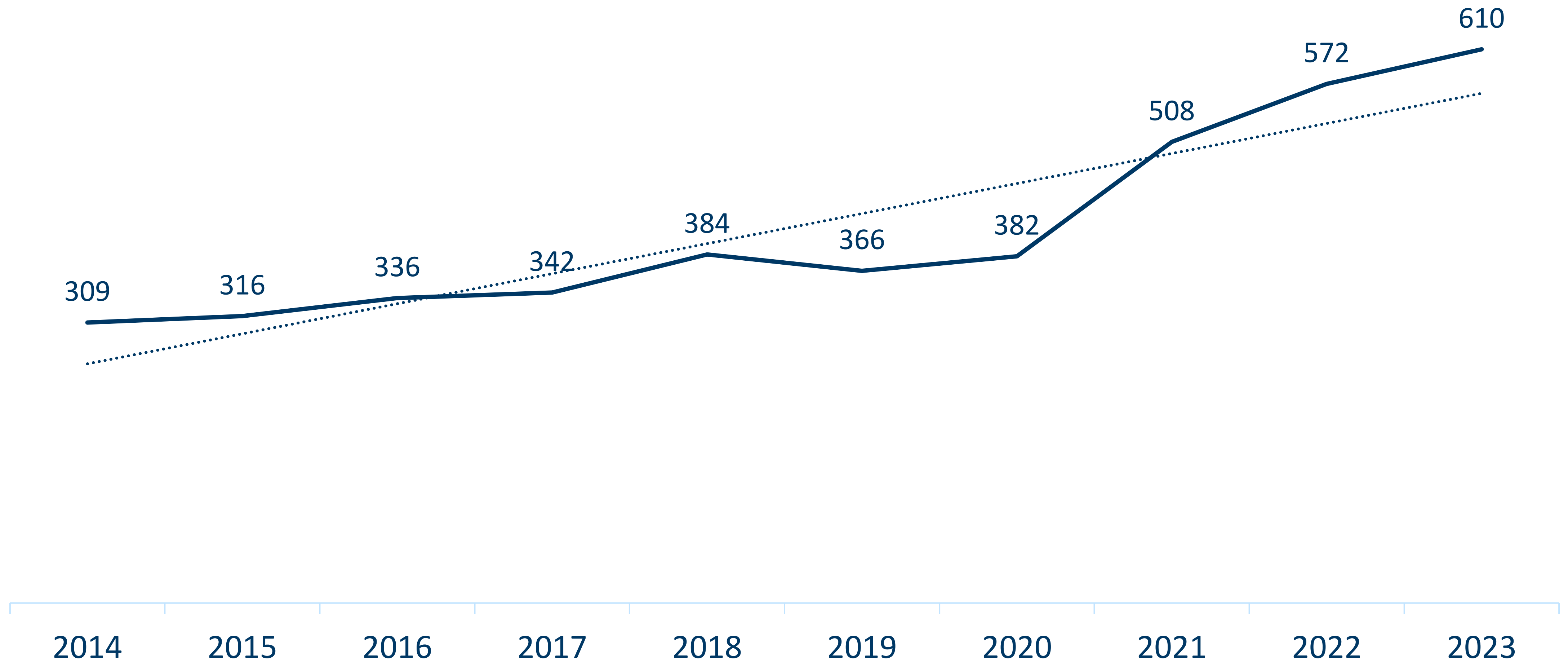
# Adverse Health Events Chartbook
May 2024

# Adverse Health Event Details

- In Minnesota, all hospitals and licensed ambulatory surgical centers are required to report whenever an adverse health event (AHE) occurs and to conduct a root cause analysis to identify the factors that led to the event.
  - Federal hospitals are excluded
- This chartbook covers the reporting period Oct 7th,2022-Oct 6th,2023
- For a list of reportable events see Minnesota's 29 Reportable Events (PDF)
- Facility level data is available on the MDH Adverse Health Events website

# Total Reported Adverse Health Events 2014-2023

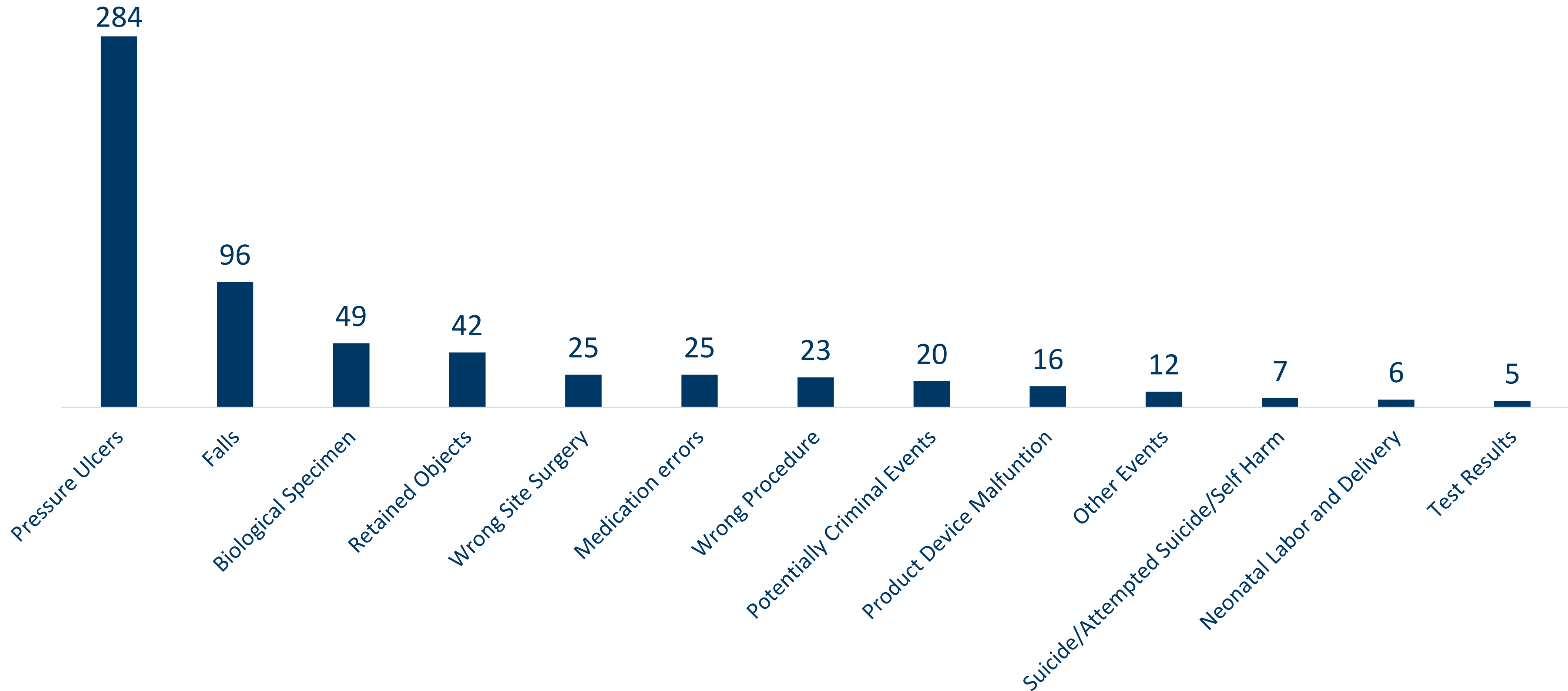



Note: During this reporting period, total inpatient & outpatient surgeries/procedures = 567,854

