11TH ANNUAL PUBLIC REPORT

ADVERSE HEALTH EVENTS IN MINNESOTA

FEBRUARY 2015

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ADVERSE HEALTH EVENTS IN MINNESOTA

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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, February 2015

The release of this report marks 11 years since Minnesota led the nation in establishing a statewide public reporting system for adverse health events (AHE) (Appendix A). This law requires all 143 hospitals and 70 ambulatory surgical centers to report whenever an AHE occurs and to conduct a thorough analysis of the causes for the event.

In the last year, the requirements for reporting facilities have increased through of the addition of four new reportable event categories:

- Death or Serious Injury Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results
- Irretrievable Loss of an Irreplaceable Biological Specimen
- Neonatal Death or Serious Injury Associated with Labor & Delivery in a Low-Risk Pregnancy
- Death or Serious Injury of a Patient Associated with the Introduction of a Metallic Object into the MRI Area

Including these new categories, there were 308 adverse health events reported to the Minnesota Department of Health (MDH) in the October 2013 to October 2014 reporting period.

While pressure ulcers and retained foreign objects continue to be areas that challenge providers, there are several key areas showing sustained improvement:

- The number of deaths as a result of AHE in the current reporting period was 13, its lowest point since 2011;
- The number of falls declined to 79 and the number of fall-related deaths was six;
- Wrong site surgical/invasive procedures declined for the second consecutive year.

Moving from collecting data to identifying and implementing best practices for prevention is the most important aspect of the reporting system in Minnesota and one that will lead to fewer adverse health events. As a result of key learnings from 2013 Adverse Health Events, a number of actions were implemented in 2014:

- In response to increasing reports of violence in the workplace against health care workers, in 2013 MDH formed the 'Violence Prevention in Healthcare Workgroup' with partners from the Minnesota Hospital Association (MHA), the Minnesota Medical Association (MMA), Minnesota Nurses Association (MNA), hospitals, surgical centers, clinics, long term care associations, and the nurses' union in order to look at the issues of patient-to-staff violence and develop best practices and/or recommendations. In 2014 that workgroup released a roadmap of best practices and accompanying toolkit for healthcare facilities to implement as they work toward a violence free workplace. The group also hosted a series of webinars with nearly 100 participating healthcare organizations on a broad range of violence prevention topics (see spotlight story on page 24).

- In response to an increase in fall related deaths and injuries related to toileting, MHA and MDH worked with a national consulting group to develop recommendations for hospitals to consider when remodeling or retrofitting patient bathrooms and patient rooms to be safer for patients. Those recommendations* were formalized in a report and released to hospitals in early 2015.
- In response to identifying that "fragments" of instruments or wires were a main contributor to reported retained foreign objects, MHA and MDH worked with a national expert to analyze the data for trends and patterns and make recommendations on how the state can improve this process. Those recommendations are expected in early 2015 and will be disseminated statewide.
- As a result of the data showing an increase in fall-related deaths related to patients receiving anticoagulation therapy, MHA formed a workgroup to look at this risk area. The workgroup developed recommendations in the form of a gap analysis and accompanying toolkit, which were disseminated in mid-2014.

In 2015, MDH and its partners will continue efforts to improve patient safety in Minnesota, including, but not limited to:

- Piloting strategies for reducing lost or damaged biological specimens. Minnesota facilities will begin reporting implementation progress in the first quarter of 2015;
- Convening a workgroup to explore strategies for reduction of test result communication errors and providing trainings and resources to facilities later in the year;
- Continue work underway with hospitals across the state to address perinatal safety;
- Continue work with surgeons and interventional radiologists in a targeted effort to improve the process for correct spine level surgery and spinal injections.

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

* http://www.mnhospitals.org/Portals/0/Documents/ptsafety/falls/CreatingASafeEnvironmenttoPreventToiletingRelatedFallsReport.pdf

HOW TO USE THIS REPORT

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

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

Patient awareness is a very important tool to improve safety, but it is important to keep these numbers in perspective. The events listed in this report represent a very small fraction of all of the procedures and admissions at Minnesota hospitals and ambulatory surgical centers.

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 Hospital Association

www.mnhospitals.org/patientsafety

Resources include various road maps and tool kits to support patient safety improvement efforts across the hospital.

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.

2014 SUCCESSES AND CHALLENGES: HOSPITAL AND SURGERY CENTER PERSPECTIVES

In December 2014, 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 58 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 2013-14 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 MDH Case Study, safety alerts, and MDH Statewide conference calls.

Facilities were asked to describe the biggest improvements in patient safety within their facilities over the past year. A number of respondents described increasing awareness of patient safety in their facilities that went hand-in-hand with an increase in reporting of patient safety issues. Others reported their facilities implementing near-miss reporting and a more rigorous root cause analysis (RCA) process. Another area of improvement that many facilities noted was in preventing falls and injury from falls.

Respondents were also asked to describe the biggest challenges their facilities faced with regard to patient safety over the past year. The most common responses were challenges with preventing falls with injury, lack of internal resources to implement safety practices and difficulty with coordination of competing patient safety efforts within their facilities and statewide.

FIGURE 1:
Facility Perspectives, 2014

RESOURCE OR TOOL	VERY USEFUL	SOMEWHAT USEFUL	NEUTRAL	NOT USEFUL	N/A
MDH/MHA Safety Alerts	63%	28%	4%	0%	5%
MDH Case Study Survey (April 2014)	52%	29%	8%	2%	9%
MDH Statewide Conference Calls	36%	8%	10%	0%	46%
MDH AHE Data Sharing Database	31%	12%	23%	3%	31%
MDH Online RCA Training Vidoes	28%	17%	35%	3%	17%
MHA "Good Catch" Award Program	26%	25%	14%	14%	21%
MDH Statewide "Prevention of Violence in Healthcare" Collaborative	25%	18%	18%	3%	36%
MDH Online RCA Toolkit	25%	14%	26%	0%	35%
Stratis Health Measurement Guide for Adverse Events	24%	14%	12%	0%	50%

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

Next, respondents were asked to describe the most valuable part of the AHE program. Similar to past years, respondents most frequently noted: the annual case study survey, increased awareness of patient safety on a statewide level, available resources through the program, data sharing with other organizations, and the ability to learn from events.

When asked to describe the least valuable part of the AHE program, respondents most frequently noted: reporting all events regardless of preventability, and public reporting, namely the public perception of adverse events.

Respondents were then asked to describe what they feel the highest priorities of the AHE reporting system should be in the upcoming year. The most common responses were: focus on continued definition of the new events, medication safety and falls prevention.

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

- Continued learning/sharing sessions and development of resources around the top problem areas;
- Assist facilities with streamlining the various patient safety efforts ongoing statewide;
- Continue the support for all facilities with resources and personnel availability for questions and concerns.

MDH and its partners will move forward in 2015 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 2014 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 2014 activities are listed below.

Strengthening the reporting system

- In April, for the fifth 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 through a webinar, with many facilities also using the survey as an internal training tool for staff. This year the case studies also addressed the newly reportable events and strived to educate facilities on the reportability of those events.
- MDH and MHA convened and expert group to help define the newly reportable neonatal death or serious injury event, biological specimen event, and test results communication event. These efforts helped operationalize these events and provide much needed clarification to facilities to ensure consistent reporting.
- As was noted in the 10 Year AHE Evaluation, facilities desired more ways to use the data-sharing database to learn from one another. Throughout 2014, modifications were made to the secure, web-based registry used to report events. The data-sharing database includes new reports and easier data mining for reporting facilities. This will assist facilities in more effectively searching the data and learning from events from other facilities.

Education

- Throughout the fall/winter of 2014, MDH and its partners hosted a series of webinars for all healthcare facilities in Minnesota on Violence Prevention in Healthcare. These webinars were attended by nearly 100 facilities and continue into 2015.
- In 2014, MDH held two statewide webinars for reporting facilities to update them on changes to the reporting system, trends in the data, new projects, and upcoming training opportunities.
- Throughout 2014, MHA held in-person and virtual education sessions to address identified issues in the areas of pressure ulcers, falls, retained objects, safe site procedures, and perinatal safety

Collaborations

- MDH, and other Minnesota stakeholders, partnered with Minnesota Alliance for Patient Safety (MAPS) to hold its bi-annual education conference, a three-day education summit on patient safety and quality in the fall of 2014, with over 300 attendees.
- MHA collaborated with MDH and Michael Graves Design and Pope Architects on a bathroom redesign project to identify new ways to prevent falls in and around hospital bathrooms. Recommendations from this collaboration were made available to facilities in early 2015.

Topic Specific Safety Activities

MDH and MHA continued to convene expert groups to examine trends and develop evidence-based strategies for prevention of falls, pressure ulcers, retained foreign objects, surgical/invasive procedure events, as well as the new event categories. A number of statewide and regional projects and individual facility efforts to prevent these types of events were implemented or continued during 2014. Those efforts are described in the following sections.

OVERVIEW OF REPORTED EVENTS & FINDINGS

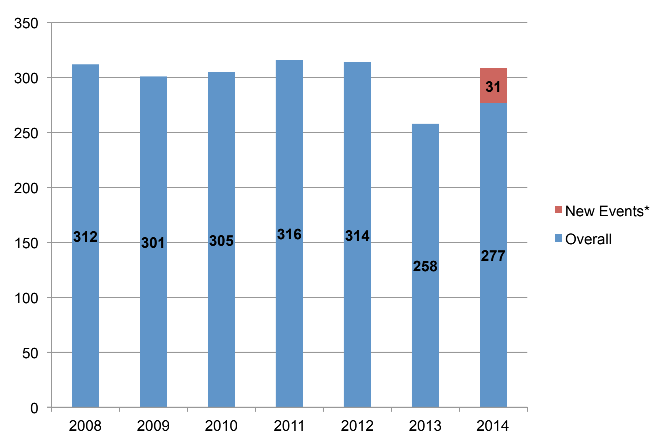
In 11 years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on more than 2,500 events. This annual report provides an overview of what the most recent year of data can teach us about the risk points for adverse health events and the best approaches for preventing them, with a highlight on the most common types of reportable events: falls, pressure ulcers and surgical/invasive procedure events. This year the report will also highlight the newly reportable 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, 2013, and October 6, 2014, a total of 308 adverse health events were reported to MDH. Thirty-one of those events were reported under one of the new event categories in this reporting period (Figure 2). This figure represents an average of 25.6 events per month or roughly six events per week.

FIGURE 2:
Overall Events Reported, 2008-2014



Overall, the data shows:

- There are currently 143 hospitals and 70 ambulatory surgical centers in Minnesota. Of those, 64 hospitals and six ambulatory surgical centers reported events during this reporting period. Three facilities were first-time reporters, experiencing their first reportable adverse event in 2014.
- Since the inception of the reporting system, 80 percent of all hospitals have reported an adverse event, which together account for more than 97 percent of all hospital beds in Minnesota.
- During October 2013-October 2014, 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 11.8 events were reported by hospitals per 100,000 total patient days. (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
2014	2.6	11.8

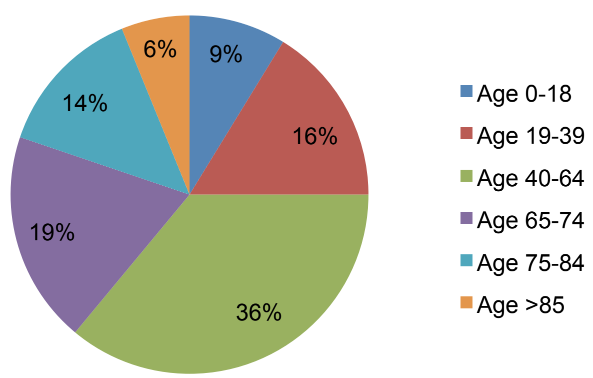
**** New Events Include:***
— Death or Serious Injury Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results
— Irretrievable Loss of an Irreplaceable Biological Specimen
— Neonatal Death or Serious Injury Associated with Labor & Delivery in a Low-Risk Pregnancy
— Death or Serious Injury of a Patient Associated with the Introduction of a Metallic Object into the MRI Area

Patient characteristics

Overall the data shows:

- In 79 percent of reportable events, the patient involved was an inpatient, 18 percent were outpatient and the remaining three 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 113 patients in that age range; this is similar to the past five years of data.

