# ADVERSE HEALTH EVENTS IN MINNESOTA



**12TH ANNUAL PUBLIC REPORT**

FEBRUARY 2016

MDH Minnesota Department *of* Health

# ADVERSE HEALTH EVENTS IN MINNESOTA

# CONTENTS



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 2016

The release of this report marks 12 years since Minnesota established a statewide public reporting system for adverse health events (AHE) (Appendix A). This law requires all hospitals, and ambulatory surgical centers, to report whenever an AHE occurs and to conduct a root cause analysis to identify the root causes of the event. Minnesota's law remains a nation-leading example of transparency around events that can lead to patient harm.

There were 316 adverse health events reported to the Minnesota Department of Health (MDH) in the October 2014 to October 2015 reporting period. As in past years, this report shows evidence of both positive trends and areas of continued challenge. In particular, while medication errors and wrong site surgery/procedures continue to be areas that challenge providers, there are several key areas showing sustained improvement:

- The number of falls declined to 67 and the number of fall-related deaths reached the lowest point since 2011;
- Retained foreign objects declined to 22, the lowest point in 12 years of reporting.

Identifying and implementing best practices for prevention is the most important aspect of the data reporting system in Minnesota and one that will lead to fewer adverse health events. As a result of key learnings from adverse health events, MDH, the Minnesota Hospital Association (MHA) and other health care stakeholders implemented a number of actions in 2015:

- MDH and MHA issued a safety alert to all MN hospitals urging them to review the process for discharge to ensure patients are not discharged from the emergency department without review of test results or a plan for follow-up on pending results;
- To address the continued need for strategies to prevent pressure ulcers, the 'SKIN 3.0' bundle, which includes best practice recommendations for the operating room, prevention of medical device-related pressure ulcers and patients in critical care, was rolled out statewide;
- MDH/MHA convened an expert group of hospitals and surgery centers to develop best practice recommendations and a gap analysis for the biological specimen and test results communication events;
- MDH/MHA convened an expert group of reporting facilities to identify underlying factors and key learnings to prevent neonatal death or serious injury; and
- The 'Violence Prevention in Healthcare Workgroup' continued to develop best practices and tools to add to the gap analysis developed in 2014, and to develop training for hospital staff. Also of note, the Minnesota legislature passed a bill requiring all hospitals in Minnesota to complete the gap analysis, provide training to staff and collect data internally on incidents of violence.

In 2016, MDH and its partners will continue their work to improve patient safety in Minnesota, including, but not limited to:

- Addressing perinatal safety, a highly complex issue;
- Working with surgery and procedural teams to address full and accurate completion of the Minnesota Time Out process for every patient every time; and,
- Implementing standardized processes for specimen collection and transport in order to prevent biological specimen loss/damage.

Minnesota's adverse health events law remains an innovative, nation-leading effort to learn from and prevent serious events that can harm patients. No other state provides the level of transparency that Minnesota does when it comes to patient safety. The partnerships and resources that have been developed over this time have built a strong foundation for continued improvement and learning.

This nation-leading program has now been in place for more than a decade and there may be new opportunities to evolve or enhance it to ensure that we continue to learn as much as possible about these events and can effectively prevent them. In recognition of the program's maturity and evolving needs, MDH has begun a systematic process of working with its partners and health care providers to assess whether any changes to the program may be necessary. That work will be a high priority throughout 2016.

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

# HOW TO USE THIS REPORT

This report is one of many sources of information now available on health care quality and patient safety in Minnesota. It is designed to help patients identify safety issues to discuss with their care providers, to help providers understand the root causes of adverse events, 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.

**Minnesota Hospital Association**
*www.mnhospitals.org/patientsafety*
The Minnesota Hospital Association leads hospitals in patient safety improvement efforts with best practices and road maps.

**Hospital Compare**
*http://www.medicare.gov/hospitalcompare/search.html?AspxAutoDetectCookieSupport=1*
A consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. This information can help consumers make informed decisions about health care.

**Minnesota Alliance for Patient Safety**
*www.mnpatientsafety.org*
MAPS is a broad-based collaborative that works to improve patient safety in MN. MAPS strategic priorities are: Convening and helping align the patient safety community around shared language and goals, bridging the gap between and across care silos with respect to transitions of care and strengthening relationships between patient s and their care teams to foster patient safety.

**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 is effectively meeting those standards.

**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.

# 2015 SUCCESSES AND CHALLENGES: HOSPITAL AND SURGERY CENTER PERSPECTIVES

In December 2015, 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 40 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 2014-15 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/MHA Safety Alerts, MDH 'Prevention of Violence in Healthcare' collaborative and the annual MDH Case Study Survey.

Facilities were asked to describe the biggest improvements in patient safety within their organizations over the past year. A number of respondents described improvement in falls prevention as well as prevention of injury from falls. Another area of improvement that many facilities noted was in preventing pressure ulcers at their facilities, as well as improving the specimen labeling and handling process.

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 lack of internal resources to implement safety practices; increases in mental health patients, a population with complex safety issues; difficulty with attaining proper medication reconciliation and adding a new area of focus to existing efforts, violence prevention.

**FIGURE 1:**
Facility Perspectives, 2015

| RESOURCE OR TOOL | VERY USEFUL | SOMEWHAT USEFUL | NEUTRAL | NOT USEFUL |
|---|---|---|---|---|
| MDH/MHA Safety Alerts | 60% | 38% | 2% | 0% |
| MDH Statewide "Prevention of Violence in Healthcare" Collaborative | 57% | 39% | 4% | 0% |
| MDH Case Study Survey (April 2015) | 51% | 27% | 17% | 5% |
| MDH Online RCA toolkit | 37% | 34% | 21% | 8% |
| Stratis Health Measurement Guide for Adverse Events | 34% | 32% | 26% | 8% |
| MDH Statewide Conference Calls | 25% | 47% | 20% | 8% |
| MDH Online RCA Training Videos | 27% | 29% | 38% | 6% |

*Note–percentages only include respondents that noted using a particular tool or resource.

Next, respondents were asked to describe the most valuable part of the AHE program. Similar to past years, respondents most frequently noted: information to increase awareness of patient safety in their organization, available resources through the program, the opportunity to learn from others and having standardized practices statewide.

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.

Organizations that responded to the survey were also asked how MDH, MHA and Stratis Health could best support them in their efforts. Looking ahead, respondents suggested:

- Continued work on violence prevention in health care;
- Continue to spread learnings from events that are occurring; and,
- Continue to support all facilities, but provide specialized tools and resources for preventing AHE in smaller organizations.

MDH and its partners will move forward in 2016 with addressing the recommendations identified in this survey.

# HIGHLIGHTS OF 2015 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 this work, MDH works closely with a variety of stakeholders including MHA, Stratis Health and the Minnesota Alliance for Patient Safety (MAPS). Highlights of the 2015 activities are listed below.

## Strengthening the reporting system

- Staff from MDH and its partner organizations held a retreat in September in order to gather preliminary ideas for ways that the system can evolve to continue to improve patient safety at the hospital or surgical center level. MDH will continue to gather input on these ideas in 2016, as we consider ways to strengthen the system to meet current needs;
- MDH/MHA convened an expert group of reporting facilities to develop best practice recommendations and a gap analysis for the biological specimen category and test results communication category. These are currently being reviewed by physicians and other providers to prepare for full roll-out in early 2016. These efforts will 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 registry sharing features to learn from one another. Throughout 2015, MHA made additional modifications to the secure, web-based registry used to report events. The number of hospitals participating in the data sharing database increased from 60 percent to 86 percent of organizations in 2015;
- MDH/MHA convened an expert group to identify underlying factors and key learnings to prevent neonatal death or serious injury; and,
- In April, for the sixth 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.

## Education/Resource Development

- During the summer of 2015, MDH hosted a series of webinars for hospitals in Minnesota on the new Violence against Health Care Workers law, to ensure that facilities can meet the expectations of the law and are positioned to prevent and prepare for violence. These webinars were attended by over 100 facilities, and there will be additional educational opportunities throughout 2016;
- In 2015, 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;
- In July 2015, MDH and MHA issued a safety alert to all MN hospitals urging them to review the process for discharge to ensure patients are not discharged from the emergency department without review of test results or a plan for follow-up on pending results;
- Representatives from more than 40 hospitals, surgical centers and nursing homes participated in Root Cause Analysis (RCA) training session in summer 2015. This training is an important way of supporting facilities as they work to conduct robust root cause analyses and take the learnings from those analyses and put interventions in place to prevent similar events from occurring;
- Hospitals and surgical centers have been working to implement the best practices for prevention of pressure ulcers, outlined in the SAFE SKIN roadmap since 2007. There was an update to the roadmap in 2011, and in 2015 the newest version, SKIN 3.0 bundle, which includes best practice recommendations for the operating room, prevention of medical device-related pressure ulcers and patients in critical care, was rolled out statewide.
- On a continuing quest to prevent falls and falls with injury, the 'FALLS 3.0' roadmap was rolled-out in 2015. The roadmap included Falls screening and assessment of fall and injury risk factors; Anti-coagulants (increased injury risk for patients taking anti-coagulants); Linking interventions to specific risk factors; Learning from events (post-fall huddles); Safe environment (rounding; equipment such as video monitoring and alarms; room design);

- MHA convened experts to develop a gap analysis and standardized processes for falls prevention for mental health patients, which will be incorporated into an updated mental health falls gap analysis in 2016;
- To move to the next level of prevention related to procedural safety, MHA, in partnership with MDH, developed a 'Road Map for Safe Procedures: Procedural Safety across the Board.' This combines the new patient safety practices related to specimen management 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;
- MDH and its partners collaborated with Suicide Awareness Voices of Education (SAVE) to put out new environmental safety recommendations for suicide prevention in health care facilities; and,
- In partnership with MDH, MHA updated the perinatal safety roadmap and tool kit to include hypertension/pre-eclampsia and maternal hemorrhage. Statewide update training was provided in mid-2015.

## Collaborations

- MDH and the Minnesota Department of Labor and Industry/MN Occupational Safety and Health Administration (MN OSHA) partnered to develop an online training module on violence prevention and verbal de-escalation that is available for all health care facilities as of January 2016.
- MDH began collaborating with the Veteran's Health Administration to share best practices around violence prevention and assist with development of resources for the state of Minnesota.

# OVERVIEW OF REPORTED EVENTS & FINDINGS

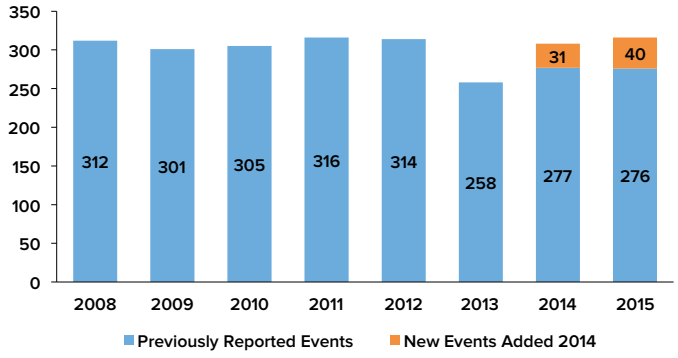
In the 12 years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on more than 2,900 events. This annual report provides an overview of what the most recent year of data can teach us about the risk points for adverse health events and the best approaches for preventing them, with a highlight on the most common types of reportable events.

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

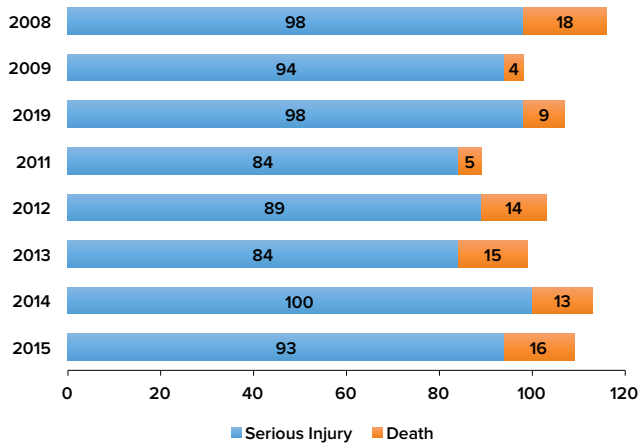
Between October 7, 2014, and October 6, 2015, a total of 316 adverse health events were reported to MDH. Forty of those events were newly reportable in 2014 (Figure 2).

**FIGURE 2:**
Overall Events Reported, 2008-2015




Of the reports submitted during this reporting period, 30 percent resulted in serious injury, while approximately five percent (16 events) led to death. This year the percentage of events that resulted in serious injury is essentially unchanged from the previous year. The number of deaths associated with these events has also remained roughly the same over the last four years, since 2012 (Figure 3).