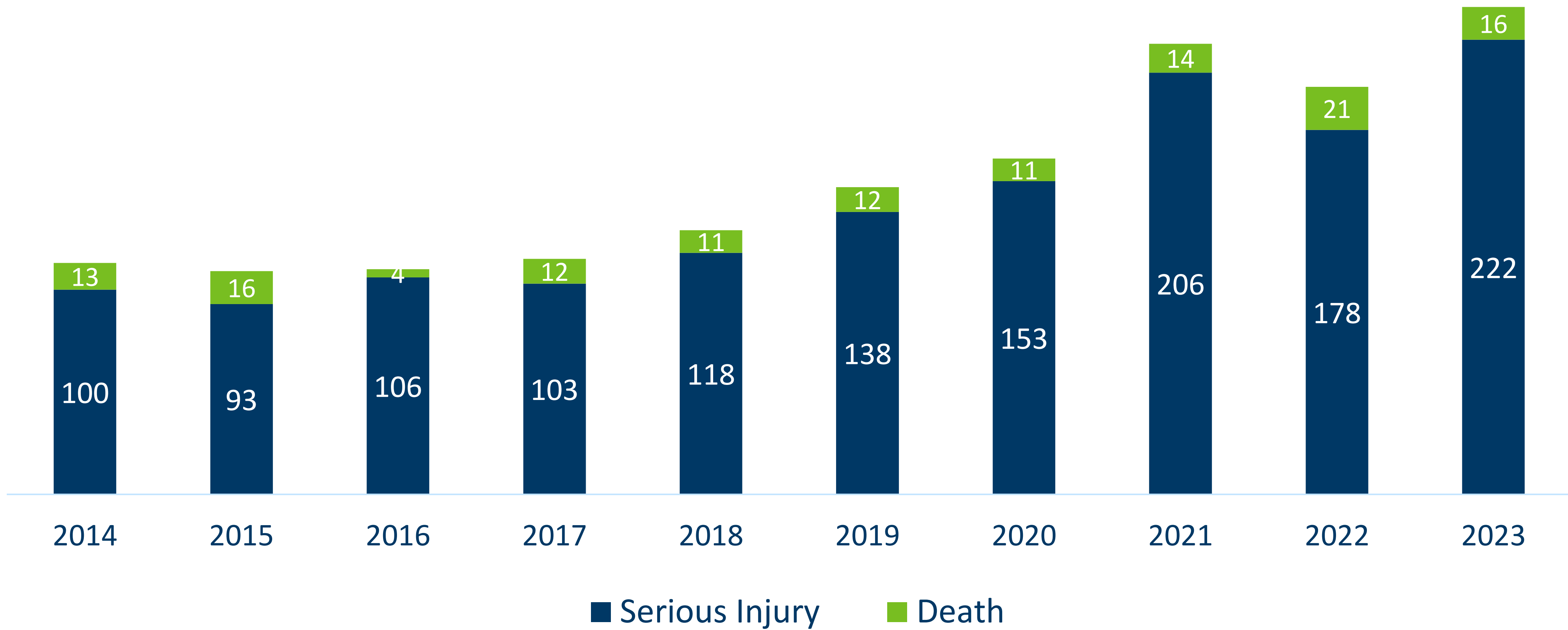
# Adverse Health Event Key Issues

- Key issues or themes for the year:
  - Increase in overall events (610 up from 572)
  - First decrease in wrong site surgeries since 2019
  - Pressure ulcers continue to be a challenge, and represent nearly half of all reported events
  - Continued increase in biological specimen events
  - Trend continues of longer length of stay post-Covid

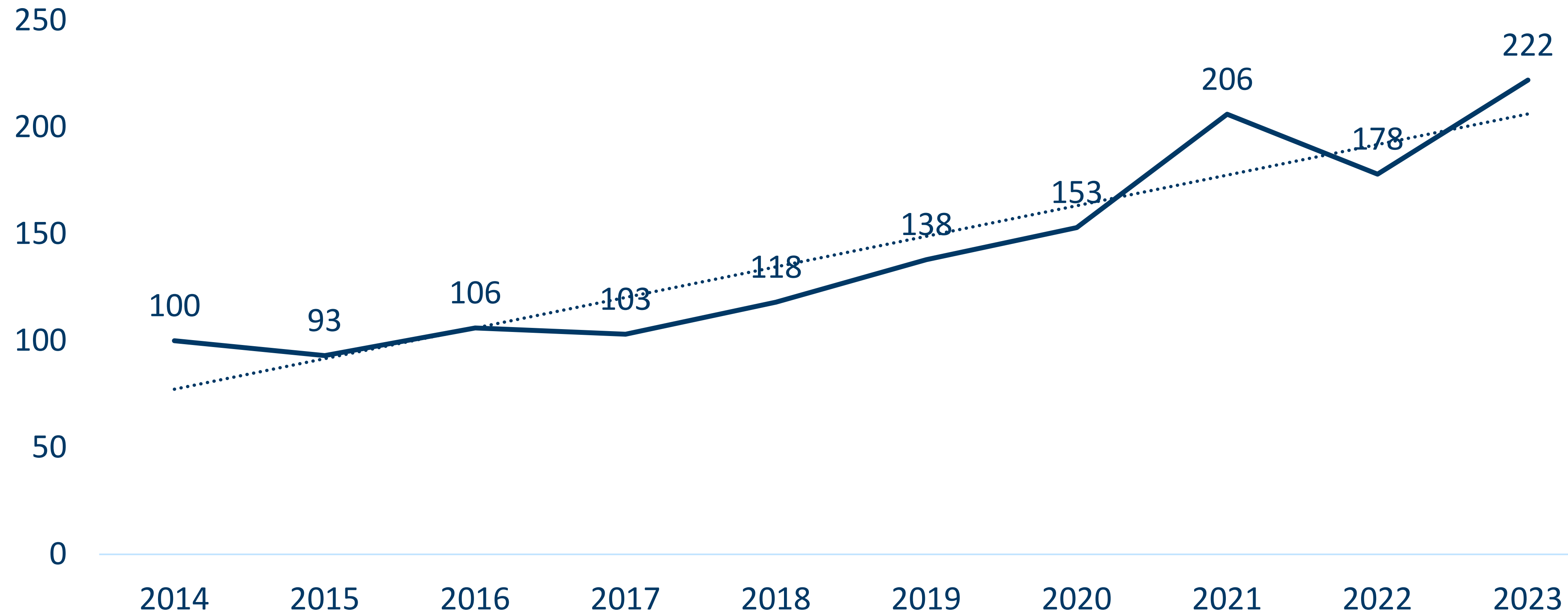
# Adverse Health Events by Category 2023



