ADVERSE HEALTH EVENTS IN MINNESOTA

THIRD ANNUAL PUBLIC REPORT | JANUARY 2007

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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INTRODUCTION

Since 2003, Minnesota hospitals, ambulatory surgical centers, and regional treatment centers have been required to report whenever one of 27 serious events takes place. These events include falls that are associated with a death, foreign objects left in the body after surgery or other invasive procedures, and surgery or other invasive procedure on the wrong person or body part. Between October 7th, 2005 and October 6th, 2006, 154 events were reported to the Minnesota Department of Health (MDH). This report provides information about where these events happened, why they happened, and what's being done to prevent them from happening again, and provides important information about quality and safety to help consumers make wise choices about their care.

The most important aspect of the reporting system is not the numbers themselves, but rather what is being learned from them. Counting events will not, by itself, make the system safer. But finding out why events happen, and then working to prevent them from happening again, will lead to changes that increase safety for all patients. The reporting system is designed to foster both inquiry and evidence-based intervention. Every facility that experiences one of these events is required to conduct an in-depth analysis of why it occurred, and every event is reviewed by a team of clinical experts. Facilities are required to implement system changes to prevent similar events from happening again, and key learnings are shared so that all facilities benefit, whether or not they've experienced an event.

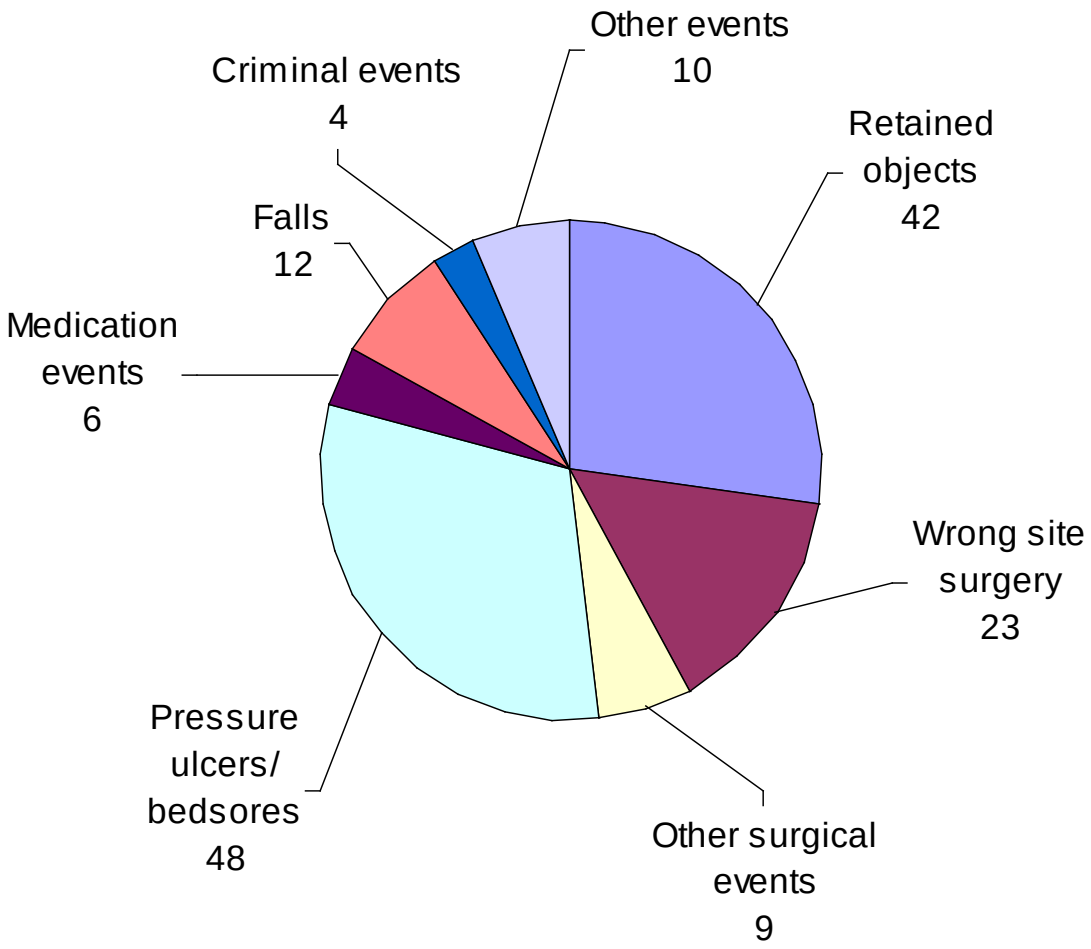
Minnesota leads the nation in its efforts to improve patient safety. The Minnesota Alliance for Patient Safety, a broad-based partnership including MDH, the Minnesota Hospital Association (MHA), the Minnesota Medical Association, and more than 50 other stakeholder groups, recently earned the 2006 John M. Eisenberg Patient Safety and Quality Award for its work in creating a more transparent and accountable health care system and its efforts to reduce adverse events. Minnesota hospitals also received top marks for patient safety in 2006 from HealthGrades, a national health care research company. Continuing this work, MDH, along with MHA, has spent the last year working to make sure that the adverse events reporting system contains high-quality information that is shared as widely as possible:

- Staff from more than 75 facilities attended regional training sessions designed to help them improve their investigation of events and develop stronger corrective actions.
- Death records from all Minnesota counties are reviewed monthly to ensure that all reportable events resulting in death are reported into the adverse health events reporting system.
- MHA is issuing "calls to action" to hospital CEO's, asking them to fully implement best practice techniques to prevent falls, retained objects, pressure ulcers and surgery on the wrong body part.
- MDH and MHA have worked with consumer groups around the state to make this information easier to understand, so that patients and family members can ask more knowledgeable questions about their care and understand the important role they play in patient safety.
- A new consumer guide to adverse events is now available at www.health.state.mn.us/patientsafety, and the adverse health events website has been modified to support a searchable database of adverse events by facility.
- Key learnings continue to be shared with facilities through newsletters, safety alerts, meetings, summits, collaborative groups, and other avenues.

Despite Minnesota's pioneering work to date to ensure the highest level of patient safety, adverse health events remain a serious issue here and across the country. Every reported event, regardless of the level of harm to the patient, represents a situation that should not have happened. The factors that lead to these events are complex and often system-wide, making simple solutions or quick fixes unlikely to succeed. Reducing the number of events will take support at all levels of hospital, surgical center, and regional treatment center administration, as well as by staff, patients, family members, and other stakeholders. It will be neither an easy nor a quick process, but it is a process to which stakeholders around the state are committed.

Reported Adverse Health Events by Category

October 7, 2005 – October 6, 2006



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

HOW TO USE THIS REPORT

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

The fact that health care providers are looking for potentially dangerous situations and reporting them in order 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.

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

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

SOURCES OF QUALITY AND PATIENT SAFETY INFORMATION

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

Minnesota Health Information
www.minnesotahealthinfo.org
Links to several sites comparing cost and quality at hospitals, physician and medical groups, and other facilities.

