Patient Safety: Adverse Health Events

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Patient Safety Catalyst

“Each year more than one million people in the U.S. suffer from preventable medical injuries and 100,000 die from them.”

_Institute of Medicine (IOM)_
_“To Err is Human’ 1999_

The Case for making Patient Safety a top priority

- 22% of Households (over 8 million) experienced a Serious Medication or Medical Error
- 8th Leading Cause of Death
- 2.9-3.7% of all hospitalized patients experience adverse events
- Patients with event found to have 59% increase in LOS(4 days) and 38% increase in costs ($2,349)
- In Minnesota, January’s 7th adverse event public report marked the 100th patient death
Brief History Minnesota’s Adverse health Event Reporting Law

- 1st state in the nation to champion an adverse event reporting system based on the National Quality Forum 28 Serious Reportable Events
- AHE Law went into effect July 2003
- Annual public report listed by hospital
- Goal is not about numbers, rather sharing of learning and prevention efforts
- What is reportable?
  - Description of the event must be reported within 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

Swiss Cheese Model

Adverse Health Event Key Findings

- Consistently top four reported events:
  - Wrong Site Procedure
  - Retained Foreign Objects
  - Falls
  - Pressure Ulcers
- 2006, MHA Board endorsed statewide calls-to-action on top four event types
- 2010 Wrong site surgery safety alert issued
- 2011 Launched time-out campaign
Why is the Campaign Necessary?

- Reports of adverse events involving procedures performed on the wrong site/side/level have been increasing in Minnesota.
- Last year, 66% of wrong site procedures were on the wrong side (right vs. left).

Minnesota Safe Surgery Coalition

- Coalition Goal: Eliminate Wrong Site, Wrong Procedure and Wrong Patient Events within 3 Years.
- Members
  - Minnesota Hospital Association
  - Minnesota Department of Health
  - Minnesota Medical Association
  - Minnesota Medical Group Management Association
  - MMIC Group
- 117 Participants
Call to Action for Physicians and Staff

- All steps of the Time Out must be conducted before every invasive procedure for every patient, every time.

Progress on Calls to Action

Leadership’s Role

- Patient safety/quality is in mission and goals
- Patient safety is a standing board agenda item
- Patient stories shared at board meetings
- Board level safety/quality committee
- Executive walk-arounds