FIGURE 4:
Events by Patient Age, 2014



Patient harm

Of the reports submitted during this reporting period, 31% percent resulted in serious injury, while four percent led to death. The level of harm this year was lower than last year, with deaths declining significantly. (Figures 5, 6). It is important to note that not all of the events 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 Including New Events, 2008-2014

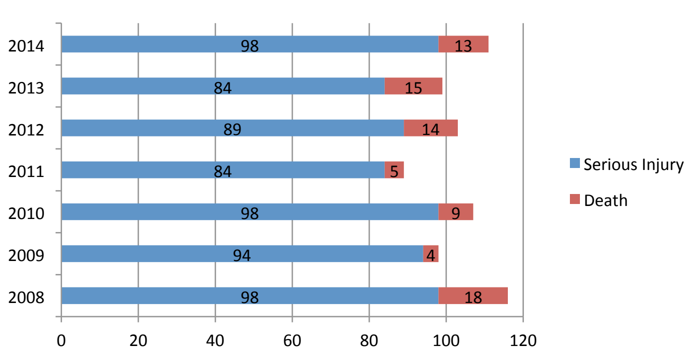
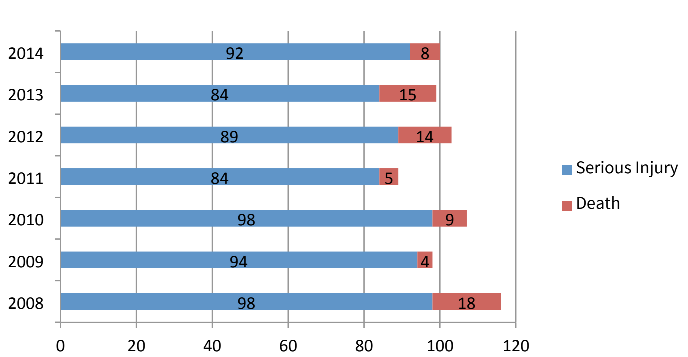
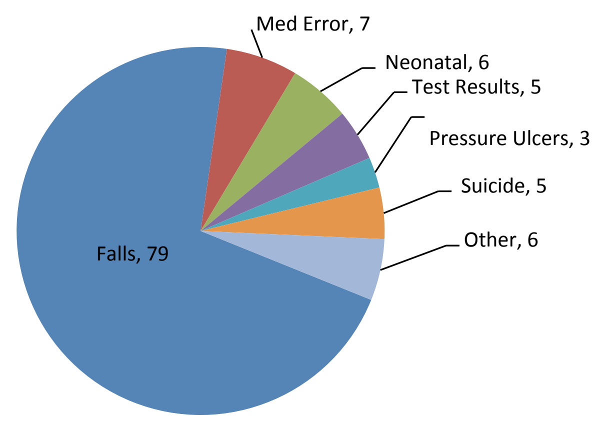


FIGURE 6:
Patient Harm Excluding New Events, 2008-2014



As in previous years, the type of event most likely to lead to serious patient harm or death was falls. Seventy-nine cases of harm or death were a result of falls, while medication errors accounted for seven and neonatal events accounted for six cases (Figure 7). 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.

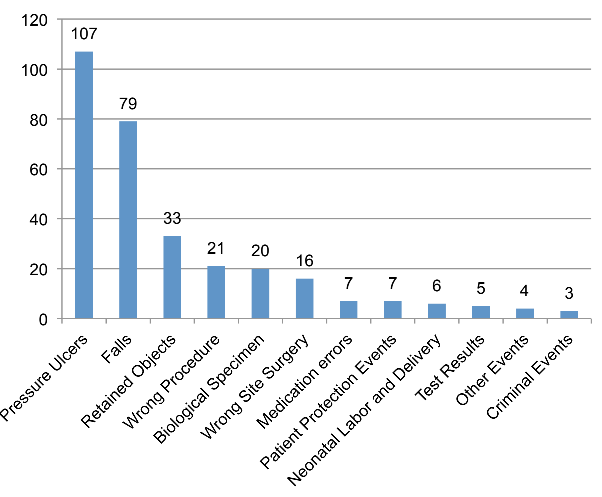
FIGURE 7:
Serious Injury or Death, 2014



Types of events

As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for 60 percent of all events reported in 2014. The four events that make up the surgical/procedural category accounted for another 23 percent of reported events this year (Figure 8). Last, the four newly reportable events accounted for 10 percent of the events this year.

FIGURE 8:
Events by Category, 2014

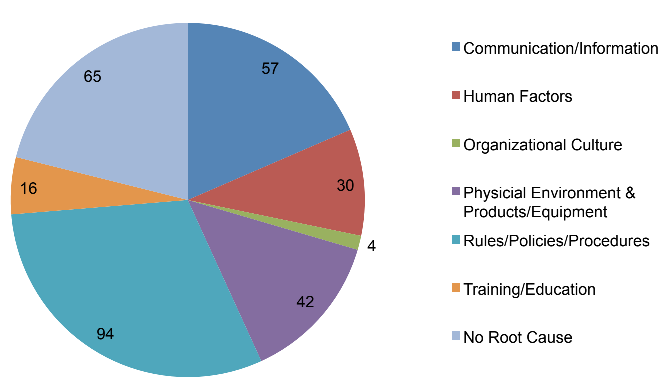


Root causes of adverse events

In Minnesota, any time an adverse health event occurs, facilities are required by law 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, education, policies and/or procedures that were not in place or confusion about roles and responsibilities. The process of completing an RCA is the most important step in learning from events and putting systems in place to prevent them from happening again.

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 9). Upon closer examination of the rules/policies/procedures category, facilities cited 38 percent of the time that the root cause was due to policies or procedures being in place but not followed (often due to distractions and/or training gaps). Another 15 percent of the time the policy or procedure was reported as being unclear to staff. Also of interest, in the communication/information category, 26 percent of the time, facilities noted a lack of communication to the correct person or provider.

FIGURE 9:
RCA by Category, 2014

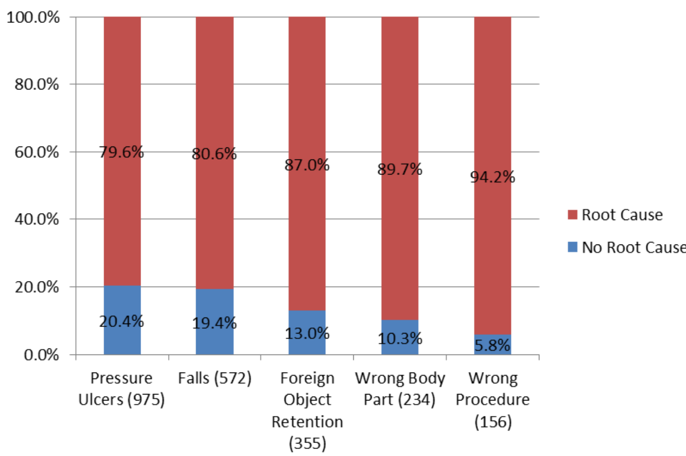


In the 10 Year Program Evaluation published in 2014, it was noted that the percentage of facilities concluding an event had “no root cause or contributing factor” after completion of a root cause analysis investigation was increasing. In 2013, over a quarter of events did not have an identifiable root cause; that number was similar in this reporting year. Due to that trend, this year, MDH worked with epidemiologists from Stratis Health to further analyze this data and identify possible trends. The percentage of reported events with no root cause varied significantly across the types of events.

For the two most common event types, pressure ulcers and falls, the proportion of no root cause/contributing factor events was similar at approximately 20 percent each, while events such as wrong site surgery/invasive procedure rarely failed to find a root cause/contributing factor. Also of note, a higher proportion of events with no root cause had death or serious injury as the level of harm and a lower proportion of monitoring or no harm, compared to events with a root cause. This could be attributed to an actual severity difference, or to the fact that some events (such as falls) are only reportable if there is a serious injury/death.

One possible explanation for the increase in no root cause events in recent years is that through their work on adverse events, facilities have prevented events with more easily identified root causes. It also is possible that the hospitalized patient population in recent years is sicker than previous years, leading to adverse events with an underlying cause related to the patients’ fragile state, rather than more directly related to facilities’ safety practices. Another factor that may affect the proportion of events with no root cause is the addition of new reportable event types. The recent addition of new data fields for tracking patient risk factors should help provide information that will answer these questions in future years.

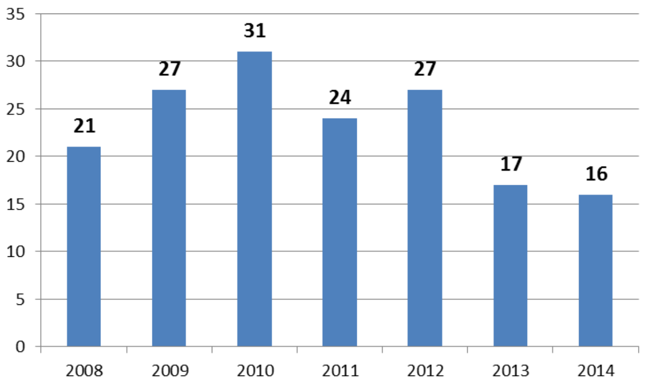
FIGURE 10:
Root Cause vs. No Root Cause by Event Type, 2003-2014



WRONG SITE SURGERIES/INVASIVE PROCEDURES

In the most recent year of reporting, 16 cases of wrong site surgeries/invasive procedures were reported, which continues a downward trend in this category (Figure 11). In 75 percent of these cases, the patient was reported to have experienced no medical harm from the incident or required additional monitoring, the remaining 25 percent had to undergo an additional procedure.

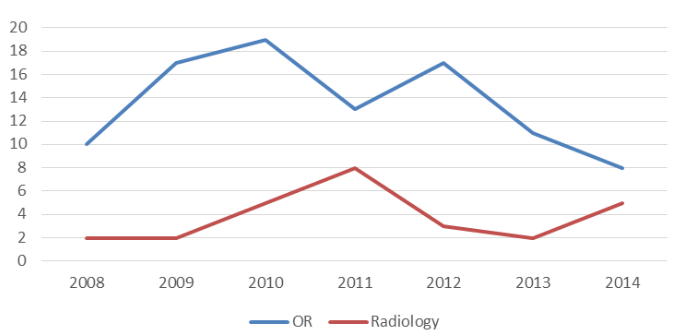
FIGURE 11:
Wrong Site Surgery or Procedure, 2008-2014



Across all Minnesota hospitals and surgical centers, nearly 2.5 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 156,000 invasive procedures.

A closer look at where these events occurred shows eight events in the operating room and five in radiology. This shows a continued downward trend in the events occurring in the operating room, presumably as the 'SAFE SITE 2.0' (statewide surgical safety effort) work is more hard-wired

FIGURE 12:
Wrong Site Surgery or Procedure, 2008-2014



in that area) and a slight increase in events occurring in radiology (Figure 12). Organizations report that this increase is likely due to an increase in awareness of these issues in radiology and an increase in the number of invasive procedures being performed in interventional radiology. Radiology has become a significant focus of the 'SAFE SITE 2.0' work and will continue as a focus in 2015.

Looking deeper into the data of the wrong site surgeries/ invasive procedures performed in the operating room, six were wrong level spine procedures. This is an area that continues to challenge health care providers locally and nationally and is often related to not having a reliable process for spine level localization. This is a highly specialized and complex process, as the spine is not able to be properly visualized prior to incision and even with imaging technology, there can be errors with the current process. In 2011, MDH and MHA issued a safety alert related to incorrect spine level procedures and there has been a decrease in the past three years, but more work needs to be done to understand and test best practices to eliminate these types of events.

Key findings

In this reporting year, as in the past, the root causes of wrong site surgeries/procedures are often related to inconsistencies with the Time Out process, especially with the step of the process in which the site mark is visualized to verify the correct site. Efforts continue to hard-wire a structured and human-factors based Minnesota Time Out process for all invasive procedures in Minnesota.

Root causes for these events included:

- Site mark referenced improperly labeled images;
- No reliable procedure for spine level localization;
- Failure of designated staff to visualize site mark and confirm with source documents during Time Out process.

Next Steps

In the coming year, Minnesota hospitals and surgical centers will continue to focus on preventing wrong site surgical/ invasive procedure adverse events. MHA's 'SAFE SITE 2.0' campaign continues in 2015 with 117 facilities participating.

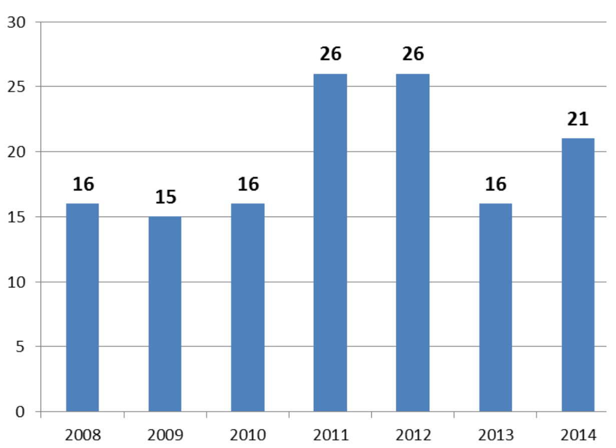
In the coming year, MDH/MHA will continue to work with surgeons and radiologists to strengthen best practice for spine level localization to prevent wrong spine level surgeries/invasive procedures. This process has been ongoing and is highly complex, but Minnesota facilities are committed to improvement.

WRONG SURGERIES/INVASIVE PROCEDURES

In the most recent year of reporting, 21 events of wrong surgeries/invasive procedures were reported (Figure 13).