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

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

Minnesota Hospital Quality Report
www.mnhospitalquality.org
Searchable database of hospital performance on best practice indicators related to heart attack, heart failure, and pneumonia.

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

HIGHLIGHTS OF 2006 ACTIVITIES

Under the Minnesota Adverse Health Care Events Reporting Law, the Commissioner of Health is directed to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities on strengthening the actions they are taking to improve the quality of care. In performing these functions, the Department works closely with several key stakeholder organizations, including the Minnesota Hospital Association (MHA), Stratis Health (Minnesota's Medicare Quality Improvement Organization), and the Minnesota Alliance for Patient Safety (MAPS).

In 2006, The Joint Commission and the National Quality Forum (NQF) awarded MAPS the prestigious John M. Eisenberg Patient Safety and Quality award. This award acknowledges the pioneering work being done throughout Minnesota to improve patient safety, including the work done to establish and strengthen the Adverse Health Care Events Reporting Law and to maximize learning from the system.

Over the last year, MDH, MHA and Stratis Health have engaged in a number of activities designed to make the reporting system easier to use, improve the quality of analysis and the strength of facility-developed action plans, share key learnings, increase awareness and accessibility of the reporting system, and spur high-level commitment to change within health care organizations. Highlights of the past year's activities are listed below and on the next page.

Improving the reporting system

- The Web-based adverse events registry was modified this year to incorporate questions about whether facilities had fully implemented the Safest in America safe-site surgery protocol, designed to prevent wrong-site surgery.
- Advisory groups to MDH and MHA met throughout the year to provide feedback on registry changes, assist with definitional issues, advise on outreach to consumers and purchasers, and provide guidance on the overall direction and goals of the reporting system.
- Death records from all Minnesota counties are now reviewed monthly. Records that reflect potentially reportable adverse health events are flagged, and the relevant facilities are contacted to discuss and, where indicated, report the events. MHA is also working with the Minnesota Coroners' and Medical Examiners' Association to evaluate the potential for changing processes related to death reporting, to ensure that potential adverse health events are not missed.

Improving the quality of analysis

- During August of 2006, MDH sponsored a series of Web-based trainings on the fundamentals of accident causation and human factors analysis. Roughly 200 staff from more than 75 facilities around the state participated in these trainings.
- More than 150 staff from 45 facilities also attended in-depth, day-long regional trainings on root cause analysis and the development of corrective action plans. Participants learned how to delve more deeply into the root causes of events, develop more effective corrective action steps, and respond to comments from MDH related to events.
- Throughout the year, a team of analysts from Stratis Health reviewed all reported events, and provided extensive feedback to facilities on their analysis and corrective action plans. The depth and breadth of analysis that the team reviews continues to improve.

Sharing Knowledge

- The Web-based registry was modified to allow facilities to view charts and graphs of their submitted events by category, as well as the most commonly-cited root causes for their events. Facilities can also view 'key learnings' submitted by other facilities, as well as literature that other facilities have found helpful for their own analyses of similar events.
- All reporting facilities receive a quarterly newsletter that keeps them up to date on registry changes, definitional guidance, and questions related to the review process. The newsletter also includes a feature article focused on patterns or trends that have been discovered through the reporting system, and how facilities are addressing the concerns.

HIGHLIGHTS OF 2006 ACTIVITIES (CONTINUED)

- Since the release of the previous report, MHA has issued three safety advisories to Minnesota facilities based on trends identified through analysis of reported adverse health events. These advisories focused on suicide by hanging, the risks associated with having manufacturer's representatives present during surgical procedures, and the importance of a 'time-out' prior to an invasive procedure or surgery.
- In April, MHA hosted a summit on falls prevention, which was attended by representatives from hospitals around the state. Participants shared tools, resources, and models for falls risk assessment and communication, intervention, and documentation, as well as discussing challenges and potential barriers to falls prevention in their facilities and how they addressed them.

Promoting organizational change

- MHA is issuing a series of "calls to action" to hospital CEO's, urging them to implement best practices related to wrong body part surgeries, pressure ulcers, retained objects, and falls.
- MDH, MHA and Stratis Health are working through the Minnesota Alliance for Patient Safety (MAPS) to create and promote tools that facilities can use to foster a patient safety culture based on justice, learning and accountability within their organizations.

Increasing accessibility

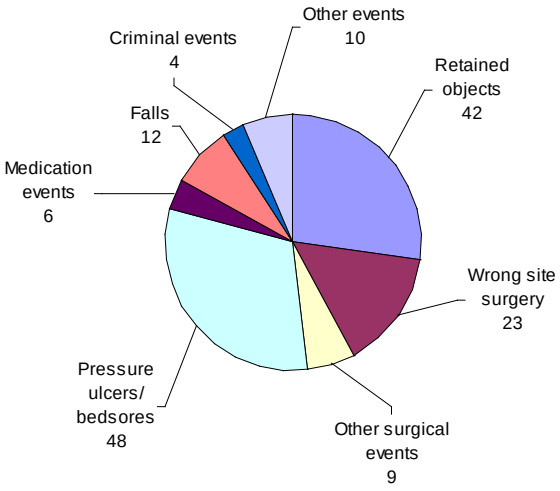
- Both MDH and MHA are working with consumer and patient advocacy organizations to develop avenues for getting information about patient safety and adverse health events to patients and their families, and to get feedback on current activities and publications.
- Key outcomes of this work include the development of an MDH consumer guide for adverse health events, expanded information for consumers and improved linkages with other sources of quality information on the adverse events website, and the development of new strategies for outreach to patients and their families.

Other activities

- MDH staff provided technical assistance to the states of Illinois and Vermont and the Victoria (Australia) Department of Human Services on implementation and reporting issues, while MHA staff presented on Minnesota's experiences to multiple state hospital associations.
- MDH staff presented information on Minnesota's reporting system at a conference of the TriCare Military Health System, to a national audience of state officials through a Webcast sponsored by the National Academy for State Health Policy (NASHP), and, with MHA, to a variety of audiences throughout Minnesota.

OVERVIEW OF REPORTED EVENTS

Between October 7, 2005, and October 6, 2006, a total of 154 adverse health events were reported to the Minnesota Department of Health (MDH). This figure represents an average of 12.8 events per month or roughly three events per week.



Currently, 137 hospitals are licensed by MDH and required to report adverse health events under this law. Federally licensed facilities, such as those operated by the Veteran's Administration or the Indian Health Service, are not covered by the law. As of November 2006, 46 ambulatory surgical centers and five regional treatment centers were also subject to the reporting law. Of the 188 facilities covered by the law, 49 (26 percent) reported adverse events during this reporting period: 40 hospitals, 7 surgical centers, and 2 regional treatment centers.

