ADVERSE HEALTH EVENTS

10 Year Program Evaluation

MINNESOTA
MDH
DEPARTMENT of HEALTH

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Executive Summary

In 2003, the Minnesota Legislature passed the Adverse Health Care Events (AHE) Law, requiring hospitals and, later, ambulatory surgical centers to report to the Minnesota Department of Health whenever one of 27 serious adverse health events occurred. The law was modified during the 2007 legislative session to add a 28th reportable event, and again in 2013 to add four new events and modify or delete others to make 29 reportable events and to expand or refine definitions of several other events. This revision to the law was not put into effect until Oct. 7, 2013, the start of the 11th year of AHE reporting, therefore those changes will not be cited in this report (Appendix A).

Since the inception of the AHE reporting law 10 years ago, the field/knowledge of patient safety, as well as the healthcare environment has changed significantly. At its core, the AHE system strives to balance learning and accountability. MDH and its partners believe that in order to encourage facilities to continue to share data and learnings throughout Minnesota, hospitals and surgical centers need to see the value in the system, which includes receiving support to identify root causes and identify action steps to proactively prevent future events from occurring. Since 2003, over 2,200 events have been reported through the adverse events system (Figure 1). However, while counting the frequency with which adverse health events occur and reporting the results publicly is part of the law, it is the focus on improving systems and learning that is of the utmost importance to sustainable improvements in patient safety.
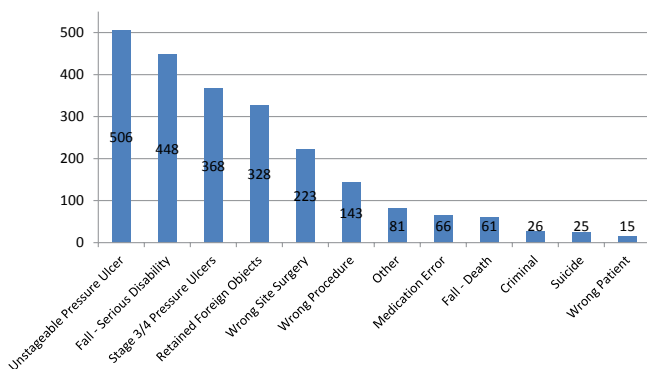
For the 10-year evaluation, MDH convened a series of focus groups with patient safety managers, conducted a survey of staff from reporting hospitals and ambulatory surgery centers, and worked with the Minnesota Hospital Association (MHA) and Stratis Health to further analyze data from both an epidemiological and statistical perspective over the 10 years of the reporting system. Throughout the evaluation, areas of success were identified as well as areas for future improvement. Key findings from the 10 year evaluation include:

- The AHE law was a catalyst for patient safety throughout the state. It has helped to bring patient safety to the forefront, increased awareness, and led to focused patient safety improvement activities.
- As the system has evolved, facilities have been asked to submit much more robust data and root causes than at the inception of the system. This has led to more in-depth analysis of events and the ability to identify focused improvement opportunities to address specific issues.
- Hospitals and surgical centers reported the AHE system works well in the current healthcare environment in Minnesota and would like the same commitment to transparency, learning and public reporting spread to all settings of care, including: cosmetic surgery centers, long term care facilities and clinics.
- Facilities have put many policies/procedures to improve patient safety in place since 2003, including policies to disclose events to patients/families, regular assessment of organizational culture and sharing AHE data with the board and throughout the facility.
- The number of deaths has declined overall since the first year of the system and events that result in serious disability are on a downward trend as well.
- Some rates of reported events that have had consistent definitions during all 10 years, such as stage III or IV pressure ulcers, have seen a reduction. However, rates of reported events as a whole have remained consistent over the 10 years (accounting for definitional changes).

FIGURE 1:
Reportable Adverse Health Events, 2004 – 2013

- The reporting system was designed as a learning system and analysis of the data across the reporting years demonstrates this primary goal of the system is being met. For example, after Safety Alerts are issued, typically the number of reported events related to the alert increase as awareness about reporting and preventing those types of events has increased. Then numbers begin to decline as identified practices are implemented across the state.

