ADVERSE HEALTH EVENTS IN MINNESOTA




TENTH ANNUAL PUBLIC REPORT / JANUARY 2014

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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EXECUTIVE SUMMARY

Adverse Health Events in Minnesota

Annual Report, January 2014

In 2003, Minnesota became the first state in the nation to pass a law requiring all hospitals, and later ambulatory surgical centers, to report whenever a serious adverse health event (AHE) (Appendix A) occurs and to conduct a thorough analysis of the causes for the event. In 2013, the 10th year of reporting, the total number of events reported under the law was 258, a decline of 18 percent from 2012.

As Minnesota has reached 10 years in this ground-breaking program, the Minnesota Department of Health (MDH) has also completed a formal 10-year evaluation designed to look at the work of the program and attempt to answer the question, "Are we safer than we were in 2003?" In 2013, the number of total reported events has shown its largest decrease since the inception of the reporting system, which is an indication that 10 years of hard work and a strong focus on learning are leading to significant improvement in patient safety in Minnesota.

Examples of additional improvements in 2013 include:

- The number of pressure ulcers declined for the second consecutive year. Since 2012 the number of pressure ulcers has decreased by 33 percent.
- The number of retained foreign objects also declined for the second consecutive year. Since 2012, retained foreign objects have decreased by 29 percent.
- Wrong body part surgical/invasive procedures are down by 36 percent. This is the largest decline in that category in 10 years and is the lowest number since ambulatory surgical centers began reporting.

Minnesota's reporting system has a strong focus on learning and improvement. The overall purpose of the reporting system is to use the data that is collected to identify the issues that led to the events and learn from these findings, with the goal of preventing these events in the future. Key learnings gleaned from 2012 events that were acted upon in 2013 include:

- In response to an increase in fall related deaths and injuries, MDH collaborated with the Minnesota Hospital Association (MHA) to issue a safety alert (Appendix D), which provided key practices that should be implemented to reduce the risk of fall injury.
- As a result of the data showing an increase in retained foreign object events due to packed or tucked items during surgical procedures, best practices for accounting for those items were developed throughout the year and rolled out by MHA through the 'SAFE ACCOUNT 2.0' roadmap in December 2013.
- Due to a slight increase in suicides or attempted suicides at Minnesota hospitals, MDH worked with Suicide Awareness Voices of Education (SAVE) to provide free suicide prevention and assessment training in the spring of 2013.
- In response to a rising need from facilities, MDH formed the 'Violence Prevention in Healthcare Workgroup' with stakeholders from hospitals, surgical centers, clinics and long term care associations, in order to look at the issues of patient to staff violence and develop best practices and/or recommendations.

In the upcoming year, MDH and its partners will take a number of steps in order to improve patient safety in Minnesota, including, but not limited to:

- Exploring and piloting additional strategies for reduction of falls and fall injury, such as continuing development of, and rolling out simulation education. Providing additional training and resources that link specific fall injury risk factors to preventative interventions, with a focus on patients receiving anticoagulation therapy.
- Working with hospitals and surgical centers in a targeted effort on the accounting for and handling of packed items, with a focus on obstetrics and gynecological surgery.
- Providing training and resources to facilities on violence prevention and risk assessment to address issues uncovered this past year related to patient to staff violence.
- Reviewing recommendations from the 10 year evaluation to continue to identify additional opportunities to improve patient safety statewide.

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 reliable 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.

Reports might be higher or lower at a specific facility for a variety of reasons. A higher number of events does not necessarily mean that a facility is less safe, and a lower number does not necessarily mean the facility is safer. What is important is that all events are seen as an opportunity for learning and system improvement – and that organizations follow up on the problems they identify.

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.

http://www.health.state.mn.us/healthreform/measurement/report/index.html

2010 Minnesota Health Care Quality Report, comparing quality at hospitals and clinics on a set of measures including diabetes, high blood pressure, asthma, and cancer.

Minnesota Alliance for Patient Safety

www.mnpatientsafety.org

MAPS is a broad-based collaborative that works together to improve patient safety in MN. 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.

Stratis Health

www.stratishealth.org

A nonprofit organization that leads collaboration and innovation in health care quality and safety. Resources include tools 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 for heart attack, heart failure, pneumonia, surgical care and how patients experience care in the hospital.

2013 SUCCESSES AND CHALLENGES: FACILITY PERSPECTIVES

In August 2013, MDH conducted a survey of all hospitals and licensed surgical centers to learn more about their successes and challenges with the reporting system, as well as to allow facilities to provide input into the direction of the reporting system for the future. Patient safety staff members and administrators at all facilities were surveyed using an online tool, with a 60 percent response rate.

Respondents were asked to rate the usefulness of a number of tools, training opportunities and resources developed by MDH, MHA and Stratis Health during the 2012-13 reporting period. Their responses indicate that the majority of facilities made use of a range of resources and training opportunities (Figure 1). Similar to past years, the most highly-rated activities were the MHA Call to Action resources, MDH Case Study, MDH Online RCA Toolkit and MDH/MHA Safety Alerts.

Facilities were asked to describe what the biggest changes have been as a result of the AHE law (since its inception in 2003). With regard to positive changes, a number of respondents described increasing awareness of patient safety in their facilities, increased leadership support of patient safety activities, heightened surgical/procedural safety and the ability to hold staff at all levels accountable for patient safety.

Next, respondents were asked to describe the most valuable part of the AHE program. The responses indicated that facilities take advantage of a number of resources provided through the program. Respondents most frequently noted: training/education, case study survey, connection with resources, data sharing with other organizations, public accountability and learning from events.

FIGURE 1:
Facility Perspectives, 2013

RESOURCE OR TOOL	NOT USEFUL	NEUTRAL	SOMEWHAT USEFUL	VERY USEFUL	N/A
MDH Case Study Survey (April 2013)	3%	17%	34%	43%	3%
MHA AHE data sharing database	6%	28%	33%	21%	12%
Measurement guide for adverse events	2%	22%	31%	41%	4%
MDH online RCA toolkit	3%	19%	25%	38%	15%
Participation in MHA advisory committees	1%	17%	17%	18%	47%
RCA Training (Spring 2013)	1%	13%	15%	14%	57%
MDH/MHA Safety Alerts	1%	9%	48%	42%	0
MDH Suicide prevention training (Spring 2013)	1%	3%	3%	20%	72%
Stratis Health review of RCA/CAP information	3%	21%	18%	20%	38%
MHA/Stratis regional meetings (Spring 2013)	2%	11%	17%	25%	43%
MHA Calls to Action	2%	12%	38%	41%	6%

** Responses are limited to facilities that indicated they had used/seen the resource.*

Respondents were then asked to describe the least valuable part of the AHE program. Respondents most frequently noted confusion between state and federal reporting, the online database feeling burdensome for staff who use it rarely, and lack of understanding of the event review process.

Lastly, respondents were asked to list suggestions for how MDH/MHA/Stratis Health could support them in improving patient safety in their facilities. The most common responses were:

- Assistance developing physician/surgeon champions to build support for safety initiatives
- Continued learning/sharing sessions around the top problem areas
- Make entering data into the online reporting system easier.
- Offering more collaborative learning opportunities/sharing around the most frequently occurring AHE categories, with national expert speakers

As was noted previously, MDH completed a 10-year evaluation of the program in 2013 that showed similar responses to resources, tools and changes facilities would like to see in the upcoming year. MDH and its partners will move forward in 2014 with addressing the needs brought forth in this survey. MDH will continue to support Minnesota facilities with making patient safety their highest priority.

HIGHLIGHTS OF 2013 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 a variety of stakeholders including MHA, Stratis Health and the Minnesota Alliance for Patient Safety (MAPS). Highlights of the 2013 activities are listed below.

Strengthening the reporting system

- Throughout 2013, MDH worked on a 10-year evaluation for the Adverse Health Events system. This evaluation was three pronged and included: focus groups, a facility survey, and data analysis. Through this evaluation, MDH and its partners are continuing to look at the reporting system and ways it can improve and evolve over the years to come. For more information on the 10-year evaluation, please see the adjunct "Adverse Health Events Program-10 Year Evaluation" report.
- In March, for the fourth year, MDH surveyed hospitals and surgical centers to assess their knowledge of the reporting law's requirements. Facilities were provided with case studies, and asked to determine whether each case was reportable under the law. The results and correct answers were discussed with facilities statewide, with many facilities also using the survey as an internal training tool for staff.
- In 2013, MDH worked with legislators to enhance the Adverse Health Events law by adding four new events, as well as modifying and further defining others. These changes resulted in a total of 29 reportable events and went into effect for the start of the 11th year of reporting (October 7, 2013). These changes were in response to modifications made in 2011 by the National Quality Forum and were put in place in Minnesota in order to maintain alignment with the national organization as well as to ensure the law is responsive to the needs brought forth in the state.
- MDH convened a group of hospitals and surgical centers to help define the new events that were put into law. This group has helped MDH to operationalize the new events and provide much needed clarification to facilities to ensure consistent reporting going forward.

Education

- Representatives from more than 40 hospitals, surgical centers and nursing homes participated in Root Cause Analysis (RCA) training sessions in March and October of 2013. This training is an important way of supporting facilities as they work to conduct robust root cause analyses and take the learnings from those analyses and put interventions in place to prevent similar events from occurring.
- In May, MDH hosted suicide prevention training with Dr. Reidenberg from Suicide Awareness Voices of Education (SAVE) in response to requests from reporting facilities in the 2012 end of year survey. Staff from over 25 facilities attended this training.
- In May, MHA and MDH jointly issued a safety alert related to falls, including recommendations for assessing patient injury risk and putting interventions in place to avoid fall-related injury (Appendix D).
- In 2013, MDH held two statewide conference calls and one webinar for reporting facilities to update them on changes to the reporting system, trends in the data, new projects, and upcoming training opportunities.

Collaborations

- MDH partnered with Minnesota Alliance for Patient Safety (MAPS) to hold a community forum "10 Years of Adverse Health Event Reporting; Looking Back and Moving Forward" in October 2013.
- MDH partnered with MAPS, MHA and Stratis Health to continue to move the Patient Safety Culture work forward throughout the state. This effort focuses on the role a facility's culture of safety plays in creating an environment that focuses on protecting patients and staff from harm and provides tools and resources for facilities.
- MDH collaborated with Stratis Health and the Department of Human Services (DHS) to spread the Minnesota Alliance for Patient Safety's 'SAFE CULTURE' roadmap into Long Term Care facilities through the DHS Performance-based Incentive Payment Program (PIPP). A pilot group of 10 long term care facilities are currently using the roadmap to improve safety in the nursing home setting of care.

Topic specific safety activities

MDH collaborated with MHA to continue to convene expert groups to examine trends and develop evidence-based strategies for prevention of falls, pressure ulcers, retained foreign objects, as well as surgical/invasive procedure events. A number of statewide and regional projects and individual facility efforts to prevent surgical/procedural events, retained foreign objects, falls and pressure ulcers were implemented or continued during 2013. Those efforts are described in the following sections.

MDH patient safety/quality improvement mini-grant program

In June 2013, MDH awarded over $35,000 in Patient Safety/ Quality Improvement Mini-Grants (maximum of $5,000 each) to facilities to support new practice implementation projects focused on prevention of reportable adverse health events. This was the second year for the MDH program and the grants challenged the health care community and the ability of organizations to develop new solutions to clinical scenarios in which adverse events could occur. The goal of this grant program was for the tools and procedures that emerge from these projects to be shared across the state to improve quality and patient safety at Minnesota hospitals and ambulatory surgical centers. The tools and resources from the 2012 grantees are on the MDH website for facilities to use.

More than 20 organizations applied and nine grantees were chosen by a panel of judges to receive the grant dollars (Figure 2). In early 2014, the learnings, as well as tools and resources developed from those projects, will be shared with all facilities in Minnesota. MDH plans to offer this grant program again in the spring of 2014.

FIGURE 2:
MDH patient safety/quality improvement mini-grant program awardees

AWARDEE	PROJECT SUMMARY
Allina Health	Performed an RPIW (Rapid Process Improvement Workshop) with assistive personnel from across the Allina Health system to look at how assistive personnel can work to prevent pressure ulcers.
CentraCare Health-Long Prairie	Purchased and implemented pressure relieving equipment in the operating room. Developed and implemented hand-off communication procedures for pressure ulcer prevention.
Lakewood Health System (Staples, MN)	Purchased and installed new equipment for gait improvement in physical therapy. This gait improvement equipment will be used to help to prevent falls in physical therapy as well as other areas of the hospital.
LifeCare Medical Center	Installed the most current edition of perinatal education software for the initial and ongoing training of nurses who work in labor and delivery with an attempt to prevent adverse health events in those areas.
Riverwood Healthcare Center	Implemented a six month medication reconciliation project to test a new model for reducing medication errors.
Sanford Canby Medical Center	Implemented a falls prevention education program for staff, family and patients through a combination of training and bedside rounding.
Sanford Luverne Medical Center	Implemented a “Staying Within Arms Reach” program, post-fall huddle process, and developed enhanced falls prevention and management training for all staff.
Sanford Tracy Medical Center	Developed policies and procedures for the use of purchased whiteboards throughout the facility in order to enhance communication and prevent pressure ulcers and falls.
University of Minnesota Medical Center, Fairview	Implemented and completed a demonstration project addressing staffing changes to attempt to reduce falls on inpatient units during change of shift.