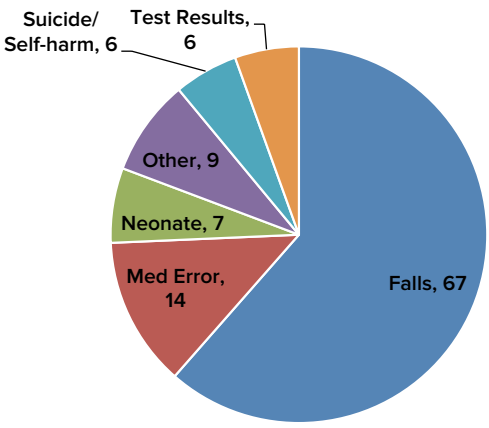
**FIGURE 3:**
Patient Harm, 2008-2015




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. It is also important to note that definitional changes resulted in four new event categories being reportable in 2014.

As in previous years, the type of event most likely to lead to serious patient harm or death was falls. Sixty seven cases of harm or death were a result of falls (four deaths). Medication errors accounted for fourteen cases (four deaths). Neonatal events accounted for seven cases (five deaths) (Figure 4).

**FIGURE 4:**
Cases of Serious Injury or Death, 2015

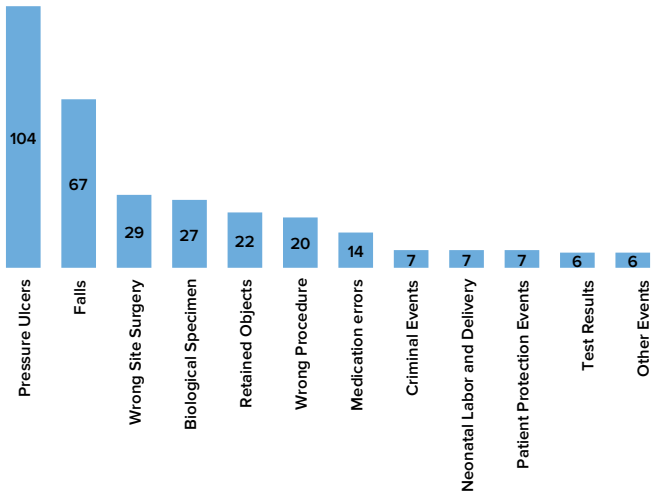


Over the life of the reporting system, the most common causes of reportable serious harm or death have been falls, medication errors, and suicide/attempted suicide.

## Types of Events

As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for 54 percent of all events reported in 2015 (171 events). The three events that make up the surgical/procedural category accounted for another 22 percent of reported events this year, with a total of 71 events (Figure 5).

**FIGURE 5:**
Events by Category, 2015

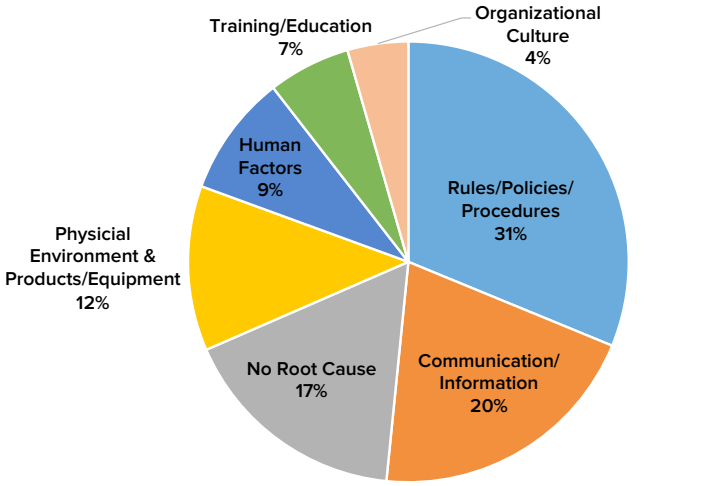



## Root Causes of Adverse Events

In Minnesota, any time an adverse health event occurs, facilities are required by law to conduct a root cause analysis (RCA). This process involves investigating 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 not followed, or environmental factors. The process of completing an RCA is the single most important step in learning from events and putting systems in place to prevent them from happening again. When high-level findings are shared through this system, they help other organizations around the state learn from that event to prevent it from happening at their facility.

As in previous years, the majority of adverse events were tied to root causes in one of three areas: rules/policies/procedures, communication and physical environment/equipment (Figure 6).

**FIGURE 6:**
RCA by Category, 2015

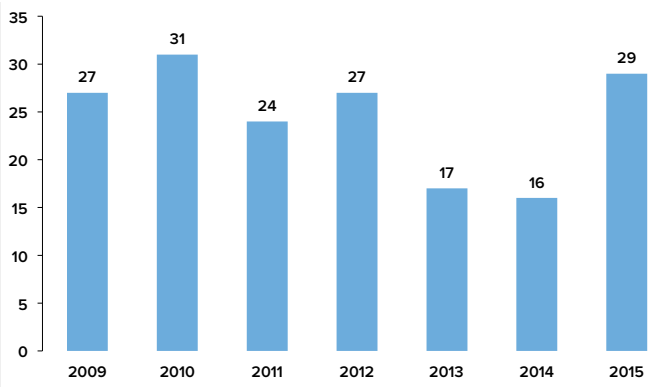



- Looking deeper into the communication category, facilities cited over half the time that information was either not communicated to the correct person or that it was not communicated using a structured process. Twenty three percent of the time the structured process for communication that was used was not used appropriately.
- With regard to rules/policies/procedures, the issues vary. However, the most commonly reported issues are policies/procedures that are not in place or that are in place but inadequate.

# WRONG SITE SURGERIES/INVASIVE PROCEDURES

Twenty-nine cases of wrong site surgeries/invasive procedures were reported in 2015 (Figure 7). Across all Minnesota hospitals and surgical centers, nearly 2.7 million surgeries and invasive procedures were performed in this reporting year. Given the volume of invasive procedures performed in a year, these events remain very rare, occurring in roughly one of every 94,000 invasive procedures.

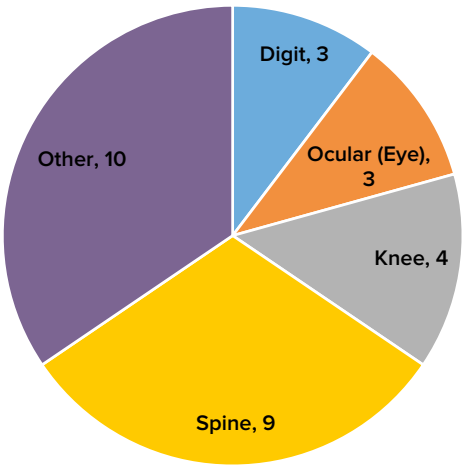
**FIGURE 7:**
Wrong Site Surgeries/Invasive Procedures, 2009-2015




## Key findings

- The most common types of procedures involved in these events were spinal procedures, knee procedures, and finger/toe or eye procedures (Figure 8).
- Facilities noted that the process for counting vertebrae in the thoracic region to confirm exact location prior to procedure is challenging. More procedures are done in a minimally invasive fashion with smaller incisions, which can be more difficult for the surgeon to visualize the intended surgical site.
- As in the past, the root causes of wrong site surgeries/procedures are often related to inconsistencies with the pre-procedural Time Out process.
  - Facilities said that the Time Out was completed in 82 percent of these cases. However, when looking at each individual step of the Time Out process, all steps of the process were completed only 68 percent of the time.
  - The most commonly reported missed steps in the process were: staff stopping all activity during the Time Out, and staff using appropriate source documents to verify the surgery and procedure location.

**FIGURE 8:**
Wrong Site Surgery/Procedure Type, 2015



## Next Steps

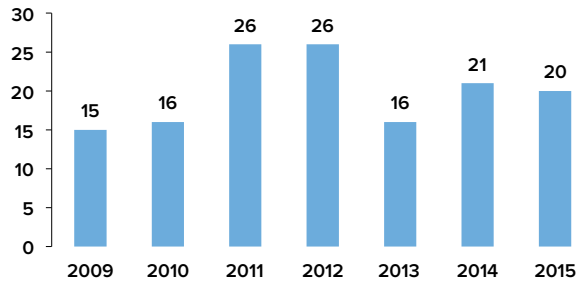
Effectively preventing wrong-site procedures remains a challenge; these events have consistently been among the most commonly reported. In the coming year, MDH and its partners will focus on these events in the following ways:

- Hospitals will work to implement an updated and streamlined set of best practices included in MHA's 'Procedural Safety across the Board' gap analysis. This more concise roadmap will allow organizations to focus on key best practices.
- An MHA surgical advisory committee will identify recommendations for making the process for spine surgery safer.
- In the coming year, MDH/MHA will explore the use of experts to dive deeper into the issues surrounding completion of the Minnesota Time Out process and to look into solutions to increase patient safety during procedures. This process has been ongoing and since it relies on human factors, is highly nuanced, but Minnesota facilities are committed to improvement.

# WRONG SURGERIES/INVASIVE PROCEDURES

In the most recent year of reporting, hospitals and surgical centers reported 20 cases of wrong surgeries/invasive procedures (Figure 9).

**FIGURE 9:**
Wrong Procedure, 2009-2015

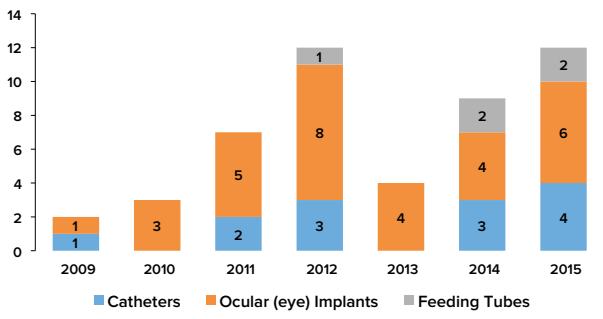



As noted previously, nearly 2.7 million surgeries and invasive procedures were performed in this reporting year across all Minnesota hospitals and surgical centers. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one out of every 150,000 invasive procedures.

## Key findings

- Sixfty percent of wrong procedure cases were related to incorrect implants being placed, up slightly from previous years.
- This year of data shows similar patterns to the previous year in terms of the types of implants involved in these events. The most common types of implant related wrong procedures were eye implants, catheters and feeding tubes (Figure 10).

**FIGURE 10:**
Wrong Procedure Implants, 2009-2015




- 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.
- The breakdown in verification processes was particularly an issue for implant-related events. The most common root cause for these events was lack of a process for ordering and verifying the correct implant prior to insertion. In 2012, MDH/MHA issued a safety alert around implant verification and those best practices are also included in the Safe Surgery roadmap; and,
- Similar to the findings for wrong-site cases, for wrong-procedure events facilities reported that the pre-procedure Time Out was completed 100 percent of the time. However, when looking at each individual step of the Time Out process, all of the steps were completed only 60 percent of the time. The most commonly reported missed step in the process for wrong procedure events was failing to use source documents to verify the procedure prior to the procedure start, this is especially true with implant related cases..

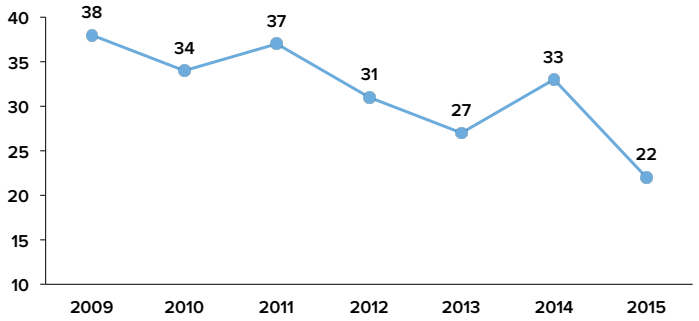
## Next Steps

In the coming year, Minnesota hospitals and surgical centers will continue to highlight the prevention of wrong surgical/invasive procedure adverse events with continued focus on implant verification and asking organizations to re-assess their policies around the topic. MDH will also work with its partners to explore how to re-energize work related to implementing and hardwiring the Minnesota Time Out process in all procedural areas. This process was developed in collaboration with Minnesota facilities and human factors experts from the University of Minnesota, and designed to be rigorous and consistent for all procedures and surgeries. Now that a number of years have passed since its development, and with data showing that not all steps of the process are being conducted for every procedure, it is time to explore what the barriers are to full implementation and how best practices can be hardwired.

