Consumer Guide to
Adverse Health Events

January, 2008
Adverse Health Events

Background
In 2003, Minnesota passed a law that tells hospitals, community behavioral health hospitals, and outpatient surgical centers to report whenever one of 27 serious events happens. These serious adverse events are things that should never happen. They include falls that are linked with a patient’s death, leaving something in someone’s body after surgery, and surgery on the wrong person or part of the body. We have to find out why these “never events” happen. That’s the best way to stop them from happening again.

The Minnesota Department of Health works to learn as much as we can from every event. We share that information with hospitals, doctors, and nurses, so they can learn and make changes, too.

Current Adverse Events Information
125 events were reported to the Minnesota Department of Health between October 2006 and October 2007. This guide tells you where these events happened.

Consumer Guide
The information in this guide is very important. You can use it to learn about questions you should ask to make sure you get the best care. You can also learn about the things that hospitals and surgical centers should do to keep you safe. The last page of this report lists websites you can visit to find even more information to help you make good choices.

Minnesota has some of the best hospitals, doctors, nurses and other health care workers in the country. But we all still need to pay attention to patient safety. Fixing the causes of adverse health events will take a long time. It will take work by many people, including patients and families. But we know that this reporting system is an important step. By learning from mistakes and making sure that patients, doctors, nurses, and others are speaking up about risks they see, we can make our health care even safer.

In this report, you can find a list showing the number of adverse events reported by each hospital, community behavioral health hospital and surgical center. For more information on events at a specific facility, go to www.health.state.mn.us/patientsafety
Why does this information matter to me?

If you are sick, need to see a doctor, or need surgery, you want to know that you will get the very best care. It’s important to ask questions and read information to find the best and safest care. This report can help you with one part of that research.

**Serious adverse events are very, very rare.** The odds of one of them happening to you or someone you love are very small. But it’s still good for you to know about them and where they happen. With this information, you can ask questions. If you read about something that happened at a hospital, and you’re worried that something similar might happen to you, you can ask what they are doing to make sure the problem won’t happen again or happen at that hospital.

Some people might want to use this information to compare hospitals. But it’s not useful to compare hospitals using these numbers. You might see more events at one facility because it is working very hard to find problems and fix them. So a bigger number might mean that a facility is safer, not less safe.

That’s why it’s important to use this as just one piece of your research puzzle. This guide tells about some of the other information that’s out there, and our Minnesota State Health Department website can also link you to other sources of information. You can also be on the lookout for the things that doctors, nurses, and others do to keep you safe. Keep reading to learn more.

What kinds of things have to be reported?

This report gives you important information about patient safety. But it only covers certain kinds of events. Things like missed or incorrect diagnoses, wrong treatments, and infections aren’t included. Hospitals only report the events on this list:

- Surgery on the wrong body part or the wrong patient, or performing the wrong surgery or procedure on a patient
- Leaving an object in someone after surgery or an invasive procedure
- Death of a healthy person during surgery or right after surgery
- Death/serious harm from a drug error or from getting the wrong kind of blood
- Death/serious harm during labor or delivery in a low-risk pregnancy
- Death/serious harm from low blood sugar
- Death/serious harm from jaundice in newborns
- Death/serious harm from spinal manipulation
- Very serious bed sores
- Death/serious harm from contaminated drugs or devices, or from a device that doesn’t work right
- Death/serious harm from air in a vein
- Death/serious harm from an electric shock or a burn while in the hospital
- Death/serious harm from the use or lack of restraints or bedrails
- Death from a fall in the hospital
- Any time when a patient gets the wrong gas or contaminated gas
- A baby is discharged to the wrong person
- Death/serious harm after a patient disappears from a facility
- Suicide, or attempted suicide that leads to serious harm
• Someone pretends to be a doctor, nurse, or other provider
• Abduction of a patient
• Sexual assault on a patient
• Death/serious harm from physical assault

How is this system making health care safer?
The most important part of this report is not how many adverse events happened at one hospital or another. What’s most important is what we’re learning about why these events happened. Learning about what caused these events is the only way to keep them from happening again.

