

Consumer Guide to Adverse Health Events

Minnesota Department of Health

January, 2012



Division of Health Policy
PO Box 64882
St Paul, MN 55164-0882
(651) 201-3550
www.health.state.mn.us

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**For more information, contact:
Division of Health Policy – Adverse Health Events
Minnesota Department of Health
PO Box 64882
85 East 7th Place, Suite 220
St. Paul, MN 55101**

**Phone: (651) 201-3550
Fax: (651) 201-5179**

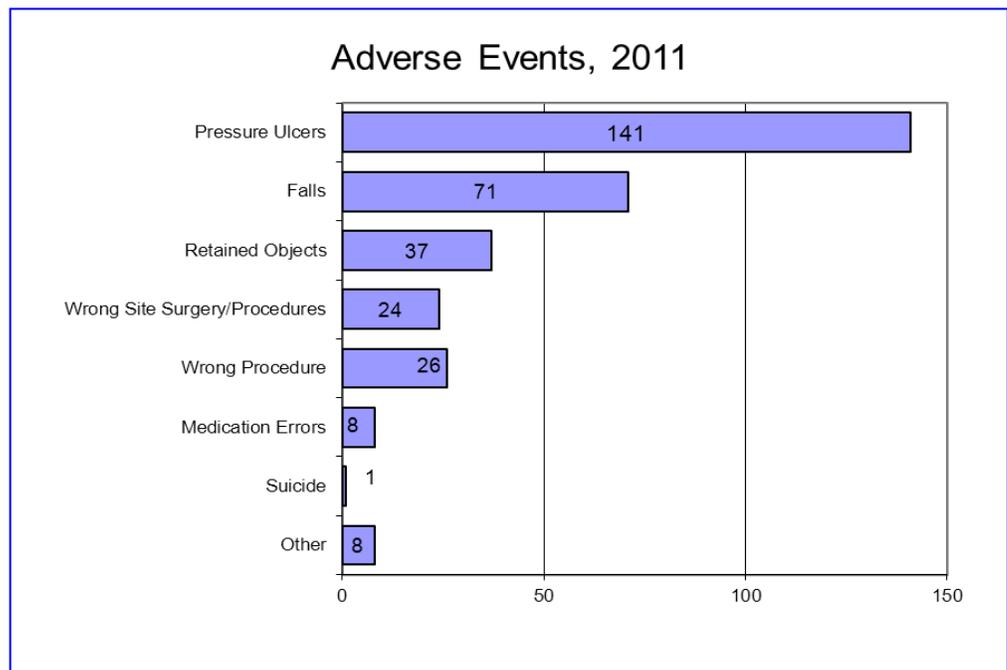
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Adverse Health Events

Background

Minnesota hospitals and surgical centers have to report to the Minnesota Department of Health whenever one of 28 serious events happens. The events include falls that lead to a patient's death or serious injury, leaving something in a patient's body after surgery, and surgery on the wrong part of the body.

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. We have to find out why these events happen. That's the best way to stop them from happening again.



Current Information

316 events were reported to the Minnesota Department of Health between October 2010 and October 2011. 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 what 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 and health care workers in the country. But we all still need to pay attention to safety. Fixing the causes of these 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 helping us to be safer. If we learn from mistakes and make sure that patients, doctors, nurses, and others speak up about risks they see, we can make our health care the safest in the country.

In this report, you can find a list of adverse events reported by each 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 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 do that.

Serious adverse events are very, very rare.

The chances 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 hear about something that happened at a hospital, you can ask what *they* are doing to make sure it won't happen to you.

Some people want to use this information to compare hospitals. But that's not the best way to use these numbers. There might be more events at one hospital because the people there are working very hard to find problems and fix them. If they look hard for these events, they will probably find more. So a bigger number can mean that a facility is safer, not less safe.



