

The Reporting of Adverse Events in Health Care: Reactions & Challenges from the First Minnesota Report

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Minnesota Department of Health

Overview

- ★ Background
 - Evolution of the law
 - Requirements of the law
- ★ 1st Report
- ★ Reaction
- ★ Challenges

Leading up to the adverse health events reporting law

- ★ Institute of Medicine report estimating 44,000 – 98,000 deaths per year from errors
- ★ Minnesota Alliance for Patient Safety (MAPS) formed in 2000
- ★ There was not one public “trigger” event that caused concern, but there were several media stories about errors
- ★ Vulnerable Adults Act basically says mistakes = abuse and neglect

Goals of the law

- ★ **Not** ...to punish errors by health care practitioners or health care facility employees
- ★ **Instead...**to balance **quality improvement** and **accountability** for public health & safety

When did the law take effect?

- ★ Hospitals reported events to MHA from July 2003, to December 2004 as part of the law's "transition period"
- ★ **Full implementation** of this law was contingent on **securing non-state funds** and on MDH providing **written notification** to all facilities
- ★ Full implementation began on **December 6, 2004**

Who must report?

- ★ Minnesota hospitals and outpatient surgical centers
- ★ Boards that regulate physicians, physician assistants, nurses, pharmacists, and podiatrists are to report to MDH events that come to their attention that may qualify as adverse health care events

What must be reported?

- ★ Any of the 27 events defined in law
- ★ A description of the event must be reported no later than 15 working days after discovery of the event
- ★ Within 60 days, findings of a root cause analysis and a corrective action plan must be reported
- ★ NO identifying information for any health professionals, employees or patients is included

Examples of reportable events

(from list of 27 “never events” created by National Quality Forum)

★ Surgical Events

- Wrong surgery
- Retention of foreign object
- OR or Post-op death

★ Product or Device

- Contaminated drugs or blood
- Air embolism

★ Patient Protection

- Infant discharged to wrong person
- Patient elopement

★ Care Management

- Medication error
- Maternal death
- Death from hypoglycemia
- Stage 3 or 4 pressure ulcers

★ Environmental Events

- Death from electric shock
- Wrong gas delivered
- Patient burns
- Patient falls

★ Criminal Events

- Abduction
- Sexual assault

How do facilities make a report?

- ★ The Minnesota Hospital Association has developed a password protected, web-based registry that hospitals used to report events during the “transition period”
- ★ MDH now has a contract with MHA to use this system for reporting by all facilities
- ★ Updating the registry to automate/prompt/categorize as much as possible, but still a need for lots of free text

Communications

Training

Scheduling

Environment/Equipment

Rules/Policies/Procedures

Barriers

Human Factors-Communication(Step 1of 6)

Entered By: pctest

Click here for
Category Definition ?

Click here for a list of
contributing factors and key
questions for this category. ?

Was Human Factors-Communication a contributing factor?

Yes No NA

If yes, was this a root cause?

Yes No NA

If yes, briefly describe the root cause finding.

Text area for describing the root cause finding.

Corrective Action Plan

If a root cause is identified above, describe the action that will be taken to reduce the risk of reoccurrence, the personnel responsible to implement the action, the date implemented and how the action will be measured.

Action

Text area for describing the corrective action plan.

Measurement Strategy

Text area for describing the measurement strategy.

Cancel

Save\Next

How are the data protected?

- ★ 2004 Legislation established that the reported data submitted by facilities & the boards to MDH are **classified as non-public**, except as required to complete the annual public report
- ★ The reports submitted electronically are also peer-review protected (145.64, Subd. 1)

What is required of MDH?

