

**Testimony for Public Hearing before State Assembly committees
on New York Patient Occurrence Reporting and Tracking System
October 19, 2009**

In late 1999, the Institute of Medicine released *To Err is Human*, the first in a series of reports produced by the Quality of Health Care in America Project. The report generated national attention when it estimated that between 48,000 and 98,000 Americans die each year due to medical errors. The importance of tracking errors – and finding ways to prevent them – came into sharp focus.

The New York Patient Occurrence Reporting and Tracking System (NYPORTS) was established in 1998 as an efficient, computer-based means for hospitals to report adverse events. Such an event was defined as an unintended adverse and undesirable development in an individual patient's condition, not just a medical error. Hospitals are required by state law to report adverse events.

In 2001, state officials commented that at least some facilities were under-reporting adverse events, based on a comparison between NYPORTS data and information submitted to the Statewide Planning and Research Cooperative System (SPARCS). The most recent NYPORTS annual report, covering the three years between 2002 and 2004, indicated that reports of adverse events had remained static.

After 2004, the annual reports stopped. New York City Comptroller William Thompson Jr. assigned his staff to review NYPORTS filings between 2004 and 2007. His study, released in March of this year, found that during that period, New York City hospitals reported only 37 medication errors.

NYPORTS is based on the viable principle that in order to prevent adverse events, hospitals have to first identify them. Then they must conduct root cause analyses of the events most injurious to patients. After 2004, however, DOH relaxed its efforts to enforce the reporting requirement set forth in state Public Health Law. As Comptroller Thompson's study revealed, DOH discontinued 22 of the 54 occurrence categories and ended enforcement for five others.

This represents a disappointing outcome in a system that started out with the commendable goal of improving patient safety. The June 1998 issue of our association newsletter announced the advent of NYPORTS. "The intent is to prevent patients from being harmed, and we support that goal 100 percent," said a nurse on our staff.

In fact, the Nurses Association has long supported legislative and regulatory actions that make patient safety information available to both policymakers and the public. Most notably, last month saw the enactment of our legislation that will require the disclosure of staffing information and patient outcomes related to the quality of nursing care.

The NYPORTS experience shows us, however, that this legislation will be effective only if government has the determination and the financial means to enforce it.

Registered professional nurses are guided by their Standards of Practice to evaluate the quality of patient care, enhance the quality of care, eliminate adverse events by collecting and analyzing data regarding policy and procedures, collaborate in efforts to identify system changes, and implement changes to improve care. They can be hindered in this effort, however, by the “culture of blame” that exists in many healthcare facilities.

In too many cases, nurses who report adverse events are punished for doing so, even when the root cause is a flaw in the system. Discipline should differentiate between honest mistakes and reckless behavior, but when the response to an error is usually punitive, nurses and other healthcare professional are less likely to report a mistake. This allows errors to continue with no effort to indentify and correct the systemic problems behind them.

Nurses who work in acute care are familiar with the ironic phrase, “Blame the nurse.” It stems from the common perception that, whatever goes wrong, the nurse will be the one who pays the consequences.

Unfortunately, this attitude can extend to society in general.

- This year, two nurses in Winkler County, Texas, were prosecuted by the local district attorney for filing a report with the Texas Medical Board about the quality of care provided by a physician who practiced at their hospital. Their case is still pending.
- In 2006, the Wisconsin Department of Justice charged a nurse with a felony for making a medical error that caused the death of a patient. The executive director of the Wisconsin Nurses Association questioned why a nurse could face criminal charges for making a mistake. “That prospect has a chilling effect on nurses who want to participate in a culture of patient safety,” she said.

A generally punitive attitude toward medical errors also contributes to the under-reporting of adverse events. Hospital administrators are concerned that if they accurately report possible errors, it will reflect badly on their reputations and those of their medical staff. This perceived liability outweighs the benefit of accurate reporting – the capability to compare data and share methods and procedures for improving patient outcomes.

The Nurses Association agrees that NYPORTS needs to be revitalized and strengthened. Its operation should be coordinated with the new reporting system for hospital-acquired infections and the event reporting required by the Nursing Care Quality Protection Act. It should be given the support it needs to step up enforcement.

In addition, however, the state should invest in an educational campaign to inform facilities and healthcare personnel about the value of reporting adverse events and ending the “culture of blame.” The emphasis should be on understanding the causes of the adverse events, correcting the causes, assisting healthcare personnel in implementing corrective procedures, and protecting patients from future adverse events.

Constituent of the American Nurses Association