ADVERSE HEALTH EVENTS IN MINNESOTA

SIXTH ANNUAL PUBLIC REPORT

JANUARY 2010

MINNESOTA
MDH
DEPARTMENT of HEALTH

TABLE OF CONTENTS

This report can be found on the internet at:
www.health.state.mn.us/patientsafety

For More Information Contact:
Division of Health Policy
Minnesota Department of Health
651-201-3550

EXECUTIVE SUMMARY
Adverse Health Events in Minnesota
Annual Report January 2010

The release of the sixth annual summary of events reported under Minnesota's adverse health care events reporting law shows that progress has been made in reducing harm to patients and in addressing some of the most common system breakdowns that lead to adverse events. But despite that progress, opportunities for learning remain, along with challenges to consistent, robust implementation of evidence-based best practices.

Under the reporting law, a total of 301 adverse health events were discovered and reported between October 7, 2008 and October 6, 2009. Results include:

▸ The total number of events decreased by 3.5 percent from the previous year's 312.

▸ A total of 4 patients died as a result of adverse health events, a lower number than in any previous year.

▸ Overall, the number of events resulting in serious harm or death decreased slightly from the previous year, from 116 (37 percent) to 98 (33 percent).

▸ The number of patient falls resulting in serious disability or death decreased by 20%, with no patient deaths from falls during the reporting year.

▸ The number of serious pressure ulcers (bed sores) remained constant at 122.

▸ The number of wrong patient, wrong procedure, and wrong-site surgeries or invasive procedures increased over the previous year, from 39 to 44.

▸ The number of retained foreign objects after surgeries or invasive procedures remained roughly constant, moving from 37 to 38.

Since the inception of Minnesota's adverse health events reporting system, nearly 1,100 events have been reported by Minnesota hospitals and ambulatory surgical centers. However, the focus of the system has always been not on counting the number of events that occur each year, but on developing a deeper understanding of why they occur, so that effective interventions can be designed to prevent future harm to patients from these events. This focus on learning helps to create an environment in which adverse events and their causes are shared, to accelerate the pace of change in the pursuit of the safest possible healthcare system. Key learnings of the past year that have contributed to this process include:

▸ A number of reported pressure ulcers developed while patients were undergoing long surgical procedures, when the potential for skin breakdown was not sufficiently addressed prior to, during and/or after surgery. In response to this finding, the Minnesota Hospital Association (MHA) worked with a group of wound care experts to develop recommendations for prevention of pressure ulcers in the operating room.

▸ Additionally, a quarter of reported pressure ulcers were related to the use of devices that pressed on or rubbed against the skin and contributed to skin breakdown. A pressure ulcer advisory group will be working to develop recommendations for safer device use over the coming year.

▸ A number of reported cases of retained foreign objects involved either packed sponges or gauze that were intended to be removed after a period of time but were not, or broken or separated device components. Both of these situations led to the release of safety alerts during 2009, as well as to the development of a statewide campaign against retained foreign objects in the operating room led by the Minnesota Hospital Association.

In the coming year, MDH and its partners will continue to focus on identifying and disseminating information about risks and successful strategies for preventing these and other serious events, and to promote a statewide culture of safety. In 2010, MDH, MHA and Stratis Health will be involved in the following activities to promote a culture of safety, transparency, accountability and learning:

▸ Working with hospitals around the state to implement the MHA "Safe Account" call to action for prevention of retained objects in operating rooms and procedural areas.

▸ Improving surgical and procedural scheduling processes to include more robust documentation of information about the surgical site and procedure and a more consistent procedure for verifying patient information with reliable source documents.

▶ Conducting follow-up evaluation of the pre-procedure time-out and verification process recommendations that were implemented in 2008.

▶ Continuing to monitor trends and patterns in reported adverse events, and making data, case studies, and trend analyses more available to reporting facilities.

▶ Working with the Department of Human Services to investigate the use of Medicaid administrative data to verify the prevalence of certain adverse events.

▶ Providing training to hospitals and surgical centers to make sure that all events are investigated thoroughly, using tools and techniques that will allow all potential sources of risk to be explored.

▶ Partnering with state and national organizations and with individual facilities to promote consistent interpretation and investigation of adverse health events and application of best practices.

For more information about the adverse health events reporting system, visit **www.health.state. mn.us/patientsafety**.

HOW TO USE THIS REPORT

This report is one of many sources of information now available on health care quality and patient safety in Minnesota. It is designed to help patients identify safety issues to discuss with their care providers, and to give policymakers an overview of patient safety activities and issues in the state. But it is only one piece of the larger picture of patient safety and quality. Other good sources of information on health care quality and safety are listed at right.

For consumers, the best way to play a role in improving safety is by using reports like these to identify situations of concern and to learn why they happen, and to learn about what safe, high-quality health care should look like. Armed with that information, patients and family members can ask providers what is being done in their facility to prevent these types of events from occurring. The information in this report should be a basis for further learning, rather than just a way to compare facilities based on incidence rates.

Patient awareness is a very important tool to improve safety, but it is important to keep these numbers in perspective. The events listed in this report represent a very small fraction of all of the procedures and admissions at Minnesota hospitals and ambulatory surgical centers, and not all are preventable.

Reports might be higher or lower at a specific facility for a variety of reasons. A higher number of reported events does not necessarily mean that a facility is less safe, and a lower number does not necessarily mean the facility is safer. In some cases, the number of events may be higher at facilities that are especially vigilant about identifying and reporting errors. The reporting system itself may also have an effect, by fostering a culture in which staff feel more comfortable reporting potentially unsafe situations without fear of reprisal. It is important to note that in these cases, higher numbers may represent a positive trend towards greater attention to adverse events and their causes, rather than the opposite. What is important is that all events are an opportunity for learning and system improvement.

SOURCES OF QUALITY AND PATIENT SAFETY INFORMATION

Minnesota Department of Health
www.health.state.mn.us/patientsafety
Consumer guide to adverse events, database of adverse events by facility, fact sheets about different types of events, FAQs, and links to other sources of information.

Minnesota Alliance for Patient Safety
www.mnpatientsafety.org
MAPS is a broad-based collaborative that works together to improve patient safety in Minnesota. Projects include informed consent, health literacy, medication reconciliation, and Just Culture.

Minnesota Community Measurement
www.mnhealthcare.org
Comparative information about provider groups and clinics including best practices for diabetes, asthma, and other conditions, as well as who does the best job providing that care.

StratisHealth
www.stratishealth.org
A non-profit organization that leads collaboration and innovation in health care quality and safety. Their resources include tools and resources to support clinical and organizational improvement, as well as training and education programs for professionals across the continuum of care.

Minnesota Hospital Quality Report
www.mnhospitalquality.org
Database of hospital performance on best practice indicators related to heart attack, heart failure, pneumonia, surgical care and how patients experience care in the hospital.

Healthcare Facts
www.healthcarefacts.org
Comparative information about quality at Minnesota hospitals and primary care clinics.

The Leapfrog Group
www.leapfroggroup.org
Hospital safety and quality ratings based on multiple factors.

HIGHLIGHTS OF 2009 ACTIVITIES

Under the Minnesota Adverse Health Care Events Reporting Law, the Commissioner of Health is directed to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities on how they can improve patient safety. In performing these functions, the Department works closely with several key stakeholder organizations and groups, including the Minnesota Hospital Association (MHA) and Stratis Health.

Over the last year, MDH, MHA and Stratis Health have been involved in a number of activities designed to make the reporting system easier to use, improve the quality of analysis and the strength of action plans, share best practices, and spur high-level commitment to change within health care organizations. Highlights of the past year's activities are listed below.

Education

▶ More than 100 hospital and surgical center staff attended in-depth, day-long training sessions on root cause analysis and the development of corrective action plans. This training, offered twice each year throughout Minnesota, is an important way of supporting facilities as they work to conduct robust root cause analyses.

▶ Stratis Health and MDH developed a new Measurement Guide for reporting facilities, to improve their ability to develop and implement strong measurement plans to gauge the effectiveness of their corrective actions. The guide will be released in early 2010, along with companion training sessions.

▶ MHA and MDH released two safety alerts during 2009, both dealing with the risk of retained foreign objects after surgery or invasive procedures. The first alert included a recommendation that facilities strengthen their processes for ensuring that devices are intact after an invasive procedure, due to the risk of inadvertent breakage and retention of device components. The second dealt with items, usually gauze or sponges, that are packed into a wound or body cavity with the intention of being retained for some period of time, but which were not subsequently removed as intended. These safety alerts are included as Appendix E of this report.

▶ MHA continued to convene expert groups to examine trends and develop evidence-based strategies for prevention of falls, pressure ulcers, retained foreign objects, and surgical events, as well as kicking off a statewide campaign to prevent retained foreign objects outside of labor and delivery. The pressure ulcer advisory group developed recommendations for prevention of pressure ulcer in the operating room in June 2009.

Strengthening the Reporting System

▶ After extensive consultation with reporting facilities and other users, MHA released a major upgrade of the web-based registry in the summer of 2009. The enhancement of the reporting system will improve the ease of use of the system for participants, and enable additional analysis of events, root causes, and corrective actions.

▶ In response to feedback from facilities during the 2008 adverse health events program evaluation, MDH began conducting periodic statewide conference calls with reporting facilities to update them on data trends, definitional changes, opportunities for learning or sharing, and revisions to reporting requirements.

▶ The 2009 Minnesota Legislature directed MDH to convene a workgroup to develop questions related to staffing levels and their impact on patient safety and adverse events, to support facilities in determining whether staffing was a contributing factor for reportable events. That workgroup developed a set of staffing-related questions for inclusion in the web-based registry's list of triggering-triage questions, and that facilities should include in their root cause analyses whenever a reportable event or relevant near miss occurs. The group's recommendations are included as Appendix D of this report.

Topic Specific Safety Activities

A number of statewide and regional campaigns and individual facility efforts to prevent wrong site surgery, retained foreign objects, falls, and pressure ulcers were implemented or continued during 2009. Those efforts are described in the following sections.

OVERVIEW OF REPORTED EVENTS & FINDINGS

In over six years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on nearly 1,100 events. MDH and its partners have used the findings from those events to identify strategies for improving processes of care, with the ultimate goal of preventing avoidable harm to patients.

Minnesota has long been a leader in healthcare quality, transparency and patient safety. Minnesota's Adverse Health Care Event Reporting Law has served as a model for a number of other states interested in promoting a culture of safety, accountability, transparency and learning, and remains one of the few mandatory statewide reporting systems to include an annual public report listing events and outcomes by facility. Along with other public reporting measures in Minnesota, it is one of several important tools for ensuring accountability.

This annual report provides an overview of what the most recent year of data can teach us about the risk points for adverse health events and the best approaches for preventing them, with a focus on the most common types of events: falls, pressure ulcers, wrong-site surgeries or invasive procedures, and retained foreign objects. For each of these categories of events, this report will discuss what we have learned about why these events happen, what's being done to prevent them from happening again, and how we can continue to move down the path towards having the safest possible healthcare system.

Frequency of Adverse Events

Between October 7, 2008 and October 6, 2009, a total of 301 adverse health events were reported to MDH, a slight decrease from the 312 events reported in the previous reporting cycle.

Overall, the data show that:

▸ Though the number of events reported per month varied throughout the year (Figure 1), the monthly average was 25.1 events per month or roughly 5.8 events per week. The month with the most reported events was June, with 34, and the lowest was September with 18.

▸ Of the 134 hospitals, 11 community behavioral health facilities and 55 ambulatory surgical centers that were subject to the reporting law during this time period,

62 (31 percent) reported adverse events during this reporting period, including 58 hospitals (43 percent) and 4 ambulatory surgical centers (7 percent).

▸ Since the inception of the reporting system, 90 hospitals have reported at least one event. This represents 67% of all hospitals, which together account for over 90 percent of all hospital beds in Minnesota.

▸ During 2008, the most recent year for which preliminary data are available, Minnesota hospitals reported roughly 2.8 million patient days. Accounting for the volume of care provided across all hospitals in the state shows that roughly 10.7 events were reported by hospitals per 100,000 total patient days. This rate is essentially unchanged from the previous year.

FIGURE 1: EVENTS BY MONTH
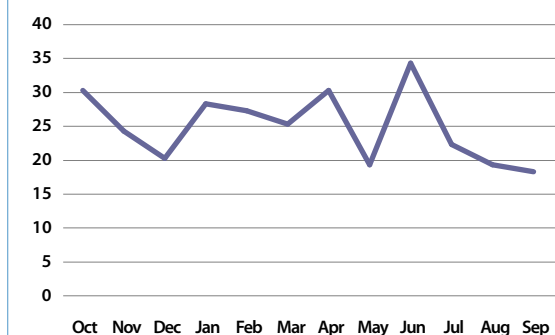
Note: October figure includes some events that were included in the January 2009 annual report.

