JANUARY 2005

ADVERSE HEALTH EVENTS IN MINNESOTA HOSPITALS

FIRST ANNUAL PUBLIC REPORT

ADVERSE HEALTH EVENTS IN MINNESOTA HOSPITALS

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This report can be found on the internet at: **www.minnesotahealthinfo.org**

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ADVERSE HEALTH EVENTS IN MINNESOTA HOSPITALS

First Annual Report • January 2005

Includes Hospital Events Reported: July 2003 – October 2004

"People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer."
– The Institute of Medicine, "To Err Is Human"

The landmark IOM Report, "To Err Is Human," estimated that the overall cost of preventable adverse events was between $17 and $29 billion. Half of this was direct health care costs.

Assuming the IOM numbers would apply in Minnesota today for our population, the estimated direct health care cost of all preventable adverse events in Minnesota is nearly $200 million per year.

BACKGROUND

It has been five years since the Institute of Medicine (IOM) released its landmark report "To Err is Human." This report introduced many Americans to the idea that medical errors in hospitals kill between 44,000 and 98,000 people each year, making medical errors the 8th leading cause of death in this country.[1] This problem was not a new one for health professionals, but the IOM report helped to focus the efforts of many in health care to address the systemic causes of medical errors.

The report helped to confirm that most of the medical errors were not the result of the actions of any one provider of care, but that most of these errors resulted from a failure of the complex systems and processes in health care. According to the report, "People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer."[2] Recognizing that entire systems of care were in need of redesign and that one of the most effective ways to accomplish this was to know more about preventable adverse events, the IOM recommended a mandatory reporting system where the most serious events would be reported, persistent safety problems would be identified and action would be taken to prevent these errors.[3]

In response to the IOM's recommendation, a national health policy group, the National Quality Forum (NQF), and their expert panel representing a broad range of health care stakeholders developed a consensus list of specific events that should never happen to patients in health facilities. This list, which became known as the "never events" list, evolved into the 27 Serious Reportable Events in Healthcare published by the NQF in 2002.[4]

In some states there was considerable debate about the accuracy of the numbers in the IOM report or the best approach among the different solutions proposed by the IOM and others. In Minnesota our health care leaders embraced the notion that one serious medical error is one too many. And with that conviction in mind, a coalition of Minnesota hospitals, doctors, nurses and patient advocates supported the legislation creating Minnesota's Adverse Health Event Reporting Law during the 2003 legislative session. With Sen. Steve Kelley and Rep. Lynda Boudreau as chief authors, the law had broad bipartisan legislative support and support from Governor Pawlenty and the Minnesota Department of Health (MDH). This law mandated the reporting of the "never events" as developed by the National Quality Forum. (For more information on the National Quality Forum and their work on the list of "Serious Reportable Events," see Appendix C.)

The law directed that non-state funds were to be used to implement the law and required a transition period prior to full implementation. The transition period was needed to work through some of the reporting requirements and data needs as well as to identify and secure funding for the start-up period. A broad group of stakeholders contributed $250,000 in the first two years to get the process started.[5] It is a tribute to the strong collaborative relationships in Minnesota's health care community and the dedication to improving patient safety that significant funds were contributed and work was able to proceed rapidly.

[1] Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 2000
[2] Ibid
[3] Ibid
[4] National Quality Forum, Serious Reportable Events in Healthcare. Washington D.C., 2002.
[5] The Minnesota Hospital Association worked with MDH to raise the necessary funds. Major donors include Stratis Health, Blue Cross Blue Shield of Minnesota, Midwest Medical Insurance Company and the Buyers Health Care Action Group. Funds were also contributed by the St. Jude Medical Foundation and the Pharmaceutical Research Manufacturers of America.

During the transition period, Minnesota hospitals began electronically reporting the adverse events as required on July 1, 2003, through the Minnesota Hospital Association's Patient Safety Registry. Hospitals are required to post information on the registry about the 27 reportable events, along with their determination of why the event happened and what is being done to prevent the event from happening again. With this web-based system and the analysis and feedback provided in the law, hospitals are able to learn from the experiences of other hospitals.

Full implementation, with reports coming to MDH, began on December 6, 2004. MDH has implemented the adverse events law as a quality improvement initiative, not as a regulatory enforcement tool and has non-regulatory staff processing and analyzing adverse event reports. MDH is required to execute a number of activities related to the adverse event reports including:

- Tracking, assessing and analyzing the incoming reports, findings and corrective action plans,
- Determining patterns of failure, if any, and successful methods to correct system problems,
- Sharing findings with individual facilities, providing follow-up and feedback as needed,
- Educating facilities across the state regarding best safety practices,
- Monitoring national efforts and those in other states to ensure consistency and best practice in the Minnesota law and proposing modifications to the law based on this analysis, and;
- Publishing an annual report of events and corrective actions and communicating with purchasers and the public about lessons learned to improve health care quality.

The analysis and feedback process has just begun with the full implementation of the law. Much work lies ahead; however, early results suggest that the law has already demonstrated success in the ongoing goals of quality improvement and accountability. Hospitals have initiated specific safety improvement strategies with measurable results (for selected examples refer to the "Corrective Actions" section of this report on page 7). The Minnesota Department of Health and provider licensing boards are working together under the adverse events reporting law to identify opportunities for learning and prevention. And Minnesota hospital leaders have remained committed to transparency, encouraging the publication of the data collected during the transition period as soon as possible.