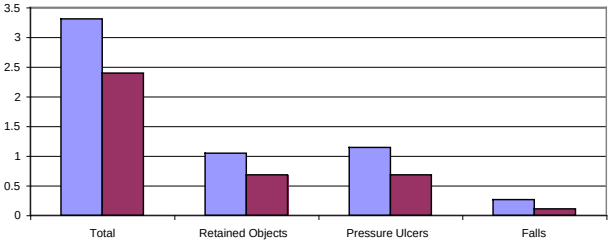
During 2005, the most recent year for which preliminary data is available, Minnesota hospitals reported more than 2.7 million patient days. Adjusting the number of reported adverse events from hospitals to account for the volume of care provided across all hospitals in the state shows that roughly 5.6 events were reported by hospitals per 100,000 patient days.

As in previous years, the events that were reported most often to MDH were stage 3 or 4 pressure ulcers and objects retained in a patient's body after surgery or an invasive procedure. These two categories of events accounted for more than 55 percent of reported events. This pattern mirrors that seen in other states that require reporting of similar lists of reportable events.

Of the reports submitted during the reporting period, 23 percent resulted in no harm to patients, while 20 percent led to either death or serious disability. A majority of events, 54 percent, resulted in a need for additional treatment or monitoring, but not a longer stay in the hospital. Of the 24 deaths reported during this time period,12 were due to falls, three were the result of suicide, two were related to the malfunction of a product or device, two were related to patient elopements, and two were related to medication errors.

Over the course of the reporting period, the number of events that occurred per week dropped slightly, from 3.3 per week between October, 2005 and March, 2006 to 2.4 per week between April 1st and October 6, 2006. Of note, the number of retained objects, pressure ulcers, and falls reported per week each declined between the first and second halves of the reporting year.

Events/week, 1st and 2nd halves of reporting period



DETERMINING WHY:
ROOT CAUSE ANALYSIS

When an adverse event occurs, facilities are required to conduct a root cause analysis. This process involves convening a team to closely examine the factors that led to the event. These factors may include communication, staffing levels, training, equipment malfunctions, failure to follow policies or protocols, or environmental issues. The process of completing a root cause analysis (RCA) 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 helps a facility identify patterns of vulnerability within their organization that might not be apparent from one event, and enables them to design corrective actions to improve patient safety across departments. 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 or impossible.

Overall findings from reported RCAs

Root causes/contributing factors	
Communication	53.2%
Training	42.9%
Fatigue/Scheduling	9.7%
Environment/Equipment	43.5%
Rules/Policies/Procedures	58.4%
Barriers	20.1%

The majority of adverse events were traced to root causes in one of four areas: communication, environment/equipment, training, and policies/procedures. These numbers are similar to, although slightly lower than, the findings of the The Joint Commission, which collects sentinel event information from accredited hospitals nationwide. While not all of The Joint Commission's categories match those used in Minnesota, between 1995 and 2004, more than 60% of the sentinel events reported to The Joint Commission indicated communication as a root cause, and roughly 55% cited issues related to orientation or training.

The most commonly cited factor contributing to adverse health events overall was related to policies and procedures. Sometimes, although a policy exists, it is not implemented as fully as it should have been. For example, all facilities have policies in place requiring a pause or "time-out" for verification prior to surgery or an invasive procedure. But in practice, distractions, conflicting responsibilities, lack of a single responsible person, lack of full participation by all people in the operating or procedure room, or pressure to start a procedure on time can lead to the policy not being effectively implemented. In other cases, no policy exists to address a particular issue that hadn't been foreseen. For example, policies related to counting objects after an invasive procedure might not cover a particular item, or might not be in place in all areas of the hospital where invasive procedures occur, such as in labor and delivery.

Communication breakdowns between providers on a care team were also commonly cited by reporting facilities as a factor contributing to adverse health events. Communication problems can happen across shifts, departments, or facilities, and can be related to written or oral communication or the lack thereof. Communication issues can include a lack of written documentation of interventions, care plans, or orders, lack of clarity in verbal orders, handwriting that is difficult to read, misunderstandings about the timing or duration of interventions, lack of clarity about functions or roles of individuals in certain situations, and inadequate written or oral communication when handing off patients at shift or unit change or upon discharge or transfer.

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. Many facilities identified more than one contributing factor for an event.

Surgical Events:

- Perceived pressure to complete procedures in a certain amount of time, or to complete a certain number of procedures led to a rushed pre-operative verification procedure.
- Staff reluctant to voice questions or concerns to surgeons.
- Noise, interruptions, multiple competing responsibilities, and other distractions immediately prior to surgery made it difficult to focus on the time-out or other pre-procedure verification policies.
- Policies related to site marking do not include the operating surgeon.

- 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.
- Policy was in place requiring a pause before beginning a procedure, but policy did not assign one person to be accountable for completion of the process, or not all staff participated in pause.
- No policy in place requiring final visual inspection or sponge/gauze counts following vaginal delivery.
- Sponges used during a procedure become more compact when moist, and are difficult to separate, leading to an incorrect count.
- Surgical drapes, betadyne, or other materials obscured the surgical site marking.
- Lack of training for new, temporary or floating staff related to sponge count procedures or the use of certain types of equipment.
- Lack of communication during staff handoffs that take place during a procedure.
- No policies in place for counting certain materials/ equipment present in surgical field, or inadequate communication of policies to staff in all areas of the facility.
- Accountability for tracking certain items before/ during/after procedure not clear.

Care Management Events - Pressure ulcers:

- No competency requirement in place for managing patients who are dependent on certain types of equipment.
- No process to update staff when specially-ordered pressure-relieving equipment has arrived and is ready for use.
- Short staffing or high patient census led to insufficient time available for following skin integrity measures.
- 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 or of interventions such as turning.
- Details about patient's risk factors for skin breakdown, or about needs for pressure redistributing devices, not fully communicated to new units upon transfer.
- Staff unable to determine what type of bed or other pressure-redistributing devices to use for particular risk factors, or unaware how to find equipment they need.
- Delays in ordering pressure-redistributing equipment.
- High workloads or staffing shortages prevented some staff from attending training on skin safety.
- Decision tools to determine risk, interventions, bed choices, etc not available, not adequate, not understood, or not utilized.

Environmental Events – Falls:

- No procedure in place to document which specific elements of a fall prevention protocol were put into place for an individual patient.
- Lack of algorithm to assist staff in determining which fall prevention interventions to use with a patient at risk for falls.
- Unclear post-fall intervention protocol, or protocol not implemented as required.
- Information about fall risk not adequately reported across shifts or units.
- Revisions to facility-wide fall prevention protocols not adequately communicated to all staff.
- Fall risk assessment and/or interventions not adjusted with change in patient's status.

Care Management Events – Medication Errors:

- Diagnosis not included with medication order information sent to pharmacy, so contraindications may not be flagged prior to administration of the medication.
- No policy in place for direct communication between ordering physician and pharmacist led to verification of order through other staff.
- Miscommunication during the medication verification process in the pharmacy, or between physician and pharmacist.
- Complete documentation of patient's medication history not available at time of medication administration.