OVERVIEW OF REPORTED EVENTS & FINDINGS

In 10 years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on more than 2,200 events. This annual report provides an overview of what the most recent year of data can teach us about the risk factors for adverse health events and the best approaches for preventing them, with a highlight on the most common types of reportable events: falls, pressure ulcers and surgical/invasive procedure events. 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 occurring again, and how we can continue to improve in the future.

Hospitals and ambulatory surgical centers that are licensed by MDH are required to report adverse health events under this law. Federally licensed facilities, such as those operated by the Veteran's Administration or the Indian Health Service, are not covered by the law.

Frequency of events

Between October 7, 2012, and October 6, 2013, a total of 258 adverse health events were reported to MDH. This figure represents an average of 21.5 events per month or roughly five events per week.

Overall, the data shows:

- The number of events per month ranged from 20 to 33 events per month, April having the highest number of events reported with 33 and October having the lowest with 20.
- There are currently 145 hospitals and 61 ambulatory surgical centers in Minnesota. Of those, 65 hospitals and six ambulatory surgical centers reported events during this reporting period. Four hospitals were first-time reporters, experiencing their first reportable adverse event in 2013.
- Since the inception of the reporting system, 117 hospitals have reported at least one event. This represents 80 percent of all hospitals, which together account for more than 96 percent of all hospital beds in Minnesota. During October 2012-October 2013, the most recent year for which preliminary data are available, Minnesota hospitals reported 2.6 million patient days. Accounting for the volume of care provided across all hospitals in the state, roughly 9.7 events were reported by hospitals per 100,000 total patient days, this is down from the past five years (Figure 3).

FIGURE 3:
Events per 100,000 patient days

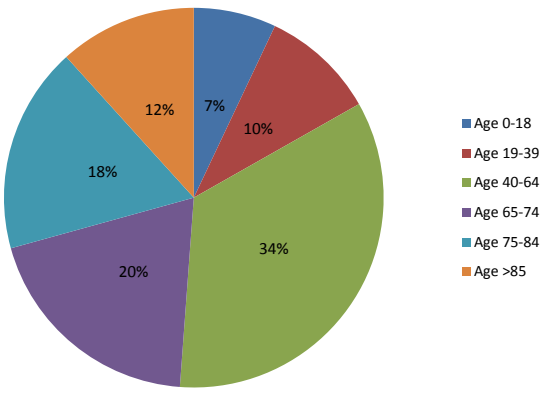
Reporting year	Patient days (million)	Events per 100,000 patient days
2009	2.8	10.7
2010	2.6	11.4
2011	2.6	12.1
2012	2.6	12.1
2013	2.6	9.7

Patient characteristics

Overall the data shows:

- In 77 percent of reportable events, the patient involved was an inpatient, 14 percent were outpatient and the remaining seven percent were in the emergency department or other location in the facility.
- Adverse health events happen to patients of a wide range of ages (Figure 4). From this year's data, the most likely population to experience an adverse event was age 40-64 with 88 patients in that age range; this is similar to the past five years of data.

FIGURE 4:
Events by patient age, 2013

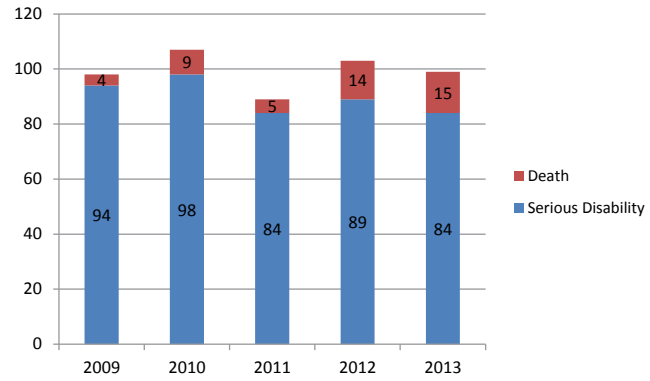


Patient harm

The goal of the reporting system is to develop an understanding of why adverse health events happen so that practices can be put into place to prevent future patient harm as a result of similar events. Over time, the hope is that both the number of events and severity of harm will decrease, as best practices are developed and implemented that reduce the likelihood of errors reaching patients and minimize the harm if they do reach the patient.

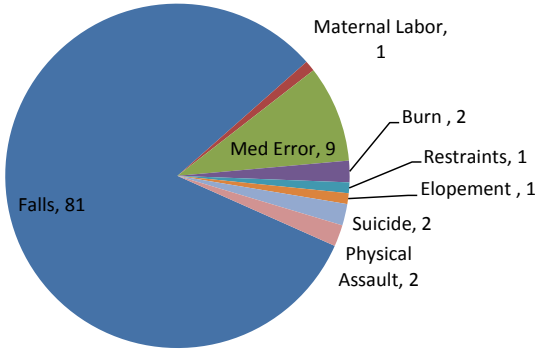
Overall, serious patient harm (defined as serious disability or death) was slightly lower in this reporting year than the previous year, with 99 events resulting in serious disability or death (Figure 5). The remaining 159 events resulted in no harm, a need for additional monitoring, or a longer stay. Although overall harm has decreased slightly, the number of deaths from adverse events in 2013 increased by one. It is important to note that not all of the events that are required to be reported under Minnesota's adverse health events reporting law require harm to occur in order to trigger reporting (such as retained foreign objects); however, all are indicators of potential system issues that could lead to harm or death.

FIGURE 5:
Patient harm, 2009–2013



As in previous years, the type of event most likely to lead to serious patient harm or death was falls. Eighty one cases of harm or death were a result of falls, while medication errors accounted for nine and physical or sexual assault accounted for five cases (Figure 6). Over the life of the reporting system, falls, medication errors, and suicide/attempted suicide have been the most common causes of reportable serious patient harm or death.

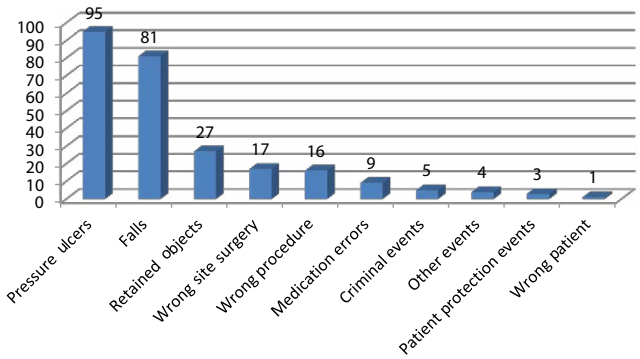
FIGURE 6:
Serious disability or death, 2013



Types of events

As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for two-thirds (68 percent) of all events reported in 2013. The four events that make up the surgical/procedural category accounted for another 23 percent of reported events this year. Of the 28 types of reportable events in Minnesota, 14 had at least one reported case in 2013 (Figure 7).

FIGURE 7:
Events by category, 2013

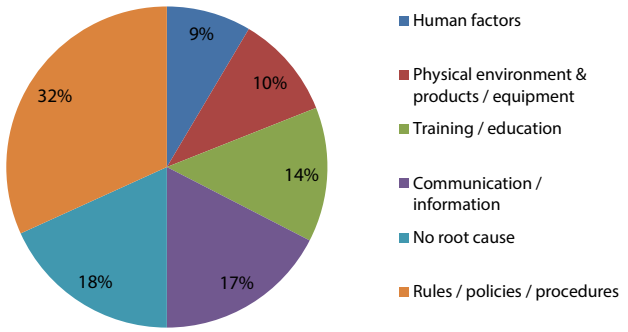


Root causes of adverse events

When a reportable adverse event occurs, facilities are required to conduct a root cause analysis (RCA). This process involves gathering a team to closely examine the factors and circumstances that led to the event. These factors can include communication, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities. The process of completing an RCA is a crucial step in determining exactly what happened and why and putting steps in place to prevent a similar event in the future.

As in previous years, the majority of adverse events were tied to root causes in one of three areas: communication, policies/procedures, and training/education (Figure 8).

FIGURE 8:
RCA by category, 2013



Upon closer examination of the communication category, facilities cited 36 percent of the time that the root cause was due to information not being communicated to the correct person. Another 32 percent of the time information was not readily accessible (such as in an electronic medical record on a separate screen), or was not communicated using a structured read back process. Also of interest, in the rules/policies/procedures category, 41 percent of the time facilities noted a particular policy/process was in place but not followed (e.g., drift in practice, time constraints, policy was not workable), followed by the policy or procedure being unclear or ineffective.

Because root causes are often complex and contain larger systems issues, simple solutions or quick fixes are unlikely to succeed or be sustained in the long-term toward preventing future occurrences. In the field of patient safety and quality, interventions or corrections that rely on repeating training or education are generally considered weaker interventions, whereas interventions that fix the underlying system or work process are considered stronger interventions.

The strength of interventions/corrective action plans can be categorized as follows (these are only examples and are not exhaustive).

Strong interventions:

- Engineering control (e.g., tubing connections, pump alarms, requiring multiple steps to override safety functions)
- Forcing functions (e.g., required information/field in software program)
- Senior management ensures adequate availability of appropriate supplies and equipment to meet safety needs
- Standardization of equipment/supplies

Intermediate interventions:

- Development/implementation of decision support tools (e.g., algorithms)
- Development/implementation of real-time checklist or other cognitive aids
- Enhanced documentation/communication or standardization of process within/across units

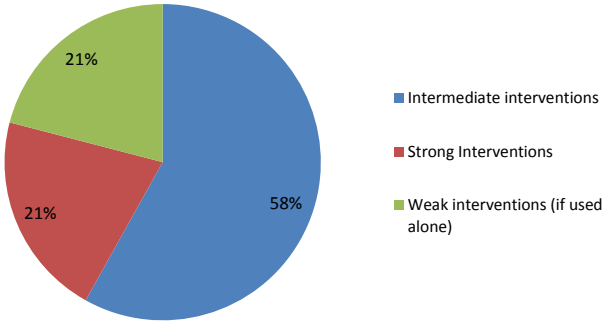
Weak interventions (if used alone):

- New policy/clarified policy
- Training alone
- Issuance of a memo

In late 2012, the AHE registry was updated to capture data on the strength of corrective action plans that are submitted to MDH, which would help MDH better understand the root causes of these events and what types of corrective action plans facilities are putting in place in order to prevent them in the future. The first year of this data shows that 58 percent of the time facilities put into place interventions with intermediate strength; 21 percent of the time those interventions were strong; and another 21 percent were considered weak interventions if used alone (Figure 9).

Despite this being the first year this data was collected through the online registry system, trends and patterns are beginning to emerge with regard to how often facilities are implementing the various strengths of interventions. This data will prove valuable as MDH is able to analyze it further and gain more insight into the data in the upcoming years. MDH will continue to work with facilities to improve the strength of their action plans.

FIGURE 9:
Strength of corrective action plans, 2013

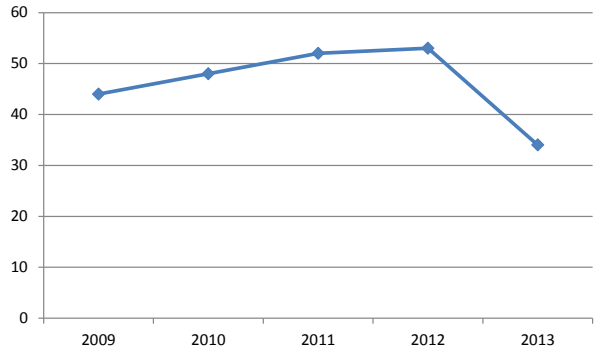


SURGICAL/INVASIVE PROCEDURE EVENTS

In the 10 years of the reporting system, 381 incidents of wrong site, wrong procedure or wrong patient surgeries/invasive procedures have been reported by facilities in Minnesota.

In the 10th year of reporting, the total number of surgical/invasive procedure events across these three reporting categories was 34. This 36 percent decrease was the largest decline in surgical events in the program's history (Figure 10).

FIGURE 10:
Total surgical/invasive procedure events



** Note: Figure 10 does not include retained foreign objects*

In just over half of these cases, the patient was reported to have experienced no medical harm from the incident or required additional monitoring. Roughly 40 percent of patients required additional treatment, usually in the form of a second procedure.

Across all Minnesota hospitals and surgical centers, nearly 2.6 million surgeries and invasive procedures were performed in this reporting year. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one of every 76,000 invasive procedures.

General surgical/invasive procedure best practices

In the most recent reporting year, MDH added fields to the patient safety registry to capture potential gaps and opportunities related to surgical safety best practices. The data collected on the 34 wrong site, patient or procedure cases in 2013 showed that facilities have done extensive work in certain areas of procedural safety but there is still work to be done in other areas.

Key findings – areas of strength

- In 100 percent of the cases, source documents were used to verify the correct procedure or site
- In 96 percent of cases in which a Time Out occurred, each team member ceased all activity for full participation in the Time Out process

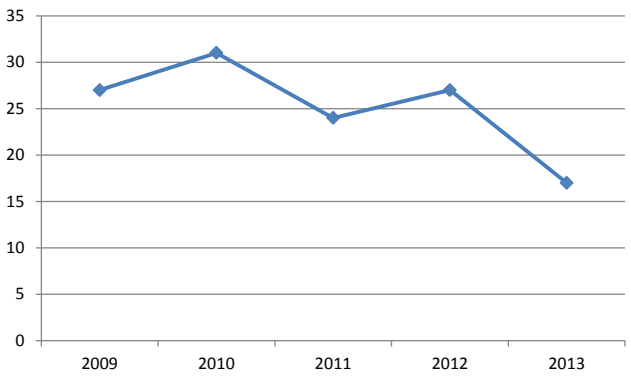
Key findings – areas for improvement

- In 21 percent of the cases, a Time Out was not conducted. Minnesota standard of care for invasive procedures is for an effective Time Out to be conducted prior to starting an invasive procedure for every patient, every procedure, every time
- In 12 percent of the cases (requiring a site mark), the procedural/surgical site was not marked with the proceduralist's initials
- In 24 percent of cases where a site mark was present, the staff did not visualize the site mark and verbally confirm its location during the Time Out process

Wrong site surgeries/invasive procedures

In the 10 years that Minnesota has been collecting data on adverse health events, wrong site surgeries/invasive procedures have been among the most commonly reported events. In 2013, the number of wrong site surgeries/invasive procedures decreased by more than 35 percent, the lowest point since 2005 (Figure 11). This is the most significant decrease in wrong site surgeries/invasive procedures in the 10 years of reporting.