This report summarizes completed event reports Minnesota hospitals have reported during the transition period of the law; from July 2003 to October 2004. Tables with the overall, state-wide information begin on page 11. Hospital-specific data follows, beginning on page 15. Outpatient surgical centers were added as reporting facilities under modifications made to the law in the 2004 legislative session and began reporting events on December 6, 2004. Surgical center events will be included in the next annual report.

HOW TO USE THIS REPORT

Consumers and patients should know that events listed in this report represent a very small fraction of all of the procedures and admissions in Minnesota's hospitals, but that patient awareness is important to help prevent these relatively rare events.

With relatively low occurrence of these serious events, it is important to be aware that differences in reports between facilities can come from differences in reporting procedures or differences in interpretation or understanding of the law as much as from differences in the quality or safety of a hospital. As clearly and concisely as the Minnesota Adverse Health Event Reporting Law is written, there will still be variation in what gets reported based on interpretation of which events are

The information in this report should not be used to compare the safety or quality of facilities. The number of reported events can vary based on many factors other than differences in the safety of care, including:

- *The size of the facility.*
- *Differences in interpretation on which events qualify as reportable.*
- *Staff awareness of situations requiring reporting.*

It is also important to remember that the scope of patient safety is much broader than what is represented with these 27 reportable events.

Because it is difficult to know which of the many factors may be influencing the number of reported events for any hospital, it is best to use this report as a guide to increase awareness of safety issues. Prepared with this information, consumers should ask questions and take action based on what is important to them. If hospitals have implemented corrective actions and prevention strategies regarding adverse events, patients and families should ask how they can support and reinforce these efforts.

reportable or the awareness of the staff to identifying potentially harmful situations and reporting events. MDH, hospitals and other patient safety stakeholders continue work to reduce this variation in understanding and application of the law.

The fact that health care providers in Minnesota's hospitals are looking for potentially dangerous situations and reporting them with the intention to learn and prevent harm to patients is a major step forward in patient safety. Consumers should use this report to identify situations of interest to them and then ask their hospital or health care provider what is being done in their facility to prevent this type of event from occurring.

Patients and families are a vital part of the health care team and play an important role in ensuring safe health care. Many resources are available for patients interested in what they can do to help make their health care safer. One such resource is the Federal Agency for Health Research and Quality (AHRQ). AHRQ has pulled together the best research on patient safety and has developed many tips for patients that can be found at www.ahrq.gov. Some of these tips are highlighted on the following page.

SELECTED SAFETY TIPS FROM THE AGENCY FOR HEALTH QUALITY AND RESEARCH[6]

Be Involved in Your Health Care

1. The single most important way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results.

Hospital Stays

2. If you have a choice, choose a hospital at which many patients have the procedure or surgery you need. Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.

3. If you are in a hospital, consider asking all health care workers who have direct contact with you whether they have washed their hands. Hand washing is an important way to prevent the spread of infections in hospitals. Yet, it is not done regularly or thoroughly enough. A recent study found that when patients checked whether health care workers washed their hands, the workers washed their hands more often and used more soap.

4. When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will use at home. This includes learning about your medicines and finding out when you can get back to your regular activities. Research shows that at discharge time, doctors think their patients understand more than they really do about what they should or should not do when they return home.

Surgery

5. If you are having surgery, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done. Doing surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. The American Academy of Orthopaedic Surgeons urges its members to sign their initials directly on the site to be operated on before the surgery.

Other Steps You Can Take

6. Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.

7. Make sure that someone, such as your personal doctor, is in charge of your care. This is especially important if you have many health problems or are in a hospital.

8. Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need to.

9. Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.

10. Know that "more" is not always better. It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.

11. If you have a test, don't assume that no news is good news. Ask about the results.

12. Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.[7]

[6] Agency for Health Quality and Research, Patient Fact Sheet: 20 Tips to Help Prevent Medical Errors Online. Available: http://www.ahrq.gov/consumer/ [Accessed January 2005]

[7] A number of good sources are available both nationally and locally on the best available healthcare treatments. For example nationally, treatment recommendations based on the latest scientific evidence are available from the National Guidelines Clearinghouse at www.guideline.gov. Local examples of information resources on evidence based health care include the Institute Clinical Systems Improvement at www.icsi.org. Ask your doctor if your treatment is based on the latest evidence.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

Detailed definitions are included in Appendix B.

SURGICAL EVENTS

- Surgery performed on a wrong body part;
- Surgery performed on the wrong patient;
- The wrong surgical procedure performed on a patient;
- Foreign objects left in a patient after surgery; or
- Death during or immediately after surgery of a normal, healthy patient.

ENVIRONMENTAL EVENTS

Patient death or serious disability associated with:

- An electric shock;
- A burn incurred while being cared for in a facility;
- A fall while being cared for in a facility;
- The use of or lack of restraints or bedrails while being cared for in a facility;. and
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

PATIENT PROTECTION EVENTS

- An infant discharged to the wrong person;
- Patient death or serious disability associated with patient disappearance; and
- Patient suicide or attempted suicide resulting in serious disability.

CARE MANAGEMENT EVENTS

Patient death or serious disability:

- Associated with a medication error;
- Associated with a reaction due to incompatible blood or blood products;
- Associated with labor or delivery in a low-risk pregnancy;
- Directly related to hypoglycemia (low blood sugar);
- In newborn infants during the first 28 days of life;
- Due to spinal manipulative therapy; and
- Stage 3 or 4 ulcers (very serious pressure sores) acquired after admission to a facility.

