

Issue: Ensuring Health Care Quality and Patient Safety

Framing the Issue

The quality of health care in the U.S. has long been the envy of the world. People from around the globe seek state-of-the-art treatment in American hospitals for their most challenging health care problems.

Yet a landmark 1999 report from the prestigious nonprofit National Academies' Institute of Medicine focused national attention on serious deficiencies in health care quality and patient safety plaguing many of our country's most highly regarded health care institutions.

The report, "To Err is Human: Building A Safer Health System," found that at least 44,000 people die in hospitals each year from preventable medical errors. The majority of these errors don't result from individual recklessness or actions of a particular group of health care professionals. Faulty systems, processes, and conditions cause most medical mistakes.

A more recent report found that "medical injuries during hospitalization resulted in longer stays, higher costs, and a higher number of deaths." ¹ The Agency for Health care Research and Quality contends, "postoperative infections, surgical wounds accidentally opening, and other preventable complications lead to more than 32,000 U.S. hospital deaths and more than \$9 billion in extra costs annually." ²

Both of these reports have generated substantial news coverage in national, regional, and local news media. These stories portray preventable medical errors as a "problem afflicting even the best health care institutions: providing exceptional treatment to a few patients is often easier than guaranteeing adequate routine care for each of the thousands they treat every year." ³

Other recent national news stories have focused on additional indications of unacceptable levels of health care quality and patient safety in the U.S. system. One recent USA TODAY article listed

¹ "Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization" conducted by the Agency for Health care Research and Quality and published in the 10-8-03 *Journal of the American Medical Association*.

² *Associated Press* news story that appeared in *USA Today* and the *Idaho Statesman* on 10-8-03.

³ "Leading Hospitals Under Fire," the *Associated Press* in the *Washington Post*, 9-29-03.

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several such indicators, beginning with an investigation by the paper itself in July that found emergency medical systems in most of the 50 largest U.S. cities "fragmented, inconsistent, and slow." A study published in June's *New England Journal of Medicine* found that "overall Americans receive the clinical care they should get only 55% of the time." And, over a recent 12-month span, 40% of patients eligible for the heart-mending treatment angioplasty didn't get the procedure primarily because "most hospitals don't have the right technology or trained personnel," according to a Washington health policy analyst.⁴

These types of errors and omissions undermine "trust in the health care system by patients and diminished satisfaction by both patients and health professionals."⁵

According to *The New York Times*, a National Academy of Sciences (NAS) report just released warns that "many hospitals nationwide are endangering patients by allowing or requiring nurses to work more than 12 hours a day." According to the *NYT* article, the NAS report says "long work hours pose one of the most serious threats to patient safety because fatigue slows reaction time, decreases energy, diminishes attention to detail, and otherwise contributes to errors." Since nurses deliver most patient care, perhaps it's not surprising that the academy also "found overwhelming evidence that as levels of nurse staffing rose the quality of care improved because nurses had more time to monitor patients and can more readily detect changes in their condition."⁶

The Health care Industry Response

In December 2002, the American Hospital Association, the Federation of American Hospitals, and the Association of American Medical Colleges launched "The Quality Initiative: A Public Resource on Hospital Performance." The Quality Initiative is designed to help hospitals continuously improve care based on meaningful evidence, and to help the public make informed choices about their care. The initiative is supported by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Agency for Health care Research and Quality, Joint Commission on Accreditation of Health care Organizations, and the National Quality Forum.⁷

Participating hospitals voluntarily report performance data on 10 measures of care for three conditions: heart attack, heart failure, and pneumonia. Collected data is already being shared with health care professionals for clinical use, and will be shared with public online beginning in summer 2004. St. Luke's is among the more than 1,700 hospitals throughout the nation already signed on to the Quality Initiative.

⁴ *USA Today* article by Washington health policy analyst Steven Findlay, 10-1-03

⁵ "To Err is Human: Building A Safer Health System," a report by the Institute of Medicine, 11-99.

⁶ *The New York Times*, 11-5-03, "Report Cites Danger in Long Nurses' Hours."