FIGURE 11:
Wrong site surgical/invasive procedure events, 2009–2013



A further look at the data shows that a decrease achieved in 2012 in wrong site surgeries/invasive procedures in radiology was maintained in the current year. Only two cases of wrong site surgery occurred in radiology this year, compared to five in 2012. Much of this decrease can be attributed to the continued work on the 'SAFE SITE 2.0' radiology roadmap, which was developed by MHA as a set of best practices for facilities to implement to prevent adverse surgical events in radiology.

Of the reported wrong site surgeries/invasive procedures this year, 50 percent were left vs. right procedures. This is an area that continues to challenge facilities and is often related to not having a consistent process for visualizing the site mark and verbalizing where it is located during the Time Out process. MDH will continue to work with facilities to engrain site marking procedures in their surgical/procedural areas. This may take the form of additional collaboration and problem solving with procedural/surgical teams, providing resources and/or continued consultation with University of Minnesota human factors experts.

Throughout 2013, work continued on correct spine level localization practices. This year, six of the wrong site events were spine procedures. In 2011, MDH/MHA issued a safety alert related to spine level localization and there has been a decrease in these types of procedures since then, but work still needs to be done to eliminate these types of events by hardwiring localization best practices.

Key findings

In this reporting year, the root causes of wrong site surgeries/procedures were often related to inconsistencies with the Time Out process. Efforts continue in the implementation of a structured and human-factors based Minnesota Time Out process for all invasive procedures in Minnesota.

Root causes for these events included:

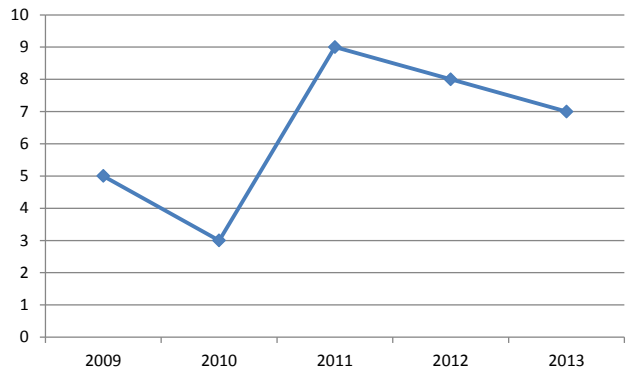
- A structured Time Out not in place for procedures conducted outside the operating room;
- Lack of multiple Time Outs when multiple procedures are being completed involving different staff members; and
- Failure of designated staff to visualize site mark during Time Out process.

Wrong surgeries/invasive procedures

The number of wrong surgeries/invasive procedures sustained a significant decrease this year, declining by 39 percent. Seven of the events involved incorrect implants being placed during procedures. However, four of the seven were incorrect lens implants during cataract procedures. This is a 50 percent decrease from 2012 in incorrect lens implants.

In 2012, MDH/MHA issued a safety alert related to implant handling and verification. When looking at the past five years of data (Figure 12), wrong surgeries/invasive procedures involving implants had been increasing until 2011. Since then, there have been two consecutive years of decline. In 2013, the safety alert, and the extensive work of hospitals and surgical centers in implementing the recommended practices is beginning to show promising results. Work will continue to hardwire implant handling best practices.

FIGURE 12:
Implant-related wrong procedures, 2009–2013



Key findings

As with wrong site procedures, the root causes of wrong procedure events are often related to breakdowns in the verification processes that occur prior to the procedure, this is especially the case with implants.

Root causes for these events included:

- Lack of standardized scheduling/ordering process;
- No standard process for implant verification;
- The process of verification did not include review of consent form.

Next steps

In the coming year, Minnesota hospitals and surgical centers will continue to focus on preventing wrong surgical/invasive procedure adverse events. MHA's 'SAFE SITE 2.0' campaign continues in 2014, with 116 facilities participating.

In 2013, MDH provided a grant to the University of Minnesota to conduct a follow-up evaluation of the Time Out process recommendations from 2010, to determine the extent to which the recommendations are being successfully implemented. This evaluation involved direct observations of surgeries/procedures around the state, completed by a human factors expert. The results showed progress in many areas of Time Outs and surgical site marking, but also continuing challenges. MDH is working with the University of Minnesota and its partners to disseminate and learn from those findings in 2014.

SPOTLIGHT STORY

Building a culture of safety in the operating room

At the foundation of successful patient safety and quality improvement effort is a culture of patient safety within the hospital or surgical center. A strong safety culture can help minimize medical errors and strong support from leadership is crucial to truly moving the needle on patient safety and quality.

Minnesota hospitals and ambulatory surgery centers performed 2.6 million invasive procedures during the 2012-13 reporting year, including procedures in the operating room, radiology, diagnostic/labs and other settings. Dr. Mark Migliori, chair of the perioperative safety committee at Abbott Northwestern Hospital in Minneapolis, part of Allina Health, believes a culture of safety is a prerequisite for delivering good care for every patient, every procedure, every time.

"Patients deserve for safety to be front and center," said Dr. Migliori. "It is the essential first step. They are entrusting us with their care and implicit in that trust is that we will be their guardian when they are under our care."

He believes surgeon leadership is critical in building a culture of safety in the operating room. While Minnesota hospitals and surgical centers have done a great job of developing multidisciplinary teams where everyone has a voice, some traditional hierarchies still persist.

"On one hand, the surgeon should have the same role as other team members in building a culture of safety," said Dr. Migliori. "In reality though, the surgeon has the capability to level the hierarchy within the operating room. By acting as a servant leader yourself—sharing power, putting the needs of others first and helping people develop and perform as highly as possible—it sends the message to the rest of the team that their professionalism demands the emphasis on safety."

By fostering a culture that enables staff to feel comfortable to speak up, Dr. Migliori feels listening goes a long way in giving people a voice.

"One of the most obvious steps we can take is to listen—to let staff talk," he says. "We create so many barriers to let someone give their opinion. We need to break down those barriers and then give them a place to carry their idea forward."

As a leader, Dr. Migliori hears the suggestion or concern and then gives the staff member ownership to carry the idea forward. He also feels it is important to recognize people when they speak up, as it creates a positive outcome. That's why he feels it is important to talk about near misses and recognize the person who caught it. "It sends the message that people are watching and this is important."

Dr. Migliori gives the example of the early days of implementing one of components of the Universal Protocol—the team briefing process. As chief of staff, he embraced the concept, yet was initially resistant to the idea that everyone needed to introduce themselves, feeling that people on the team already knew one another. Others felt strongly about its importance and so the team kept that critical piece of the protocol in place. He soon realized its significance.

"It helps people talk. When the tech introduces herself, it gives her a reason to talk. So next time there's a reason to speak up for safety, she's less intimidated to do so," he explained. "When you don't know someone well, you're less likely to speak up and question them."

A strong leader, says Dr. Migliori, is one who has balance. Balance between confidence and humility; competence and being unsure enough to look at a situation from a different angle; and someone who is passionate and yet can observe and allow others to impact. A strong leader is always looking to give a voice to those who don't have one, and advocating for those who are the most vulnerable, whether it is staff, a patient or someone else.

Building a culture of safety takes continuous improvement. Hospitals and staff must be willing to constantly reevaluate what they're doing and say, what can we do to make it better? Dr. Migliori feels it's good to have the awareness that mistakes can happen at any time. It's realizing that while you're good, it's not good enough.

"Any organization that does safety work has glimpses of a safety culture," he says. "It's maintaining it that is hard. And that takes energy and humility."

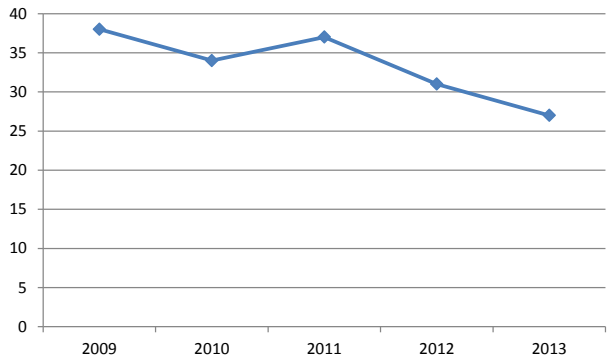
Collaboration and communication are key to driving forward a culture of safety. Dr. Migliori encourages surgeon leaders to discard old approaches where members of the team are separate and instead create opportunities for groups to come together and have a dialogue around safety.

"We must create the constant message that we're in this together. It all falls to communication and doing everything you can to enable voices to be heard," he says. "I'm so appreciative of the effort to make safety culture bigger than hospital versus hospital, but rather something that if we want to provide care in Minnesota, this is the standard."

RETAINED FOREIGN OBJECTS

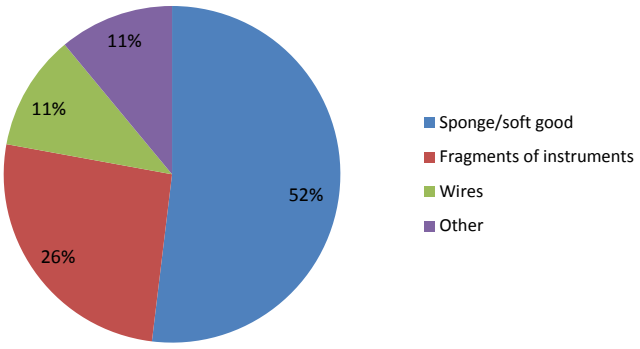
In 2013, 27 cases of retained foreign objects were reported, a decline of 13 percent from 2012 and a 27 percent decline from two years ago (Figure 13). Device fragments and sponges/soft goods accounted for the largest portion of retained objects.

FIGURE 13:
Retained foreign objects, 2009 – 2013



Sponges and other soft goods remained the most common retained foreign object (52 percent). Fragments of instruments accounted for 26 percent of the total number of retained items with another 22 percent being either wires (or pieces of wires) or other items (Figure 14).

FIGURE 14:
Type of retained foreign object, 2013



Packed or tucked items (items placed by the staff and intended to be removed prior to patient discharge) accounted for 37 percent of the total number of retained items this year, which is up from 17 percent in 2012 and highlights the need for work in this area. Of those retained packed items, 60 percent were vaginal packing in either labor and delivery or gynecological surgery.

Further analysis of the data shows eight events occurring during obstetrics or gynecological surgical procedures, with the majority being sponges retained following Cesarean sections and hysterectomies. Similar to the previous year, the most common root cause findings for these events were lack of communication of packed items.

Key findings

Root causes for these types of events included:

- Lack of a process for measuring or inspecting devices/ instruments prior to and after use;
- In some cases, the retained device piece was so small that it was not detected during inspections of the surgical field;
- Breakdowns in communication of packed or tucked items;
- Inconsistent tracking process for packed items.

Next steps

In 2012, a safety alert was issued related to accounting for items in gynecological procedures performed in the operating room; however the number of these events has not declined, and in late 2013 MHA rolled out the 'SAFE ACCOUNT 2.0' roadmap with its sole focus being on accounting for packed or tucked items. Currently, 111 facilities are participating in this campaign and efforts will continue to consistently implement key best practices across the state.

With regard to retained pieces or fragments of items, the challenge is greater. These items are often extremely small and often it is not immediately known to staff that the item has broken or split apart. To date there is lack of consensus/ research on best practices that have been identified to consistently address this issue. In 2014, MDH will work with MHA to continue to test and refine practices to address the retention of these small retained items.

SPOTLIGHT STORY

Communication, education help Fairview Southdale Hospital apply Time Out principles to regional nerve blocks

At Fairview Southdale Hospital in Edina, the Universal Protocol instituted by the Joint Commission to address surgical safety practices was implemented in 2000. The policy and procedure has gone through various revisions over the past 10 years. In 2011, Fairview Southdale began participating in the statewide effort to expand safety practices, such as site marking and the Time Out process (a pause by the procedure team prior to the start of a procedure to ensure the correct patient is receiving the correct procedure at the correct site) outside of the operating room, which included applying the best practices for patients receiving regional nerve blocks.

Since the implementation of these safety practices for regional nerve block patients, Fairview Southdale identified gaps in applying the Time Out principles. In fact, one wrong site block was performed in December 2012. This sentinel event created an opportunity to delve deeper into the actual implementation of key safety practices within anesthesia and the hospital found that clinical practice changes were needed.

In early 2013, a plan was implemented to educate the anesthesiologists utilizing an SBAR approach. SBAR communication is a communication process between team members to convey situation, background, assessment, and recommendation/ requirement information in a concise and structured format. The anesthesiologists were expected to review the educational SBAR and acknowledge with their signature, their compliance for implementing the Time Out prior to initiation of a regional nerve block. Scheduled auditing of the Time Out process was completed by the perianesthesia nurse educator to validate compliance. Audits demonstrated compliance by the anesthesiologists in completing the Time Out process.

