



November 1, 2010

Timothy Babineau, MD
President and Chief Executive Officer
Rhode Island Hospital
593 Eddy Street
Providence, RI 02903

Dear Dr. Babineau:

I have noticed some of the unfavorable press coverage Rhode Island Hospital has been receiving related to retained foreign bodies during surgery. Since Rhode Island Hospital (RIH) is a member of the University HealthSystem Consortium (UHC), I thought I would share with you some of our data and thinking about patient safety issues that you may find helpful as you continue to pursue solutions and communicate those efforts to external audiences. UHC is a member-owned alliance of 111 academic health centers (AHCs) dedicated to improving its members' performance in quality, safety and cost effectiveness. We collect extensive data on university teaching hospitals, and UHC was one of the first 10 listed AHRQ Patient Safety Organizations. We have been invited to share our experiences this year alone at the AHRQ National Meeting and the NPSF Annual Meeting.

Electronic data from hospital discharge abstracts is used each year to rank UHC member AHCs in safety, effectiveness, mortality, equity and patient centeredness. This year was RIH's first year to be included in UHC's rankings, and RIH scored in the top quartile in a composite of safety measures that included rates for pressure ulcers, bloodstream infections, iatrogenic pneumothoraces, post-operative respiratory failure and post-operative hemorrhage. Numerator data on retained foreign bodies also indicate that RIH is not an outlier among its peers. These measures constitute only a partial view of safety, and clearly all organizations should have zero instances of preventable harm as a goal. However, the data we have reviewed do not point to unusual problems in your organization.

A more in-depth view of patient safety is afforded through event reports shared by front line clinicians of the sort submitted to the UHC Patient Safety Net (PSN) adverse event reporting system. This system is now used by 90 hospitals across the country and has accumulated over a million adverse event reports in its 7 years on the market. Its software formed the basis for the Pennsylvania Safety Reporting System, a state based reporting network that is the country's most robust and that was awarded AHRQ's prestigious Eisenberg Award. I understand that the State of Rhode Island has recently implemented the GE-MERS system, which has many common features with the PSN, so I believe what we have learned may be relevant.

We have found that after implementation of such a system, reporting rises briskly compared with legacy paper systems to rates of approximately 1 report/inpatient bed/month. Our best performers have encouraged reporting, some by awarding “good catch” lapel pins to clinicians who spot an event that leads to an improvement in safety. About 75% of these reports are near miss or no harm events. While some of these are rather minor, others are related to and help to understand more serious harmful events. Our best performing AHCs have organized to group like reports for statistical trending, allowing for root cause investigations to be done on the aggregate data. This approach to triage and focus allows for prioritizing and targeting of safety issues rather than forcing safety professionals to respond to high and low risk events one by one in the same manner. Furthermore, a culture which punishes or sanctions based on reporting will be self-defeating in my view, in that sharing of information will diminish, depriving the organization of valuable learning.

Transforming the culture of health care to one that acknowledges the inevitability of human error and designs systems to prevent harm to patients resulting from human error is a complex and multifaceted endeavor. It entails a clear statement of values by leadership of openness and transparency that is captured in David Marx’s “Just Culture” work. It also demands an environment that encourages reporting and learning and the involvement of senior leaders in setting a standard for continuous improvement. I know that these are values that you have held for a long time, based on your work both in Maryland and Rhode Island, so I am optimistic that you will lead your organization out of its current difficulties to set an example for hospitals nationwide. Please do not hesitate to contact UHC if we can provide support in these efforts in any way.

Sincerely yours,

A handwritten signature in black ink that reads "Mark A. Keroack MD". The signature is fluid and cursive, with the letters "M", "K", and "M" being particularly prominent and stylized.

Mark A. Keroack, MD, MPH
Senior Vice President and Chief Medical Officer
University HealthSystem Consortium