Medical Error Report
Hospital Toolkit

Following the release of the Indiana State Department of Health's 2014 Medical Error Report, it's important for us as health care providers to review the new data, identify areas of improvement and work internally to ensure every hospital has processes in place to minimize or eliminate the potential occurrence of an adverse event.

As health care leaders, we're constantly striving for zero harms. One harm is one too many. Despite our best efforts, however, human error can and does occur. When patients are harmed, we must do the right thing for them, their families and the caregivers involved.

Indiana hospitals are committed to providing safe care. As you know, hospitals across the state have made tremendous progress to prevent harms through programs like the *Partnership for Patients* campaign, which launched in 2012 and ran through last year.

When it comes to patient safety, Indiana hospitals don't compete with one another – we collaborate to share best practices. Eleven regional patient safety coalitions meet regularly to address regional needs and work together on quality improvements for the sake of our patients and the communities we serve.

Through initiatives like IHA's Indiana Patient Safety Center, we continue to support efforts of quality improvement and patient safety throughout Indiana. It's up to all of us to engage and inspire others to create cultures of patient safety and reliable systems of care that will ensure patients receive optimal, safe care across the state.

We are extremely proud of the results achieved by Indiana hospitals that reflect leadership and commitment to quality and patient safety.

Please feel free to reach out to the Indiana Hospital Association with any questions or feedback regarding the 2014 Indiana Medical Error Report.

Thank you.

Sincerely,

Doug Leonard
IHA President

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BACKGROUND INFORMATION

The Indiana State Department of Health (ISDH) released the 2014 Medical Error Report today. This is the ninth report and public release. Indiana law requires hospitals, ambulatory surgery centers, abortion clinics and birthing centers to report serious adverse events in six categories to the ISDH. The reporting system is known as the Indiana Medical Error Reporting System, or INMERS. Once a hospital's quality assessment and improvement program determines a serious adverse event has taken place, it must be reported to the state within 15 days. The data elements that are reported include the name of the hospital, the type of event and the quarter of the year it occurred. The ISDH must maintain a record of all events reported and make that information public at least once a year.

2014 Medical Error Report Highlights

Statewide, the total number of reported adverse events in 2014 was 114, with 102 reported by hospitals. This is the same total number of reported events as 2013. The four highest event types were relatively unchanged; however, three event types were reported in 2014 that were not reported in 2013. Total hospital serious adverse events for 2014, as well as historically reported numbers, are listed below:

HOSPITAL ADVERSE EVENTS	2007	2008	2009	2010*	2011	2012	2013	2014
Stage 3 or 4 pressure ulcers acquired after admission	27	33	22	34	41	30	45	44
Retention of a foreign object in a patient after surgery	24	28	28	30	15	19	25	25
Surgery performed on the wrong body part	19	13	13	12	15	13	13	12
Death or serious disability associated with a fall*	5	8	8	17	12	14	12	10
Death or serious disability associated with hypoglycemia	1	2	2	1	0	0	3	1
Wrong surgical procedure performed on a patient	1	1	2	2	3	2	2	3
Intra-operative or post-operative death in a normal, healthy patient	1	0	2	0	1	0	1	0
Death or serious disability associated with intravascular aim embolism	1	1	3	0	0	3	1	0
Death or serious disability associated with medication error	8	7	3	0	3	0	0	4
Death or serious disability associated with misuse or malfunction of device	1	2	2	1	0	1	0	2
Maternal death or serious disability associated with low-risk pregnancy labor or delivery	1	0	0	1	0	0	0	1

**Change in definition to include falls resulting in serious disability*

TOTAL REPORTABLE EVENTS

SURGICAL

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient
3. Wrong surgical procedure performed on patient
4. Retention of foreign object in patient after surgery
5. Intra-operative or post-operative death in a normal, healthy patient

PRODUCTS OR DEVICES

6. Death or serious disability associated with contaminated drugs, devices or biologics
7. Death or serious disability associated with misuse or malfunction of device
8. Death or serious disability associated with intravascular air embolism

PATIENT PROTECTION

9. Infant discharged to wrong person
10. Death or serious disability associated with patient elopement
11. Suicide or attempted suicide resulting in serious disability

