



University of Connecticut Health Center
John Dempsey Hospital

TESTIMONY
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010

**SB 248, an Act Concerning Adverse Events at Hospitals and Outpatient
Surgical Facilities**

My name is Mike H. Summerer, MD and I am the Director of John Dempsey Hospital. I appreciate the opportunity to provide written testimony in opposition to SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities.

John Dempsey Hospital (JDH) opposes the bill as the changes it proposes to the adverse event reporting system, we believe, would not improve quality of care or patient safety, and would likely have the opposite effect. As demonstrated in other industries, and widely accepted in healthcare, it is important to have a system that fosters safety by encouraging reporting of adverse events in a confidential, non-punitive environment so that trends can be detected and systems can be made safer and more reliable.

JDH has been committed to patient safety since its inception. With the passage of the first adverse event reporting legislation in 2002, JDH has worked closely with the state and CHA to promptly report adverse events and to seek preventive solutions. Over the past year a complete reorganization and restructuring of our quality programs with new medical and nursing executive leadership is in place and has enhanced our focus on safer, reliable patient care of the highest quality.

JDH has developed mechanisms to identify and act on patient safety concerns raised by our employees, providers, patients and family members. We participate in an on-line reporting system with other academic medical centers that allows anyone to report patient safety events without risk of retaliation. These reports allow our hospital to quickly find the root cause of an incident and implement a corrective action plan. This reporting system is just one cornerstone of our safety culture at JDH. A yearly patient safety culture survey of hospital employees is another tool used by our leadership to identify improvement opportunities. We highlight our performance improvement projects each year at an annual Patient Safety Fair.

JDH has been actively involved in several collaboratives sponsored by the Connecticut Hospital Association (CHA) to improve patient safety. Through our current state wide adverse event reporting system Connecticut hospitals have identified the need to improve skin care, take additional steps to prevent patient falls and decrease our infection rates. These collaboratives have been possible because of a non-punitive reporting structure within our state.

JDH is concerned SB248 duplicates improvement initiatives already in place, adds administrative burdens for DPH and Connecticut hospitals, and creates disincentives for reporting. The national safety improvement movement in hospitals, learning from other industries such as commercial aviation, promotes reporting of all incidents and "near misses" so that safety can be improved. A culture of blame will actually have the opposite effect of intent of the bill and will decrease transparency for the citizens of CT.

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Thank you for your consideration.