ADVERSE HEALTH EVENTS IN MINNESOTA

PUBLIC REPORT

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MINNESOTA MDH DEPARTMENT OF HEALTH

ADVERSE HEALTH EVENTS IN MINNESOTA PUBLIC REPORT

TABLE OF CONTENTS

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

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STATEMENTS

2nd Adverse Health Events Public Report

"Minnesota is a national leader when it comes to patient safety. With the Minnesota reporting system and six other states having implemented the national standardized National Quality Forum events, we can begin to learn and share information across the nation, as the Institute of Medicine recommended in the To Err is Human report."

—Mary Wakefield, PhD
Co-chair, Hospital Performance Measures Committee, National Quality Forum.
Associate Dean for Rural Health, School of Medicine and Health Sciences, University of North Dakota

"The Joint Commission supports state-based efforts to identify and learn from adverse events, which were called for in the Institute of Medicine's seminal report To Err is Human. The State of Minnesota, in collaboration with its hospitals, is a leader in its innovative efforts to make health care safer for its citizens. The Joint Commission recently evaluated the State's adverse event reporting system to ensure that it is thorough and credible. The State has established a comprehensive reporting and analysis process to identify system weaknesses and ensure corrective actions, thereby reducing the likelihood of the errors from occurring again."

—The Joint Commission on Accreditation of Healthcare Organizations

"The key to the success of any reporting system is the translation of what is learned from reports into concrete actions to improve the safety of health care delivery for patients in a health system. This is a powerful tool that facilitates the sharing of information across the VA health system and will do the same across health systems in Minnesota. As Minnesota's reporting system matures, I would expect an increase in the rate of reporting with the attendant lessons learned that will follow."

—Edward Dunn, MD, MPH
Director, Policy & Clinical Affairs, VHA National Center for Patient Safety
Ann Arbor, Michigan

"I am encouraged by the lead Minnesota has taken in identifying areas where safety in our care can be improved. The adverse events report is an opportunity for healthcare consumers to be informed and involved with their health care decisions and is a major step in the transparency necessary to make healthcare in Minnesota as safe as it can be."

—Roxanne Goeltz
Past President and Co-Founder, Consumers Advancing Patient Safety

"Minnesota has led the way in state public reporting of the National Quality Forum's recommened list of 27 events by facility, and their experience serves as a powerful learning opportunity for other states interested in using reporting systems to improve patient safety and transparency in the health care system. By identifying and disseminating information about best practices, Minnesota's reporting system has the potential to create a safer healthcare system, one in which facilities learn from their own adverse events as well as from those that happen at other facilities."

—Jill Rosenthal, MPH
Project Manager, Patient Safety, National Academy for State Health Policy
Washington, D.C.

"Minnesota is well on the journey to improve the safety of care through a 'Just Culture' — a culture which focuses on improving the systems that surround the caregiver, giving them the best opportunity to make safe choices in all aspects of care. By creating this state-wide reporting system, Minnesota is fostering a learning culture that will help stakeholders in the healthcare community help share responsibility for the safety care, and provide the poeple of Minnesota the best possible care."

—David Marx
President, Outcome Engineering
Founder, The Just Culture Community
Plano, Texas

INTRODUCTION

This report presents information about 106 adverse health events reported under Minnesota's Adverse Health Events Reporting Law between October 7th, 2004 and October 6th, 2005. For the first time, adverse events that occurred at ambulatory surgery centers, which have been subject to the Adverse Health Events Reporting Law since December, 2004, are included with reports from hospitals and regional treatment centers.

The facilities that are included in this report have conducted in-depth analyses of why these events occurred, a process which has helped to uncover some key commonalities that underlie many adverse events. Their results confirm what research has long shown; that most adverse health events are caused not by the negligence of a single provider but by a breakdown in the complex systems that surround the provision of even the simplest of interventions. System-wide issues identified in this report include policies that are inconsistent or unclear across departments within a facility, communication breakdowns between providers, lack of clarity about individual roles, and staff reluctance to speak up about potential safety issues.

The Minnesota Department of Health (MDH), along with the Minnesota Hospital Association (MHA), and Minnesota's Quality Improvement Organization (Stratis Health), is using these key findings to educate providers about best practice strategies for preventing future adverse events through a variety of methods:

- Issuing safety alerts about potentially risky situations, including the use of monitoring alarms on certain types of equipment and the danger of wrong body part events when procedures are performed outside of the operating room;
- Publishing newsletters highlighting patterns in root causes or best practices related to reported events;
- Convening a state-wide summit on pressure ulcer prevention;
- Conducting training on how to conduct a thorough root cause analysis; and
- Working with the Minnesota Alliance for Patient Safety, Safest in America, and other collaborative groups on statewide patient safety initiatives.

Creating a safer healthcare system is a complicated and long-term undertaking, and measurable results may come more slowly than we'd like. But these efforts and others described in this report - together with those being implemented by individual facilities in response to their analyses – are helping to move us toward a culture that looks beyond blame to system changes that support patient safety. As more states begin to adopt mandatory reporting systems similar to Minnesota's, the lessons being learned here about why adverse events occur and how they can be prevented will become increasingly important, not only for providers but also for patients and family members interested in making sure that their healthcare is as safe as possible.

BACKGROUND

In 2003, Minnesota became the first state in the nation to institute a mandatory adverse health event reporting system that included all 27 "never events" identified by the National Quality Forum (NQF) and a public report that identified adverse events by facility. This report marks the first year of full implementation of Minnesota's Adverse Health Event Reporting System, including reports by hospitals, regional treatment centers and outpatient surgical centers, and gives an opportunity to highlight the numerous patient safety activities happening in facilities around the state that have developed, at least in part, in response to the Adverse Health Event Reporting System.

Momentum toward a system for mandatory adverse event reporting began with the publication of the Institute of Medicine report "To Err is Human" in 2000. At that time, the idea that medical errors in hospitals kill between 44,000 and 98,000 people[1] each year surprised many people. While this issue was not a new one for health professionals, most Americans reacted strongly to the idea that preventable errors could have such an impact on patient safety. The public and media attention that followed the report's publication helped to start a national conversation about the reasons why such errors occur, and a primary focus of the discussions was the concept of systemic causes for errors.

In the past, discussions of medical errors had often focused on identifying—and punishing—those who had caused the error. But the IOM report helped to confirm that most medical errors were not the result of the isolated actions of any one provider of care, but rather of a failure of the complex systems and processes in health care. The IOM recommended a mandatory reporting system wherein the most serious events would be reported, persistent safety problems would be identified and action would be taken to prevent these errors.[2]

In Minnesota, discussions led by Minnesota hospitals and the Minnesota Alliance for Patient Safety (MAPS), a broad alliance of health care leaders, hospitals, doctors, professional boards, patient advocacy groups, health plans, and the Minnesota Department of Health (MDH), resulted in the creation of Minnesota's Adverse Health Care Event Reporting Act during the 2003 legislative session. The law had broad support from both legislative parties and from Governor Pawlenty and MDH. This law mandated the reporting of 27 events that should never happen in health care, based on the Serious Reportable Events list developed through a consensus process by the National Quality Forum.