CARE MANAGEMENT

12. Death or serious disability associated with medication error
13. Death or serious disability associated with hemolytic reaction
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy
15. Death or serious disability associated with hypoglycemia
16. Death or serious disability associated with hyperbilirubinemia in neonates
17. Stage 3 or 4 pressure ulcers acquired after admission
18. Death or serious disability due to joint movement therapy
19. Artificial insemination with the wrong donor sperm or wrong egg

ENVIRONMENTAL

20. Death or serious disability associated with electric shock
21. Wrong gas/contamination in patient gas line
22. Death or serious disability associated with a burn
23. Death or serious disability associated with a fall
24. Death or serious disability associated with restraints or bedrails

CRIMINAL

25. Care ordered by someone impersonating a health care provider
26. Abduction of patient of any age
27. Sexual assault of a patient on the facility grounds
28. Death/injury of patient or staff from physical assault occurring on facility grounds

For additional analysis, please review the 2014 Medical Error Report, focusing on the analysis of reported events on pages 29-30.

KEY MESSAGES

TALKING POINTS

One error is one too many. We regret that any patient has suffered while in our care. Despite our best efforts, human error can and does occur. When patients are harmed, we must do the right thing for them, their families and the caregivers involved. (Always apologize and express regret for harm caused.)

Report…Learn…Improve. Reporting leads to learning, which leads to improved safety. It is just one of many efforts to improve patient safety within organizations.

Our hospital is committed to providing safe care. We strive to create safe and reliable systems of care that prevent harm to patients. This includes the adoption of evidence-based practices proven to improve safety. We have also participated in national and statewide safety initiatives such as the national *Partnership for Patients* initiative. These initiatives provide an opportunity for our hospital to learn and improve. (Provide examples of your hospital's patient safety work.)

A safer state to receive health care. The IHA's Indiana Patient Safety Center works collaboratively with hospitals statewide to accelerate the spread of evidence-based practices that prevent harm to patients and reduce health care-acquired conditions and readmissions. A much larger safety initiative exists in Indiana that includes an emphasis on community wide safety improvement through 11 regional patient safety coalitions. From administrative leaders to front-line staff, more patient safety leaders are emerging throughout Indiana, that ultimately benefit Indiana residents committed to creating safer patient care environments.

Indiana's health care workforce continues to receive many educational opportunities through the Indiana Patient Safety Center. Hundreds of individuals participate in the annual Indiana Patient Safety Summit and educational programs throughout the year.

TOUGH MEDIA QUESTIONS & ANSWERS

Q: Why were there X adverse events reported at your hospital in 2014? Isn't one event too many?

A: *We regret that any patient has suffered while in our care. Despite our best efforts, human error can and does occur. When patients are harmed, we must do the right thing for them, their families and the caregivers involved.*

Q: Why would your hospital report zero errors when errors were reported by patients?

A: *State reporting guidelines include a specific set of what ISDH considers serious adverse events and it is possible a patient may claim a harm that is not currently monitored by the state. Our hospital has a policy to address all harms reported by patients regardless of the state's reporting guidelines. When patients are harmed, we must do the right thing for them, their families and the caregivers involved.*

Q: Why do medical errors reported keep rising year over year? What are you doing to mitigate these errors?

A: *While some medical errors reported are higher than in years past, in some cases the reporting definitions may have also changed. Ultimately, reporting leads to learning, which leads to improved safety. It is just one of many efforts to improve patient safety within organizations. (Use this question as an opportunity to share information about how you have improved.)*

We strive to create safe and reliable systems of care that prevent harm to patients. This includes the adoption of evidence-based practices proven to improve safety. We have also participated in national and statewide safety initiatives, such as the national Partnership for Patients initiative, which ran from 2012-2014 and prevented 4,690 harms in Indiana in 11 harm topics. (If your hospital did not participate in the IHA Hospital Engagement Network (HEN), share results from your HEN work or another improvement project.)

Q: How can patients trust your hospital to provide quality care when avoidable medical errors have been reported?

