

Dear Co-worker,

We in health care hold a sacred trust. Patients trust us with their lives; family members trust us with their loved ones. Nothing we do is more important than working to ensure the safest environment possible for our patients, to show that their trust is well placed.

In developing and living out a culture of patient safety, it's important that everyone share a sense of openness to improving our systems and processes. It's important that we trust each other — trust that everyone wants to do her or his best, every day.

We trust each other, and we don't believe that people come to work to do a bad job or make an error, but given the right set of circumstances any of us can make a mistake. That's why our culture of patient safety focuses on prevention, not punishment. We see patient safety events as opportunities to learn. We encourage co-workers to report events and "near misses" or close calls in a cooperative, open way, without fear of punishment.


At St. John's Mercy, we must never let "good enough" be good enough. We must be relentless in our pursuit of finding ways to improve our systems and processes. We must look past the easy answer that it was "someone's fault" to answer the tougher questions about why a mistake happened.

To do that we must all work together in a spirit of trust.

Thank you for doing your part to make our culture of patient safety part of your daily work life.

Best personal regards,

Sincerely,



Michael L. Morgan
President and CEO



Living a Culture of
Patient Safety

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A Call for Patient Safety

It has been reported that as many as 180,000 deaths occur in the United States each year due to errors in medical care. Many of these errors are preventable. An Institute of Medicine report in 1999 called for "a bold overhaul of the U.S. health care system — and a strategy to address serious shortcomings in the quality of health care available to all Americans."

As a result, organizations across the country, from the Joint Commission on Accreditation on Healthcare Organizations to business groups such as Leapfrog, are calling on hospitals to develop new and better ways to improve patient safety.

When we talk about a patient safety concern, we mean anything that might impact the well being of a patient. Patient safety concerns include but are not limited to:

- Hazards that could lead to falls
- Dangerous use of materials, equipment, supplies or waste
- Fire hazards
- Security issues
- Medication events.

A common misconception is that patient safety is about reminding people to be more careful. But in fact, health care workers are some of the most careful people on Earth. Improving patient safety is about changing the culture in health care from one of blame to one where we examine our systems from beginning to end to reduce the opportunities for mistakes.

A Pervasive Commitment to Patient Safety



Improvement in patient safety does not occur unless there is a pervasive commitment by the organization and a clearly defined and ongoing effort by leaders, physicians, and co-workers. St. John's Mercy Medical Center has made such a commitment, beginning at the highest levels of the Board of Directors and continuing through the executive leadership, management, co-workers and physicians of the Medical Center.

Patient safety — it is a concept that seems so simple that it's one of the basic tenets of medical practice.

Lucian L. Leape, M.D.
Harvard School of Public Health

St. John's Mercy is committed to an environment in which co-workers and physicians feel free to contribute to building and maintaining a culture of safety. We are establishing a non-punitive, blame-free culture that encourages co-workers to focus on safety issues; identify and report all events, "near misses" or close calls, and hazardous conditions; and help to develop and implement performance improvement processes across the organization. We're creating an environment where reporting about adverse medical events and patient safety is the norm, without fear of retribution or punishment.

The success of this effort depends on each co-worker's willingness to participate, to contribute, and to be open to sharing and receiving information about safety events and close calls. St. John's Mercy expects and requires that all co-workers fully take part in building our culture of safety.

A Non-punitive, Blame-free Environment

We live in a culture that manages errors by looking for people to blame, that discourages people from admitting errors, and that focuses on the end result — the error — instead of the systems or processes that led to the error.

St. John's Mercy's culture of patient safety, on the other hand, strongly encourages people to report adverse events and "near misses" or close calls without fearing what might happen to them. We want co-workers to feel that they are full partners in the job of improving the safety of patient care processes and systems. The organization's primary response to adverse events is to learn from them, not to assign blame or impose discipline. One of the best ways to reduce adverse events is to take advantage of lessons present in close calls, where things almost go awry but no harm is done. A culture of safety where people are able and willing to report both adverse events and close calls without fear of punishment will lead to a safer environment for not only patients, but also co-workers, physicians and visitors.