# RETAINED FOREIGN OBJECTS

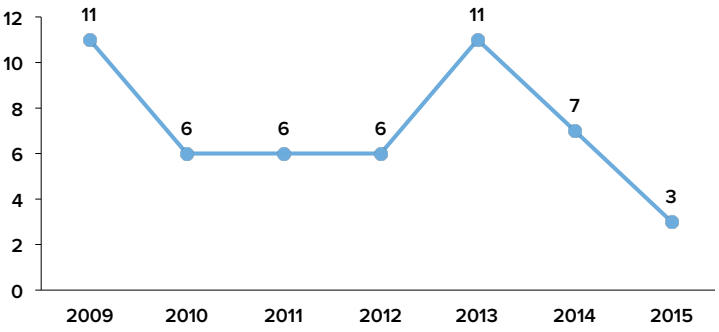
In 2015, hospitals and surgical centers reported 22 cases of retained foreign objects (RFO), continuing a positive trend (Figure 11). As in the past, approximately 50 percent of the events occurred in the operating room, while another 14 percent occurred on patient units/during bedside procedures.

**FIGURE 11:**
Retained Foreign Objects, 2009-2015




In past years, "packed" items (items that are inserted to control bleeding after surgery and are intended to be removed at a later time) have made up a significant percentage of RFOs; prevention of these types of RFOs has been a focus area for the AHE system. In the last three years, that work has started to show positive impact. In the most recent reporting year, only three events occurred related to retained packing material (Figure 12).

**FIGURE 12:**
Retained Foreign Objects – Packing, 2009-2015




## Key findings

In this reporting year, many of the items that were retained were small device fragments or broken items. These RFOs were often related to a lack of policies or procedures, or policies and procedures that were not followed:

- Several facilities reported lack of a policy or procedure to identify whether a device is intact upon removal; and
- Facilities reported that a policy or procedure was in place, but it was unclear whose responsibility it was to insure the device was intact.

Root causes for other types of RFO include:

- Breakdowns in communication of tucked items,
- Inconsistent tracking process for packed items once patient leaves operating room.

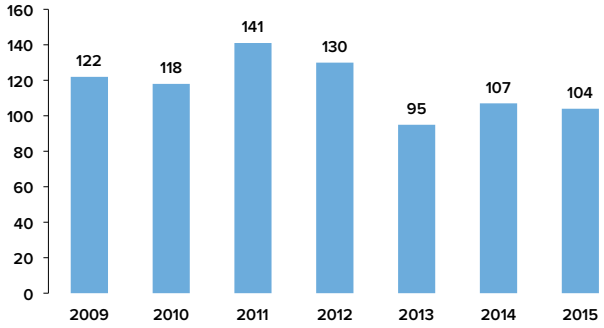
## Next Steps

The issue of ensuring intactness of devices is highly complex and best practices have not been developed nationally as of this time. Through MHA's surgical committee, work will continue to investigate and share best practices for accounting for items being intact and in leveraging technology to support a reduction in retained objects. Also in 2016, the surgical advisory group plans to review the available best practices and streamline those into a document for hospitals and surgical centers to follow for every procedure every time.

# PRESSURE ULCERS

Pressure ulcers, or bedsores, happen when a patient's skin breaks down due to pressure or friction. Pressure ulcers have consistently been the most commonly reported adverse health event, often representing roughly a third of all reported events. In the most recent year of reporting, 104 pressure ulcers were reported (Figure 13).

**FIGURE 13:**
Pressure Ulcers, 2009-2015

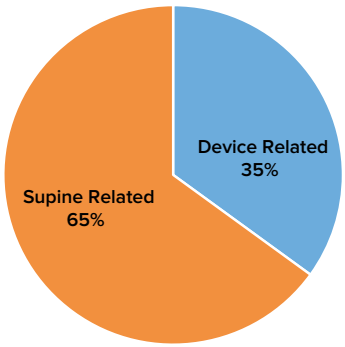



## Key findings

A closer look at the data shows:

- Sixty five percent of reported pressure ulcers were related to the patient being on their back (Figure 14). Pressure ulcers associated with a 'supine' position generally appear on the sacrum or coccyx;

**FIGURE 14:**
Pressure Ulcers – Device and Supine Related, 2015




- A significant percentage of pressure ulcers are also caused by medical devices that are in contact with a patient's body, although the percentage of pressure ulcers that were device-related declined from 41 percent last year to 35 percent this year. The majority (two-thirds) developed under respiratory equipment in critical care units (tracheostomy equipment, endotracheal tubes/ties, and CPAP/BIPAP oxygen masks);
- This year hospitals reported that 18 percent of patients who developed a pressure ulcer were able to position themselves, compared to 58 percent last year.
  - This could be attributed to better education of patients on the importance of repositioning if they are physically able;

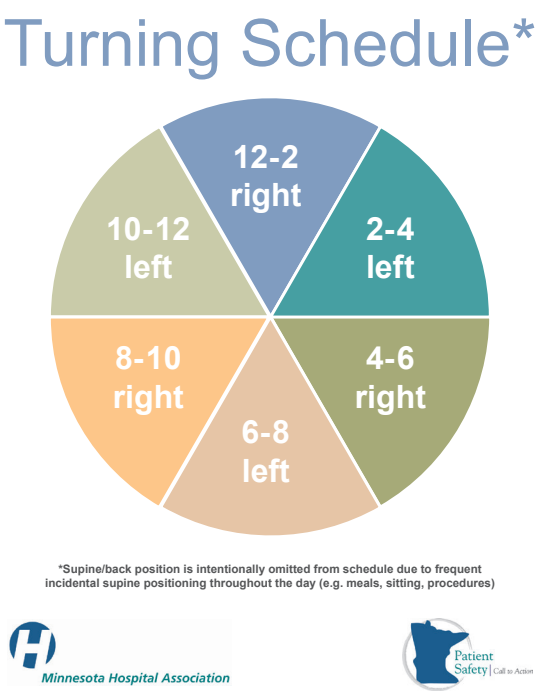
- Fewer patients (26 percent last year, 16 percent this year) refused repositioning for pressure ulcer prevention. This may be related to better patient education on the importance of repositioning.
- Incontinence and having the head of the bed (HOB) greater than 30 degrees are contributing factors to pressure ulcer development on the patient's backside. This year 39 percent (35 percent last year) of ulcers developed on patients that were incontinent and 22 percent had the HOB greater than 30 degrees without contraindications written or specialty beds implemented; and,
- This year supine related pressure ulcers were equally distributed among medical/surgical units and critical care patients. This could be important because the patients on medical/surgical units are not usually considered critically ill and most likely do not have medical contraindications to positioning and turning; they should be more able to be repositioned to avoid development of these types of ulcers.

## Next Steps

As noted above, 65 percent of pressure ulcers develop when patients are on their backs. Most of these are in areas that touch the bed (back of the head, sacrum, coccyx, heels). These ulcers are strongly related to inadequate patient positioning in the bed or the chair. Preventing them involves consistent and effective use of a bundle of interventions that includes: accurate pressure ulcer risk assessment and skin inspection, effective patient positioning (including the head of the bed and heels), appropriate and timely use of support surfaces/mattresses, and evidence based incontinence skin care. In 2016, hospitals and surgery centers, with support from MHA, will continue to work on full implementation of the preventive measures in these areas.

Due to the volume of pressure ulcers that are related to patients being in supine position, in 2015 MHA developed and disseminated a new turning schedule (Figure 15). The supine/back position has been intentionally omitted from the schedule, because patients often end up incidentally in the supine position throughout the day (e.g. meals, sitting, procedures). A focus on implementing the new turning clock and minimizing incidental supine positioning will continue in 2016 through the 'SAFE SKIN' program.

**FIGURE 15:**
MHA Turning Clock, 2015




With regard to device related and supine related pressure ulcers, both type of pressure ulcers have their own bundle of preventive interventions. New questions were added to the adverse health events registry in late 2015, and the additional information will help clarify the areas of need for education and resources. MDH will collect the new data elements and work with MHA to develop any new best practices that come out of those elements.

MDH and its partners will promote use of the new turning schedule, minimizing supine position, and support the consistent use of standardized practices to reduce device-related pressure ulcers in 2016, with an increased focus on respiratory devices, especially tracheostomy care. In addition, efforts will continue to implement the pressure ulcer prevention bundle in the perioperative areas and earlier implementation of specialty beds for at risk patients.

# SPOTLIGHT STORY

## Preventing Pressure Ulcers in the SICU

Care team members in the Surgical Intensive Care Unit (SICU) at Hennepin County Medical Center (HCMC) have championed changes to both culture and practice in order to prevent the occurrence of pressure ulcers, or injuries to skin and underlying tissue resulting from prolonged pressure on the skin. Using a combination of research, training and clear communication, the hospital has seen remarkable success – which translates into better outcomes for patients.

HCMC began its strong focus on pressure ulcer reduction in 2008, when the hospital hired Kim Kleinschmidt, a certified wound ostomy nurse, to develop a program for reducing hospital-acquired pressure ulcers.

"Previously, HCMC had lots of people with interests and skills in preventing pressure ulcers, but we didn't have dedicated resources for managing pressure ulcers," said Lori Johnson, RN, MA, vice president of performance improvement and safety. "Our organization committed to bringing in the right resources to tackle this issue."

"The key to our success was that the hospital made this a huge priority," said Kleinschmidt. "We had resources and attention focused on the issue. If a pressure ulcer developed, we had the ability to bring the right people together."

HCMC received a grant from the Minnesota Hospital Association funded by the Centers for Medicare and Medicaid Services' Partnership for Patients Hospital Engagement Network initiative to support its work on pressure ulcer reduction. Part of the grant was used to help educate nurses on ICU-related devices, such as cervical collars or spinal braces. HCMC conducted in-person training in which nurses tried on the devices and practiced putting them on their colleagues. The hospital also developed a training video about applying braces and conducting skin assessments.

"Our expectation is that skin underneath devices is assessed every shift," said Kim Schneider, SICU senior staff nurse. "We learned that some people were afraid of causing harm by removing the devices. Training helped alleviate those concerns because our nurses were able to experience firsthand what the devices felt like, where they were applying pressure and where issues might arise."

"Education was a key part of our improvement," said Beth Heather, the nursing practice specialist for critical care. "The training was successful because we were able to respond directly to the concerns we heard from nurses. Now our nurses feel confident that they know the devices and what they're stabilizing."

Another important element in HCMC's successful reduction of pressure ulcers was the development of a Skin Team on each unit. Skin Team members serve as experts within their own units to share new knowledge and help colleagues who have questions. In addition to monitoring patients for pressure ulcers, Skin Team members participate in rounds and regularly meet to reflect on what they are seeing, review data on areas of success and areas for improvement, and identify gaps that can be addressed.

In one instance, SICU Skin Team members realized they expected nurses to know how to prevent pressure ulcers but had not clearly laid out guidelines. The team developed a document that clearly outlined expectations for prevention of pressure ulcers and shared it with SICU nurses. The SICU Skin Team was recognized organizationwide with a staff excellence award for its dedicated improvement work and focus on safety.

"The SICU Skin Team has led the way for the whole hospital," said Kleinschmidt. "The team members set the bar very high and have inspired people with the commitment they made to preserving skin."

HCMC plans to continue its pressure ulcer prevention efforts by sustaining effective practices and procedures, continuing education and training, persisting in the use of data to target interventions, and maintaining its organizational focus on the importance of skin protection.

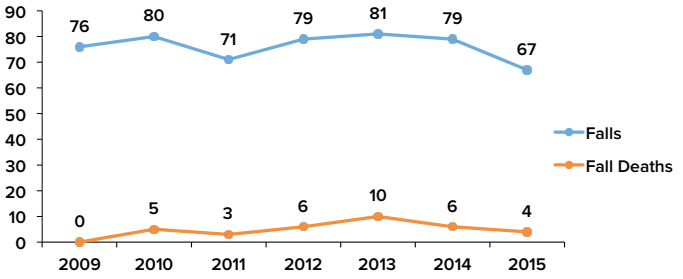
Results have been promising. From 2008 to 2014, the hospital had an average of three reportable pressure ulcers per year, which were attributed to cervical collars or thoracolumbosacral orthosis (TLSO) braces. Since the fall of 2014, after education and training, no reportable pressure ulcers have been attributed to either device.

"Care team members throughout the hospital really believe that we can prevent pressure ulcers," said Johnson. "We've seen a culture change where prevention is now first and foremost."

# FALLS

Over the years that the reporting system has been in place, falls have generally been among the most commonly reported events. In 2015, hospitals reported 67 falls that resulted in serious injury or death (Figure 16), continuing a positive downward trend. Both total falls and falls resulting in death had been relatively stable across several years.