Patient Harm

The ultimate goal of the reporting system is to develop a deeper understanding of why adverse health events happen, so that strategies can be developed to prevent future patient harm as a result of similar events. Over time, both the number and severity of events should decrease, as interventions are implemented that reduce the likelihood of errors reaching patients, and minimize the harm to patients when they do.

Overall, serious patient harm was lower in this reporting year than in previous years, with 33 percent of cases involving either serious disability[1] or death, down slightly from 37 percent last year. A total of 94 events (31.2 percent) resulted in serious disability and 4 events (1.3 percent) resulted in a patient's death.

[1] For the purposes of this reporting system, 'serious disability' includes loss of a body part, physical or mental impairments that substantially limit one or more major life activities for at least seven days, or a loss of bodily function that lasts for at least seven days. Serious disabilities include fractures, serious head injuries, and events that require surgery or a higher level of care for at least 48 hours.

As in previous years, the types of events most likely to lead to serious patient harm or death were falls; roughly 80 percent of all cases of serious patient harm were related to falls (Figure 2). Medication errors accounted for four percent of all cases of serious patient harm, while hypoglycemia, suicide/attempted suicide and physical assault each accounted for three percent. Over the life of the reporting system, falls, medication errors, device malfunctions, and suicide/attempted suicide have been the most common causes of serious patient harm.

FIGURE 2: SERIOUS INJURY/DEATH

Fall 78%

Hypoglycemia 3%

Suicide 3%

Medication Error 4%

Wrong Procedure 2%

Physical Assault 3%

Other 7%
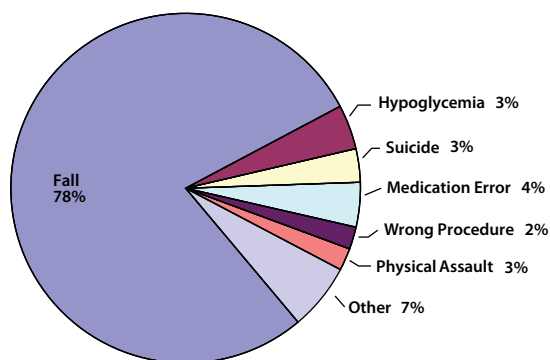
FIGURE 3: PATIENT HARM, 2003–2009

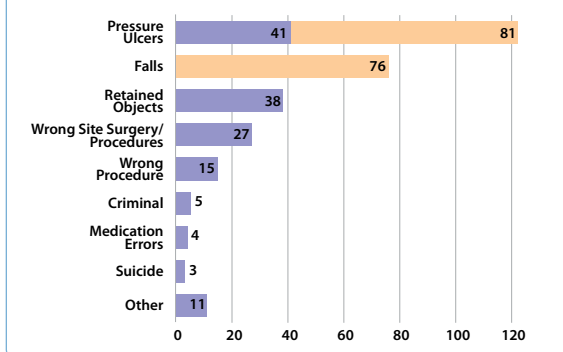|	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Serious Disabilities (top)	4	4	7	10	98	94
Deaths (bottom)	20	12	24	13	18	4

■ Deaths   ■ Serious Disabilities
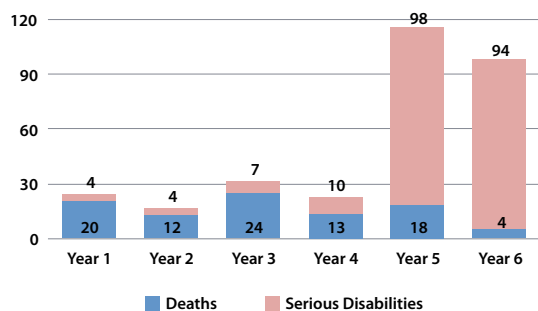
* Reporting requirements changed in 2007, resulting in a higher number of serious disabilities starting in Year 5 of the reporting system.

This reporting year, fewer patient deaths were reported from adverse health events than in any previous year: 4 events (1.3 percent) led to death this year, compared with an average of 12.7 percent across previous reporting years (Figure 3). Of particular note is the fact that no deaths associated with falls were reported in any Minnesota hospital during the entire reporting period. This may be due to facilities improving their ability to mitigate harm when falls do occur.

Just over half of all events, 51 percent, resulted in either a need for additional treatment or a longer stay in the hospital. The remainder of events resulted in no harm or a need for additional monitoring; for example, cases where a retained foreign object falls out naturally with no intervention.

Types of Events

In the first four years of reporting, stage 3 or 4 pressure ulcers were the most commonly reported events, followed by retained foreign objects and surgery or other invasive procedure on the wrong part of the body. That pattern changed when Minnesota's adverse health events reporting law was modified in 2007 to include falls associated with serious injuries such as fractures, and when an administrative decision was made that same year to expand the definition of reportable pressure ulcers.

FIGURE 4: ADVERSE EVENTS BY CATEGORY

Category	Value
Pressure Ulcers	41 / 81
Falls	76
Retained Objects	38
Wrong Site Surgery/Procedures	27
Wrong Procedure	15
Criminal	5
Medication Errors	4
Suicide	3
Other	11

Note: Events listed in peach became reportable starting on 10/7/07. These events were not included in annual Adverse Health Events reports prior to January 2009.

In the two years since those changes went into effect, falls have displaced retained foreign objects as the second most commonly reported adverse health event. During the current reporting year, falls and pressure ulcers accounted for 65% of all reported events. If the reporting requirements had not been changed in 2007, the total number of reported events over the course of this year would have been 144.

Events by Facility Size

Adverse health events were reported by facilities of all sizes, a good indication that reporting is robust around the state. However, the percentage of events reported by large hospitals was higher than the percentage of beds

represented by those facilities (Figure 5). The reverse was true for the smallest hospitals, which reported fewer events than their percentage of the state's total beds might suggest. This may indicate that the ability to monitor and track potentially reportable events is more well-developed in larger facilities, or it may reflect a difference in the types of procedures and patients in large versus small hospitals, with very small hospitals less likely to perform surgical or invasive procedures or to have many patients with long or complicated stays.

FIGURE 5: REPORTED EVENTS BY HOSPITAL SIZE
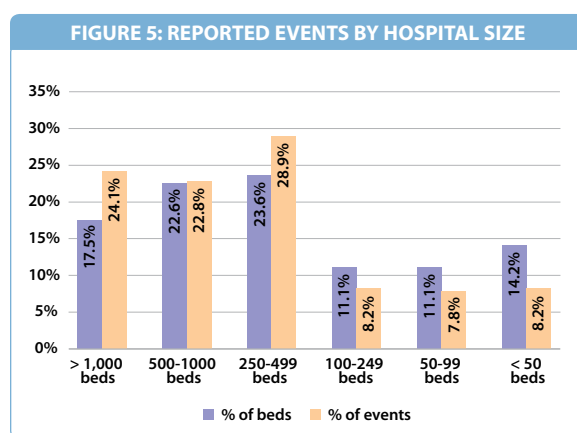
Root Causes of Adverse Events

When an adverse event occurs, facilities are required to conduct a root cause analysis. This process involves gathering a team to closely examine the factors that led to the event (See "Responding to Adverse Health Events," page 8, for one health system's perspective on this issue). These factors can include communication, staffing levels, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities.

The process of completing a root cause analysis is a crucial step in determining exactly what happened and why it happened. Without uncovering root causes, it becomes very difficult to prevent a recurrence of an event. It's also important that facilities look at patterns of events and investigate the systems or steps involved in caring for the patient. If multiple similar events occur, analysis of their root causes can reveal patterns of vulnerability that might not be apparent from one event.

On occasion, reporting facilities report that there are cases where the complexity of a patient's clinical condition makes prevention of the event particularly challenging or even impossible, and no root cause is identified. However, the vast majority of events can be traced to

breakdowns in larger systems of care rather than to individual patient characteristics or provider mistakes.

As in previous years, the majority of adverse events were related to communication, policies/procedures, environment/equipment, and training. However, in many cases the causes are closely intertwined. For example, even in cases where a policy is in place to prevent something from happening, it may not be correctly implemented due to a lack of understanding of the roles of individuals in carrying out the policy (training), an inadequately written rule (rules/policies/procedures), pressure to complete a process quickly (scheduling), forgetting about a step or a rule at the end of a shift (fatigue), distractions (environment), misunderstandings about what has been done or needs to be done (communication), or physical factors that prevent staff from carrying out the policy (barriers). Cultural issues can also come into play, particularly in cases where providers, staff, or patients feel uncomfortable speaking up if a person has not followed a policy or if they perceive a risk.

Because the root causes of these events are complex and often system-wide, simple solutions or quick fixes are unlikely to succeed in the long term in preventing their recurrence. Often, realizing lasting change is a cyclical process, involving repeated attempts to identify why a problem has occurred, define the best approach to address it, and implement the solution, and then continue to monitor progress until the solution has been shown to be successful and sustainable. But the root cause data submitted over the last six years verify that the most successful strategies are likely to be those that include a focus on broad issues such as communication and organizational culture, rather than just technical changes to policies or procedures. These types of changes, by necessity, often take much longer to develop than technical fixes, and can take years to become fully imbedded within an organization.

ROOT CAUSES/CONTRIBUTING FACTORS*	
Communication	38%
Rules/Policies/Procedures	38%
Environment/Equipment	32%
Training	30%
Barriers	11%
Fatigue/Scheduling	3%

Does not include events with no identified root cause.

RESPONDING TO ADVERSE HEALTH EVENTS

Carol Beehler, *System Director of Risk Management, HealthEast*
Rosie Emmons, *Performance Improvement Specialist, Quality Management, HealthEast*
Catherine Hinz, *Patient Safety Lead, Quality Institute, HealthEast*
Karen MacDonald: *Associate Administrator, Care Management and Quality Institute, HealthEast*
Dr. Robert Moravec, *Chief Medical Officer, HealthEast St. Joseph's Hospital*

It is 2:30 am on a medical surgical unit. An elderly patient who has been reliable to use her call light, attempts to get out of bed to use the restroom. On her way, she slips in the dim light and falls; she remains on the floor until a nurse's aide discovers her. The nurses' aide calls for help and staff members are able to safely get the patient back into bed. Several diagnostic imaging tests later, it is verified that the patient has suffered a left hip fracture.

A registration clerk checks a patient in for pre-operative lab work. It was an extremely busy day in admitting, and using an electronic patient record system, the registration clerk mistakenly selects the wrong patient, a patient with the same name and date of birth. As the patient undergoes lab work, the phlebotomist recognizes the error, and saves the patient from potentially receiving the wrong blood type during a transfusion in surgery.

When an adverse event or a near-miss like the ones above occur, a series of actions are initiated to care for the patient, investigate the cause of the event, and take steps to prevent the event from occurring again. The series of actions begins with immediately addressing the patient and concerns of the family. At HealthEast, we believe that patients are entitled to information about the outcomes of diagnostic tests, medical treatment, and surgical intervention. This perspective is the same whether the outcome was expected, the product of an adverse event or near-miss event, or an otherwise unanticipated outcome.

Caregivers must maintain communication with patients and when appropriate, their families, by providing information that fosters trust, rapport and informed decision-making. We work with our professional staff to achieve complete, prompt, factual, and truthful disclosure of information and counseling to patients regarding situations where an adverse event has occurred; one of our guiding principles is that the truth must lead all

discussions. This honest communication in the face of an adverse event promotes trust among the patient, the caregivers, and the organization.

An initial investigation takes place in order to gather factual and anecdotal information about the event. Depending upon the severity of the injuries or potential harm, this information is shared with hospital administration, quality management, and risk management. An identified team from these areas will non-judgmentally apply the definitions of a reportable event from the state of Minnesota Adverse Event Reporting rules and determine if the event should be reported. In the case of a reportable event a root cause analysis (RCA) will be conducted; an RCA may also be conducted for near misses that could have resulted in patient harm, or for other serious events.

Quality Management will facilitate a RCA. They will collaborate with the involved unit manager to identify staff who were involved and have knowledge of the event. For many of the RCAs, a member of the senior executive team participates. If a member of the medical staff is involved, a medical director is asked to participate as well. During the RCA, all the factors which could have contributed to the event are thoroughly examined. In the case of the female patient who fell, was the call light in reach? Were the nurses able to conduct hourly rounding? Was her room free of clutter? Was she taking medications that would have made her more likely to fall? Once staff have identified and discussed the contributing factors, they determine the key issues or root causes. These key issues are then used to build an action plan.

