

WRITTEN TESTIMONY OF
The Hospital of Central Connecticut
To
PUBLIC HEALTH COMMITTEE
Monday, March 1, 2010
Regarding
SB 248, An Act Concerning Adverse Events At Hospitals And Outpatient
Surgical Facilities

My name is Kate Betancourt and I am the Director of Performance Improvement for the Hospital of Central Connecticut (HCC). I appreciate the opportunity to provide comment on behalf of HCC regarding **SB 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities**.

HCC appreciates the *intent* of the Attorney General in advocating for certain modifications to current legislation. We recognize that there is global concern regarding incidents of harm related to healthcare delivery. The problem has been well-defined in both professional and lay literature, and we share the concerns of the nation's leading patient safety experts, e.g. Robert Wachter, Lucian Leape and Donald Berwick. As the committee knows, there is a well-established body of research that demonstrates the need for a *just culture* in assuring that factors impacting safe healthcare delivery are brought to light, and other industries (aviation, nuclear safety) have provided guidance in how best to achieve such an end. It has long since been established that a non-punitive environment, one that balances an appreciation for the role of systems-failure with personal accountability, is the best environment for improving safety. Accordingly, any legislation that fosters a punitive approach would be a step backwards for Connecticut, and that assumption is well founded in evidence-based research.

HCC has been on the same journey as most hospitals in the nation to better understand how errors occur, and we recognize that transparency is paramount in establishing and maintaining the trust of our community. We have worked collaboratively with the Connecticut Department of Public Health since the inception of the 2002 Quality of Care program, and have reported events in accordance with regulatory requirements. We have learned from our colleagues around the state and indeed *around the nation* by sharing "lessons learned" in discussion of actual or near-miss events, and we have in turn shared our gained wisdom. HCC was among the first in the nation in 2002 to voluntarily report performance data for public scrutiny via the National Healthcare Quality Alliance. We have sought the input of nationally recognized patient safety experts in our efforts to improve the culture of our organization, including Dr. James Bagian and Dr. Brian Sexton. Our Department of Surgery spearheaded the introduction of Crew Resource Management (team training) to our organization, bringing safety expert Dr. Donald Moorman to our facility back in 2008. To date, over 200 physicians, nurses and technicians have participated in this important program to improve safety in the perioperative setting. We consistently work proactively to employ strategies to create an environment where risk is minimized, e.g. senior leadership rounds to regularly interact with front line staff and discuss their concerns regarding quality and safety, regular survey of staff to gauge perceptions of safety and hear suggestions for improvement, and significant resource commitment in maintaining a "league" of more than 40 patient safety liaisons throughout the organization. Our nursing staff was the recipient of the 2009 Excellence in Nursing award from the Connecticut Nurse's Association, in recognition of a grassroots project that reduced fall rates on one unit from well above the national average to among the lowest in the nation.

These improvement activities, just a few of the many that are ongoing at HCC, occur as a result of dedication and commitment to providing excellent care to our patients, not from external pressure to improve. Any legislation that increases administrative burden, diverts resources from patient care, and potentially demoralizes caregivers, will be counterproductive to any intended goal of making healthcare safer. Legislation that enhances open dialogue and supports learning would be most welcome.

Thank you for your consideration of our position.