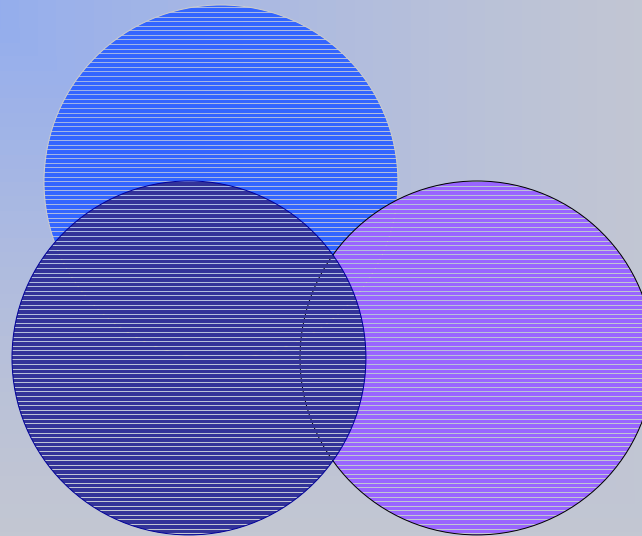
- ★ Track, assess and analyze incoming reports, findings and corrective action plans for thoroughness and appropriateness
- ★ Determine patterns of process and system weaknesses and successful methods to correct identified issues
- ★ Publish an annual report of events and corrective actions
- ★ Communicate with purchasers and the public about lessons learned to improve health care

What about the other regulatory responsibilities of MDH?

- ★ This is an **added requirement** above and beyond the existing state and federal regulatory requirements for health care facilities
- ★ Patients and families may always contact MDH regarding concerns with facilities and file complaints
- ★ The events in the criminal section of the adverse events reporting law must be reported to the appropriate authorities in addition to the adverse event report

Adverse events law in relation to other laws and requirements

State & Federal
Licensing & Complaints



VAA &
Maltreatment of Minors

AE Reports

Foundation for Success

- ★ Non-state funding secured
 - \$250k transferred or committed to date
 - Ongoing funding is included in the Governor's proposed budget for 2006-2007 biennium
- ★ Collaborative effort, strong foundation
- ★ Focus – to work on the problems and streamline solutions

JANUARY 2005

ADVERSE HEALTH EVENTS IN MINNESOTA HOSPITALS

FIRST ANNUAL PUBLIC REPORT



1st Public report

- ★ First report released on January 19, 2005
- ★ Provides background, context, state-wide aggregate information and hospital-specific information
- ★ Includes consumer tips
- ★ Entire “transition” period is covered in the first report (July 2003 – October 2004)
- ★ Full text can be found at:
www.minnesotahealthinfo.org
 - Over 10,000 copies downloaded

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This report can be found on the internet at: www.minnesotahealthinfo.org

For More Information Contact:
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marie.dotseth@health.state.mn.us

Upon request, this document can be made available in alternate formats,
such as large print or Braille.

Adverse event reporting in context

- ★ It is only ONE component of broad patient safety initiatives
- ★ Reporting will vary by factors other than the safety of the facility:
 - Awareness/training of staff
 - Size and complexity of the facility
 - Interpretation of reportable events
- ★ Increased awareness — among providers, purchasers, patients and families — is an important outcome

1st Public report -- Minnesota results

- ★ 99 events were reported by hospitals during the transition period from July 1, 2003 through October 6, 2004
- ★ These events are categorized as follows:
 - **Surgical – 52 events**
 - **Product or device – 4 events**
 - **Patient Protection – 2 events**
 - **Care Management – 31 events**
 - **Environmental – 9 events**
 - **Criminal – 1 event**

1st Public report -- Minnesota results

- The most frequently reported events were **foreign objects** left in patients after surgery
- The next most frequently reported event was stage 3 or 4 **pressure ulcers**
- Almost a third of the “Wrong Body Part Surgery” reports occurred in spine surgeries.
- Of the 99 events, 20 resulted in a death
- 8 of the deaths were associated with a **fall** in a hospital
- 4 of the deaths were due to a **medication error**

1st Public report -- Minnesota results

- ★ Hospital-specific corrective actions are outlined in the report
- ★ A number of community-wide collaborative responses have been developed as well, including:
 - MHA & “Safest in America” implementing measurable improvements in surgical processes
 - MAPS developing strategy for the prevention of pressure ulcers

Reaction

THE WALL STREET JOURNAL.