The action plan captures all these changes and assigns responsibility to follow through and make certain changes are made. A target date is identified to ensure changes are made in a timely manner. Quality Management and the manager design a measurement

plan to determine if the changes put in place are successful. This measurement plan identifies what should be measured, the sampling plan, and acceptable threshold. If the threshold is not met, the manager will work with the staff to determine why the process change was unsuccessful, re-design the process change, and re-measure. Once the action plan has been determined successful, the changes are communicated with hospital administration and other departments through our Quality Councils in order to share success and best practices throughout our system.

Within the entire disclosure, investigation, and follow-up process, it is critical that the organization approaches the adverse event or near-miss with a system perspective that embraces a culture of learning, justice, and accountability. The organization must balance both individual and system accountability for an event or near-miss. Again, the truth guides this process; we need to have freedom

from bias and anecdotal information must be verified. It must not be forgotten that although humans contribute to error, they are oftentimes the hero who recovers these situations. More so than any technological advancement, humans have the critical thinking and problem-solving skills to catch and intercept these events before they ever reach the patient.

The world of medicine moves fast; we need to take the time to pause and reflect when adverse events take place and near-misses happen. The time devoted for disclosure, investigation, and implementation of plans to prevent adverse events cannot be forgone. We owe our patients, our staff, and our communities an effective process for addressing, learning from, and preventing events. Realigning our systems to embrace human factors and develop a robust event investigation process will improve the care delivered and keep our caregivers and patients safe.

WRONG SITE SURGERY/INVASIVE PROCEDURES

Over the six years that the adverse events reporting system has been in place, nearly 200 incidents of wrong site, wrong procedure, or wrong patient surgeries and invasive procedures have been reported by Minnesota hospitals and ambulatory surgical centers. In the most recent reporting year, 44 wrong patient, procedure or site events were reported, up from 39 in the previous reporting year. The most common types of reported wrong site events involved spinal or other orthopedic procedures, regional anesthetic blocks or other injections, and biopsies in the incorrect location.

Of the reported wrong site, patient or procedure cases, roughly 60 percent happened in the operating room (including outpatient surgical procedures), with the remainder happening in procedural areas such as radiology or cardiology, in the laboratory, or during a bedside procedure. Of the procedural areas, the radiology unit was the most common location for wrong-site, patient or procedure events, with 16 percent of all wrong surgery/invasive procedure cases occurring in radiology.

Across all Minnesota hospitals, more than 2.6 million surgeries and invasive procedures were performed in 2008, with thousands more taking place in ambulatory surgical centers. Given the volume of procedures, these events are very rare, occurring in roughly one of every 60,000 invasive procedures.

In the majority of cases (57 percent), the patient experienced no harm from the incident or required additional monitoring. Roughly a third of patients required additional treatment, usually in the form of a second procedure, and two patients (five percent) experienced a serious disability. (Figure 6)

FIGURE 6: PATIENT OUTCOMES, WRONG SITE, PATIENT, OR PROCEDURE EVENTS

Longer Stay 4.5%
Monitoring 20.5%
Treatment 34.1%
No Harm 36.4%
Serious Disability 4.5%
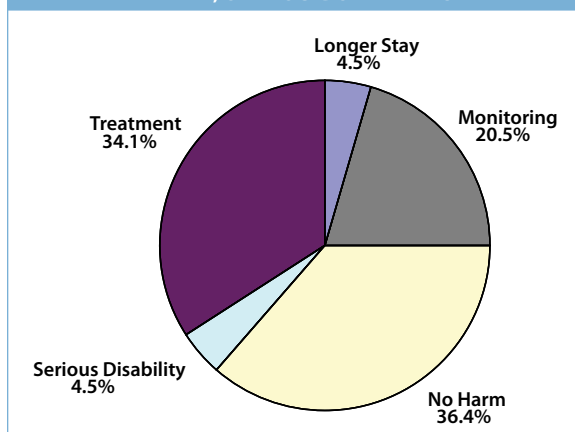
Key findings

The root causes of wrong procedure, site or patient events are often related to a lack of consistency or rigor in the verification processes that lead up to the procedure. These processes can begin weeks before the event, when the procedure is initially ordered or scheduled by a physician's office, and continue up until the moment the procedure begins. Based on reported events for this and previous years, the areas where process breakdowns most often occur are:

▸ During the scheduling process, if scheduling documents do not list the site or side of the intended procedure, or list the site incorrectly;

▸ During the pre-procedure verification process, if source documents such as imaging or test results are not available for the provider to review;

▸ During the informed consent process, if multiple independent checks of source documents are not conducted or if the source documents are incorrect;

▸ During the time-out process (a final verification that takes place immediately prior to the beginning of the procedure, involving the entire surgical team), if the site mark is not visualized as part of the process, if a time-out is not conducted or not conducted effectively.

As in previous years, the lack of a time-out policy for procedures taking place at the bedside, or in procedural or preoperative areas, has contributed to several incidents of wrong-sided regional anesthesia blocks, radiation therapy treatments, and biopsies, all of which were done outside of the OR. Inside the OR, as well, inconsistencies in the conduct or rigor of the time-out process are not uncommon, though in most cases the errors are caught before they result in a reportable adverse event.

A number of larger issues are also often at play when it comes to surgical events. Distractions, interruptions, and confirmation bias (the tendency to look for, or to see, only that information which confirms what we already thought was true) can all increase the risk of wrong site surgery. The culture within the OR can also play a role, particularly when junior team members are reluctant to speak up about potential errors or assume that others must have knowledge that they lack.

Preventing surgical/procedural events

Statewide, much of the work around preventing surgical errors continues to focus on systematizing and strengthening the pre-procedure verification process, including the site marking and time-out processes, and working to make the surgical scheduling process more reliable and consistent.

Statewide, hospitals and ambulatory surgical centers continue to implement the strengthened time-out recommendations developed by the University of Minnesota in 2007. As of December 2009, participating hospitals reported:

▸ 52% are using a visual reminder of the time-out process, such as a towel or other barrier over the instrument tray;

▸ 78% have the surgeon initiate the time-out;

▸ 78% require the scrub person to visualize and state the location of the site mark during the time-out;

▸ 100% conduct the time-out immediately prior to the start of the procedure.

Hospitals and ambulatory surgical centers also continue to participate in the Minnesota Hospital Association's "Safe Site" campaign against wrong-site surgery, which began in late 2007. The 120 hospitals and surgical centers that are participating in the campaign are now implementing more than 90 percent of the campaign's best practices for prevention of wrong-site, patient or procedure events, up from below 60 percent at the start of the campaign.

In response to the discovery of potential risk points in the surgical scheduling process related to the lack of complete information about the planned procedure's location/laterality and the use of source documents, several clinics and hospitals are beginning to participate in a pilot project through the Minnesota Alliance for Patient Safety designed to improve and standardize the scheduling and documentation process. Participating facilities will explore whether standardized scheduling documents and processes can be put into place across clinics and hospitals, reducing the risk that errors in the scheduling and documentation process will contribute to wrong-site, procedure, or patient events.

Individual facilities are also implementing specific strategies based on the root causes that they have uncovered. Corrective actions being implemented include:

▸ Ensuring that staff in all procedural areas understand and follow time-out policies.

▸ Developing scripting for pre-operative verification procedures and clarifying who is responsible for calling for a time-out.

▸ Creating mandatory checklists for use during invasive procedures, including site marking for all cases and a second time-out for multiple procedures.

▸ Ensuring that team members who enter the OR after the time-out are fully briefed on the consented procedure, and that the informed consent is visible to all team members during surgery.

▸ Making sure that electronic health records are set up in such a way that crucial information about a procedure is easy for all providers to see.

▸ Ensuring that the provider who will be conducting the procedure is the only one allowed to mark the site.

▸ Using a time-out towel or other barrier to cover the instrument tray prior to the procedure, which cannot be removed until a time-out is done.

▸ Requiring that scheduling documents include the site and laterality of the planned procedure.

Next steps

In 2010, organizations will continue to implement the pilot scheduling/documentation project and evaluate their successes and barriers, which will be shared as they become available. In addition, MDH and MHA will be partnering with the University of Minnesota to conduct follow-up evaluation of the pre-procedure time-out and verification process recommendations that were implemented in 2008.

PREVENTING WRONG SITE SURGERY

LIFECARE MEDICAL CENTER, ROSEAU

One year after implementing the statewide SAFE SITE call-to-action outside the operating room (OR) campaign, LifeCare had improved from 58 percent compliance in use of the recommended checklist to prevent wrong site surgery or invasive procedures outside the OR to 100 percent compliance. Overall compliance continues to be consistently above 90 percent.

LifeCare's campaign outside the OR is used in the imaging department, for such procedures as CT guided biopsies, pain control interventions, and thyroid aspirations; in the endoscopy department for endoscopies and colonoscopies; and in the nursery for circumcisions, and more.

LifeCare also has successfully followed recommended protocols in the OR since 2007. This work is ongoing with 95 to 100 percent compliance for the use of a newly revised time-out protocol that requires every member of the operating room team to actively participate.

"The work done inside the OR certainly became a model for what we tried to spread for invasive procedures outside the OR," said Marilyn Grafstrom, B.S.N., LifeCare's Director of Quality and Risk Management, who championed the SAFE SITE work in both areas. "LifeCare had not experienced any wrong site surgeries or procedures prior to joining the initiative, but we wanted to proactively add extra layers of safety to provide the safest care possible."

Two different teams work on the SAFE SITE initiatives at LifeCare. The team for SAFE SITE outside the OR includes Grafstrom, the imaging director, an imaging technologist, the outpatient manager, and the inpatient manager.

And what does SAFE SITE outside the OR mean for LifeCare's patients? "While the process may seem like an additional step that can slow you down, in fact, it is a vital step in the performance of any procedure of any type and it helps improve patient care and ensures that the procedure you are performing is one that is intended for the patient," said Daniel Courneya, M.D., a LifeCare radiologist.

There are very few things that I've incorporated into the safety chain in my practice that have had as much an effect as SAFE SITE outside the OR," said Courneya. "It's a minor effect in some cases but when you have clerks reading physicians' handwritten orders and trying to figure out exactly what they are supposed to enter into the computer, there are errors that can happen there. And sometimes doctors mix up their lefts and rights. It helps to check and make sure that you are doing the right thing on the right patient in the right location."

To date, 120 Minnesota hospitals and outpatient surgery centers are participating in the Minnesota Hospital Association's SAFE SITE campaign, which works to prevent wrong-site surgery, wrong-surgery and wrong-patient adverse health events.

RETAINED FOREIGN OBJECTS

In the most recent reporting year, 38 cases of retained foreign objects were reported. The most commonly retained foreign objects were small sponges or absorbent pads or, less commonly, guidewires or the small tips of instruments that have broken off during a procedure. The procedures most often linked with retained objects in Minnesota are obstetrical or gynecological procedures, followed by procedures related to the digestive or musculoskeletal systems.

In many cases, retained foreign objects are removed by patients at home (this is particularly common with sponges or gauze retained after gynecological procedures), or by a provider in the hospital, with no need for a return to surgery. However, in roughly one-third of cases, a second procedure was required to remove the object. An additional 11 percent were removed by a physician or other provider in a clinic or office setting, usually after the patient complained of discomfort. The time that elapsed between the retention of an object and its discovery ranged from a few hours to several months.

Key findings

Over the years, facilities have developed elaborate processes for counting objects that could be retained after surgery or an invasive procedure. The strongest policies are those that account for all objects, including sponges, sharps, instruments, and other items, that could potentially be retained. Policies should also include redundancy, with more than one person independently counting each type of object and reconciling the counts.

However, even in the presence of strong counting policies, objects can be retained. In fact, the majority of retained foreign objects occur in cases where the count appeared to be correct. Humans can make errors even in redundant systems – for example, if two people use different processes to count items, do not count in each others' presence, or each make a simple cognitive error. Given that tendency to err, a correct count does not necessarily mean an object has not been retained – and a count that does not include all potentially retained items can appear correct even in the presence of a retained object.

In a number of retained object cases, certain types of objects were not included as part of the count, or objects with potentially separable parts were not examined to determine whether fragments were left behind. This situation led to the development of a safety alert in 2009, recommending that facilities establish a method

for examining devices before and after procedures, to minimize the risk of retention of broken or separated device components.