PRODUCT OR DEVICE EVENTS

Patient death or serious disability associated with:

- The use of contaminated drugs, devices, or biologics;
- The use or malfunction of a device in patient care; and
- An intravascular air embolism.

CRIMINAL EVENTS

- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
- Abduction of a patient of any age;
- Sexual assault on a patient within or on the grounds of a facility; and
- Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

EVENTS REPORTED BETWEEN JULY 1, 2003 – OCTOBER 6, 2004[8]

Detailed information is provided in the tables beginning on page 10.

THE PURPOSE OF THE LAW IS TO LEARN FROM SERIOUS EVENTS SO THAT HARM TO PATIENTS CAN BE PREVENTED.

EARLY FINDINGS:

- *THE MOST FREQUENTLY REPORTED EVENTS WERE FOREIGN OBJECTS LEFT IN PATIENTS AFTER SURGERY.*
- *THE NEXT MOST FREQUENTLY REPORTED EVENT WAS STAGE 3 OR 4 PRESSURE ULCERS.*
- *ALMOST A THIRD OF THE "WRONG BODY PART SURGERY" REPORTS OCCURRED IN SPINE SURGERIES.*

For the period covered in this report, 99 events were reported into the web-based registry. These events are categorized as follows:

Category	Events
Surgical	52 events
Product or device	4 events
Patient Protection	2 events
Care Management	31 events
Environmental	9 events
Criminal	1 event

OVERVIEW OF ROOT CAUSE ANALYSES AND ACTION PLANS

Hospitals have put in place procedures for determining the underlying causes of adverse events in their facilities. This process is called a "root cause analysis" or an "RCA." The process of completing a root cause analysis helps a hospital determine exactly what happened and why it happened. Once the findings from an RCA are known, the hospital may then put actions in place to prevent future adverse events. These actions are called "corrective action plans."

The new Adverse Health Event Reporting law requires hospitals to submit the findings from their root cause analyses and corrective action plans whenever events are reported. These findings are an important part of the reporting process. Information from the RCAs and correction action plans will foster learning among facilities and help spread preventive actions across the state of Minnesota.

RCAs REPORTED DURING THE TRANSITION PERIOD

On an individual level, hospitals have been conducting RCAs and implementing a number of actions to reduce the harm from events and to prevent future adverse events. This work is typically conducted by teams within the facilities. These teams develop actions that will range from effective, yet simple quick "fixes" to significant changes that require more time and resources to implement.

The RCA information that has been reported during the transition period has varied from a minimum amount of reported information — sometimes only a couple of sentences — to very detailed reports of the RCA team findings. One of the challenges for future reporting will be to work with the facilities to determine what level of information is most useful to report in order to help other facilities learn from the work that has been completed. MDH will work with the facilities over the next year to help ensure that the RCA processes are consistently high quality and thorough across all facilities in the state.

CORRECTIVE ACTION PLANS DURING THE REPORTING PERIOD

The findings from the RCAs have led to a number of different action plans within the individual hospitals. These actions are a direct result of the reporting law. The majority of the planned actions have fallen under three main categories: providing care in a consistent manner; adopting practices that have been shown to improve patient safety; and restructuring of the hospital environment.

Examples of action plans that have been submitted for the most frequently reported adverse event types include:

SURGICAL

- Developing new ways to track objects used in surgical procedures
- Purchasing surgical sponges and other materials that are easier to track and count
- Making sure that surgery teams are pausing before surgery to review patient information

[8] This represents all event reports completed during the transition, or start-up period of the law.

- Marking the surgical site prior to surgery
- Increasing the use of x-rays in the operating room to identify the correct surgery site

Patient Falls

- Providing tools and processes to consistently assess patients at risk for falls
- Designing new processes for toileting patients at risk for falls
- Trialing different types of slippers

Pressure Ulcers (Bed Sores)

- Providing tools and methods to consistently assess patients at risk for pressure ulcers
- Purchasing special equipment to use for patients at risk for pressure ulcers
- Set up physician orders to make sure patients at risk for pressure ulcers are re-positioned on a regular basis
- Increasing the involvement of staff that specialize in wound care

Medication Errors

- Adding special labels to high risk medications
- Purchasing medications that are pre-packaged and pre-labeled
- Evaluating different types of pumps to deliver medications

COLLABORATIVE EFFORTS TO PREVENT ADVERSE EVENTS:

In addition to the work individual hospitals are doing to make improvements through their root cause analyses and corrective action plans, hospitals are taking several collaborative steps that are worth noting.

- The Minnesota Hospital Association formed a Registry Advisory Council, made up of patient safety professionals from member hospitals, to review the information being reported. The council looks for trends, identifies the need for safety alerts and develops recommendations for acting on data and sharing what has been learned. The first safety alert was issued in April 2004. This alert identified the relatively high number of surgical events and pressure ulcers reported. Some of the specific hospital actions as well as the actions of the Minnesota Alliance for Patient Safety and Safest in America (below) were taken based on the information in this alert.