- AHE data indicates that hospitals and surgical centers are very responsive to learnings from the system. An impact on the number of reported events is demonstrated in the data in a very short period of time following the issuing of alerts or best practice recommendations.

- Some facilities still struggle to engage physicians/surgeons and other staff members in certain safety initiatives (usually surgical safety), and would like assistance developing physician/surgeon champions to build support for safety initiatives.

In the upcoming year, MDH and its partners will take steps to address the key learnings from the annual report as well as this 10-year evaluation in order to improve patient safety in Minnesota, including:

- Developing additional methods, tools or resources for data sharing across facilities. This includes sharing learnings from events as well as near misses.

- Improved functionality in the current data sharing database for running reports and data mining.

- Developing additional education/training opportunities on most frequently reported events (falls, pressure ulcers and surgical/procedural events).

- Developing physician/surgeon champions to build support for safety initiatives.

- Working with stakeholders throughout the state to expand the same commitment to transparency, learning and public reporting to all healthcare settings in Minnesota.

Evaluation Overview

In January 2014, MDH released its 10th annual adverse health events report, providing information about 258 events that occurred during the previous reporting period and highlighting steps taken by hospitals and surgical centers to prevent future events. Along with this work in 2013, MDH embarked on a 10-year evaluation of the reporting system, seeking to answer questions including, but not limited to:

- Are we safer, or not safer, than we were 10 years ago?
- What changes have facilities put in place since 2003?
- How does the AHE process help or hinder the patient safety journey?
- What are the most significant patient safety challenges facing reporting facilities today related to event reporting and process improvement?
- How can the AHE process evolve to continue to advance patient safety forward in Minnesota?

To answer these questions, MDH convened a series of focus groups with patient safety managers from hospitals and surgical centers around the state, conducted a survey of staff and leaders from reporting facilities, and worked with the Minnesota Hospital Association (MHA) and Stratis Health to analyze data from the 10 years of the reporting system.

Facility Survey

In August 2013, MDH conducted a survey of more than 200 hospital and surgical center CEOs/administrators, patient safety managers, directors of nursing, risk managers, and others involved in reporting/analyzing adverse health events, and monitoring safety and quality measures within their facilities. The survey included the following questions:

- In your opinion, is your facility safer, or not safer, than it was 10 years ago?
- How would you rate patient safety as a priority within your organization?
- What are the priorities for your organization and where does your organization spend time with regard to those priorities?
- What resources will be helpful for your organization going forward?

Survey respondents represented a wide variety of facilities: 12 percent represented ambulatory surgical centers, 38 percent came from hospitals with fewer than 25 beds, and seven percent came from hospitals with more than 500 beds. Respondents were most likely to be patient safety/ quality managers, although CEOs, directors of nursing and risk managers were also well represented (Figure 2).

FIGURE 2:
Facility survey respondents

Respondent Type	Percent of respondents	Number of Respondents
Patient Safety/Quality manager	37.70%	50
Other	18.50%	25
Director of Nursing	16.20%	22
CEO/Administrator	15.40%	23
Risk Manager	10.80%	20
Physician	0.80%	2
Staff nurse	0.80%	2

Data Analysis

Throughout 2013, MDH, Stratis Health and MHA worked to analyze data across the 10 years of reporting. Throughout the data analysis, two different types of data were analyzed:

- Process measure data, such as: how quickly facilities report their events, type of root causes reported and how often facilities cite that there is no root cause for an event.
- Outcome measure data, such as: rates of falls, number of retained foreign objects (RFO) in various settings and frequency of medication errors.

Since the data that the online system collects has evolved significantly over the years, some data was not easily compared across the full 10-year span; however, trends and patterns were evaluated across as wide a range of years as possible given the available data. The goal of the data analysis was for MDH to look at the reporting system as a whole and identify which aspects of the system have worked well and which can be improved in the future, as well as paint a 10-year picture of data gathered through the system.