Because of what we have learned through this law, hospitals, surgical centers, and behavioral health hospitals are making many changes in how they provide care. These changes will make health care safer for all patients. Below are some examples of changes that hospitals and surgical centers have already made to prevent these events from happening again:

Surgery
• Making sure operating room teams stop before every surgery or invasive procedure to make sure that they have the right patient, are ready to do surgery on the right part of the body, and are about to do the right procedure.
• Allowing more time in-between surgeries so that doctors and nurses aren’t rushed.
• Using x-rays in the operating room to see if there are any objects left behind before surgery is finished.
• Changing how they count sponges and other small objects used in surgery, and making sure that these objects are counted by more than one person.

Pressure Ulcers (Bedsores)
• Using special beds and other supplies to use with patients who are at risk for bedsores.
• Helping nurses know how to identify bedsores before they get serious, and what type of bed or other equipment is right for a patient.
• Making sure that doctors and nurses work with physical therapy, nutrition, and other departments when they care for these patients, so that the whole team knows about skin problems.

Falls
• Using colored slippers, wristbands, or stars on a patient’s door to show that they are at risk of falling.
• Making sure that all staff members are watching patients who are at risk of falling, and know what to do if they see a patient who is in danger of a fall.
• Having a nurse or other provider go to a patient’s room at least every two hours to see if they need any help or need to go to the bathroom.
Frequently Asked Questions

Pressure Ulcers/Bedsores

What is a pressure ulcer/bed sore?
Pressure ulcers (bedsores) happen when the skin breaks down because of friction or lack of movement. Pressure ulcers start as red areas, and sometimes turn into blisters. Finally, they can become open wounds. They most often happen on the heels, hips, back, head, buttocks, or other areas where the skin is very close to the bone. They can cause serious damage if they are not treated.

How do bedsores happen?
Most people think bedsores take a long time to happen. But they can happen very quickly if you can’t move all or part of your body. Pressure ulcers can even develop in a few hours. The people with the highest risk are those with fragile skin, limited ability to move, incontinence, poor circulation or poor nutrition.

Retained Objects

What is a retained object?
A retained object is something that is left in a patient’s body after surgery, delivery of a baby, or another procedure. Small sponges and clamps are the most common retained objects.

Sometimes retained objects are discovered right away, before the person leaves the operating room. Other times, they are found later if a patient has pain or problems healing.

Usually there is no lasting harm to the patient. Often, the object can be removed right away, without another surgery. Sometimes, a surgical cut needs to be opened again to take the object out. Some small objects might be left in the body if they won’t cause health problems.

General Questions

Why do some places have higher numbers than others?
Numbers can be higher or lower at different places for many reasons. Sometimes numbers are higher at one facility because people are looking very hard to find and report problems that might lead to adverse events. Sometimes, the more you look for adverse events, the more you will find. Hospitals also come in many sizes, and they see very different types of patients. This can also make the numbers higher or lower.

Because it’s hard to know why the numbers are higher or lower at one place, you should not compare hospitals, surgical centers, or regional treatment centers using just these numbers. It’s best to use these numbers to ask your doctor what they are doing to prevent adverse events.

Why did these events happen?
The people who take care of you are professionals. They care about your health and want you to feel better. But sometimes, things go wrong even when everyone is trying their best to do good work. Often, these events happen because of a communication problem. Forgetting to tell someone about an important fact, poor handwriting, misunderstandings, or forms that weren’t filled out the right way are examples of communication problems that can lead to errors. Sometimes, people are not comfortable speaking up if they think there is a problem. That’s also a communication problem.

Other times, adverse events happen because there are many steps and many people involved in a process. That’s why every system needs to have ways to double-check every step.

How many people were hurt by these events?
In the last year, 13 people died from these events. Some patients had to stay in the hospital longer or get extra treatment. In most cases, there was no serious harm to the patient.
What are people doing about these events?
When one of these events happens, a team of people at the facility looks very closely at why it happened. They find out what went wrong. They come up with a plan to prevent it from happening again, and then they put that plan into action. They also share what they learned, so others won’t have the same problem. The Department of Health makes sure that they are looking hard enough to find answers, and that they come up with strong plans to prevent the event from happening again.