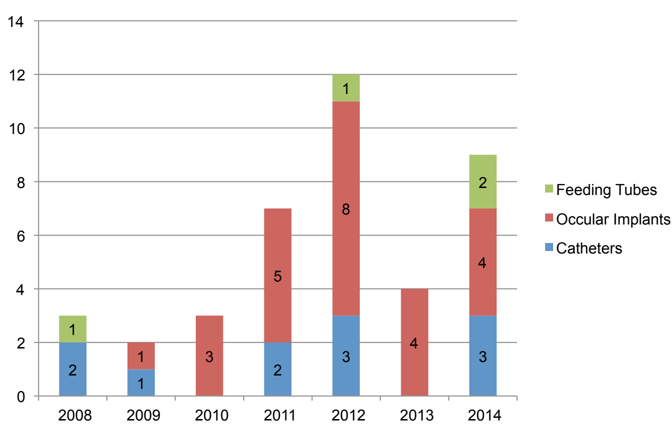
Across all Minnesota hospitals and surgical centers, nearly 2.5 million surgeries and invasive procedures were performed in this reporting year. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one of every 119,000 invasive procedures.

FIGURE 13:
Wrong Procedure, 2008-2014



A closer look at the data shows an increase in events occurring in radiology and also events related to incorrect catheter placement (usually incorrect lumens, such as a triple lumen vs. a double lumen catheter) or feeding tube placement, while incorrect lens implants have maintained the improvement in number of events from 2013 (Figure 14). In 2012, MDH and MHA issued a safety alert related to implant handling and verification; improvements were seen in 2013 with regard to lens implants. However, much of that work can be applied to other types of implants, such as lumens and feeding tubes. MDH and its partners will support organizations in implementing best practices for the placement of catheters and feeding tubes in 2015.

FIGURE 14:
Wrong Procedure Implants, 2008-2014



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 verification of feeding tubes/ lumens;
- The verification process did not include review of proper source documents.

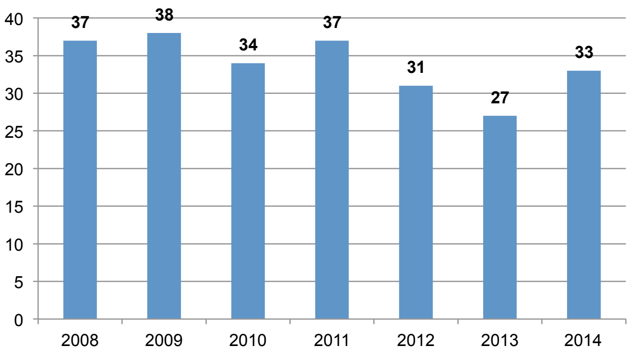
Next Steps

In the coming year, Minnesota hospitals and surgical centers will continue to focus on preventing wrong surgical/ invasive procedure adverse events by working specifically on preventing wrong catheter and feeding tube placement. MHA's 'SAFE SITE 2.0' campaign continues in 2015, with 117 facilities participating.

RETAINED FOREIGN OBJECTS

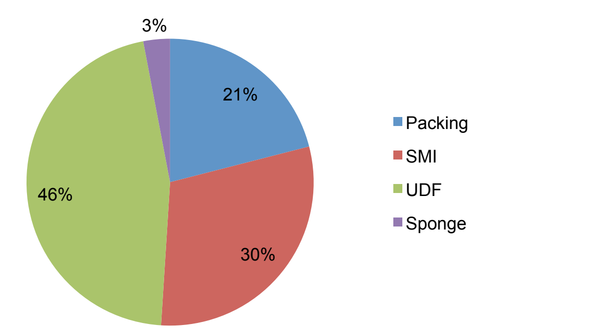
In 2014, 33 cases of retained foreign objects (RFO) were reported (Figure 15). Most of these RFO cases occurred in the operating room.

FIGURE 15:
Retained Foreign Objects, 2008-2014



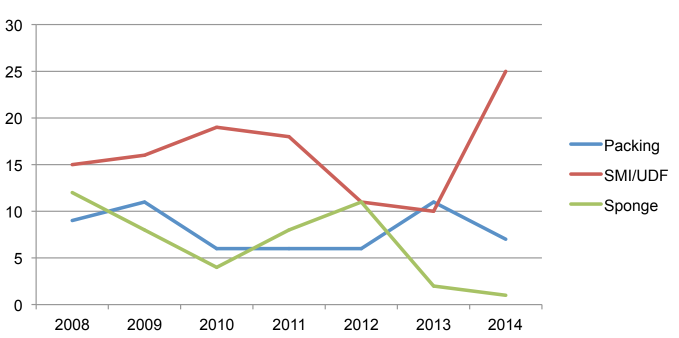
Throughout 2014, much work has been done to look at device fragments and other small miscellaneous items that may be retained during surgery. In the past few years, facilities in Minnesota have made progress in reducing the number of soft goods/retained sponges. However, the reporting system has helped identify an opportunity to improve the retention of small miscellaneous items (SMI) and unretrieved device fragments (UDF). UDFs are broken pieces of instruments, trocars, guide wires and sheaths. In the most recent reporting year, UDFs and SMIs accounted for the largest portion of retained objects, while sponges and packing made up less than a quarter of the reported events (Figure 16).

FIGURE 16:
Retained Foreign Object by Type, 2008-2014



As the percentage of retained sponges has decreased, the percentage of SMI/UDFs has increased. (Figure 17). This is likely due to the progress made in preventing retained sponges, and the ability for facilities to turn the focus to preventing SMIs and UDFs. This change has resulted in increased awareness and reporting. Furthermore, previously if a device broke it was categorized as an instrument in the reporting system, when it was really a UDF. With proper reporting and categorization, these numbers are clearer in this reporting year, which helps to characterize the issue and helps facilities focus on best practices to decrease the retention of these items.

FIGURE 17:
Retained Foreign Object by Type, 2008-2014



Key findings

In this reporting year, the root causes were often related to the lack of effective strategies to ensure that items that are placed during a procedure are fully intact at the end of the procedure. For example, if a guide wire is placed in radiology for a breast biopsy and the patient then goes to the operating room for the surgery, it is difficult to account for a small piece of the guide wire that may have been cut during the procedure and retained in the patient.

In addition, during surgical procedures in which packing is placed during the procedure to control bleeding and is intended to be removed after the patient leaves the operating room, there are a number of hand-offs that need to occur within the operating room, to the recovery room, and then to staff on the floor to communicate that packing was placed in the operating room and needs to be removed at a certain time during the patient hospital stay.

Next Steps

In late 2014, MDH and MHA began working with Dr. Verna Gibbs, a national surgical safety expert, on preventing the retention of SMI/UDF, as well as all types of RFOs. Work will continue to investigate and share best practices for accounting for items being intact and in leveraging information technology to support effective communication of items that are placed during surgery but intended to be removed in a different location in the hospital. In addition, discussions will be pursued with regulators and manufacturers to explore possibilities for manufacturing devices that are less likely to come apart or break during surgery. Also in 2015, 'SAFE ACCOUNT' (statewide work to address retained objects in the OR) continues with participation by 111 hospitals.

SPOTLIGHT STORY

Preventing retained surgical items

While items should never be left behind following an operation or other invasive procedure it unfortunately does happen. Retained items can result in serious adverse events including infection, obstruction, perforation, or thrombosis, and if not retrieved, may require a subsequent procedure to remove the item. At the foundation of the prevention of retained surgical items (known in Minnesota as retained foreign objects) is a culture of safety where safe practices are used consistently and all stakeholders employ strong communication strategies.

Surgical items fall into four main categories: soft goods/sponges, needles, instruments and small miscellaneous items (SMI). Two of the most commonly retained items are soft goods, such as sponges, and small miscellaneous items. While hospitals in Minnesota have made strong progress in reducing the number of retained sponges by implementing effective practices to account for items placed during surgical and other invasive procedures, the Adverse Health Event reporting system has helped hospitals identify an opportunity to improve practices to prevent the retention of SMIs and unretrieved device fragments (UDF). These include intact but separated parts of surgical items, broken pieces of instruments, trocars, guidewires and sheaths.

Hospitals in Minnesota have honed in on this opportunity and are working with national surgical safety expert Verna C. Gibbs, MD to identify best practices to prevent the retention of SMIs and UDFs. According to Dr. Gibbs, there are several factors that may explain the rise in this subset of retained items, much of which can be attributed to reporting.

Gibbs says that as hospitals have made progress preventing sponges, needles and instruments they increasingly recognized the cases of SMIs and UDFs resulting in increased reporting. Furthermore, previously if a device broke or a piece went missing, it was usually categorized as an instrument and bundled in with the retained instruments, falsely elevating the number of cases in that category. That was misleading because it wasn't the entire instrument that was retained, but rather a piece or part from the instrument. Now that these items are documented as SMI or UDFs they have their own "count". Finally, there are simply a lot of new devices and instruments used in operations and procedures as a result of the rise in minimally invasive procedures, for example. This creates an increase in the number and kind of devices that scrubs and surgeons have to use which can possibly break.

According to Dr. Gibbs, there are two key steps hospitals can take to reduce the number of retained SMIs and UDFs. First, hospitals need to develop strong management practices that require that all surgical items are accounted for, both inside and outside of the operating room including areas such as the intensive care unit or cardiac catheterization lab.

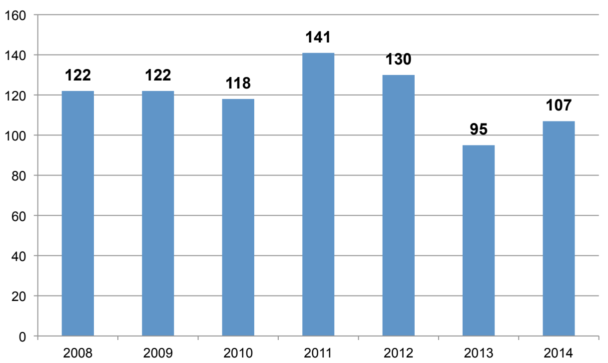
"Counting the items is one thing hospitals can do, but it's not the only thing," said Gibbs. For example, hospitals have strong protocols for preventing central line-associated blood stream infections (CLABSI). As part of the CLABSI protocol, hospitals need to ensure that the guidewire is back in the central line kit at the end of the procedure and not left in the patient. "The same degree of focus you put on reducing the incidence of infection needs to be put on ensuring you don't have an unretrieved device," recommends Gibbs.

Second, comprehensive training and education for staff, especially providers, is critical. Surgical team members need to know how each instrument works so they can identify if something is missing or a piece is gone when the instrument is returned. Physicians are the ones doing the procedures, so it's imperative they understand that the way a device is used can contribute to it breaking or coming apart.

PRESSURE ULCERS

Pressure ulcers, previously known as bedsores, happen when a patient's skin breaks down due to pressure or friction. The highest risk patients are those who have limited mobility, circulation issues or incontinence, although pressure ulcers can and do occur in patients with none of these comorbidities as well. The long-term trend in pressure ulcers is declining. (Figure 18). Similar to last year, the majority of reported pressure ulcers were found on the coccyx or sacrum (54 percent).

FIGURE 18:
Pressure Ulcers 2008-2014



Key findings

A closer look at the data shows, of reported pressure ulcers, 41 percent were device related. Of those device related pressure ulcers, 37 percent were related to respiratory devices (usually respiratory masks, oxygen cannulas or tracheostomy tubes/plates). This correlates with the fact that 48 percent of patients who developed a pressure ulcer had respiratory failure as a listed comorbidity. While this is a significant increase in device related pressure ulcers, one to two years more of data, will help to understand if this is a true increase in these types of events or an ongoing trend that needs to be addressed. Also of note, 40 percent of patients had neurological comorbidities and 37 percent were malnourished, both factors that significantly increase a patient's risk for developing a pressure ulcer (Figure 19).

While many pressure ulcers can be prevented if the patient is regularly moved to alleviate pressure, a high percentage of patients who developed pressure ulcers had conditions that prevented them from repositioning themselves or being repositioned. This, along with the high percentage of patients who had comorbidities that could also affect skin integrity, signals the high level of medical complexity of these patients.

FIGURE 19:
Characteristics of Patients with Reportable Pressure Ulcers

Respiratory Failure	48%
Neurological	40%
Malnourished	37%
Incontinence	35%
Kidney Failure	30%
Heart Failure	25%
Sepsis	21%

However, despite the complexities that many of these patients present, the root causes of pressure ulcers often involve breakdowns in communication that are unrelated to the patient's condition. These can include 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 respiratory failure can also contribute to pressure ulcers by making standard preventative interventions more difficult to apply.