Sharing of Information

Since the inception of the reporting law, MDH and its partners have held numerous education and training events for reporting facilities on such topics as falls, pressure ulcers, safe surgical practices, suicide risk assessment and prevention, and root cause analysis. This education is based on the learnings that come from the reported events in the Patient Safety Registry and is a crucial element in supporting the program's goal to create a learning healthcare system.

Resources provided through the AHE system include, but are not limited to:

- MHA 'Calls to Action' on five topics with an average of 110 hospitals participating per campaign
- Eighteen 'Safety Alerts' on topics such as: implant verification, fall injury risk and suicide prevention
- Semiannual Root Cause Analysis training(s) done throughout the state since 2007, with an average of 40 participants per training
- An online Root Cause Analysis toolkit with resources compiled nationally and at a local level
- Measurement for Adverse Health Events Guide developed by Stratis Health
- Regional training/education sessions on safe surgical practices and how to audit pre-surgical Time Outs
- Two suicide prevention trainings

Many participants in the focus groups and survey stated that one of the most valuable parts of the AHE program are the training and resources that have been made available, in particular the MHA 'Calls to Action.' In these campaigns, developed in response to data submitted through the adverse events system, facilities agree to implement a series of evidence-based best practices and to report quarterly on their progress. Participants described feeling supported in their patient safety efforts with this education and training as well as hundreds of resources and toolkits that have been made available online for all facilities. When asked about the resources that are available to them, participants responded that most of the resources were useful and or very useful (Figure 21). *Note, Figure 21, does not include respondents who answered "not applicable."*

FIGURE 21:
Use of Adverse Event Resources, 2013
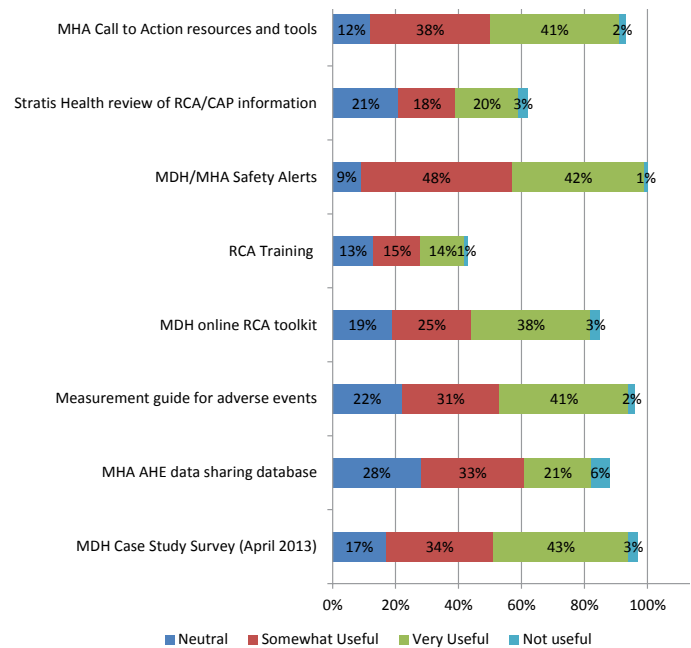
This approach of training/education and sharing all resources publicly has helped facilities by allowing them to use those resources instead of creating their own tools at individual facilities, which is time consuming and can be cost prohibitive. Participants also reported a benefit to attending training and education with other facilities throughout the state and sharing learnings and best practices with one another in-person. They state that these sharing sessions can sometimes be the most beneficial to them, providing innovative and outside the box ideas.

Although event information is shared between hospitals that have agreed to share their data in a de-identified manner, and key learnings are incorporated into statewide improvement initiatives, facilities are interested in continuing to expand their ability to learn from each other. Often facilities will use the database after an event, in order to gain perspective from other facilities that have experienced similar events and look at what types of corrective action plans may have put into place and how successful those were.