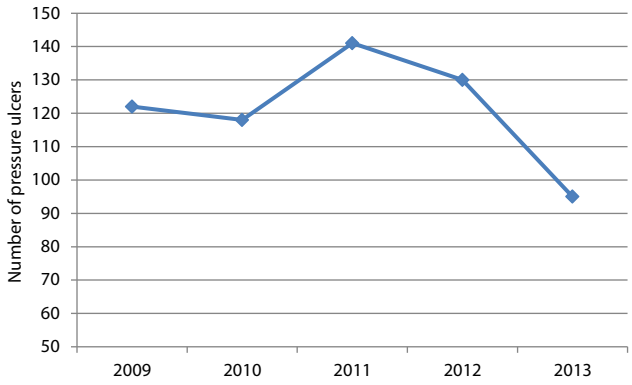
In addition, the perianesthesia nursing staff received education. This education was provided by a staff anesthesiologist who taught the scientific principles and related nursing interventions for patients receiving regional nerve blocks. An enhancement of the electronic medical record was utilized to provide documentation fields for the regional nerve block Time Out. Education was provided through short sessions to staff nurses regarding Association of PeriAnesthesia Nursing (ASPAN) Standards of Care related to conscious sedation and block monitoring.

The support of department leadership was essential in this practice implementation, along with professional journal articles citing best practices. These efforts have helped Fairview Southdale achieve 360 days without a reportable wrong site regional nerve block.

PRESSURE ULCERS

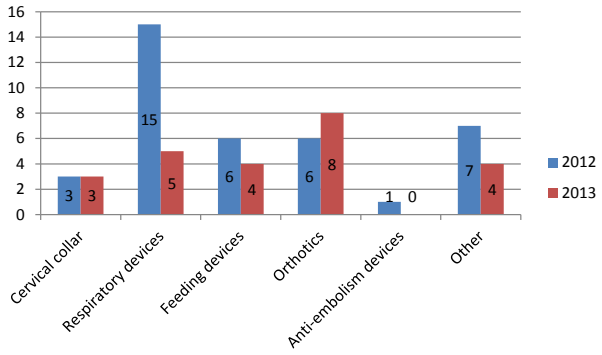
Pressure ulcers happen when a patient's skin breaks down due to unrelieved pressure or friction. While they are commonly known as 'bed sores,' pressure ulcers can occur while a patient is in various positions, such as sitting, laying or in surgery. The number of reported pressure ulcers decreased for the second consecutive year, falling from 130 to 95, a 27 percent decrease (Figure 15) this year with a 33 percent decrease over the past two years.

FIGURE 15:
All reported pressure ulcers, 2009–2013



The highest risk patients are those who have limited mobility, incontinence or circulation problems. Although elderly patients are at a higher risk for pressure ulcers, with patients 75 and older accounting for 19 percent of the reported pressure ulcers, patients ages 65-74 constitute the highest risk category with 24 percent of the events occurring in this population. This is consistent with previous years. Similar to last year, the majority of reported pressure ulcers were found on the coccyx or sacrum (48 percent), on the head, neck or face (23 percent), or on the heel/ankle/foot (eight percent).

FIGURE 16:
Devices associated with pressure ulcers



Upon further analysis of the data, there are some findings of note:

- Of reported pressure ulcers, 26 percent were device-related. There were 14 fewer pressure ulcers reported this year related to devices resulting in a 37% decrease since last year.
- After focused efforts to engage respiratory therapists in pressure ulcer prevention around respiratory devices, the number of pressure ulcers around respiratory devices decreased from 15 the previous year to 5 this year. Examples of successful efforts include switching to softer, more flexible oxygen tubing and trialing different masks and different methods to secure tracheostomy tubes.
- Following focused work over the past few years related to anti-embolism stockings (AES), many hospitals have either reduced or eliminated their use of AES' resulting in zero pressure ulcer cases reported this year related to this device.

Key findings

During 2012 and 2013, MHA focused on caring for patients' skin in the intensive care unit (ICU) through the 'SAFE SKIN ICU Campaign.' This year the number of staff reporting having repositioned their patient every two hours if they had impaired mobility or sensory perception (as is the case with many ICU patients) increased from 40 percent to 60 percent. This repositioning is crucial because one of the most critical times for pressure ulcer development is when patients are in the ICU and are much more immobile. This has been a challenging area for many hospitals, as these patients are the most critically ill and many times cannot be repositioned as easily due to their tenuous condition. Also, in 52 percent of cases involving patients with devices such as stockings or splints, staff documented removal each shift (up from 42 percent the previous year).

FIGURE 17:
Characteristics of patients with reportable pressure ulcers

Respiratory Failure	65%
Clinically Malnourished	57%
Incontinence	48%
Diabetic	39%
Kidney Failure	37%
Sepsis	34%
Obesity	18%
Multiple Conditions	98%

Many patients who developed pressure ulcers also had multiple comorbidities or conditions that may increase their risk for skin breakdown, including: incontinence, respiratory failure, kidney failure, diabetes and malnourishment (Figure 17). This year, 98 percent of patients who developed a pressure ulcer had at least one comorbidity that increased their risk for developing a pressure ulcer, and the average number of comorbidities was just over four. Forty four percent of patients had conditions that medically prohibited repositioning and another 20 percent could have been repositioned but refused.

Often, root causes of pressure ulcers involve breakdown in communication; risk factors or skin inspection results that were not documented properly or communicated between staff; or lack of communication related to appropriate interventions. As was noted previously, patient factors such as clinical malnourishment can also contribute to pressure ulcers by making standard interventions more difficult to apply.

Next steps

In 2013, 'SAFE SKIN 2.0' continued with participation by 104 hospitals. This effort continues to focus on skin inspection around and beneath medical devices, prevention of pressure ulcers in the operating room and regular repositioning of all patients – even critically ill patients (unless physician orders are in place not to reposition a patient).

SPOTLIGHT STORY

Hospitals making strong progress in preventing pressure ulcers

Pressure ulcers are one of the most reported adverse health events. The injuries they cause to skin and underlying tissue are painful and can lead to infection or other complication for patients. The adverse health event reporting system has helped identify previously unknown risks for pressure ulcers, and it appears hospitals are making solid progress in preventing pressure ulcers.

In particular, in the 2012-13 reporting a long term acute care hospital and two of Minnesota's large short term acute care hospitals made significant progress in reducing the number of reportable pressure ulcers: Bethesda Hospital, part of HealthEast Care System in St. Paul; as well as Hennepin County Medical Center and the University of Minnesota Medical Center, Fairview, both in Minneapolis.

The hospitals describe the progress made as a journey with the underlying theme of early identification and prevention of pressure ulcers. Each hospital described it as a change in how they approached pressure ulcer prevention, from something viewed as inevitable in critically ill, often immobile patients to a focus on restoring patients to health and protecting their skin at the same time. At the foundation of this culture change is strong communication and a strong commitment to patient safety and teamwork among interdisciplinary teams. The hospitals believe this culture change will allow them to sustain the gains going forward. Helping keep patients' skin safe, no matter how critically ill, is a new standard of care. Each hospital's effort is described below.

Bethesda Hospital, part of HealthEast Care System

Bethesda Hospital cares for highly complex, critically ill patients, many following discharge from an ICU of a typical short term acute care hospital. The average length of stay at Bethesda is 28 days. In 2012, Bethesda Hospital in St. Paul identified an upward trend in both its quarterly pressure ulcer incidence rate and reportable events. The hospital set a goal to reduce its hospital-acquired pressure ulcer incidence rates below 4.88% for 2013 and to not have any pressure ulcers progress to stage III or greater, which is the trigger for becoming a reportable event under the adverse health event law. In addition, the hospital set a goal to perform concurrent pressure ulcer tracking (reporting them as they happen) and for handovers between direct patient care providers and charge nurses to always include an update on pressure ulcers and skin integrity.

Interventions applied:

- Increased risk assessment from two times per week to every day, helping to bring pressure ulcer prevention to the forefront for nurses.
- Increased the frequency of incidence studies from quarterly to monthly.
- Created an action algorithm for staff to follow when the patient would have difficulty complying with the plan.
- Implemented "four eyes" – two nurses complete skin inspection upon admission, which ensured identification of all pressure ulcers on admission and implementation of a treatment plan in a timely fashion.
- Raised awareness that pressure ulcer prevention is everyone's job, for example charge nurses now round to ensure patients are turned as expected.
- Engaged the interdisciplinary team with respiratory therapists, occupational therapists and physical therapists in performing pressure ulcer skin inspections; provided education and visual cues on proper documentation and identification of pressure ulcers.
- Perform skin inspection around devices at every shift.
- Increased accountability and teamwork through huddle discussions. Initiated interdisciplinary huddles twice daily and used it as a mechanism to spread real-time information. Each unit also leads a day for the hospital-wide "house" huddle and reports status of pressures ulcers and which patients are high risk.
- Implemented a Value Based Improvement (VBI) Front Line Management system to generate staff ideas to improve prevention and discuss with the team these clinical quality metrics at huddles.

The foundation of Bethesda's strategy is that every patient, every nursing staff, every shift is held accountable in pressure ulcer prevention. To sustain its gains, the hospital will continue to make pressure ulcer education and prevention visible across the hospital and throughout the HealthEast Care System. It will also continue to use the foundation of VBI and LEAN improvement system by standardizing work, as a solid routine and daily work for nurses and all caregivers that interact with the patient and family.

Hennepin County Medical Center

In 2006, Hennepin County Medical Center in Minneapolis (HCMC) formed a Skin Team to increase awareness of skin and wound care and to empower nurses to take action to care for patients. It is a multidisciplinary team represented by at least one nurse from every inpatient unit as well as dietary, physical therapy, occupational therapy and a physician skin champion.

Skin Team members universally attributed the gains made in 2013 to a gradual shift in culture from viewing pressure ulcers as an inevitable part of treating critically ill patients to something that can be prevented.

"HCMC has always had such a strong focus on quality and healing sick and broken patients," said Kim Kleinschmidt, certified wound and ostomy nurse. "Initially, I don't think we realized we could restore their health and protect their skin."

"In the ICU (intensive care unit) we've always known patients were at high risk," said Kim Schneider, senior staff nurse in the surgical ICU. "We've really changed the philosophy from 'pressure ulcers are par for the course' to 'we can prevent it.'"

Interventions applied:

- Every nurse, every shift performs skin inspection on each of their patients.
- In the surgical ICU, a skin team member performs a head-to-toe inspection of every patient weekly. This allows for an extra set of eyes to assess patients and can serve as an education opportunity for nurses on the units. It also helps identify trends in the development of pressure ulcers, under blood pressure cuffs, for example.
- Provided education on device-related pressure ulcers and how to prevent them.
- Developed an expectation list for nurses and asked them to sign it so they clearly understood the expectations related to pressure ulcer prevention.
- Added pressure ulcers to discussion items during multidisciplinary rounds.
- Involvement of more front line nurses in the root cause analysis process for pressure ulcers.
- Demonstrations from Skin Team members to other staff on how to integrate skin assessment into other assessments performed by nurses.

The emphasis for HCMC has been on awareness of pressure ulcers and communication between team members. The Skin Team members serve as conduits to spread information and knowledge back to their units, and it opens a dialogue about what can be done to prevent pressure ulcers.

"I've seen an increased receptiveness on all units," said Cindy Petrie, wound ostomy and continence nurse and nurse clinician. "There's been an elevation of skin safety in everyone's minds."

The hospital plans to continue to keep skin safety at the forefront. They will continue the dialogue around skin safety and hold each other accountable. They will continue to standardize the work and make skin safety the standard of care across the hospital.

"I don't think this will ever be something where we say, 'OK, we've mastered this and can check it off the list,'" said Schneider. "It's become standard care. It's the care you and I would expect if in the hospital."

University of Minnesota Medical Center, Fairview

Pressure ulcer prevention ramped up for the University of Minnesota Medical Center, Fairview (UMMC) in 2007 with the addition of unstageable pressure ulcers as reportable events. Leadership, working with the risk management team, created a common cause analysis that reviewed all pressure ulcer events in the hospital and made the Pressure Ulcer Prevention Task Force more robust. Out of this work grew a detailed action plan that covered education, physical changes, enhancements to the electronic medical record, involvement of interdisciplinary teams and more. One of the first changes made was to replace all mattresses across the entire facility.

Like the other facilities, UMMC believes that skin safety and pressure ulcer prevention has been a journey and is the responsibility of each staff member. The hospital has worked hard to make skin safety, and early identification of skin issues, a priority. There is also an emphasis on documenting all pressure ulcers present upon admission so staff can immediately begin working to reverse them or at the very least, prevent them from progressing.

Interventions applied:

- Incorporated skin documentation in electronic medical record so it could be embedded in daily work.
- Provided staff with tip sheets and articles on pressure ulcer prevention.
- Organized unit-level skin care champions who meet at least once per quarter for education and spread that learning back to other staff members on their units.
- Reviewed new equipment thoroughly to identify those that create higher risk for pressure ulcers.
- Developed individualized interventions for specific patient risk factors.
- Performed total body skin assessment at every shift – provided scripting for staff to overcome barriers from patients.
- Provided education to patients and families on the importance of turning or making small adjustments to redistribute pressure.

Empowered all staff, including housekeeping, to make changes to improve safety. For example, if housekeeping discovers a mattress in poor condition, they have authority to replace it.
Added discussion of pressure ulcers to hourly rounding and handoffs to keep it at the forefront.
Limited staging of pressure ulcers to be performed by wound ostomy and continence nurses to maintain consistency and provide more reliable and actionable data.