ADDRESSING THE ISSUES:
HOW CAN FUTURE EVENTS BE PREVENTED?

The goal of the Adverse Health Care Events Law is to improve patient safety by increasing awareness of why adverse events happen and developing strong solutions to prevent them from happening again. Individual facilities use the findings from their root cause analyses to prevent a repeat of similar events. At the same time, Minnesota facilities and other collaborative groups have developed several notable initiatives to improve patient safety. Initiatives undertaken by individual facilities are outlined below, and Appendix C provides links to organizations that are also doing important work around prevention of adverse events.

Patients and their families can play an important role 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. Additional information and resources for patients and families are available in MDH's Consumer Guide to Adverse Health Events as well as from the Agency for Healthcare Research and Quality (www.ahrq.gov/consumer/), The Joint Commission (http://www.jointcommission.org/GeneralPublic/), and other sources outlined in Appendix C of this report.

Surgical Events

What Facilities Are Doing to Prevent Surgical Events

- Redesigning documentation to require check off when "time-out" is done.
- Assigning one individual to be accountable for implementation of time-out.
- Revising orientation and training around pre-operative procedures for new or temporary employees.
- Revising site marking policies to include procedures for marking and including a second time-out in cases with internal laterality.
- Purchasing surgical sponges and other materials that are easier to track and count.
- Changing processes for scheduling surgeries to reduce time pressures that may lead to adverse events.
- Standardizing operating or procedure room turnover and preparation processes.
- Implementing "pause for the gauze" policy in labor and delivery, including sponge counting and/or a final visual inspection.
- Increasing the use of x-rays in the operating room to identify the correct surgery site and/or to identify retained objects.
- Expanding the list of objects to be counted after a surgery or invasive procedure.
- Implementing visual inspection of all instruments before/after a procedure.

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. So if you can, choose a facility that treats many people with your 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. Your surgeon should always mark his or her initials on the site where you are having surgery.
- **If possible, verify that your surgeon has marked the correct site with indelible ink.**

SPOTLIGHT ON: RETAINED OBJECTS
UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

Summary: Between 2003 and 2004, eight objects were retained inadvertently in patients after surgery at University of Minnesota Medical Center, Fairview. No patients were permanently injured. Fairview leaders reported all the events as part of the Minnesota Adverse Health Events Reporting Law. They set to work to learn from, and reduce the incidence of, unintended retained objects using an innovative approach with help from the University of Minnesota. Since 2004, the medical center has not experienced an unintended retained object after a procedure.

Despite the hard work of caregivers nationally, about 1,500 retained object events after a procedure occur each year, according to the *New England Journal of Medicine*. Events typically involve surgery, but might include delivery of a baby or performing diagnostic procedures. Retained objects can range from something as small as a needle that is barely visible to the naked eye or a tiny piece of gauze, to an instrument or a piece of an instrument that breaks during the procedure. Objects usually are removed with no lasting harm to the patient; more rarely, they can cause serious harm or death. Unintentional retained objects after procedures are not acceptable to Fairview.

Teams at University of Minnesota Medical Center, Fairview perform some 25,000 inpatient and outpatient surgeries annually. Over a two-year period between 2003 and 2004, eight objects unintentionally were retained in patients (throat packing or sponges). While no patients were permanently injured, staff conducted investigations into what happened.

Part of the problem involved how staff counted and kept track of small pieces of surgical gauze. Clinical leaders tried to correct the problem with changes to operating room policies and reminders to staff. Despite these efforts, several more retained object incidents occurred.

Trying a different approach

In mid-2004, medical center leaders tried a different approach. They combined a problem-solving process called Failure Mode Effect Analysis with structured observation of operating room procedures. They worked with professionals from the University of Minnesota who have special training in the field of human factors. This discipline examines how people work and remember information while under pressure and in the face of many distractions.

Through the combined approach, Fairview leaders identified several weaknesses in their process for counting surgical sponges and gauze:

- Lack of awareness or knowledge of the counting policy.
- Lack of standardization around best practices for counting and verification of the count.
- Distractions during the counting process, such as beeping pagers, increased chance of error.
- Cultural factors, such as hierarchy between physicians and nurses, sometimes prevented communication of potential problems. For example, a nurse may notice a mistake in a process, but hesitate to point it out to a physician.

Fairview leaders responded with an action plan:

- Introducing a required "time-out for patient safety" when staff has any concern about patient safety.
- Standardizing around best practices for counting and verification of the count; for example, how best to do a recount if the count is off.
- Managing distractions at critical times during surgery.
- Introducing assertive communication methods to the OR staff.
- Standardizing the size of surgical packing and prohibiting cutting to eliminate confusion about number of packs.
- Standardizing policy development and implementation processes, including minimizing frequent policy changes that cause confusion.

Since 2004, the medical center has not experienced an unintended retained object after surgery. In 2007, Fairview hospitals system-wide will standardize counting processes to prevent retained objects as part of a community initiative.

ADDRESSING THE ISSUES:
HOW CAN FUTURE EVENTS BE PREVENTED?

Pressure Ulcers (Bed Sores)

What Facilities Are Doing to Prevent Pressure Ulcers

- Revising skin assessment documentation to make assessment easier and more accurate.
- Developing new 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.
- Increasing use of wound care or ostomy nurses as consultants.
- Providing additional training on pressure ulcer prevention and wound care.
- Developing specially trained skin care teams to serve as experts on assessment and intervention.
- Modifying electronic systems to allow simpler choice of interventions through drop-down menus.

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.** 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 in bed, change positions every 1-2 hours to limit pressure over bony parts of the body. If you are in a chair, try to shift your weight every 15 minutes. When you move or are moved, try not to pull or drag yourself across the sheets; this 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.

SPOTLIGHT ON: PRESSURE ULCERS
HENNEPIN COUNTY MEDICAL CENTER

Getting a Head Start on Pressure Ulcers

Skin is the body's largest organ and has an amazing ability to heal. When caring for patients with the most complicated illnesses and critical injuries, addressing the skin's condition and its effect on a patient's return to good health is often a challenge. Traditional methods to maintain skin integrity may not always work for every patient, and in spite of diligent efforts to avoid pressure ulcers, once they start developing, they can be difficult to manage.

That changed at Hennepin County Medical Center after key clinical staff attended a pressure ulcer summit in late 2005. With a fresh perspective and determination, caregivers left the summit and implemented diligent tracking measures, treatment methods, and staff education, which led to significant results: The overall number of pressure ulcers identified in 2006 went up initially, but the development and progression of ulcers has since dropped 75 percent in the Surgical ICUs and 57 percent throughout the hospital.

Hennepin's approach to the problem

Hennepin started by developing an organization-wide Skin Team of more than 20 members to:

- establish baseline data on the prevalence of pressure ulcers in the hospital
- make recommendations to reduce that number
- educate all staff on skin safety (assessment, prevention, and intervention)
- standardize skin care practices and products across the organization

The team now makes monthly visits to nine inpatient units to conduct head-to-toe assessments on every patient available. This had never been done before, and initially it meant Hennepin was seeing – and counting – in a new way, resulting in a high number of reported adverse health events. Analysis of the new data, which included age, gender, risk assessment scoring, timeliness of prevention strategies and assessment of skin breakdown, became a guide for the next steps of change.