Reporting and Review Process

In the 10 years that the adverse events reporting system has been in place, it has evolved from a basic web-based reporting tool and review process to a much more comprehensive system that involves reviews of reported events, a higher level of granularity of data that is required for each event, and alerts and campaigns based on best practices and other issues identified through the reporting and review process.

The reporting and review process is designed to support reporting facilities in using RCA to review the systems they use to provide care for breakdowns or contributing factors related to the event and to assist with development of strong and effective corrective action plans.

During this evaluation, MDH sought input on the reporting and review process from participants. The vast majority of participants stated that the web-based reporting system is effective and works well within their facility. However, participants that rarely use the web-based tool reported confusion and burden with the use of the system. Through the years, MHA has worked closely with MDH and reporting facilities to refine the web-based system and make its use as intuitive as possible, including changes to make its use easier and quicker and to add additional categories for data collection in order to accommodate changing practice.

One key aspect of the reporting system is the review process that allows the State to assess the quality of the RCAs and corrective actions that are submitted in response to adverse events. A team of clinical and quality improvement experts from Stratis Health reviews a sample of pressure ulcer events and 100 percent of all other events. Root causes and corrective action plans are reviewed against a set of criteria that serves as an evaluation of the information submitted. The goal of the review is to assess that the information in the registry is clear and thorough, and provides a summary of the event and root cause finding (or explanation for lack of a root cause finding) of systems breakdown, and that the corrective action plan is appropriate and reflective of the finding(s) of the root cause analysis. Through the review process, a reporting facility is given individualized feedback on the information submitted to the registry; the facility is asked to provide updates or clarification to the information so that it can be used for analysis and potential future event prevention efforts.

Each event can go through this review process up to three times. MDH and its partners continually work with facilities that bring issues with the review process forward or that need assistance with reporting. This assistance and continued work at making the system and the reported data more robust has led to a 24 percent decrease in the number of times that an event has to go through the review process (Figure 22).

At the inception of the reporting system, the majority of submitted root cause analyses, corrective action plans or measurement methodologies were found to have deficits. In fact, in 2005 (the first year this data is available) only 15 percent of events passed on the first review. In year 10 of the reporting system, 52 percent of reported events are passed by the independent reviewer following the first review, indicating the information submitted was clear and sufficient for use in objective aggregate analysis. This reduction in average reviews per event can be attributed, again, to the learning nature of the system.
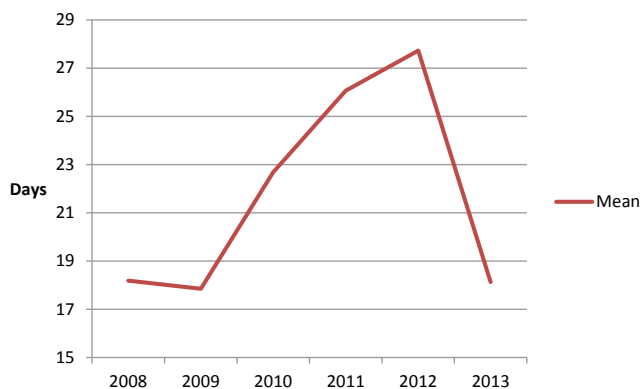
FIGURE 22:
Average reviews per event, 2004–2013
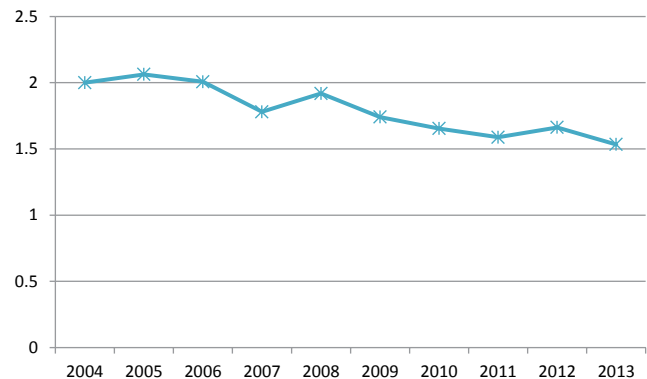
As issues are brought forth, MDH and its partners work to resolve them and similarly, facilities have worked to make their RCA process and reporting process much more robust over the past 10 years. A five year evaluation completed by MDH revealed that participants thought the review process should be modified so that it has an increased focus on learning and coaching, rather than on pointing out insufficiencies. During this 10 year evaluation, those concerns were not noted and the majority of participants reported satisfaction with the review process overall and many felt that it had helped them to dive deeper into their root cause analysis than previously.