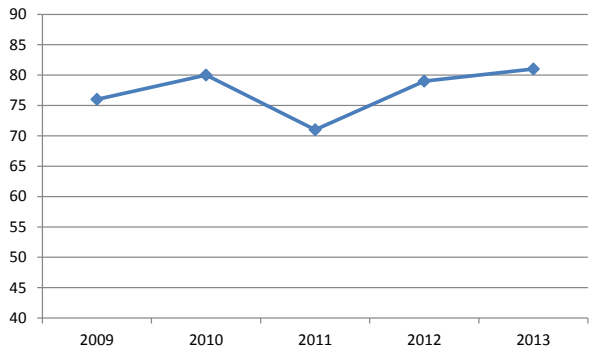
Going forward, UMMC plans to further engage providers in the dialogue around prevention. If they give an order not to turn a patient, staff will engage them to ask about microturning and will continue to raise the issue so the patient can be turned as soon as safely possible. In addition, as a teaching facility, UMMC will be working with the medical school to provide resident training on pressure ulcers.

“ This is extraordinarily important work,” said Mike Flynn, nurse manager, special programs and co-chair of the Pressure Ulcer Prevention Task Force. “No matter the size of the pressure ulcer, we take it very seriously.”

FALLS

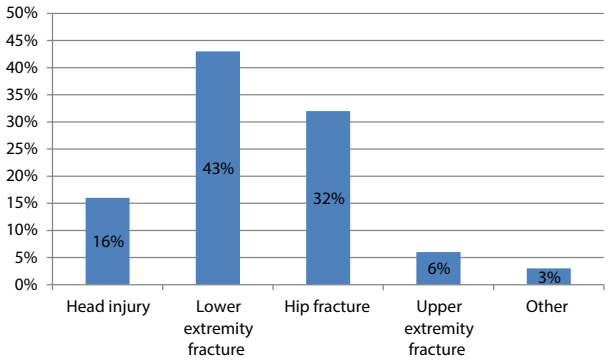
In 2013, hospitals reported 81 falls that resulted in serious disability or death, an increase of three percent from the previous year (Figure 18). Ten patients died from injuries associated with their falls, an increase of one from the previous year.

FIGURE 18:
Reported falls, 2009–2013



Overall, the most common serious injury sustained during a fall was a lower extremity fracture (most commonly leg or ankle fractures) making up 43 percent of the serious disabilities. Hip fractures, head injuries and upper extremity injuries accounted for an additional 54 percent of injuries (Figure 19).

FIGURE 19:
Fall injury types, 2013

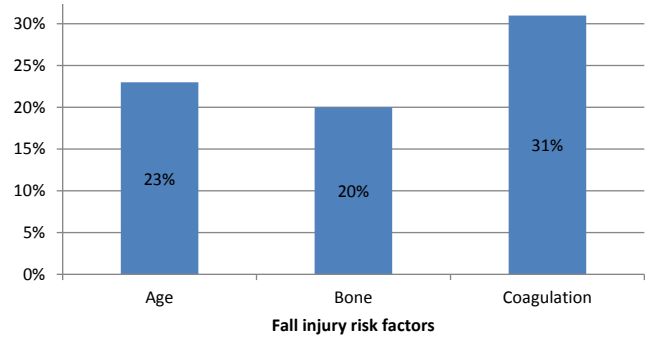


Key findings

Falls continue to be an area of challenge for healthcare facilities. Occasionally, all appropriate interventions are in place and a patient can still fall and sustain a serious injury. Falls reported in 2013 show only slight changes in terms of where and how they occur. In general, these patterns have been stable over the years. Key findings and actions from 2013 include:

- This year was the first year in which the registry system collected data not only on risk factors for falls but also for injury. The injury factors collected are; patient age greater than 85, bone issues such as osteoporosis, if a patient is on anticoagulant therapy (to prevent their blood from clotting), and whether the patient is post-surgical. This data has proven valuable and shows that 69 percent of patients who were seriously injured from a fall had at least one injury risk factor and 90 percent of patients who died from those injuries had at least one injury risk factor (Figure 20). This leads to the conclusion that not only fall risk is important to assess, but injury risk as well.
- Two thirds of all patients who fell and sustained a serious injury were assessed to be at risk for falls, with 69 percent being at risk for injury (as was noted previously), and therefore should have had fall and injury prevention interventions in place. However, only 34 percent of patients were placed on a hi/low bed to keep them closer to the floor and in none of the 81 reported falls was there a floor mat in place to prevent fall related injury. This is a potential gap, as floor mats are one of the interventions that 'SAFE from FALLS 2.0' indicates as a best practice to consider for patients who are assessed as high-risk for falls.
- Last year, falls occurring in treatment settings for behavioral health had nearly doubled; however, strong work on the part of facilities at addressing the issues in behavioral health falls have resulted in only three falls in those locations this year, as compared to 13 in 2012. MHA has convened the Behavioral Health Falls Workgroup tasked with developing an assessment of fall risk and appropriate interventions for this complex population and that work will continue throughout 2014.

FIGURE 20:
Number of patients with fall injury risk factors, 2013



- This year, more than 40 percent of falls were toileting related, most often occurring when a patient got up to use the toilet on their own without assistance. This is a decrease from previous years and may be linked to the work that has been done by facilities on the 'Staying Within Arm's Reach' campaign, which calls for staff to stay within arm's reach of high-risk patients at all times while toileting.
- Also of note, a quarter of all falls with serious disability or death occurred two days or less from the date of anticipated discharge. This may be attributed to the patients feeling better and stronger and overestimating their strength and balance, which can lead to a fall. In the statewide 'SAFE from FALLS 2.0' roadmap, facilities are urged to not only educate patients on fall risk and prevention at admission, but also as they are getting stronger and approaching discharge, as this has proven to be a time of risk for falling.

Next steps

Last year, facilities began focusing on how to prevent the injury from a fall vs. only preventing the fall itself. In analyzing 2013 data, it was found that facilities are not consistently putting all appropriate interventions in place to prevent falls or fall injuries (e.g., hi-low beds; floor mats) and interventions, such as bed alarms, are not effectively alerting staff in time to prevent an injury from occurring. Additional work is needed, and efforts are underway, to identify key interventions that will truly prevent falls and injuries from falls for the older adult population. In the upcoming year MDH will work with its partners to focus on ways that facilities can standardize those interventions for all patients who are deemed at risk.

In the upcoming year, MHA's 'SAFE from FALLS 2.0' continues with 113 facilities participating. The continued focus will be injury risk screening, assessment, and linking appropriate interventions, particularly related to patients who are on anticoagulant medications (to prevent their blood from clotting). MHA has formed a workgroup to look specifically at this subgroup of medications and identify innovative ways that facilities can better protect patients who are anti-coagulated from fall related injury.

SPOTLIGHT STORY

Identifying anticoagulation therapy as a key patient risk factor helps hospitals tailor fall prevention efforts

The Adverse Health Event reporting system has helped identify a specific population that is at a very high risk for injury if they sustain a fall. Due to increasing medical complexities in an aging population, falls resulting in serious injury or death continue to challenge hospitals and evidence shows falls are increasing across the community. In the past year it has been identified that 90 percent of fall deaths in Minnesota hospitals occur in patients who are either over age 85 or are on medications known as anticoagulants.

One of the major indications for use of anticoagulant medications is to prevent stoke in patients with a heart rhythm abnormality called atrial fibrillation. This is an irregular and often rapid heart rate that promotes blood pooling in the heart, increasing the risk for blood clots that can lead to stroke. According to Dr. Bruce Burnett, director of thrombosis and anticoagulation services at Park Nicollet Methodist Hospital in St. Louis Park, the risk of stroke with atrial fibrillation increases with age and is quite substantial in the elderly population. As a result, patients are often placed on anticoagulant medications, which decrease blood clotting and help prevent strokes.

In an effort to prevent patients from suffering a stroke, health care professionals are balancing the risk for bleeding injury should the patient fall. The evidence shows that elderly patients are more likely to suffer a stroke than fall. Yet the risk of becoming injured from a fall while on anticoagulants is significant. Studies show that if the patient is on an anticoagulant medication, the risk for bleeding or serious injury is greater.

“Elderly patients who are on anticoagulant therapy have a 50 percent greater chance of suffering an intracranial hemorrhage (brain bleeding) than those patients not on anticoagulants,” explained Dr. Burnett. “And, of those patients who fall and suffer an intracranial hemorrhage, the risk of mortality is increased by 45 percent if they are on anticoagulants.”

The introduction of new anticoagulant medications has made the situation even more complex for hospitals trying to keep patients safe. Three new drugs have been approved by the Federal Drug Administration for use in patients with atrial fibrillation and one has been approved for treatment and prevention of venous thromboembolism (deep vein thrombosis and pulmonary embolism).

“Traditional anticoagulants such as Warfarin require consistent monitoring and dosing adjustments due to the fact that many factors can affect the patient’s response to the medication,” said Dr. Burnett. He says that one of the things that makes the new anticoagulants attractive for providers is there is no need for dosage adjustments or monitoring of anticoagulation affect due to how the medications work. These agents may actually be a better option for patients who have difficulty in managing Warfarin therapy safely.

A major concern when putting elderly patients on these newer anticoagulants is that there’s an underrepresentation of patients over age 75 in clinical trials of these medications. Therefore, providers don’t have as clear of an idea of the risk-benefit of these agents in the elderly. Additionally, these newer medications are sensitive to kidney dysfunction and are not immediately reversible should bleeding complications occur.

Keeping patients safe

Hospitals across Minnesota are working hard to not only prevent falls but to also reduce the potential for injury if a patient at risk for serious injury does fall by identifying those who are risk for bleeding.

Additionally, providers are looking at other risk factors for anticoagulation therapy and trying to reduce the risk of injury if a patient does fall.

“We are trying to get better management of dosing for patients on Warfarin therapy and are minimizing the use of other antithrombotic agents such as aspirin and Plavix for elderly patients who are also on anticoagulation therapy as this doubles or triples their risk of intracranial hemorrhage,” explained Dr. Burnett.

Hospitals across the state have begun to incorporate “risk for injury” into assessments for fall risk, which allows staff to tailor interventions after identifying individual risk factors (known as the ABCs) such as:

- **Age** (patients over 85 are at greater risk for injury from falls);
- Risk for **bone** fracture (a patient has osteoporosis, for example);
- **Anticoagulant** use (commonly used to prevent stroke and blood clots, this medication can cause the patient to hemorrhage); and
- Whether the patient is post-**surgical**.

The Minnesota Hospital Association has formed a work group, comprised of physicians, pharmacists and nurses, to review fall events involving patients who were taking anticoagulants at the time of the fall. The work group aims to identify best practices for managing elderly patients on anticoagulants while they are in the hospital as well as practices that can be implemented to keep them safe from falls and from sustaining a serious injury as a result of a fall.

“Our goal is to disseminate preliminary best practices in early 2014,” said Julie Apold, MHA senior director of patient safety and a member of the work group. “However, our work will evolve as we continue to learn about how to keep this very vulnerable population safe from falls and injuries from falls.”

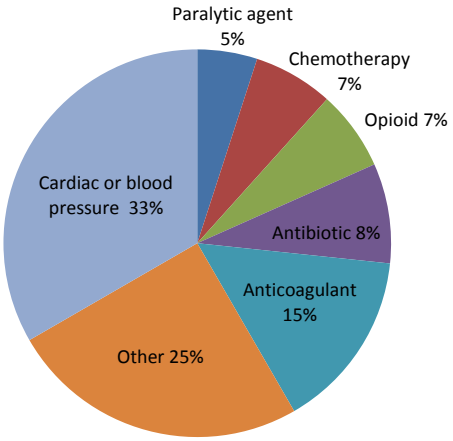
MEDICATION ERRORS

In 2013, there were nine reported medication errors that led to serious disability or death. Medication errors that rise to the level of serious disability or death are rare, averaging around five per year over the history of the reporting law. These events also tend to be very complex in nature and it can be hard to draw conclusions or identify trends from the small number of events that are collected in the registry.

Medication errors can and do occur in all locations, such as medical/surgical units, emergency departments and ICUs. Medication errors can occur at any point in the medication administration process—during ordering, transcription, dispensing or administering medications. However, a review of national literature leads to the conclusion that the majority of errors occur during the ordering and administration stages.

With respect to types of medications that are involved in these events, in 33 percent of events the medication that was involved was a cardiac and/or blood pressure medication, with another 15 percent being anticoagulant medications (Figure 21). This may highlight an area for improvement and continued work.

FIGURE 21:
Medication errors by type of medication, 2003–2013



When looking at the root causes of these types of events, no clear pattern emerges; however, they tend to involve communication breakdowns or training/education deficits (e.g., lack of training, incorrect training/education). As trends and patterns in the data emerge, MDH will work with facilities to identify needs from a training and resource perspective and spread learnings statewide.

One of the recommendations to reduce medication errors and harm is for all practitioners to use the "five rights of medication administration:" the right patient, the right drug, the right dose, the right route, and the right time. This has been the standard of care nationwide for many years. However, the five rights focus on individual performance and not on human factors and system defects that may be in place. If facilities find that practitioners are unable to complete the five rights due to system issues (e.g., time constraints; lack of equipment), the organization needs to further identify these barriers and put processes in place to address these issues.