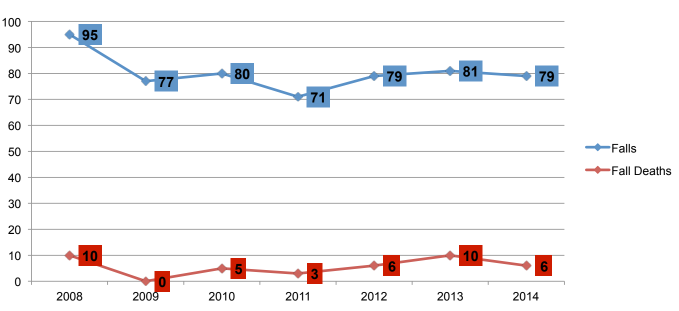
Next Steps

Although progress has been made on reducing device-related pressure ulcers, these efforts will expand in 2015 with a focused effort on respiratory devices which includes all hospitals moving to the use of flexible oxygen tubing, developing best practices to prevent pressure ulcers on the bridge of the nose when using oxygen masks, and working with surgeons to explore best practices for preventing pressure ulcers related to the need to suture tracheostomy plates when new tracheostomies are placed in surgery. In addition, efforts will continue to promote repositioning critically ill patients using small weight shifts more often when complete repositioning is not possible due to their critical status and providing additional education to patients and families on the importance of changing positions to prevent pressure ulcers. 'SAFE SKIN 2.0' (statewide pressure ulcer prevention effort) continues in 2015 with 105 hospitals participating.

FALLS

In 2014, hospitals reported 79 falls that resulted in serious injury or death (Figure 20). Both total falls and falls resulting in death have been relatively stable across a six year period. These events continue to challenge facilities and continued emphasis on prevention is key.

FIGURE 20:
Falls by Injury Type, 2008-2014

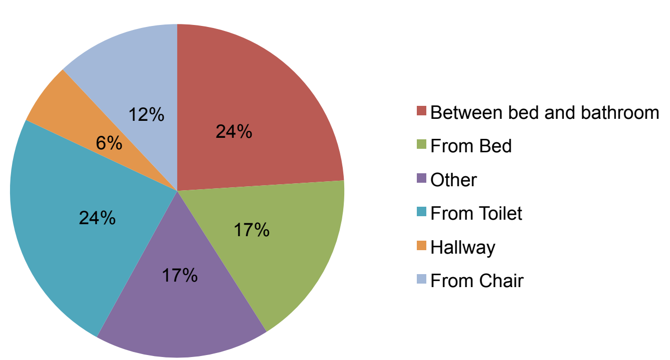


Key findings

Falls reported in this reporting period show only slight changes in terms of where and how they occur. Key findings and actions from 2014 include:

- This year, nearly 40 percent of falls were toileting related (Figure 21), most often occurring when a patient got out of bed to use the bathroom on their own without assistance. This is similar to previous years. In past years, facilities have done extensive work 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, however, falls are still occurring during or around toileting.

FIGURE 21:
Falls by Location, 2014



- With regard to event location, 60 percent of falls occurred on medical/surgical units with another 12 percent taking place on both rehabilitation units and behavioral health / inpatient psych units.
- In nearly half the cases, the patient who fell was on high-risk medications that may increase the risk for falling, such as sleep or pain medications.
- With regard to patients who died from their fall injury, the majority of patients were on anti-coagulant medications (to prevent blood clotting) and sustained subdural hematomas (accumulation of blood on the brain beneath the skull from a head injury) after hitting their head. The majority of these falls were unwitnessed, with the patient denying having hit their head. In the absence of obvious external injury to the head in a patient who does not recall hitting their head, the potential for a serious internal head injury exists. Once identified this type of injury requires an intensive level of monitoring and early intervention to address effectively. This signals an improvement opportunity related to evaluation for injury in patients on anticoagulants.

Next Steps

In recent years, it has been noted that the majority of falls are occurring in and around the bathroom. In 2014, MHA partnered with MDH, Michael Graves Design and Pope Architects on a bathroom redesign project. This project looked at new ways to prevent falls in and around hospital bathrooms. Recommendations from this collaboration were made available to facilities in early 2015 and education was provided to facilities on how to incorporate the recommended strategies into their current patient room designs and in future remodels or new builds. Opportunities will be made available in 2015 for hospitals to implement these strategies and share lessons learned with colleagues.

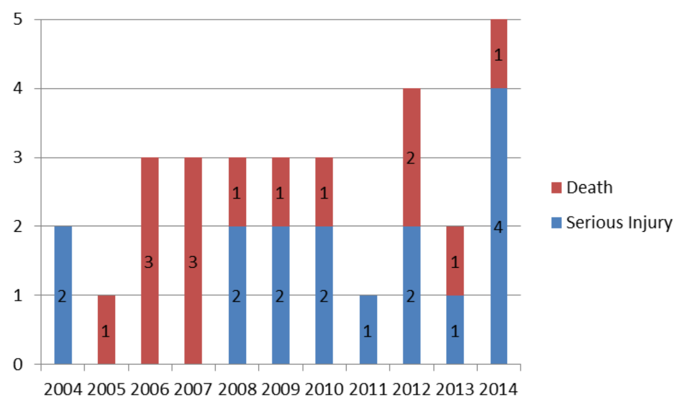
In 2013, MHA formed a work group to look specifically at anticoagulant medications and identify innovative ways that facilities can better protect patients who are taking anti-coagulant medications from fall related injuries. In 2014, this work group released a set of best practices for facilities aimed at preventing these types of injuries. Best practices were rolled into the current 'SAFE from FALLS 2.0' (statewide falls prevention effort) roadmap/gap analysis. With the high percentage of fall deaths that involve a patient on anti-coagulants, where the fall is unwitnessed, caregivers should assume that the patient hit their head and a rapid response team should immediately evaluate the patient and institute an intensive level of monitoring and early intervention if changes are noted.

In the upcoming year, MHA's 'SAFE from FALLS 2.0' continues with 112 facilities participating. The continued focus will be injury risk assessment, and linking appropriate interventions, particularly related to patients who are on anticoagulant medications, as well as reducing toileting related falls.

SUICIDE/ATTEMPTED SUICIDE EVENTS

In 2014, there were five reported patient suicides or attempted suicides that resulted in serious injury or death. While these events are rare, averaging about 3 per year across the 11 years that MDH has been collecting data (Figure 22), there are still some trends of note. When looking at the patient population for these types of events, nearly 90 percent of the patients who committed suicide or attempted suicide while in a healthcare facility were behavioral health patients. This means that they were actively being treated for a mental health/behavioral health issue, usually on a behavioral health unit within the hospital.

FIGURE 22:
Suicide or Attempted Suicide, 2004-2014



When looking deeper into the data, this year, over half of the reported events were due to a patient hanging or attempted hanging using door hardware. In Minnesota and nationally, inpatient suicide by hanging mostly occurs in bathrooms, bedrooms, or closets. A large percentage of all hanging suicides are not fully suspended, meaning the ligature points (beams, hooks, banisters) are below head level. Also of note, several cases of suicide/attempted suicide in recent years have been the result of self-inflicted stab wounds from items in the patient room. These events also have common root causes related to the environment (e.g. items that were in the patient's room that could be used to inflict harm).

In 2006, MDH and MHA issued a Safety Alert surrounding hanging events and many hospitals implemented changes to their environment and door hardware as a result. However, these types of events have seen an increase again in the most recent year of reporting. In 2013, MDH held a suicide prevention training conference with over 100 participants and in 2015, MDH will collaborate with MHA and local suicide prevention experts to explore and disseminate additional recommendations for facilities on environmental guidelines and policies/procedures related to suicide.

SPOTLIGHT STORY

Preventing suicides in the hospital setting

Each year in the United States, 38,000 people die by suicide[1] making it the 11th[2] leading cause of death in the country. In Minnesota, the state's overall suicide rate has been rising in recent years. In 2013, 683[3] people committed suicide in Minnesota. While extremely rare, averaging just three events per year in the past decade, people do attempt to take their life while in the hospital.

Dan Reidenberg, a suicide prevention expert and executive director of Suicide Awareness Voices of Education (SAVE), has provided training for hospitals to prevent suicide for more than six years. His trainings, which involve administrators, nurses, physicians and other team members, focus on risk assessment for suicide in health care settings. "Our trainings provide an overview of what the research says about suicide and what we know about how to prevent it, including environmental safety issues and staffing best practices," said Reidenberg.

Hospitals learn research based warning signs—which can be remembered by the phrase IS PATH WARM (see pg 23)—risk factors and protective factors. "During our trainings, I present case scenarios where participants are presented cases and asked to identify and rate a risk level for a patient," said Reidenberg. "When looking at warning signs, it's important to understand what the warning signs are, but also that the patient might not currently be exhibiting a warning sign, but that the warning signs are based on a year's time. We also know that patients diagnosed with bipolar disorder and schizophrenia have a higher risk for suicide than those with depression."

Often, a lack of services within the community brings people in crisis into the hospital for treatment. To keep patients safe, Reidenberg says hospitals need to have policies and procedures in place, conduct training for staff, identify and remedy environmental safety concerns, and perform more stringent monitoring of patients' risks. "During training, we teach hospitals to have policies and procedures that identify suicide protocols and checks – how often patients are seen by whom? What kind of safety measures are taken for patients actively engaging in suicidal acts? And importantly, that they need to have training for staff at all levels, including physicians, nurses, administration, but also others like environmental services team members," described Reidenberg.

"Treating patients with mental illnesses can be difficult for health care workers without the proper resources. Often there is no short action that can be done to treat the patient and that can be frustrating for health care workers who are used to administering a specific treatment," said Reidenberg.

Hospitals are working to create a supportive and understanding environment for patients who are in a mental health crisis. For example, Reidenberg encourages hospitals to treat a patient contemplating suicide with the same urgency they would a patient with a gunshot wound. "Hospitals have specific procedures they need to follow—for good reason, to keep patients safe. But if a nurse has a series of forms he or she needs to get through with the patient, it can be done in a rote way, or in a supportive way. If staff communicate with one another, it prevents the patient from having to repeat his or her story over and over again to myriad different team members."

Hospitals are also redesigning physical spaces to better prevent suicide attempts by patients. For example, architectural designs are specifically addressing physical features such as doors, bathrooms, and windows that could aid a suicide attempt. In addition, many inpatient behavioral health units are creating sensory rooms that offer quiet places for patients to relax and calm themselves, helping to prevent a crisis from occurring or escalating to a suicide attempt.

There are also efforts at the state level to reduce Minnesota's suicide rate. The Minnesota Hospital Association and its member hospitals participated on the statewide task force to implement a national suicide prevention plan which led to the creation of the Minnesota Department of Health's draft 2015 Statewide Suicide Prevention Plan that is currently available for public comment. The plan includes a goal to promote suicide prevention as a core component of health care services. In 2013, the Minnesota Department of Health also held a suicide prevention training led by Reidenberg.

Finally, as hospitals look to prevent suicide, it's important to be aware of the protective factors that can help prevent a patient from committing suicide:

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships, especially follow-up care, and compliance/adherence to treatment
- Skills in problem solving, conflict resolution and handling problems in a non-violent way
- Cultural and religious beliefs that discourage suicide and support self-preservation

WARNING SIGNS FOR SUICIDE

Ideation (expressed ideation, threats)

Substance abuse (increased)

Purposelessness (no reason for living)

Anxiety (agitation)

Trapped (there's no way out)

Hopelessness

Withdrawal (from family, friends, society)

Anger (rage, revenge)

Recklessness (high risk activities)

Mood (dramatic mood changes)

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[1] *National Institute of Mental Health, http://www.nimh.nih.gov/health/publications/suicide-in-america/index.shtml*

[2] *The Joint Commission, http://www.jointcommission.org/assets/1/18/sea_46.pdf*

[3] *Minnesota Department of Health*

SPOTLIGHT STORY

Coalition makes preventing workplace violence a top priority

Health care professionals are committed to providing the highest quality, safest care possible to patients. Yet this deep-seated commitment to caring for others may sometimes lead health care workers to experience verbal threats or potentially physical acts of violent behavior from patients as simply "part of the job."

A survey conducted by the Minnesota Department of Health (MDH) in 2012 as part of the statewide Adverse Health Events reporting system found that patient/visitor violence toward staff was a concern at Minnesota health care facilities. In addition, federal workplace injury data show that doctors, nurses and mental health workers are more likely than other workers to be assaulted on the job.

To address this concern, MDH convened a broad coalition of health care stakeholders to help organizations effectively prevent and respond to workplace violence toward staff in health care settings, identify risks for violence, and put effective strategies in place.

Hospitals, health systems, long term care facilities, clinics and other health care organizations were asked to make workplace violence prevention a top priority in 2014 and beyond by:

- Declaring workplace violence prevention a priority and committing to participate in the statewide Prevention of Violence in Healthcare effort;
- Completing a "Prevention of Violence in Healthcare" gap analysis to assess their current state of best practices and identify opportunities for improvement;
- Supporting the development or continued work of a workplace violence prevention committee within their organization; and
- Participating in educational webinars supported by the coalition.