One requirement of the AHE law is that facilities enter the event into the Patient Safety Registry (PSR) within 15 working days of discovering the event occurred. Over the years, this average time frame was increasing as the requirements for reporting other data increased on facilities. In the past year, MDH and its partners have worked with facilities on consistently reporting their events in a timely fashion, not only to meet the requirements of the law, but so that data can be analyzed and learnings can be disseminated as quickly as possible statewide. In the past year, the mean days it took to report the event into the system decreased by over 60 percent to an average of 18 days (Figure 23).

Also of note, the time between when an event occurred and when it was discovered has decreased steadily (Figure 24), which could be attributed to increased awareness of patient safety and heightened emphasis on reporting and mitigating events. In the case of pressure ulcers, this decrease may be related to the ways in which pressure ulcers are identified. When the reporting system began, facilities were doing prevalence and incidence studies on a quarterly basis and would identify the majority of pressure ulcers retrospectively, even if they had occurred much earlier. Over the course of the 10 years of reporting, facilities have moved toward concurrent identification and reporting of pressure ulcers and are able to identify and treat pressure ulcers much sooner.

Note: With some categories of events, such as retained foreign objects, the event may not be discovered the same day it occurs or may be discovered at a later date or clinic visit.

FIGURE 24:
Time between event date and discovery date, 2004–2013

FIGURE 23:
Time between discovery date and PSR, 2008–2013
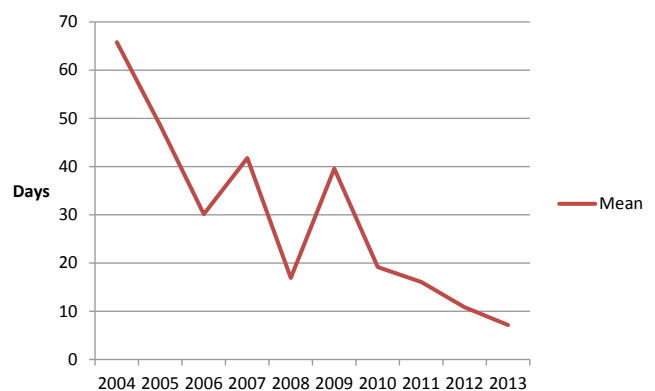
Root Cause Analysis/Corrective Action Plans

One of the pillars of the AHE system is that facilities investigate their events by completing a root cause analysis. MDH has been collecting data on the type of root causes identified by facilities for each event since the inception of the law.

Root cause categories have shifted and changed slightly over the years, but overall have remained mostly consistent. The percentage of times that facilities choose 'Communication' as the root cause of an event has steadily decreased over time, while the percentage of times that facilities had a finding of no root cause or contributing factor (CF) has increased (Figure 25).

FIGURE 25:
RCA categories, 2004–2013
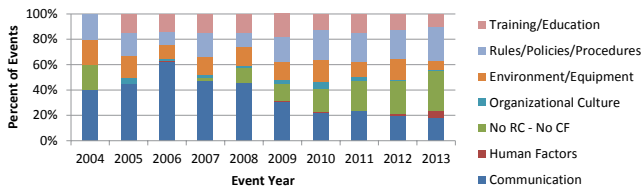
The 'Communication' category includes all forms of communication, such as: verbal, electronic, communication of test results, etc. and is often reported as communication of important information to the incorrect person, lack of communication of important information or lack of team work during a stressful situation.