Key findings

Root causes of medication errors typically do not follow a pattern and trends are hard to identify. Examples of root causes of medication errors are:

- Appropriate order for medication was present, however, staff person chose the wrong medication off the cart during emergency situation
- Patient was given a contraindicated medication due to failure to review medical chart before administering medication
- On-call physician was not given up-to-date laboratory values on a patient before writing dosing orders for medication
- Staff knowledge deficit on certain medication policy

Next steps

In the upcoming year, MDH and its partners will continue to work with facilities on key issues related to medication errors. MHA, through its 'Partnership for Patients' work, has convened an Adverse Drug Events Advisory group which developed a comprehensive collection of best practices called "A Roadmap to Medication Safety" with associated toolkit. The advisory group is currently analyzing adverse drug event data and adoption of medication management best practices on a statewide level. Data analysis and best practice adoption findings will help determine 2014 educational and resource offerings for hospitals.

Also, Stratis Health, through its Medicare Quality Improvement Organization program, in support of the National Quality Strategy, is also working with hospitals and communities to reduce and prevent adverse drug events. The focus of this program is to assist in developing systems for medication therapy management including anticoagulation therapy, hypoglycemic agents and antipsychotic agents.

CONCLUSION

Improving patient safety is a long-term process. While the reporting system has been a change agent for significant improvements in patient safety, transparency and data sharing/learning throughout the state, it also continues to bring to light areas for continued work and improvement. This continued work leads to new standards of care and therefore safer care for patients in Minnesota.

It is crucial to remember that this reporting system is just one part of a broader patient safety and quality movement in Minnesota. Patient safety has been a focus for more than 10 years through the reporting system and prior to that in different capacities as well. Consumers and patients should use this report, along with other sources of information to increase their awareness of patient safety issues and challenges, and to encourage their providers to provide the highest level of patient safety. This report is only released once per year; however, facilities in Minnesota are working continuously to provide the highest quality, safest care possible each and every day.

Throughout this report, there are successes that are highlighted and should be celebrated, but the continued focus is on reducing and eliminating harm to patients in Minnesota. In particular, consistent focus is needed around reducing falls and eliminating fall injury, strengthening the Time Out process to eliminate all wrong surgical/invasive procedure events and preventing medication errors in Minnesota hospitals and surgical centers. As has been the case in all years of the reporting system, the issues are deeper than human error and are often system issues that take dedicated time, resources and consistent leadership to correct.

As we move forward with the adverse health events system, MDH and its partners will continue to learn from the successes and challenges of the first 10 years while continually monitoring trends and working to support facilities as they implement new ways to improve safety for their patients. The community standard in Minnesota needs to be one of ownership, one in which patient safety is top of mind for all staff, and leadership provides consistent encouragement for staff to speak up for patient safety, for every patient, every time.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2012 and October 6, 2013. 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

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

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.

** 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.

TABLE 1: OVERALL STATEWIDE REPORT

Reported Adverse Health Events: **ALL EVENTS** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
Surgical/Invasive Procedure	61 Events	Neither: 61
Products or Devices	0 Events	—
Patient Protection	3 Events	Serious Disability: 1 Death: 2
Care Management	105 Events	Serious Disability: 7 Death: 3 Neither: 95
Environmental	84 Events	Serious Disability: 74 Death: 10
Criminal	5 Events	Serious Disability: 2 Neither: 3
Total for All Events	**258 Events**	**Serious Disability: 84** **Death: 15** **Neither: 159**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
1. Wrong body part	17 Events	Neither: 17
2. Wrong patient	1 Event	Neither: 1
3. Wrong procedure	16 Events	Neither: 16
4. Foreign object	27 Events	Neither: 27
5. Intra / post-op death	0 Events	—
Total for Surgical/Invasive Procedure	**61 Events**	**Serious Disability: 0** **Death: 0** **Neither: 61**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
6. Contaminated drugs, devices or biologics	0 Events	—
7. Misuse or malfunction of device	0 Events	—
8. Intravascular air embolism	0 Events	—
Total for Products or Devices	**0 Events**	**—**

Details by Category: **PATIENT PROTECTION** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
9. Wrong discharge of infant	0 Events	—
10. Patient disappearance	1 Event	Death: 1
11. Suicide or attempted suicide	2 Events	Serious Disability: 1 Death: 1
Total for Patient Protection	**3 Events**	**Serious Disability: 1** **Death: 2** **Neither: 0**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
12. Death or disability due to medication error	9 Events	Serious Disability: 7 Death: 2
13. Death or disability due to hemolytic reaction	0 Events	—
14. Death or disability during low-risk pregnancy labor or delivery	1 Event	Death: 1
15. Death or disability associated with hypoglycemia	0 Events	—
16. Death or disability associated with failure to treat hyper-bilirubinemia	0 Events	—
17. Stage 3, 4 or unstageable pressure ulcers acquired after admission	95 Events	Neither: 95
18. Death or disability due to spinal manipulation	0 Events	—
19. Artificial insemination with wrong donor egg or sperm	0 Events	—
Total for Care Management	**105 Events**	**Serious Disability: 7** **Death: 3** **Neither: 95**

Details by Category: **ENVIRONMENTAL** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
20. Death or disability associated with an electric shock	0 Events	—
21. Wrong gas or contamination in patient gas line	0 Events	—
22. Death or disability associated with a burn	2 Events	Serious Disability: 2
23. Death or serious disability associated with a fall	81 Events	Serious Disability: 71 Death: 10
24. Death or disability associated with restraints	1 Event	Serious Disability: 1
Total for Environmental	**84 Events**	**Serious Disability: 74** **Death: 10** **Neither: 0**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2012 – October 6, 2013)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
25. Care ordered by someone impersonating a physician, nurse or other provider	0 Events	—
26. Abduction of patient	0 Events	—
27. Sexual assault of a patient	3 Events	Neither: 3
28. Death or injury of patient or staff from physical assault	2 Events	Serious Disability: 2
Total for Criminal Events	**5 Events**	**Serious Disability: 2** **Death: 0** **Neither: 3**

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

Abbott Northwestern Hospital

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
952

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
132,622

NUMBER OF PATIENT DAYS:
242,513

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, 2012 – OCTOBER 6, 2013)

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
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive procedure performed	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**8**	Deaths: 0; Serious Disability: 0; Neither: 8
Labor or delivery in a low-risk pregnancy	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
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	**16**	**Deaths: 1; Serious Disability: 2; Neither: 13**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

Associated Eye Care, L.L.C.

ADDRESS:
280 Smith Ave.
St. Paul, MN 55102

WEBSITE:
www.associatedeyecare.com

PHONE NUMBER:
651-275-3113

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

Avera Marshall Regional Medical Center

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

WEBSITE:
www.avera.org

PHONE NUMBER:
507-537-9087

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,883

NUMBER OF PATIENT DAYS:
17,858

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
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
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

Bethesda Hospital

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

WEBSITE:
www.healtheast.org/patient-safety/reporting-adverse-health-events.html

PHONE NUMBER:
651-232-7238

NUMBER OF BEDS:
254

NUMBER OF PATIENT DAYS:
35,012

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 0; Neither: 3**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

CentraCare Health – Melrose

ADDRESS:
525 Main Street West
Melrose, MN 56352

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-256-1761

NUMBER OF BEDS:
28

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,257

NUMBER OF PATIENT DAYS:
6,996

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

Children's Hospitals and Clinics of Minnesota

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

WEBSITE:
www.childrensmn.org

PHONE NUMBER:
612-813-6615

NUMBER OF BEDS:
381

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
25,207

NUMBER OF PATIENT DAYS:
133,592

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, 2012 – OCTOBER 6, 2013)

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
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 0; Serious Disability: 0; Neither: 6**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

Community Memorial Hospital

ADDRESS:
512 Skyline Boulevard
Cloquet, MN 55720

WEBSITE:
www.cloquethospital.com

PHONE NUMBER:
218-878-7605

NUMBER OF BEDS:
36

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
9,343

NUMBER OF PATIENT DAYS:
13,479

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
A medication error	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

Douglas County Hospital

ADDRESS:
111 E. 17th Ave.
Alexandria, MN 56308-3703

WEBSITE:
www.dchospital.com

PHONE NUMBER:
320-762-6025

NUMBER OF BEDS:
127

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
25,523

NUMBER OF PATIENT DAYS:
34,047

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, 2012 – OCTOBER 6, 2013)

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
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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

Essentia Health – Deer River

ADDRESS:
115 10th Ave NE
Deer River, MN 56636

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2802

NUMBER OF BEDS:
20

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,461

NUMBER OF PATIENT DAYS:
5,509

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

Essentia Health – St. Mary's Medical Center

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2802

NUMBER OF BEDS:
380

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
66,455

NUMBER OF PATIENT DAYS:
109,374

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, 2012 – OCTOBER 6, 2013)

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
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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

Fairview Lakes Health Services

ADDRESS:
5200 Fairview Blvd.
Wyoming, MN 55092-8013

WEBSITE:
www.fairview.org/hospitals/lakes

PHONE NUMBER:
651-982-7450

NUMBER OF BEDS:
61

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
28,139

NUMBER OF PATIENT DAYS:
29,567

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, 2012 – OCTOBER 6, 2013)

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, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

Fairview Northland Medical Center

ADDRESS:
911 Northland Drive
Princeton, MN 55371-2172

WEBSITE:
www.fairview.org

PHONE NUMBER:
763-389-6451

NUMBER OF BEDS:
54

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
19,130

NUMBER OF PATIENT DAYS:
18,893

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

Fairview Ridges Hospital

ADDRESS:
201 E. Nicollet Blvd.
Burnsville, MN 55337-5799

WEBSITE:
www.fairview.org

PHONE NUMBER:
612-672-4165

NUMBER OF BEDS:
150

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
60,120

NUMBER OF PATIENT DAYS:
67,201

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, 2012 – OCTOBER 6, 2013)

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
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	**6**	**Deaths: 0; Serious Disability: 4; Neither: 2**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

Fairview Southdale Hospital

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

WEBSITE:
www.fairview.org/hospitals/southdale

PHONE NUMBER:
612-672-7061

NUMBER OF BEDS:
390

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
98,556

NUMBER OF PATIENT DAYS:
115,235

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, 2012 – OCTOBER 6, 2013)

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:		
Stage 3, 4 or unstageable 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	**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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

FirstLight Health System

ADDRESS:
301 S. Highway 65
Mora, MN 55051-1899

WEBSITE:
www.firstlighthealthsystem.org

PHONE NUMBER:
320-225-3328

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,184

NUMBER OF PATIENT DAYS:
16,515

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

Gillette Children's Specialty Healthcare

ADDRESS:
200 East University Avenue
St. Paul, MN 55101

WEBSITE:
www.gillettechildrens.org

PHONE NUMBER:
651-229-1753

NUMBER OF BEDS:
60

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
9,319

NUMBER OF PATIENT DAYS:
22,927

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Wrong surgical/invasive procedure performed	**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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

Glacial Ridge Health System

ADDRESS:
10 4th Ave. SE
Glenwood, MN 56334

WEBSITE:
www.glacialridge.org

PHONE NUMBER:
320-634-2208

NUMBER OF BEDS:
34

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,144

NUMBER OF PATIENT DAYS:
7,446

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

Glencoe Regional Health Services

ADDRESS:
1805 Hennepin Ave. N.
Glencoe, MN 55336-1416

WEBSITE:
www.grhsonline.org

PHONE NUMBER:
320-864-3121

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,887

NUMBER OF PATIENT DAYS:
9,502

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, 2012 – OCTOBER 6, 2013)

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
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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

Grand Itasca Clinic and Hospital

ADDRESS:
1601 Golf Course Road
Grand Rapids, MN 55744

WEBSITE:
www.granditasca.org

PHONE NUMBER:
218-999-1444

NUMBER OF BEDS:
64

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,860

NUMBER OF PATIENT DAYS:
31,041

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, 2012 – OCTOBER 6, 2013)

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
PATIENT PROTECTION EVENTS		
Patient death or serious disability associated with patient disappearance	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

HealthEast Midway Surgery Center

ADDRESS:
1700 University Ave W.
St. Paul, MN 55104

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-232-7122

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,128

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

Hendricks Community Hospital Association

ADDRESS:
503 East Lincoln Street
Hendricks, MN 56136

WEBSITE:
www.hendrickshosp.org

PHONE NUMBER:
507-275-3134

NUMBER OF BEDS:
24

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
791

NUMBER OF PATIENT DAYS:
1,368

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

Hennepin County Medical Center

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

WEBSITE:
www.hcmc.org

PHONE NUMBER:
612-873-3337

NUMBER OF BEDS:
894

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
108,027

NUMBER OF PATIENT DAYS:
208,120

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, 2012 – OCTOBER 6, 2013)

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:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**10**	Deaths: 0; Serious Disability: 0; Neither: 10
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
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	**17**	**Deaths: 0; Serious Disability: 6; Neither: 11**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

Lake Region Healthcare

ADDRESS:
712 South Cascade St.
Fergus Falls, MN 56537

WEBSITE:
www.lrhc.org

PHONE NUMBER:
218-736-8193

NUMBER OF BEDS:
108

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,739

NUMBER OF PATIENT DAYS:
43,640

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

LakeWood Health Center

ADDRESS:
600 Main Ave. South
Baudette, MN 56623

WEBSITE:
www.lakewoodhealthcenter.org

PHONE NUMBER:
218-634-3407

NUMBER OF BEDS:
15

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
120

NUMBER OF PATIENT DAYS:
2,726

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

Lakewood Health System

ADDRESS:
49725 County 83
Staples, MN 56479-5280

WEBSITE:
www.lakewoodhealthsystem.com

PHONE NUMBER:
218-894-8429

NUMBER OF BEDS:
40

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,820

NUMBER OF PATIENT DAYS:
21,612

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

Maple Grove Hospital

ADDRESS:
9875 Hospital Drive
Maple Grove, MN 55369-4648

WEBSITE:
www.maplegrovehospital.org

PHONE NUMBER:
763-581-1563

NUMBER OF BEDS:
90

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
34,026

NUMBER OF PATIENT DAYS:
31,586

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, 2012 – OCTOBER 6, 2013)