The Adverse Health Event reporting law mandated a transition period prior to full implementation, during which reporting requirements, data needs, and funding sources would be finalized. Completed event reports received during that transition period, which included the 15 months between July 2003 and October 2004, were included in the first annual public report from the Adverse Health Events reporting system, released in January, 2005. This report includes events reported during a 12-month period between October 7, 2004 and October 6, 2005.

From the beginning, Minnesota's Adverse Health Event Reporting System has been a collaborative effort, with strong support from Minnesota's health care community and 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. The focus of the system is to use information submitted by facilities to identify opportunities to prevent future occurrences. Developing avenues for education about patient safety and best practices is also a key area of activity.

While much work lies ahead, the results so far strongly suggest that the law has already served to increase awareness of patient safety issues throughout the state and led to the adoption of numerous new initiatives designed to make healthcare safer. Facilities throughout the state have initiated specific safety improvement strategies with measurable results, and effective approaches are being shared with other facilities through multiple channels. The Minnesota Department of Health, the Minnesota Hospital Association, the state Quality Improvement Organization, provider licensing boards and other interested parties are working together to identify opportunities for learning about best practices, some of which are outlined on pages 11-15 of this report.

[1] Institute of Medicine, To Err is Human: Building a Safer Health System. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds. Washington, D.C.: National Academy Press, 2000

[2] Ibid

HOW TO USE THIS REPORT

Events listed in this report represent a very small fraction of all of the procedures and admissions in Minnesota's hospitals, regional treatment centers and ambulatory surgical centers. Although these events are rare relative to the overall volume of care provided at these facilities, patient awareness is important to help prevent them from happening.

The fact that health care providers are looking for potentially dangerous situations and reporting them with the intention to learn and prevent harm to patients is a major step forward in patient safety. Rather than using this report to compare facilities based on incidence rates or to compare data from multiple years for a facility, consumers should use this report to identify situations of interest to them and then ask providers what is being done in their facility to prevent this type of event from occurring.

With relatively low occurrence of these events, it is important to be aware that the number of reports from a facility between two years, or across facilities in any given year, may differ for a variety of reasons. Facilities vary not only by size but also in the number and type of procedures that are conducted each year and in the type of patients seen; this can lead to fluctuations in the number of events reported. The reporting system itself may also have an effect; in some cases, fostering a culture in which staff at all levels feel more comfortable reporting potentially unsafe situations without fear of reprisal can lead to an increase in reported events.

As clearly as the Minnesota Adverse Health Event Reporting Law is written, there are still situations where the reportability of an event is uncertain. In those cases, facilities can contact MDH or the hospital association for guidance or clarification. MDH, MHA and other stakeholders continue to work to reduce this variation in understanding of the law by clarifying questions as they arise.

Analysis of patterns in events and root causes as a way of identifying opportunities for education or safety alerts is a key element of the reporting system. However, it is also important to note that the different time frames covered by the first and second annual reports, as well as the addition of ambulatory surgical centers in this report, make comparisons between numbers of reported events in the two reports difficult.

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

- **The size of the facility and the number of procedures or admissions per year.**
- **Differences in interpretation on which events qualify as reportable.**

It is also important to remember that the scope of patient safety is much broader than what is represented by these 27 reportable events. Facilities throughout the state have undertaken important initiatives to improve patient safety, many of which would not be covered in this report.

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

THE ADVERSE HEALTH EVENTS REVIEW PROCESS

The Adverse Health Events Reporting Law directs MDH to track, assess, and analyze all incoming reports of adverse events, along with the accompanying root cause analyses and corrective action plans. This process begins when an adverse health event is submitted by a hospital, regional treatment center or ambulatory surgical center into a password-protected web-based registry that is maintained by the Minnesota Hospital Association. Facilities are required to report events within 15 working days of their discovery, and to submit the findings of their internal root cause analysis and corrective action plan(s) within 60 days.

A root cause analysis is a process that is usually conducted by a team of clinical and patient safety professionals within a facility, and which is designed to uncover the various systemic or process factors that led to the adverse event. A root cause may be related to lack of communication, a problem in the flow of information, equipment that does not function as expected, lack of adherence to a policy or established procedure, lack of training, staffing issues, or many other factors.

The process of working to discover all of the factors that led to the incident, rather than just the most obvious or immediately preceding causes, is crucial for preventing a repeat of the situation. Conducting a thorough root cause analysis requires a facility to dig deeply into preceding events and policies, repeatedly asking why something did or did not occur as a way of identifying broader systemic issues.

From the findings of these root cause analyses, facilities develop corrective action plans that address those underlying factors. Corrective actions may range from simple yet effective quick "fixes" to significant changes that require more time and resources to implement. A single event may have multiple root causes, as well as multiple associated corrective action plans.

To be effective, an action plan needs to include specific plans and timelines for implementation, a plan for communicating changes in processes or protocols within and across the departments of a facility, and a clear plan for monitoring the success of the new approach over time. An effective plan will also describe how the facility will respond if the new approach does not achieve the desired results.

Facilities are required to share the outcomes of these processes with MDH, which works with a team of adverse events analysts to determine whether each root cause finding and corrective action plan is thorough, appropriately targeted, and timely. The analysis team uses a set of pre-determined criteria to evaluate each submitted report, to ensure consistent and thorough reviews.

Facilities receive feedback from this team on their root cause analysis findings and corrective action plans, and are expected to make changes to their reports within 30 days based on that feedback. Revised root cause analyses and corrective action plans are reviewed again by the analysis team and additional feedback given to the facility.

Sharing Information

Along with providing feedback to individual facilities about their root cause analyses and corrective action plans, MDH is also responsible for determining patterns of system failure and successful methods for addressing them, and for sharing this information with facilities. This information sharing takes many forms.

Information about patterns in root causes and best practices is regularly shared with facilities through newsletters, safety alerts, presentations, and meetings. Many hospitals also choose to participate in a data-sharing agreement, through the Minnesota Hospital Association, whereby they can learn directly from other hospitals' experiences with similar events.

Over the first year of full implementation of the law, the analysis and feedback process, as well as the identification of educational opportunities for providers, have become more fully developed and streamlined. This process will likely evolve as the adverse events reporting system matures, and we anticipate that learning by reporting facilities and analysts will continue to grow along with the reporting system.