- The Minnesota Alliance for Patient Safety (MAPS), which was co-founded by the Minnesota Department of Health, the Minnesota Hospital Association and the Minnesota Medical Association, has formed a MAPS Best Practices Subcommittee to research and promote best practices around prevention and treatment of reportable events. The subcommittee is focusing on identifying and highlighting best practices for implementing pressure ulcer assessments and treatments that have led to a successful reduction in pressure ulcers. There are many guidelines and tools that already exist, however the challenge is implementing and sustaining them. MAPS will be identifying barriers to implementing existing tools and educating health care professionals, patients and families on how to successfully implement a pressure ulcer reduction program. MAPS plans to apply for a federal AHRQ grant to assist in the dissemination of tools and methods to prevent pressure ulcers and to measure the effectiveness of different approaches.

- Safest in America – Safest in America is a collaboration of 10 hospital systems in the Twin Cities and Rochester that are committed to working together to improve patient care. In 2002 the group issued a protocol to standardize surgical site marking practices at the participating hospitals. The group has begun using information reported into the adverse health event system, reviewing each surgical event from their hospitals that involved a wrong body part, wrong patient or wrong procedure. This careful analysis has led Safest in America to revise its surgical site marking protocol. For example, the protocol now says that imaging (such as CT scans) should be done during spinal surgery to confirm that a procedure is being done at the correct position on the spine. In addition, Safest in America has taken further steps to ensure providers are adhering to the surgical marking protocol.

  In 2005 Safest in America will work to standardize steps hospitals can take to prevent patients from developing serious bed sores.

CONCLUSION

Reducing medical errors and preventing harm to patients requires more than just counting events. Disseminating the evidence-based best practices about patient safety, implementing these changes and sustaining them over time is critical if we want to see reduced harm to patients from medical errors. Leveraging the improvements directly resulting from the implementation of this law and sustaining them is the goal of the Minnesota Department of Health and its partners as we move forward. The specific activities listed on page 3 will be accomplished in the next phase, events from outpatient surgical centers will be reported and progress in patient safety improvements will be tracked. Generalized findings from the reports will be shared with the hospitals and surgical centers throughout the year and all of the activities for the year will be summarized in the next annual public report.

There is still much work to be done to improve patient safety. Comprehensive efforts to reduce adverse events are underway nationally and here in Minnesota. Initiatives like the adverse health events reporting law help to focus attention and energy on preventing the most serious adverse events and harm to patients. It is important to remember, however, that this reporting system is just one component of broader patient safety improvement strategies in Minnesota. Consumers and patients should use reports like this one to increase their awareness of patient safety issues and let their health providers know that patient safety and adverse event prevention strategies are a priority for them. This awareness and attention will help ensure that patient safety will continue to be a priority for hospitals and health providers in Minnesota.

TABLES AND DETAILED INFORMATION

TABLE 1:
Overall State-Wide Report **page 11**

This table describes the total number of reported events for the state during the transition period from July 1, 2003 through October 6, 2004. The events are grouped under the six major categories of events. The severity details are also included for the events reported, indicating if the result was death, serious disability or if the outcome was neither death nor serious disability.

TABLE 2:
State-wide Report by Event Category **pages 12 – 14**

This table also provides overall information for the state, but shows each type of reportable event within each of the six major categories.

TABLE 3.1 – 3.30:
Hospital-Specific Events **pages 15 – 44**

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

HOW TO READ HOSPITAL-SPECIFIC TABLES

Information on the size of the facility is presented on each hospital table. This information is given in two ways:

1) **Number of beds:** This is a common measure of the size of a hospital and provides a sense of the maximum number of patients who could stay at the facility at any one time. In Minnesota, hospitals range in size from 10 to 1,700 beds.

2) **Patient Days:** This measure represents how busy the hospital was over the reporting time period. It is a measure of the number of days that inpatients are hospitalized. Patient days were adjusted to account for inpatient and outpatient services.

- Hospitals are listed in alphabetical order.
- If there is no table for a hospital, it means that hospital did not report any events.

The Minnesota Hospital Association worked with each of its member hospitals to verify the accuracy of the reported events and, in cases where there were no events reported, asked hospitals to verify that they had no events.

TABLE 1
OVERALL STATE-WIDE REPORT

Reported adverse health events: **ALL EVENTS** (July 1, 2003- October 6, 2004)

	CATEGORY OF EVENTS						
	SURGICAL	PRODUCTS OR DEVICES	PATIENT PROTECTION	CARE MANAGEMENT	ENVIRONMENTAL	CRIMINAL	TOTAL
ALL HOSPITALS	52 Events	4 Events	2 Events	31 Events	9 Events	1 Event	99 Events
SEVERITY DETAILS	Serious Disability: 0 Death: 2 Neither: 50	Serious Disability: 0 Death: 4	Serious Disability: 2 Death: 0	Serious Disability: 2 Death: 5 Neither: 24	Serious Disability: 0 Death: 9	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 4 Death: 20 Neither: 75

TABLE 2
STATE-WIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS					
	1. WRONG BODY PART	2. WRONG PATIENT	3. WRONG PROCEDURE	4. FOREIGN OBJECT	5. INTRA/POST-OP DEATH	TOTAL
ALL HOSPITALS	13 Events	1 Event	5 Events	31 Events	2 Events	52 Events
SEVERITY DETAILS	Serious Disability: 0 Death: 0 Neither: 13	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 0 Death: 0 Neither: 5	Serious Disability: 0 Death: 0 Neither: 31	Serious Disability: 0 Death: 2 Neither: 0	Serious Disability: 0 Death: 2 Neither: 50