# AHE Injury Severity 2014-2023

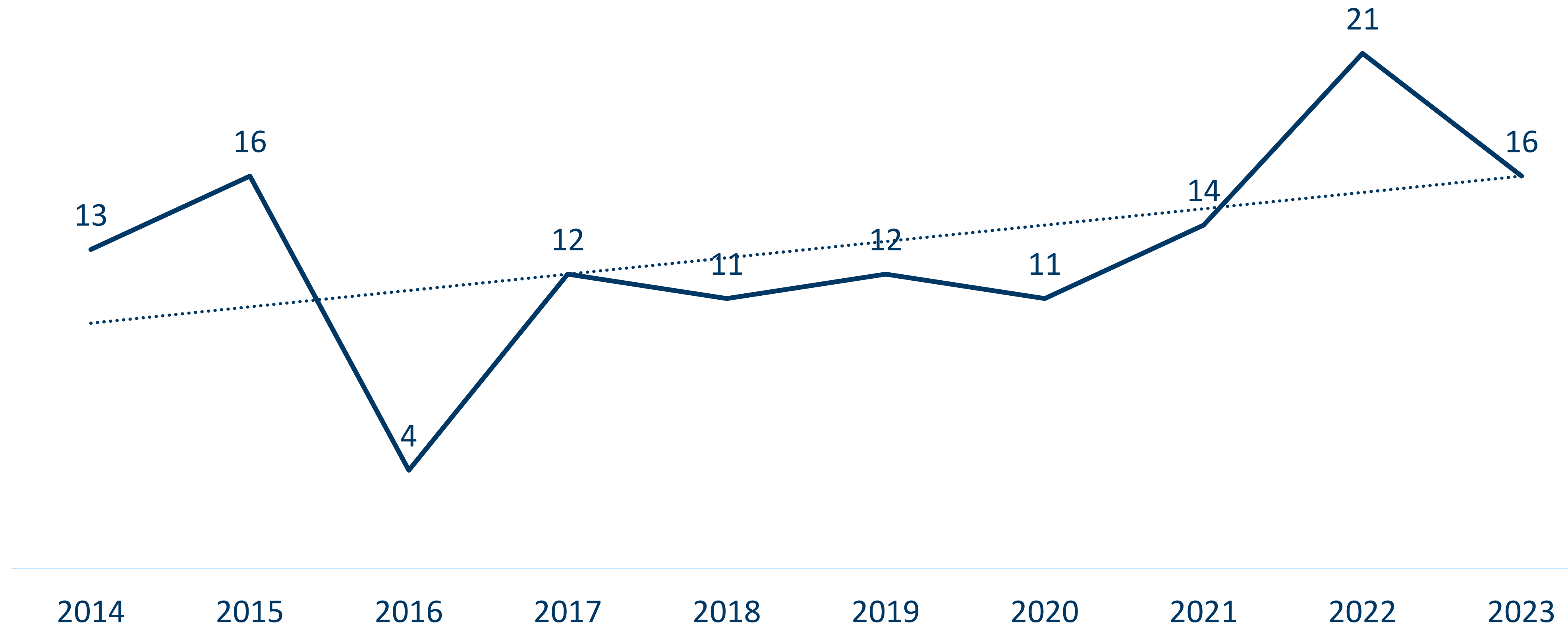


# AHE Resulting in Serious Injury 2004-2023



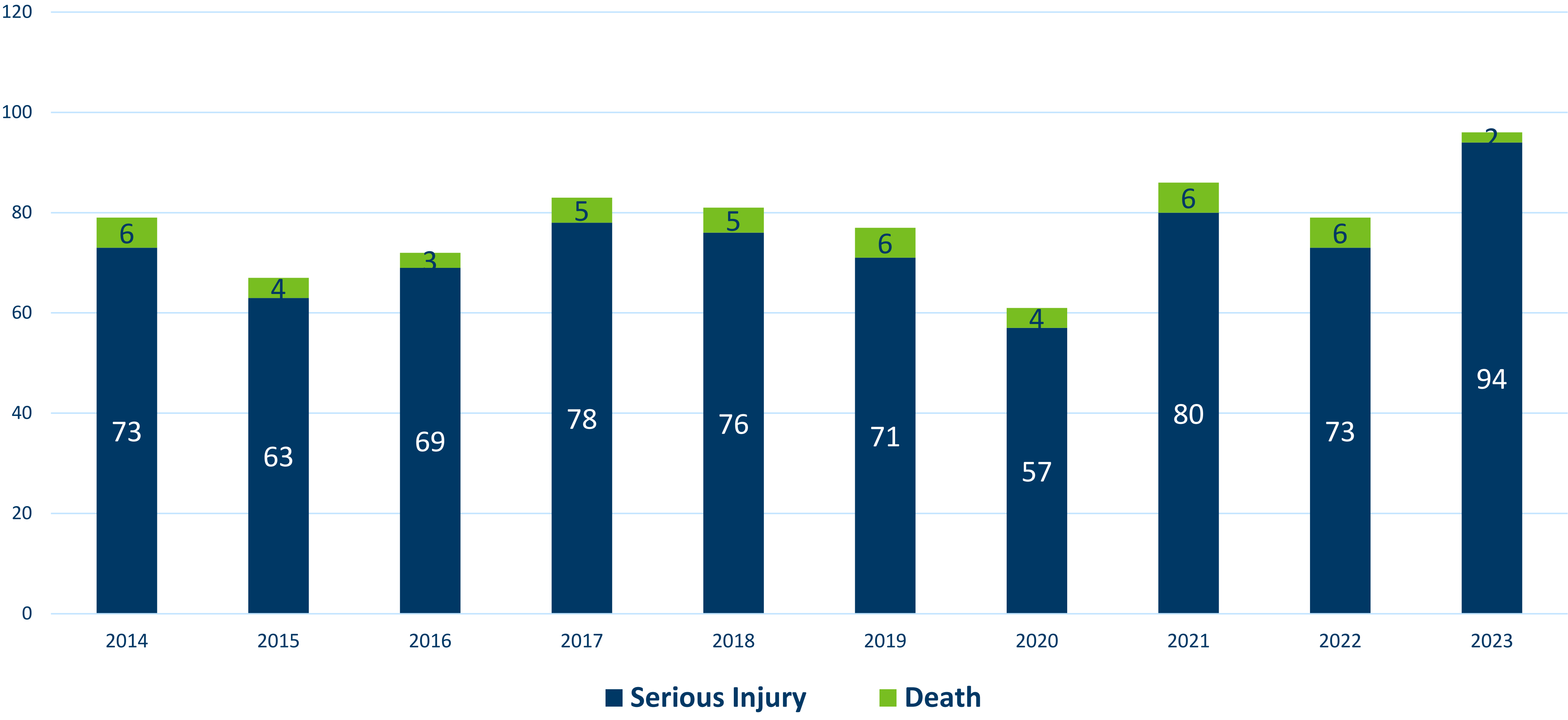

**Serious Injury Totals 2023**: Falls 94, Pressure Ulcers 33, Retained Foreign Object 22, Pressure Ulcer 22, Physical Assault 15, Product/Device Malfunction 13, Suicide/Attempted Suicide 6, Burn 5, Test Results 3, Wrong Body Part Procedure 2, Air Embolism 2, Other 5.