In other cases, the root cause of a retained foreign object is a communication breakdown. A provider may "tuck" gauze or a sponge into a wound or body cavity during a procedure and not tell anyone else on the team that they are doing so, which results in the item not being accounted for post-procedure. Or a provider may 'pack' gauze into a wound or cavity, intending for it to stay for a set period of time, but there is no clear accountability for its removal after that time has passed. This situation led to a second safety alert in 2009, recommending that facilities develop clear policies to document the placement of all packed items, and to establish clear accountability and timelines for their removal.

FIGURE 7: OUTCOME OF RETAINED OBJECTS
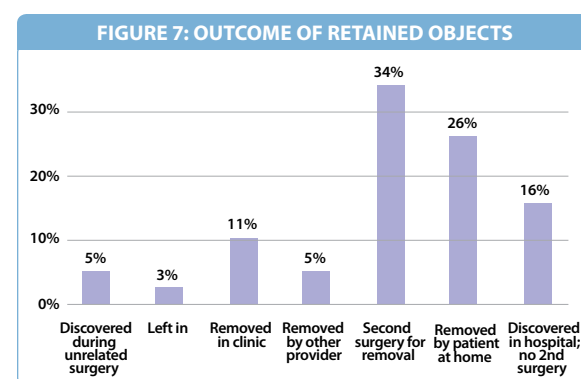
Preventing retained foreign objects

Since the 2008 inception of MHA's statewide campaign to prevent retained sponges in labor and delivery, the number of retained sponges after vaginal deliveries has remained low. In the six months prior to the kickoff of the campaign, nine such incidents had been reported; in the most recent reporting year, four were reported. The 65 hospitals that are participating in the "Safe Count" campaign report implementing an average of more than 90 percent of the best practices outlined by the campaign, compared with a baseline of less than 50 percent.

Based on the success of this campaign, as well as the continuing occurrence of retained objects in the OR and in procedural areas, MHA implemented a new statewide retained foreign objects campaign in October 2009. The "Safe Account" campaign focuses on ensuring that all objects or object components that have the potential for retention are accounted for and intact, that the process

for counting is clear and consistent, and the environment for counting is free of distractions. The 107 hospitals that are participating in the campaign will be reporting quarterly on their progress towards implementing a set of more than 25 evidence-based best practices for prevention of retained foreign objects.

Individual facilities are also implementing specific strategies based on the root causes that they have uncovered. Corrective actions being implemented include:

▸ Revising documentation to ensure that all items that enter the surgical field are accounted for.

▸ Modifying order sets when gauze or sponges are packed into a cavity with the intent of later removal, so that accountability for removal of the items is clear.

▸ Redesigning products or materials so that they are less likely to migrate within a body cavity, or are more visible upon inspection.

▸ Modifying scheduling and staffing practices so that multiple duties for team members during the counting process are minimized.

▸ Revising training when new products or devices are being used, to ensure that team members are aware of the risk of breakage, separation of parts, or retention.

▸ Instituting policies for inspection of devices before and after procedures, to ensure that no breakage has occurred, or removing items with high breakage risk from inventory.

Next steps

In the coming year, the "Safe Account" campaign will continue to work with facilities around the state to strengthen their policies for accounting for all objects that may pose a risk of retention.

PREVENTING RETAINED FOREIGN OBJECTS

MERITCARE THIEF RIVER FALLS NORTHWEST MEDICAL CENTER

Since the beginning of the Safe Count call-to-action to prevent objects from unintentionally being retained at Merit Care Thief River Falls Northwest Medical Center in the fall of 2008, the hospital has not had one retained object after a vaginal birth.

"That's the best outcome," said Lee Ann Harwarth, R.N., B.S.N., M.B.A., the medical center's inpatient and trauma coordinator. "100 percent, no retained objects."

The initiative is focused on sponges, sharps and instruments used in a vaginal birth — in short, anything used to set up for a delivery.

"We started training with the nurses because that's where the counting starts, with the set-up before the physician gets in the room," Harwarth said. "At one of our staff meetings we went over what the expectations were and how to do it, and we introduced all the tools, like the white board. To educate the doctors, the nurses actually spoke directly one-on-one with the physicians who deliver babies and said, 'Ok, we have to count and that is the expectation and you are ultimately responsible for it so let's do it together as a team,' which has worked very well."

Tools for the program were not expensive. Staff at the hospital initiated a white board in each of the delivery rooms. Sponges, instruments, and sharps counts are written on the board at the beginning and end of the delivery. As the nursing staff is setting up, they write their counts at the beginning and if they open another pack of sponges during the delivery, they count them and add them to the white board. After the delivery, there is a final check to make sure everything is accounted for and nothing has been left behind.

Chart audits are completed on a regular basis to ensure the process of counting is followed.

"We have an annual competency check for the OB staff to make sure they are doing the correct process for the counting — the pre-count, the count during and the count afterwards," Harwarth said.

The SAFE COUNT initiative was important to the medical center because of patient safety and quality of care. "There is no other outcome but best patient outcome," Harwarth said. "We don't want to put any foreign object into the patient that we haven't accounted for because it's not good for the patient. It can cause infections and a lot of risk. Needless to say it might mean another surgery. It's just all about giving good, safe care and making sure the birthing experience is a happy time."

Nearly 70 hospitals are participating in the Minnesota Hospital Association's SAFE COUNT campaign, which works to prevent adverse health events involving retained foreign objects.

PRESSURE ULCERS

Pressure ulcers, otherwise known as bedsores, happen when a patient's skin breaks down due to pressure or friction. The highest-risk patients are those who have limited mobility, circulation problems, or incontinence, although pressure ulcers can also occur in patients with none of these risk factors. The majority of reported pressure ulcers are found on the coccyx or buttocks, on the head or neck, or on the ankles or feet.

FIGURE 8: LOCATION OF PRESSURE ULCER

Other 7%
Back/Spine 6%
Heel/Ankle/Foot 15%
Head/neck 17%
Coccyx/buttocks 55%
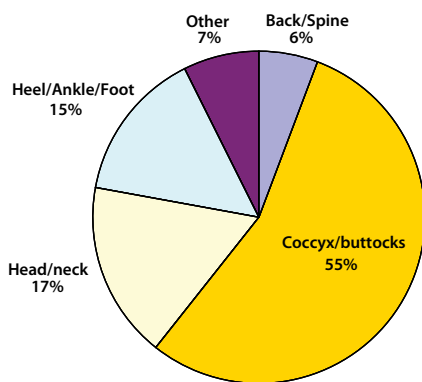
Elderly patients are generally more at risk for the development of pressure ulcers than younger patients. As in previous years, nearly half of the pressure ulcers reported during the current reporting period (46 percent) involved patients aged 65 or older. However, more than one third of pressure ulcer cases involved patients aged 40 to 64; these patients were likely to have had multiple comorbidities, long surgeries, or complicated courses of stay in the intensive or critical care unit.

Key findings

Often, the root causes of pressure ulcers involve breakdowns in communication; risk factors or skin inspection results that were not documented properly or communicated between shifts or providers, or lack of communication related to appropriate interventions. Patient factors, such as morbid obesity or the presence of multiple comorbidities or trauma, can also contribute to pressure ulcers by making interventions more complicated or difficult to apply.

The reporting system began collecting expanded data on pressure ulcers starting in March 2009. The responses have revealed several key patterns related to the formation of pressure ulcers due to immobility during long surgeries, or when a device such as a tube or brace

is in constant contact with the skin over a prolonged period. Of the pressure ulcers reported since the expanded data collection began:

▶ 25 percent were related to the use of a device (most commonly oxygen tubing or masks, endotrachial or nasogastric tubes, and immobilizing devices such as collars or splints).

▶ An additional 13 percent were associated with immobility, pressure or friction during extended surgical procedures. Contributing factors for the surgical pressure ulcers included a lack of awareness of the risk of skin breakdown among operative teams and a lack of algorithms for determining the types of surgical cases that have the greatest likelihood of increasing risk for skin breakdown.

▶ The majority involved patients with multiple or complicated health conditions, including kidney, respiratory or heart failure, diabetes, obesity, incontinence, or malnutrition.

Preventing pressure ulcers

Prevention of pressure ulcers can be a challenging and sometimes frustrating process. The 92 hospitals that are participating in MHA's Safe Skin campaign continue to report quarterly on their progress in implementing best practices for pressure ulcer prevention. Nearly three years after the campaign began, participating hospitals report that an average of just over 90 percent of the campaign's bundle of best practices are in place: the practices that facilities report still finding challenging to implement include the development of decision tools for selection of support surfaces and the regular review and analysis of reported pressure ulcers for learning and improvement opportunities.

PRESSURE ULCER STAGES

Stage 1: Intact, reddened skin

Stage 2: Partial thickness wound presenting as a shallow ulcer or blister

Stage 3: Full thickness tissue loss

Stage 4: Full thickness tissue loss with exposed muscle, tendon or bone

Unstageable: Full thickness tissue loss, covered with slough or scabbing so that the stage cannot be determined.

Individual hospitals are taking a number of steps to prevent pressure ulcers, including:

▶ Using pressure-reducing surfaces in the operating room for high-risk patients or during longer procedures.

▶ Adding information about skin breakdown risk to "patient passports" used to convey information during handoffs to other care areas.

▶ Developing new decision-making algorithms to assist nursing staff in knowing when additional patient education related to turning may be needed, or when family conferences related to skin integrity should be called.

▶ Purchasing special equipment to use for patients at risk for pressure ulcers.

▶ Ensuring that all providers, including respiratory and physical therapists, are aware of skin breakdown risk and how particular treatments may increase risk of pressure ulcer development.

▶ Providing additional training in skin assessment and inspection to assist nursing staff in correctly staging pressure ulcers, implementing treatment, and communicating skin issues upon shift transfer.

▶ Revising electronic health records to include alerts linked to best practices whenever patients are assessed at the highest levels of risk.

▶ Providing additional training to staff on risks for skin breakdown related to feeding tubes, TED stockings, vents, and other devices that are in place for prolonged periods, and providing guidance on how to assess skin integrity in patients with these devices.
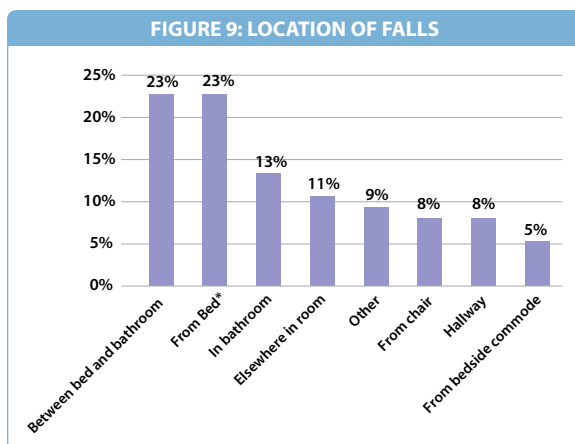
Next steps

In the coming year, MDH and MHA will continue to work with wound, ostomy and continence nurses, as well as with other clinical advisors, to analyze common patient characteristics and clinical and environmental factors associated with pressure ulcers across facilities, and develop recommendations for preventing pressure ulcers in clinically complex patients.

FALLS

In Minnesota and nationally, falls in the community, in the hospital, or in long term care settings are a leading cause of injury and accidental death. In all of these settings, falls are more likely to happen to the elderly and to those with balance or gait problems, dizziness, or altered elimination/ incontinence. Additional risk factors for falls include the use of multiple medications and cognitive impairments. While not all of these factors are within the control of the health care facility, a successful fall prevention program will create processes and environments that minimize each patient's risk, with added interventions for those who face more complicated risk profiles.

In the most recent reporting period, the number of reported falls declined by 20 percent from the previous year. For the first time, no deaths from falls were reported. Of the 76 falls reported during this reporting period, more than three-quarters involved patients aged 65 or older, and 54 percent involved patients 75 or older. Overall, the most common serious injury sustained during a fall was a hip fracture (47 percent), with other lower extremity fractures accounting for an additional 22 percent of injuries.

FIGURE 9: LOCATION OF FALLS

Location	Percentage
Between bed and bathroom	23%
From Bed*	23%
In bathroom	13%
Elsewhere in room	11%
Other	9%
From chair	8%
Hallway	8%
From bedside commode	5%

The "From Bed" category also includes some patients who were attempting to use the bathroom unassisted.