Details by Category: **PRODUCTS OR DEVICES** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS			
	6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	7. MISUSE OR MALFUNCTION OF DEVICE	8. INTRAVASCULAR AIR EMBOLISM	TOTAL FOR PRODUCTS OR DEVICES
ALL HOSPITALS	0 Events	4 Events	0 Events	4 Events
SEVERITY DETAILS		Serious Disability: 0 Death: 4		Serious Disability: 0 Death: 4

Details by Category: **PATIENT PROTECTION** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS			
	9. WRONG DISCHARGE OF INFANT	10. PATIENT DISAPPEARANCE	11. SUICIDE OR ATTEMPTED SUICIDE	TOTAL FOR PATIENT PROTECTION
ALL HOSPITALS	0 Events	0 Events	2 Events	2 Events
SEVERITY DETAILS			Serious Disability: 2 Death: 0	Serious Disability: 2 Death: 0

TABLE 2 (CONTINUED)

Details by Category: **CARE MANAGEMENT** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS							
	12. DEATH OR DISABILITY DUE TO MEDICATION ERROR	13. DEATH OR DISABILITY DUE TO HEMOLYTIC REACTION	14. DEATH OR DISABILITY DURING LOW-RISK PREGNANCY LABOR OR DELIVERY	15. DEATH OR DISABILITY ASSOCIATED WITH HYPO-GLYCEMIA	16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPER-BILIRUBI-NEMIA	17. STAGE 3 OR 4 PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULA-TION	TOTAL FOR CARE MANAGE-MENT
ALL HOSPITALS	6 Events	0 Events	0 Events	1 Event	0 Events	24 Events	0 Events	31 Events
SEVERITY DETAILS	Serious Disability: 2 Death: 4 Neither: 0			Serious Disability: 0 Death: 1 Neither: 0		Serious Disability: 0 Death: 0 Neither: 24		Serious Disability: 2 Death: 5 Neither: 24

Details by Category: **ENVIRONMENTAL** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS					
	19. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	20. WRONG GAS OR CONTAMINA-TION IN PATIENT GAS LINE	21. DEATH OR DISABILITY ASSOCIATED WITH A BURN	22. DEATH ASSOCIATED WITH A FALL	23. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	TOTAL FOR ENVIRON-MENTAL
ALL HOSPITALS	0 Events	0 Events	1 Event	8 Events	0 Events	9 Events
SEVERITY DETAILS			Serious Disability: 0 Death: 1	Death: 8	Serious Disability: 0 Death: 0	Serious Disability: 0 Death: 9

TABLE 2 (CONTINUED)

Details by Category: **CRIMINAL** (July 1, 2003- October 6, 2004)

	TYPES OF EVENTS				
	24. CARE ORDERED BY SOMEONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	25. ABDUC-TION OF PATIENT	26. SEXUAL ASSAULT OF A PATIENT	27. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT	TOTAL FOR CRIMINAL
ALL HOSPITALS	0 Events	0 Events	0 Events	1 Event	1 Event
SEVERITY DETAILS				Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 0 Death: 0 Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address: 800 East 28th Street Minneapolis, MN 55407
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 926

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**36,537 surgeries were performed at this facility during this time period**
Surgery performed on wrong patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical procedure performed	2	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	3	Deaths: 0; Serious Disability: 0; Neither: 3
Patient Protection Events		**There were 288,326 patient days at this facility during this time period**
Patient suicide or attempted suicide resulting in serious disability	1	Deaths: 0; Serious Disability: 1; Neither: 0
Care Management		**There were 288,326 patient days at this facility during this time period**
Hypoglycemia	1	Deaths: 1; Serious Disability: 0; Neither: 0
Environmental Events		**There were 288,326 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	9	Deaths: 2; Serious Disability: 1; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.2

ALBERT LEA MEDICAL CENTER – MAYO HEALTH SYSTEM

Address: 404 West Fountain Street Albert Lea, MN 56007
Website: www.almedcenter.org
Phone number: 507-373-2384
Number of beds: 219

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**4,054 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.3

BETHESDA REHABILITATION HOSPITAL

Address: 559 Capitol Boulevard St Paul, MN 55103
Website: www.healtheast.org/patientsafety
Phone number: 651-326-2273
Number of beds: 264

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Care Management		**There were 58,710 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.4

FAIRVIEW LAKES REGIONAL MEDICAL CENTER

Address: 5200 Fairview Boulevard Wyoming, MN 55092-8013
Website: www.fairview.org
Phone number: 651-982-7835
Number of beds: 70

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**4,687 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.5

FAIRVIEW NORTHLAND REGIONAL HOSPITAL

Address: 911 Northland Drive Princeton, MN 55371
Website: www.fairview.org
Phone number: 763-389-6305
Number of beds: 41

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Product or Device Events		**There were 27,614 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.6

FAIRVIEW RED WING MEDICAL CENTER

Address: 701 Fairview Blvd. Red Wing, MN 55066
Website: www.fairview.org
Phone number: 651-267-5757
Number of beds: 57

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**3,840 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.7

FAIRVIEW RIDGES HOSPITAL

Address: 201 East Nicollet Boulevard Burnsville, MN 55337
Website: www.fairview.org
Phone number: 952-892-2262
Number of beds: 150

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**12,611 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.8