Many facilities in Minnesota have started to perform teamwork training for all staff as a way of preventing communication errors and increasing a culture of patient safety. Much of this work has come out of the MAP'S "SAFE CULTURE" roadmap. Also of note is an increase in facilities choosing 'Rules/Policies/Procedures' as a root cause since the first few years of the reporting system. This is often reported as lack of a policy/procedure or an ineffective policy/procedure in place. Of note, 'Human Factors' as a root cause was not an option in the reporting system until 2012.

When this data is broken down by type of facility, it shows that surgical centers identify 'Communication' as a root cause more often than hospitals of any size and surgical centers on average do not conclude a finding of no root cause following their analysis of the adverse event (Figure 26). This could be due to the subset of events that surgical centers encounter, or for other reasons, such as training or education differences. When comparing small hospitals to larger hospitals, both types of facilities choose similar root causes equally.

FIGURE 26:
RCA categories by facility type
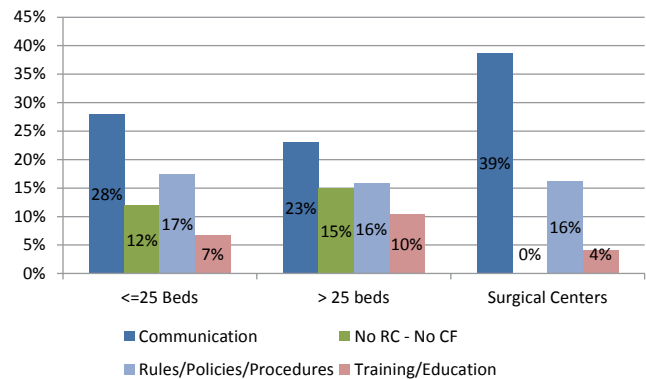
As noted above, facilities are increasingly reporting an inability to identify a root cause or contributing factor for their events. In 2007, only two percent of events had no identified root cause, whereas in 2013 over a quarter of events were reported without an identified root cause or contributing factor (Figure 27). The vast majority of events with no root cause or contributing factor were pressure ulcers and falls.

Through the AHE system, facilities are required by law to complete a RCA, however, those findings may conclude there was no root cause (system breakdown) or contributing factor (any possible factors that could have played a role aside from system breakdowns) or that the event could not have been prevented. The challenge with the issue of preventability is to assure that facilities are looking at all possible avenues for improvement, rather than looking at preventability, and working to reduce risk as much as possible. The fact that these types of events with no identified root cause or contributing factors are increasing is of note and MDH will be working with facilities to increase the rigor with which they recognize and strive to reduce risks and look for opportunities for improve safety in the upcoming year. This may take the form of additional training, resources or education for reporting facilities.

FIGURE 27:
Percentage of events with no root cause, 2007–2013
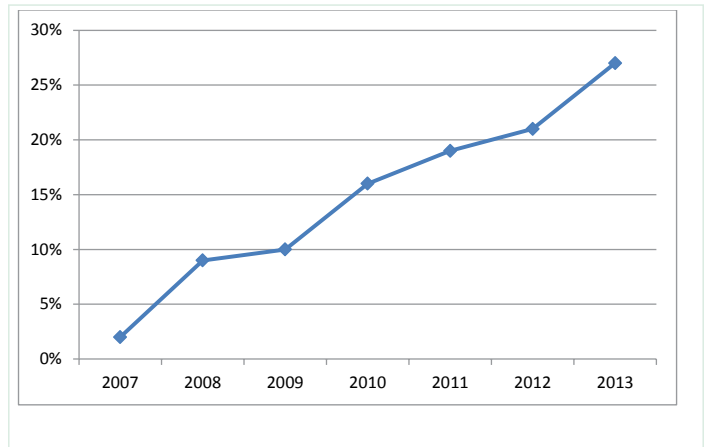
Recommendations and Evolution of the System

As MDH and its partners embarked on this 10-year evaluation of the adverse health events system, MDH explicitly sought ideas about ways to change the system. Input from stakeholders across the state went into the evaluation and all participants were asked "How should the AHE system evolve in the future?" The consensus was that the system as a whole is functioning well as one of learning and sharing, however, there are some minor changes and additional resources needed. The system will continue to evolve as new information becomes available and through the learnings from reported events.