That's why you should use this report as just one piece of your research. If you can pick your doctor or hospital, you should think about other things, too. You can ask about costs, results for similar procedures, quality scores, and other factors to help you make the best decision about where to get care. This guide tells about some of the information that's out there, and our website can also link you to other sources of information. You can also look for the things that doctors, nurses, and others should always 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 includes certain kinds of events. Things like missed or wrong diagnoses, wrong treatments, and infections aren't included here. Hospitals only report the events on this list:

- Surgery on the wrong body part or the wrong patient, or performing the wrong surgery 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/serious harm 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 or
- Sexual assault on a patient
- Death/serious harm from physical assault
- Artificial insemination with the wrong donor sperm or egg

How is this system making health care safer?

The most important part of this report is not how many events happened. What's most important is that we're learning about why these events happened. That's 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. They are also sharing their good solutions with other hospitals, so the same thing doesn't happen again. These changes will make health care safer for all patients. Here 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 invasive procedure to make sure that they have the right patient, are doing surgery on the right part of the body, and are doing the right procedure.
- Allowing more time between surgeries so that doctors and nurses aren't rushed.
- Covering the surgical instruments with a special towel so the surgery can't start until everyone has done a "time out" to check on the patient and the procedure.
- 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.

Bedsore

- Using special beds and other equipment with patients who might get bedsore.
- Helping nurses know how to identify bedsore 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 might fall.
- Making sure that all staff members are watching patients who might fall, and know what to do if they see a patient who is in danger of falling.
- 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.
- Helping patients understand that even if they feel better, they should use their call light if they need to go to the bathroom.

Questions and Answers

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. Usually, the more you look for adverse events, the more you will find. Hospitals also come in many sizes, and they see very different kinds 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 or surgical centers using just these numbers. It's best to use these numbers to ask your doctor what they are doing to prevent adverse events. When you are trying to pick a hospital or surgery center, you should also ask other questions about costs, results, and quality.

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, bad 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 we need to have ways to double-check every step.

How many people were hurt by these events?

Last year, 5 people died from these events, and 84 people had a serious injury like a broken bone. Some patients had to stay in the hospital

longer or get extra treatment. But in most cases, the patient didn't get badly hurt.

What are people doing about these events?

When an event 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. 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 finding 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 these events happened. Hospitals kept track of some events, but there wasn't a place to report and count them. Now, we know how often they happen. That's a big improvement.

We also know 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 for everyone.

What happens to the doctor or nurse who was involved?

These 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 people. 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 make sure that even if someone forgets a step, it is caught before the mistake can hurt a patient.

Sometimes 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. She wanted to let the patient rest, but then she gave the wrong medication. The hospital needs to understand why people take shortcuts, to make sure it doesn't happen again. 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 discipline doctors if they put patients at risk on purpose. Other boards deal with nurses, pharmacists, and other caregivers who deliberately put their patients at risk.

Why don't you publish doctors' names?

We are not allowed to collect the names of doctors, nurses, or patients. 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 these events happen because of a problem in a complicated process, not because of just one nurse or doctor.

What 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.

What is a pressure ulcer/bedsore?

Another name for pressure ulcers is bedsores. Bedsores happen when the skin breaks down because of rubbing or lack of movement. Bedsores start as red areas, and sometimes turn into blisters or open wounds. They usually happen on the heels, hips, back, head, buttocks, or other areas where the skin is very close to the bone. They can hurt a lot 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.

What is a retained object?

A retained object is something that is left in a patient's body after surgery, having a baby, or another procedure. Small sponges are the most common retained objects. Sometimes they are discovered 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 has to be opened again to take the object out.

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 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. They do these things to keep you safe, and to make sure these events don't happen to you.

These things should always happen. So, if you are in the hospital, surgical center, or doctor's office, look for these best practices that help keep you safe. If you don't see them, Speak up!

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 infections.
- 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.

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 get the safest 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. A family member or a friend can speak up for you when you can't.

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 Medicine List" that you can use. Fill it out and keep it with you. Make sure to include everything – prescription drugs, over the counter medications, herbal supplements and even 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

If you need surgery, and you can choose your hospital, pick one that does a lot of them each year. For example, if you are having hip replacement surgery, look for a hospital that does lots of hip replacements. 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 and other team members before the surgery starts. Make sure you know what procedure you are having done. Make sure 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. If you can't find a hospital or other facility in this table, that means they reported no events.