FAIRVIEW SOUTHDALE HOSPITAL

Address: 6401 France Avenue South Edina, MN 55435
Website: www.fairview.org
Phone number: 952-924-5161
Number of beds: 390

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**23,744 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Product or Device Events		**There were 131,466 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
Environmental Events		**There were 131,466 patient days at this facility during this time period**
A fall while being cared for in a facility	2	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 3; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.9

FAIRVIEW-UNIVERSITY MEDICAL CENTER

Address: 2450 Riverside Avenue Minneapolis, MN 55454
Website: www.fairview.org
Phone number: 612-672-6396
Number of beds: 1700

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**26,310 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	6	Deaths: 0; Serious Disability: 0; Neither: 6
Product or Device Events		**There were 362,802 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
Care Management		**There were 362,802 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	5	Deaths: 0; Serious Disability: 0; Neither: 5
TOTAL EVENTS FOR THIS FACILITY	13	Deaths: 1; Serious Disability: 1; Neither: 11

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.10

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

Address: 200 East University Avenue St. Paul, MN 55101
Website: www.gillettechildrens.org
Phone number: 651-229-1723
Number of beds: 60

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**3,470 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.11

GRANITE FALLS MUNICIPAL HOSPITAL AND MANOR

Address: 345 Tenth Ave. Granite Falls, MN 56241-1442
Website: www.gfmhm.com
Phone number: 320-564-3111
Number of beds: 30

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Environmental Events		**There were 13,222 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.12

HENNEPIN COUNTY MEDICAL CENTER

Address: 701 Park Ave S   Minneapolis, MN 55145-1829
Website: www.hcmc.org/patients/patientsafety
Phone number: 612-873-2338
Number of beds: 910

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**11,139 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
Patient Protection Events		**There were 215,174 patient days at this facility during this time period**
Patient suicide or attempted suicide resulting in serious disability	1	Deaths: 0; Serious Disability: 1; Neither: 0
Care Management		**There were 215,174 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	3	Deaths: 0; Serious Disability: 0; Neither: 3
Criminal Events		**There were 215,174 patient days at this facility during this time period**
Death or significant injury of patient or staff from physical assault	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 0; Serious Disability: 1; Neither: 5

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.13

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

Address: 1025 Marsh Street Mankato, MN 56001
Website: www.isj-mhs.org
Phone number: 507-345-2646
Number of beds: 272

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**8,338 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Death of a normal, healthy patient during or immediately after surgery	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 1; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.14

METHODIST HOSPITAL PARK NICOLLET HEALTH SERVICES

Address: 6500 Excelsior Blvd. St Louis, MN 55426
Website: www.parknicollet.com/methodist/patients-visitors/patient_safety.cfm
Phone number: 952-993-5114
Number of beds: 426

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**25,860 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	6	Deaths: 0; Serious Disability: 0; Neither: 6
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 0; Serious Disability: 0; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.15

NORTH COUNTRY HEALTH SERVICES

Address: 1300 Anne St. N.W. Bemidji, MN 56601-5103
Website: www.nchs.com/ptsafe.htm
Phone number: 218-333-5760
Number of beds: 98

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Care Management		**There were 49,582 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.16

NORTH MEMORIAL MEDICAL CENTER

Address: 3300 Oakdale Avenue North Robbinsdale, MN 55422
Website: www.northmemorial.com
Phone number: 763-520-5183
Number of beds: 518

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**23,637 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	3	Deaths: 0; Serious Disability: 0; Neither: 3
Care Management		**There were 202,022 patient days at this facility during this time period**
A medication error	1	Deaths: 1; Serious Disability: 0; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	3	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	7	Deaths: 1; Serious Disability: 0; Neither: 6

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.17

REGIONS HOSPITAL

Address: 640 Jackson Street St Paul MN 55101
Website: www.regionshospital.com
Phone number: 651-254-4725
Number of beds: 427

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**19,854 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
Care Management		**There were 197,500 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
Environmental Events		**There were 197,500 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	5	Deaths: 1; Serious Disability: 1; Neither: 3

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.18

RIVERVIEW HEALTHCARE ASSOCIATION

Address: 323 S. Minnesota St. Crookston, MN 56716-1601
Website: www.riverviewhealth.org
Phone number: 612-775-9762
Number of beds: 49

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**2,871 surgeries were performed at this facility during this time period**
Death of a normal, healthy patient during or immediately after surgery	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.19

ROCHESTER METHODIST HOSPITAL

Address: 201 West Center Street Rochester, MN 55902
Website: www.mayoclinic.org/event-reporting
Phone number: 507-284-5005
Number of beds: 794

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**28,438 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.20

SAINT MARYS HOSPITAL

Address: 1216 Second Street SW Rochester, MN 55902
Website: www.mayoclinic.org/event-reporting
Phone number: 507-284-5005
Number of beds: 1157

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**38,259 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
Care Management		**There were 485,961 patient days at this facility during this time period**
A medication error	2	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	5	Deaths: 2; Serious Disability: 0; Neither: 3

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.21

ST. CLOUD HOSPITAL

Address: 1406 Sixth Avenue North St. Cloud, MN 56303
Website: www.centracare.com
Phone number: 320-251-2700 ext 54100
Number of beds: 489

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**17,641 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	2	Deaths: 0; Serious Disability: 0; Neither: 2
Care Management		**There were 205,813 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 0; Serious Disability: 0; Neither: 4