**FIGURE 16:**
Falls by Injury Type, 2009-2015

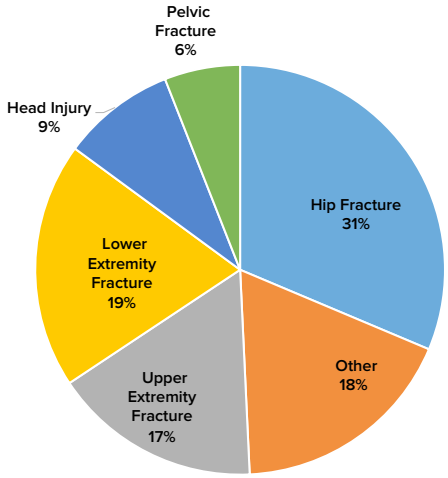



## Key findings

A closer look at the data shows:

- With regard to event location, 64 percent of falls occurred on medical/surgical units with another nine percent taking place on behavioral health /inpatient psych units;
- Nearly half (47 percent) of patients had been assessed to be at high risk for falling prior to the fall;
- In 23 percent of cases, the patient who fell had dementia or delirium, a condition that makes patients' participation in fall prevention more challenging;
- Thirty one percent of falls were toileting related, down from 40 percent in the year prior. This type of fall most often occurred when a patient fell while getting up to use the toilet on their own without assistance;
- With regard to injury type, 31 percent of patients who fell sustained a hip fracture, followed by lower extremity fractures with 19 percent and nine percent sustaining a head injury (Figure 17).

**FIGURE 17:**
Falls by Injury Location, 2015




## Next Steps

As noted above, falls have consistently been among the most commonly reported events, throughout the life of the system. While this year's results show an encouraging trend towards fewer falls associated with serious injury or death, the data also point to areas for continued improvement:

- In recent years, the majority of falls have occurred in and around the bathroom. In early 2015, MDH/MHA studied bathroom redesign opportunities and disseminated bathroom redesign recommendations statewide. These recommendations share new ways to prevent falls in and around hospital bathrooms. Throughout 2015 and into 2016, hospitals are working to implement some of those recommendations, such as: more appropriate locations of grab bars in patient bathroom, proper lighting in patient rooms and bathrooms and choosing appropriate flooring in patient bathrooms;
- Hospitals will continue to focus on preventing falls with injury through the FALLS 3.0 bundle that MHA developed; and,
- Starting in late 2015, hospitals and surgical centers that report falls will be required to answer additional questions to help the AHE system identify gaps in fall prevention and put processes in place to prevent them in the future.

# SPOTLIGHT STORY

## Simulation Training Drives Improvements for Safe Patient Care

Glencoe Regional Health Services uses simulation training – that is, realistically practicing clinical scenarios using a mannequin or other educational resource – to drive improvements that benefit patients. "Simulation is a good way to provide a safe environment for staff to be able to practice skills they may not use on a daily basis," said Rachel Squibb, education coordinator. "We also find it helpful for identifying areas for improvement and ways we can change processes or protocols to make them more foolproof."

Glencoe Regional Health Services works with partners who provide the necessary equipment for simulation training. The hospital conducted three training sessions using a mobile simulation center from Children's Hospitals and Clinics of Minnesota. "Emergency Room staff, nurses, providers, nurse anesthetists and pharmacists all participated in trainings where they practiced different pediatric scenarios they do not regularly experience," said Squibb. "Simulation training increased our staff's comfort level with rare situations and identified practices we could carry through to our daily work."

Ridgewater College also provided a mobile simulation center that care teams at Glencoe Regional Health Services used to conduct more specialized training. "Ridgewater brought maternal and newborn mannequins that allowed us to simulate shoulder dystocia, a condition where an infant's head has delivered but his or her shoulders are stuck," said Squibb. "Our staff worked as a team to discuss what the provider was considering during the delivery. We also participated in an education session after the simulation about the causes of shoulder dystocia and the corrective measures that can be taken."

In addition to participating in on-site training in Glencoe, Squibb represented her hospital at a statewide simulation training presented by the Minnesota Hospital Association (MHA). "I found the training so interesting and useful that I invited the presenters out to our facility to train with all of our staff," said Squibb. "A multidisciplinary group focused on postpartum hemorrhage and placental abruption leading to an emergency cesarean section. The debriefing gave us a host of ideas, tips and useful things to discuss. We actually ended up incorporating part of this training into our annual skill sessions for nurses, and we continue to use some of what we learned in our own regular drills."

As a result of its practices, the hospital discovered that one of the most important steps in simulation is the debriefing that occurs after the exercise concludes. "It is so important for the team to come together to discuss what went well and what did not," said Squibb. "A provider may see something that I as a nurse didn't notice, or vice versa – so everyone's feedback is important. The debriefing also allows us to identify how we are going to address areas that were flagged for improvement."

Simulation training allowed Glencoe Regional Health Services to identify policy and practice changes to enhance safety for both mothers and newborns. Based on results of simulations, the hospital updated policies and changed the location of equipment to better meet patients' needs. In addition, the hospital identified ways of streamlining processes to more rapidly assist patients. "Simulations and drills have helped us refine our procedures to more quickly serve patients," said Squibb. "For example, we streamlined the steps that need to be taken before bringing a patient to the operating room and we now offer training to familiarize charge nurses and acute care nursing assistants with the standardized steps."

The value of simulation training is understood by care team members, department managers and hospital leaders alike. The hospital includes in-house drills and on-site trainings with mobile simulation equipment in its annual budget planning. Schedulers and department managers also work together to identify training dates far in advance so that as many care team members as possible are able to participate.

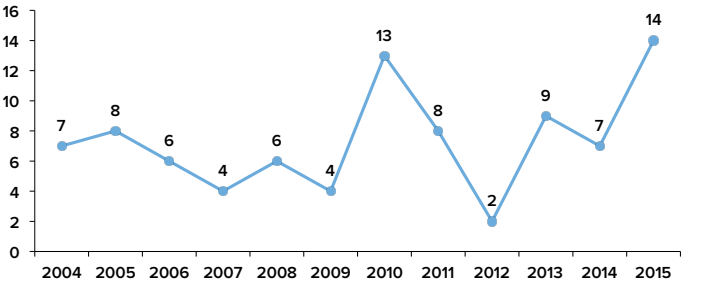
"Our leaders understand that simulation is a truly important part of our work that is valuable for everyone," said Squibb. "Not only does it allow us to exercise infrequently used skill areas, but it also helps us continue to develop skills we use every day, like effective multidisciplinary communication. After every simulation, we take the information we gain from debriefing with care teams and look at what we can improve in order to make their daily work run more smoothly and provide the safest care for patients."

# OTHER EVENT TYPES WITH NOTABLE FINDINGS

## Medication Errors

In the most recent year of data, there were 14 medication error events reported. While the number of medication errors reported through this system tends to vary from year to year, this represents an increase from previous years and the highest number reported since the reporting system began (Figure 18). Four of these events resulted in death of the patient and the remaining ten resulted in serious injury.

**FIGURE 18:**
Medication Errors, 2004-2015




## Key Findings

These events are very rare and in the past have had even smaller reported numbers. The low numbers have made it very difficult to identify trends and patterns in the data. However, a review of the last several years of reported medication errors has identified a number of patterns:

- In 28 percent of cases, the medication involved in the error was an antithrombotic agent (a medication to thin the blood and prevent clots), with cardiac medications making up another 20 percent.
- In 40 percent of cases the wrong dose of a medication was administered to the patient, and in another 28 percent of cases the intended medication was not given;
- In terms of where in the medication administration process the error occurred, the most common breakdowns were in discharge medication reconciliation; and,
- The root causes of these events fall into three categories: lack of standardized process for discharged medication reconciliation; issues surrounding the electronic health record, such as lack of or lack of use of a standardized electronic order set; and human factors issues.

### Next Steps

Medication safety experts in Minnesota convened by MHA are working to develop a standardized process for discharge medication reconciliation. This process will be shared statewide in mid-2016. Accompanying the roll-out of the standardized process, MHA is planning an education event on medication safety in mid-2016.

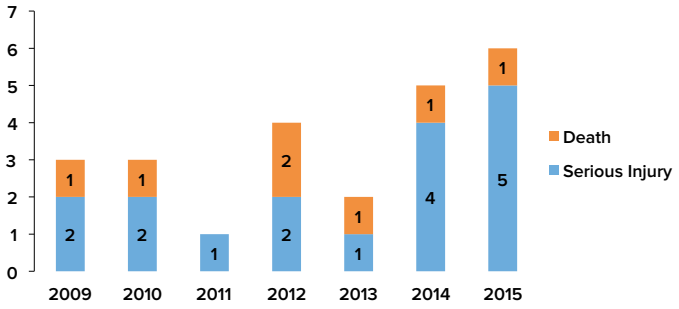
## Suicide/Attempted Suicide/ Self Harm

In 2014, the definition of this event was expanded to include self-harm that results in serious injury or death in addition to suicide or attempted suicide resulting in serious injury.

### Key Findings

- In 2015, there were six reported patient suicides/attempted suicides or cases of self-harm that resulted in serious injury or death (Figure 19).
- More than half of the events were self-harm resulting in serious injury, not suicide attempts.
- Two of the events were due to a patient hanging or attempted hanging using door hardware.

**FIGURE 19:**
Suicide/Attempted Suicide/Self-Harm, 2009-2015




### Next Steps

Over the years, around half of the reported suicide/attempted suicide events have been due to a patient hanging or attempted hanging using door hardware and another third of events have been due to a patient using items in the patient environment to harm themselves. In 2015, MDH and its partners collaborated with Suicide Awareness Voices of Education (SAVE) to put out new environmental safety recommendations to adapt patient rooms to better prevent suicide attempts in health care facilities. Throughout 2016, MDH and its partners will continue to encourage organizations to implement these recommendations. MDH will follow-up with organizations in the coming year to check on implementation progress and share learnings statewide.

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

This event was added to the list of reportable events in 2014 to acknowledge that the issue of failure to follow up or communicate test results to a patient in a timely and accurate manner imposes significant increased risk of death or serious injury. This is the second year of data collection on this event type in Minnesota; six cases were reported.

### Key Findings

- Of the six cases, half involved blood/fluid culture results not being communicated or followed up on, two involved laboratory blood tests (such as bilirubin) that were not communicated or followed up on and one involved a delay in pathology results that led to a delay in cancer diagnosis;
- Half of the events were related to failure to communicate test results in the outpatient setting;
- Two events were related to failure to communicate or follow up on test results during the transition from inpatient to outpatient care; and,
- In half of the cases, the patient required admission to the hospital due to the event.

As is inherent with this category of events, these cases were related to communication failures. Two thirds of these events were due to communication breakdowns from provider to provider with the remainder due to breakdowns in communication from provider to patient. In most cases, there was not a standardized process for that communication to occur.

### Next Steps

In 2015, MHA convened a workgroup of experts to explore strategies for reduction of test result communication errors. This group has worked throughout 2015 and into 2016 to create the 'Management of Critical Test Results and Significant Findings' best practices. These best practices will highlight guidelines around communication of test results as well as how to track unresolved test results in real time and escalate the communication process as appropriate. The updated document will be disseminated statewide in early 2016.

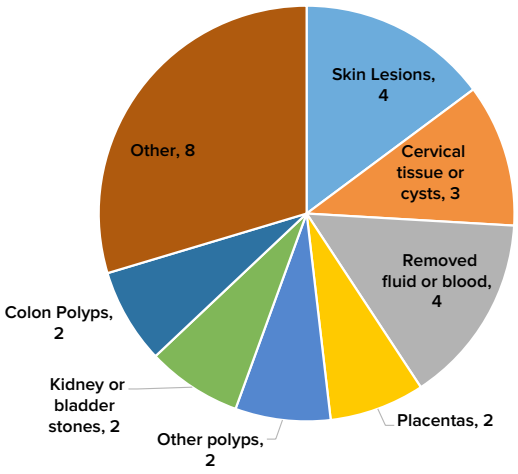
## Irretrievable Loss of an Irreplaceable Biological Specimen

This event was added to list of reportable events in 2014, 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. Twenty seven of these events were reported during this second year of reporting.

### Key Findings

- Of the 27 reported cases, a range of types of specimens were lost, but most fit into one of several categories (Figure 20). The majority of these specimens were skin lesions lost during the process of obtaining or processing the specimen, although facilities also reported cases of lost placentas, cervical tissue/cysts and fluid or blood.

**FIGURE 20:**
Biological Specimens by Type, 2015




- In terms of where in the process these specimens were lost or destroyed, in 44 percent of cases, the loss occurred during the process of obtaining the specimen from the patient with another 33 percent occurring during internal transport of the specimen from the point of collection to another area of the facility.

The root causes for these events include:

- Information about the specimen's presence or location in the operating room was not communicated to the correct person
- The facility had no clear procedure for disposal of specimens removed during procedures
- The process for internal transportation of specimen to laboratory was unclear.

### Next Steps

In 2014, the expert group that was convened to look at these types of events developed best practices for specimen handling. Those best practices, and accompanying toolkits and gap analyses, were distributed statewide in early 2015. MHA will continue to support organizations on implementation of these best practices in 2016. Because this is a new event, in 2016 MDH will also be exploring whether additional data elements could be collected to aid in learning why these events happen, and working with facilities to explore other opportunities for learning.