Prevention and treatment – Picking the right treatment methodology, products and equipment

The Skin Team found a connection between certain treatment protocols and an increased likelihood of pressure ulcers. In many cases, the equipment being used was to blame. In these cases, simply choosing another way to treat the condition made a world of difference in preventing pressure ulcers from developing.

In the past, proactive options for skin healing and prevention were limited, but today's products use principles from physics. Special positioning pillows diffuse pressure from single areas of the body. A new alginate used on Stage 4 (community acquired) pressure ulcers and dressings specifically designed for debridement are also showing amazing results.

Prevention and treatment – Nutrition and Physical Therapy

The responsibility for skin integrity has long been associated with nursing care, but many other caregivers play a critical role to prevent and treat pressure ulcers. Research by Hennepin's Skin Team shows the value of nutritional supplements, positioning and other interventions, which make the expertise from Hennepin's nutritionists, physical and occupational therapists essential in the fight to protect skin breakdown. For example, a patient's admitting lab levels indicate protein stores in his or her skin. These levels need to be high – or else the patient is an increased risk for breakdown. The urgency and need for additional nutritional interventions is determined based on these levels.

It is clear that a better analysis of a patient's risk of skin breakdown upon admission, through overall improved documentation and interdisciplinary team collaboration, will lead to better outcomes.

Hennepin's Results

The results are significant. The incidence of Stage 2 pressure ulcers is down 75 percent in the Surgical ICUs and 57 percent throughout the hospital. The medical ICU has made tremendous strides in reducing pressure ulcers with bariatric (obese) patients. Caregivers are seeing remarkable healing of Stage 2 ulcers and the prevention of further breakdown.

Most importantly, the interventions have captured the attention of patients and families, and several have shared their gratitude for the intense focus on skin condition. Patients really appreciate that their caregivers are concerned about their skin; it is a place where the clinical team connects with the patient on something that really matters to them.

ADDRESSING THE ISSUES:
HOW CAN FUTURE EVENTS BE PREVENTED?

Falls

What Facilities Are Doing to Prevent Falls

- Implementing new fall risk assessment policies and assessment tools.
- Using high-visibility indicators of patient's fall risk (stars, bands, colored slippers, etc).
- Modifying progress reports and flowsheets to incorporate information about patient falls during hospital stay; ensuring that all units to which patient may be transferred are aware of fall risk and fall history.
- Developing post-fall intervention protocol with clear assignment of roles.
- Reviewing and potentially revising Heparin protocols for patients at high risk for falls.
- Providing additional staff training on best practices in fall risk assessment.
- Posting fall prevention actions prominently in each patient's room, visible to staff, patient, and family.

What You Can Do to Prevent Falls

- **Ask for help if you need it.** Many falls happen when a patient gets up unassisted to use the bathroom or for other reasons. If you are at risk for a fall, use a call light to ask for help before getting out of bed.
- **Make sure you know how to use call lights, alarms, and other safety equipment in your room.** Lights, bedrails, bed alarms, walkers, and other types of equipment are all there to help you prevent falls. Make sure that you know how to use these tools, and that they are within reach.
- **Pay attention to how you feel.** Medications that you are receiving while you are in the hospital may make you feel dizzy or drowsy. Other treatments that you are receiving may also make you feel different than usual. If you are worried about whether you can walk unassisted, ask for help.

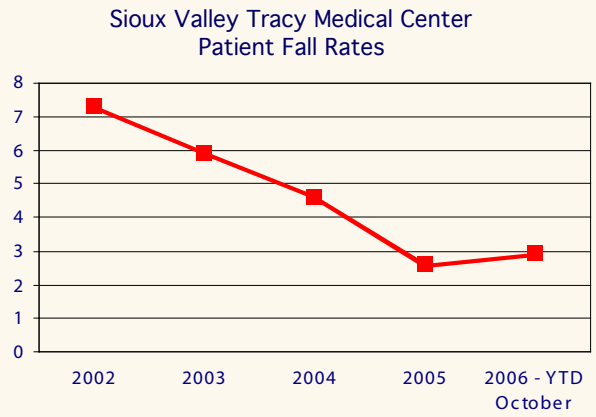
SPOTLIGHT ON: FALLS
SIOUX VALLEY TRACY MEDICAL CENTER

In 2002, an analysis of falls at Sioux Valley Tracy Medical Center revealed that patient falls were increasing toward eight falls per 1,000 bed days. This fall rate was not acceptable to us, and we determined that we needed to turn it around.

In response to these concerns, we convened a multi disciplinary team including physicians, nurses, and administrators to address the increase in patient falls. The team determined that, if we wanted to decrease the number of falls, we would have to change the culture of our organization so that falls prevention was a priority for all staff. The first step was to educate both the staff and patients on fall prevention. The team outlined a fall prevention process that would cover a patient's entire stay, from admission through discharge:

- Upon admission, nursing staff do an assessment to determine if a patient is at risk for falls. If the patient is determined to be at risk of a fall, nursing staff makes a note in the patient's daily plan of care and places a yellow star on the patient's doorframe so that all staff is aware of the fall risk.
- Patients are educated to use the call light if they need anything, and monitors are placed on the patient to alert staff if they try to move out of their bed or chair.
- Families are educated on the fall prevention program, and a brochure is given to the patient and family members.
- Patients are reassessed for fall risk at every shift change.
- All employees are trained to intervene in the care process if they notice a yellow star on the door and a patient trying to move out of the bed or chair. All newly hired employees are also trained on the "Falling Star" program.

This program was implemented in July 2004, and immediately and dramatically cut the fall rate at Tracy Medical Center. Our fall rate per 1,000 patient days has decreased from nearly eight in 2002 to less than three in 2005 and 2006. As importantly, we have increased awareness of fall risk and interventions throughout the facility.



We think that one of the keys to the success of the Falling Stars program is that everyone, from administration to housekeeping, is involved. The entire staff holds themselves accountable for helping to prevent falls within the hospital, and all feel a sense of ownership over the safety of our patients. We continually retrain and re-educate on our "Falling Stars" program, to make sure that we can maintain our focus.

CONCLUSION

The annual release of data on adverse health events is an important way to focus attention on the incidence and causes of adverse events. But preventing harm to patients requires more than just counting events, and the focus on preventing adverse health events needs to be maintained throughout the year. 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, the Minnesota Department of Health and its partners will continue to create new opportunities for learning from the adverse events reporting system and for incorporation of best practices into everyday care throughout the state.