Key findings

As in previous years, the most common causes of falls included breakdowns in the fall risk assessment process: either patients were not appropriately placed at high risk, the risk was not adequately documented or communicated, or the risk reduction interventions weren't matched to the patient's individual risk factors or weren't consistently applied. But the falls reported over the last year also revealed other patterns:

▶ At least 40 percent of all falls happened when patients were moving from the bed to the bathroom, or when they were in the bathroom or using a bedside commode; in addition, a number of cases where patients fell from their bed involved patients who were attempting to use the bathroom unassisted (Figure 9). This suggests that more frequent toileting assistance, or increased patient education around the need to ask for help with toileting, may be needed.

▶ In several cases, bed alarms were not in use for patients at risk for falls, as the patients were oriented, coherent, compliant with staff, and had previously used call lights and been able to walk without assistance.

▶ Several falls involved patients who were cognitively impaired, or who were not aware of their surroundings at the time of their fall.

▶ A slightly higher percentage of falls occurred between midnight and eight a.m. than during the afternoon and evening, suggesting that sleep medications, drowsiness/ disorientation, or lighting may have been contributing factors.

▶ A number of falls involved patients who had previously always used call lights for assistance, but did not use the light when the fall occurred, or who had been ambulating independently prior to the fall.

▶ Not all fall risk assessments include previous falls as a risk factor, and not all are able to incorporate falls that occur during the hospital stay; this may mean that not all high-risk patients are correctly classified as at risk for falling.

▶ Some fall risk assessments are insufficiently clear in linking high-risk status to specific interventions or bed selection.

▶ In some cases, physician orders related to physical activity do not mesh with fall risk-reduction measures, leading to confusion about when patients need to be accompanied by a nurse or other staff member.

▶ A number of patients who experienced serious falls were taking multiple medications, including anti-anxiety medications or sleep aids, that may have contributed to the fall.

Preventing falls

The Minnesota Hospital Association's statewide "Safe from Falls" campaign continued throughout 2009, with 109 hospitals participating. Since the campaign began in May 2007, participating hospitals have increased the average implementation rate of falls prevention best practices

from less than 60 percent to more than 90 percent. For some best practices, including putting an interdisciplinary falls prevention team into place and having a system to alert staff to patient risk, the adoption rate is nearly 100 percent.

Individual hospitals also reported implementing a number of corrective actions in response to specific falls, including:

▸ Implementing new fall risk assessment policies and assessment tools.

▸ Clarifying when low beds are necessary, and ensuring that sufficient quantities of low beds are available and that staff understand their use.

▸ Establishing policies for fall risk assessment and the use of tab alarms in the ER.

▸ Clarifying policies for shift change and other handoff communication, so changes in patient status and fall

risk are clearly communicated.

▸ Providing additional staff training on best practices in fall risk assessment.

▸ Posting fall prevention actions prominently in each patient's room, visible to staff, patient, and family.

Next steps

In the coming year, hospitals will continue to explore innovative fall prevention activities, including implementation of hourly rounding systems, staying within arms reach when assisting in toileting for patients at risk for falls, use of alternative fall risk assessment tools, spreading prevention strategies across all facility departments, and using additional strategies and equipment to reduce the risk of harm if a fall does occur.

PREVENTING FALLS HOSPITAL-WIDE

FAIRVIEW NORTHLAND MEDICAL CENTER, PRINCETON

Fairview Northland has taken the statewide Safe from Falls call-to-action framework hospital-wide. "We have always monitored falls and fall rates in the inpatient setting," said Pamela Pringle, R.N., Director of Clinical Practice, Fairview Northland Medical Center, "but we had not approached it from an organizational perspective, as a Northland-wide prevention program."

About two and a half years ago, Northland staff organized an interdisciplinary team to look at other areas of the hospital, besides the inpatient setting, where patients were at risk for falls. The team includes representatives from pharmacy, rehabilitation services (PT and OT), social services, nursing, radiology and environmental services. They developed processes, a policy, and interventions for keeping people safe from falls for every direct patient care department except for laboratory.

Northland uses several MHA tools recommended by the SAFE from FALLS campaign: a fall risk assessment, a post-fall monitoring flow sheet, and a post-fall safety huddle form. Interventions include yellow fall precaution wristbands, fall precaution signage, direct or close observation, assistance and supervision during toileting, hourly rounds, and chair and bed alarms.

Education about falls has been very important at Northland. "Until people understand the scope and the complexity of the problem, until they understand their individual accountability and responsibility in terms of patient safety and keeping patients safe, and until they understand what they need to do if a patient falls, or a visitor falls, or a co-worker falls, they don't really understand what fall prevention really means," Pringle said.

Every Fairview Northland employee has completed mandatory education for fall prevention — from housekeepers to dietary aides, to RNs and nursing assistants, to the maintenance engineers, to lab personnel, to radiology.

Pringle reviews each occurrence report, the post-fall safety huddle and the medical record of every patient who falls. After this first-level analysis, she goes back to the department where the fall occurred for second-level analysis with department nursing leaders and staff. The Fall Prevention Team also reviews the analysis and makes recommendations.

Quarterly reports, including overall evaluation of the fall prevention program, are sent to the Northland administration team, and an annual report is submitted to the Fairview Northland Board of Directors.

"The interdisciplinary team continues to meet bi-monthly with a focus on data analysis, team member continuing education, staff and patient education, and other improvement initiatives that arise in the process of measurement and evaluation," Pringle said. "A large part of our work now is to ensure that we keep fall prevention at the forefront."

Currently, 109 Minnesota hospitals are participating in the Minnesota Hospital Association's SAFE from FALLS campaign.

CONCLUSION

Improving patient safety is a long-term process. The reporting system has been a catalyst for a strong commitment to patient safety, transparency, and best practices at all levels of healthcare organizations. However, particularly in a healthcare environment in which cost-cutting remains a priority and in which state and national health reform efforts may influence how care is delivered and reimbursed, the need for a continued focus on these issues remains.

It is important to remember that this reporting system is just one component of a broader patient safety and quality movement in Minnesota. Comprehensive efforts to reduce adverse events are underway throughout Minnesota, and the number of sources of data on hospital and clinic performance on key quality indicators are increasing. Consumers and patients should use reports like this one, along with these other sources of information, to increase their awareness of patient safety issues and let their health providers know that safety is a high priority for them. This awareness and attention will help ensure that patient safety will continue to be a priority for hospitals, surgical centers and other health providers in Minnesota.

As the reporting system moves into its seventh year, the work in some ways becomes more challenging. MDH and its partners will need to learn from the successes and challenges of the first six years, while also continually monitoring trends, working to support facilities as they implement new approaches to preventing events and finding new ways to share data and learning with reporting facilities. But on a broader level, finding ways to ensure that healthcare leaders are engaged in patient safety and actively working to create a safe and transparent culture during a time of continuing budget challenges will be increasingly important – as will working to prevent 'burnout' among front-line staff that are working to implement multiple process changes.

Achieving a significant and lasting reduction in the number of events will require an ongoing commitment of resources, time, and leadership by all levels of administration and staff within healthcare facilities, as well as continued efforts to engage patients and family members in the delivery of safe care. It will be neither an easy nor a quick process, but it is a process to which stakeholders around the state remain committed.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2008 and October 6, 2009. For each facility, a table shows the number of events reported in each category and the level of severity of each event in terms of patient impact.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

SURGICAL/OTHER INVASIVE PROCEDURE EVENTS

▸ Surgery/invasive procedure performed on a wrong body part;

▸ Surgery/invasive procedure performed on the wrong patient;

▸ The wrong surgical/invasive procedure performed on a patient;

▸ Foreign objects left in a patient after surgery/invasive procedure; or

▸ Death during or immediately after surgery of a normal, healthy patient. (Figure 3)

* Note: "Surgery," as defined in the Adverse Health Events Reporting Law, includes endoscopies, regional anesthetic blocks and other invasive procedures.

ENVIRONMENTAL EVENTS

Patient death or serious disability associated with:

▸ A fall while being cared for in a facility;

▸ An electric shock;

▸ A burn incurred 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);

▸ Associated with hyperbilirubinemia (jaundice) in newborns during the first 28 days of life;

▸ Due to spinal manipulative therapy;

And;

▸ Stage 3 or 4 pressure ulcers (serious bed sores) or unstageable pressure ulcers acquired after admission to a facility;

▸ Artificial insemination with the wrong donor sperm or wrong egg.

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 (air that is introduced into a vein).

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/staff member resulting from a physical assault within or on the grounds of a facility.

Current statutory language is available on the MDH website at
www.health.state.mn.us/patientsafety

TABLE 1: OVERALL STATEWIDE REPORT

Reported adverse health events: **ALL EVENTS** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS							
	SURGICAL	PRODUCT	PATIENT PROTECTION	CARE MANAGEMENT	ENVIRONMENTAL	CRIMINAL	TOTAL
ALL FACILITIES	83 events	1 event	3 events	131 events	78 events	5 events	**301 events**
SEVERITY DETAILS	Serious Disability: 3 Death: 1 Neither: 79	Serious Disability: 1 Death: 0	Serious Disability: 2 Death: 1	Serious Disability: 7 Death: 2 Neither: 122	Serious Disability: 78 Death: 0	Serious Disability: 3 Death: 0 Neither: 2	**Serious Disability: 94** **Death: 4** **Neither: 203**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS						
	1. WRONG BODY PART	2. WRONG PATIENT	3. WRONG PROCEDURE	4. FOREIGN OBJECT	5. INTRA/ POST-OP DEATH	TOTAL FOR SURGICAL
ALL FACILITIES	27 events	2 events	15 events	38 events	1 event	83 events
SEVERITY DETAILS	Serious Disability: 0 Death: 0 Neither: 27	Serious Disability: 0 Death: 0 Neither: 2	Serious Disability: 2 Death: 0 Neither: 13	Serious Disability: 1 Death: 0 Neither: 37	Serious Disability: 0 Death: 1 Neither: 0	Serious Disability: 3 Death: 1 Neither: 79

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS				
	6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	7. MISUSE OR MALFUNCTION OF DEVICE	8. INTRAVASCULAR AIR EMBO-LISM	TOTAL FOR PRODUCTS OR DEVICES
ALL FACILITIES	0 events	1 event	0 events	1 event
SEVERITY DETAILS		Serious Disability: 1 Death: 0		Serious Disability: 1 Death: 0

Details by Category: **PATIENT PROTECTION** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS				
	9. WRONG DISCHARGE OF INFANT	10. PATIENT DISAPPEARANCE	11. SUICIDE OR ATTEMPTED SUICIDE	TOTAL FOR PATIENT PROTECTION
ALL FACILITIES	0 events	0 events	3 events	3 events
SEVERITY DETAILS			Serious Disability: 2 Death: 1	Serious Disability: 2 Death: 1

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2008 – October 6, 2009)

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 HYPOGLYCEMIA	16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPERBILIRUBINEMIA	17. STAGE 3 OR 4 PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULATION	19. ARTIFICIAL INSEMINATION WITH WRONG DONOR EGG OR SPERM	TOTAL FOR CARE MANAGEMENT
ALL FACILITIES	4 events	0 events	1 event	3 events	0 events	122 events	0 events	1 event	**131 events**
SEVERITY DETAILS	Serious Disability: 4 Death: 0		Serious Disability: 1 Death: 0	Serious Disability: 1 Death: 2		Serious Disability: 1 Death: 0 Neither: 121		Neither: 1	**Serious Disability: 7** **Death: 2** **Neither: 122**

Details by Category: **ENVIRONMENTAL** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS					
	20. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	21. WRONG GAS OR CONTAMINATION IN PATIENT GAS LINE	22. DEATH OR DISABILITY ASSOCIATED WITH A BURN	23. DEATH OR SERIOUS DISABILITY ASSOCIATED WITH A FALL	24. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	TOTAL FOR ENVIRONMENTAL
ALL FACILITIES	0 events	0 events	1 event	76 events	1 event	**78 events**
SEVERITY DETAILS			Serious Disability: 1 Death: 0	Serious Disability: 76 Death: 0	Serious Disability: 1 Death: 0	**Serious Disability: 78** **Death: 0**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2008 – October 6, 2009)

TYPES OF EVENTS					
	25. CARE ORDERED BY SOME-ONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	26. ABDUCTION OF PATIENT	27. SEXUAL ASSAULT OF A PATIENT	28. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT	TOTAL FOR PATIENT PROTECTION
ALL FACILITIES	0 events	0 events	2 events	3 events	**5 events**
SEVERITY DETAILS			Serious Disability: 0 Death: 0 Neither: 2	Serious Disability: 3 Death: 0 Neither: 0	**Serious Disability: 3** **Death: 0** **Neither: 2**