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

This event was added to the list of reportable events in 2014 as a companion to the requirement to report the death or serious injury of a mother in a similar circumstance. This event category is limited to low-risk pregnancies and deaths or injuries that are associated with labor and delivery only. For example, a neonatal death associated with a high-risk pregnancy, or an injury that was unrelated to labor or delivery, would not fall into this category. There were seven cases reported in this second year of reporting this event.

### Key Findings

The very small number of events that fall into this category, and the complexity of these events, makes it difficult to identify patterns of root causes. However, some findings did emerge in this second year of reporting that may provide direction for future work. In one or more reported cases:

- Neonatal resuscitation equipment was not present or was present but not ready for use;
- There was lack of a process for the staff to differentiate between non-scheduled and emergency cesarean sections which led to a delay in the time between the decision for cesarean and the start of the procedure;
- There was not a clear process for managing concerns/disagreements in patient care between providers that led to a delay; and,
- As in the previous reporting year, in several cases the baby was born after a relatively uncomplicated birth and there was not a clear indication of why the death or serious injury occurred.

### Next Steps

Efforts continue in collaboration with MHA's perinatal committee to better understand and define "associated with labor and delivery" and to identify additional information that can be collected to facilitate learning from these types of events and reduce the likelihood of future occurrence. In mid-2016, MHA is planning a Perinatal Education Summit and will use that platform to highlight lessons learned from the past two years of reported cases and share best practices.

# SPOTLIGHT STORY

## Ensuring Medication Helps – Not Harms – the Patient

At Fairview Health Services, medication safety is not only part of the daily routine – it's a critical component of patient care that is ingrained in the organizational culture. Fairview's far-reaching focus on medication safety and preventing adverse drug events has helped the health system drive change and innovation.

An adverse drug event is an injury a patient incurs resulting from the use of a drug in any care setting or at home. Minnesota's hospitals are involved in their own efforts and statewide initiatives to enhance medication safety and prevent adverse drug events. Fairview's emphasis on medication safety has been ongoing and sustained for nearly two decades. During the past eight years, University of Minnesota Medical Center has achieved a 49.4 percent reduction in adverse drug events due to antidiabetic agents, a 72 percent reduction in adverse drug events due to narcotics and a 53.4 percent reduction in adverse drug events due to anticoagulants.

"This is something that we pay attention to continuously," said John Pastor, Pharm.D., director of pharmacy at University of Minnesota Medical Center and University of Minnesota Masonic Children's Hospital. "We refine our medication processes as a part of our daily work, as we actively identify and act on areas where we can improve."

Medication safety is not just adherence to procedures and reducing problems with pharmacy turnaround times. "It's more patient-focused, with the intent of reducing harm to patients," said Steve Meisel, Pharm.D., Fairview director of patient safety. "The medication system is not owned by any individual caregiving discipline, and we can't optimize one area of the hospital at the expense of another. We all need to work together to improve patient outcomes."

Both leadership and organizational culture are crucial components of Fairview's successful medication safety program. "You have to have leaders who understand what's important, as well as care teams and staff who are engaged in the work," said Meisel. "Fairview has built up a high degree of credibility in medication safety as a result of efforts from the bottom up, the middle out and the top down."

"Nurses, nurse leaders, physicians, physician leaders, respiratory therapists and others – every member of the care team is part of our work groups and problem-solving groups," said Pastor. "Without their engagement and support, we wouldn't be able to effect change."

Technology partnerships are also critical to both solving problems and implementing solutions. Fairview's Information Technology (IT) department develops custom programs that work with existing systems to help enhance medication safety. Many organizations struggle with recording accurate medication histories and ensuring providers consistently complete medication reconciliation. Fairview's IT team developed an alert that appears when a provider accesses a patient's electronic health record (EHR) that prompts the provider to reconcile medications, greatly improving safety of care. Additionally, the IT team implemented EHR features that guard against errors like giving a medication in an incorrect dosage or prescribing a drug that could trigger a drug-disease interaction.

Fairview's IT team tackled another challenge by addressing EHR "alert fatigue," which occurs when providers encounter multiple alerts in a patient's EHR. Alert fatigue can lead to providers dismissing relevant alerts because of the sheer number of overall alerts. The IT team was able to identify unnecessary "nuisance alerts" and reduce them by about 10 percent, minimizing alert fatigue among providers and decreasing their likelihood of incorrectly dismissing an alert.

Process, practice and purchasing changes also have helped Fairview improve medication safety. For example, the health system intentionally purchased varying models of IV pumps for use in different situations to avoid medication route errors. In addition, it redesigned pharmacy department processes related to medication preparation, storage and distribution to promote safer practices.

# SPOTLIGHT STORY

## Ensuring Medication Helps – Not Harms – the Patient (continued)

"A painkilling drug called hydromorphone used to come in a 2-milligram prefilled syringe but was typically administered in much smaller doses – 0.2, 0.3 or 0.4 milligrams," said Meisel. "A mistake could have led to a five- or tenfold overdose. For years, we repackaged tens of thousands of hydromorphone syringes into smaller sizes better suited to the dose needed. The drug now comes in a smaller dose from the manufacturer, but we still repackage doses for our pediatric patients, because an appropriate dose is not commercially available."

Fairview goes the extra mile to ensure that its gains are sustained. The health system is heavily invested in the Road Map to a Medication Safety Program developed by the MHA Adverse Drug Event Advisory Group with funding through the Centers for Medicare and Medicaid Services' (CMS) Partnership for Patients initiative. The road map provides evidence-based recommendations and standards for Minnesota hospitals in the development of a comprehensive medication safety program.

Fairview also engages in ongoing improvement in the area of medication safety. The health system is investing in capnography monitoring devices for adult postoperative inpatient units in order to improve early detection of and intervention in narcotic oversedation cases. Additionally, Fairview further bolstered its medication reconciliation efforts by increasing the role of pharmacists in reconciling medications for patients discharged from the hospital.

"Medication safety is an area that requires continuous learning, adapting and innovating. There is always room for improvement," said Meisel.

# SPOTLIGHT STORY

## When Handling Specimens, Communication is Key

For Regions Hospital, the foundation for success in safe specimen handling is robust communication. “The need for communication dovetails into so many things,” said Michele Island, patient safety program manager. “Everyone needs to know that we have a specimen, what the plan for the specimen is, where it needs to go and who’s responsible for getting it there.”

Safe handling of specimens has been a focus at Regions for many years. The hospital manages process improvement in part through a longstanding good catch program that recognizes care team members for actions that prevent potential errors from occurring, such as the loss of a specimen. “Our good catches have helped identify steps where specimens might be lost and opportunities to make our procedures better,” said Theresa Cain, manager of patient safety, quality and infection control for surgical services.

In 2014, irretrievable loss of an irreplaceable biological specimen was added as a reportable category of adverse health events in Minnesota. “Having our good catch program in place for so long allowed us to keep building on our work after the reporting law went into effect,” said Lynne Preese, quality/business laboratory manager. “The additional reporting requirements further catalyzed our efforts, but we benefited because we already had a strong knowledge base.”

One tool in Regions’ toolkit for handling specimens is highlighting specimens in the debriefing at the end of procedures to ensure that specimens are accounted for and next steps are identified. The lab monitors the operating room schedule to see which specimens are anticipated and makes sure they arrive for testing, following up if an expected specimen is not received. Staff at all levels of the organization – lab technicians, surgical assistants, nurses, surgeons and others – are educated about their critical role in maintaining specimen integrity.

To bring further attention to handling specimens as part of surgeries, the hospital implemented a specimen-tagging practice in which a bright specimen tag is included in every surgical setup kit. “Some specimens – like a placenta – are large and apparent, but others can be very difficult to see – like a 2 millimeter skin tag or a small translucent item,” said Island. “When a specimen is difficult to identify, it heightens the risk and the need for tight communication. We remove some of the difficulty by following standard practices for tagging specimens and communicating next steps.”

Hospital leaders play a crucial role in ensuring open, actionable communication. “Leadership support from surgeons, operating room leaders, lab leaders and others means that our care team members have time to think through processes and feel comfortable recommending improvements based on their own knowledge and experience,” said Debra Friend, director of patient safety, regulatory compliance, infection prevention and patient representatives. “Clear communication helps us continue to do our best work.”

Regions’ specimen-handling procedures helped inform the Specimen Management in the Operating Room Gap Analysis developed in 2015 by the Minnesota Hospital Association (MHA) – and the hospital also used the gap analysis, once it was published by MHA, to continuously improve its own practices. The gap analysis provides evidence-based recommendations and standards for hospitals in the development of a comprehensive specimen management program to prevent the loss or damage of specimens in the operating room and during transport to the lab.

Regions care team members from multiple disciplines participated in completing the gap analysis, which helped the hospital determine where procedures were effective and where there was risk that could be mitigated. “It wasn’t just one department, like the lab, analyzing its workflow in a silo,” said Cain. “Instead, staff from different areas of the hospital were able to work together to ensure that communication was aligned and expectations were clear throughout the specimen-handling process.”

“When it comes to handling specimens, we know that we may only have one chance to test some of the specimens that come in,” said Preese. “We empathize with our patients who are awaiting test results that hinge on the work that we do. Because of this, we constantly challenge ourselves to look at how we can continue improving.”

# CONCLUSION

The annual release of facility-specific data on adverse health events in Minnesota helps to focus attention on the incidence and root causes of adverse health events. However, preventing harm to patients requires much more than simply counting events. The goal of the reporting system is to disseminate best practices about patient safety and provide support for organizations during implementation and for sustainability over time. Each year the reporting system continues to illuminate new areas of learning that lead to new standards of care and improvement in patient safety.

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:

- Completing the Minnesota Time Out process, in its entirety, for every patient, every procedure, every time;
- Providing adequate communication and follow up of test results in the outpatient setting;
- Addressing areas of patient environmental risks to reduce cases of patient self-harm;
- Providing adequate positioning and repositioning for patients in the bed or chair in order to prevent pressure ulcers;
- Understanding the causes of neonatal death and serious injury during labor and delivery and implementing strategies for prevention;
- Implementing standardized processes for specimen collection and transport in order to prevent biological specimen loss/damage; and,
- Tailoring patient safety tools and resources to better fit the needs of critical access hospitals and other small facilities;

As the reporting system moves into its thirteenth year, patient safety is as serious of a concern on a state and national level as it was when the system was first established, although on a national level the debate has shifted to how best to address diagnostic errors and issues that span multiple settings. While this system remains a nation-leading effort that has led to transformation in what is known about why adverse events happen, how safety is talked about in Minnesota, and in how learning is shared across systems, patient safety improvement is a long-term process and there is still much work to be done.

In the coming year, MDH will be working with its partners across the state to explore ways to strengthen and evolve the system, to ensure that we are providing the right kinds of resources and supports to reporting facilities that we are responding to emerging risks that may harm patients, and that we are holding ourselves accountable for continued improvement. Achieving a lasting reduction in these adverse health events will require continued commitment of resources, time and leadership by Minnesota health care providers and leaders; through its ongoing strategic planning processes, MDH will work in 2016 to determine how best to target these efforts.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2014 and October 6, 2015. 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, 2014 – October 6, 2015)

| TYPES OF EVENTS | ALL FACILITIES | SEVERITY DETAILS |
|---|---|---|
| **Surgical/Invasive Procedure** | 72 Events | Neither: 72 |
| **Products or Devices** | 2 Events | Serious Injury: 1<br>Death: 1 |
| **Patient Protection** | 7 Events | Serious Injury: 6<br>Death: 1 |
| **Care Management** | 226 Events | Serious Injury: 83<br>Death: 14<br>Neither: 129 |
| **Environmental** | 2 Events | Serious Injury: 2 |
| **Criminal** | 7 Events | Serious Injury: 1<br>Neither: 6 |
| Total for All Events | **316 Events** | **Serious Injury: 93**<br>**Death: 16**<br>**Neither: 207** |

## TABLE 2: STATEWIDE REPORTS BY CATEGORY

### Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2014 – October 6, 2015)

| TYPES OF EVENTS | ALL FACILITIES | SEVERITY DETAILS |
|---|---|---|
| 1. Wrong body part | 29 Events | Neither: 29 |
| 2. Wrong patient | 1 Event | Neither: 1 |
| 3. Wrong procedure | 20 Events | Neither: 20 |
| 4. Foreign object | 22 Events | Neither: 22 |
| 5. Intra / post-op death | 0 Events | — |
| Total for Surgical/Invasive Procedure | **72 Events** | **Neither: 72** |

### Details by Category: **PRODUCTS OR DEVICES** (October 7, 2014 – October 6, 2015)

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

### Details by Category: **PATIENT PROTECTION** (October 7, 2014 – October 6, 2015)

| TYPES OF EVENTS | ALL FACILITIES | SEVERITY DETAILS |
|---|---|---|
| 9. Wrong discharge of a patient of any age | 0 Events | — |
| 10. Patient disappearance | 1 Event | Serious Injury: 1 |
| 11. Suicide or attempted suicide/self-harm | 6 Events | Serious Injury: 5<br>Death: 1 |
| Total for Patient Protection | **7 Events** | **Serious Injury: 6**<br>**Death: 1** |

## TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2014 – October 6, 2015)

| TYPES OF EVENTS | ALL FACILITIES | SEVERITY DETAILS |
|---|---|---|
| **12. Death or serious injury due to medication error** | 14 Events | Serious Injury: 10<br>Death: 4 |
| **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** | 1 Event | Death: 1 |
| **15. Death or serious injury of a neonate associated with labor or delivery during a low-risk pregnancy** | 7 Events | Serious Injury: 2<br>Death: 5 |
| **16. Stage 3, 4 or unstageable pressure ulcers acquired after admission** | 104 Events | Serious Injury: 2<br>Neither: 102 |
| **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;** | 67 Events | Serious Injury: 63<br>Death: 4 |
| **19. The irretrievable loss of an irreplaceable biological specimen; and** | 27 Events | Neither: 27 |
| **20. Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results** | 6 Events | Serious Injury: 6 |
| Total for Care Management | **226 Events** | **Serious Injury: 83**<br>**Death: 14**<br>**Neither: 129** |

## TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **ENVIRONMENTAL** (October 7, 2014 – October 6, 2015)

| 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, 2014 – October 6, 2015)

| 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** | 1 Events | Neither: 1 |
| **27. Sexual assault of patient** | 5 Events | Neither: 5 |
| **28. Death or serious injury of patient or staff from physical assault** | 1 Event | Serious Injury: 1 |
| Total for Criminal Events | **7 Events** | **Serious Injury: 1**<br>**Neither: 6** |

Details by Category: **RADIOLOGIC EVENTS** (October 7, 2014 – October 6, 2015)

| 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:**
135,352

**NUMBER OF PATIENT DAYS:**
251,895

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **6** | Deaths: 0; | Serious Injury: 0; | Neither: 6 |
| 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 |
| **TOTAL EVENTS FOR THIS FACILITY** | **11** | **Deaths: 0;** | **Serious Injury: 1;** | **Neither: 10** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

# Associated Eye Care, LLC

**ADDRESS:**
2950 Curve Crest Blvd. W.
Stillwater, MN 55082-5085

**WEBSITE:**
www.associatedeyecare.com

**PHONE NUMBER:**
651-275-3113

**NUMBER OF BEDS:**

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
2,766

**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, 2014 – OCTOBER 6, 2015)

| 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 3.3

# Bethesda Hospital

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

**WEBSITE:**
www.healtheast.org

**PHONE NUMBER:**
651-232-1613

**NUMBER OF BEDS:**
254

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
0

**NUMBER OF PATIENT DAYS:**
34,387

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **10** | Deaths: 0; | Serious Injury: 1; | Neither: 9 |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | 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 3.4

# CentraCare Health – Melrose

**ADDRESS:**
525 Main St. W.
Melrose, MN 56352-1043

**WEBSITE:**
www.centracare.com

**PHONE NUMBER:**
320-256-1761

**NUMBER OF BEDS:**
28

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
3,088

**NUMBER OF PATIENT DAYS:**
6,388

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **POTENTIAL CRIMINAL EVENTS** | | | | |
| Abduction 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 3.5

# CentraCare Health – Monticello

**ADDRESS:**
1013 Hart Blvd.
Monticello, MN 55362-8575

**WEBSITE:**
www.centracare.com

**PHONE NUMBER:**
763-271-2385

**NUMBER OF BEDS:**
39

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
11,056

**NUMBER OF PATIENT DAYS:**
9,846

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 |
| **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 3.6

# CHI St. Gabriel's Health

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

**WEBSITE:**
www.chistgabriels.com

**PHONE NUMBER:**
320-631-5613

**NUMBER OF BEDS:**
49

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
6,702

**NUMBER OF PATIENT DAYS:**
14,266

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.7

# Child & Adolescent Behavioral Health Services

**ADDRESS:**
1701 Technology Drive N.E.
Willmar, MN 56201-2275

**WEBSITE:**
www.dhs.state.mn.us

**PHONE NUMBER:**
320-231-5421

**NUMBER OF BEDS:**
16

**NUMBER OF PATIENT DAYS:**
1,471

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient suicide/attempted suicide/self-harm resulting in serious disability | **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 3.8

# 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:**
25,199

**NUMBER OF PATIENT DAYS:**
143,401

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **4** | Deaths: 0; | Serious Injury: 0; | Neither: 4 |
| **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 |
| **TOTAL EVENTS FOR THIS FACILITY** | **6** | **Deaths: 0;** | **Serious Injury: 0;** | **Neither: 6** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

# Chippewa County – Montevideo Hospital

**ADDRESS:**
824 N. 11th St.
Montevideo, MN 56265-1629

**WEBSITE:**
http://www.montevideomedical.com

**PHONE NUMBER:**
320-269-8877 Ext 100

**NUMBER OF BEDS:**
30

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
5,384

**NUMBER OF PATIENT DAYS:**
9,996

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A medication error | **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 3.10

# Community Behavioral Health Hospital – Rochester

**ADDRESS:**
251 Wood Lake Drive S.E.
Rochester, MN 55904-5530

**WEBSITE:**
www.dhs.state.mn.us

**PHONE NUMBER:**
651-431-2729

**NUMBER OF BEDS:**
16

**NUMBER OF PATIENT DAYS:**
8,004

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient suicide/attempted suicide/self-harm 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 3.11

# 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:**
17,526

**NUMBER OF PATIENT DAYS:**
17,555

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **1** | Deaths: 1; | Serious Injury: 0; | Neither: 0 |
| **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** | **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 3.12

# Douglas County Hospital

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

**WEBSITE:**
www.dchospital.com

**PHONE NUMBER:**
320-762-6189

**NUMBER OF BEDS:**
127

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
31,037

**NUMBER OF PATIENT DAYS:**
35,820

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| The irretrievable loss of an irreplaceable biological specimen | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| **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** | **3** | **Deaths: 0;** | **Serious Injury: 0;** | **Neither: 3** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

# Essentia Health – Duluth

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

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
218-786-2802

**NUMBER OF BEDS:**
165

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
17,102

**NUMBER OF PATIENT DAYS:**
98,598

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| The irretrievable loss of an irreplaceable biological specimen | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **ENVIRONMENTAL EVENTS** | | | | |
| 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** | **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 3.14

# Essentia Health – Fosston

**ADDRESS:**
900 Hilligoss Blvd. S.E., Fosston MN 56542-1542

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
701-364-4212

**NUMBER OF BEDS:**
43

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
3,867

**NUMBER OF PATIENT DAYS:**
5,355

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **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** | **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 3.15

# Essentia Health – Northern Pines

**ADDRESS:**
5211 Highway 110
Aurora, MN 55705-1522

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
218-229-4222

**NUMBER OF BEDS:**
16

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
1,967

**NUMBER OF PATIENT DAYS:**
4,443

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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

# 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:**
30,809

**NUMBER OF PATIENT DAYS:**
52,574

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.17

# Essentia Health – St. Mary's Hospital, Detroit Lakes

**ADDRESS:**
1027 Washington Ave.
Detroit Lakes, MN 56501-3409

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
701-364-4212

**NUMBER OF BEDS:**
87

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
13,187

**NUMBER OF PATIENT DAYS:**
20,806

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | |
| Surgery/Other invasive procedure performed on wrong body part | **2** | Deaths: 0; Serious Injury: 0; Neither: 2 |
| **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 3.18

# Essentia Health – St. Mary's Medical Center

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

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
218-786-2802

**NUMBER OF BEDS:**
380

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
65,091

**NUMBER OF PATIENT DAYS:**
117,753

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **3** | Deaths: 0; | Serious Injury: 3; | Neither: 0 |
| **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 |
| **TOTAL EVENTS FOR THIS FACILITY** | **6** | **Deaths: 0;** | **Serious Injury: 3;** | **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 3.19

# Essentia Health – Virginia

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

**WEBSITE:**
www.essentiahealth.org

**PHONE NUMBER:**
218-749-9496

**NUMBER OF BEDS:**
83

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
11,445

**NUMBER OF PATIENT DAYS:**
28,282

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| 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** | **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 3.20

# Fairview Lakes Health Services

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

**WEBSITE:**
www.fairview.org

**PHONE NUMBER:**
612-672-6919

**NUMBER OF BEDS:**
61

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
24,887

**NUMBER OF PATIENT DAYS:**
26,583

**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, 2014 – OCTOBER 6, 2015)

| 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 3.21

# Fairview Maple Grove Ambulatory Surgery Center

**ADDRESS:**
14500 99th Ave. N.
Maple Grove, MN 55369-4478

**WEBSITE:**
www.fairview.org

**PHONE NUMBER:**
612-672-4165

**NUMBER OF BEDS:**

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
4,098

**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, 2014 – OCTOBER 6, 2015)

| 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 3.22

# Fairview Ridges Hospital

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

**WEBSITE:**
www.ridges.fairview.org

**PHONE NUMBER:**
612-672-1778

**NUMBER OF BEDS:**
150

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
59,015

**NUMBER OF PATIENT DAYS:**
71,281

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| 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** | **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 3.23

# Fairview Southdale Hospital

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

**WEBSITE:**
www.southdale.fairview.org

**PHONE NUMBER:**
612-672-1778

**NUMBER OF BEDS:**
390

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
82,398

**NUMBER OF PATIENT DAYS:**
116,774

**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, 2014 – OCTOBER 6, 2015)

| 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 |
| Retention of a foreign object in a patient after surgery or other procedure | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **5** | Deaths: 0; | Serious Injury: 0; | Neither: 5 |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| A medication error | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| 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** | **10** | **Deaths: 1;** | **Serious Injury: 2;** | **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 3.24

# FirstLight Health System

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

**WEBSITE:**
www.firstlighthealthsystem.org

**PHONE NUMBER:**
320-225-3328

**NUMBER OF BEDS:**
49

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
10,858

**NUMBER OF PATIENT DAYS:**
18,852

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.25

# Glacial Ridge Health System

**ADDRESS:**
10 Fourth Ave. S.E.
Glenwood, MN 56334-1820

**WEBSITE:**
www.glacialridge.org

**PHONE NUMBER:**
320-634-2208

**NUMBER OF BEDS:**
34

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
4,523

**NUMBER OF PATIENT DAYS:**
6,975

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.26

# Glencoe Regional Health Services

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

**WEBSITE:**
www.grhsonline.org

**PHONE NUMBER:**
320-864-7823

**NUMBER OF BEDS:**
49

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
6,995

**NUMBER OF PATIENT DAYS:**
7,217

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.27

# 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:**
21,947

**NUMBER OF PATIENT DAYS:**
30,465

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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:**
113,996

**NUMBER OF PATIENT DAYS:**
223,798

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **6** | Deaths: 0; | Serious Injury: 0; | Neither: 6 |
| A medication error | **1** | Deaths: 0; | Serious Injury: 1; | 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 | **4** | Deaths: 0; | Serious Injury: 4; | 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 |
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient suicide/attempted suicide/self-harm resulting in Serious Injury | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **17** | **Deaths: 0;** | **Serious Injury: 7;** | **Neither: 10** |

* 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

# 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:**
14,964

**NUMBER OF PATIENT DAYS:**
28,113

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.30

# Lake View Memorial Hospital

**ADDRESS:**
325 11th Ave.
Two Harbors, MN 55616-1300

**WEBSITE:**
www.lvmhospital.com

**PHONE NUMBER:**
218-834-7345

**NUMBER OF BEDS:**
25

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
2,164

**NUMBER OF PATIENT DAYS:**
2,422

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.31

# Lakewalk Surgery Center Inc.

**ADDRESS:**
1420 London Road, Ste. 100
Duluth, MN 55805-2437

**WEBSITE:**
www.lakewalk.com

**PHONE NUMBER:**
218-728-8505

**NUMBER OF BEDS:**

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
10,371

**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, 2014 – OCTOBER 6, 2015)

| 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 3.32

# 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:**
7,912

**NUMBER OF PATIENT DAYS:**
27,147

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 | **2** | Deaths: 0; | Serious Injury: 2; | 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 3.33

# Mankato Surgery Center

**ADDRESS:**
1411 Premier Drive
Mankato, MN 56001-6076

**WEBSITE:**
www.m-surgery.com

**PHONE NUMBER:**
507-386-5543

**NUMBER OF BEDS:**

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
4,756

**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, 2014 – OCTOBER 6, 2015)

| 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 3.34

# 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:**
40,066

**NUMBER OF PATIENT DAYS:**
38,174

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| 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 |
| Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy | **1** | Deaths: 1; | Serious Injury: 0; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **4** | **Deaths: 1;** | **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 3.35