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
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	**3**	**Deaths: 0; Serious Disability: 2; Neither: 1**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

Mayo Clinic – Rochester Methodist Hospital

ADDRESS:
201 West Center Street
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:
161,794

NUMBER OF PATIENT DAYS:
150,082

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, 2012 – OCTOBER 6, 2013)

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
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**3**	Deaths: 1; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 1; Serious Disability: 2; Neither: 2**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

Mayo Clinic – 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:
1,265

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
128,803

NUMBER OF PATIENT DAYS:
298,490

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, 2012 – OCTOBER 6, 2013)

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
Surgery/other invasive procedure performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**17**	Deaths: 0; Serious Disability: 0; Neither: 17
A medication error	**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	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**24**	**Deaths: 0; Serious Disability: 3; Neither: 21**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

Mayo Clinic Health System – Albert Lea and Austin (Albert Lea)

ADDRESS:
404 W. Fountain Street
Albert Lea, MN

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-434-1706

NUMBER OF BEDS:
77

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,176

NUMBER OF PATIENT DAYS:
40,086

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, 2012 – OCTOBER 6, 2013)

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
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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

Mayo Clinic Health System – Albert Lea and Austin (Austin)

ADDRESS:
1000 1st Dr NW
Austin, MN 55912

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-434-1706

NUMBER OF BEDS:
82

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,687

NUMBER OF PATIENT DAYS:
41,937

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**2**	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 2; Serious Disability: 0; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

Mayo Clinic Health System in Mankato

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

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-385-2938

NUMBER OF BEDS:
272

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
35,423

NUMBER OF PATIENT DAYS:
66,310

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, 2012 – OCTOBER 6, 2013)

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
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
CRIMINAL EVENTS		
Sexual assault of a patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 2; Neither: 2**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

Meeker Memorial Hospital

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

WEBSITE:
www.meekermemorial.org

PHONE NUMBER:
320-693-3242

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
5,037

NUMBER OF PATIENT DAYS:
13,104

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

Mercy Hospital – Coon Rapids

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
271

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
78,363

NUMBER OF PATIENT DAYS:
123,140

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, 2012 – OCTOBER 6, 2013)

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, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

Minnesota Eye Laser & Surgery Centers, LLC. (Bloomington)

ADDRESS:
9801 Dupont Ave S.
Bloomington, MN 55431

WEBSITE:
www.mneye.com

PHONE NUMBER:
952-888-5800

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,321

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

Minnesota Surgery Centers (Edina, Maple Grove)

ADDRESS:
7400 France Ave., Ste. 102
Edina, MN 55435

WEBSITE:
www.painphysicians.com

PHONE NUMBER:
763-537-6000 x155

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

Minnesota Valley Surgery Center

ADDRESS:
1000 West 140th Street
Burnsville, MN 55337

WEBSITE:
www.minnesotavalleysurgerycenter.com

PHONE NUMBER:
952-232-1133

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

Murray County Medical Center

ADDRESS:
2042 Juniper Avenue
Slayton, MN 56172

WEBSITE:
www.murraycountymed.org

PHONE NUMBER:
507-836-1272

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,857

NUMBER OF PATIENT DAYS:
4,497

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

North Memorial Medical Center

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

WEBSITE:
www.northmemorial.com

PHONE NUMBER:
763-581-4645

NUMBER OF BEDS:
518

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
76,303

NUMBER OF PATIENT DAYS:
146,862

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, 2012 – OCTOBER 6, 2013)

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
Wrong surgical/invasive procedure performed	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**9**	Deaths: 0; Serious Disability: 0; Neither: 9
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 0; Serious Disability: 0; Neither: 12**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

Owatonna Hospital

ADDRESS:
2250 26th St. N.W.
Owatonna, MN 55060-5503

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
77

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,616

NUMBER OF PATIENT DAYS:
20,506

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

Park Nicollet Methodist Hospital

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

WEBSITE:
www.parknicollet.com

PHONE NUMBER:
952-993-6409

NUMBER OF BEDS:
426

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
107,447

NUMBER OF PATIENT DAYS:
147,362

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, 2012 – OCTOBER 6, 2013)

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, 4 or unstageable pressure ulcers (with or without death or serious disability)	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
A medication error	**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	**5**	Deaths: 0; Serious Disability: 5; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 0; Serious Disability: 6; Neither: 6**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

Phillips Eye Institute

ADDRESS:
2215 Park Avenue
Minneapolis, MN 55404

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
20

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,515

NUMBER OF PATIENT DAYS:
6,728

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

Range Regional Health Services

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:
21,668

NUMBER OF PATIENT DAYS:
48,503

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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	**3**	**Deaths: 0; Serious Disability: 2; Neither: 1**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

Redwood Area Hospital

ADDRESS:
100 Fallwood Road
Redwood Falls, MN 56283

WEBSITE:
www.redwoodareahospital.org

PHONE NUMBER:
507-637-4529

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,098

NUMBER OF PATIENT DAYS:
4,854

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

Regency Hospital of Minneapolis

ADDRESS:
1300 Hidden Lakes Parkway
Golden Valley, MN 55422

WEBSITE:
www.minneapolis.regencyhospital.com

PHONE NUMBER:
763-588-2750

NUMBER OF BEDS:
92

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
–

NUMBER OF PATIENT DAYS:
20,107

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

Regina Medical Center

ADDRESS:
1175 Nininger Road
Hastings, MN 55033-1056

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
57

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,740

NUMBER OF PATIENT DAYS:
12,070

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

Regions Hospital

ADDRESS:
640 Jackson St.
Saint Paul, MN 55101-2502

WEBSITE:
www.regionshospital.com

PHONE NUMBER:
651-254-4730

NUMBER OF BEDS:
454

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
129,680

NUMBER OF PATIENT DAYS:
198,742

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, 2012 – OCTOBER 6, 2013)

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
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**8**	Deaths: 0; Serious Disability: 0; Neither: 8
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
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**2**	Deaths: 1; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**16**	**Deaths: 1; Serious Disability: 4; Neither: 11**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

Rice Memorial Hospital

ADDRESS:
301 Becker Avenue Southwest
Willmar, MN 56201

WEBSITE:
www.ricehospital.com

PHONE NUMBER:
320-231-4228

NUMBER OF BEDS:
136

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,521

NUMBER OF PATIENT DAYS:
25,131

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, 2012 – OCTOBER 6, 2013)

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
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 0; Neither: 1**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

Ridgeview Medical Center

ADDRESS:
500 South Maple Street
Waconia, MN 55387

WEBSITE:
www.ridgeviewmedical.org

PHONE NUMBER:
952-442-2191 ext. 6102

NUMBER OF BEDS:
109

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
38,834

NUMBER OF PATIENT DAYS:
51,689

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**2**	Deaths: 1; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

Sanford Bemidji Medical Center

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

WEBSITE:
www.nchs.com

PHONE NUMBER:
218-333-5040

NUMBER OF BEDS:
118

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
30,712

NUMBER OF PATIENT DAYS:
46,577

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.50

Sanford Luverne Medical Center

ADDRESS:
1600 N. Kniss Ave.
Luverne, MN 56156-1067

WEBSITE:
www.sanfordluverne.org

PHONE NUMBER:
605-366-2432

NUMBER OF BEDS:
28

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,565

NUMBER OF PATIENT DAYS:
8,255

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.51

Sanford Worthington

ADDRESS:
1018 Sixth Ave. P.O. Box 997
Worthington, MN 56187-2298

WEBSITE:
www.sanfordworthington.org

PHONE NUMBER:
507-372-3272

NUMBER OF BEDS:
48

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,701

NUMBER OF PATIENT DAYS:
12,462

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.52

St. Cloud Hospital

ADDRESS:
1406 Sixth Ave. N.
St. Cloud, MN 56303-1900

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-251-2770 Ext. 74983

NUMBER OF BEDS:
489

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
93,179

NUMBER OF PATIENT DAYS:
183,531

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, 2012 – OCTOBER 6, 2013)

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
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
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	**10**	**Deaths: 0; Serious Disability: 5; Neither: 5**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.53

St. Francis Regional Medical Center

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
93

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
27,904

NUMBER OF PATIENT DAYS:
35,653

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS — Death or serious disability associated with:		
A fall while being cared for in a facility	**2**	Deaths: 1; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.54

St. Gabriel's Hospital

ADDRESS:
815 2nd Street Southeast
Little Falls, MN 56345

WEBSITE:
www.stgabriels.com

PHONE NUMBER:
320-631-5605

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,597

NUMBER OF PATIENT DAYS:
16,127

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.55

St. John's Hospital

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

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-232-7122

NUMBER OF BEDS:
184

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
67,304

NUMBER OF PATIENT DAYS:
80,013

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, 2012 – OCTOBER 6, 2013)

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
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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.56

St. Joseph's Area Health Services Inc.

ADDRESS:
600 Pleasant Ave.
Park Rapids, MN 56470-1431

WEBSITE:
www.sjahs.org

PHONE NUMBER:
218-616-3507

NUMBER OF BEDS:
50

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,363

NUMBER OF PATIENT DAYS:
13,375

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.57

St. Joseph's Hospital

ADDRESS:
45 W. 10th St.
Saint Paul, MN 55102-1062

WEBSITE:
www.healtheast.org/patientsafety

PHONE NUMBER:
651-232-3122

NUMBER OF BEDS:
401

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
35,646

NUMBER OF PATIENT DAYS:
91,818

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, 2012 – OCTOBER 6, 2013)

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
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, 4 or unstageable 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: 0; Neither: 3**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.58

St. Luke's Hospital

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

WEBSITE:
www.slhduluth.com

PHONE NUMBER:
218-249-5694

NUMBER OF BEDS:
267

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
49,404

NUMBER OF PATIENT DAYS:
84,908

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.59

Tri-County Health Care

ADDRESS:
415 Jefferson St. N.
Wadena, MN 56482-1264

WEBSITE:
www.tricountyhospital.org

PHONE NUMBER:
218-631-7481

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,348

NUMBER OF PATIENT DAYS:
14,404

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

United Hospital

ADDRESS:
333 N. Smith Ave.
Saint Paul, MN 55102-2344

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
546

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
91,271

NUMBER OF PATIENT DAYS:
159,316

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, 2012 – OCTOBER 6, 2013)

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
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**6**	Deaths: 0; Serious Disability: 0; Neither: 6
A medication error	**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: 1; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**13**	**Deaths: 1; Serious Disability: 3; Neither: 9**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.61

Unity Hospital

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

WEBSITE:
www.allina.com

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
275

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
40,227

NUMBER OF PATIENT DAYS:
75,391

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, 2012 – OCTOBER 6, 2013)

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
Wrong surgical/invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.62

University of Minnesota Medical Center, Fairview

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

WEBSITE:
www.uofmmedicalcenter.org

PHONE NUMBER:
612-672-6422

NUMBER OF BEDS:
1,700

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
193,224

NUMBER OF PATIENT DAYS:
335,703

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
Surgery/other invasive procedure performed on wrong body part	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**7**	Deaths: 0; Serious Disability: 0; Neither: 7
A medication error	**5**	Deaths: 1; Serious Disability: 4; Neither: 0
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
CRIMINAL EVENTS		
Sexual assault of a patient	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**26**	**Deaths: 1; Serious Disability: 9; Neither: 16**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.63

Winona Health Services

ADDRESS:
855 Mankato Ave. P.O. Box 5600
Winona, MN 55987-0600

WEBSITE:
www.winonahealth.org

PHONE NUMBER:
507-457-4157

NUMBER OF BEDS:
99

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
22,745

NUMBER OF PATIENT DAYS:
35,932

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, 2012 – OCTOBER 6, 2013)

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 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.64

Woodbury Ambulatory Surgery Center

ADDRESS:
8675 Valley Creek Road Ste 300
Woodbury, MN 55125

WEBSITE:
www.summitortho.com

PHONE NUMBER:
651-968-5655

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
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
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

* The surgical/invasive procedure count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.65

Woodwinds Health Campus

ADDRESS:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-232-6880

NUMBER OF BEDS:
86

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
31,007

NUMBER OF PATIENT DAYS:
37,861

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, 2012 – OCTOBER 6, 2013)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or serious disability associated with:		
Stage 3, 4 or unstageable 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 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.

APPENDIX A:
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[1]

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.

[1] *Minnesota Statutes 144.7063, subd. 5 defines 'surgery' as "the treatment of disease, injury, or deformity by manual or operative methods. Surgery includes endoscopies and other invasive procedures."*

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.

