Minnesota's Adverse Health Events
Pressure Ulcers and the Patient Safety Community's Response

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Background/Purpose

A National Quality Forum (NQF) report, *Serious Reportable Events in Healthcare* released a consensus list of 27 "never events" (events that should never happen), which **included Stage III and IV pressure ulcers**. Minnesota became the first state to sign into law mandatory and public reporting of the NQF list of serious reportable events. Two states have since signed similar laws and it is speculated that all states will eventually collect and publicly report data on occurrence of pressure ulcers and other "never events". The purpose of this poster is to share Minnesota's experience and response to the law mandating public reporting of pressure ulcers.

Timeline of Events

2000 - Minnesota Alliance for Patient Safety (MAPS) formed
2002 - NQF report *"Serious Reportable Events in Healthcare"* released.
2003 - Adverse Health Care Event Reporting Law went into effect.
July 2003 to December 2004 - Hospitals begin reporting events as part of the law's "transition period".
December, 2004 - Full implementation began.
January, 2005 –PUBLIC REPORT of the first 15 months released.

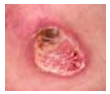
Reporting Process

1. Each hospital required to self report stage III and IV pressure ulcers. Necrotic wounds and wounds that are initially classified as a stage 2 are excluded.
2. Reports are made to the Minnesota Department of Health (MDH) through a password protected web based registry.
3. Within 15 working days, initial information about the event must be reported.
4. Within 60 days, findings of a **Root Cause Analysis** and a corrective action plan must be reported. NO identifying information for any health professionals, employees or patients is included.

Summary of the Public Report

- **99** adverse health events during a 15-month period.
- Stage III and IV pressure ulcers are second most frequently reported "never event".

Minnesota's Response to Stage III & IV Pressure Ulcer "Never Events"



Collaboratively, the Minnesota Alliance for Patient Safety (MAPS) and the Minnesota Institute for Clinical Systems Improvement (ICSI) formed an expert panel of practitioners (including WOC nurses) from Minnesota hospitals to share best practices and barriers to implementation. This group then:

- ❑ **Assessed aggregate root cause analysis findings**
- ❑ **Reviewed local and national guidelines**
- ❑ **Developed recommendations to address "barriers to guideline implementation" as identified by aggregate root cause analysis**
- ❑ **Convened a Pressure Ulcer Summit for hospitals, patient safety managers and other key players to discuss existing guidelines and identified "barriers" to guideline implementation**
- ❑ **Published protocols, documents and tools *online* so readily accessible to hospitals**

Root Cause Analysis Results: Barriers to Implementing Pressure Ulcer Prevention Guidelines

BARRIERS	DESCRIPTION
Documentation	❑ Inconsistent ❑ Incomplete
Knowledge Deficit	❑ Skin inspection ❑ How quickly pressure ulcer can develop ❑ Support surface selection
Communication	❑ Inconsistent, insufficient and lacking between staff, units, and facilities ❑ At-risk status not effectively communicated
Tools/Equipment	❑ Decision making tools for support surface selection are inadequate or not available ❑ Equipment (including Bariatric) not readily available
Administrative Directives	❑ Resources allocated for wound care rather than prevention and risk reduction

State Mandated Public Reporting

Benefits	Disadvantages
Heightened motivation to dedicate resources to pressure ulcer prevention (FTEs, funds for support surfaces, etc.).	**Self reporting may lead to under reporting.**
Increased value of the WOC Nurse position.	**Potential to maintain necrotic wounds to avoid reporting.**
Greater focus on evidence based care.	**The consumer has access to the public information without a framework to accurately interpret meaning and clinical relevance.**

References

National Quality Forum, Serious Reportable Events in Healthcare. Washington DC, 2002 Adverse Health Events in Minnesota. Available at: http://www.mnhospitals.org/inc/data/pdfs/MDH_Report1.pdf
MAPS website: http://www.mnpatientsafety.org
ICSI website: http://www.icsi/knowledge/index.asp. Go to health care protocols

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