The gap analysis (a set of comprehensive best practices for prevention and response to violence in health care formatted to help assess adoption of best practices) and tool kit helps organizations implement best practices to prevent violence from patients to staff and to share findings and resources across organizations. The toolkit includes tools such as: sample data collection templates, sample policies/procedures and education resources. Regular webinars provide participants with information on prevention, education, what to do after an event happens, developing behavioral emergency response teams, and strategies specific to critical access hospitals.

Key learnings from the process so far include:

- Violence against health care workers occurs across all settings of care and is not just about hospital emergency rooms and behavioral health units;
- Leaders of organizations need to set a clear tone that violence in health care settings is not 'just the way things work.' Staff need to be protected, patients need to be protected, and the health care setting needs to be a place where care can be delivered safely, and violence is not condoned in any way;
- Organizations should establish inter-disciplinary teams, including front line staff, leaders, security and others to develop a violence prevention plan;
- Having a central place to gather and analyze all data related to incidents of violence is crucial; and
- Organizations should develop a relationship with law enforcement early so you know how to respond when something happens, when to bring them in, and who to contact.

To date, 92 organizations, including 66 hospitals, have signed on to the effort. Keeping patients and staff safe is a top priority for health care organizations in Minnesota. By participating in this effort, organizations can begin to create a culture in which violence in health care settings is no longer considered an expected part of daily life for health care professionals. This effort continues in 2015 with learning sessions and best practice data collection.

For more information, as well as the best practice gap analysis and accompanying tool kit, please visit http://www.health.state.mn.us/patientsafety/preventionofviolence/index.html

NEWLY REPORTABLE EVENTS

The National Quality Forum (NQF) developed a list of "Serious Reportable Events" in 2002 in an effort to enable healthcare quality and safety improvement through measuring and reporting organizational performance. The purpose of this NQF-endorsed list of events was to facilitate uniform and comparable public reporting and learning from events. This set of events was originally developed to form the basis for a national state-based reporting system and individual states have used or adapted this list to facilitate learning and improvement.

The NQF-endorsed list of events was the basis for the Adverse Health Care Events Reporting Law in Minnesota, which was enacted in 2003. In 2011, the NQF-endorsed list was updated to ensure the continued currency and appropriateness of each event on the list, as well as to ensure that the events remain appropriate for public accountability. During the 2013 legislative session, these changes to the NQF-endorsed list were applied to the state's Adverse Health Care Events Reporting Law, with the new events becoming reportable as of October 7, 2013.

This report reflects the first time that Minnesota is publicly reporting these new events. While having only one year of data limits our ability to discuss longer-term trends, the following sections will discuss what we have learned to date about why these events happen, what's being done to prevent them from occurring again, and how we can continue to improve.

These are the four new events added in the 2014 report:

Death or Serious Injury Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results

This event was added to the NQF-endorsed list of events to acknowledge that the issue of failure to follow up or communicate test results imposes significant increased risk of death or serious injury. This event is intended to capture events where the failure to follow up or communicate critical test results led to outcomes including, but not limited to: new diagnosis or an advancing stage of an existing diagnosis (e.g. cancer) or other negative outcomes associated with lack of follow up of critical test results.

Key Findings

Out of five events in the first year of reporting, four of the events were related to failure to communicate or follow up on critical blood value test results (e.g. blood urea nitrogen or calcium levels) and one was related to a urinalysis result. With regard to location of the involved patient, two cases occurred in the emergency room, one in the intensive care unit and two in the outpatient laboratory area.

Overall these events were due to communication failures such as:

- Miscommunication between providers about who was responsible for follow up;
- Lack of communication of critical test results from lab to provider;
- Attending physician not available for results and unclear procedures for notifying a back-up provider.

Next Steps

A work group of experts is convening to review findings from reported events in this category and develop strategies to address identified gaps. Recommendations from this expert group, along with implementation tools, will be disseminated to hospitals and ASCs across the state.

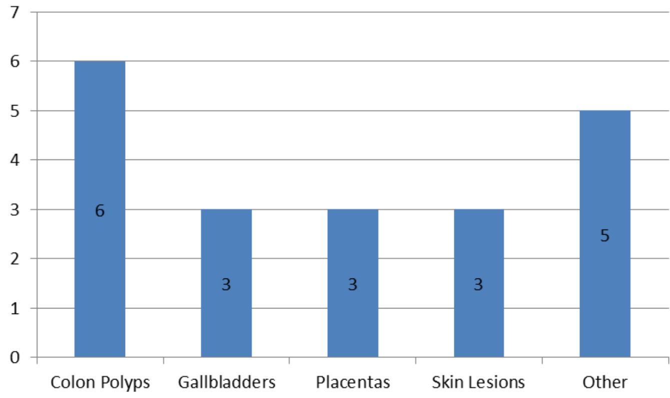
Irretrievable Loss of an Irreplaceable Biological Specimen

This event was added to the NQF-endorsed list of events to protect patients from the loss of a biological specimen prior to testing, which could lead to undiagnosed disease or advancing state of an existing disease. It is important to note that this event is intended to capture events where the specimen is mishandled (e.g., misidentified, disposed of, lost) and another procedure cannot be done to produce a specimen. The specimen must be both irretrievable and irreplaceable in order to fit the criteria for reporting.

Key Findings

Twenty of these events were reported during the first year and the data shows a range of specimens that were lost, but most fit into one of several categories (Figure 23). The majority of these specimens were colon polyps lost after colonoscopy, although facilities also reported several cases of lost gallbladder specimens, placentas and skin lesions.

FIGURE 23:
Biological Specimens by Type, 2014



In terms of where in the process these specimens were lost or destroyed, the data is mixed. In 40 percent of the cases, the loss occurred during processing of the specimen (usually in the lab), and 30 percent each occurred during the process of obtaining/collecting the specimen or during internal transport.

The root causes for these events include:

- No clear procedure for disposal of specimens removed during procedures;
- Lack of clear process for ordering specimen testing;
- Disorganized process for internal transportation of specimen to laboratory;
- Ineffective specimen labeling procedures.

Next Steps

In late 2014, an expert group was convened to review findings from reported events and develop recommendations to address key improvement opportunities. The best practices identified by the work group were disseminated to hospitals and ASCs throughout the state. Work is also underway to combine these practices with other surgical safety practices to create a comprehensive set of recommendations across the topics of: correct site procedures, correct procedure, correct patient, prevention of retained foreign objects, and safe specimen handling. Also, the workgroup finalized a list of specimens that do not routinely need to be sent for testing and that list will help to provide consistency in specimen handling throughout the state. The next step is to convene a subgroup of experts to develop and disseminate practices specifically for management of placentas post-delivery.

Neonatal Death or Serious Injury Associated with Labor & Delivery in a Low-Risk Pregnancy

This event was added to the NQF-endorsed list of events as a companion to the death or serious injury of a mother in a similar circumstance. MDH and its partners have been working since 2013 to make the reporting criteria as clear as possible. It is important to note that this event is intended to capture cases in which a patient is admitted to the hospital with a viable fetus, but a neonatal death or serious injury occurs during the hospital stay that is *associated* with the labor and delivery process in a low-risk pregnancy.

Key Findings

One of the biggest challenges in this event category is in determining whether or not a neonatal death or serious injury is associated with the labor and delivery process. In almost all of the cases reported this first year, a thorough analysis by the hospitals did not find a clear reason why the deaths or injuries occurred, which underscores the complexity of these cases. Although clear causes for these events were not found, opportunities were identified for continued role definition in the labor and delivery process and on-going simulation practice to prepare for emergent situations such as newborn resuscitation and early identification of potential neonate issues and notification to the provider.

Next Steps

Efforts continue, in collaboration with a perinatal advisory group (comprised of experts from Minnesota hospitals), to better understand and define "associated with labor and delivery" and to identify additional information that can be collected when an event does occur to facilitate learning from these types of events and reduce the likelihood of future occurrence. Minnesota hospitals have been working collectively for a number of years on implementing best practices related to overall perinatal safety. For example, Minnesota hospitals have reduced the number of elective deliveries prior to 39 weeks gestation by 94 percent resulting in 1,752 early elective deliveries avoided since 2010. Hospitals have also been participating in on site in-situ training and simulation training for obstetrical hemorrhage emergencies and are implementing practices outlined in the Perinatal Safety Roadmap that include standardization of the management of oxytocin and use of vacuum extractors for operative vaginal deliveries. These efforts will continue in 2015 with the incorporation of lessons learned from this new event reporting category throughout the year.

Death or Serious Injury of a Patient Associated with the Introduction of a Metallic Object into the MRI Area

This event was added to the NQF-endorsed list of events because the occurrence of such events continues nationally, suggesting there is an opportunity for learning and improvement. Hospitals have been working on this area for a number of years following a safety alert from The Joint Commission in 2002. Through the reporting period, none of these events were reported in Minnesota; however, MDH will continue to work with facilities to address issues that may arise with regard to MRI safety.

SPOTLIGHT STORY

Keeping mother and baby safe: Simulation improves safety and prevents perinatal injuries

In 2013, Minnesota hospitals delivered more than 65,000 babies. While many women do not experience complications with the birth of a child, labor and delivery raise several risks for both mother and infant. Hospitals have made great advances in newborn and mother safety during labor and delivery, but research shows that at least 1.5 percent of hospitalized obstetric patients in the U.S. experience an unexpected negative outcome. Efforts are underway across Minnesota to prevent perinatal injuries and reduce obstetrical adverse events.

Birthing hospitals across the state have been taking part in simulation training and are implementing a road map of best practices to help improve patient safety and prevent perinatal injuries.

According to Kristi Miller, RN, MS, a perinatal expert and consultant with Medical Teamwork Consultants, in perinatal adverse events where a root cause is identified, breakdowns in communication are often at fault. “Simulation training allows hospital teams to practice for emergency situations before they arise and helps improve communication and teamwork – two things that are critical for labor and delivery teams.”

Simulation can be provided in a simulation center, or onsite on a hospital patient unit, called in situ simulation. This is an experiential training strategy that recreates, as closely as possible, the real world environment, equipment and team members’ roles. One of the benefits to performing the simulation on site is that team members get to practice with the equipment and underlying processes they’ll actually use. Teams can identify real-time how long it’s going to take a person to come to an emergency from the blood bank, for example.

“We ask simulation participants to ‘do what they would normally do;’ practice how they give information to one another, how they call for help, how they share the sense of urgency, was equipment where team members expected it to be?” said Miller.

“And it’s not just about nurses. Simulation only works if you have all team members around the table.” When planning simulations, Miller encourages hospitals to include the nurse, OB or midwife, lab, blood bank, respiratory therapy, pediatrician, a nurse for the baby, the unit secretary, and of course the patient.

One of the key elements of the simulation training is a period of debrief afterward. “The debriefing is really the most powerful part,” said Miller. “It gives team members the chance to talk about what went well, what didn’t go well or what could have gone better. And based on that, what would you do different next time? Just putting people together in a room doesn’t make them a team. The biggest failure is because the team members don’t have a shared mental model for the plan of care gained primarily through how they communicate,” she added.

According to Dr. Stan Davis, an OB-GYN and Miller’s partner at Medical Teamwork Consultants, a major shift that has occurred in health care is the move from an individual doctor being the end-all-be-all for delivering care. “Today, the doctor needs to not only be an experienced clinician, but also the leader of a team of people responsible for delivering safe care,” said Davis.

In addition to simulation training, hospitals are implementing the Perinatal Patient Safety Road Map, which provides evidence-based recommendations/standards for Minnesota hospitals in the development of a comprehensive Perinatal Safety Program. The Road Map includes patient education and nurse training on key areas to prevent adverse events, including standardization of the management of oxytocin and use of vacuum extractors for operative vaginal deliveries. It also includes best practices for managing hypertension and postpartum hemorrhage emergencies.

It only takes a minute for low risk to become high risk

Low-risk pregnancies can turn high risk at a moment’s notice. It is estimated that about 20 percent of any case of low risk pregnancy can turn into a high risk one. For example, there may be something innate in the placenta or the fetus itself that is undetected during pregnancy, but uterine contractions create a compromising stress for the fetus, potentially causing injury. Or the fetus may have a short umbilical cord, or could wrap itself in its cord – things that can’t always be identified ahead of time.

“Low risk pregnancy can turn high risk in a minute,” said Davis. “These simulations give teams the chance to practice cases that require emergent responses, like when a baby has a prolapsed cord (cord comes out first). Even then there’s no guarantee that we’ll be able to prevent the adverse outcome, but practicing for these situations gives us the best opportunity to respond quickly, efficiently and reliably to whatever emergency is going on and provide the optimum outcome.”

“There needs to be a mindfulness that risk is everywhere and we’re all accountable to notice it,” said Miller. “It’s not if something’s going to happen, but when something does happen can we stop it or mitigate it before harm gets to the patient.”

CONCLUSION

As a result of 11 years of adverse health event reporting in Minnesota, health care providers recognize that improving patient safety is a more akin to a marathon than a sprint. While the reporting system has been successful in helping to make improvements in patient safety and transparency throughout the state, it continues to highlight new areas of learning that can lead to additional work and improvement. This continued work leads to new standards of care and therefore safer care for patients in Minnesota.