Making mistakes is part of being human. How many days have you gone through without making at least one mistake in your private or professional life? Have you ever driven into a gas station and released the trunk instead of the gas cap? How many times have you driven to the grocery store and made a wrong turn out of habit? Although most of our mistakes are easily corrected and cause no harm, mistakes in the health care field are not always that way.

This culture of safety means designing systems geared to preventing, detecting, and minimizing hazards and the likelihood of error — not finding and attaching blame to individuals.

William C. Richardson
Chair, Committee on Quality of Health Care in America



Recognizing that humans make mistakes, St. John's Mercy encourages co-workers to report adverse events and close calls — not to assign blame, but to learn what happened so we can keep it from happening again. Most mistakes occur as a result of ineffective, improperly designed or flawed systems. When co-workers report events and close calls, we are able to track them to find patterns and trends, which helps us learn how we can improve our systems to prevent future mistakes.

Our non-punitive policy on patient safety reporting is designed to encourage co-workers to feel comfortable reporting adverse events and near misses, and to participate in improving processes and systems. At the same time, it acknowledges that individuals are responsible and accountable to patients, the public and each other for doing whatever they can to make St. John's Mercy a safe healing environment. Each individual is responsible for using sound judgment and being aware of potential hazards to patients before taking action. Naturally, our non-punitive reporting environment does not excuse co-workers who:

- Willfully or knowingly choose to ignore or bypass established hospital or medical policies and procedures, or
- Repeatedly fail or refuse to adequately participate in the detection of, reporting of, and implementation of system-based activities to prevent events, accidents or near misses, or
- Intentionally contribute to or cause an event, accident or near miss, or
- Attempt to hide, modify or withhold the reporting of an event, accident or near miss, or
- Knowingly present false information in relation to the investigation or reporting of an event, accident or near miss.

You may view or receive your personal copy of the St. John's Mercy Culture of Patient Safety Reporting policy through the Intranet, in your area's copy of the administrative manual, or through Quality Management at 314-569-6405.

Medical errors most often result from a complex interplay of multiple factors. Only rarely are they due to the carelessness or misconduct of single individuals.

Lucian L. Leape, M.D.
Harvard School of Public Health

Patient Safety is Your Call

Because patient safety is everyone's responsibility, everyone has a duty to report his or her concerns. This also means everyone shares in the responsibility of improving safety. By reporting our concerns, we are helping each other achieve this goal together. Remember, reporting is about improving processes, procedures and systems, not about blaming individuals. If you had a concern about the safety of a member of your family, you wouldn't worry about who was to blame. Instead, you would let someone know your concern and make sure your loved one was as safe as possible. It's the same with our patients, who trust us with their care and safety.

For an **emergency safety** or **security issue** at the Medical Center, including emergency patient safety concerns, call **ext. 4911**.

Otherwise, **your first resource** should be your **manager or supervisor**. If you have a patient safety concern, talk with her or him about it.

For patient safety issues regarding Housekeeping, Maintenance, Central Supply or Clinical Engineering call the CARE center at Medical Center extension 4444. For non-emergency facilities or security concerns, call 314-569-6050.

Other resources available to you are your area's safety manual, Risk Management (314-569-6905), Quality Management (314-569-6405) and the Patient Safety Officer (314-569-6544).

Also, the following reporting methods are available for your use when appropriate:

- Confidential Event Report — for an unexpected event resulting in injury or the potential for injury to a patient, or for process issues — available on the St. John's Mercy Intranet.
- Medication Event Report — available on the St. John's Mercy Intranet.
- Adverse Drug Reactions — Suspected Drug Reaction Card (yellow) or ADR hotline (Medical Center ext. 5556).