Key findings from the 10-year evaluation include:

- The AHE law was a catalyst for advancing patient safety throughout Minnesota. It has helped to bring patient safety to the forefront and has increased awareness of patient safety risks as well as best practices for prevention of adverse events.

- The number of deaths has declined overall since the first year of the system and events that result in serious disability are on a downward trend as well.

- Some rates of reported events that have had consistent definitions during all 10 years, such as stage III or IV pressure ulcers, have seen a reduction. However, rates of reported events as a whole have remained consistent over the 10 years (accounting for definitional changes).

- Facilities are submitting more robust data and root causes than at the inception of the system. This has led to more in-depth analysis of events and the ability to put systems in place to prevent them in the future.

- The reporting system was designed as a learning system and analysis of the data across the reporting years demonstrates this primary goal of the system is being met. For example, after Safety Alerts are issued, typically the number of reported events related to the alert increase as awareness about reporting and preventing those types of events has increased. Then numbers begin to decline as identified practices are implemented across the state.

- The AHE system works well in the current healthcare environment in Minnesota, but facilities would like the same commitment to transparency, learning and public reporting spread to other settings of care, including cosmetic surgery centers, long term care facilities and clinics.

- Facilities have put many policies/procedures to improve patient safety in place since 2003, including policies to disclose events to patients/families, regular assessment of organizational culture and sharing AHE data with the board and throughout the facility.

- MDH needs to investigate other ways for facilities to share learnings with one another in addition to the MHA Data Share Database, safety alerts and the sharing that occurs within the statewide Calls to Action.

The majority of stakeholders from hospitals and surgical centers, as well as long term care organizations, would like to see the same commitment to transparency and public reporting (similar to this system) expanded to include clinics and long term care facilities in Minnesota. Current reporting facilities feel very strongly that the AHE system and its commitment to learning and transparency has been a catalyst for change and has made the care patients in those settings receive much safer. Reporting facilities also feel that expanding a similar system to other settings would even the playing field in some cases. For example, ambulatory surgery centers that are licensed by MDH are subject to the reporting law; however, the majority of cosmetic surgery centers in Minnesota are not licensed by MDH and therefore are not subject to the law. In addition, clinics that are licensed under a hospital are required to report under the AHE law, however independent clinics are not currently required to report. Surgery centers feel that this offers an opportunity to spread the learnings of the AHE system to new settings and further improve the safety of care.

In the upcoming year, MDH will convene discussions with stakeholders, including state regulators, long term care associations, hospitals, clinics, surgery centers and other invested parties to begin discussing the idea of expanding a similar adverse health events system across other settings of care in the state. Movement toward expanding to other settings is complex and involves many stakeholders and therefore, may be a lengthy process. But it is a conversation that a wide range of partners are committed to exploring.

Additional recommendations for next steps include:

- Develop new methods, tools or resources for data sharing across facilities. This includes sharing learnings from events as well as near misses.

- Improve functionality in the current data sharing database for running reports and data mining.

- Develop additional education/training opportunities on most frequently reported events (falls, pressure ulcers and surgical/procedural events).

- Work with all providers, including physicians, to encourage adoption of best practices in patient safety.

Hospitals and surgical centers have been on a journey with MDH and its partners though the adverse health events system for 10 years now. Progress toward eliminating adverse health events has been made, however, the work continues and will be an ongoing process, defined by new types of events and evolving best practices and shared learnings throughout the state. Facilities have committed many resources and are beginning to see progress. They should be proud of the work that they have invested in improving patient safety and quality in Minnesota and therefore providing a higher level of care to their patients. However, based on responses by evaluation participants, MDH and its partners are committed to taking steps to ensure that the progress from the first 10 years of the reporting system continues to advance.