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address:
800 E. 28th St.
Minneapolis, MN 55407-3723

Website:
http://www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
952

Number of surgeries/invasive procedures performed:
144,648

Number of patient days:
241,415

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**6**	Deaths: 0; Serious Disability: 6; Neither: 0
CRIMINAL EVENTS		
Sexual assault on a patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**15**	**Deaths: 0; Serious Disability: 6; Neither: 9**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

AVERA MARSHALL REGIONAL MEDICAL CENTER

Address:
300 S. Bruce St.
Marshall, MN 56258-1934

Website:
www.averamarshall.org

Phone number:
507-537-9240

Number of beds:
49

Number of surgeries/invasive procedures performed:
10,611

Number of patient days:
14,941

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL EVENTS		
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

BETHESDA HOSPITAL

Address:
559 Capitol Blvd.
St. Paul, MN 55103-2101

Website:
www.healtheast.org/patientsafety

Phone number:
651-326-2273

Number of beds:
254

Number of surgeries/invasive procedures performed:
1,175

Number of patient days:
40,686

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
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	**5**	**Deaths: 0; Serious Disability: 0; Neither: 5**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

BRAINERD LAKES SURGERY CENTER

Address:
13114 Isle Drive
Baxter, MN 56425

Phone number:
218-822-2405

Number of beds:
N/A

Number of surgeries/invasive procedures performed:
7,984

Number of patient days:
N/A

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
Surgery/other invasive procedure 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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

BRIDGES MEDICAL CENTER

Address:
201 9th St. W.
Ada, MN 56510-1243

Website:
www.bridgesmed.com

Phone number:
218-784-5000

Number of beds:
14

Number of surgeries/invasive procedures performed:
717

Number of patient days:
1,865

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

CAMBRIDGE MEDICAL CENTER

Address:
701 Dellwood St. S.
Cambridge, MN 55008

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
86

Number of surgeries/invasive procedures performed:
17,738

Number of patient days:
42,991

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA (MPLS)

Address:
2525 Chicago Ave. S.
Minneapolis, MN 55404-4518

Website:
www.childrensmn.org

Phone number:
612-813-6615

Number of beds:
153

Number of surgeries/invasive procedures performed:
29,898

Number of patient days:
72,409

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
SURGICAL EVENTS Death or serious disability associated with:		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA (ST. PAUL)

Address:
345 N. Smith Ave.
St. Paul, MN 55102

Website:
www.childrensmn.org

Phone number:
612-813-6615

Number of beds:
126

Number of surgeries/invasive procedures performed:
20,794

Number of patient days:
52,830

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
SURGICAL EVENTS Death or serious disability associated with:		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

CUYUNA REGIONAL MEDICAL CENTER

Address:
320 E. Main St.
Crosby, MN 56441-1645

Website:
www.cuyunamed.org

Phone number:
218-546-2300

Number of beds:
42

Number of surgeries/invasive procedures performed:
11,418

Number of patient days:
13,298

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

DOUGLAS COUNTY HOSPITAL

Address:
111 E. 17th Ave.
Alexandria, MN 56308

Website:
www.dchospital.com

Phone number:
320-762-1511

Number of beds:
127

Number of surgeries/invasive procedures performed:
23,173

Number of patient days:
31,760

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS **Death or serious disability associated with:**		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

FAIRMONT MEDICAL CENTER-MAYO HEALTH SYSTEM

Address:
800 Medical Center Drive
Fairmont, MN 56031-0800

Website:
www.fairmontmedicalcenter.org

Phone number:
507-238-8100

Number of beds:
57

Number of surgeries/invasive procedures performed:
9,118

Number of patient days:
28,935

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
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	**3**	**Deaths: 0; Serious Disability: 2; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

FAIRVIEW LAKES MEDICAL CENTER

Address:
5200 Fairview Blvd.
Wyoming, MN 55092

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
61

Number of surgeries/invasive procedures performed:
38,250

Number of patient days:
49,810

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS **Death or serious disability associated with:**		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

FAIRVIEW NORTHLAND MEDICAL CENTER

Address:
911 Northland Drive
Princeton, MN 55371

Website:
www.fairview.org

Phone number:
763-389-1313

Number of beds:
54

Number of surgeries/invasive procedures performed:
19,741

Number of patient days:
28,355

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS Death or serious disability associated with:		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
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	**4**	**Deaths: 0; Serious Disability: 0; Neither: 4**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

FAIRVIEW RED WING MEDICAL CENTER

Address:
701 Fairview Blvd.
Red Wing, MN 55066

Website:
www.fairview.org

Phone number:
651-267-5000

Number of beds:
50

Number of surgeries/invasive procedures performed:
14,430

Number of patient days:
25,641

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS **Death or serious disability associated with:**		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		
The use or malfunction of a device in patient care	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 1; Neither: 2**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

FAIRVIEW RIDGES HOSPITAL

Address:
201 E. Nicollet Blvd.
Burnsville, MN 55337

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
150

Number of surgeries/invasive procedures performed:
57,256

Number of patient days:
65,547

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS Death or serious disability associated with:		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability:1; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

FAIRVIEW SOUTHDALE HOSPITAL

Address:
6401 France Ave. S.
Edina, MN 55435-2104

Website:
www.fairview.org

Phone number:
952-924-5000

Number of beds:
390

Number of surgeries/invasive procedures performed:
103,807

Number of patient days:
127,810

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Hypoglycemia	1	Deaths: 1; Serious Disability: 0; Neither: 0
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	6	Deaths: 0; Serious Disability: 0; Neither: 6
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
CRIMINAL EVENTS		
Death or significant injury of patient or staff from physical assault	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 1; Serious Disability: 3; Neither: 7**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

FAIRVIEW UNIVERSITY MEDICAL CENTER – MESABI

Address:
750 E. 34th St.
Hibbing, MN 55746-2341

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
175

Number of surgeries/invasive procedures performed:
17,973

Number of patient days:
50,512

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability:1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

Address:
200 E. University Ave.
St. Paul, MN 55101-2507

Website:
www.gillettechildrens.org

Phone number:
651-291-2848

Number of beds:
60

Number of surgeries/invasive procedures performed:
11,208

Number of patient days:
20,143

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
CRIMINAL EVENTS		
Death or significant injury of patient or staff from physical assault	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0; Serious Disability: 2; Neither: 3**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

HENNEPIN COUNTY MEDICAL CENTER

Address:
701 Park Ave. S.
Minneapolis, MN 55415-1623

Website:
www.hcmc.org

Phone number:
612-873-5719

Number of beds:
910

Number of surgeries/invasive procedures performed:
177,507

Number of patient days:
196,238

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**20**	Deaths: 0; Serious Disability: 0; Neither: 20
TOTAL EVENTS FOR THIS FACILITY	**24**	**Deaths: 0; Serious Disability: 4; Neither: 20**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

HIGH POINTE SURGERY CENTER

Address:
8650 Hudson Blvd., Ste. 200 & 235
Lake Elmo, MN 55042-8448

Website:
www.hpsurgery.com/aboutus

Phone number:
651-702-7431

Number of beds:
N/A

Number of surgeries/invasive procedures performed:
4,686

Number of patient days:
N/A

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
Surgery/other invasive procedure 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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

Address:
1025 Marsh St., P.O. Box 8673
Mankato, MN 56002-8673

Website:
www.isj-mhs.org

Phone number:
507-385-2938

Number of beds:
177

Number of surgeries/invasive procedures performed:
37,905

Number of patient days:
63,907

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 0; Neither: 4**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

LAKE REGION HEALTHCARE CORPORATION

Address:
712 Cascade St. S.
Fergus Falls, MN 56538-0728

Website:
www.lrhc.org

Phone number:
218-736-8193

Number of beds:
108

Number of surgeries/invasive procedures performed:
11,295

Number of patient days:
31,588

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure 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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

LAKEWOOD HEALTH CENTER

Address:
600 Main Ave. S.
Baudette, MN 56623

Website:
www.lakewoodhealthcenter.org

Phone number:
218-634-3447

Number of beds:
15

Number of surgeries/invasive procedures performed:
260

Number of patient days:
3,507

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure 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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

LIFECARE MEDICAL CENTER

Address:
715 Delmore Drive
Roseau, MN 56751

Website:
www.lifecaremedicalcenter.org

Phone number:
218-463-2500

Number of beds:
25

Number of surgeries/invasive procedures performed:
1,889

Number of patient days:
3,309

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

MEEKER MEMORIAL HOSPITAL

Address:
612 S. Sibley Ave.
Litchfield, MN 55355-3340

Website:
www.meekermemorial.org

Phone number:
320-693-3242

Number of beds:
38

Number of surgeries/invasive procedures performed:
6,457

Number of patient days:
12,661

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

MELROSE AREA HOSPITAL – CENTRACARE

Address:
11 N. Fifth Ave. W.
Melrose, MN 56352

Website:
www.centracare.com/hospitals/melrose

Phone number:
320-256-4231

Number of beds:
28

Number of surgeries/invasive procedures performed:
3,022

Number of patient days:
5,129

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure 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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

MERCY HOSPITAL

Address:
4050 Coon Rapids Blvd. N.W.
Coon Rapids, MN 55433-2522

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
271

Number of surgeries/invasive procedures performed:
85,737

Number of patient days:
124,535

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 1; Neither: 3**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

MERITCARE THIEF RIVER FALLS NORTHWEST MEDICAL CENTER

Address:
120 LaBree Ave. S.
Thief River Falls, MN 56701

Website:
www.meritcare.com

Phone number:
218-681-4240

Number of beds:
99

Number of surgeries/invasive procedures performed:
1,446

Number of patient days:
13,605

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

MILLE LACS HEALTH SYSTEM

Address:
200 N. Elm St.
Onamia, MN 56359

Website:
www.mlhealth.org

Phone number:
320-532-3154

Number of beds:
28

Number of surgeries/invasive procedures performed:
6,308

Number of patient days:
12,268

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0; Serious Disability: 4; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30
NEW RIVER MEDICAL CENTER

Address:
1013 Hart Blvd.
Monticello, MN 55362

Website:
www.newrivermedical.com

Phone number:
763-271-2385

Number of beds:
39

Number of surgeries/invasive procedures performed:
16,772

Number of patient days:
15,326

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

NORTH COUNTRY HEALTH SERVICES

Address:
1300 Anne St. N.W.
Bemidji, MN 56601-5103

Website:
www.nchs.com

Phone number:
218-333-5760

Number of beds:
118

Number of surgeries/invasive procedures performed:
21,457

Number of patient days:
40,595

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

NORTH MEMORIAL MEDICAL CENTER

Address:
3300 Oakdale Ave. N.
Robbinsdale, MN 55422-2926

Website:
www.northmemorial.com

Phone number:
763-520-5200

Number of beds:
518

Number of surgeries/invasive procedures performed:
97,725

Number of patient days:
153,796

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure 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
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	6	Deaths: 0; Serious Disability: 6; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0; Serious Disability: 6; Neither: 4**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

ORTONVILLE AREA HEALTH SERVICES

Address:
450 Eastvold Ave.
Ortonville, MN 56278

Website:
www.oahs.us

Phone number:
320-839-2502

Number of beds:
25

Number of surgeries/invasive procedures performed:
1,910

Number of patient days:
4,652

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

OWATONNA HOSPITAL

Address:
2250 26th St. N.W.
Owatonna, MN 55060-3200

Website:
www.owatonnahospital.com

Phone number:
507-977-2330

Number of beds:
77

Number of surgeries/invasive procedures performed:
13,417

Number of patient days:
18,867

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

PARK NICOLLET METHODIST HOSPITAL

Address:
6500 Excelsior Blvd.
St Louis Park, MN 55426-4702

Website:
www.parknicollet.com

Phone number:
952-993-3791

Number of beds:
426

Number of surgeries/invasive procedures performed:
110,441

Number of patient days:
159,846

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**9**	Deaths: 0; Serious Disability: 0; Neither: 9
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**5**	Deaths: 0; Serious Disability: 5; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**22**	**Deaths: 0; Serious Disability: 5; Neither: 17**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

PAVILION SURGERY CENTER

Address:
920 E. First St., Ste. 101
Duluth, MN 55805-2203

Phone number:
218-279-6200

Number of beds:
N/A

Number of surgeries/invasive procedures performed:
2,730

Number of patient days:
N/A

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL EVENTS		
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