# AHE Resulting in Death 2014-2023

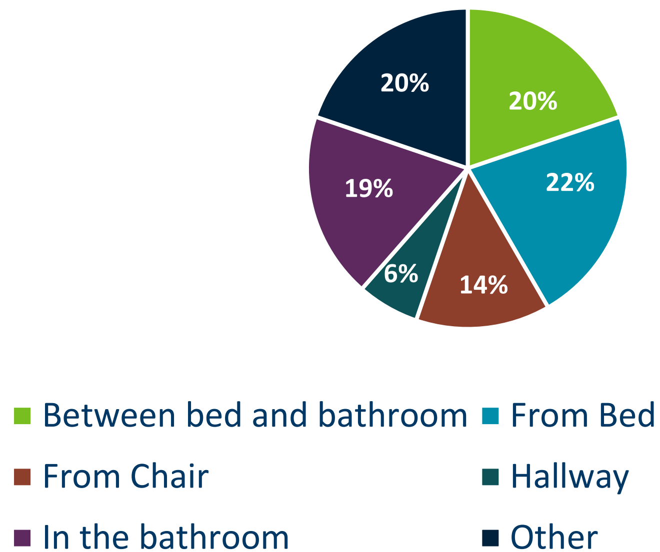



**Death totals 2023:** Neonatal Labor/Delivery 4, Product/Device Malfunction 3, Med Error 3, Test Results 2, Falls 2, Patient Suicide 1, Patient Elopement 1.

# Reported Falls 2014-2023



# Reported Falls
# Additional Information




Falls information:

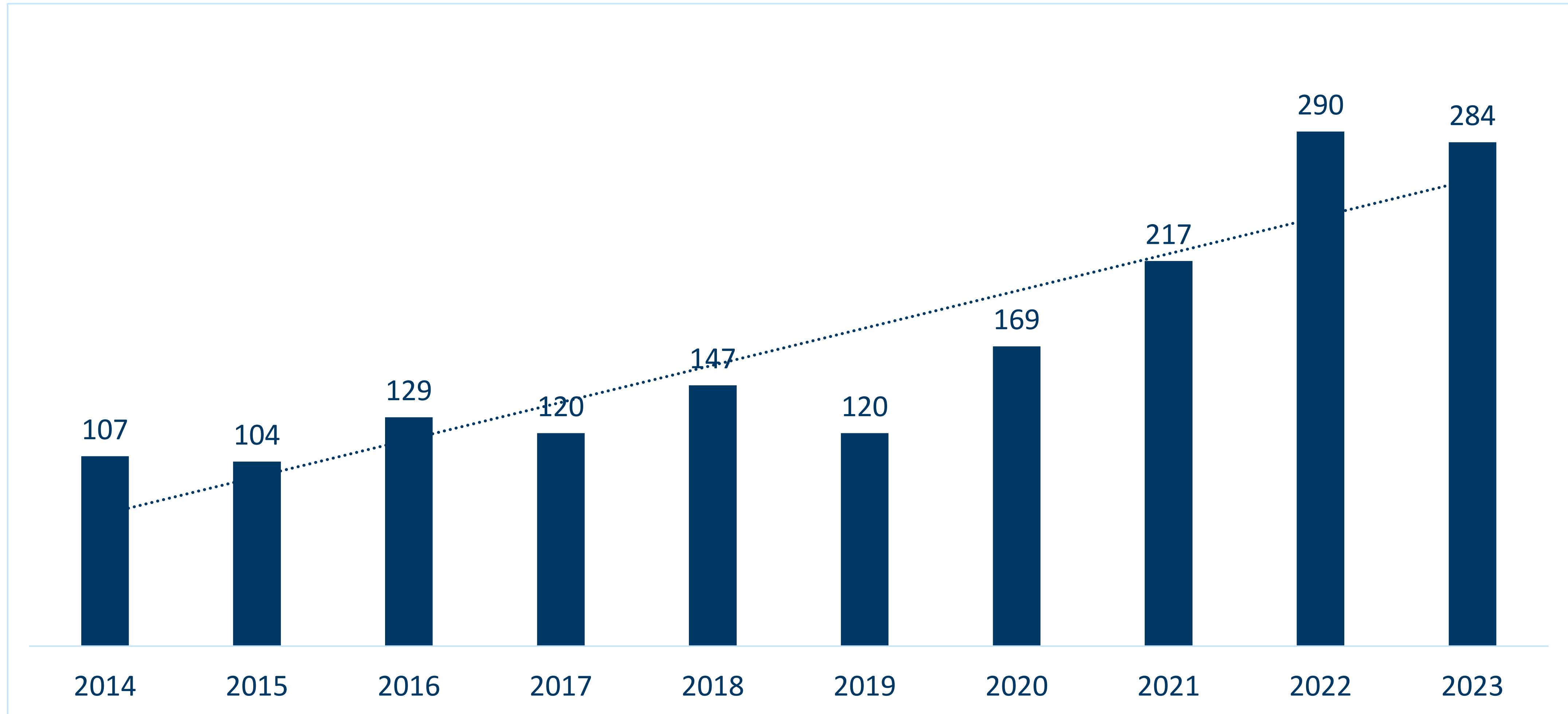
- 42% were toileting related falls
  - Of those falls, 76% were patients attempting to toilet unassisted for reasons such as privacy, overestimation of physical ability or urgency.
- 19% patient refused fall prevention measures

# Reported Falls
# Additional Information

## Commonly reported root causes/contributing factors:

- Longer patient stay resulting from inability to transfer patient to next level of care (due to bed availability)
- Patient’s desire for privacy vs. staff staying within arms reach during toileting
- Equipment availability (lifts, floor mats, chair alarms)
- Lack of sensitivity of fall risk assessment for special situations