Ensuring Accountability

While MDH has implemented the Adverse Health Events Reporting Law as a quality improvement and accountability initiative rather than as a regulatory tool, the Department is still authorized and required to investigate complaints and enforce licensing and certification standards for certain health care facilities. Adverse health event reporting does not supplant these other regulatory requirements. Adverse events and regulatory staff have worked to develop a system wherein the policy goals of the Adverse Health Events reporting system are balanced with the regulatory obligations of the Department, and facilities are held accountable through multiple channels.

Adverse health event reports that are submitted in a timely manner and in compliance with the Adverse Health Events Reporting Law are reviewed solely under that law following the procedure described above. However, if an adverse health event is discovered that has not been submitted within the time frame required by statute, the facility where the event occurred would be subject to investigation by the Department of Health under the Vulnerable Adult Act (VAA) or the Maltreatment of Minors act.

If MDH's Office of Health Facility Complaints receives a complaint about a potential incident, the facility may also be subject to an investigation whether or not the event was reported through the adverse health events reporting system. In either case, a facility may be subject to state or federal sanctions depending on the findings of the investigation, and information may also be provided to the appropriate professional boards. Findings of complaint investigations are also made public.

Four of the 27 reportable adverse events are criminal events. Facilities must still report these events under the existing VAA or Maltreatment of Minors requirements, along with events that fall outside the scope of the 27 reportable adverse events but meet the reporting requirements of the VAA, the Maltreatment of Minors Act, or other state, federal or accreditation reporting requirements.

Finally, the licensing boards that regulate physicians, physician assistants, nurses, pharmacists and podiatrists are also required to report to MDH when events come to their attention that may qualify as adverse health events. This serves as an additional level of accountability for facilities that are required to submit adverse health events, and another way for the Department to ensure that events are being reported.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

Detailed definitions are included in Appendix C.

SURGICAL EVENTS

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

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

ENVIRONMENTAL EVENTS

Patient death or serious disability associated with:

- An electric shock;
- A burn incurred while being cared for in a facility;
- The use of or lack of restraints or bedrails while being cared for in a facility.

And;

- Death associated with a fall while being cared for in a facility; and
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

PATIENT PROTECTION EVENTS

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

CARE MANAGEMENT EVENTS

- Stage 3 or 4 pressure ulcers (very serious bed sores) acquired after admission to a facility.

And;

Patient death or serious disability:

- Associated with a medication error;
- Associated with a reaction due to incompatible blood or blood products;
- Associated with labor or delivery in a low-risk pregnancy;
- Directly related to hypoglycemia (low blood sugar);
- Associated with hyperbilirubinemia (jaundice) in newborns during the first 28 days of life;
- Due to spinal manipulative therapy.

PRODUCT OR DEVICE EVENTS

Patient death or serious disability associated with:

- The use of contaminated drugs, devices, or biologics;
- The use or malfunction of a device in patient care; and
- An intravascular air embolism (air that is introduced into a vein).

CRIMINAL EVENTS

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

DETERMINING WHY:
ROOT CAUSE ANALYSIS

The process of completing a root cause analysis helps a facility determine exactly what happened and why it happened. These findings are the key to preventing future events. Analyzing information from multiple RCA's can help a facility to identify patterns of system vulnerability within their organization that might not be immediately apparent from one event, and enable them to design corrective action plans that will improve patient safety across departments of the facility. Identifying common factors underlying events at multiple facilities can also lead to collaboration on finding solutions. This is particularly important with relatively rare events, where small numbers would otherwise make trend analysis difficult, if not impossible.

Overall findings from reported RCAs

Below is a summary of RCA information submitted by hospitals, regional treatment centers and ambulatory surgical centers over the past year for the top reporting categories. While the specifics of each event differ, it is possible to identify some commonalities in root or contributing causes across facilities, particularly for the most common categories of events. Overall, facilities commonly cite issues related to communication, environmental or equipment factors, non-adherence to or lack of established procedures, or a lack of clarity about how policies or procedures should be applied to different situations or settings. Many facilities identified more than one contributing factor for an event.

Surgical Events:

- A time-out for verification of the correct site or correct procedure before beginning an invasive procedure was not conducted.
- Distractions or interruptions during counts of sponges or other supplies in the surgical field, caused by pagers, staff changes, equipment issues, competing conversations, a change in the patient's condition, or other factors, led to an incorrect count and a retained object.
- Policies or protocols that are used in the operating room to verify surgical sites may not be used in procedure rooms or during bedside procedures, or it may not be clear to staff that policies apply in other settings. Documentation or protocols for procedures conducted in other settings may not include a trigger for a time-out to stop the procedure and verify correct patient/site/procedure.
- Surgical site marking was not specific enough.
- Perceived time pressure to complete a procedure led to a second verification of the surgical site not being conducted.
- Surgical team not all clear on individual roles within the team related to the Universal Protocol (steps facilities should follow to prevent wrong site, wrong procedure, or wrong person surgery).
- Lack of staff training on active communication.
- Policies/procedures may vary in different areas of the hospital; if staff move from one area of the facility to another, they may not be familiar with standard procedures.
- Relevant documentation (operative notes, consent form, etc) is not always available/ visible at the point when it is needed.
- Individual team members may use inconsistent sponge count policies.
- Sponge counts are not conducted for certain types of procedures.
- Protocols related to pre-closure x-rays for identification of potential retained objects not followed.
- Lack of communication during staff handoffs (i.e. one technician or nurse leaves the OR, another comes in).
- No policies in place for counting certain materials/equipment present in surgical field.
- Accountability for tracking certain items before/during/after procedure not clear.
- Staff members didn't always feel comfortable speaking up about potential errors.

Care Management Events - Pressure ulcers:

- Risk assessments for skin breakdown not routinely conducted.
- Regular skin inspections not done, or not reflective of current best practice.
- Other critical health issues take precedence over skin integrity, particularly in critical care or ICU, or prevent certain preventive measures from being taken in a timely manner.
- Inconsistent or incomplete documentation of skin inspections.
- Communication falters between unit and wound care staff, at shift change, or with patient's move to a new unit.
- Lack of communication about patients at risk for developing pressure ulcers.
- Staff unable to determine what type of bed or other pressure-redistributing devices to use.
- Delays in ordering pressure-redistributing equipment.
- Decision tools to determine risk, interventions, bed choices, etc not available or not utilized.

Care Management Events – Medication Errors:

- Five rights of medication administration (right patient, medication, dose, route, time) not verified.
- Medication verification procedure inconsistent, or documentation not double-checked against physician's medication order.
- Documentation not available with patient record.

ADDRESSING THE ISSUES:
How can future events be prevented?