Reported Events, October 2010-October 2011

	Beds	Serious Falls	Bedsore	Other	Total
Abbott Northwestern Hospital	952	7	4	6	17
Avera Marshall Regional Medical Center	49	1			2
Bethesda Hospital	254	1	6		7
Bigfork Valley Hospital	20			1	1
Buffalo Hospital	65	1			1
Centracare Health System – Melrose	28		1		1
Children's Hospitals and Clinics of MN - Mpls	153		1	1	2
Children's Hospitals and Clinics of MN – St. Paul	126		1		1
Essentia Health Duluth	165			1	1
Essentia Health Sandstone	30	1		1	2
Essentia Health St. Joseph's Medical Center	162	1	1	2	4
Essentia Health St. Mary's Hospital – Detroit Lakes	87	1			1
Essentia Health St. Mary's Medical Center	380	3		3	6
Fairview Lakes Medical Center	61	1	1	2	4
Fairview Ridges Hospital	150	1		1	2
Fairview Southdale Hospital	390		1	10	11
Fairview University Medical Center - Mesabi	175			1	1
Gillette Children's Specialty Healthcare	60		1	1	2
Grand Itasca Clinic and Hospital	64	1			1
Hennepin County Medical Center	894	9	22	2	33
Hutchinson Area Health Care	66	1			1
ILBNC Special Procedures Surgical Center				1	1
Lakewood Health Center	15	1			1
Landmark Surgery Center				1	1
Lifecare Medical Center	25	1		1	2
Madison Hospital	12	1			1
Maple Grove Hospital			1	1	2
Mayo Clinic Health System – Albert Lea	77			1	1
Mayo Clinic Health System – Austin	82			1	1
Mayo Clinic Health System – Fairmont	57			1	1
Mayo Clinic Health System – Mankato	272			1	1

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Reported Events, October 2010-October 2011

	Beds	Serious Falls	Bedsore s	Other	Total
Mayo Clinic – Methodist Hospital	794	2	3	7	12
Mayo Clinic – Saint Marys Hospital	1,157	1	38	6	45
Meeker Memorial Hospital	35	2			2
Mercy Hospital	271	2	2	2	6
Minnesota Eye Consultants, P.A.				1	1
New Ulm Medical Center	62	1			1
North Memorial Medical Center	518	2	5	2	9
Park Nicollet Methodist Hospital	426		5	10	15
Pipestone County Medical Center	44			1	1
Rainy Lake Medical Center	49	1			1
Regina Medical Center	57	1			1
Regions Hospital	454		5	2	7
Ridgeview Medical Center	109	1			1
Riverview Health	49	1	1	1	3
Riverwood Healthcare Center	24	1			1
Saint Elizabeth's Medical Center	31	1			1
Sanford Bemidji Medical Center	118		1		1
Sanford Luverne Medical Center	28	1			1
Sanford Medical Center Thief River Falls	99			1	1
Sanford Worthington	64	1			1
Sleepy Eye Medical Center	25	1			1
South Central Surgical Center				1	1
St. Cloud Hospital	489	3	1	5	9
St. Francis Regional Medical Center	93	1	1		2
St. John's Hospital	184	1	2	3	6
St. Joseph's Area Health Services, Inc.	50	1			1
St. Joseph's Hospital	401		1	2	3
St. Luke's Hospital	267	3	3		6
St. Michael's Hospital & Nursing Home	28	1			1
Tria Orthopaedic Center				1	1
United Hospital	546	3	5	1	9
Unity Hospital	275		3	3	6

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Reported Events, October 2010-October 2011

	Beds	Serious Falls	Bedsore s	Other	Total
University of MN Medical Center - Fairview	1,700	5	17	13	35
Westhealth				1	1
Willmar Surgery Center, LLP				1	1
Windom Area Hospital	35			1	1
Winona Health Services	99		1		1
Woodwinds health Campus	86		1		1
Total:		71	141	104	316

Where Can I Get More Information?

Minnesota 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.

Minnesota 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. It also includes measures of surgical care, and how patients experience care in the hospital.

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.