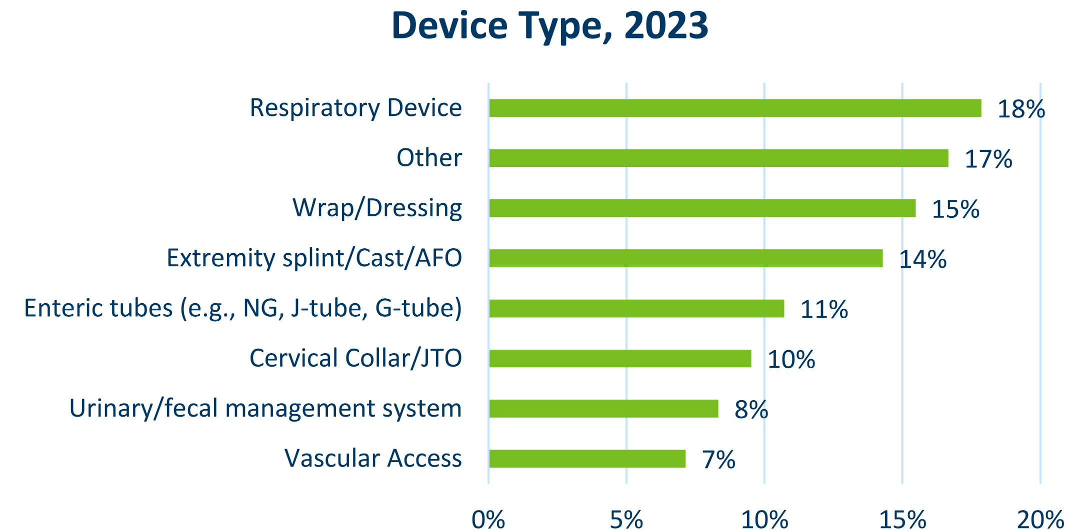
# Reported Pressure Ulcers 2014-2023



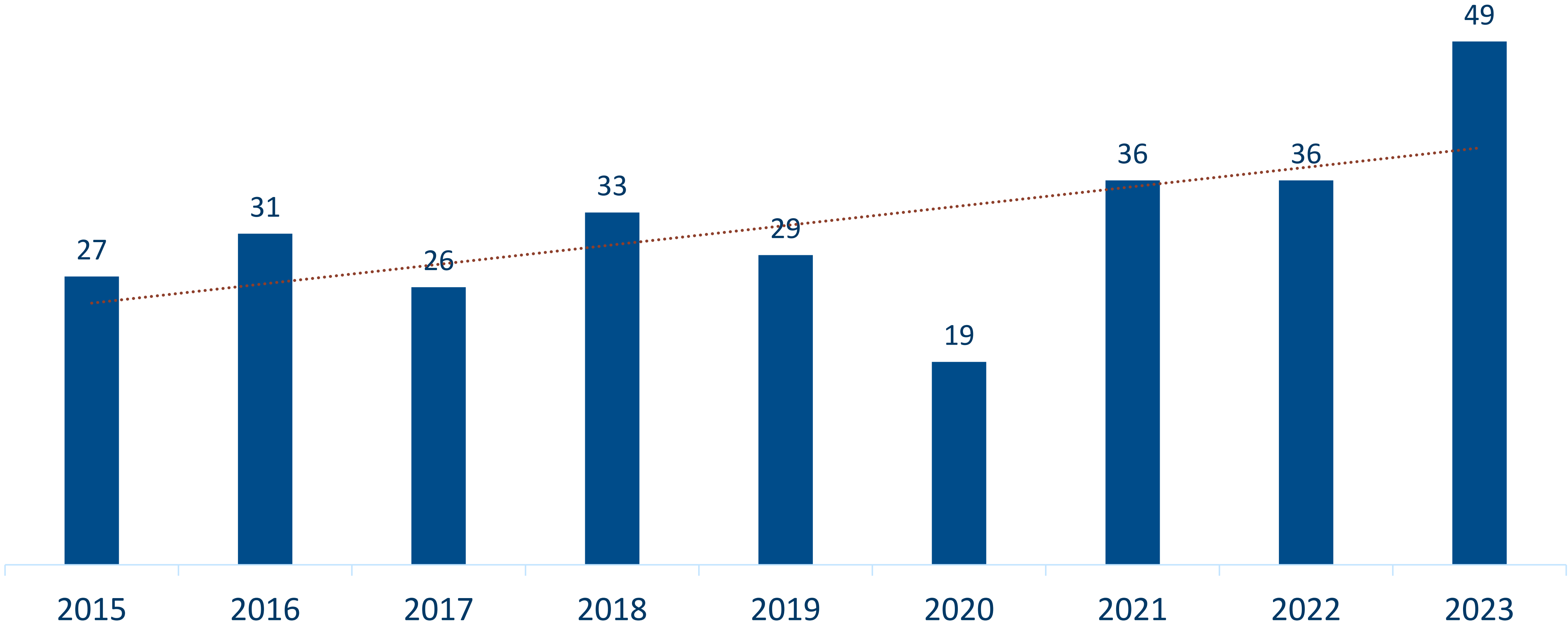
# Reported Pressure Ulcers Additional Information

- Pressure ulcer injury severity
  - Treatment required 62%
  - Monitoring required 25%
  - Serious injury 13%
- Most common areas of pressure ulcer development
  - Coccyx
  - Sacrum
  - Heel/feet

- Thirty percent of reported pressure ulcers were related to medical devices



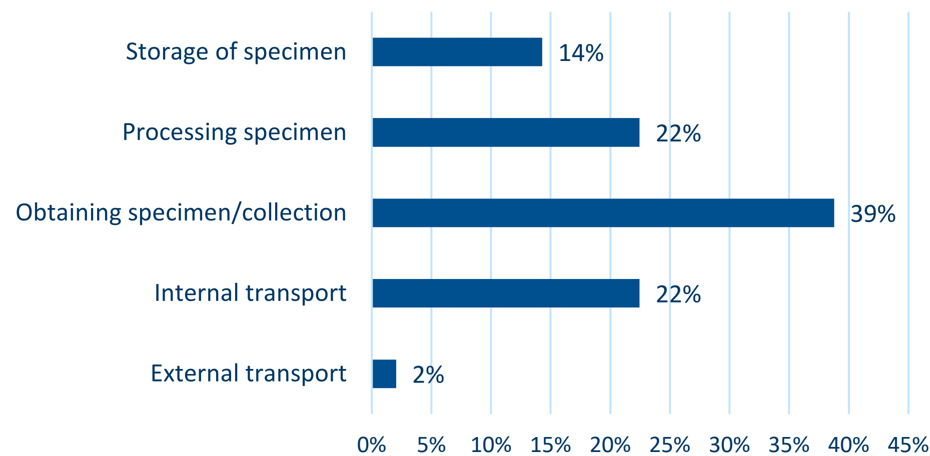
# Reported Biological Specimen Events 2015-2023