Health care providers don’t want these events to happen, either. They are changing the way they do things because of these events. They are developing new ways to count objects used in surgery, and new policies to prevent other events. Some have started using new equipment or new ways to keep people from falling or developing bedsores. These are important changes that will keep patients safer.

Are there fewer adverse events now because of this reporting system?
Before we had this law, we didn’t know how often adverse events happened in the state. Hospitals kept track of some events, but there wasn’t a place to report and count them.

What we do know is that hospitals and surgical centers are working very hard to find and report these events, to learn from them, and to prevent them from happening again. Over time, this will make the health care system safer.

What happens to the doctor or nurse who was involved?
Adverse events usually happen because of a problem with a process or a policy, not because of just one nurse or doctor. Health care is provided by a team of caregivers. The team has to work together to make sure patients get the safest care. Hospitals and surgical centers are looking at what they can do to change processes or policies so that even if someone forgets a step, it is caught before the mistake can hurt a patient. Sometimes these events happen when a caregiver forgets a step or takes a shortcut. For example, maybe a nurse didn’t want to wake a patient up to check his name before giving him a drug. The nurse didn’t mean to hurt anyone - they assumed there would be no problems. If that happens, the hospital needs to understand why people take shortcuts, so they can make sure it doesn’t happen again. If the caregiver was taking risks, the hospital might discipline the person, or train them so they understand the risks of their behavior.

In very rare cases, a doctor or nurse might do something that they know could hurt a patient. This is very unusual, and very serious. If that happens, the person might be warned, fired, or put on probation. The Board of Medical Practice can also discipline doctors if they deliberately put patients at risk. Other boards deal with nurses, pharmacists, and other caregivers who deliberately put their patients at risk.

Why don’t you publish doctors’ names?
The law does not allow us to collect the names of the doctors, nurses, or patients who were involved. But the hospital or surgical center knows the names of the people who were involved, and they will take all necessary steps to prevent the problem from happening again. Usually, though, these events happen because of a problem in a complicated process, not because of just one nurse or doctor.

What should I do if something happens to me?
If you have concerns about your care, the first thing you should do is talk to a doctor, nurse, or patient representative. Usually, they can help you, and answer questions about your care or about something that happened to you.

If you still have concerns, you can call the Minnesota Department of Health at 1-800-369-7994 to file a complaint about a hospital. Or call 651-201-3564 with questions about these events.

Consumer Guide to Adverse Health Events
What Should Hospitals Do To Keep Me Safe?

It is the responsibility of your caregivers to keep you safe and give you the best care. There are many things that they should do to make sure you are safe. If you are in the hospital, you might see your doctors or nurses doing things that you don’t understand or don’t like. They might ask you for your name over and over again. They might ask you to do things that you don’t want to do, like roll over or wake up when you’re tired. And they might ask you questions that you’ve already answered.

These are some of the steps that health care providers take to keep you safe. These things should always happen. So, if you are in the hospital, surgical center, or doctor’s office, look for these best practices to help keep you safe.

Doctors or nurses should always:

- Wash their hands before they touch you
- Check your name many times, especially before giving you drugs or taking you to surgery
- Use a marker to put their initials on the place where you will have surgery
- If needed, use clippers instead of a razor to remove hair from the surgical site (cuts from razors can cause infection)
- Confirm the details before starting surgery or a procedure
- Confirm the exact surgery or procedure you are going to have, even if you already know
- Ask you about medications that you are taking
- Ask you about allergies
- Explain the risks of surgery or other procedures, in a way that you can understand
- Give you a chance to ask questions about your care
- Show you how to use call lights, alarms, and other safety equipment in your room
- Turn you at least every two hours if you are at risk for bedsores
- Inspect your skin every day, on all parts of your body, if you are at risk for bedsores
- Explain exactly what you should do when you get home, in a way that you can understand

These things should happen every time.

Consumer Guide to Adverse Health Events
What Can I Do?

