

## EXECUTIVE SUMMARY

Since the beginning of Tennessee's history of reporting medical errors/unusual events, there has been an emphasis on reporting, changing the "blame game" and completing root cause analysis and appropriate action plans. Our progress does reflect increased reporting and extensive quality improvement efforts as demonstrated in corrective action plans.

Creating a patient safety culture within their organization is a major concern for health care providers in Tennessee. Although the Department experienced a 38% increase in reporting of medical errors/unusual events by hospitals in 2005, the Department realized that there continued to be a problem with under-reporting and a need for improvement of facilities' environment that would support patient safety improvements. Counting and reporting errors does nothing to eliminate the errors themselves. Only with the creation of a health care organizational culture that promotes the reporting of errors by staff, the careful and thorough review of the errors and the processes that caused or contributed to those errors, and the inclusion of staff in the improvements and changes to the process will there be any changes in the environment of patient safety within health care organizations. It takes a commitment on the part of the organization's leadership to take on the crusade for patient safety. Frontline or "sharp end" staff will only feel safe in coming forward to report errors when they realize that the organizational culture is not about blame, but truly creating an environment of patient safety.

During the third year following implementation of the Health Data Reporting Act in Tennessee, the Department continued to work with all facilities to better understand the reporting requirements and the development of acceptable corrective action plans. On September 15, 2005, the second statewide patient safety conference was held with over 350 individuals attending.

In accordance with the Tennessee Health Data Reporting Act of 2002, all licensed health care facilities are required to report to UIRS (Unusual Incident Reporting System) any occurrence of unusual events and identify measures to address the cause(s) of those events. For purposes of UIRS reporting, an unusual event is defined as "an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient that is not related to the natural course of the patient's illness or underlying condition". Facilities have the capability to query the system to find comparative data to use in internal quality improvement efforts and prevention. It must be noted, however, that many of the unusual events reported to the Department are not medical errors, but are other types of unusual events such as fires, loss of services and disasters.

While all facility types have made strides in the reporting of unusual events to UIRS, many improvements are still needed. Complete and accurate reporting is critical for UIRS data to be used effectively as a tool for quality improvement and error reduction efforts.

In this fourth annual report of unusual events/medical errors, the Department provides a compilation of information from 2005 reported events and from the 1998-2004 administrative data sets from hospital discharge data. This report also contains:

- Progress report of identified areas of improvement outlined in the 2004 report,
- Summary of patient safety indicator data identified by Agency for Healthcare Research and Quality (AHRQ), including a correlation between Tennessee hospital discharge data;
- Comparative reports received in each of the three grand regions of the state;
- Comparative charts of reporting methods by facility type and occurrence codes;
- Summary of root causes and actions taken; and
- Continued areas of improvement

The Department's achievements in 2005 include:

- Increase in the volume of reporting by the same number of facilities.
- Increased reporting to UIRS from 3,805 in 2002 to 6,764 in 2005, 78 % increase;
- Added current information to the Department's patient safety web page which provides a comprehensive look at the patient safety initiatives implemented in Tennessee.
- Hospital Acquired Infection Task Force was organized as required by Public Chapter 323 to provide a report to the legislature (attachment).
- With assistance from the Tennessee Hospital Association (THA), Tennessee Health Care Association (THCA), and other agencies in Tennessee, the second Patient Safety Symposium was held September 15, 2005.

The Department of Health, licensed health care facilities and health care professionals continue to face an enormous challenge in the area of patient safety. Although there continues to be resistance to reporting an unusual event both internally and externally, it is felt that this is due to the slow process of changing human behaviors. However, we do recognize the increased reporting of unusual events in 2005 as a sign of progress and success in our licensed facilities.

The Department has clearly raised the profile of patient safety as an integral component of quality care and risk management in licensed health care facilities. The Department, however, realizes the need to continue to encourage senior leadership and middle managers in facilities to make patient safety a priority within their organization and to remove those roadblocks that hinder advancement.