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

**ADDRESS:**
404 W. Fountain St.
Albert Lea, MN 56007-2437

**WEBSITE:**
www.mayoclinichealthsystem.org

**PHONE NUMBER:**
507-434-1706

**NUMBER OF BEDS:**
77

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
14,139

**NUMBER OF PATIENT DAYS:**
41,243

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| A medication error | **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 3.36

# 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:**
507-434-1706

**NUMBER OF BEDS:**
82

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
12,505

**NUMBER OF PATIENT DAYS:**
41,709

**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, 2014 – OCTOBER 6, 2015)

| 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 3.37

# Mayo Clinic Health System in Cannon Falls

**ADDRESS:**
32021 County 24 Blvd.
Cannon Falls, MN 55009-5003

**WEBSITE:**
www.mayoclinichealthsystem.org

**PHONE NUMBER:**
507-263-9703

**NUMBER OF BEDS:**
15

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
2,877

**NUMBER OF PATIENT DAYS:**
4,158

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| 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 Health System in Fairmont

**ADDRESS:**
800 Medical Center Drive
Fairmont, MN 56031-4575

**WEBSITE:**
www.mayoclinichealthsystem.org

**PHONE NUMBER:**
507-238-5070

**NUMBER OF BEDS:**
57

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
7,622

**NUMBER OF PATIENT DAYS:**
23,669

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.39

# 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:**
30,622

**NUMBER OF PATIENT DAYS:**
69,378

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| 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 |
| **CRIMINAL EVENTS** | | | | |
| Sexual assault on a patient | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **ENVIRONMENTAL EVENTS** | | | | |
| A burn received while being care 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 3.40

# Mayo Clinic Health System in New Prague

**ADDRESS:**
301 Second St. N.E.
New Prague, MN 56071-1709

**WEBSITE:**
www.mayoclinichealthsystem.org

**PHONE NUMBER:**
952-257-8101

**NUMBER OF BEDS:**
49

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
6,250

**NUMBER OF PATIENT DAYS:**
7,759

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| 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 3.41

# Mayo Clinic Health System in Red Wing

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

**WEBSITE:**
www.mayoclinichealthsystem.org

**PHONE NUMBER:**
651-267-5077

**NUMBER OF BEDS:**
50

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
10,925

**NUMBER OF PATIENT DAYS:**
20,352

**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, 2014 – OCTOBER 6, 2015)

| 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 3.42

# Mayo Clinic Rochester Hospital

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

**WEBSITE:**
www.mayoclinic.org/event-reporting

**PHONE NUMBER:**
507-284-5005

**NUMBER OF BEDS:**
2,059

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
314,850

**NUMBER OF PATIENT DAYS:**
470,082

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **5** | Deaths: 0; | Serious Injury: 0; | Neither: 5 |
| Surgery/other invasive procedure performed on wrong body part | **3** | Deaths: 0; | Serious Injury: 0; | Neither: 3 |
| Surgery/Other invasive procedure performed on wrong patient | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **7** | Deaths: 0; | Serious Injury: 0; | Neither: 7 |
| 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 | **3** | Deaths: 0; | Serious Injury: 0; | Neither: 3 |
| A fall while being cared for in a facility | **9** | Deaths: 0; | Serious Injury: 9; | Neither: 0 |
| **CRIMINAL EVENTS** | | | | |
| Sexual assault on a patient | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **PRODUCT OR DEVICE EVENTS** | | | | |
| The use or malfunction of a device in patient care | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **31** | **Deaths: 0;** | **Serious Injury: 11;** | **Neither: 20** |

* 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

# 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:**
6,152

**NUMBER OF PATIENT DAYS:**
7,823

**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, 2014 – OCTOBER 6, 2015)

| 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** | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **1** | Deaths: 0; Serious Injury: 0; Neither: 1 |
| **CRIMINAL EVENTS** | | |
| Sexual assault on a patient | **1** | Deaths: 0; Serious Injury: 0; Neither: 1 |
| **TOTAL EVENTS FOR THIS FACILITY** | **3** | **Deaths: 0; Serious Injury: 0; Neither: 3** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

# Mercy Hospital

**ADDRESS:**
4572 County Rd. 61
Moose Lake, MN 55767-9405

**WEBSITE:**
www.mercymooselake.org

**PHONE NUMBER:**
218-485-4481

**NUMBER OF BEDS:**
31

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
4,384

**NUMBER OF PATIENT DAYS:**
6,555

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| **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 3.45

# 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:**
77,191

**NUMBER OF PATIENT DAYS:**
119,624

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Surgery/other invasive procedure performed on wrong body part | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient suicide/attempted suicide/self-harm resulting in Serious Injury | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **6** | **Deaths: 0;** | **Serious Injury: 2;** | **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 3.46

# Mille Lacs Health System

**ADDRESS:**
200 Elm St. N.
Onamia, MN 56359-7901

**WEBSITE:**
www.mlhealth.org

**PHONE NUMBER:**
320-532-2608

**NUMBER OF BEDS:**
28

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
7,964

**NUMBER OF PATIENT DAYS:**
21,160

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.47

# Minnesota Eye Laser & Surgery Center, LLC – Blaine

**ADDRESS:**
11091 Ulysses St. N.E. Ste. 400
Blaine, MN 55434-4237

**WEBSITE:**
www.mneye.com

**PHONE NUMBER:**
952-567-6100

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
2798

**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, 2014 – OCTOBER 6, 2015)

| 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 3.48

# MNGI Endoscopy – Maplewood

**ADDRESS:**
1997 Sloan Place
Maplewood, MN 55117-2084

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
17,280

**WEBSITE:**
www.mngastro.com/locations/maplewood-endoscopy-center-clinic

**PHONE NUMBER:**
612-870-5528

**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, 2014 – OCTOBER 6, 2015)

| 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 3.49

# New Ulm Medical Center

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

**WEBSITE:**
www.allinahealth.org

**PHONE NUMBER:**
612-775-9762

**NUMBER OF BEDS:**
62

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
17,077

**NUMBER OF PATIENT DAYS:**
38,849

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| The irretrievable loss of an irreplaceable biological specimen | **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 3.50

# North Memorial Ambulatory Surgical Center

**ADDRESS:**
9855 Hospital Dr., Ste. 175
Maple Grove, MN 55369

**WEBSITE:**
www.northmemorial-asc.com

**PHONE NUMBER:**
763-581-9032

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
14,108

**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, 2014 – OCTOBER 6, 2015)

| 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 3.51

# 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:**
81,157

**NUMBER OF PATIENT DAYS:**
143,130

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **25** | Deaths: 0; | Serious Injury: 0; | Neither: 25 |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **27** | **Deaths: 0;** | **Serious Injury: 1;** | **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 3.52

# Olmsted Medical Center

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

**WEBSITE:**
www.olmmed.org

**PHONE NUMBER:**
507-292-7200

**NUMBER OF BEDS:**
61

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
15,507

**NUMBER OF PATIENT DAYS:**
41,628

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.53

# Owatonna Hospital

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

**WEBSITE:**
www.allinahealth.org

**PHONE NUMBER:**
612-775-9762

**NUMBER OF BEDS:**
43

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
15,551

**NUMBER OF PATIENT DAYS:**
22,070

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.54

# 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:**
111,462

**NUMBER OF PATIENT DAYS:**
148,224

**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, 2014 – OCTOBER 6, 2015)

| 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 |
| Retention of a foreign object in a patient after surgery or other procedure | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **3** | Deaths: 0; | Serious Injury: 0; | Neither: 3 |
| A fall while being cared for in a facility | **3** | Deaths: 0; | Serious Injury: 3; | 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 3.55

# Phillips Eye Institute

**ADDRESS:**
2215 Park Ave.
Minneapolis, MN 55404-3711

**WEBSITE:**
www.phillipseyeinstitute.com

**PHONE NUMBER:**
612-775-8800

**NUMBER OF BEDS:**
20

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
14,607

**NUMBER OF PATIENT DAYS:**
40,405

**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, 2014 – OCTOBER 6, 2015)

| 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 3.56

# Redwood Area Hospital

**ADDRESS:**
100 Fallwood Road
Redwood Falls, MN 56283-1828

**WEBSITE:**
www.redwoodareahospital.org

**PHONE NUMBER:**
507-637-4529

**NUMBER OF BEDS:**
25

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
3,355

**NUMBER OF PATIENT DAYS:**
5,086

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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

# Regency Hospital of Minneapolis

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

**WEBSITE:**
www.minneapolis.regencyhospital.com

**PHONE NUMBER:**
989-295-6728

**NUMBER OF BEDS:**
92

**NUMBER OF PATIENT DAYS:**
21,141

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.58

# 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:**
12,345

**NUMBER OF PATIENT DAYS:**
22,554

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.59

# Regions Hospital

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

**WEBSITE:**
www.regionshospital.com

**PHONE NUMBER:**
651-254-9546

**NUMBER OF BEDS:**
454

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
138,952

**NUMBER OF PATIENT DAYS:**
207,129

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **13** | Deaths: 0; | Serious Injury: 0; | Neither: 13 |
| 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** | **18** | **Deaths: 0;** | **Serious Injury: 2;** | **Neither: 16** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

# Rice Memorial Hospital

**ADDRESS:**
301 Becker Ave. S.W.
Willmar, MN 56201-3302

**WEBSITE:**
www.ricehospital.com

**PHONE NUMBER:**
320-231-4223

**NUMBER OF BEDS:**
136

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
18,018

**NUMBER OF PATIENT DAYS:**
25,196

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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: 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 3.61

# Ridges Surgery Center

**ADDRESS:**
14101 Fairview Dr. Ste. 400
Burnsville, MN 55337

**WEBSITE:**
www.ridgessurgerycenter.com

**PHONE NUMBER:**
952-658-8034

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
1,597

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A medication error | **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 3.62

# 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:**
38,330

**NUMBER OF PATIENT DAYS:**
68,436

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| 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** | **2** | **Deaths: 1;** | **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 3.63

# 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:**
8,024

**NUMBER OF PATIENT DAYS:**
8,930

**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, 2014 – OCTOBER 6, 2015)

| 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 |
| **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 3.64

# Riverwood Healthcare Center

**ADDRESS:**
200 Bunker Hill Drive
Aitkin, MN 56431-1865

**WEBSITE:**
www.riverwoodhealthcare.org

**PHONE NUMBER:**
218-927-5536

**NUMBER OF BEDS:**
25

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
9,073

**NUMBER OF PATIENT DAYS:**
14,286

**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, 2014 – OCTOBER 6, 2015)

| 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 3.65

# Sanford Bemidji Medical Center

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

**WEBSITE:**
www.sanfordhealth.org/bemidji

**PHONE NUMBER:**
218-333-5040

**NUMBER OF BEDS:**
118

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
30,742

**NUMBER OF PATIENT DAYS:**
73,803

**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, 2014 – OCTOBER 6, 2015)

| 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** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **4** | Deaths: 0; | Serious Injury: 0; | Neither: 4 |
| 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 | **3** | Deaths: 0; | Serious Injury: 3; | Neither: 0 |
| **CRIMINAL EVENTS** | | | | |
| Sexual assault on a patient | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **TOTAL EVENTS FOR THIS FACILITY** | **10** | **Deaths: 1;** | **Serious Injury: 3;** | **Neither: 6** |

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

**TABLE 3: FACILITY-SPECIFIC DATA**

TABLE 3.66

# Sanford Canby Medical Center

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

**WEBSITE:**
www.sanfordcanby.org

**PHONE NUMBER:**
507-223-7277 Ext. 213

**NUMBER OF BEDS:**
25

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
1,820

**NUMBER OF PATIENT DAYS:**
2,766

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME |
|---|---|---|
| **CARE MANAGEMENT EVENTS** | | |
| 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 3.67

# Sanford Luverne Medical Center

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

**WEBSITE:**
www.sanfordluverne.org

**PHONE NUMBER:**
507-449-1215

**NUMBER OF BEDS:**
28

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
3,393

**NUMBER OF PATIENT DAYS:**
8,093

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.68

# Sanford Thief River Falls Medical Center

**ADDRESS:**
3001 Sanford Pkwy.
Thief River Falls, MN 56701-2700

**WEBSITE:**
www.sanfordhealth.org

**PHONE NUMBER:**
701-200-6080

**NUMBER OF BEDS:**
99

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
10,836

**NUMBER OF PATIENT DAYS:**
28,016

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A medication error | **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 3.69