First State Hospital Report Card Is Issued --- In Tallying Medical Errors, Minnesota Hopes to Spur Improvements for Patients

- By Paul Davies, January 20, 2005

Reaction

- ★ Extensive media coverage locally & nationally
- ★ In general, hospital's worst fears did not materialize
 - Pressure in a couple of communities
- ★ Public happy to know that something was being done – good start...
- ★ Trial lawyers – not far enough

Challenges

★ 2nd Report

- What will the “*data*” show?
- Is there other information to inform this discussion?

★ Public expectation that we will move fast to fix identified problems

★ Growing expectation for transparency & information for patients

Challenges – IOM recommendation

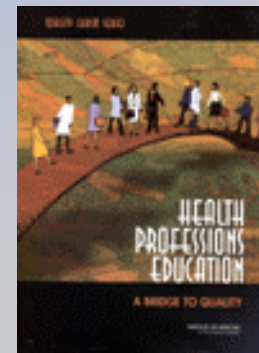
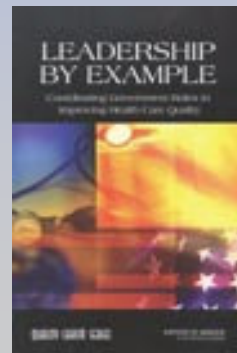
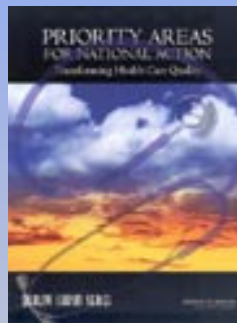
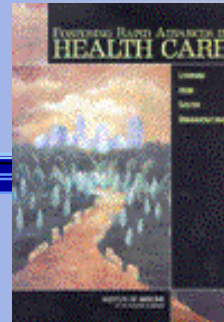
Patient Safety : Achieving a New Standard for Care, 2004

“Americans expect and deserve safe care. Improved information and data systems are needed to support efforts to make patient safety a standard of care...”

Challenges – IOM recommendation

“All health care organizations should establish comprehensive patient safety systems that:

- ★ Provide **immediate access** to complete patient information and **decision support** tools for clinicians and their patients.
- ★ Capture information on patient safety – including both adverse events and near misses – as a **by-product of care**, and use this information to design safer care delivery systems.”



Challenges - The big questions

- ★ How do we know the “problem” has been corrected?
- ★ Is the state/ facility/ public learning anything from the reports?
- ★ Is any of this making a difference?
 - How will we know?
 - How do we keep improving?
- ★ How do we work on these questions?
 - Patience? Trust?

For more information:

★ www.health.state.mn.us/patientsafety

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Patient Safety Registry

Julie Apold

Patient Safety Registry Manager
Minnesota Hospital Association



Patient Safety Registry

- Web-based reporting system
 - Developed using .net technology
 - Database is Microsoft SQL server
 - Secure encrypted connection
- Registry user established for each reporting facility or system
 - Read/Write Access
 - Ready Only Access
- Registry user provided with User Name and Password



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Password:

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Welcome pstest to the Patient Safety Registry

MHA's Patient Safety Registry aggregates safety event and medical error information from hospitals around the state in order to share existing safeguards, identify common safety issues and facilitate new collaborative solutions among hospitals.

By participating in the Registry, hospitals gain access to valuable information including benchmark reports, and key learnings and action steps from peer hospitals. This information will arm participating hospitals with better tools for making systemic safety improvements.

Beyond the benefits to any one facility, the Registry also promises to spark more statewide improvements. And with recent legislation, the state has identified the Registry as the best vehicle for hospitals to meet the Adverse Healthcare Event reporting requirements.

For assistance or general questions please contact Julie Apold at (651) 641-1121, toll free (800) 462-5393 or email at japold@mnhospitals.org.