Successes have been highlighted throughout this report, but the continued focus is on reducing and eliminating harm to patients in Minnesota, and opportunities for improvement remain. In particular, additional focus is needed around:

- reducing pressure ulcers for critically ill patients and patients with medical devices;
- strengthening the process to localize the correct level for spine procedures and processes in interventional radiology;
- preventing injury related to patient falls;
- understanding the causes of neonatal death and serious injury during labor and delivery after low-risk pregnancies; and
- preventing biological specimen loss/damage in Minnesota hospitals and surgical centers.

As the reporting system moves into its 12th year, hospitals and ASCs continue to learn from the successes and challenges of the first 11 years, as well as from new events, and from sharing of successes and challenge across organizations within the state and across the country. Achieving a significant and lasting reduction in these adverse health events requires on-going commitment by Minnesota health care providers of their resources, time and leadership.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2013 and October 6, 2014. 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 Events

1. Surgery or other invasive procedure 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 or other invasive procedure performed on the wrong patient;
3. The wrong surgical or other invasive 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 invasive 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 or other invasive procedure of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

6. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;
7. Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
8. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

9. A patient of any age, who does not have decision-making capacity, discharged to the wrong person;
10. Patient death or serious injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and
11. Patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

12. Patient death or serious injury associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
13. Patient death or serious injury associated with unsafe administration of blood or blood products;
14. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post- delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
15. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
16. Stage 3, 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
17. Artificial insemination with the wrong donor sperm or wrong egg;
18. Patient death or serious injury associated with a fall while being cared for in a facility;
19. The irretrievable loss of an irreplaceable biological specimen; and
20. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

21. Patient death or serious injury associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
22. 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;
23. Patient death or serious injury associated with a burn incurred from any source while being cared for in a facility;
24. Patient death or serious injury associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Potential Criminal Events

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

Radiologic Events

29. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

TABLE 1: OVERALL STATEWIDE REPORT

Reported Adverse Health Events: **ALL EVENTS** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
Surgical/Invasive Procedure	70 Events	Neither: 70
Products or Devices	2 Events	Serious Injury: 1 Death: 1
Patient Protection	7 Events	Serious Injury: 5 Death: 1 Neither: 1
Care Management	224 Events	Serious Injury: 89 Death: 11 Neither: 124
Environmental	2 Events	Serious Injury: 2
Criminal	3 Events	Serious Injury: 1 Neither: 2
Total for All Events	**308 Events**	**Serious Injury: 98** **Death: 13** **Neither: 197**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
1. Wrong body part	16 Events	Neither: 16
2. Wrong patient	0 Events	—
3. Wrong procedure	21 Events	Neither: 21
4. Foreign object	33 Events	Neither: 33
5. Intra / post-op death	0 Events	—
Total for Surgical/Invasive Procedure	**70 Events**	**Neither: 70**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
6. Contaminated drugs, devices or biologics	0 Events	—
7. Misuse or malfunction of device	1 Event	Serious Injury: 1
8. Intravascular air embolism	1 Event	Death: 1
Total for Products or Devices	**2 Events**	**Serious Injury: 1** **Death: 1**

Details by Category: **PATIENT PROTECTION** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
9. Wrong discharge of a patient of any age	1 Event	Neither: 1
10. Patient disappearance	1 Event	Serious Injury: 1
11. Suicide or attempted suicide	5 Events	Serious Injury: 4 Death: 1
Total for Patient Protection	**7 Events**	**Serious Injury: 5** **Death: 1** **Neither: 1**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
12. Death or serious injury due to medication error	7 Events	Serious Injury: 7
13. Death or serious injury associated with unsafe administration of blood or blood products	0 Events	—
14. Maternal death or serious injury during low-risk pregnancy labor or delivery	0 Events	—
15. Death or serious injury of a neonate associated with labor or delivery during a low-risk pregnancy	6 Events	Serious Injury: 2 Death: 4
16. Stage 3, 4 or unstageable pressure ulcers acquired after admission	107 Events	Serious Injury: 3 Neither: 104
17. Artificial insemination with wrong donor egg or sperm	0 Events	—
18. Patient death or serious injury associated with a fall while being cared for in a facility;	79 Events	Serious Injury: 73 Death: 6
19. The irretrievable loss of an irreplaceable biological specimen; and	20 Events	Neither: 20
20. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results	5 Events	Serious Injury: 4 Death: 1
Total for Care Management	**224 Events**	**Serious Injury: 89** **Death: 11** **Neither: 124**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **ENVIRONMENTAL** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
21. Death or serious injury associated with an electric shock	0 Events	—
22. Wrong gas or contamination of patient gas line	0 Events	—
23. Death or serious injury associated with a burn	1 Event	Serious Injury: 1
24. Death or serious injury associated with restraints	1 Event	Serious Injury: 1
Total for Environmental	**2 Events**	**Serious Injury: 2**

Details by Category: **POTENTIAL CRIMINAL EVENTS** (October 7, 2013 – October 6, 2014)

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 patient	2 Events	Neither: 2
28. Death or serious injury of patient or staff from physical assault	1 Event	Serious Injury: 1
Total for Criminal Events	**3 Events**	**Serious Injury: 1** **Neither: 2**

Details by Category: **RADIOLOGIC EVENTS** (October 7, 2013 – October 6, 2014)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
29. Death or serious injury associated with the introduction of a metallic object into the MRI area	0 Events	—
Total for Radiologic Events	**0 Events**	**—**

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:
13,7065

NUMBER OF PATIENT DAYS:
25,1688

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**4**	Deaths: 0;	Serious Injury: 0;	Neither: 4
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
PRODUCTS OR DEVICES — Death or Serious Injury associated with:				
An intravascular air embolism	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 1;**	**Serious Injury: 2;**	**Neither: 8**

* 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

Allina Health – Regina Hospital

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:
13,453

NUMBER OF PATIENT DAYS:
21,936

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**4**	Deaths: 0;	Serious Injury: 4;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0;**	**Serious Injury: 4;**	**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 3.3

Appleton Area Health Services

ADDRESS:
30 S. Behl St.
Appleton, MN 56208-1616

WEBSITE:
www.appletonareahealth.org

PHONE NUMBER:
320-289-8508

NUMBER OF BEDS:
15

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
697

NUMBER OF PATIENT DAYS:
2,305

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1;**	**Serious Injury: 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 3.4

Avera Marshall Regional Medical Center

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

WEBSITE:
www.averamarshall.org

PHONE NUMBER:
605-668-8585

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,991

NUMBER OF PATIENT DAYS:
16,071

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.5

Bethesda Hospital

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

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-326-3590

NUMBER OF BEDS:
254

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
0

NUMBER OF PATIENT DAYS:
36,673

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**6**	Deaths: 0;	Serious Injury: 2;	Neither: 4
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 0;**	**Serious Injury: 3;**	**Neither: 4**

* 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

Buffalo Hospital

ADDRESS:
303 Catlin St.
Buffalo, MN 55313-4507

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,645

NUMBER OF PATIENT DAYS:
19,320

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.7

Cambridge Medical Center

ADDRESS:
701 Dellwood St. S.
Cambridge, MN 55008-1920

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
86

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
18,874

NUMBER OF PATIENT DAYS:
36,022

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1;**	**Serious Injury: 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 3.8

CentraCare Health – Sauk Centre

ADDRESS:
425 Elm St. N.
Sauk Centre, MN 56378-1010

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-352-2221

NUMBER OF BEDS:
28

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,955

NUMBER OF PATIENT DAYS:
5,400

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.9

CHI LakeWood Health

ADDRESS:
600 Main Ave. S.
Baudette, MN 56623-2855

WEBSITE:
www.lakewoodhealthcenter.org/

PHONE NUMBER:
218-634-3401

NUMBER OF BEDS:
15

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
132

NUMBER OF PATIENT DAYS:
2,755

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.10

CHI St. Gabriel's Health

ADDRESS:
815 Second St. S.E.
Little Falls, MN 56345-3596

WEBSITE:
www.stgabriels.com

PHONE NUMBER:
320-631-5603

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,901

NUMBER OF PATIENT DAYS:
15,944

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.11

CHI St. Joseph's Health

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:
7,284

NUMBER OF PATIENT DAYS:
13,001

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.12

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:
279

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
25,033

NUMBER OF PATIENT DAYS:
142,415

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**7**	Deaths: 0;	Serious Injury: 0;	Neither: 7
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 0;**	**Serious Injury: 0;**	**Neither: 7**

* 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

Community Behavioral Health Hospital – Baxter

ADDRESS:
14241 Grand Oaks Drive
Baxter, MN 56425-8749

WEBSITE:
www.mn.gov/dhs

PHONE NUMBER:
651-431-2729

NUMBER OF BEDS:
16

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:

NUMBER OF PATIENT DAYS:

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in Serious Injury	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.14

Community Memorial Hospital

ADDRESS:
512 Skyline Boulevard
Cloquet, MN 55720-1199

WEBSITE:
www.cloquethospital.com

PHONE NUMBER:
218-878-7605

NUMBER OF BEDS:
36

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,609

NUMBER OF PATIENT DAYS:
13,456

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Injury: 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 3.15

Cuyuna Regional Medical Center

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

WEBSITE:
www.cuyunamed.org

PHONE NUMBER:
218-545-4447

NUMBER OF BEDS:
42

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
18,452

NUMBER OF PATIENT DAYS:
19,270

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Injury: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Injury: 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 3.16

District One Hospital

ADDRESS:
200 State Ave.
Faribault, MN 55021-6345

WEBSITE:
www.districtonehospital.com

PHONE NUMBER:
507-332-4854

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,885

NUMBER OF PATIENT DAYS:
18,439

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Injury: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Injury: 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 3.17

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:
28,397

NUMBER OF PATIENT DAYS:
34,532

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.18

Essentia Health – Deer River

ADDRESS:
115 10th Ave NE
Deer River, MN 56636-8795

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2315

NUMBER OF BEDS:
20

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,200

NUMBER OF PATIENT DAYS:
5,818

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.19

Essentia Health – Duluth

ADDRESS:
502 E. Second St.
Duluth, MN 55805-1913

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2315

NUMBER OF BEDS:
165

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
16,677

NUMBER OF PATIENT DAYS:
97,387

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A medication error	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0;**	**Serious Injury: 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 3.20

Essentia Health – St. Joseph's Medical Center

ADDRESS:
523 N. Third St.
Brainerd, MN 56401-3054

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-828-7564

NUMBER OF BEDS:
162

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
27,492

NUMBER OF PATIENT DAYS:
61,392

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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

Essentia Health – St. Mary's Medical Center

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2315

NUMBER OF BEDS:
380

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
65,490

NUMBER OF PATIENT DAYS:
111,526

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
The irretrievable loss of an irreplaceable biological specimen	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
A fall while being cared for in a facility	**6**	Deaths: 1;	Serious Injury: 5;	Neither: 0
ENVIRONMENTAL EVENTS — Death or Serious Injury associated with:				
Use of or lack of restraints or bedrails while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 1;**	**Serious Injury: 6;**	**Neither: 4**

* 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

Essentia Health – Virginia

ADDRESS:
901 9th St. N.
Virginia, MN 55792-2348

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-2315

NUMBER OF BEDS:
83

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,720

NUMBER OF PATIENT DAYS:
24,117

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1;**	**Serious Injury: 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 3.23

Fairview Lakes Health Services

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

WEBSITE:
www.fairview.org/hospitals/lakes

PHONE NUMBER:
763-389-6451

NUMBER OF BEDS:
61

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
24,848

NUMBER OF PATIENT DAYS:
26,593

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0; Serious Injury: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Injury: 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 3.24

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:
58,937

NUMBER OF PATIENT DAYS:
69,811

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.25

Fairview Southdale Hospital

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

WEBSITE:
www.southdale.fairview.org

PHONE NUMBER:
612-672-6422

NUMBER OF BEDS:
390

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
84,735

NUMBER OF PATIENT DAYS:
116,884

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
ENVIRONMENTAL EVENTS — Death or Serious Injury associated with:				
A burn received while being care for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Injury: 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 3.26

Gillette Children's Specialty Healthcare

ADDRESS:
200 East University Avenue
St. Paul, MN 55101-2507

WEBSITE:
www.gillettechildrens.org

PHONE NUMBER:
651-229-1753

NUMBER OF BEDS:
60

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
9,696

NUMBER OF PATIENT DAYS:
23,473

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**5**	Deaths: 0;	Serious Injury: 1;	Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Injury: 1;**	**Neither: 4**