The goal of the Adverse Health Events Law is to increase awareness of why adverse events happen and to develop solutions to prevent them from happening again. Individual facilities use the findings from their root cause analyses to prevent a repeat of that or a similar event. At the same time, Minnesota facilities and other collaborative groups have developed several notable initiatives to improve patient safety. Initiatives undertaken by individual facilities and by other stakeholders are outlined below.

Patients and their families also have a role to play in preventing these types of events. In our complex health care system, ensuring safety is an ongoing process, one that involves not only clinicians and patient safety experts but also patients and their families. Tips for patients and their families on how to make their health care safer are also outlined below. Additional information and resources for patients and families is available through the Federal Agency for Healthcare Research and Quality (AHRQ) at www.ahrq.gov and through the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) at www.jcipatientsafety.org. Links to both organizations are also provided in Appendix E.

Surgical Events

What Facilities Are Doing to Prevent Surgical Events

- Developing new ways to track objects used in surgical procedures
- Ensuring that sponges and other surgical materials are counted in a consistent manner for all types of procedures
- Developing new policies to cover counts of sponges and other materials in procedure rooms or other non-OR settings
- Purchasing surgical sponges and other materials that are easier to track and count
- Making sure that surgery teams are pausing before surgery to review patient information and that all team members understand their role in this process
- Ensuring that 'time-out' policies are used for all bedside procedures as well as those performed in operating rooms
- Having a standard procedure for marking the surgical site prior to surgery
- Increasing the use of x-rays in the operating room to identify the correct surgery site and/or to identify retained objects

What Others Are Doing to Prevent Surgical Events

- Safest in America (SIA) is a collaboration of 10 hospital systems in the Twin Cities and Rochester that are working with the Institute for Clinical Systems Improvement to improve patient care by learning from group members' experiences. SIA has been very active in reducing wrong site, wrong patient, and wrong procedure events.
- In 2004, SIA updated their Safe Site Protocol for Surgical and Invasive Procedures to include imaging (such as CT scans) for spinal surgery to confirm that a procedure is being done at the correct spine level.

What You Can Do to Prevent Surgical Events

- **If you have a choice, choose a facility at which many patients have the procedure or surgery you need.** Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.
- **If you are having surgery or other medical procedures, make sure that you, your doctor, and your surgeon all agree and are clear on exactly what will be done.** Doing surgery at the wrong site (for example, on the left knee instead of the right) is rare. But even once is too often, and wrong-site surgery is always preventable. The American Academy of Orthopaedic Surgeons urges its members to sign their initials directly on the site to be operated on before the surgery.
- **If possible, verify that your surgeon has marked the correct site with indelible ink.**

Pressure Ulcers (Bed Sores)

What Facilities Are Doing to Prevent Pressure Ulcers

- Using tools and methods to consistently assess patients at risk for pressure ulcers
- Providing new resources and decision-making algorithms to assist nursing staff in implementing appropriate interventions for at-risk patients
- Purchasing special equipment to use for patients at risk for pressure ulcers
- Setting up physician orders to make sure patients at risk for pressure ulcers are re-positioned on a regular basis
- Providing additional training on pressure ulcer prevention and wound care
- Improving between-shift and between-unit communication regarding assessment and interventions for at-risk patients
- Increasing the involvement of staff that specialize in wound care

What Others Are Doing to Prevent Pressure Ulcers

- The Minnesota Alliance for Patient Safety (MAPS) worked with wound care experts to identify barriers to implementing existing tools and educate health care professionals, patients and families on how to successfully implement a pressure ulcer reduction program.
- MAPS worked with the Institute for Clinical Systems Improvement to develop a protocol for pressure ulcer prevention specific to acute-care. The protocol was shared during a statewide pressure ulcer prevention summit that took place in November 2005.

What You Can Do to Prevent Pressure Ulcers

- **Participate in your own care by inspecting your own skin and ensuring that your caregivers do so daily.**[3] Examine areas of your body (or your family member's body) that are exposed to pressure and watch for reddened skin.
- **Limit pressure by moving often.** If you are able, change positions every 1-2 hours to limit pressure over bony parts of the body. When you move or are moved, lift rather than drag to avoid friction, which can damage the skin.
- **Ask questions to understand your care.** Your caregivers may need to reposition you, use special equipment to relieve or redistribute pressure, or conduct regular skin inspections to help you avoid a pressure ulcer. If you don't understand why something is being done, ask. You can also ask what you can do in the hospital or at home to prevent pressure ulcers from forming.

[3] AHCPR (AHRQ) Supported Consumer Guides #3, Preventing Pressure Ulcers: A Patient's Guide. May, 1992.

Medication Errors

What Facilities Are Doing to Prevent Medication Errors

- Developing color-coding systems to distinguish medications
- Designing simulations for providers to practice administration of high-risk medications
- Evaluating use of automated devices for administering certain medications

What Others Are Doing to Prevent Medication Errors

- SIA has established a medication safety work group, and has developed recommendations on the elimination of unsafe abbreviations on handwritten prescriptions.
- The Institute for Healthcare Improvement (IHI), through its 100,000 Lives Campaign, is working to improve medication reconciliation procedures as a way of minimizing adverse drug events.
- The Minnesota Alliance for Patient Safety has developed tools for consumers (at right).

What You Can Do to Prevent Medication Errors

- **Keep track of medications you're currently taking, and make sure that all of your doctors know everything that you are taking.** Consider keeping track of all medications on a medication card, and share the information with your doctor. A medicine tracking form, along with background tips, is available from the Minnesota Alliance for Patient Safety at www.mnpatientsafety.org.
- **Make sure you can read the handwriting on your prescription.** If you can't read the physician's handwriting, the pharmacist might not be able to, either. Make sure that the prescription has the right name, drug, and dosage; many medications have similar names.
- **When you are prescribed a new medication, ask if it is safe to take with your other medications or supplements.**[4] **And when you pick up medicine from the pharmacy, ask 'Is this the medicine that my doctor prescribed?'**

[4] Joint Commission on the Accreditation of Health Care Organizations, Things you can do to prevent medication mistakes. Available: http://www.jcaho.org/general+public/gp+speak+up/speakup_brochure_meds.pdf [Accessed October 2005]

Other Events

What Stakeholders Are Doing to Prevent Other Types of Events

- The Minnesota Hospital Association (MHA) has established a Registry Advisory Council, made up of patient safety professionals from member hospitals, to review the information being reported, look for clusters of events, identify the need for safety alerts and develop recommendations for acting on data and sharing what has been learned.
- MHA also produces an e-newsletter for hospitals that discusses adverse health event findings, highlights best practices, and keeps facilities up to date on reporting system requirements and system changes.
- MHA educates hospitals on best practices throughout the year, and honors facilities who have developed programs resulting in dramatic improvements in patient safety.
- SIA has established medication safety, rapid response team, and hospital-acquired infection work groups, and has developed recommendations on the elimination of unsafe abbreviations on handwritten prescriptions.
- Working with SIA, The Institute for Clinical Systems Improvement (ICSI) has developed standardized order sets for managing insulin and for preventing ventilator-associated pneumonia.
- The Institute for Healthcare Improvement (IHI) is leading the 100,000 Lives Campaign, designed to engage hospitals in a commitment to implement changes in care that will lead to a reduction in deaths due to ventilator-associated pneumonia, adverse drug events, surgical site and central line infections, acute myocardial infarction (heart attacks), and to deploy rapid response teams. MAPS is working to collect data from hospitals around the state as part of the 100,000 Lives Campaign, as well as serving as the coordinator for initiatives related to rapid response teams and ventilator-associated pneumonia.
- Numerous organizations, including ICSI, ISMP, JCAHO, AHRQ, and many others, have patient safety information and resources for consumers available on their websites. See Appendix E for additional information and links.