Patient Safety Registry

Entered By: pctest

* = Required Items

[Live Help](#)

* Facility:	<input type="text" value="Minnesota Hospital Association"/>	* Event Date:	<input type="text"/>
* Event Discovery Date:	<input type="text"/>	Event Time:	<input type="text" value="..."/>
* Facility Internal ID: 	<input type="text"/>	* Patient Type:	<input type="text"/>
Describe the event in detail:	<input type="text"/>		
* Adverse Event Type : 	<input type="text"/>	* Injury Severity : 	<input type="text"/>
Immediate Action Taken:	<input type="text"/>		



Patient Safety Registry

Entered By: pstest

* = Required Items

[Live Help](#)

* Facility:

* Event Date:

* Event Discovery Date:

Event Time:

* Facility Internal ID:

* Patient Type:

Describe the event in detail:

* Adverse Event Type :

- Care Management - Wrong Blood Product
- Care Management - Wrong Blood Product
- Care Management - Maternal Labor
- Care Management - Hypoglycemia
- Care Management - Neonate Hyperbilirubinemia
- Care Management - Ulcers
- Care Management - Spinal
- Criminal - Impersonation
- Criminal - Abduction
- Criminal - Sexual Assault
- Criminal - Physical Assault
- Environmental - Electric Shock

* Injury Severity :

Immediate Action Taken:

Cancel

Save



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Entered By: pctest

* = Required Items

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* Facility:

* Event Date:

* Event Discovery Date:

Event Time:

* Facility Internal ID:

* Patient Type:

Describe the event in detail:

* Adverse Event Type :

* Injury Severity:

Immediate Action Taken:

- A-Potential
- B-Error but No Reach
- C-Reach but No Harm
- D-Monitoring Required
- E-Treatment Required
- Emotional
- F-Longer Stay Required
- G-Permanent Injury
- H-Near Death
- I-Death

Cancel



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* = Required Items

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* Facility:

* Event Date:

* Event Discovery Date:

Event Time:

* Facility Internal ID:

Describe the event in detail:

* Adverse Event Type :

Immediate Action Taken:

Cancel

Save

http://psr.mha-apps.com - Patient Safety Help - ...

Care Management - Wrong Blood Product

Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

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Human Factors-Communication(Step 1of 6)

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Click here for
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Measurement Strategy

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Save\Next



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Human Factors-Communication(Step 1of 6)

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High-risk assessment findings were not communicated to t

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Action


Patients at high-risk for pressure ulcers will be identified wi

Measurement Strategy

100% of patients identified as high-risk through the Brader checks by nursing staff.

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Human Factors-Communication

Human Factors/Communication: Questions that help assess issues related to communication, flow of information, and availability of information as needed. These questions also reveal the importance of communication in use of equipment and application of policy and procedure, unintended barriers to communication, and the organization's culture with regard to sharing information.

For example: A patient without an identifying bracelet is administered medication based on the nurse's memory of the patient's identity. The hospital has a policy requiring that wrist bracelets be checked before every dose of medicine, but because the dose is overdue, the nurse delivers the medicine without confirming the patient's identity.

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Human Factors-Communication(Step 1 of 6)

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Human Factors-Communication

1. Was the patient correctly identified?
2. Was information from various patient assessments shared and used by members of the treatment team on a timely basis?
If "No" -- This could be a Root Cause/Contributing Factor.
3. Did existing documentation provide a clear picture of the work-up, the treatment plan and the patient's response to treatment?
Including:
 - assessments
 - consultations
 - orders
 - treatment team notes
 - progress notes

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Beyond the benefits to any one facility, the Registry also promises to spark more statewide improvements. And with recent legislation, the state has identified the Registry as the best vehicle for hospitals to meet the Adverse Healthcare Event reporting requirements.