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 a broader patient safety movement in Minnesota. Comprehensive efforts to reduce adverse events are underway nationally and here in Minnesota, and the effects of these efforts are being seen in the increased adoption of best practices by facilities and the increased focus on transparency and learning. 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, surgical centers and other health providers in Minnesota.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

SURGICAL/OTHER INVASIVE PROCEDURE EVENTS

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

** 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

Patient death or serious disability:

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

And;

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

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.

TABLES AND DETAILED INFORMATION

TABLE 1:

Overall Statewide Report ..... **page 21**

- This table describes the total number of reported events for the state during the period from October 7, 2005 through October 6, 2006. 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 22–24**

- 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 – 3.49:

Facility-Specific Data ..... **page 25**

- 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.

TABLE 1: OVERALL STATE-WIDE REPORT

Reported adverse health events: **ALL EVENTS** (October 7, 2005 – October 6, 2006)

	TYPES OF EVENTS						
	SURGICAL	**PRODUCT**	**PATIENT PROTECTION**	**CARE MANAGEMENT**	**ENVIRONMENTAL**	**CRIMINAL**	**TOTAL**
ALL FACILITIES	74 events	4 events	5 events	55 events	12 events	4 events	154 events
SEVERITY DETAILS	Serious Disability: 0 Death: 2 Neither: 72	Serious Disability: 2 Death: 2	Serious Disability: 0 Death: 5	Serious Disability: 5 Death: 2 Neither: 48	Serious Disability: 0 Death: 12	Serious Disability: 0 Death: 1 Neither: 3	Serious Disability: 7 Death: 24 Neither: 123

TABLE 2: STATE-WIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (October 7, 2005 – October 6, 2006)

	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	23 events	3 events	5 events	42 events	1 events	74 events
SEVERITY DETAILS	Serious Disability: 0 Death: 0 Neither: 23	Serious Disability: 0 Death: 0 Neither: 3	Serious Disability: 0 Death: 0 Neither: 5	Serious Disability: 0 Death: 1 Neither: 41	Serious Disability: 0 Death: 1 Neither: 0	Serious Disability: 0 Death: 2 Neither: 72

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2005 – October 6, 2006)

	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	0 Events	4 Events	0 Events	4 Events
SEVERITY DETAILS		Serious Disability: 2 Death: 2		Serious Disability: 2 Death: 2

Details by Category: **PATIENT PROTECTION** (October 7, 2005 – October 6, 2006)

	TYPES OF EVENTS			
	9. WRONG DISCHARGE OF INFANT	**10. PATIENT DISAPPEARANCE**	**11. SUICIDE OR ATTEMPTED SUICIDE**	**TOTAL FOR PATIENT PROTECTION**
ALL FACILITIES	0 Events	2 Events	3 Events	5 Events
SEVERITY DETAILS		Serious Disability: 0 Death: 2	Serious Disability: 0 Death: 3	Serious Disability: 0 Death: 5

TABLE 2: STATE-WIDE REPORTS BY CATEGORY (CONTINUED)

Details by Category: **CARE MANAGEMENT** (October 7, 2005 – October 6, 2006)

	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-BILIRUBINEMIA	17. STAGE 3 OR 4 PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULATION	TOTAL FOR CARE MANAGEMENT
ALL HOSPITALS	6 Events	0 Events	0 Events	1 Event	0 Events	48 Events	0 Events	55 Events
SEVERITY DETAILS	Serious Disability: 4 Death: 2			Serious Disability: 1 Death: 0		Serious Disability: 0 Death: 0 Neither: 48		Serious Disability: 5 Death: 2 Neither: 48

Details by Category: **ENVIRONMENTAL** (October 7, 2005 – October 6, 2006)

	TYPES OF EVENTS					
	19. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	20. WRONG GAS OR CONTAMINATION 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 ENVIRONMENTAL
ALL HOSPITALS	0 Events	0 Events	0 Events	12 Events	0 Events	12 Events
SEVERITY DETAILS				Death: 12		Death: 12

TABLE 2: STATE-WIDE REPORTS BY CATEGORY (CONTINUED)

Details by Category: **CRIMINAL EVENTS** (October 7, 2005 – October 6, 2006)

	TYPES OF EVENTS				
	24. CARE ORDERED BY SOMEONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	**25. ABDUCTION OF PATIENT**	**26. SEXUAL ASSAULT OF A PATIENT**	**27. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT**	**TOTAL FOR PATIENT PROTECTION**
ALL FACILITIES	0 Events	0 Events	3 Events	1 Event	4 Events
SEVERITY DETAILS			Serious Disability: 0 Death: 0 Neither: 3	Serious Disability: 0 Death: 1 Neither: 0	Serious Disability: 0 Death: 1 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**26,023 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
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 237,564 patient days at this facility during this time period**
Hypoglycemia	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 237,564 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
CRIMINAL EVENTS		**There were 237,564 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: 1; Serious Disability: 1; Neither: 5

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2
ANOKA METRO REGIONAL TREATMENT CENTER

Address: 3301 Seventh Avenue North Anoka, MN 55303
Website: www.dhs.state.mn.us (click on disabilities, then on state operated services)
Phone number: 651-431-3688
Number of beds: 200

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PATIENT PROTECTION EVENTS		**There were 65,604 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 3.3

BETHESDA REHABILITATION HOSPITAL

Address: 559 Capitol Blvd. St. Paul, MN 55103-2101
Website: www.healtheast.org/patient_safety
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 44,639 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 3.4

BUFFALO HOSPITAL

Address: 303 Catlin Street Buffalo, MN 55313-1947
Website: http://www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 65

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**2,624 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

DOUGLAS COUNTY HOSPITAL

Address: 111 East 17th Avenue Alexandria, MN 56308-3703
Website: www.dchospital.com
Phone number: 320-762-6189
Number of beds: 127

HOW TO READ THESE TABLES

These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**5,004 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 3.6

FAIRVIEW LAKES HEALTH SERVICES

Address: 5200 Fairview Blvd. Wyoming, MN 55092-8013
Website: www.fairview.org
Phone number: 612-672-6396
Number of beds: 61

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 46,049 patient days at this facility during this time period**
A medication error	**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 3.7

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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**3,146 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: 1; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	Deaths: 1; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

FAIRVIEW RIDGES HOSPITAL

Address: 201 East Nicollet Blvd. Burnsville, MN 55337
Website: www.fairview.org
Phone number: 612-672-6396
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**10,348 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 3.9

FAIRVIEW SOUTHDALE HOSPITAL

Address: 6401 France Avenue South Edina, MN 55435
Website: www.southdale.fairview.org
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**21,253 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
Death of a normal, healthy patient during or immediately after surgery	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 116,064 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
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 116,064 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	**4**	Deaths: 2; Serious Disability: 0; Neither: 2

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

GRAND ITASCA CLINIC AND HOSPITAL

Address: 1601 Golf Course Road Grand Rapids, MN 55744
Website: www.granditasca.org
Phone number: 218-999-1460
Number of beds: 95

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**2,980 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