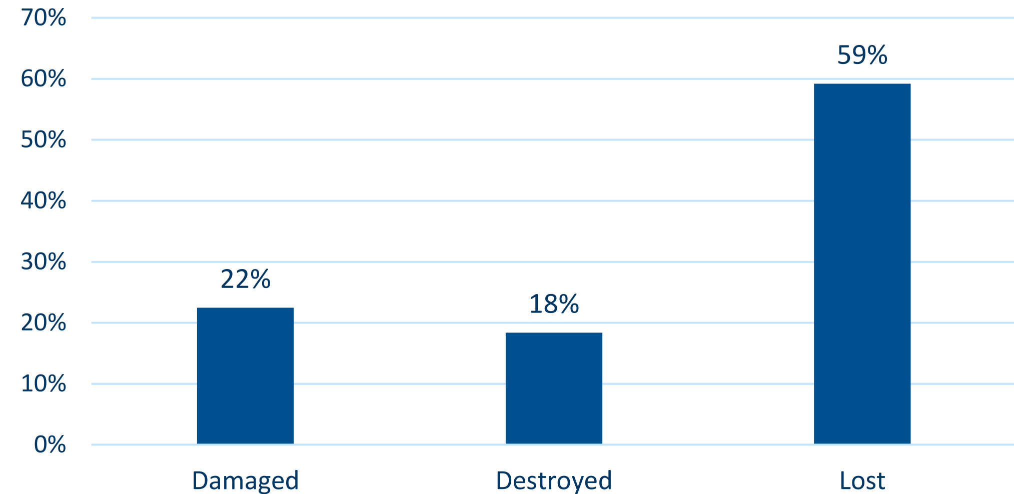



*Note: This event was reportable starting in 2015.*

# Reported Biological Specimen Events Additional Information

Most common type of lost/destroyed specimen: placentas and colon polyps



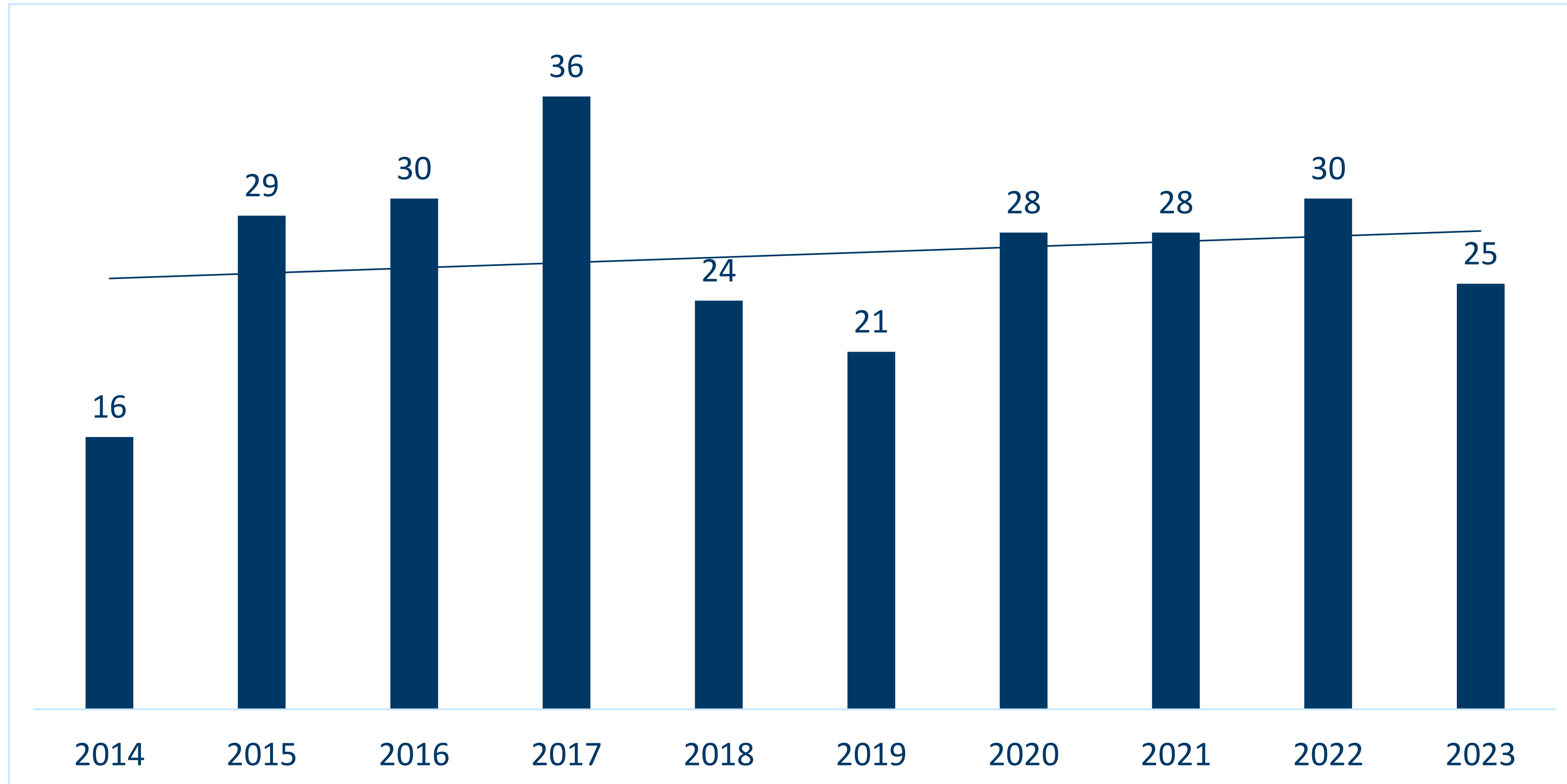



# Reported Biological Specimen Events Additional Information

## Commonly reported root causes/contributing factors

- Lack of post-procedure debrief
- Lack of defined storage area for specimens prior to transport to lab
- No direct handoff from procedure staff to lab staff
- Loss of specimen due to placement in the incorrect medium
- Issues with locating specimen orders in the EHR

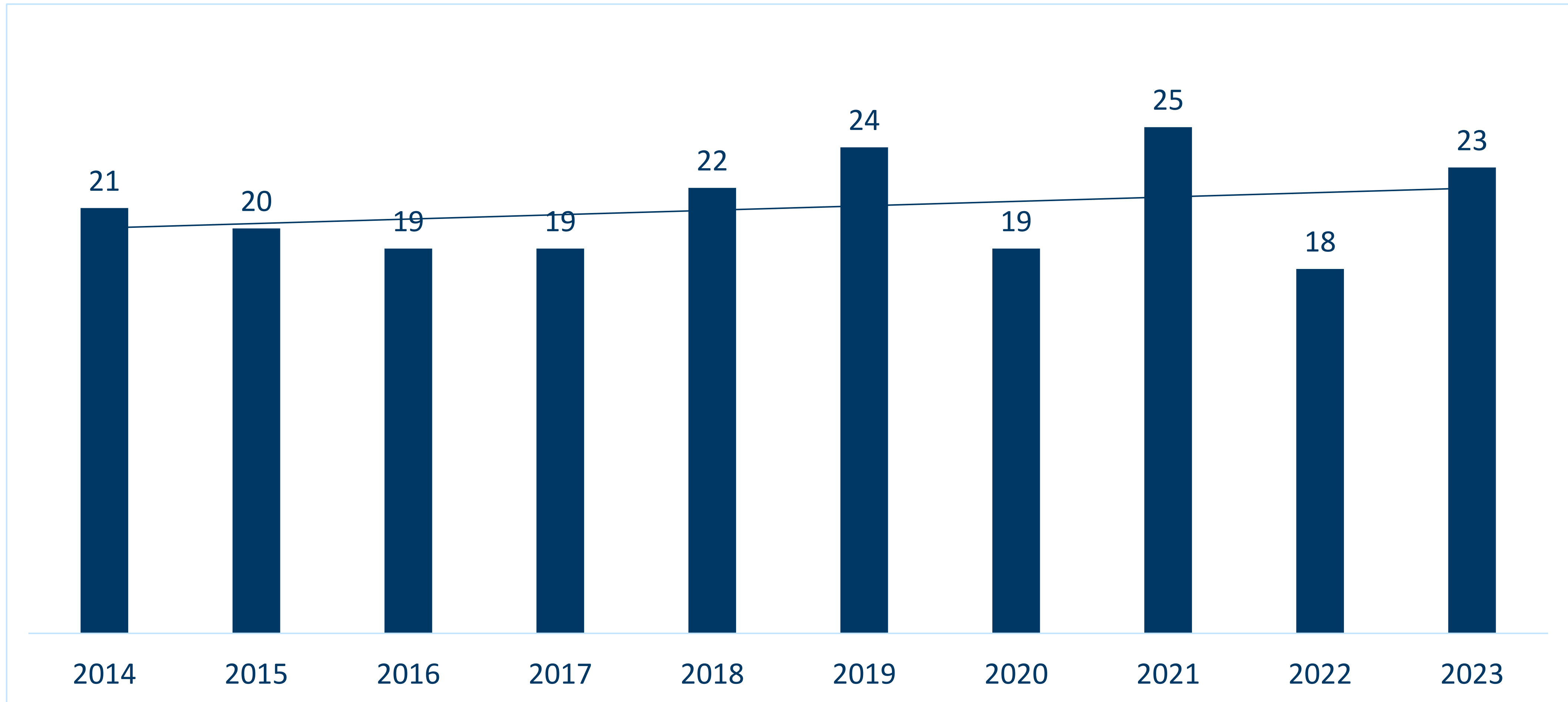
# Wrong Body Part Procedure Events 2014-2023



# Wrong Body Part Procedure Events Additional Information

- Definition of wrong body part surgery/procedure:
  - Surgery or other invasive procedure performed on a wrong body part that is not consistent with the documented informed consent for that patient.
- Most common types of wrong body part procedures:
  - Wrong side (e.g. left vs. right)
  - Spine
  - Orthopedic
  - Urology

# Wrong Procedure Events 2014-2023



# Wrong Procedure Events Additional Information

- Definition of wrong procedure:
  - The wrong surgical or other invasive procedure performed on a patient that is not consistent with the documented informed consent for that patient.

