

Adverse Health Events Reporting in Minnesota: First Annual Public Report

Background

It has been five years since the Institute of Medicine (IOM) released its landmark report "To Err is Human". This report introduced many Americans to the idea that medical errors in hospitals kill between 44,000 and 98,000 people each year, making medical errors the 8th leading cause of death in this country.

The report helped to confirm that most of the medical errors were not the result of the actions of any one provider of care, but that most of these errors resulted from a failure of the complex systems and processes in health care.

In Minnesota our health care leaders embraced the notion that one serious medical error is one too many and that broad system changes were needed to make health care safer. With that conviction in mind, a coalition of Minnesota hospitals, doctors, nurses and patient advocates supported the legislation creating Minnesota's Adverse Health Event Reporting Law during the 2003 legislative session.

This law requires that hospitals disclose when any of the 27 serious events defined in the law occur and requires the Minnesota Department of Health (MDH) to publish reports of the events by facility, along with a summary of the corrections implemented by hospitals.

MDH has released the first annual public report on preventable adverse events in Minnesota hospitals. This report summarizes completed event reports that hospitals have submitted during the transition period of the law, from July 2003 to October 2004.

What is included in the report?

- Background information on the Minnesota reporting law,
- Safety tips and resources for patients and consumers,
- Information about the reported events for each hospital, and
- A summary of the actions put in place by hospitals to prevent future events.

Summary of reported events:

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

Which serious events are reportable?

Examples of incidents that must be reported include wrong-site surgery, retention of a foreign object in a patient after surgery, and death or serious disability associated with medication error. A full list of the 27 reportable events is included in the report.



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Why these events?

One of the principle recommendations in the original IOM report was to create a mandatory reporting system for the most serious errors.

In response to the IOM's recommendation, a national health policy group, the National Quality Forum (NQF), developed a broad consensus around a specific, targeted list of events that should never happen to patients in hospitals. This list, which started as the "never events" list, evolved into the 27 Serious Reportable Events in Healthcare published by NQF in 2002. Minnesota is the first state to fully adopt the standards established by NQF for reporting medical errors.

What is being done about the events included in this report?

Minnesota's hospitals are already implementing a variety of proven strategies for preventing many types of errors. Such strategies include developing new ways to track objects used in surgical procedures, improving how patients are assessed for the risk of falling, regularly re-positioning patients at risk of pressure sores, and adding special labels to high-risk medications.

The law requires hospitals to do a detailed analysis of why an event occurred and to report the findings of this analysis (called a "root cause analysis") into the electronic registry. In addition, hospitals must report the actions that were put in place to prevent future events.

The full report includes summaries of the corrective actions individual hospitals have implemented along with some collaborative initiatives designed for broad implementation at several hospitals.

How should consumers use this report?

This report should be used as a guide to increase awareness of safety issues. Patients and families should ask questions and take action based on issues of concern to them. If

hospitals have implemented corrective actions and prevention strategies regarding adverse events, patients and families should ask how they can support and reinforce these efforts.

The events listed in this report represent a very small fraction of all of the procedures and admissions in Minnesota's hospitals. With relatively low occurrence of these serious events, it is important to be aware that differences in reports between facilities can come from differences in reporting procedures or differences in interpretation or understanding of the law as much as from differences in the quality or safety of a hospital.

What about the other regulatory responsibilities of MDH?

The adverse event reporting law 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. Reports to provider-licensing boards will be acted on according to the laws regulating providers in Minnesota. The events that are categorized under the criminal section of the adverse events reporting law must be reported to the appropriate authorities in addition to the adverse event report.

The new adverse event reporting law and existing regulatory processes function in a complementary manner to provide patients and families with a system for accountability and a system for learning and prevention.

For more information:

The full report can be found on the Internet at: www.minnesotahealthinfo.org

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