REGENCY HOSPITAL OF MINNEAPOLIS

Address:
1300 Hidden Lakes Parkway
Golden Valley, MN 55422-4286

Website:
www.regencyhospital.com

Phone number:
763-302-8302

Number of beds:
92

Number of surgeries/invasive procedures performed:
N/A

Number of patient days:
15,100

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

REGIONS HOSPITAL

Address:
640 Jackson St.
St Paul, MN 55101-2502

Website:
www.regionshospital.com

Phone number:
651-254-0760

Number of beds:
417

Number of surgeries/invasive procedures performed:
116,434

Number of patient days:
180,167

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/invasive procedure performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**9**	**Deaths: 0; Serious Disability: 3; Neither: 6**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

RICE MEMORIAL HOSPITAL

Address:
301 Becker Ave. S.W.
Willmar, MN 56201

Website:
www.ricehospital.com

Phone number:
320-231-4223

Number of beds:
136

Number of surgeries/invasive procedures performed:
16,075

Number of patient days:
30,679

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

RIVER'S EDGE HOSPITAL & CLINIC

Address:
1900 N. Sunrise Drive
St. Peter, MN 56082

Website:
www.riversedgehealth.org

Phone number:
507-934-7419

Number of beds:
17

Number of surgeries/invasive procedures performed:
3,414

Number of patient days:
4,638

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

RIVERWOOD HEALTHCARE CENTER

Address:
200 Bunker Hill Drive
Aitkin, MN 56431-1865

Website:
www.riverwoodhealthcare.com

Phone number:
218-927-2121

Number of beds:
24

Number of surgeries/invasive procedures performed:
8,872

Number of patient days:
13,384

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

ROCHESTER METHODIST HOSPITAL

Address:
201 W. Center St.
Rochester, MN 55902-3003

Website:
www.mayoclinic.org/event-reporting

Phone number:
507-284-5005

Number of beds:
794

Number of surgeries/invasive procedures performed:
133,482

Number of patient days:
147,922

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	2	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Labor or delivery in a low-risk pregnancy	1	Deaths: 0; Serious Disability: 1; Neither: 0
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	**8**	**Deaths: 0; Serious Disability: 1; Neither: 7**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

SAINT ELIZABETH'S MEDICAL CENTER

Address:
1200 Grant Blvd. W.
Wabasha, MN 55981

Website:
www.saintelizabethswabasha.org

Phone number:
651-565-5580

Number of beds:
31

Number of surgeries/invasive procedures performed:
2,951

Number of patient days:
4,543

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

SAINT MARYS HOSPITAL

Address:
1216 Second St. S.W.
Rochester, MN 55902-1906

Website:
www.mayoclinic.org/event-reporting

Phone number:
507-284-5005

Number of beds:
1,157

Number of surgeries/invasive procedures performed:
123,602

Number of patient days:
267,016

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**20**	Deaths: 0; Serious Disability: 0; Neither: 20
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**30**	**Deaths: 1; Serious Disability: 2; Neither: 27**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

SANFORD HOSPITAL LUVERNE

Address:
1600 N. Kniss Ave.
Luverne, MN 56156

Website:
www.sanfordluverne.org

Phone number:
507-283-2321 ext. 298

Number of beds:
28

Number of surgeries/invasive procedures performed:
2,958

Number of patient days:
7,397

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

SLEEPY EYE MEDICAL CENTER

Address:
400 Fourth Ave. N.W.
Sleepy Eye, MN 56085

Website:
www.semedicalcenter.org

Phone number:
507-794-3571

Number of beds:
25

Number of surgeries/invasive procedures performed:
1,125

Number of patient days:
3,261

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

SMDC MEDICAL CENTER

Address:
502 E. Second St.
Duluth, MN 55805

Website:
www.smdc.org

Phone number:
218-786-4429

Number of beds:
165

Number of surgeries/invasive procedures performed:
24,575

Number of patient days:
64,176

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Death of a normal, healthy patient during or immediately after surgery	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
A medication error	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Artificial insemination with the wrong sperm/egg	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CRIMINAL EVENTS		
Sexual assault on a patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 1; Serious Disability: 2; Neither: 3**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

ST. CLOUD HOSPITAL

Address:
1406 Sixth Ave N.
St. Cloud, MN 56503-1900

Website:
www.centracare.com

Phone number:
320-229-4983

Number of beds:
489

Number of surgeries/invasive procedures performed:
103,869

Number of patient days:
181,775

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure 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	2	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	5	Deaths: 0; Serious Disability: 0; Neither: 5
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	4	Deaths: 0; Serious Disability: 4; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**13**	**Deaths: 0; Serious Disability: 4; Neither: 9**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

ST. CLOUD SURGICAL CENTER

Address:
1526 Northway Drive
St. Cloud, MN 56303

Website:
www.stcsurgicalcenter.com

Phone number:
320-251-8385

Number of beds:
N/A

Number of surgeries/invasive procedures performed:
11,802

Number of patient days:
N/A

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	**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
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 0; Neither: 4**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.50

ST. FRANCIS REGIONAL MEDICAL CENTER

Address:
1455 St. Francis Ave.
Shakopee, MN 55379-3380

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
93

Number of surgeries/invasive procedures performed:
29,607

Number of patient days:
39,089

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 2; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.51

ST. GABRIEL'S HOSPITAL

Address:
815 Second St. S.E.
Little Falls, MN 56345

Website:
www.stgabriels.com

Phone number:
320-631-5608

Number of beds:
49

Number of surgeries/invasive procedures performed:
3,683

Number of patient days:
12,374

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the
   definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.52

ST. JOHN'S HOSPITAL

Address:
1575 Beam Ave.
Maplewood, MN 55109-1126

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-7122

Number of beds:
184

Number of surgeries/invasive procedures performed:
80,052

Number of patient days:
89,241

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0; Serious Disability: 2; Neither:3**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.53

ST. JOSEPH'S HOSPITAL

Address:
69 W. Exchange St.
St Paul, MN 55102-1004

Website:
www.healtheast.org/patientsafety

Phone number:
651-326-2273

Number of beds:
401

Number of surgeries/invasive procedures performed:
40,827

Number of patient days:
87,321

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 0; Serious Disability: 5; Neither:1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.54

ST. JOSEPH'S MEDICAL CENTER

Address:
523 N. Third St.
Brainerd, MN 56401

Website:
www.brainerdlakeshealth.org

Phone number:
218-454-5807

Number of beds:
162

Number of surgeries/invasive procedures performed:
24,093

Number of patient days:
52,758

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.55

ST. LUKE'S HOSPITAL

Address:
915 E. First St.
Duluth, MN   55805-2107

Website:
www.slhduluth.com

Phone number:
218-249-5555

Number of beds:
267

Number of surgeries/invasive procedures performed:
42,083

Number of patient days:
83,621

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 3; Neither:1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.56

ST. MARY'S MEDICAL CENTER

Address:
407 E. Third St.
Duluth, MN 55805-1950

Website:
www.smdc.org

Phone number:
218-786-4429

Number of beds:
380

Number of surgeries/invasive procedures performed:
72,817

Number of patient days:
105,828

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Hypoglycemia	**1**	Deaths: 1; Serious Disability: 0; 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 **Death or serious disability associated with:**		
A fall while being cared for in a facility	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 1; Serious Disability: 2; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.57

STEVENS COMMUNITY MEDICAL CENTER

Address:
400 E. First St.
Morris, MN 56267-0660

Website:
www.scmcinc.org

Phone number:
320-589-1313

Number of beds:
54

Number of surgeries/invasive procedures performed:
1,498

Number of patient days:
14,677

How to read these tables:

These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.58

TYLER HEALTHCARE CENTER/AVERA

Address:
240 Willow St.
Tyler, Minnesota 56178

Website:
www.tylerhealthcare.org

Phone number:
507-247-5521

Number of beds:
20

Number of surgeries/invasive procedures performed:
1,537

Number of patient days:
2,152

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.59

UNITED HOSPITAL

Address:
333 N. Smith Ave.
St Paul, MN 55102-2344

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
546

Number of surgeries/invasive procedures performed:
87,341

Number of patient days:
158,401

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A burn received while being care for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
A fall while being cared for in a facility	**5**	Deaths: 0; Serious Disability: 5; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0; Serious Disability: 6; Neither: 4**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

UNITY HOSPITAL

Address:
550 Osborne Road N.E.
Fridley, MN 55432-2718

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
275

Number of surgeries/invasive procedures performed:
46,612

Number of patient days:
78,877

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 1; Neither: 2**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.61

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

Address:
2450 Riverside Ave.
Minneapolis, MN 55454-1400

Website:
www.fairview-university.fairview.org

Phone number:
612-672-7061

Number of beds:
1,700

Number of surgeries/invasive procedures performed:
146,247

Number of patient days:
289,771

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
Wrong surgical/invasive procedure performed	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
Retention of a foreign object in a patient after surgery or other procedure	**4**	Deaths: 0; Serious Disability: 1; Neither: 3
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CARE MANAGEMENT EVENTS Death or serious disability associated with:		
A medication error	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
Hypoglycemia	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**20**	Deaths: 0; Serious Disability: 0; Neither: 20
ENVIRONMENTAL EVENTS Death or serious disability associated with:		
A fall while being cared for in a facility	**6**	Deaths: 0; Serious Disability: 6; Neither: 0
Use of or lack of restraints or bedrails while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**41**	**Deaths: 0; Serious Disability: 14; Neither: 27**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.62

WOODWINDS HEALTH CAMPUS

Address:
1925 Woodwinds Drive
Woodbury, MN 55125

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-0100

Number of beds:
86

Number of surgeries/invasive procedures performed:
32,018

Number of patient days:
36,677

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

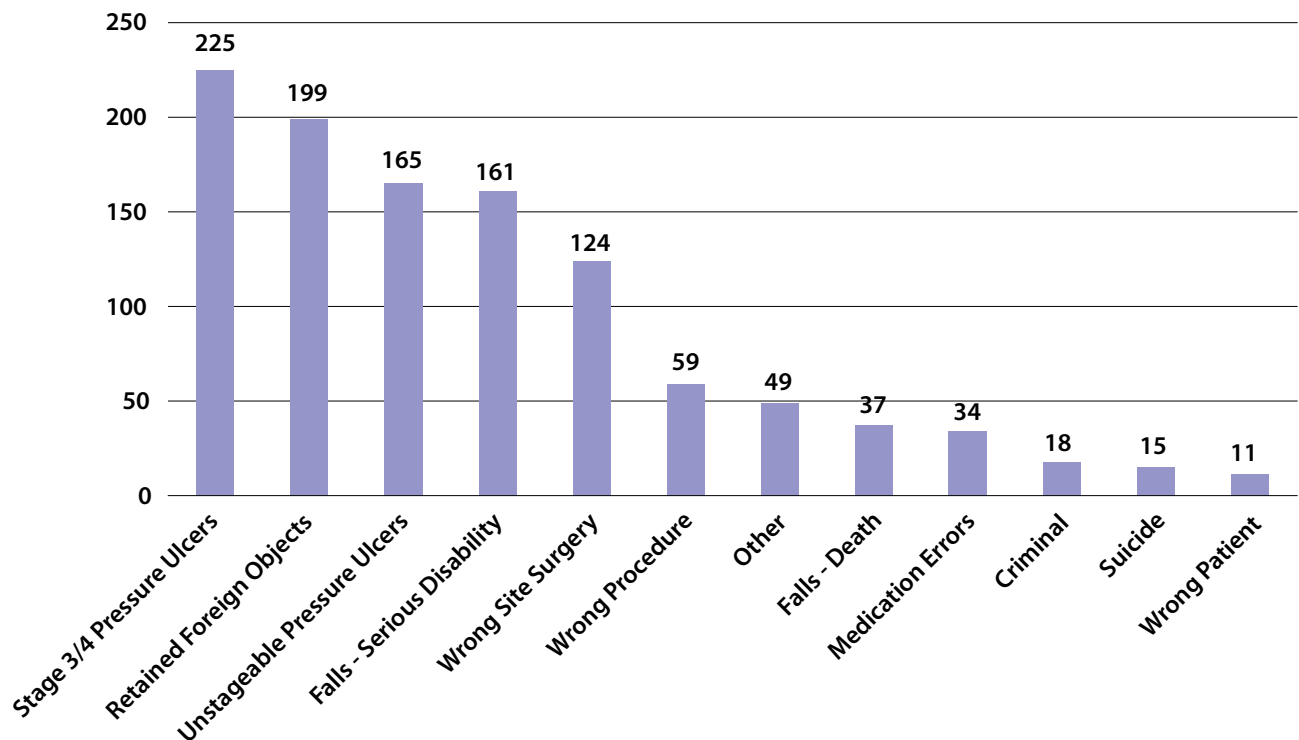| REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2008-OCTOBER 6, 2009)		
CATEGORY AND TYPE	**NUMBER**	**OUTCOME**
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/invasive procedure performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

APPENDIX A:
ADVERSE EVENTS DATA, 2003-2009

Hospitals began reporting adverse health events data to the Minnesota Department of Health in 2003, with ambulatory surgical centers joining the list of required reporting facilities in December, 2004. Since that time, a total of 1,097 events have been reported to MDH.