# Sanford Worthington Medical Center

**ADDRESS:**
1018 Sixth Ave.
Worthington, MN 56187-2298

**WEBSITE:**
www.sanfordworthington.org

**PHONE NUMBER:**
507-372-3272

**NUMBER OF BEDS:**
48

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
7,798

**NUMBER OF PATIENT DAYS:**
12,483

**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, 2014 – OCTOBER 6, 2015)

| 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 3.70

# 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:**
98,404

**NUMBER OF PATIENT DAYS:**
184,501

**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, 2014 – OCTOBER 6, 2015)

| 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 | **4** | Deaths: 0; | Serious Injury: 0; | Neither: 4 |
| **CARE MANAGEMENT EVENTS** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **3** | Deaths: 0; | Serious Injury: 0; | Neither: 3 |
| Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results. | **2** | Deaths: 0; | Serious Injury: 2 | 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 | **4** | Deaths: 0; | Serious Injury: 4; | Neither: 0 |
| A medication error | **2** | Deaths: 0; | Serious Injury: 2; | Neither: 0 |
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient death or serious disability associated with patient disappearance | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| Patient suicide/attempted suicide/self-harm resulting in Serious Injury | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **PRODUCT OR DEVICE EVENTS** | | | | |
| The use or malfunction of a device in patient care | **1** | Deaths: 1; | Serious Injury: 0; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **20** | **Deaths: 1;** | **Serious Injury: 10;** | **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 3.71

# St. John's Hospital

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

**WEBSITE:**
www.healtheast.org

**PHONE NUMBER:**
651-232-1613

**NUMBER OF BEDS:**
184

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
59,403

**NUMBER OF PATIENT DAYS:**
78,089

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| The irretrievable loss of an irreplaceable biological specimen | **2** | Deaths: 0; | Serious Injury: 0; | Neither: 2 |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **2** | Deaths: 0; | Serious Injury: 1; | Neither: 1 |
| **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** | **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 3.72

# St. Joseph's Hospital

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

**WEBSITE:**
www.healtheast.org

**PHONE NUMBER:**
651-232-1613

**NUMBER OF BEDS:**
401

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
33,152

**NUMBER OF PATIENT DAYS:**
87,345

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| Retention of a foreign object in a patient after surgery or other procedure | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **CARE MANAGEMENT EVENTS** | | | | |
| A fall while being cared for in a facility | **2** | Deaths: 0; | Serious Injury: 2; | 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 3.73

# St. Luke's Hospital

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

**WEBSITE:**
www.slhduluth.com

**PHONE NUMBER:**
218-249-2475

**NUMBER OF BEDS:**
267

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
54,804

**NUMBER OF PATIENT DAYS:**
100,476

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 |
| **CRIMINAL EVENTS** | | | | |
| Sexual assault on a patient | **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 3.74

# TRIA Orthopaedic Center

**ADDRESS:**
8100 Northland Drive
Bloomington, MN 55431-4800

**WEBSITE:**
www.tria.com

**PHONE NUMBER:**
952-806-5358

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
11,779

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| 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** | **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 3.75

# 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:**
90,045

**NUMBER OF PATIENT DAYS:**
152,789

**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, 2014 – OCTOBER 6, 2015)

| 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 |
| Wrong surgical/invasive procedure performed | **1** | Deaths: 0; | Serious Injury: 0; | Neither: 1 |
| **CARE MANAGEMENT EVENTS** | | | | |
| The irretrievable loss of an irreplaceable biological specimen | **3** | Deaths: 0; | Serious Injury: 0; | Neither: 3 |
| A fall while being cared for in a facility | **3** | Deaths: 1; | Serious Injury: 2; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **9** | **Deaths: 1;** | **Serious Injury: 2;** | **Neither: 6** |

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

## TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.76

# University of Minnesota Medical Center – Fairview

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

**WEBSITE:**
www.uofmmedicalcenter.org

**PHONE NUMBER:**
612-672-6919

**NUMBER OF BEDS:**
1,700

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
200,894

**NUMBER OF PATIENT DAYS:**
346,791

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **SURGICAL/OTHER INVASIVE PROCEDURE EVENTS** | | | | |
| Wrong surgical/invasive procedure performed | **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** | | | | |
| Stage 3, 4 or unstageable pressure ulcers (with or without death or Serious Injury) | **10** | Deaths: 0; | Serious Injury: 0; | Neither: 10 |
| 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 | **4** | Deaths: 0; | Serious Injury: 4; | Neither: 0 |
| A medication error | **5** | Deaths: 2; | Serious Injury: 3; | Neither: 0 |
| **PATIENT PROTECTION EVENTS** | | | | |
| Patient suicide/attempted suicide/self-harm resulting in Serious Injury | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| **TOTAL EVENTS FOR THIS FACILITY** | **25** | **Deaths: 2;** | **Serious Injury: 8;** | **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 3.77

# Windom Area Hospital

**ADDRESS:**
2150 Hospital Drive
Windom, MN 56101-0339

**WEBSITE:**
www.windomareahospital.com

**PHONE NUMBER:**
507-831-0625

**NUMBER OF BEDS:**
18

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
4,245

**NUMBER OF PATIENT DAYS:**
5,131

**HOW TO READ THESE TABLES:**
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | NUMBER | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| 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 3.78

# Woodwinds Health Campus

**ADDRESS:**
1925 Woodwinds Drive
Woodbury, MN 55125-2270

**WEBSITE:**
www.healtheast.org

**PHONE NUMBER:**
651-232-1613

**NUMBER OF BEDS:**
86

**NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:**
30,034

**NUMBER OF PATIENT DAYS:**
37,556

**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, 2014 – OCTOBER 6, 2015)

| CATEGORY AND TYPE | | OUTCOME | | |
|---|---|---|---|---|
| **CARE MANAGEMENT EVENTS** | | | | |
| A medication error | **1** | Deaths: 0; | Serious Injury: 1; | Neither: 0 |
| 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** | **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.

# 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

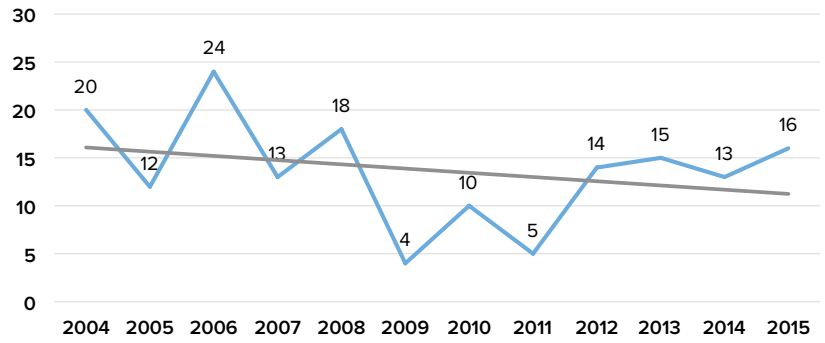
1. Death or serious injury of a patient associated with the introduction of a metallic object into the MRI area.

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.

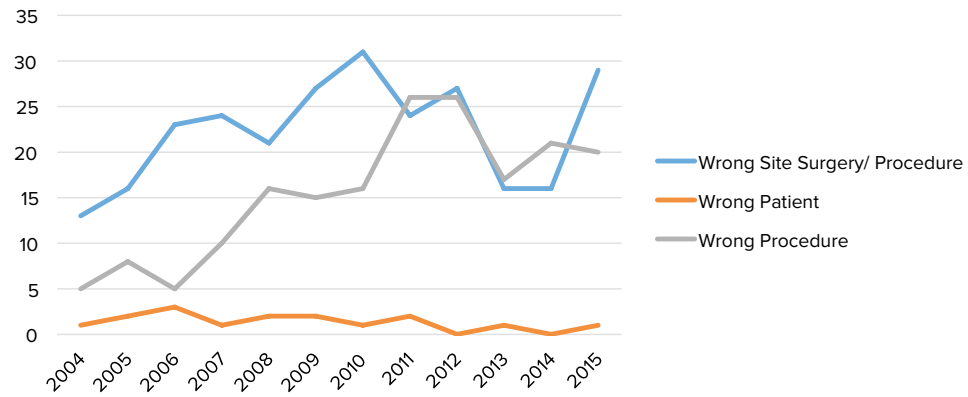
# APPENDIX B:
## Adverse Events Data, 2003-2015

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 2,910 events have been reported to MDH.

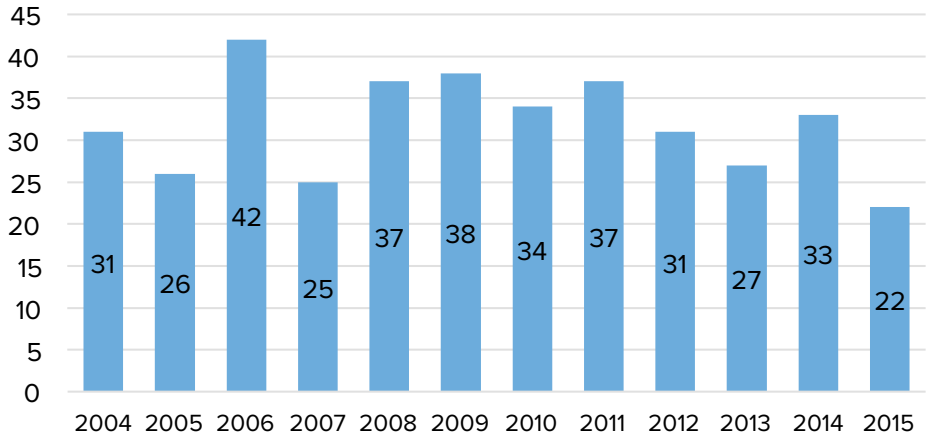
### DEATHS PER YEAR, 2003-2015



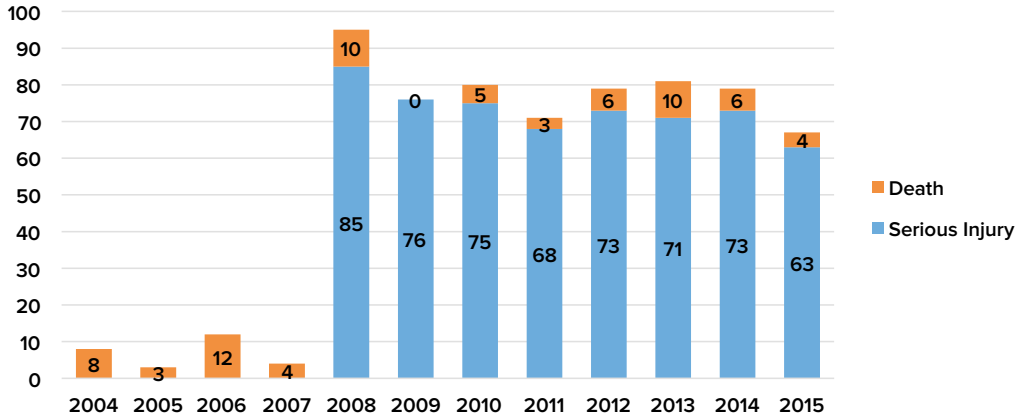

### SURGICAL EVENTS, 2003-2015



## RETAINED FOREIGN OBJECTS, 2003-2015

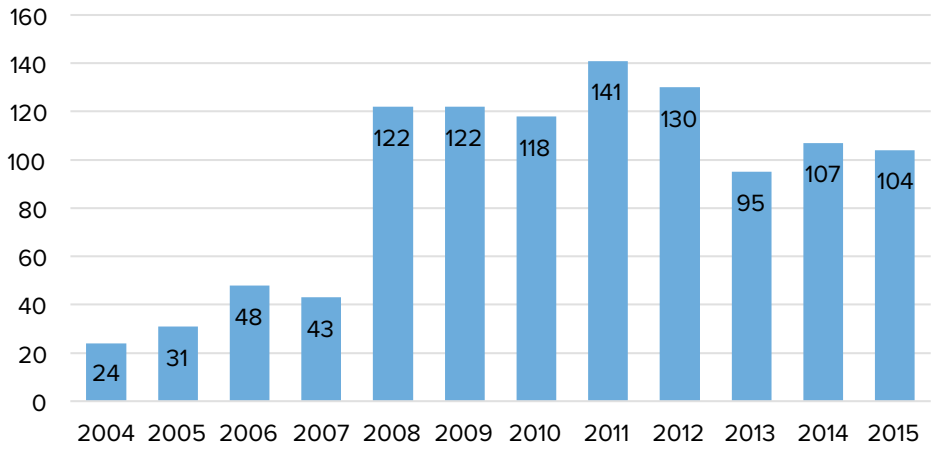



## REPORTED FALLS, 2003-2015




*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, 2003-2015




*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:

- The irretrievable loss of an irreplaceable biological specimen;
- Patient death or serious injury resulting from the failure to follow up or communicate laboratory, pathology, or radiology test results;
- Death or serious injury of a neonate associated with labor or 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.

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

# ADVERSE HEALTH EVENTS IN MINNESOTA

**12TH ANNUAL PUBLIC REPORT**

FEBRUARY 2016

MDH Minnesota Department *of* Health