purpose of the reporting system is the improvement of patient safety, not the penalizing of providers;
2. A pilot project is undertaken to evaluate how best to collect and use medical errors information from a national data base to improve patient safety;
3. Institutional and professional providers are protected from any legal liability relative to the reported data;
4. The term "reportable events" (i.e., "serious adverse events") is clearly defined;
5. An independent, third party (preferably in the private sector) compiles and maintains all information collected from such reporting;
6. Appropriate resources, no less than those recommended by the IOM, are provided to ensure the best use of the data in identifying general trends;
7. Medical error reports on individuals are kept in strict confidence and must not be released publicly in any form;
8. Reporting requirements are phased in, beginning with serious adverse events which cause death or serious medical harm, and;
9. Appropriate regulations are developed through a legislated negotiated rule-making process.

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