What You Can Do to Prevent Other Types of Events

- **Be an active member of your health care team.** Take part in every decision about your care, and don't be afraid to ask questions. Patients who are more involved with their care tend to get better results.
- **Speak up if you have questions or concerns.** You have a right to question anyone who is involved with your care. Don't be embarrassed if you don't understand; it's your right to know what's happening. If you feel that you are about to be given the wrong medication or treatment, or if something doesn't feel right, speak up. Ask a family member or friend to speak up for you if you can't.
- **When you are being discharged, ask your doctor to explain the treatment plan you will use at home.** Learn about your medicines and find out when you can get back to your regular activities. Research shows that at discharge, doctors think patients understand more than they really do about what they should or shouldn't do when they return home.
- **Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.**[5]
- **Ask for written materials related to your condition and to proposed treatments.** You can read information at home, and think of additional questions to ask at your next visit.
- **Make sure that someone, such as your personal doctor, is in charge of your care.** This is especially important if you have many health problems or are in a hospital.
- **Make sure that all health professionals involved in your care have important health information about you.** Do not assume that everyone knows everything they need to.

For more information:

Minnesota Hospital Association
www.mnhospitals.org

Safest in America
www.safestinamerica.org

Minnesota Alliance for Patient Safety
www.mnpatientsafety.org

100,000 Lives Campaign
www.ihi.org/IHI/Programs/Campaign/Campaign.htm

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

CONCLUSION

The annual release of facility-specific data on adverse health events helps to focus attention on the incidence and causes of adverse events. But preventing harm to patients requires more than just counting events. Disseminating evidence-based best practices about patient safety, implementing these changes, and making sure that they are sustainable over time is critical. As we move forward with the implementation of this law, the Minnesota Department of Health and its partners will continue to use the improvements directly resulting from the implementation of this law to create new opportunities for learning.

Improving patient safety is a long-term process, and there is still much work to be done. Initiatives like the Adverse Health Events Reporting Law help to focus attention and energy on preventing the most serious adverse events and harm to patients, but it is important to remember that this reporting system is just one component of broader patient safety improvement strategies in Minnesota. Comprehensive efforts to reduce adverse events are underway nationally and here in Minnesota, and the effects of these efforts are already being seen in the increased adoption of best practices by facilities. Consumers and patients should use reports like this one to increase their awareness of patient safety issues and let their health providers know that patient safety and adverse event prevention strategies are a priority for them. This awareness and attention will help ensure that patient safety will continue to be a priority for hospitals, ambulatory surgical centers and other health providers in Minnesota.

TABLES AND DETAILED INFORMATION

TABLE 1:

Overall Statewide Report . . . . . page 17

- This table describes the total number of reported events for the state during the period from October 7, 2004 through October 6, 2005. The events are grouped under the six major categories of events. The severity details are also included for the events reported, indicating if the result was death, serious disability or neither.

TABLE 2:

Statewide Report by Event Category . . . . . pages 18–20

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

TABLES 3.1 – 3.31:

Facility-Specific Data . . . . . page 21

- These tables show the number of events reported at each facility. They include the reported number for each of the 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.
- Information on the size of the facility is presented on each table. This information is given in two ways:
  1) **Number of beds:** This is a common measure of the size of a hospital and provides a sense of the maximum number of patients who could stay at the facility at any one time. In Minnesota, hospitals range in size from 10 to 1,700 beds. This measure is shown just for hospitals, not ambulatory surgical centers.
  2) **Patient days:** This measure represents how busy the hospital was over the reporting time period. It is a measure of the number of days that inpatients are hospitalized. Patient days were adjusted to account for inpatient and outpatient services.
- For facilities that reported surgical events, a measure of the number of surgeries performed at the facility during the reporting period is also included. This figure does not include endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.
- Facilities are listed in alphabetical order.
- If there is no table for a facility, it means that facility did not report any events.

The Minnesota Hospital Association worked with each hospital and ambulatory surgical center to verify the accuracy of the reported events and, in cases where there were no events reported, asked facilities to verify that they had no events.[6]

[6] One facility, Madison Hospital, declined to provide verification of the data; they had reported no events during the reporting period.

TABLE 1
OVERALL STATEWIDE REPORT

Reported adverse health Events: **ALL EVENTS** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS						
	SURGICAL	PRODUCT	PATIENT PROTECTION	CARE MANAGEMENT	ENVIRONMENTAL	CRIMINAL	TOTAL
ALL FACILITIES	53 Events	6 Events	1 Event	39 Events	4 Events	3 Events	106 Events
SEVERITY DETAILS	Serious Disability: 1 Death: 1 Neither: 51	Serious Disability: 1 Death: 5	Serious Disability: 0 Death: 1	Serious Disability: 6 Death: 2 Neither: 31	Serious Disability: 1 Death: 3	Serious Disability: 0 Death: 0 Neither: 3	Serious Disability: 9 Death: 12 Neither: 85

TABLE 2
STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS					
	1. WRONG BODY PART	2. WRONG PATIENT	3. WRONG PROCEDURE	4. FOREIGN OBJECT	5. INTRA/POST-OP DEATH	TOTAL FOR SURGICAL
ALL FACILITIES	16 Events	2 Events	8 Events	26 Events	1 Event	53 Events
SEVERITY DETAILS	Serious Disability: 1 Death: 0 Neither: 15	Serious Disability: 0 Death: 0 Neither: 2	Serious Disability: 0 Death: 0 Neither: 8	Serious Disability: 0 Death: 0 Neither: 26	Serious Disability: 0 Death: 1 Neither: 0	Serious Disability: 1 Death: 1 Neither: 51