* 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

Grand Itasca Clinic and Hospital

ADDRESS:
1601 Golf Course Road
Grand Rapids, MN 55744-8648

WEBSITE:
www.granditasca.org

PHONE NUMBER:
218-999-1444

NUMBER OF BEDS:
64

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,902

NUMBER OF PATIENT DAYS:
23,473

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.28

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:
113,326

NUMBER OF PATIENT DAYS:
210,036

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**11**	Deaths: 0;	Serious Injury: 0;	Neither: 11
A medication error	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
CRIMINAL EVENTS				
Sexual assault of a patient	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in Serious Injury	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**19**	**Deaths: 0;**	**Serious Injury: 4;**	**Neither: 15**

* 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

High Pointe Surgery Center

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

WEBSITE:
www.hpsurgery.com

PHONE NUMBER:
651-702-7431

NUMBER OF BEDS:

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
5,979

NUMBER OF PATIENT DAYS:

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.30

Hutchinson Health

ADDRESS:
1095 Highway 15 S.
Hutchinson, MN 55350-5000

WEBSITE:
www.hutchhealth.com

PHONE NUMBER:
320-484-4519

NUMBER OF BEDS:
66

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
12,947

NUMBER OF PATIENT DAYS:
28,132

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.31

Lake Region Healthcare

ADDRESS:
712 South Cascade St.
Fergus Falls, MN 56537-0728

WEBSITE:
www.lrhc.org

PHONE NUMBER:
218-736-8193

NUMBER OF BEDS:
108

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,065

NUMBER OF PATIENT DAYS:
38,511

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.32

Lakewood Health System

ADDRESS:
49725 County 83
Staples, MN 56479-5280

WEBSITE:
www.lakewoodhealthsystem.com

PHONE NUMBER:
218-894-8429

NUMBER OF BEDS:
37

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,656

NUMBER OF PATIENT DAYS:
22,959

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:		
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0; Serious Injury: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Injury: 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 3.33

Maple Grove Hospital

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

WEBSITE:
www.maplegrovehospital.org

PHONE NUMBER:
763-581-1563

NUMBER OF BEDS:
130

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
36,782

NUMBER OF PATIENT DAYS:
34,880

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 1;**	**Serious Injury: 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 3.34

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

ADDRESS:
1000 First Drive N.W.
Austin, MN 55912-2941

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-377-6452

NUMBER OF BEDS:
82

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
12,829

NUMBER OF PATIENT DAYS:
41,244

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in Serious Injury	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1;**	**Serious Injury: 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 3.35

Mayo Clinic Health System in Mankato

ADDRESS:
1025 Marsh Street
Mankato, MN 56001-4752

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-385-2938

NUMBER OF BEDS:
272

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
18,922

NUMBER OF PATIENT DAYS:
65,661

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Injury: 3;	Neither: 0
PRODUCTS OR DEVICES — Death or Serious Injury associated with:				
The use or malfunction of a device in patient care	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 0;**	**Serious Injury: 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 3.36

Mayo Clinic Health System in Red Wing

ADDRESS:
701 Hewitt Blvd.
Red Wing, MN 55066-0095

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
651-267-5050

NUMBER OF BEDS:
50

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
11,801

NUMBER OF PATIENT DAYS:
23,508

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.37

Mayo Clinic Health System in St. James

ADDRESS:
1101 Moulton and Parsons Drive
Saint James, MN 56081-0460

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-304-7178

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,702

NUMBER OF PATIENT DAYS:
3,937

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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

Mayo Clinic Rochester

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

WEBSITE:
www.mayoclinic.org/event-reporting

PHONE NUMBER:
507-284-5005

NUMBER OF BEDS:
2,059

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
307,549

NUMBER OF PATIENT DAYS:
438,705

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**6**	Deaths: 0;	Serious Injury: 0;	Neither: 6
Surgery/other invasive procedure performed on wrong body part	**4**	Deaths: 0;	Serious Injury: 0;	Neither: 4
Wrong surgical/invasive procedure performed	**4**	Deaths: 0;	Serious Injury: 0;	Neither: 4
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**17**	Deaths: 0;	Serious Injury: 0;	Neither: 17
A medication error	**3**	Deaths: 0;	Serious Injury: 3;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
A fall while being cared for in a facility	**8**	Deaths: 1;	Serious Injury: 7;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**44**	**Deaths: 1;**	**Serious Injury: 10;**	**Neither: 33**

* 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

McCannel Eye Surgery LLC

ADDRESS:
3124 W. 70th St.
Edina, MN 55435-4227

WEBSITE:
www.mccanneleye.com

PHONE NUMBER:
952-848-8338

NUMBER OF BEDS:

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,312

NUMBER OF PATIENT DAYS:

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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

Meeker Memorial Hospital

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

WEBSITE:
www.meekermemorial.org

PHONE NUMBER:
320-693-4573

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,312

NUMBER OF PATIENT DAYS:
7,262

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.41

Mercy Hospital

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:
77,469

NUMBER OF PATIENT DAYS:
117,212

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**6**	Deaths: 1;	Serious Injury: 5;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1;**	**Serious Injury: 5;**	**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

Minnesota Eye Laser & Surgery Center, LLC – Bloomington

ADDRESS:
9801 Dupont Ave. S., Ste. 100
Bloomington, MN 55431-3200

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,287

WEBSITE:
www.mneye.com

PHONE NUMBER:
952-567-5800

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.43

Minnesota Eye Laser & Surgery Center, LLC – Maplewood

ADDRESS:
9801 Dupont Ave. S., Ste. 100
Minneapolis, MN 55431-3200

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,338

WEBSITE:
www.mneye.com

PHONE NUMBER:
952-567-5800

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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

New Ulm Medical Center

ADDRESS:
1324 Fifth St. N.
New Ulm, MN 56073-1514

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
62

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
16,392

NUMBER OF PATIENT DAYS:
32,611

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in Serious Injury	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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

North Memorial Medical Center

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

WEBSITE:
www.northmemorial.com

PHONE NUMBER:
763-581-2402

NUMBER OF BEDS:
518

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
73,149

NUMBER OF PATIENT DAYS:
133,660

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**7**	Deaths: 0;	Serious Injury: 0;	Neither: 7
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0;**	**Serious Injury: 2;**	**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 3.46

Northfield Hospital

ADDRESS:
2000 North Ave.
Northfield, MN 55057-1498

WEBSITE:
www.northfieldhospital.org

PHONE NUMBER:
507-646-1034

NUMBER OF BEDS:
37

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
10,674

NUMBER OF PATIENT DAYS:
14,419

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.47

Olmsted Medical Center

ADDRESS:
210 Ninth St. S.E.
Rochester, MN 55901-6425

WEBSITE:
www.olmmed.org

PHONE NUMBER:
507-529-6795

NUMBER OF BEDS:
61

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
15,711

NUMBER OF PATIENT DAYS:
29,668

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.	**2**	Deaths: 1;	Serious Injury: 1;	Neither: 0
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 1;**	**Serious Injury: 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 3.48

Orthopaedic Institute Surgery Center

ADDRESS:
8100 W. 78th St., Ste. 220
Edina, MN 55439-2568

WEBSITE:
www.oiscmn.com

PHONE NUMBER:
952-914-8418

NUMBER OF BEDS:

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,239

NUMBER OF PATIENT DAYS:

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.49

Park Nicollet Methodist Hospital

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

WEBSITE:
www.parknicollet.com

PHONE NUMBER:
952-993-7188

NUMBER OF BEDS:
426

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
109,647

NUMBER OF PATIENT DAYS:
145,470

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1;**	**Serious Injury: 1;**	**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 3.50

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:
22,730

NUMBER OF PATIENT DAYS:
49,872

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CRIMINAL EVENTS				
Sexual assault of a patient	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.51

Regency Hospital of Minneapolis

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

WEBSITE:
www.regencyhospital.com

PHONE NUMBER:
763-302-8315

NUMBER OF BEDS:
92

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:

NUMBER OF PATIENT DAYS:
19,400

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.52

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:
133,408

NUMBER OF PATIENT DAYS:
199,395

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**14**	Deaths: 0;	Serious Injury: 0;	Neither: 14
The irretrievable loss of an irreplaceable biological specimen	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in Serious Injury	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
Wrong discharge of a patient of any age	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
Patient death or Serious Injury associated with patient disappearance	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**22**	**Deaths: 0;**	**Serious Injury: 4;**	**Neither: 18**

* 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

Ridgeview Medical Center

ADDRESS:
500 South Maple Street
Waconia, MN 55387-1752

WEBSITE:
www.ridgeviewmedical.org

PHONE NUMBER:
952-442-2191 ext. 6102

NUMBER OF BEDS:
109

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
39,390

NUMBER OF PATIENT DAYS:
75,155

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 2
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.54

RiverView Health

ADDRESS:
323 S. Minnesota St.
Crookston, MN 56716-1601

WEBSITE:
www.riverviewhealth.org

PHONE NUMBER:
218-281-9440

NUMBER OF BEDS:
49

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,791

NUMBER OF PATIENT DAYS:
9,288

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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

Sanford Bemidji Medical Center

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

WEBSITE:
www.sanfordhealth.org/bemidji

PHONE NUMBER:
218-333-6422

NUMBER OF BEDS:
118

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
28,559

NUMBER OF PATIENT DAYS:
42,138

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.56

Sanford Canby Medical Center

ADDRESS:
112 St. Olaf Ave. S.
Canby, MN 56220-1433

WEBSITE:
www.sanfordcanby.org

PHONE NUMBER:
507-223-7277

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,594

NUMBER OF PATIENT DAYS:
2,969

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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

Sanford Thief River Falls Medical Center

ADDRESS:
120 LaBree Ave. S.
Thief River Falls, MN 56701-2840

WEBSITE:
www.sanfordhealth.org

PHONE NUMBER:
218-683-4420

NUMBER OF BEDS:
99

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
6,500

NUMBER OF PATIENT DAYS:
28,527

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0;**	**Serious Injury: 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 3.58

Sanford Worthington Medical Center

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:
8,620

NUMBER OF PATIENT DAYS:
13,235

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.59

Sleepy Eye Medical Center

ADDRESS:
400 Fourth Ave. N.W.
Sleepy Eye, MN 56085-0323

WEBSITE:
www.semedicalcenter.org

PHONE NUMBER:
507-794-8440

NUMBER OF BEDS:
16

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,445

NUMBER OF PATIENT DAYS:
3,688

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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

St. Cloud Hospital

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

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-229-4983

NUMBER OF BEDS:
489

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
96,791

NUMBER OF PATIENT DAYS:
190,027

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**5**	Deaths: 0;	Serious Injury: 0;	Neither: 5
Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**5**	Deaths: 1;	Serious Injury: 4;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**15**	**Deaths: 1;**	**Serious Injury: 5;**	**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

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:
26,540

NUMBER OF PATIENT DAYS:
33,768

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A medication error	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
The irretrievable loss of an irreplaceable biological specimen	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0;**	**Serious Injury: 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 3.62

St. John's Hospital

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

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-326-3590

NUMBER OF BEDS:
184

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
66,796

NUMBER OF PATIENT DAYS:
79,469

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.63

St. Joseph's Hospital

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

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-326-3590

NUMBER OF BEDS:
401

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
33,327

NUMBER OF PATIENT DAYS:
89,109

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.64

St. Luke's Hospital

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

WEBSITE:
www.slhduluth.com

PHONE NUMBER:
218-249-5389

NUMBER OF BEDS:
267

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
51,385

NUMBER OF PATIENT DAYS:
90,321

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.65

Tyler Healthcare Center/Avera

ADDRESS:
240 Willow St.
Tyler, MN 56178-1166

WEBSITE:
www.tylerhealthcare.org

PHONE NUMBER:
507-247-5521

NUMBER OF BEDS:
20

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,473

NUMBER OF PATIENT DAYS:
1,559

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.66

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:
89,284

NUMBER OF PATIENT DAYS:
151,925

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**3**	Deaths: 0;	Serious Injury: 0;	Neither: 3
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A medication error	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**8**	**Deaths: 0;**	**Serious Injury: 3;**	**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 3.67

Unity Hospital

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
275

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
37,599

NUMBER OF PATIENT DAYS:
75,723

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Injury: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Injury: 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 3.68

University of Minnesota Medical Center

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

WEBSITE:
www.fairview.org

PHONE NUMBER:
651-643-0228

NUMBER OF BEDS:
1,700

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
193,901

NUMBER OF PATIENT DAYS:
343,276

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**8**	Deaths: 0;	Serious Injury: 0;	Neither: 8
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury)	**15**	Deaths: 0;	Serious Injury: 0;	Neither: 15
The irretrievable loss of an irreplaceable biological specimen	**2**	Deaths: 0;	Serious Injury: 0;	Neither: 2
A fall while being cared for in a facility	**4**	Deaths: 0;	Serious Injury: 4;	Neither: 0
CRIMINAL EVENTS				
Death or significant injury of patient or staff from physical assault	**1**	Deaths: 0;	Serious Injury: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**31**	**Deaths: 0;**	**Serious Injury: 5;**	**Neither: 26**

* 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 3.69

Willmar Surgery Center

ADDRESS:
1320 1st St. S.
Willmar, MN 56201-0773

WEBSITE:
www.acmc.com/wsc/

PHONE NUMBER:
320-441-6004

NUMBER OF BEDS:

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,981

NUMBER OF PATIENT DAYS:

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

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 Injury: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Injury: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Injury: 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 3.70

Woodwinds Health Campus

ADDRESS:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-326-3590

NUMBER OF BEDS:
86

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
31,181

NUMBER OF PATIENT DAYS:
38,331

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 29 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2013 – OCTOBER 6, 2014)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS — Death or Serious Injury associated with:				
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy	**1**	Deaths: 1;	Serious Injury: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1;**	**Serious Injury: 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.