⁷ *AHA News*, 7-17-03

St. Luke's Position & Practices

While no health care provider or institution can ever claim perfection, St. Luke's has a long and well-established record of quality health care and patient safety recognized by the hospital's health care peers and patients alike.

Peer & Patient Recognition

St. Luke's is nationally recognized as a leader in quality health care. For example, St. Luke's has been designated a Top 100 Cardiovascular Hospital for the second consecutive year and the seventh time since 1993. This recognition identifies the top hospitals in the U. S. based on publicly available performance data. The St. Luke's team has also earned prestigious Avatar⁸ national service quality awards in the categories of Overall Best Performer, Ambulatory Surgery Care, and Meeting or Exceeding Patient Expectations based on patient surveys.

The quality of nursing care at St. Luke's is recognized as among the very best in the nation. St. Luke's is the only hospital in Idaho and one of only three hospitals among neighboring Northwest states designated as Magnet hospitals. Magnet designation is bestowed on select hospitals by the nation's largest and foremost nursing accreditation and credentialing organization to recognize health care organizations that demonstrate sustained excellence in nursing care.⁹

Additionally, St. Luke's is already in substantial compliance with standards for nursing recommended in the NAS' just released "Keeping Patients Safe: Transforming the Work Environment of Nurses," a report referenced November 5 in *The New York Times*.¹⁰

Patients have also signaled their confidence in the care we provide. St. Luke's is the only Idaho hospital to receive a National Research Corporation (NRC) Consumer Choice Award in 2003, recognition we also earned in 2000, 2001, and 2002. This coveted annual award recognizes hospitals that consumers choose as having the highest quality in over 100 U.S. markets.¹¹

These and other prestigious awards indicate the commitment to quality health care and patient safety that has been St. Luke's hallmark for many years.

Continuous Performance Improvement

The hospital industry as a whole is working to improve health care quality and patient safety nationwide, but St. Luke's has been continuously monitoring and improving its performance in

⁸ Avatar is a leading international health care research and consulting firm.

⁹ Excerpted from the American Nurses Credentialing Center website at www.nursingworld.org.

¹⁰ See footnote 6 on page 2 of this document.

¹¹ NRC website at www.nationalresearch.com, 7-3-03.

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these crucial areas for a long time. Our success comes from careful continual attention to details throughout the St. Luke's system.

"Everyone at St. Luke's is involved in providing each patient the best patient care humanly possible," emphasizes Noreen Davis, senior vice president of Nursing & Patient Care Services. "Providing each patient with the care he or she needs is an intricate, complex challenge that by its very nature poses opportunity for error somewhere in the process, no matter how dedicated and competent our staff is. We're committed to making sure we achieve the desired medical outcomes error-free."

St. Luke's closely monitors and measures its performance systemwide to prevent problems from occurring, and to respond quickly and effectively when they do. Everyone at St. Luke's has the opportunity to get involved. For example, any team member is encouraged to formally identify a problem or an improvement that needs to be addressed before it impacts patients.

St. Luke's health care professionals routinely use two processes that are industry standards for patient safety. First, where the potential exists to inadvertently perform a medical procedure on the wrong part of a patient, the correct site is marked as part of the pre-op procedure. This surgical site marking is done with the patient and the patient's family. Then, just before surgery begins, the medical team involved participates in a "procedural pause," one last team check to ensure they are performing the correct procedure on the correct site on the correct patient.

A formal "determination meeting" is held when St. Luke's feels that there is something in its system that is either causing or could cause a problem. The review team identifies the cause of the problem and the best way to fix it. Progress on the fix is measured and monitored until the team is satisfied.

Many of the medical errors that other hospitals experience may be due at least in part to the growing nursing shortage, a problem not currently afflicting St. Luke's. "Our annual nursing vacancy rate is about 4%," Davis explains. "Our relatively low number of open nursing positions compares to a national average of about 10-12%, with some hospitals suffering vacancy rates as high as 25%. We try very hard to hire the best nurses and other staff, and then collaborate with them to create a work environment conducive to providing the best possible care."

Ensuring health care quality and patient safety requires a never-ending vigil by everyone involved. St. Luke's community board of directors, health care professionals, and volunteers feel no greater responsibility than caring for patients and their families every day.