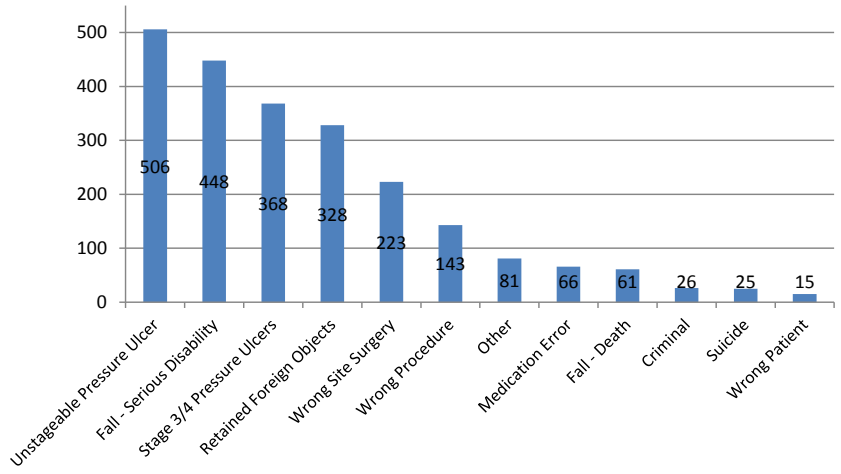
Criminal Events

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 of 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.

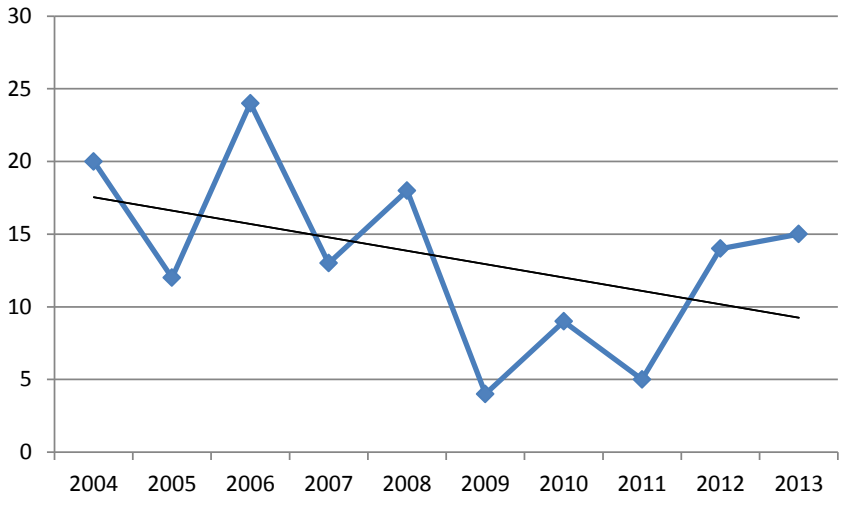
APPENDIX B:
ADVERSE EVENTS DATA, 2004-2013

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 2,288 events have been reported to MDH.

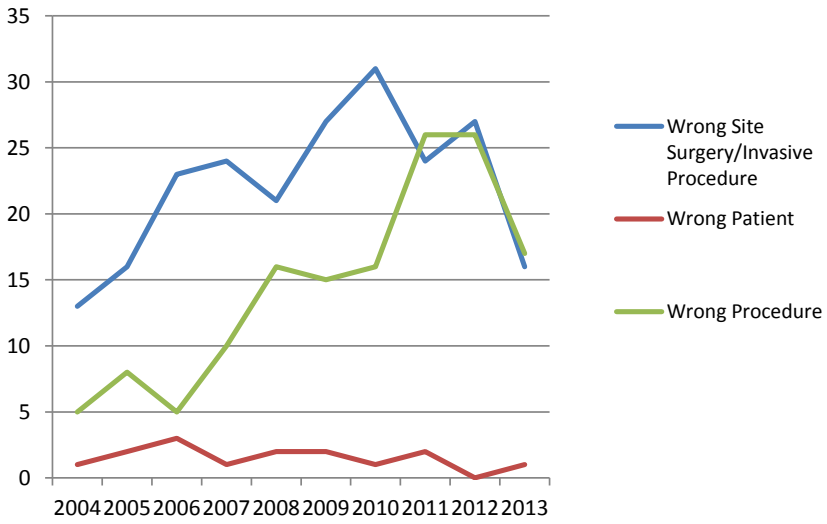
REPORTED ADVERSE EVENTS, 2004 – 2013



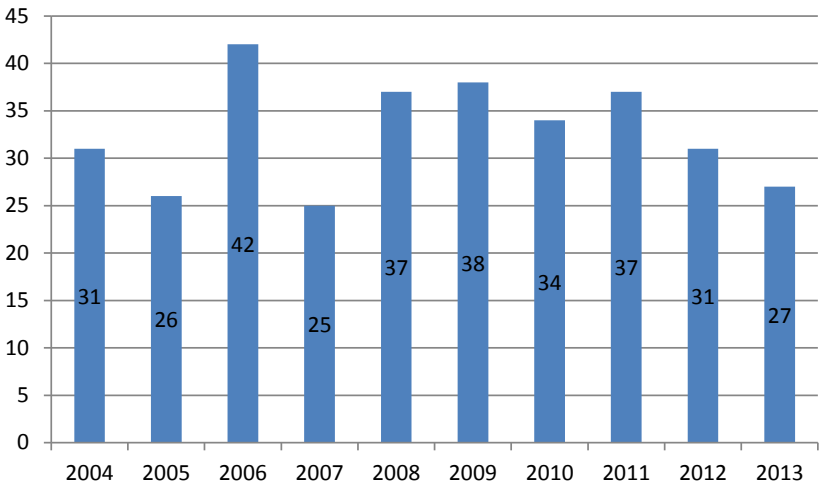
DEATHS PER YEAR, 2004 – 2013



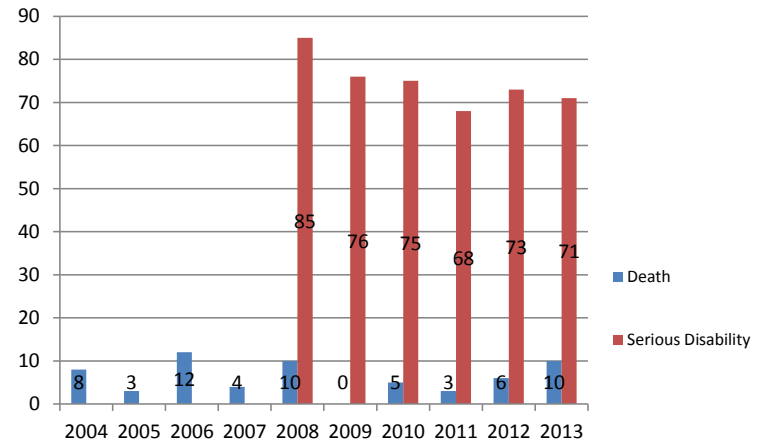
REPORTED SURGICAL EVENTS, 2004 – 2013



REPORTED RETAINED FOREIGN OBJECTS, 2004 – 2013

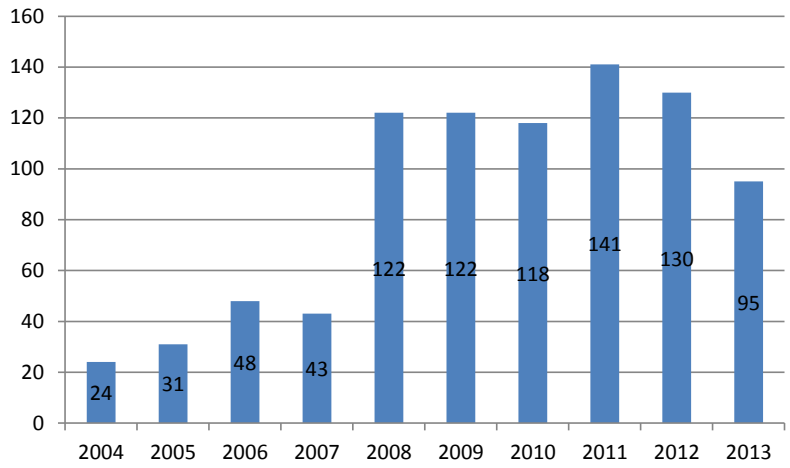


REPORTED FALLS, 2003 – 2013



Note, prior to 2008, facilities were only reporting falls that resulted in patient death. In 2008, the law was expanded to include falls resulting in serious disability as well.

REPORTED PRESSURE ULCERS, 2003 – 2013



Note, prior to 2008, facilities were only reporting "stage III and IV" pressure ulcers. In 2008, the law was expanded to include "unstageable" pressure ulcers.

APPENDIX C:
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 serious reportable events identified by the National Quality Forum and a public report that identified adverse events by facility. The law covers Minnesota hospitals and licensed outpatient surgical centers.

Momentum toward a system for mandatory adverse event reporting began with the publication of the Institute of Medicine (IOM) report "To Err is Human" in 2000. While the issue of medical errors was not a new one for health professionals, 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 started a national conversation about the reasons why such errors occur. 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, MDH, and other stakeholders worked together to create the reporting law, 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. At the same time, the pressure ulcer category was expanded to include 'unstageable' pressure ulcers.

APPENDIX D:
FALLS SAFETY ALERT

Minnesota Hospital Association

MINNESOTA MDH DEPARTMENT OF HEALTH

Patient Safety Registry

Minnesota Patient Safety Alert

April 16, 2013

Background

Although Minnesota hospitals have been working diligently to eliminate falls and injury from falls, last year Minnesota had an increase in falls resulting in serious injury and fall deaths and there is a concerning trend that could lead to a higher number of deaths related to falls this year.

Review of the root cause information submitted in relation to these fall events indicate the following common factors:

1) **In 100% of fall death cases this year, the patients were at high-risk for injury from falls.** In addition to having a system in place to identify and address an individual's risk factors that put them at a higher risk for falls, MHA and MDH recommend facilities use the Fall Injury Reduction Protocol included in this alert as a guide to identify and mitigate modifiable risk factors that place patients at a higher risk of being injured if they do fall.

2) **In 67% of fall death cases this year, the patients were on anticoagulants and at risk for bleeding if a fall occurred.** Interventions should be customized for patients with a coagulation risk factor that puts them at higher risk for injury, including the use of high/low beds, staying within arm's reach, and educating patients and families about the increased risk of injury due to anticoagulation therapy.

3) **It was also noted that in 100% of the cases in which an alarm was in place, the alarm was ineffective in alerting the staff prior to the patient fall.** Issues identified included:
    - Patient took alarm off
    - Alert not functioning properly
    - Alarms were not reactivated
    - Alarm not audible to nursing staff
    - Alarm did not provide sufficient lead time to prevent patient from getting up on their own.

    MHA and MDH remind facilities that alarms alone are not a prevention strategy. If bed alarms are used, other redundancies need to be built in to the falls plan. Interventions should be customized to specific patient risks, including the use of high/low beds, floor mats, or staying within arm's reach of patients when they are out of bed or the chair. If alarms are used, facilities should ensure they operate properly.

MHA and MDH recommend that facilities revisit their fall and fall injury prevention policies and processes to address the issue of screening, assessing and linking appropriate interventions for patients with a coagulation fall injury risk factor. Recommendations your organization should consider in developing processes are reviewed in greater depth on the following pages.

For more information on this alert, contact Julie Apold, MHA senior director of patient safety, at japold@mnhospitals.org, 651-641-1121 or toll-free at 800-462-5393; or Rachel Jokela, adverse health events program director, Division of Health Policy, MDH, 651-201-5807.

Recommendations for Mitigating Fall Injury Risk for Patients on Coagulants

April 16, 2013

These recommendations are intended to share best practices based on learnings from the adverse health event reporting system and statewide falls prevention activities involving Minnesota hospitals and ambulatory surgical centers. The recommendations are not intended to address all fall program related clinical and regulatory requirements.

It is recommended that in addition to having a robust system in place to identify and address an individual patient's risk factors that place them at a higher risk for falling (Appendix B), each organization should incorporate within this system a robust process for identifying and addressing each patient's specific injury risk factors that place them at a higher risk for sustaining a serious injury if they do fall.

A Fall Injury Reduction Protocol to identify and mitigate modifiable risk factors has been developed in consultation with the MHA Fall Advisory Work Group and Patricia Quigley, *PhD, MPH, ARNP, FAAN, FAANP* which provides a decision algorithm for identifying and mitigating specific fall injury risk factors (Appendix A). The algorithm is based on the ABCs fall injury risk factors:

A = Age >85
B = Bones
C = Coagulation
S = Surgical (post-surgical patients)

Although any of these risk factors places the patient at greater risk for sustaining a serious injury from a fall, 67% of the deaths associated with an inpatient fall this current year have occurred in patients with a coagulation risk factor.

It is critical that interventions are customized for those patients identified at risk of injury from a fall according to their specific risk factors.

Interventions that should be considered for patients with a coagulation risk factor include:

- Provide education to patients and families, which includes teach back, on why they are at a higher risk for serious injury if they do fall now that they are on blood thinners
- High/low beds
- Physical therapy consult to evaluate the patient's mobility and patient's physical environment for areas of injury risk
- Include environmental checks within regular patient rounds, e.g., checking clutter, eliminating or padding sharp edges, floor mats are in place and are being used appropriately to pad flooring
- "Staying within arm's reach" (more information in Appendix C)
- If the patient has a traumatic brain injury, consider a helmet
- If the patient uses a wheelchair, place an anti-tipping device on chair
- Alarms alone are not a prevention strategy: If bed alarms are used, other redundancies need to be built in to the falls plan, such as those outlined above. If an alarm is used, strategies need to be in place to ensure that the appropriate alarm is used for the patient, the alarm is operating properly, is activated and is set at the appropriate sensitivity and volume level.

ADVERSE HEALTH EVENTS
IN MINNESOTA

TENTH ANNUAL PUBLIC REPORT / JANUARY 2014