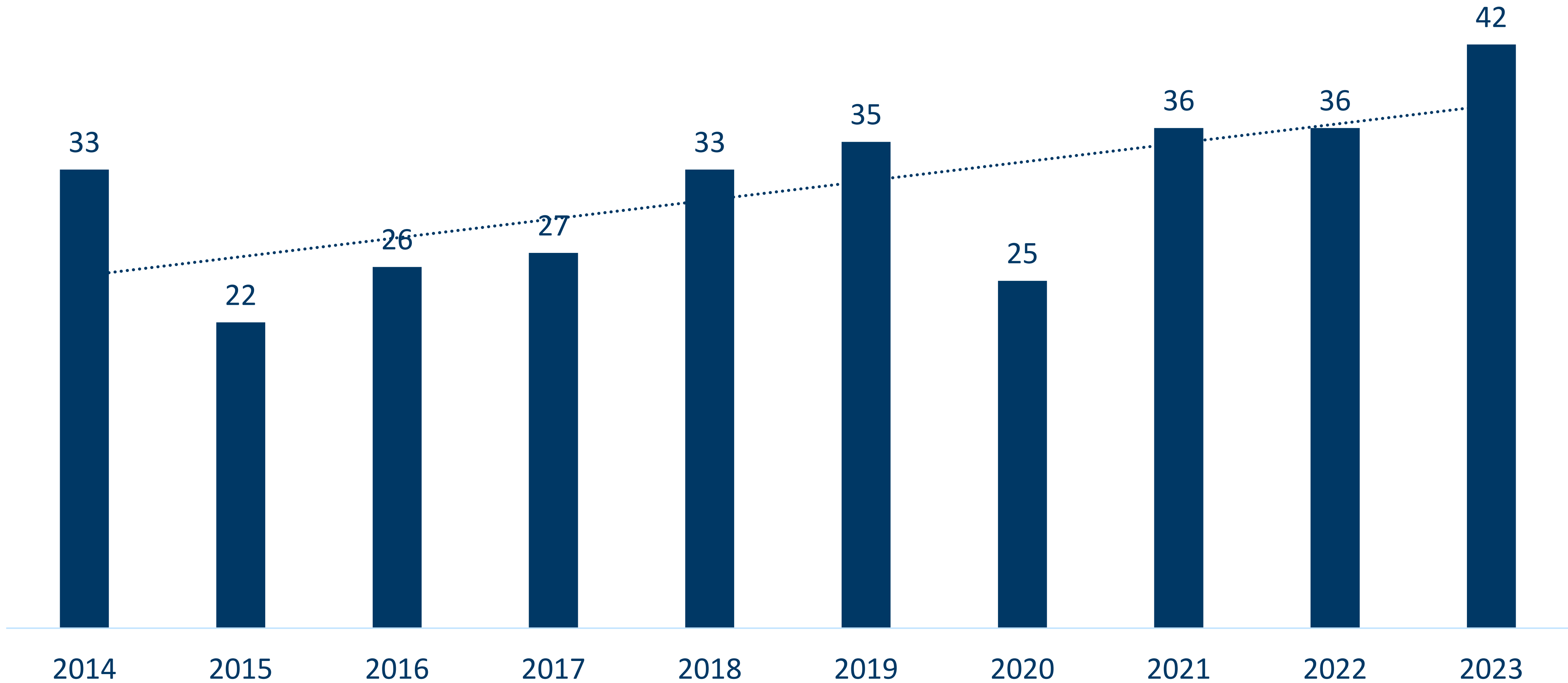
- Most Common types of reported wrong procedure events:
  - Eye procedures (incorrect implant placed)
  - Orthopedics
  - Gynecology

# Wrong Body Part/Wrong Procedure

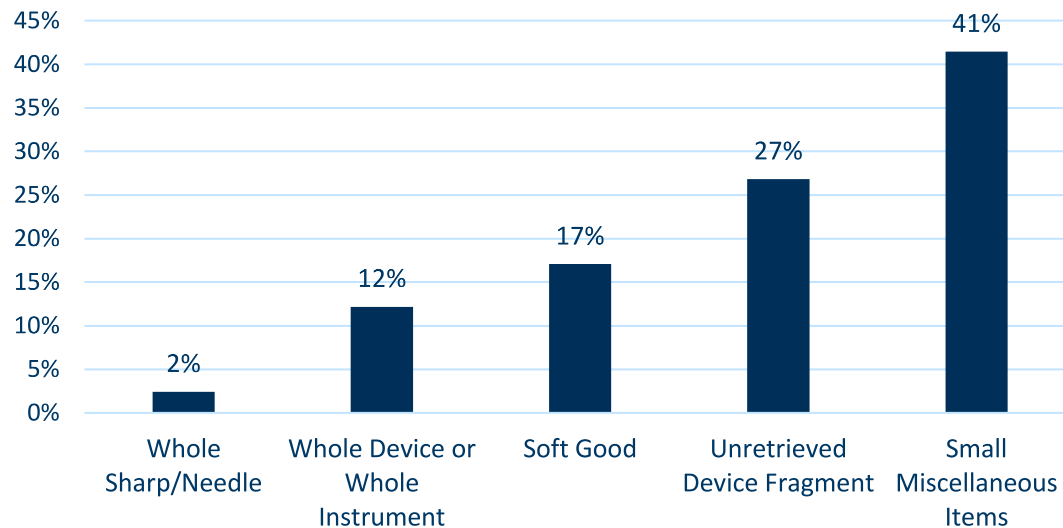
## Commonly reported root causes/contributing factors:

- Drift in Time Out rigor
  - Site mark not visualized
  - Laterality not confirmed
  - Lack of proper source documents
- Multiple procedures on same patient with different staff in and out of room
- Procedure not consistent with consent form
- Pressure to prioritize productivity