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.22

ST. FRANCIS REGIONAL MEDICAL CENTER

Address: 1455 St. Francis Avenue Shakopee, MN 55379
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 70

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**5,440 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.23

ST. JOHN'S HOSPITAL

Address: 1575 Beam Avenue Maplewood, MN 55109
Website: www.healtheast.org/patientsafety
Phone number: 651-326-2273
Number of beds: 184

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**8,198 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.24

ST. JOSEPH'S HOSPITAL

Address: 69 West Exchange Street St. Paul, MN 55102
Website: www.healtheast.org/patientsafety
Phone number: 651-326-2273
Number of beds: 401

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**7,352 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.25

ST. JOSEPH'S MEDICAL CENTER

Address: 523 North Third Street Brainerd, MN 56401
Website: www.sjmcmn.org
Phone number: 218-828-7339
Number of beds: 162

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003–OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Care Management		**There were 75,795 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.26

ST. LUKE'S HOSPITAL

Address: 915 East First Street Duluth, MN 55805
Website: www.slhduluth.com
Phone number: 218-249-5359, 218-249-5389
Number of beds: 267

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**12,790 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
Product or Device Events		**There were 129,283 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1; Serious Disability: 0; Neither: 0
Care Management		**There were 129,283 patient days at this facility during this time period**
A medication error	1	Deaths: 1; Serious Disability: 0; Neither: 0
Environmental Events		**There were 129,283 patient days at this facility during this time period**
A burn received while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 4; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.27

ST. MARY'S MEDICAL CENTER

Address: 407 East Third Street Duluth, MN 55805
Website: www.smdc.org/customer_serv_patient_rep.cfm
Phone number: 218-786-3827
Number of beds: 380

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Care Management		**There were 133,523 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
Environmental Events		**There were 133,523 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	3	Deaths: 1; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.28

UNITED HOSPITAL

Address: 333 North Smith Avenue St. Paul, MN 55102
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 556

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**19,978 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Care Management		**There were 198,887 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.29

UNITY HOSPITAL

Address: 550 Osborne Road N.E. Fridley, MN 55432-2718
Website: www.allina.com/patientsafety
Phone number: 612-775-9762
Number of beds: 275

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Surgical Events		**11,046 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	2	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
Environmental Events		**There were 98,412 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 1; Serious Disability: 0; Neither: 3

TABLE 3: HOSPITAL-SPECIFIC DATA

TABLE 3.30

VALLEY HOSPITAL AT HIDDEN LAKES*

Address: 1300 Hidden Lakes Parkway Golden Valley, MN 55422
Website: www.regencyhospital.com
Phone number: 763-588-2750
Number of beds: 92

HOW TO READ THESE TABLES

These tables show the number of events reported at each hospital. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

	REPORTED ADVERSE HEALTH EVENTS (JULY 1, 2003-OCTOBER 6, 2004)	
CATEGORY AND TYPE	NUMBER	BACKGROUND
Care Management		**There were 3,611 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

* Valley Hospital at Hidden Lakes was purchased by Regency Hospital Company after the reporting period and has been renamed Regency Hospital of Minneapolis.

APPENDIX A:
Definitions

ACTION PLAN
The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, timelines, and strategies for measuring the effectiveness of the actions.[9]

ADVERSE EVENT
An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.[10]

ERROR
Error is the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning). [11]

PATIENT SAFETY
Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.[12]

ROOT CAUSE ANALYSIS
Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.[13]

SERIOUS DISABILITY [14]
(1) A physical or mental impairment that substantially limits one or more of the major life activities of an individual,
(2) A loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or
(3) Loss of a body part.

[9] Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Glossary of Terms, Online. Available at: http://www.jcaho.org/accredited+organizations/sentinel+event/glossary.htm. [Accessed January 2005]
[10] Ibid.
[11] National Quality Forum, Serious Reportable Events in Healthcare. Washington D.C., 2002.
[12] Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 2000
[13] Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Glossary of Terms, Online. Available at: http://www.jcaho.org/accredited+organizations/sentinel+event/glossary.htm. [Accessed January 2005]
[14] Minnesota statutes 144.7065

APPENDIX B:
Reportable events as defined in the law

Below are the events that must be reported under the law. This language is taken directly from Minnesota statutes 144.7065.

SURGICAL EVENTS

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

2. Surgery performed on the wrong patient;

3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

PRODUCT OR DEVICE EVENTS

6. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

PATIENT PROTECTION EVENTS

9. An infant discharged to the wrong person;

10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and

11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

CARE MANAGEMENT EVENTS

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;

13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;

APPENDIX B: (CONTINUED)
Reportable events as defined in the law

15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;

16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. “Hyperbilirubinemia” means bilirubin levels greater than 30 milligrams per deciliter;

17. Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission; and

18. Patient death or serious disability due to spinal manipulative therapy.

ENVIRONMENTAL EVENTS

19. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;

20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;

22. Patient death associated with a fall while being cared for in a facility; and

23. Patient death or serious disability associated with the use of or lack of restraints or bedrails while being cared for in a facility.

CRIMINAL EVENTS

24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

25. Abduction of a patient of any age;

26. Sexual assault on a patient within or on the grounds of a facility; and

27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

APPENDIX C:
Background Information on the National Quality Forum and the "Serious Reportable Events"

MINNESOTA'S ADVERSE EVENT REPORTING LAW

by Kenneth W. Kizer, MD, MPH

The people of Minnesota today benefit from the release of "Adverse Health Events in Minnesota Hospitals," which details the most serious medical care errors that have occurred in Minnesota hospitals in the past year. Publication of this document demonstrates that Minnesota is in the vanguard of public reporting of medical errors.