The people who are taking care of you are responsible for providing high quality care. If an error happens to you while you are in the hospital, it’s not your fault. It is your caregivers’ job to make sure that they do everything they can to keep you safe. But there are some things you can do to make sure that you receive the best possible care:

1. **Speak up**
   When you are sick, you might feel vulnerable or scared. It can be hard to speak up, and many people feel intimidated by doctors or nurses. But it’s okay to ask questions. In fact, asking questions is very important. If you don’t understand something the doctor or nurse says, ask him/her. Make sure you understand what is going to be done for you, and what to expect. If you don’t think you can speak up for yourself, bring someone with you.

2. **Repeat instructions to make sure you understand**
   Sometimes we get so much information from doctors or nurses that we feel overwhelmed. Then, when we get home, we forget what they told us to do. One good way to make sure that you understand and remember instructions is to repeat them back to your caregivers. Even if you have papers from the hospital with instructions, read them with someone in the hospital and make sure you understand everything before you go home.

3. **Keep track of your medications**
   The people taking care of you need to know about all of the medications you take, so they don’t give you something you don’t need. They also need to know about any allergies or sensitivities that you have. The Minnesota Alliance for Patient Safety (MAPS) has a form called “My Medication List” that you can use. Fill it out, and make sure to include everything – prescription drugs, over the counter medications, herbal supplements and vitamins. You can get this form at www.mnpatientsafety.org.

4. **If you can, go to a hospital or surgical center that sees a lot of people with your condition**
   For example, if you are having hip replacement surgery, look for a hospital that does lots of hip replacements. If you need bypass surgery, and you have a choice of hospitals, choose one that does a lot of them each year. It’s safer to go to a hospital or surgical center that does a lot of procedures than one that does only a few.

5. **Make sure everyone agrees about your surgery or procedure**
   You will probably meet with the surgeon, the anesthesia provider, and nurses before the surgery starts. Make sure you know what procedure you are having done, and that everyone agrees on that procedure and the location. The doctor should always use a marker to put his or her initials on the place where you are having surgery.
Where did these events happen?

Remember:
1. Use these numbers to think about questions you can ask your doctor or hospital.
2. A higher number at one facility doesn’t necessarily mean that it is less safe than another facility.
3. Knowing about these events helps us learn how to make healthcare safer.
4. If you can’t find a hospital or other facility in this table, that means they reported no events.

Reported Events, October 2006-October 2007

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<thead>
<tr>
<th>Hospital Name</th>
<th>Patient Days</th>
<th>Retained Objects</th>
<th>Bedsores</th>
<th>Other Events</th>
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Where did these events happen?

**Remember:**
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### Reported Events, October 2006-October 2007

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<th>Facility</th>
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<th>Bedsores</th>
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For more information about adverse health events and health care quality at these facilities, and to learn more about what’s being done to prevent these events, visit [www.health.state.mn.us/patientsafety](http://www.health.state.mn.us/patientsafety).
Where Can I Get More Information?

Minneapolis Department of Health – Patient Safety
www.health.state.mn.us/patientsafety
This website includes a full report on adverse events in Minnesota, with detailed information on individual hospitals. You can also look up facilities in a database, read factsheets about different types of events, read questions and answers, and link to other information.

Minneapolis Health Information
www.minnesotahealthinfo.org
This website has links to several sites where you can compare cost and quality at hospitals, physician and medical groups, and other facilities.

Healthcare Facts
www.healthcarefacts.org
This website lets you ‘shop’ for healthcare using information about quality, price, number of procedures done, adverse events, and other performance information at Minnesota hospitals and primary care clinics.

The Leapfrog Group
www.leapfroggroup.org
This website provides hospital safety and quality ratings based on multiple factors.

Minnesota Hospital Quality Report
www.mnhospitalquality.org
This website contains a database showing how well hospitals treat heart attacks, heart failure, and pneumonia.

Minnesota Community Measurement
www.mnhealthcare.org
This website shows you how your clinic or provider group compares to others in areas of care such as breast or cervical cancer screening, diabetes care, high blood pressure, and asthma treatment.
If you require this document in another format, such as large print, Braille or cassette tape, call (651) 201-3560