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS			
	6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	7. MISUSE OR MALFUNCTION OF DEVICE	8. INTRAVASCULAR AIR EMBOLISM	TOTAL FOR PRODUCTS OR DEVICES
ALL FACILITIES	1 Event	4 Events	1 Event	6 Events
SEVERITY DETAILS	Serious Disability: 0 Death: 1	Serious Disability: 1 Death: 3	Serious Disability: 0 Death: 1	Serious Disability: 1 Death: 5

Details by Category: **PATIENT PROTECTION** (October 7, 2004- October 6, 2005)

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

TABLE 2 (CONTINUED)
STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS							
	12. DEATH OR DISABILITY DUE TO MEDICATION ERROR	13. DEATH OR DISABILITY DUE TO HEMOLYTIC REACTION	14. DEATH OR DISABILITY DURING LOW-RISK PREGNANCY LABOR OR DELIVERY	15. DEATH OR DISABILITY ASSOCIATED WITH HYPO-GLYCEMIA	16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPER-BILIRUBI-NEMIA	17. STAGE 3 OR 4 PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULA-TION	TOTAL FOR CARE MANAGE-MENT
ALL HOSPITALS	7 Events	0 Events	0 Events	1 Event	0 Events	31 Events	0 Events	39 Events
SEVERITY DETAILS	Serious Disability: 6 Death: 1			Serious Disability: 0 Death: 1		Serious Disability: 0 Death: 0 Neither: 31		Serious Disability: 6 Death: 2 Neither: 31

Details by Category: **ENVIRONMENTAL** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS					
	19. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	20. WRONG GAS OR CONTAMINA-TION IN PATIENT GAS LINE	21. DEATH OR DISABILITY ASSOCIATED WITH A BURN	22. DEATH ASSOCIATED WITH A FALL	23. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	TOTAL FOR ENVIRON-MENTAL
ALL HOSPITALS	0 Events	0 Events	0 Events	3 Events	1 Event	4 Events
SEVERITY DETAILS				Death: 3	Serious Disability: 1 Death: 0	Serious Disability: 1 Death: 3

TABLE 2 (CONTINUED)
STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL** (October 7, 2004- October 6, 2005)

	TYPES OF EVENTS				
	24. CARE ORDERED BY SOMEONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	25. ABDUC-TION OF PATIENT	26. SEXUAL ASSAULT OF A PATIENT	27. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT	TOTAL FOR CRIMINAL
ALL HOSPITALS	0 Events	0 Events	2 Events	1 Event	3 Events
SEVERITY DETAILS			Serious Disability: 0 Death: 0 Neither: 2	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 0 Death: 0 Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address: 800 East 28th Street Minneapolis, MN 55407-3723
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 926

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**23,345 surgeries were performed at this facility during this time period**
Surgery performed on wrong patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 245,861 patient days at this facility during this time period**
Hypoglycemia	1	Deaths: 1; Serious Disability: 0; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	5	Deaths: 1; Serious Disability: 0; Neither: 4

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

ALBERT LEA MEDICAL CENTER – MAYO HEALTH SYSTEM

Address: 404 West Fountain Street Albert Lea, MN 56007
Website: www.almedcenter.org
Phone number: 507-377-6447
Number of beds: 107

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 20,940 patient days at this facility during this time period**
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

AVERA MARSHALL REGIONAL MEDICAL CENTER

Address: 300 S. Bruce St. Marshall, MN 56258-1934
Website: www.averamarshall.org
Phone number: 507-537-9167
Number of beds: 49

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**1,273 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

BETHESDA HOSPITAL

Address: 559 Capitol Boulevard St Paul, MN 55103-2101
Website: www.healtheast.org/patientsafety
Phone number: 651-232-2185
Number of beds: 264

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 46,474 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	**3**	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

BRAINERD REGIONAL HUMAN SERVICES CENTER

Address: 11800 State Hwy 18 Brainerd, MN 56401-7300
Website: www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_000087.hcsp
Phone number: 651-582-1678
Number of beds: 188

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PATIENT PROTECTION EVENTS		**There were 30,013 patient days at this facility during this time period**
Patient suicide or attempted suicide resulting in serious disability	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

CAMBRIDGE MEDICAL CENTER

Address: 701 Dellwood St. S. Cambridge, MN 55008-1920
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 86

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**4,101 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA, MINNEAPOLIS

Address: 2525 Chicago Ave. S. Minneapolis, MN 55404-4518
Website: www.childrensmn.org
Phone number: 612-813-6693
Number of beds: 153

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 69,818 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 1; Neither: 0

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA, ST PAUL

Address: 345 N. Smith Ave. St Paul, MN 55102-2346
Website: www.childrensmn.org
Phone number: 612-813-6693
Number of beds: 126

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**7,574 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

COOK COUNTY NORTH SHORE HOSPITAL

Address: 515 Fifth Ave. W. Grand Marais, MN 55604-0010
Phone number: 218-387-3040
Number of beds: 16

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 6,269 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

FAIRVIEW NORTHLAND REGIONAL HOSPITAL

Address: 911 Northland Drive Princeton, MN 55371-2172
Website: www.fairview.org/patient_safety/c_094508.asp
Phone number: 763-389-6305
Number of beds: 41

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**3,861 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 23,982 patient days at this facility during this time period**
The use of contaminated drugs, devices, or biologics	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 1; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

FAIRVIEW RED WING MEDICAL CENTER

Address: 701 Fairview Blvd., P.O. Box 95 Red Wing, MN 55066
Website: www.redwing.fairview.org
Phone number: 651-267-5050
Number of beds: 50

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**2,952 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

FAIRVIEW RIDGES HOSPITAL

Address: 201 East Nicollet Boulevard Burnsville, MN 55337
Website: www.fairview.org/patient_safety/c_094508.asp
Phone number: 952-892-2459
Number of beds: 150

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 64,441 patient days at this facility during this time period**
A medication error	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	Deaths: 0; Serious Disability: 1; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

FAIRVIEW SOUTHDALE HOSPITAL

Address: 6401 France Avenue South Edina, MN 55435
Website: www.fairview.org/patient_safety/c_094508.asp
Phone number: 612-672-6396
Number of beds: 390

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**20,762 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 116,699 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	3	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

FAIRVIEW UNIVERSITY MEDICAL CENTER - MESABI

Address: 750 E. 34th Street Hibbing, MN 55746-2341
Website: www.range.fairview.org
Phone number: 218-362-6655
Number of beds: 175

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CRIMINAL EVENTS		**There were 37,902 patient days at this facility during this time period**
Sexual assault on a patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

Address: 200 East University Avenue St. Paul, MN 55101-2507
Website: www.gillettechildrens.org
Phone number: 651-229-1732
Number of beds: 60

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**2,958 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

GRANITE FALLS MUNICIPAL HOSPITAL

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

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 7,866 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 1; Neither: 0