REPORTED ADVERSE EVENTS, 2003–2009

Category	Count
Stage 3/4 Pressure Ulcers	225
Retained Foreign Objects	199
Unstageable Pressure Ulcers	165
Falls - Serious Disability	161
Wrong Site Surgery	124
Wrong Procedure	59
Other	49
Falls - Death	37
Medication Errors	34
Criminal	18
Suicide	15
Wrong Patient	11

APPENDIX B:
BACKGROUND ON MINNESOTA'S ADVERSE HEALTH EVENTS REPORTING LAW

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 "never events" identified by the National Quality Forum and a public report that identified adverse events by facility. The law covers Minnesota hospitals, freestanding outpatient surgical centers, and community behavioral health hospitals.

Momentum toward a system for mandatory adverse event reporting began with the publication of the Institute of Medicine report "To Err is Human" in 2000. While the issue of medical errors was not a new one for health professionals, most Americans reacted strongly to the idea that preventable errors could contribute to the deaths of up to 98,000 people per year. The public and media attention that followed the report's publication helped to start a national conversation about the reasons why such errors occur, and a primary focus of the discussions was the concept of systemic causes for errors.

In the past, discussions of medical errors often focused on identifying and punishing those who had caused the error. While individual accountability for behavior that could put patients at risk is very important, the IOM report confirmed that most errors were not the result of the isolated actions of any one care provider, but rather of a failure of the complex systems and processes in health care. Given that knowledge, the old 'blame and train' mentality, wherein individual providers were blamed for mistakes and provided with training in the hopes of preventing future slip-ups, has to make way for a new approach that encompasses a broader view of accountability and learning from errors or near misses.

Every facility has processes for dealing with individual providers who exhibit dangerous or inappropriate behavior or who knowingly put patients at risk. Disciplining, educating or dismissing an individual provider will always be an option in those cases. But the focus of the reporting system is on using focused analysis of events to develop broader opportunities for education about patient safety and best practices – solutions that can be applied across facilities. Responses focused on an individual provider may or may not prevent that provider from making a mistake again, but changing an entire system or process to eliminate opportunities for error, whether by building in cross-checks, establishing a 'stop the line' policy, or using automation to prevent risky choices, will help to keep all patients safer.

From the beginning, the reporting system has been a collaborative effort. Health care leaders, hospitals, doctors, professional boards, patient advocacy groups, health plans, the Minnesota Department of Health, and other stakeholders worked together to create the Adverse Health Care Event Reporting Act, with a shared goal of improving patient safety. The vision for the reporting system is of a tool for quality improvement and education that provides a forum for sharing best practices, rather than a tool for regulatory enforcement.

In 2007, the Adverse Health Care Events Reporting Law was modified to include a 28th event and to expand the definitions of certain other events. The most significant change was an expansion of reportable falls to include those associated with a serious disability in addition to those associated with a death.

APPENDIX C:
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. Current statutory language is available on the MDH website at **www.health.state.mn.us/patientsafety**.

Surgical Events [2]

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

1. 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;

2. 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

3. 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

1. An infant discharged to the wrong person;

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

3. 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

1. 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;

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

3. 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;

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

5. 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;

6. 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 (includes unstageable ulcers);

7. Patient death or serious disability due to spinal manipulative therapy; and.

8. Artificial insemination with the wrong donor sperm or wrong egg.

Environmental Events

1. 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;

2. 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;

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

4. Patient death or serious disability associated with a fall while being cared for in a facility; and

5. 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

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

2. Abduction of a patient of any age;

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

4. 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 D:
STAFFING AND PATIENT SAFETY FACT SHEET AND RECOMMENDATIONS

Background Information

Minnesota Department of Health

November 2009

Staffing and Patient Safety

In 2003, the Minnesota Legislature passed the Minnesota Adverse Health Care Events reporting law (Minnesota Statutes, sections 144.7063-144.7069). This law requires Minnesota hospitals and ambulatory surgical centers to report to the Minnesota Department of Health whenever one of 28 serious reportable events, including surgery or an invasive procedure on the wrong patient or wrong body part, a foreign object retained after surgery or an invasive procedure, or a fall, medication error, or burn resulting in serious disability or death, occurs.

During the 2008 legislative session, in response to concerns that inadequate nurse staffing might be contributing to some of these events, the Minnesota Department of Health was directed to "consult with hospitals, RN staff nurses, and quality assurance staff working in facilities that report under Minnesota Statutes, section 144.7065, subdivision 8, and other stakeholders, taking into account geographic balance, to define and develop questions related to staffing for inclusion in the root cause analysis tool required under that subdivision."

In response to this charge, MDH convened a workgroup in the fall of 2009. Workgroup participants included representatives from large, mid-size and small hospitals throughout the state, the Minnesota Board of Nursing, the Minnesota Nurses Association, the Minnesota Hospital Association, the University of Minnesota, Stratis Health, and other stakeholder organizations, with workgroup member positions ranging from front-line nursing staff to quality/patient safety officers to nursing managers and other roles.

The charge to the workgroup included the following goals:

1. To develop an understanding of what Minnesota data show about the role of staffing in adverse events;
2. To discuss staffing-related factors that may contribute to adverse events, and how these factors interact;
3. To develop an understanding about how staffing decisions are made, and how the contribution of staffing to adverse events is evaluated as part of the root cause analysis or investigation process;
4. To develop questions that would enable facilities to more accurately determine whether staffing has been a factor in a reportable adverse event, and that would aid in thoroughly evaluating the role of staffing in an event.

Workgroup Discussion

While staffing is an issue that concerned all group members, the group generally agreed that staffing-related issues emerge relatively rarely as contributing factors or root causes for reportable adverse health events, and that these events are much more often related to flawed processes or protocols than to an insufficient number of nurses or other staff on duty at the time of the event. At the same time, however, the group acknowledged that when staffing issues do exist, they can have a significant influence on work environment, work flow, and safety. As one workgroup participant phrased it, staffing can be a symptom of larger system issues, and is often a starting rather than an ending point in the analysis of an event.

The workgroup's discussion highlighted the difficulty of determining whether staffing levels were adequate for safety at the time of an event:

MINNESOTA MDH DEPARTMENT of HEALTH

Commissioner's Office
625 Robert Street North
PO Box 64975
St. Paul, MN 55164-0975
(651) 201-4989
www.health.state.mn.us

Staffing and Patient SafetyPage 2

- The process of defining the appropriate staffing level for a unit should involve a consideration of average acuity levels, experience of staff, budget, and other issues. But staffing grids cannot reflect all patient contact that nurses and other staff have during a shift, and they often cannot capture issues such as time pressure or organizational culture that may impact workload.
- Organizational leaders also need to look beyond staffing numbers to discover whether nurses or other staff are doing work to cover for other roles, particularly in smaller rural hospitals where nurses may 'wear many hats.' Retrospective reviews of staffing levels should also include, where possible, patient safety indicators such as fall, pressure ulcer, or infection rates.
- Mechanisms should be in place to obtain staff feedback on staffing levels, including documentation of requests for additional staff.
- A distinction should be made between events whose time can be pinpointed, like patient falls, and events such as pressure ulcers, which develop over the course of hours, days or weeks and may not be linked to staffing on a particular shift. The analysis of longer-term events needs to include a discussion of staffing levels and roles over time.

Workgroup Recommendations

The workgroup recommended that three questions be added to the set of triage questions that facilities should ask whenever a reportable event occurs. These questions should be included in the root cause analysis for every reportable event. In addition to their potential implication for staffing levels, the responses to

these questions may also point to other system issues that the facility needs to address. Facilities should also consider asking these questions when investigating other serious events or near misses that are not reportable under Minnesota's adverse health care events reporting law.

Recommended Questions

Note: For the purposes of these questions, staffing includes not only the number of staff on duty at the time of the event, but also such considerations as competency, mix of credentials, skill/experience mix, and fatigue. Staffing questions refer to all disciplines potentially involved in the event, including nursing, pharmacy, medical, and other staff as appropriate.

1. Did staff who were involved in the event believe that staffing was appropriate to provide safe care?
   a. If no, did staff who were involved in the event believe that staffing issues contributed to the event?

2. Did actual staffing deviate from the planned staffing at the time of the adverse event, or during key times that led up to the adverse event?

3. Were there any unexpected issues or incidents that occurred at the time of the adverse event, or during key times that led up to the adverse event?
   a. If yes, did the unexpected issue/incident impact staffing or workload for staff involved in the adverse event?
   b. If yes, did staff who were involved in the adverse event believe that this change in staffing or workload contributed to the adverse event?

For more information:

Diane Rydrych
Minnesota Department of Health
651-201-3564
diane.rydrych@state.mn.us

APPENDIX E:
2009 SAFETY ALERTS

Minnesota Patient Safety Alert

Aug. 18, 2009

Accounting for removal of "packing" materials used during surgical procedures

Background

The Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH) have reviewed data from the adverse health event reporting system and have noted a cluster of retained foreign objects involving materials used for packing that are intended to be removed following the procedure but are not removed as intended. Root cause analyses reviewed indicate that in most cases the placement of the packing is not clearly communicated and documented, a process for ensuring removal is not well defined and accountability for removal of the item is not clearly assigned. A high percentage of reported cases involve retained vaginal packs following procedures such as suburethral sling or cystocele repair.

Recommendation

MHA and MDH recommend that facilities revisit their surgical policies and processes to address the issue of ensuring items that are used for packing are removed as intended. The following suggestions should be considered in developing processes within your organization:

- Packed items are communicated to the team;

- The item placed, and its location, is documented in a manner that it can be accounted for at the end of the case;

- There is a clear process for accounting for packed items at the end of the case;

- An order is written by the physician for packing removal indicating when the packing should be removed;

- The presence of packed materials is communicated during hand-off to post-procedure staff;

- A standardized process and clear accountability is in place for removal of the item post-procedure. For example: A flag is placed in the medical record, visible across departments, that is present until the packing is removed.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393; or Diane Rydrych, assistant director, Division of Health Policy, Minnesota Department of Health, (651) 201-3564.

Minnesota Patient Safety Alert

April 30, 2009

Ensuring objects used during invasive procedures are intact

Background

The Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH) have reviewed data from the adverse health event reporting system and have noted a cluster of retained foreign objects involving devices or instruments in which a component of the object (e.g., an insertion tip or sleeve) is retained or a piece of an object breaks and is retained (e.g., a guide wire used during a biopsy, a catheter tip breaking upon removal or a piece of a drill bit used during an orthopedic procedure). The root cause analyses reviewed for these events indicate that there may not be clear policies in place to assign responsibility for visual inspection of devices and instruments pre- or post-procedure to check for broken or missing components. In some cases, surgical teams may not be aware that a particular device has multiple components that can break or separate, or are not aware that certain components need to be removed when a device is implanted, indicating training and communication as additional contributing factors.

Recommendation

MHA and MDH recommend that facilities revisit their surgical and other invasive procedure policies and processes to address the issue of ensuring objects used in procedures are intact. The following suggestions should be considered in developing processes within your organization:

- Responsibility is assigned to a specific team role for visualization of equipment/devices that will be used during the procedure to ensure the device and all of its components are intact prior to the procedure and that the device is intact and all components are accounted for following the procedure.

- Before deployment of a new device or equipment, staff should be educated on all component parts of the object that could potentially be retained or may be at higher risk for breakage.

- Any breakage or separation of device components during a procedure, even if the object is not retained, should be tracked to identify potentially higher-risk devices or instruments for breakage.

(more)

Additional Actions Implemented by Hospitals Reporting Broken Retained Objects

- Verification of wire barb removal will take place prior to skin closure through either mammogram or pathology examination of specimen.

- When possible, device or equipment with removable parts will be replaced with equally effective devices or equipment without removable parts.

- Work with vendor to modify devices or equipment at higher-risk for breakage or separation.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393 or Diane Rydrych, Assistant Director, Division of Health Policy, MN Department of Health, 651-201-3564.

ADVERSE HEALTH EVENTS IN MINNESOTA
SIXTH ANNUAL PUBLIC REPORT