Under state law, Minnesota hospitals must report the occurrence of any of the 27 so-called "never events" that are described in the National Quality Forum's report, Serious Reportable Events in Healthcare. This 2002 report presents a consensus list of harmful events that everyone agrees should never happen; they're known as "never events" because all stakeholders agree that these things should never happen in any care setting.

The objective of NQF's Serious Reportable Events project, which was undertaken at the request of the federal government, was to establish agreement among consumers, providers, purchasers, researchers and other healthcare stakeholders about those preventable adverse events that should never occur and to define them in a way that should they occur it would be clear what had to be reported to the authorities. The goal was to bring order to the chaos that typifies adverse event reporting in most of the relatively few states that have adverse event reporting laws.

Minnesota was the first state to require reporting of the entire NQF list of Serious Reportable Events. It has since been joined by Connecticut and New Jersey, and a number of other states are considering doing the same thing. Our hope is that before long all states will collect and publicly report data on the occurrence of these events, forming a national system for tracking the worst kinds of medical mishaps.

Why these events in particular? This was the set of events about which a diverse array of healthcare stakeholders were able to achieve consensus that the evidence was clear that the occurrence of these things was under the control of the healthcare facilities and the events simply should never happen. This consensus is very important. Getting the disparate groups of people with their divergent interests to agree on anything was a challenge; however, without such consensus there is not sufficient focus to get anything done. Indeed, that has been the experience of states having less clear reporting laws. To fix a problem there must be a common ground to which limited resources can be directed. The NQF list of "never events" provides that common ground.

The events on this list are clearly identifiable and measurable, and thus feasible to expect compliance with in a reporting system; and they are events for which the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility. The nature of these events is unambiguous, and they are usually preventable.

There is no question that lapses in patient safety are a major healthcare quality problem; that the occurrence of patient harm due to such lapses is too common; and that a large majority of these lapses are preventable. In the literature review, we learned that these lapses are rarely the result of professional misconduct or criminal acts, despite headlines that sometimes suggest the contrary. Instead, we found that the overwhelming majority of these lapses are unintended consequences of an exceedingly complex and imperfect healthcare delivery system.

The public expects healthcare professionals to go to great lengths to ensure that care is safe, and to the government and other oversight authorities to make sure that this is done. Part of providing oversight is collecting data and investigating serious adverse events. With the new law and its clearly defined list of adverse healthcare events, Minnesota's state government is now able to provide more effective oversight and to make healthcare safer.

Kenneth W. Kizer, MD, MPH, is President and CEO of the National Quality Forum, Washington, DC.

APPENDIX D:
Links and Other Resources

- Full text of Minnesota's Adverse Health Care Events Reporting Law can be found at: www.revisor.leg.state.mn.us/stats/144/ sections 144.706 through 144.7069

- Additional background information on the law can be found at: www.health.state.mn.us/patientsafety

- The Minnesota Alliance for Patient Safety (MAPS) was established in 2000 as a partnership between the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Department of Health and more than 50 other public-private health care organizations working together to improve patient safety. More information about Minnesota's patient safety coalition can be found at: www.mnpatientsafety.org

- The federal Agency for Healthcare Research and Quality's (AHRQ) provides a number of safety and quality tips for consumers. The mission of AHRQ is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ's research helps people make more informed decisions and improve the quality of health care services. The AHRQ tips for consumers can be found at: www.ahrq.gov/consumer/

- The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, and works in partnership with the states to administer Medicaid and the State Children's Health Insurance Program (SCHIP). CMS has developed a number of quality improvement initiatives that can be found at: www.cms.hhs.gov/quality/

- Institute for Safe Medication Practices (ISMP) Alerts for Patients page containing a listing of frequent medication errors and how to avoid them, general information and advice on medication safety for consumers. The web address for this page is: www.ismp.org/Pages/Consumer.html

- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits more than 15,000 health care organizations and programs in the United States. JCAHO's mission is to continuously improve the safety and quality of care provided to the public. JCAHO provides a number of patient safety tips for patients and consumers. This information can be found at: www.jcaho.org/general+public/index.htm

- Consumers Advancing Patient Safety (CAPS) is a consumer-led nonprofit organization, formed to be a collective voice for individuals, families and healers who wish to prevent harm in healthcare encounters through partnership and collaboration. CAPS envisions creating a healthcare system that is safe, compassionate and just. In addition to the CAPS resources available on their web site, this site also provides several links to other patient safety web sites of interest to consumers. www.patientsafety.org

- The National Academy for State Health Policy (NASHP) is a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. NASHP provides resources to compare patient safety initiatives and approaches across the states. www.nashp.org

- The Leapfrog Group is an initiative driven by organizations that buy health care who are working to initiate breakthrough improvements in the safety, quality and affordability of healthcare for Americans. The Leapfrog website provides quality and safety information about hospitals that consumers can search. www.leapfroggroup.org

This list represents only a small fraction of the resources available on patient safety. The web sites listed here provide an example of the types of information available. There are additional local and national resources on patient safety that can provide valuable information for patients, consumers, purchasers and policy-makers.

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