

## Increased scrutiny has hospitals focusing more on safety

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Sharp HealthCare executives have spent the past two weeks trying to reassure the public that their hospitals are safe amid news that recent lapses in management and medical care at Sharp Grossmont caused the deaths of at least three patients.

They're not alone in that challenge. Hospitals everywhere are vulnerable to human error, and they've all had to deal with patient-care crises.

In the past 16 months, state and federal regulators have named at least five hospitals in San Diego County with serious problems that contributed to the deaths of five patients, including those at Sharp Grossmont, and put hundreds of others in harm's way.

Since the California Department of Public Health began issuing fines in January 2007 for "immediate jeopardy" mistakes – those causing death or grave injury – it has penalized 39 hospitals statewide.

Local hospital administrators have strived to reduce errors by boosting training for their staffs, hiring more workers who focus on regulatory compliance and borrowing ideas from the airline industry, where workers contend with pressures and risks similar to those in an operating room or emergency department.

The administrators said significant mistakes at their facilities generally have not increased over the years, but that scrutiny and prevention efforts have.

"I don't think there is any question that hospitals are more focused on quality and safety than ever before," said Chris Van Gorder, president and CEO of Scripps Health, which operates four hospitals in the county.

Two of the network's hospitals – Scripps Memorial and Scripps Green, both in La Jolla – have suffered "immediate jeopardy" cases since last year.

The other facilities with such incidents include Sharp Grossmont, UCSD Medical Center in Hillcrest and UCSD's Thornton Hospital in La Jolla.

Besides handing out penalties, California health regulators are drawing the public's attention to big hospital mistakes by issuing news releases.

Starting in October, Medicare will stop paying hospitals for the cost of treating many of the mistakes their doctors and nurses cause.

And consumers concerned about the quality of their medical care can tap dozens of Web sites to compare hospitals.



JOHN GIBBINS / Union-Tribune

Registered nurse Yvonne Green started a pre-surgery brief at the UCSD Medical Center by confirming with the patient that he had consented to surgery. The procedure is aimed at cutting down on medical mistakes.

### GROWING SCRUTINY

Health regulators and the public are paying more attention to the quality of patient care at hospitals:

California regulators are imposing fines as high as \$25,000 on hospitals for each "immediate jeopardy" mistake that endangers patients. They're also publicizing the penalties.

In October, Medicare will stop paying for the cost of treating many infections and injuries caused by hospital errors.

Consumers, emboldened by the power of the Internet, are increasingly choosing hospitals based on quality rankings and reports.

Other policies are helping to create an overall carrot-and-stick approach to making hospitals safer. For example, Medicare and a growing number of private insurers base some of their payments on hospitals' ability to meet or exceed quality standards for patient care.

The elevated scrutiny is transforming the way many hospitals operate.

Teamwork has become the mantra among doctors and nurses, who traditionally have been divided by strict codes of hierarchy. Also, some hospitals have asked patients to join their systems of checks and balances.

At Thornton Hospital and the UCSD Medical Center in Hillcrest, surgery patients go through a checklist with their doctors and nurses before receiving anesthesia. Among other things, the list is designed to ensure that the right person has the right operation.

It was modeled after safety checklists that pilots use before flying.

"The culture of silence and the culture of secrecy that used to exist in hospitals is being stripped away," said Memphis-based hospital consultant Stephen Harden, a commercial airline pilot and former Navy Top Gun instructor.

He helps hospitals, including those in the University of California system, and physicians apply safety practices from the aviation world

to their health care settings.

The higher level of monitoring will push even the best medical centers to do a better job of preventing errors, said regulators and some hospital operators. But they also wonder whether heightened attention to each "immediate jeopardy" case will help patients make better decisions when choosing a hospital.

"It's difficult for consumers to judge whether a particular problem is isolated or whether it's part of a series of events," said Ken August, spokesman for the state Department of Public Health. "Trying to decide the quality of care of a facility strictly from news stories is difficult at best."

Sharp HealthCare's four hospitals have always done as much as possible to keep patients safe, said Nancy Pratt, the network's senior vice president of clinical effectiveness.

"Every health care organization wants to fix these things. It's not a lack of interest or effort," she said.

But for decades, hospitals largely didn't face outside pressure to improve patient care.

In California, the shift kicked into high gear in January 2007, when state regulators began issuing fines as high as \$25,000 for each serious safety breach. Regulators are developing rules to double that limit, and there is a bill in the Legislature to raise the maximum penalty even higher.

Nationwide, the current drive to minimize hospital mistakes dates back to 1999, when the Institute of Medicine issued its landmark report "To Err is Human." The study estimated that 98,000 Americans die each year because of hospital and physician errors.



JOHN GIBBINS / Union-Tribune  
Scrub technician Sylvia Bello stood in front of an operating room chart detailing safety measures designed to reduce the number of medical mistakes.



JOHN GIBBINS / Union-Tribune  
Registered nurse Yvonne Green filled out an inventory of surgical instruments being used in a procedure.

The recent increase in federal and state requirements for hospital patient care suggests that regulators aren't satisfied with the pace and breadth of change, said Roy Snell, CEO of the Health Care Compliance Association, which represents 7,000 professionals who manage regulatory compliance for hospitals and physician groups.

Most health care organizations are proficient at identifying lapses, Snell said, but they often fall short when correcting a weakness that requires changing well-established routines or punishing specific staff members.

Part of the problem is that the people charged with enforcement and disciplinary actions frequently come from the same ranks of doctors and nurses who make the mistakes, he said.

One solution is to transfer those duties to regulatory compliance specialists.

In a recent survey, about 52 percent of the compliance association's members said their responsibilities include helping ensure the quality of patient care, Snell said. That represents a major shift since the association was created 12 years ago, when almost none of the group's members dealt with quality assurance.

But some health care providers worry about giving oversight of medical care to people lacking clinical backgrounds. They said those individuals might not fully understand the complex and technical nature of hospital medicine.

"The idea is to improve patient care, not to punish doctors," said Dr. Gary Vilke, who heads UCSD Medical Center's peer review committee.

An increasingly punitive regulatory system runs the risk of discouraging hospitals from disclosing mistakes, said Debby Rogers, vice president of quality and emergency services for the California Hospital Association.

"There's a balance of creating an environment where reporting (errors) is rewarded," she said. "The last thing we want is for people not to report."

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