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Select only "Facility Internal ID" containing the text: [Filter](#)

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	Facility Internal ID	Event Date	Event Discover Date	Description
Event RCA/CAP	11-11	01/11/2005	01/12/2005	Patient fell from bed..
Event RCA/CAP	1555	01/03/2005	12/27/2004	Stage III Ulcer found at time of discharge.
Event RCA/CAP	5555	12/09/2004	12/17/2004	Surgery scheduled for right knee. Incision made on left knee before surgical nurse noticed the discrepancy. Incision closed and surgery performed on right knee.
Event RCA/CAP	445566	02/17/2005	02/07/2005	Patient slipped on ice while entering hospital
Event RCA/CAP	89	02/03/2005	02/07/2005	
Event RCA/CAP	1122334455667788	02/24/2005	02/16/2005	test event
Event RCA/CAP	121212121212	02/17/2005	02/19/2005	Test Event
Event RCA/CAP	abc	03/06/2005	03/07/2005	
Event RCA/CAP	abcdef	03/30/2005	04/01/2005	
Event RCA/CAP	1122q	04/04/2005	04/04/2005	Patient was prepped for wrong knee

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Human Factors-Communication(Step 1 of 6)

Facility Name: Minnesota Hospital Association

Entered By: *psTest*

[Click here for Category Definition](#) ?

[Click here for a list of contributing factors and key questions for this category.](#) ?

Was Human Factors-Communication a contributing factor? Yes

If yes, was this a root cause? Yes

If yes, briefly describe the root cause finding.

High-risk assessment findings were not communicated to the operating room staff.

Corrective Action Plan

If a root cause is identified above, describe the action that will be taken to reduce the risk of reoccurrence, the personnel responsible to implement the action, the date implemented and how the action will be measured.

Action

Patients at high-risk for pressure ulcers will be identified with a purple wrist band.

Measurement Strategy

100% of patients identified as high-risk through the Braden assessment will be wearing purple arm bands at monthly checks by nursing staff.

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Patient Safety Registry

Event Info

Event Discovery Date:	12/17/2004	Event Date:	12/9/2004
RCA/CAP Due Date:	2/15/2005	Event Time:	19:00
Facility Internal ID:	5555	Patient Type:	Outpatient
Describe the event in detail:	<i>Surgery scheduled for right knee. Incision made on left knee before surgical nurse noticed the discrepancy. Incision closed and surgery performed on right knee.</i>		
Adverse Event Type:	<i>Surgical.1.0</i>	Injury Severity:	<i>E-Treatment</i>
Immediate Action Taken:	<i>Surgery stopped and correct site verified. Patient notified of incident following recovery.</i>		

RCA/CAP Info

Category Type:	<i>Human Factors-Communication</i>
Root Cause Finding:	<i>Surgical team did not conduct a pause for the cause prior to beginning procedure.</i>
Corrective Action Plan:	<i>Pause for the cause will be conducted on 100% of cases.</i>
Measurement Strategy:	<i>A pause for the cause will be documented on 100% of cases audited for a 6 month period.</i>
Category Type:	<i>Rules/Policies/Procedures</i>
Root Cause Finding:	<i>The P&P for conducting a pause for the cause was not clearly written and communicated to surgical staff.</i>
Corrective Action Plan:	<i>The P&P outlining Pause for the Cause will be reviewed at each monthly staff meeting.</i>
Measurement Strategy:	<i>Review of P&P documented in meeting minutes each month for 6 months.</i>

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Select type of chart to create

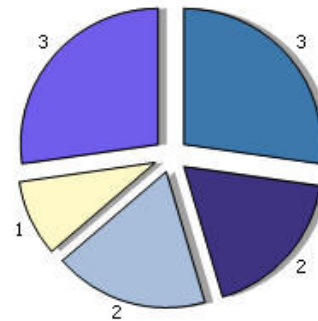
Top Percent Event Type Choose Event Type to view

Start Date:

End Date:

Create Chart

Top Events Chart - Dates: 5/7/2000 - 5/18/2005



- Care Management - Med Error
- Environmental - Fall
- Surgical - Wrong Body Part
- Care Management - Maternal Labor
- Other