HENNEPIN COUNTY MEDICAL CENTER

Address: 701 Park Ave. S. Minneapolis, MN 55415-1829
Website: www.hcmc.org/patients/patientsafety
Phone number: 612-873-5719
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**9,139 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
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 194,790 patient days at this facility during this time period**
A medication error	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**15**	Deaths: 0; Serious Disability: 0; Neither: 15
PATIENT PROTECTION EVENTS		**There were 194,790 patient days at this facility during this time period**
Patient death or serious disability associated with patient disappearance	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**21**	Deaths: 2; Serious Disability: 2; Neither: 17

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

Address: 1025 Marsh Street P.O. Box 8673 Mankato, MN 56002-8673
Website: www.isj-mhs.org
Phone number: 507-385-2938
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**6,601 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 83,191 patient days at this facility during this time period**
The use or malfunction of a device in patient care	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	Deaths: 0; Serious Disability: 1; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

LAKEVIEW HOSPITAL

Address: 927 Churchill St. W. Stillwater, MN 55082-6605
Website: www.lakeview.org
Phone number: 651-430-4648
Number of beds: 97

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**5,741 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 3.14

LAKEWOOD HEALTH SYSTEM

Address: 401 Prairie Ave. N.E. Staples, MN 56479-3201
Website: www.lakewoodhealthsystem.com
Phone number: 218-894-1515
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**898 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 3.15

LANDMARK SURGERY CENTER

Address: 17 W. Exchange St., Suite 310 St. Paul, MN 55102
Website: www.summitortho.com/patientsafety
Phone number: 651-501-3451

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**3,562 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

MAPLEWOOD ENDOSCOPY CENTER

Address: 1973 Sloan Place St. Paul, MN 55117-2084
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**17,378 surgeries were performed at this facility during this time period**
Wrong surgical/other invasive 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 3.17

MERCY HOSPITAL

Address: 4050 Coon Rapids Blvd. N.W. Coon Rapids, MN 55433-2522
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 271

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**17,276 surgeries were performed at this facility during this time period**
Wrong surgical/other invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**3**	Deaths: 0; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

METHODIST HOSPITAL PARK NICOLLET HEALTH SERVICES

Address: 6500 Excelsior Blvd. St. Louis Park, MN 55426-4702
Website: www.parknicollet.com
Phone number: 1-800-862-7412
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**22,386 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
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 167,014 patient days at this facility during this time period**
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**13**	Deaths: 0; Serious Disability: 0; Neither: 13
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 167,014 patient days at this facility during this time period**
A fall while being cared for in a facility	**2**	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**18**	Deaths: 2; Serious Disability: 0; Neither: 16

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

MIDWEST SURGERY CENTER

Address: 110 Midwest Eye & Ear Institute
2080 Woodwinds Drive Woodbury, MN 55125
Phone number: 651-642-9199

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**6,343 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

MILLER-DWAN MEDICAL CENTER

Address: 502 E. Second St. Duluth, MN 55805-1913
Website: www.smdc.org
Phone number: 218-786-3827
Number of beds: 165

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**8,032 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

MINNESOTA EYE LASER AND SURGERY CENTER - MAPLEWOOD

Address: 1965-11th Ave. E. Maplewood, MN 55109
Website: www.mneye.com
Phone number: 612-813-3619

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**568 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

NORTH COUNTRY HEALTH SERVICES

Address: 1300 Anne St. NW Bemidji, MN 56601
Website: www.nchs.com
Phone number: 218-333-5760
Number of beds: 116

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 44,285 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 3.23

NORTH MEMORIAL MEDICAL CENTER

Address: 3300 Oakdale Ave. N. 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**18,014 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
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 156,263 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	**6**	Deaths: 0; Serious Disability: 0; Neither: 6

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

OLMSTED MEDICAL CENTER

Address: 1650 Fourth St. S.E. Rochester, MN 55904-4717
Website: www.olmstedmedicalcenter.org
Phone number: 507-529-6795

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**3,242 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 3.25

PHILLIPS EYE INSTITUTE

Address: 2215 Park Ave. Minneapolis, MN 55404-3711
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
Number of beds: 20

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**10,176 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

REGENCY HOSPITAL OF MINNEAPOLIS

Address: 1300 Hidden Lakes Parkway Golden Valley, MN 55422
Website: www.regencyhospital.com
Phone number: 763-302-8326
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 7,986 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 3.27

REGIONS HOSPITAL

Address: 640 Jackson St. St. Paul, MN 55101-2502
Website: www.regionshospital.com
Phone number: 651-254-0760
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**16,316 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
Surgery performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 160,593 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
CRIMINAL EVENTS		**There were 160,593 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 3.28

RENVILLE COUNTY HOSPITAL

Address: 611 E. Fairview Olivia, MN 56277-4213
Website: www.renvillecountyhospital.org
Phone number: 320-523-3477
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 4,137 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 3.29

RICE MEMORIAL HOSPITAL

Address: 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 33,519 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 3.30

RIDGEVIEW MEDICAL CENTER

Address: 500 S. Maple St. Waconia, MN 55387-1752
Website: http://ridgeviewmedical.org
Phone number: 952-442-2191 x 5050
Number of beds: 109

HOW TO READ THESE TABLES

These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**7,046 surgeries were performed at this facility during this time period**
Surgery performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

RIVERVIEW HEALTHCARE ASSOCIATION

Address: 323 S. Minnesota St. Crookston, MN 56716-1601
Website: http://www.riverviewhealth.org/links/default.asp
Phone number: 218-281-9401
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**2,370 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/other invasive procedure performed	**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 3.32

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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**22,515 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
Surgery performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 149,211 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	**5**	Deaths: 0; Serious Disability: 0; Neither: 5

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

SAINT MARYS HOSPITAL

Address: 1216 2nd St. S.W. Rochester, MN 55902-1906
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**26,510 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 279,760 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
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 279,760 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	**7**	Deaths: 1; Serious Disability: 0; Neither: 6

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

SHRINERS HOSPITALS FOR CHILDREN – TWIN CITIES

Address: 2025 E. River Parkway Minneapolis, MN 55414-3604
Website: www.shrinershq.org
Phone number: 612-596-6111
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CRIMINAL EVENTS		**There were 3,793 patient days at this facility during this time period**
Death or significant injury of patient or staff from physical assault	**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 3.35

ST. CLOUD CENTER FOR OPTHALMIC SURGERY

Address: 2055 15th Street North, Suite B St. Cloud, MN 56303
Phone number: 320-258-6621

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**1,695 surgeries were performed at this facility during this time period**
Wrong surgical/other invasive 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 3.36

ST. CLOUD HOSPITAL

Address: 1406 Sixth Ave N. St Cloud, MN 56503-1900
Website: www.centracare.com
Phone number: 320-251-2700 x54100
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**15,708 surgeries were performed at this facility during this time period**
Retention of a foreign object in a patient after surgery or other procedure	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
TOTAL EVENTS FOR THIS FACILITY	**5**	Deaths: 0; Serious Disability: 0; Neither: 5