APPENDIX A:
REPORTABLE EVENTS AS DEFINED IN THE LAW

Below is a list of the events that hospitals and licensed ambulatory surgical centers are required to report to the Minnesota Department of Health.

The language is taken directly from Minnesota statutes 144.7065.

Surgical Events[1]

1. Surgery or other invasive procedure 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 or other invasive procedure performed on the wrong patient;
3. The wrong surgical or other invasive 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 invasive 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 or other invasive procedure 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 injury 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 injury 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 injury 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. A patient of any age, who does not have decision-making capacity, discharged to the wrong person;
2. Patient death or serious injury associated with patient disappearance, excluding events involving adults who have decision-making capacity; and
3. Patient suicide, attempted suicide resulting in serious injury, or self-harm resulting in serious injury or death 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 injury 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 injury associated with unsafe administration of blood or blood products
3. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post- delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
4. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
5. Stage 3, 4 or unstageable ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
6. Artificial insemination with the wrong donor sperm or wrong egg;
7. Patient death or serious injury associated with a fall while being cared for in a facility;
8. The irretrievable loss of an irreplaceable biological specimen; and
9. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results.

Environmental Events

1. Patient death or serious injury 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 injury associated with a burn incurred from any source while being cared for in a facility;
4. Patient death or serious injury associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Potential Criminal Events

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

Radiologic Events

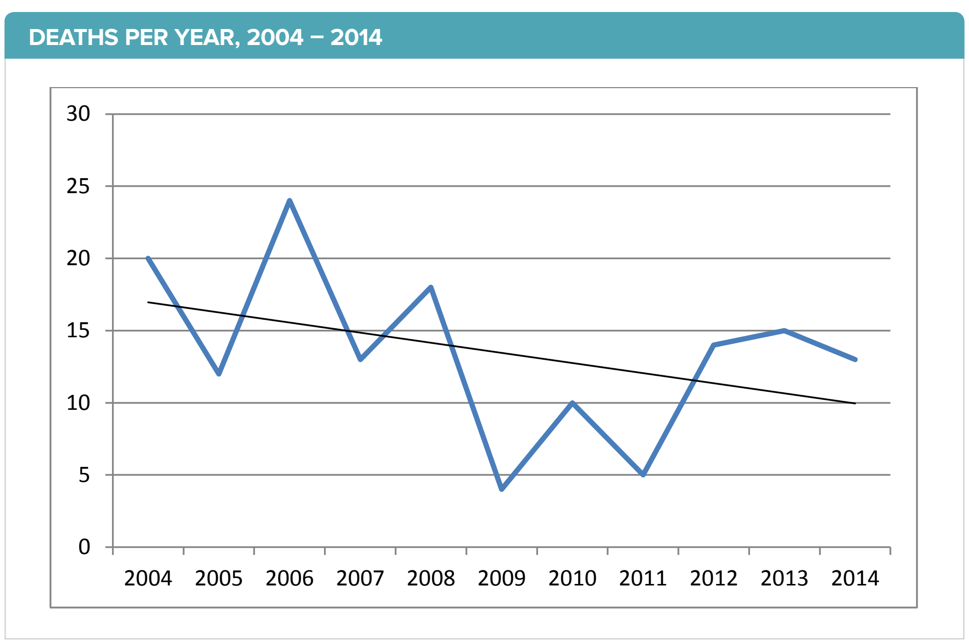
1. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

For more information about Minnesota's Adverse Health Events Reporting Law, or to view annual reports or facility-specific data, go to www.health.state.mn.us/patientsafety.

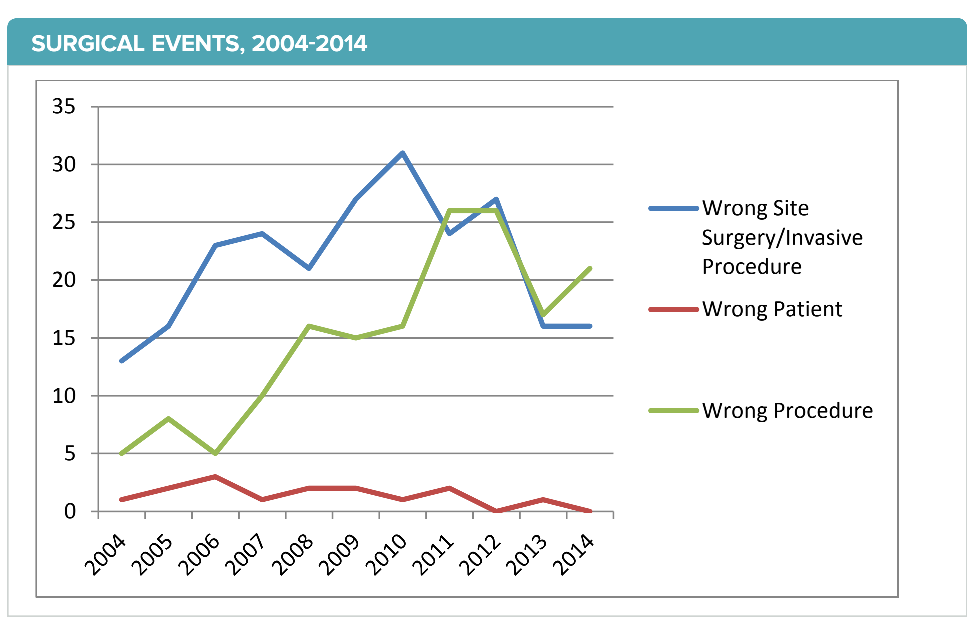
APPENDIX B:
ADVERSE EVENTS DATA, 2004-2014

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 2,596 events have been reported to MDH.

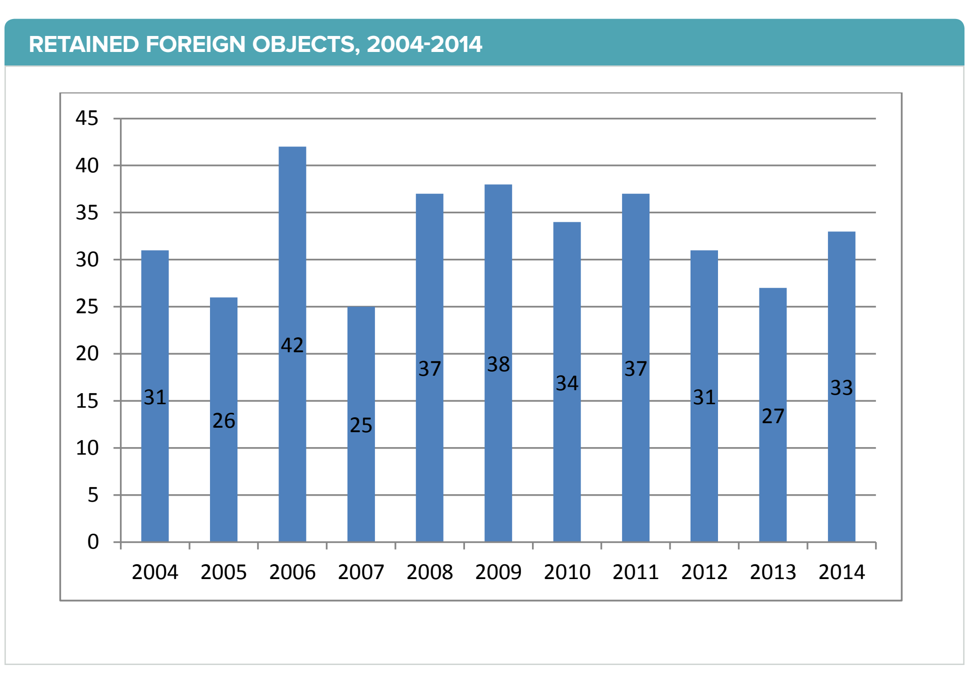
DEATHS PER YEAR, 2004 – 2014



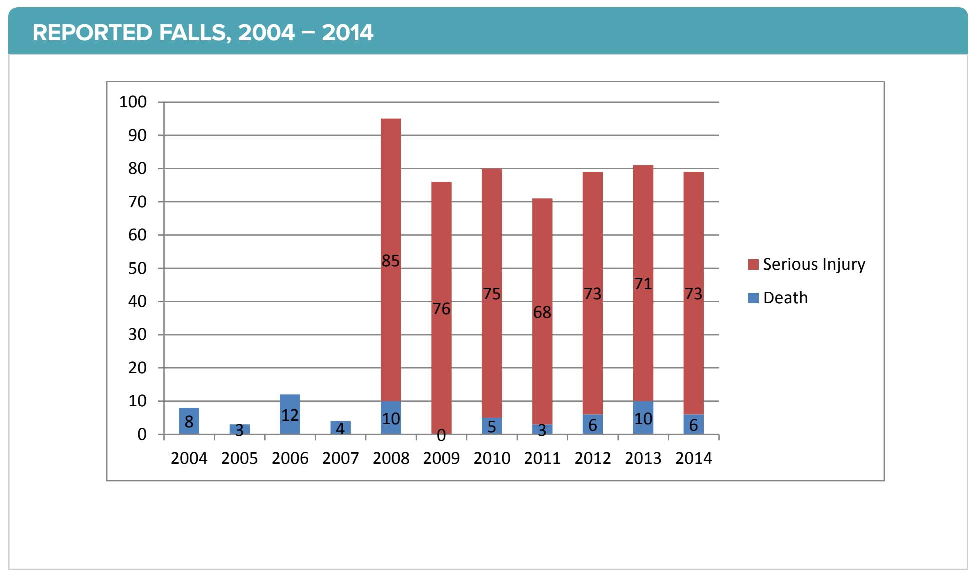
SURGICAL EVENTS, 2004-2014



RETAINED FOREIGN OBJECTS, 2004-2014

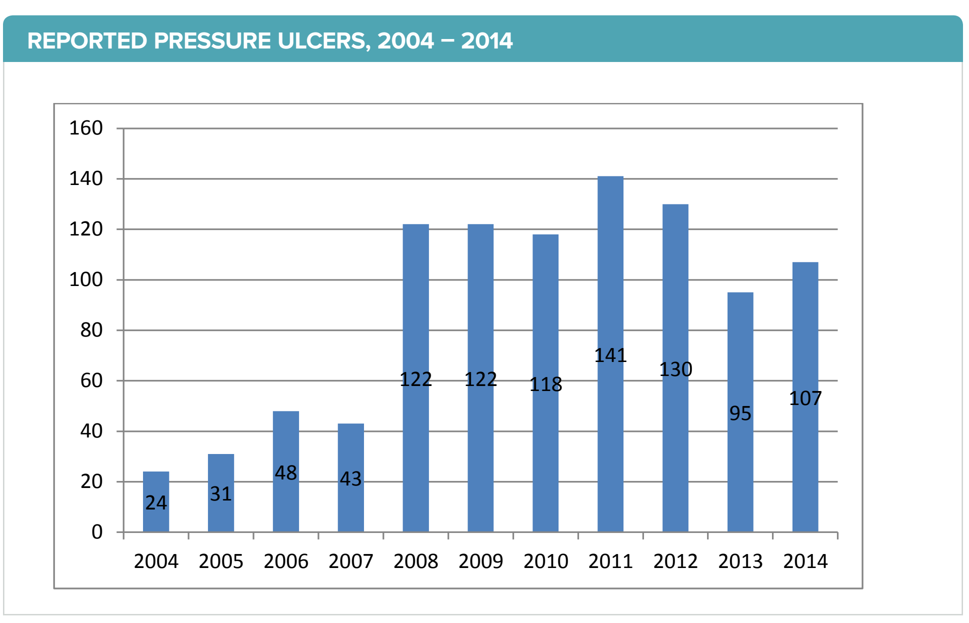


REPORTED FALLS, 2004 – 2014



**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 injury as well.*

REPORTED PRESSURE ULCERS, 2004 – 2014



**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.

In 2012, the Adverse Health Care Events Reporting Law was modified to expand the definitions of several events, re-categorize several events, delete two events and add four additional events. The four new events were:

1. The irretrievable loss of an irreplaceable biological specimen;
2. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results;
3. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;
4. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

At the same time the "serious disability" language was changed to "serious injury." The reporting of these new events began on October 7, 2013.

11TH ANNUAL PUBLIC REPORT

ADVERSE HEALTH EVENTS IN MINNESOTA

FEBRUARY 2015