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

HENNEPIN COUNTY MEDICAL CENTER

Address: 701 Park Ave S Minneapolis, MN 55415-1829
Website: www.hcmc.org/patients/patientsafety.htm
Phone number: 612-873-5588
Number of beds: 910

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**9,009 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 179,501 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	5	Deaths: 0; Serious Disability: 0; Neither: 5
CRIMINAL EVENTS		**There were 179,501 patient days at this facility during this time period**
Sexual assault on a patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	7	Deaths: 0; Serious Disability: 0; Neither: 7

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

Address: 1025 Marsh Street, P.O. Box 8673 Mankato, MN 56001-4752
Website: www.isj-mhs.org
Phone number: 507-345-2646
Number of beds: 272

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**6,716 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

KITTSON MEMORIAL HEALTHCARE CENTER

Address: 1010 S. Birch Ave., P.O. Box 700 Hallock, MN 56728-4208
Phone number: 218-843-3612
Number of beds: 15

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**113 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

LAKE REGION HEALTHCARE CORPORATION

Address: 712 S. Cascade, P.O. Box 728 Fergus Falls, MN 56537
Website: www.lrhc.org
Phone number: 218-736-8191
Number of beds: 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 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**3,753 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

LAKEWALK SURGERY CENTER

Address: 1420 London Road, Suite 100 Duluth, MN 55805
Website: www.lakewalk.com

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**9,378 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

LAKEWOOD HEALTH SYSTEM

Address: 401 Prairie Ave. N.E. Staples, MN 56479-3201
Website: www.lakewoodhealthsystem.com
Phone number: 218-894-8300
Number of beds: 25

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**950 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

METHODIST HOSPITAL – PARK NICOLLET HEALTH SERVICES

Address: 6500 Excelsior Blvd. St Louis Park, MN 55426-4702
Website: www.parknicollet.com
Phone number: 952-993-5000
Number of beds: 426

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**18,939 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 110,886 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	4	Deaths: 0; Serious Disability: 0; Neither: 4

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

MIDWEST SURGERY CENTER

Address: 110 Midwest Eye & Ear Institute
2080 Woodwinds Drive Woodbury, MN 55125
Phone number: 651-642-1106

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**5,996 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

NORTH MEMORIAL MEDICAL CENTER

Address: 3300 Oakdale Avenue North Robbinsdale, MN 55422-2926
Website: www.northmemorial.com
Phone number: 763-520-5183
Number of beds: 518

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**20,027 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 156,832 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	3	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

NORTHFIELD HOSPITAL

Address: 2000 North Ave. Northfield MN 55057-1498
Website: www.northfieldhospital.org
Phone number: 507-646-1176
Number of beds: 37

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**1,980 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

PLYMOUTH ENDOSCOPY CENTER

Address: 15700 37th Ave. N. Plymouth, MN 55446
Website: www.mngastro.com
Phone number: 612-870-5492

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**49,573 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

REGENCY HOSPITAL OF MINNEAPOLIS

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

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 5,437 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

REGIONS HOSPITAL

Address: 640 Jackson Street St Paul MN 55101-2502
Website: www.regionshospital.com
Phone number: 651-254-4710
Number of beds: 427

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**12,037 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 164,721 patient days at this facility during this time period**
A medication error	1	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 164,721 patient days at this facility during this time period**
Use of or lack of restraints or bedrails while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 0; Serious Disability: 2; Neither: 4

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

RICE MEMORIAL HOSPITAL

Address: 301 Becker Ave. S.W. Willmar, MN 56201-3302
Website: www.ricehospital.com
Phone number: 320-231-4227
Number of beds: 136

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**5,864 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

RIDGEVIEW MEDICAL CENTER

Address: 500 S. Maple St. Waconia, MN 55387-1752
Website: www.ridgeviewmedical.org
Phone number: 952-442-2191 x 5021
Number of beds: 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 27 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**7,439 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

ROCHESTER METHODIST HOSPITAL

Address: 201 W. Center St. Rochester, MN 55902-3003
Website: www.mayoclinic.org/event-reporting
Phone number: 507-284-5005
Number of beds: 794

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**21,770 surgeries were performed at this facility during this time period**
Surgery performed on wrong patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 151,714 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

SAINT MARYS HOSPITAL

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

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**27,445 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	2	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 277,143 patient days at this facility during this time period**
The use or malfunction of a device in patient care	2	Deaths: 1; Serious Disability: 1; Neither: 0
An intravascular air embolism	1	Deaths: 1; Serious Disability: 0; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 277,143 patient days at this facility during this time period**
A medication error	3	Deaths: 1; Serious Disability: 2; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	6	Deaths: 0; Serious Disability: 0; Neither: 6
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 277,143 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	18	Deaths: 4; Serious Disability: 3; Neither: 11

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

SHRINERS HOSPITAL FOR CHILDREN

Address: Twin Cities Unit, 2025 E. River Parkway Minneapolis, MN 55414-3604
Website: www.shrinershq.org/shc/twincities
Phone number: 612-596-6100
Number of beds: 40

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**614 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

ST. CLOUD HOSPITAL

Address: 1406 Sixth Avenue North St. Cloud, MN 56303-1900
Website: www.centracare.com
Phone number: 320-251-2700 ext 54100
Number of beds: 489

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**14,539 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 166,892 patient days at this facility during this time period**
The use or malfunction of a device in patient care	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	Deaths: 1; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

ST. CLOUD SURGICAL CENTER

Address: 1526 Northway Drive St. Cloud, MN 56303-1255
Phone number: 320-251-8385

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**11,636 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

ST. GABRIEL'S HOSPITAL

Address: 815 Second St. S.E. Little Falls, MN 56345-3505
Website: www.stgabriels.com/patientsafety.html
Phone number: 320-632-1209
Number of beds: 49

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**2,387 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

ST. JOSEPH'S AREA HEALTH SERVICES, INC.

Address: 600 Pleasant Ave Park Rapids, MN 56470-1431
Website: www.sjahs.org
Phone number: 218-237-5526
Number of Beds: 50

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**2,785 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

ST. JOSEPH'S HOSPITAL

Address: 69 W. Exchange St. St Paul, MN 55102-1004
Website: www.healtheast.org/patientsafety
Phone number: 651-326-2273
Number of beds: 401

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**25,107 surgeries were performed at this facility during this time period**
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 88,766 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	5	Deaths: 0; Serious Disability: 0; Neither: 5
TOTAL EVENTS FOR THIS FACILITY	6	Deaths: 0; Serious Disability: 0; Neither: 6

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

ST. LUKE'S HOSPITAL

Address: 915 E. First St. Duluth, MN 55805-2107
Website: www.slhduluth.com
Phone number: 218-249-5389
Number of Beds: 267

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**11,937 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
Death of a normal, healthy patient during or immediately after surgery	1	Deaths: 1 Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 1 Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

ST. MARY'S MEDICAL CENTER

Address: 407 E. 3rd St. Duluth MN 55805-1950
Website: http://www.smdc.org/customer_serv_patient_rep.cfm
Phone number: 218-786-3091
Number of beds: 380

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**10,834 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

UNITED HOSPITAL, INC.