Appendix A: Reportable Adverse Health Events

Below is a list of the events that hospitals and licensed ambulatory surgical centers are required to report to the Minnesota Department of Health.

The language is taken directly from Minnesota statutes 144.7065. *Changes enacted during the 2013 legislative session, which will first appear in the 2014 annual report, are shown here.*

Surgical Events

1. Surgery or other invasive procedure performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

2. Surgery or other invasive procedure performed on the wrong patient;

3. The wrong surgical or other invasive procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

4. Retention of a foreign object in a patient after surgery or other invasive procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

5. Death during or immediately after surgery or other invasive procedure of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

1. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

2. Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

3. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

1. A patient of any age, who does not have decision-making capacity, discharged to the wrong person;

2. Patient death or serious injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and

3. Patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

1. Patient death or serious injury associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

2. Patient death or serious injury associated with unsafe administration of blood or blood products

3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post- delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

4. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

5. Stage 3, 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;

6. Artificial insemination with the wrong donor sperm or wrong egg;

7. Patient death or serious injury associated with a fall while being cared for in a facility;

8. The irretrievable loss of an irreplaceable biological specimen; and

9. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

1. Patient death or serious injury associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

3. Patient death or serious injury associated with a burn incurred from any source while being cared for in a facility;

4. Patient death or serious injury associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Potential Criminal Events

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider;

2. Abduction of a patient of any age;

3. Sexual assault on a patient within or on the grounds of a facility; and

4. Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

Radiologic Events

1. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

Appendix B: Background on Minnesota's Adverse Health Events Reporting Law

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 serious reportable events identified by the National Quality Forum and a public report that identified adverse events by facility. The law covers Minnesota hospitals and licensed outpatient surgical centers.

Momentum toward a system for mandatory adverse event reporting began with the publication of the Institute of Medicine (IOM) report "To Err is Human" in 2000. While the issue of medical errors was not a new one for health professionals, Americans reacted strongly to the idea that preventable errors could contribute to the deaths of up to 98,000 people per year. The public and media attention that followed the report's publication started a national conversation about the reasons why such errors occur. A primary focus of the discussions was the concept of systemic causes for errors.

In the past, discussions of medical errors often focused on identifying and punishing those who had caused the error. While individual accountability for behavior that could put patients at risk is very important, the IOM report confirmed that most errors were not the result of the isolated actions of any one care provider, but rather of a failure of the complex systems and processes in health care. Given that knowledge, the old 'blame and train' mentality, wherein individual providers were blamed for mistakes and provided with training in the hopes of preventing future slip-ups, has to make way for a new approach that encompasses a broader view of accountability and learning from errors or near misses.

Every facility has processes for dealing with individual providers who exhibit dangerous or inappropriate behavior or who knowingly put patients at risk. Disciplining, educating or dismissing an individual provider will always be an option in those cases. But the focus of the reporting system is on using focused analysis of events to develop broader opportunities for education about patient safety and best practices – solutions that can be applied across facilities. Responses focused on an individual provider may or may not prevent that provider from making a mistake again, but changing an entire system or process to eliminate opportunities for error, whether by building in cross-checks, establishing a 'stop the line' policy, or using automation to prevent risky choices, will help to keep all patients safer.

From the beginning, the reporting system has been a collaborative effort. Health care leaders, hospitals, doctors, professional boards, patient advocacy groups, health plans, MDH, and other stakeholders worked together to create the reporting law, with a shared goal of improving patient safety. The vision for the reporting system is of a tool for quality improvement and education that provides a forum for sharing best practices, rather than a tool for regulatory enforcement.

In 2007, the Adverse Health Care Events Reporting Law was modified to include a 28th event and to expand the definitions of certain other events. The most significant change was an expansion of reportable falls to include those associated with a serious disability in addition to those associated with a death. At the same time, the pressure ulcer category was expanded to include 'unstageable' pressure ulcers.

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