# Retained Foreign Objects 2014-2023



# Retained Foreign Objects Additional Information




## Trends/Patterns

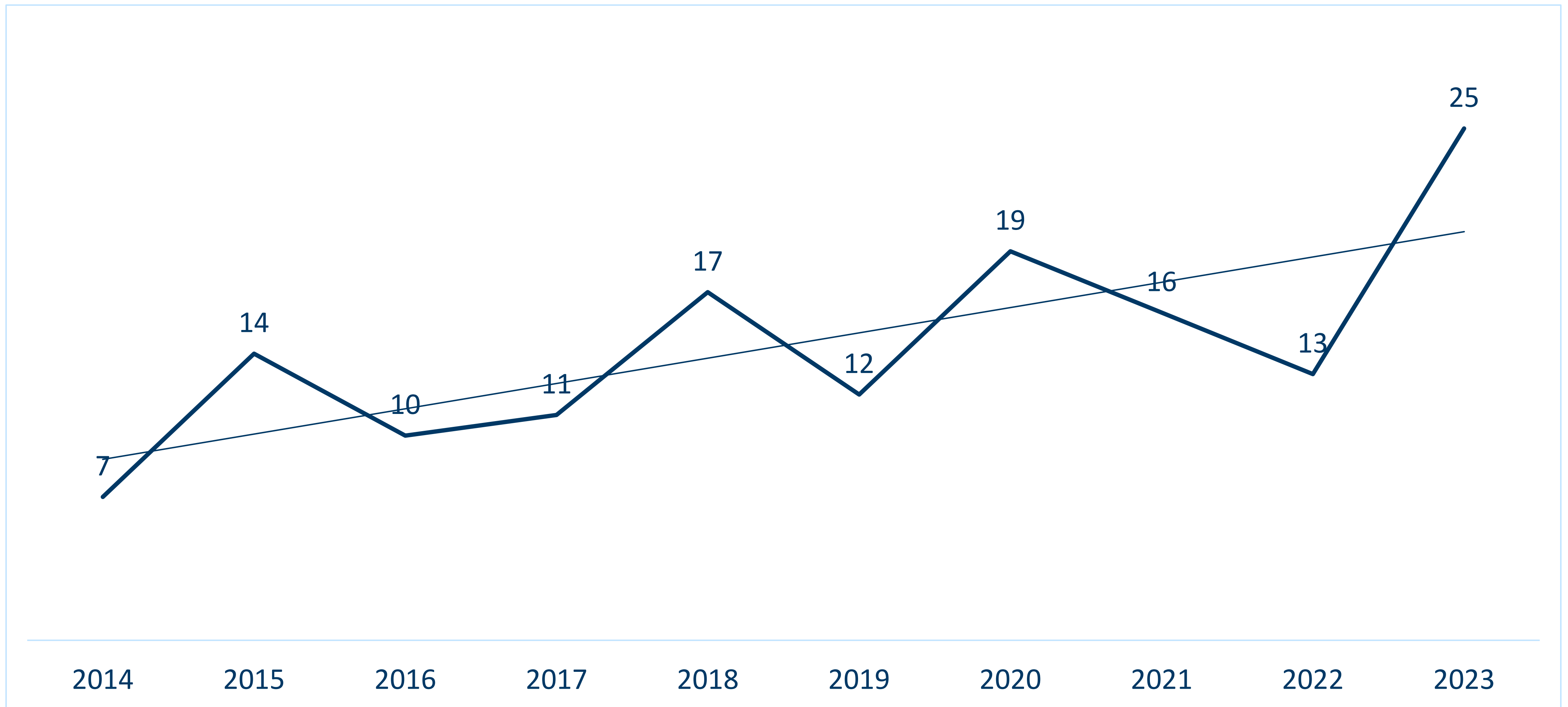
- Patient type
  - 64% inpatient
  - 34% outpatient
  - 2% observation status
- 29% were packed items intended to be removed at a later time but not removed as intended
- 32% broken items

# Retained Foreign Objects Additional Information

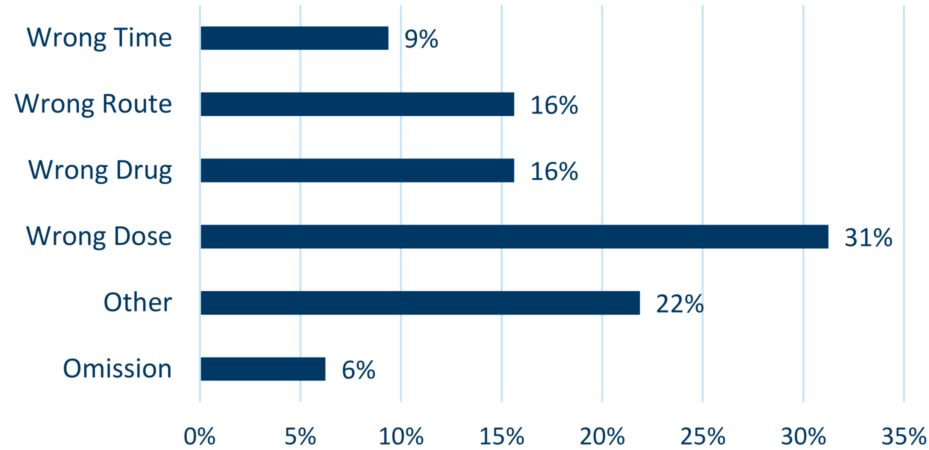
## Commonly reported root causes/contributing factors:

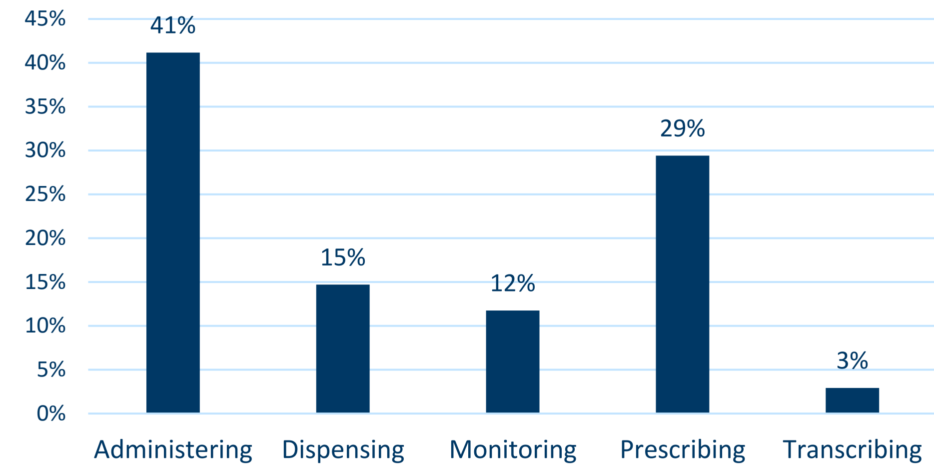
- Drift in rigor for the count of items
- Staff changeover during procedure
- Missing packed items that were intended to be removed after the procedure and before discharge
    - Communication breakdown between staff
    - Missing orders to remove packing or other devices

# Reported Medication Errors 2014-2023



# Medication Errors Additional Information



# Next Steps

- In the upcoming year, MDH will work with its partners to:
  - Work with reporting facilities on implementing best practices around specimen handling
  - Provide in-person and webinar training on a variety of patient safety topics
  - Continue Phase II of the Adverse Health Events Evolution Project to potentially make changes to the system to increase patient safety in MN
  - Work with reporting facilities around adherence to best practices for reducing pressure ulcers and falls
  - Work with the MHA Surgery Committee to identify trends and patterns around surgical events and put best practices in place to prevent events in the future

# Additional Information from the Adverse Health Events Program Available Online

- **Adverse Health Events Homepage**

(https://www.health.state.mn.us/facilities/patientsafety/adverseevents/index.html)

- **Searchable Database for Facility Specific Data**

Adverse Health Events Reporting - MN Dept. of Health (state.mn.us)

- **List of Minnesota's 29 Reportable Events**

(https://www.health.state.mn.us/facilities/patientsafety/adverseevents/adverseevents.html)