Address: 333 North Smith Avenue St. Paul, MN 55102-2344
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 546

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**14,949 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

UNITY HOSPITAL

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

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**8,467 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	2	Deaths: 0; Serious Disability: 0; Neither: 2

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

Address: 2450 Riverside Ave. Minneapolis, MN 55454-1450
Website: www.fairview.org/patient_safety/c_094508.asp
Phone number: 612-672-6396
Number of beds: 1700

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004-OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**21,771 surgeries were performed at this facility during this time period**
Surgery performed on wrong body part	1	Deaths: 0; Serious Disability: 1 Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 284,724 patient days at this facility during this time period**
The use or malfunction of a device in patient care	1	Deaths: 1 Serious Disability: 0; Neither: 0
CRIMINAL EVENTS		**There were 284,724 patient days at this facility during this time period**
Death or significant injury of patient or staff from physical assault	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	3	Deaths: 1; Serious Disability: 1; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

VIRGINIA REGIONAL MEDICAL CENTER

Address: 901 Ninth St. N. Virginia, MN 55792-2348
Website: www.vrmc.org
Phone number: 218-742-8600
Number of beds: 83

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 24,431 patient days at this facility during this time period**
A fall while being cared for in a facility	1	Deaths: 1 Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 1; Serious Disability: 0; Neither: 0

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

WOODWINDS HEALTH CAMPUS

Address: 1925 Woodwinds Drive Woodbury, MN 55125-2270
Website: www.healtheast.org/patientsafety
Phone number: 651-326-2273
Number of beds: 70

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 29,493 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

WORTHINGTON REGIONAL HOSPITAL

Address: 1018 Sixth Ave. Worthington, MN 56187-2202
Website: www.worthingtonhospital.com
Phone number: 507-372-3272
Number of beds: 66

HOW TO READ THESE TABLES

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2004–OCTOBER 6, 2005)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		**1,976 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	1	Deaths: 0; Serious Disability: 0; Neither: 1

APPENDIX A:

Statement from the Joint Commission on Accreditation of Healthcare Organizations

February 1, 2006

As part of the Joint Commission on Accreditation of Healthcare Organization's intensified efforts to improve patient safety over the past decade, the Joint Commission created a Sentinel Event Database that today is this country's most complete record of the full spectrum of serious medical errors and their underlying causes. This database, combined with knowledge gained from working with health care organizations to address their patient safety problems, has allowed the Joint Commission to share lessons learned with other health care organizations to reduce the risk of future tragedies.

Moreover, the Joint Commission supports state-based efforts to identify and learn from adverse events, which were called for in the Institute of Medicine's seminal report To Err is Human. The State of Minnesota, in collaboration with its hospitals, is a leader in its innovative efforts to make health care safer for its citizens. The Joint Commission recently evaluated the State's adverse event reporting system to ensure that it is thorough and credible. The State has established a comprehensive reporting and analysis process to identify system weaknesses and ensure corrective actions, thereby reducing the likelihood of the errors from occurring again.

In an effort to reduce the duplication and burden of reporting for Minnesota hospitals, the State's Department of Health will share de-identified aggregate adverse event data, including root cause and corrective action information, with the Joint Commission for inclusion in its Sentinel Event Database. In turn, the Joint Commission has agreed to rely on the adverse event review analysis conducted by the State of Minnesota, rather than conduct its own sentinel event review activities for each participating hospital. By sharing lessons learned, the State of Minnesota, Minnesota hospitals and the Joint Commission are helping to improve the safety of care for not only all Minnesotans, but for patients receiving care in healthcare organizations throughout the country.

Joint Commission
on Accreditation of Healthcare Organizations
Setting the Standard for Quality in Health Care

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APPENDIX B:

Events reported July 2003–October 6, 2004 – from the previous public report

TABLE 1
OVERALL STATEWIDE REPORT

Reported adverse health events: **ALL EVENTS** (July 1, 2003- October 6, 2004)
From the previous public report.

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

TABLE 2
STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (July 1, 2003- October 6, 2004)
From the previous public report.

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

Details by Category: **PRODUCTS OR DEVICES** (July 1, 2003- October 6, 2004)
From the previous public report.

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

Details by Category: **PATIENT PROTECTION** (July 1, 2003- October 6, 2004)
From the previous public report.

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

TABLE 2 (CONTINUED)

Details by Category: **CARE MANAGEMENT** (July 1, 2003- October 6, 2004)
From the previous public report.

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

Details by Category: **ENVIRONMENTAL** (July 1, 2003- October 6, 2004)
From the previous public report.

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

TABLE 2 (CONTINUED)

Details by Category: **CRIMINAL** (July 1, 2003- October 6, 2004)
From the previous public report.

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

APPENDIX C:
Definitions

Action Plan

The product of the root cause analysis is an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.[7]

Adverse Event

An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.[8]

Error

Error is the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).[9]

Patient Safety

Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.[10]

Root Cause Analysis

Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse event. A root cause analysis focuses primarily on systems and processes, not individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines, after analysis, that no such improvement opportunities exist.[11]

Serious Disability[12]

(1) A physical or mental impairment that substantially limits one or more of the major life activities of an individual,

(2) A loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or

(3) Loss of a body part.

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

APPENDIX D:
Reportable events as defined in the law

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

Surgical Events[13]

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
2. Surgery performed on the wrong patient;
3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

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

Patient Protection Events

9. An infant discharged to the wrong person;
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and
11. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care Management Events

12. Patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
13. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
16. Death or serious disability, including kernicterus, associated with failure to identify and treat

[13] 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."

hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;

17. Stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission; and
18. Patient death or serious disability due to spinal manipulative therapy.

Environmental Events

19. Patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
21. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
22. Patient death associated with a fall while being cared for in a facility; and
23. Patient death or serious disability associated with the use of or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

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

APPENDIX E:
Links and other Resources

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

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

- The National Quality Forum (NQF) convened a broad panel of healthcare stakeholders to develop a list of 27 events that should never happen in healthcare. These Serious Reportable Events (sometimes known as the 'never events') form the basis of Minnesota's Adverse Health Events Reporting Law. For more information about the Serious Reportable Events or NQF's consensus process, go to www.qualityforum.org/neverteaser.pdf.

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

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

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

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

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

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

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

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

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

ADVERSE HEALTH EVENTS IN MINNESOTA PUBLIC REPORT

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