Minnesota’s adverse event reporting system has led to patient safety improvements

The number of patient falls, wrong-site procedures, and suicides increased slightly in Minnesota during 2012, but pressure ulcers, medication errors, and objects left in patients decreased, according to a recent study of the state’s hospitals and surgery centers.

The “Adverse Health Events in Minnesota 2012 Public Report,” released in January 2013, has inspired renewed efforts to avoid wrong implants and retained objects, while the state hospital association continues to examine ways to prevent falls. Last year, the reported events resulted in 14 deaths and 89 serious injuries.

Minnesota began putting patient safety under a microscope in 2003, and in 2008, ambulatory surgery centers (ASCs) joined hospitals in submitting required adverse event reports to the state health department. Those adverse events are compiled into an annual public report that offers recommendations for improvement.

State law places responsibility on facilities to track, report, and improve performance in 5 general categories: surgery, patient protection, case management, environmental, and criminal. Using a secure online database maintained by the health department, every facility must report each adverse event within 15 days of occurrence, and a designated quality reporting specialist must then develop and file an action plan. Within 30 to 90 days, the facility must measure the success of the plan and report the results to the state health department.

“It’s a lot of work for them,” says Rachel Jokela, the report’s author. As the state’s adverse health events program director, she has seen both improvement and regression, but she says the reports have led to development of best practices and better awareness of risks. In the report, she urges hospitals and ASCs “to dig deeper into the heart of the issues, to the culture of the organization as a whole.”

The ASC perspective

The most common events for ASCs are wrong site or wrong patient, retained objects, and falls, with the current focus on preventing wrong-site surgery.

Lakewalk Surgery Center in Duluth, Minnesota, reported only its second event in about 50,000 procedures—a retained sponge—with no resulting patient harm. A stand-alone center, Lakewalk has 6 ORs and 3 procedure rooms.

“It’s a really good program,” administrator Joe Majerus says of the state’s tracking program.

At Lakewalk, a standing committee called the Peer Review Quality and Risk Management Committee, or PQR, meets quarterly to review risk and quality issues. The committee includes 5 nurses, 2 physicians, and Majerus, the administrator.

After the retained sponge incident, the PQR ordered a root cause analysis, and 3 changes were made:

• A section was added to the surgical record for noting “sponges in” and “sponges out” times. A nurse initials the record after confirming sponge recovery with the surgeon.
A brightly colored magnet was attached to the door of the OR with a reminder to verify placement and removal of sponges. This is important, Majerus says, because during longer procedures, the circulating nurse’s shift may end before the procedure is done, which means the replacement nurse must verify sponge counts.

Management communicated the changes in a memorandum to all physicians and nurses, and those changes were discussed at staff meetings.

Regardless of the setting, surgical adverse events have similar causes and remedies, so hospitals and ASCs have been working together to reduce these events.

**Verifying IOLs**

The 2012 report generated a series of safety alerts from Minnesota’s health department. One covers verification of correct implants, both intraocular lens (IOL) and orthopedic.

The IOL portion advises that surgeons submit IOL requests in writing before any case preparation begins.

Every request should contain at least the following information:

- date of surgery
- patient
- surgeon
- right or left
- posterior or anterior
- model number
- diopter.

Facilities should then verify the information at the following times:

- when selecting IOLs from the supply area
- at the preoperative team briefing
- during the time out
- when opening the implant package; read the package label aloud and show it to the surgeon.

—Paula DeJohn

**Reference**