



Medical Error Report Hospital Toolkit

Indiana hospitals are committed to providing safe care. Every Hoosier deserves access to safe, reliable health care. The Indiana State Department of Health (ISDH) recently released its [2017 Medical Error Report](#). It is critical for us as health care providers to review the new data, identify areas of improvement, and ensure that every hospital has processes in place to minimize or eliminate the potential occurrence of an adverse event.

One harm is one too many, and, as health care leaders, we constantly strive for zero harms. However, human error can occur. When patients are harmed, we must do the right thing for them, their families, and the caregivers involved.

The 2017 report shows that, in the past year, we have seen a significant reduction in stage 3 or 4 pressure ulcers acquired after admission. The report also shows a continued need to work towards the reduction of surgical adverse events. Collaboration and sharing best practices are key to keeping patients safe across Indiana. Eleven regional patient safety coalitions meet regularly to work together on quality improvement for the sake of our patients and the communities we serve. Indiana hospitals do not compete when it comes to patient safety.

Hospitals across the state have made tremendous progress to prevent harms through programs like the Hospital Improvement Innovation Network (HIIN), currently in progress. Other initiatives focused on quality improvement and patient safety across the state include the *See It. Stop It. Survive It.* Sepsis Awareness Month, and Patient Safety Awareness Month.

By uniting around common principles and encouraging the creation of reliable systems of care, we can create a healthier Indiana with safer care for all.



Please feel free to reach out to IHA with any questions regarding the 2017 Medical Error Report.

Sincerely,

A handwritten signature in black ink that reads "Brian Tabor".

Brian Tabor
IHA President

BACKGROUND INFORMATION

The Indiana State Department of Health (ISDH) has released the 2017 Medical Error Report. This is the 12th 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. ISDH must maintain a record of all events reported and make that information public at least once a year.

2017 Medical Error Report Highlights

Statewide, the total number of adverse events reported by hospitals in 2017 was 105. This year saw a reduction of reported events over last year's record high 122 events. The most reported event for 2017 was retention of a foreign object in a patient after surgery with 33. The next most reported event at 28 was stage 3 or 4 pressure ulcers acquired after admission. Total hospital adverse events for 2017, as well as reported numbers for the last five years, are listed below:

HOSPITAL ADVERSE EVENTS	2013	2014	2015	2016	2017
Retention of a foreign object in a patient after surgery	25	25	33	19	33
Stage 3 or 4 pressure ulcers acquired after admission	45	44	37	57	28
Surgery performed on the wrong body part	13	12	18	23	19
Death or serious disability associated with a fall	12	10	13	13	11
Death or serious disability associated with medication error	0	4	2	1	2
Death / injury of patient or staff from physical assault occurring on facility grounds	0	0	0	1	2
Wrong surgical procedure performed on a patient	2	3	6	3	1
Suicide or attempted suicide resulting in serious disability	0	0	1	2	1
Surgery performed on the wrong patient	0	0	0	1	1
Death or serious disability associated with intravascular air embolism	1	0	0	1	1
Sexual assault of a patient on the facility grounds	0	0	1	1	1
Death or serious disability associated with hypoglycemia	3	1	1	0	1
Death or serious disability associated with a burn	0	0	0	0	1
Maternal death or serious disability associated with low-risk pregnancy labor or delivery	0	1	0	0	1
Death or serious disability associated with restraints or bedrails	0	0	1	0	1
Care ordered by someone impersonating a health care provider	0	0	0	0	1
Intra-operative or post-operative death in a normal, healthy patient	1	0	0	0	0
Death or serious disability associated with contaminated drugs, devices, or biologics	0	0	0	0	0
Death or serious disability associated with patient elopement	0	0	0	0	0
Death or serious disability associated with misuse or malfunction of device	0	2	0	0	0
Wrong gas / contamination in patient gas line	0	0	0	0	0
Death or serious disability associated with hemolytic reaction	0	0	1	0	0
Abduction of patient of any age	0	0	0	0	0
Infant discharged to wrong person	0	0	0	0	0
Death or serious disability (kernicterus) associated with hyperbilirubinemia in neonates	0	0	0	0	0
Death or serious disability due to joint movement therapy	0	0	0	0	0
Artificial insemination with the wrong donor sperm or wrong egg	0	0	0	0	0
Death or serious disability associated with electric shock	0	0	0	0	0
	102	102	114	122	105

Note: There were no changes to the 2017 reporting requirements and standards

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 2017 Medical Error Report, focusing on the analysis of reported events on page 27.

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. Prompt disclosure and transparency is essential to identify failures and avoid future events.

Reporting helps us avoid future events. 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 are also participating in national and statewide safety initiatives such as the national Hospital Improvement Innovation Network (HIIN). These initiatives provide an opportunity for our hospital to learn and improve. (Provide examples of your hospital's patient safety work.)

Indiana hospitals work together to improve 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. In addition, hospitals work together on community-wide safety improvement initiatives through 11 regional patient safety coalitions. From administrative leaders to frontline staff, more patient safety leaders are emerging throughout Indiana who are committed to creating safer patient care environments.

Our staff are committed to ongoing education and training. Our employees attend educational opportunities offered through the Indiana Patient Safety Center and other resources. 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 2017? 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 report 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 requirements. When patients are harmed, we must do the right thing for them, their families, and the caregivers involved.

Q: Why do medical errors occur? What are you doing to mitigate these errors?

A: 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 Hospital Engagement Network, which ran from 2012-2014, and the Hospital Engagement Network 2.0, which ran from 2015-2017, and prevented 3,751 harms in Indiana in 11 harm topics. We are currently participating in the third phase of this project, the Hospital Improvement Innovation Network. (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 2017 and in each of the prior reporting years.
- Read the 2017 Medical Error Report, focusing on the analysis of reported events on page 27.
- Create talking points for your hospital program and consider including ways in which patients and family members are engaged in patient safety improvement efforts, such as patient and family advisory councils.
- 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 ISDH and know your hospital's internal designated point of contact for reporting adverse events to ISDH.
- Know your hospital's policies for addressing 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:
 - Karin Kennedy
Vice President, Quality and Patient Safety
317-423-7737
kkennedy@IHAconnect.org
 - Julie Brackemyre
Communications Specialist
317-423-7726
jbrackemyre@IHAconnect.org



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SUGGESTED HOSPITAL EMPLOYEE NEWSLETTER ARTICLE / EMAIL 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 our 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 email 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 2017 Indiana Medical Error Report

Body:

The Indiana State Department of Health (ISDH) recently released the 2017 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 2017 was 110, with 105 reported by hospitals. This year saw a reduction of reported events over last year's record high when 127 events were reported. The most reported event for 2017 was retention of a foreign object in a patient after surgery with 34. The next most reported event at 28 was stage 3 or 4 pressure ulcers (also known as bed sores) acquired after admission.

[NAME OF HOSPITAL] reported XX errors in 2017 compared to XX in 2016.

As health care providers, it's important for us to review the data, identify areas for 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 our success 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]