A: *Our hospital strives to create safe and reliable systems of care that prevent harm to patients, which include the adoption of evidence-based practices proven to improve safety. (Provide an example about how your organization has taken an adverse situation, learned from the situation and made improvements. Describe how you do an analysis and make changes to processes. This is an opportunity to share how you engage patients and families.)*

ACTION STEPS

- Designate a hospital spokesperson.
- Know the number of events your hospital reported in 2014 and in each of the prior reporting years.
- Read the 2014 Medical Error Report, focusing on the analysis of reported events on pages 29-30.
- Create talking points for your hospital program and consider including ways in which patients and family members are engaged in patient safety improvement efforts.
- Identify a positive safety improvement story for possible media interest, potentially in your area of highest reported adverse events.
- Be prepared to talk about what your hospital is doing to improve patient safety and outcomes. Consider your total efforts in promoting a culture of patient safety and patient and family engagement as well as your efforts to reduce harm.
- Inform and educate your stakeholders about INMERS and your hospital's quality and patient safety agenda. Board members, employees and physicians are often the most influential communicators of your hospital's quality and safety record.
- Review your policy on reporting serious adverse events to the ISDH and know your hospital's internal designated point of contact for reporting adverse events to ISDH.
- Know your hospital's policies on payment for serious adverse events and be prepared to talk about them.
- Review your hospital's apology and disclosure policy. If your hospital has no written policy, review the document "When Things Go Wrong."
- Use the IHA as a resource for media calls. IHA's contacts are as follows:
  - Carolyn P. Konfirst, RN, DrPH
    Clinical Director, Indiana Patient Safety Center
    317-423-7799
    ckonfirst@IHAconnect.org
  - Jennifer Hurtubise
    Director of Communications
    317-423-7733
    jhurtubise@IHAconnect.org

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SUGGESTED HOSPITAL EMPLOYEE NEWSLETTER / E-MAIL BLAST

As part of our efforts to prevent unnecessary harms and improve quality care for patients, no one is more important to the success of our efforts than your own employees. They are the ambassadors of what Indiana hospitals represent. Through them, we can ensure hospitals are well equipped to make Indiana a safer state to receive health care.

Below you will find suggested content for your employee newsletter or e-mail blast. We understand that not every hospital newsletter is the same, and that each hospital is unique in the development and execution of its communication. This is merely suggested content. Please feel free to adapt for your own purposes and requirements.

Headline / Subject Line:
State Releases 2014 Indiana Medical Error Report

Body:
The Indiana State Department of Health (ISDH) recently released the 2014 Indiana Medical Error Report, a public record of serious adverse events that are required to be reported annually by hospitals, ambulatory surgery centers, abortion clinics and birthing centers.

Statewide, the total number of reported adverse events in 2014 was 114, with 102 reported by hospitals. This is the same total number of reported events as 2013. The four highest event types were relatively unchanged; however, three event types were reported in 2014 that were not reported in 2013.

[NAME OF HOSPITAL] reported XX errors in 2014 compared to XX in 2013.

As health care providers, it's important for us to review the data, identify areas of improvement and work internally to ensure our hospital has the processes in place to minimize or eliminate the potential occurrence of an adverse event.

At [NAME OF HOSPITAL], we're constantly striving for zero harms. One harm is one too many. Despite our best efforts, however, human error can and does occur.

Our hospital is committed to providing safe care. Reporting leads to learning, which leads to improved safety. [NAME OF HOSPITAL] aims to create safe and reliable systems of care that prevent harm to patients. This includes the adoption of evidence-based practices proven to improve safety.

As part of our efforts to improve quality care for patients, no one is more important to the success of our efforts than you – our staff. You are the ambassadors of what Indiana hospitals represent, providing the critical care to help improve the lives of all Hoosiers – each and every day. Working together, we can ensure [NAME OF HOSPITAL] is well equipped to provide optimal, safe care for all patients.

For any questions regarding [NAME OF HOSPITAL's] medical error reporting protocol, or general questions regarding this year's report, please contact [FIRST NAME LAST NAME] at [PHONE] or [EMAIL].

Thank you for your continued work to improve the quality of care for our patients.

Sincerely,

[FIRST NAME LAST NAME]

[TITLE]