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**11,272 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

ST. FRANCIS REGIONAL MEDICAL CENTER

Address: 1455 St. Francis Ave. Shakopee, MN 55379-3380
Website: www.allina.com/ahs/aboutall.nsf/page/patientsafety
Phone number: 612-775-9762
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**4,472 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 3.39

ST. JOHN'S HOSPITAL

Address: 1575 Beam Ave. Maplewood, MN 55109-1126
Website: www.healtheast.org/patient_safety
Phone number: 651-326-2273
Number of beds: 184

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 73,861 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
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 73,861 patient days at this facility during this time period**
The use or malfunction of a device in patient care	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	Deaths: 0; Serious Disability: 1; Neither: 1

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

ST. JOSEPH'S HOSPITAL

Address: 69 W. Exchange St. St Paul, MN 55102-1004
Website: www.healtheast.org/patient_safety
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**6,093 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 89,334 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
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 89,334 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	**3**	Deaths: 1; Serious Disability: 0; Neither: 2

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

ST. JOSEPH'S MEDICAL CENTER

Address: 523 N. Third St. Brainerd, MN 56401-3054
Website: www.sjmcmn.org
Phone number: 218-828-7656
Number of beds: 162

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PATIENT PROTECTION EVENTS		**There were 58,320 patient days at this facility during this time period**
Patient death or serious disability associated with patient disappearance	**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 3.42

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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 108,584 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 3.43

ST. MARY'S MEDICAL CENTER

Address: 407 E. Third St. Duluth MN 55805-1950
Website: www.smdc.org
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**11,998 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
Surgery/other invasive procedure performed on wrong body part	**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 3.44

ST. MARY'S REGIONAL HEALTH CENTER

Address: 1027 Washington Ave. Detroit Lakes, MN 56501
Website: smrhc.com
Phone number: 218-847-0854
Number of beds: 87

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 4,958 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 3.45

ST. PETER REGIONAL TREATMENT CENTER

Address: 100 Freeman Drive St. Peter, MN 56082
Website: www.dhs.state.mn.us (click on disabilities, then on state operated services)
Phone number: 651-431-3688
Number of beds: 158

HOW TO READ THESE TABLES

These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CRIMINAL EVENTS		**There were 4,379 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 3.46

UNITED HOSPITAL, INC.

Address: 333 N. Smith Av 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**18,213 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
Wrong surgical/other invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 165,639 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 3.47

UNITY HOSPITAL

Address: 550 Osborne Road NE 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**9,340 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
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 75,963 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
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 75,963 patient days at this facility during this time period**
A fall while being cared for in a facility	**2**	Deaths: 2; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	Deaths: 2; Serious Disability: 0; Neither: 3

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

Address: 2450 Riverside Av. Minneapolis, MN 55454-1450
Website: www.fairview.org
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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**20,692 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**5**	Deaths: 0; Serious Disability: 0 Neither: 5
CARE MANAGEMENT **Death or serious disability associated with:**		**There were 289,091 patient days at this facility during this time period**
A medication error	**2**	Deaths: 1; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		**There were 289,091 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
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		**There were 289,091 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
PATIENT PROTECTION EVENTS		**There were 289,091 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	**13**	Deaths: 4; Serious Disability: 1; Neither: 8

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

WILLMAR SURGERY CENTER, LLP

Address: 1320-1st St. So. Willmar, MN 56201
Phone number: 320-235-6506

HOW 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, 2005-OCTOBER 6, 2006)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		**3,370 surgeries were performed at this facility during this time period**
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	Deaths: 0; Serious Disability: 0; Neither: 1

APPENDIX A:
Background on Minnesota's Adverse Health Events Reporting Law

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 "never events' identified by the National Quality Forum (NQF) and a public report that identified adverse events by facility. The law covers Minnesota hospitals, freestanding outpatient surgical centers, and regional treatment centers. This report is the third to be released under the reporting law.

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

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

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

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

Since the inception of the law, facilities throughout the state have initiated specific safety improvement strategies with measurable results. Some of those strategies are highlighted in this report. The Minnesota Department of Health, the Minnesota Hospital Association, Stratis Health, provider licensing boards and other interested parties are also working together to identify additional opportunities for learning about and sharing best practices.

APPENDIX B:
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

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 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 C:
Links and other Resources

Minnesota's Adverse Health Care Events Reporting Law

- 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
- For more information about the list of 27 Serious Reportable Events developed by the National Quality Forum (NQF) that form the basis of Minnesota's Adverse Health Events Reporting Law, go to www.qualityforum.org/neverteaser.pdf.
- Additional background information on the law, along with additional materials for consumers and other stakeholders, can be found at: www.health.state.mn.us/patientsafety

Minnesota Organizations

- The Minnesota Alliance for Patient Safety (MAPS) was established in 2000 as a partnership between the Minnesota Department of Health, the Minnesota Hospital Association, the Minnesota Medical Association, and more than 50 other health care organizations working together to improve patient safety. In 2006, MAPS earned the John M. Eisenberg award from NQF and The Joint Commission for their work advancing patient safety in Minnesota. More information about MAPS can be found at: www.mnpatientsafety.org
- The Institute for Clinical Systems Improvement (ICSI), based in Minnesota, works with hospitals, medical groups, and health plans to develop evidence-based health care guidelines and protocols to ensure high-quality care. ICSI also has information for patients and family members. For more information, visit www.icsi.org.
- Stratis Health, Minnesota's Medicare Quality Improvement Organization, provides clinical improvement information, health literacy information, opportunities to join patient safety projects and other quality improvement and patient safety resources and tools at www.stratishealth.org.

National Organizations

- The federal Agency for Healthcare Research and Quality (AHRQ) provides a number of safety and quality tips for consumers. 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/
- 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 Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States. The Joint Commission's website contains a number of resources for providers, including an online database of patient safety practices, at http://www.jointcommission.org/GeneralPublic/

Information for Consumers

- 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 health care encounters through partnership and collaboration. CAPS envisions creating a health care 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
- Blue Cross Blue Shield of Minnesota provides comparative information about hospital and primary care clinic safety and quality at www.healthcarefacts.org.
- Minnesota Health Information (www.minnesotahealthinfo.org) provides links to a variety of websites with information on cost and quality, information about managing chronic health conditions, and staying healthy.
- The Institute for Safe Medication Practices (ISMP) Alerts for Patients page contains a list of frequent medication errors and how to avoid them, general information and advice on medication safety for consumers http://www.ismp.org/Newsletters/consumer/consumerAlerts.asp
- 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 health care for Americans. The Leapfrog website provides quality and safety information about hospitals that consumers can search. www.leapfroggroup.org/for_consumers
- Minnesota Community Measurement (www.mnhealthcare.org) provides comparative information about provider groups and clinics. Consumers can learn about best practices in care for diabetes, asthma, and other conditions, as well as who does the best job providing that care.
- The Minnesota Hospital Quality Report (http://www.mnhospitalquality.org) provides comparative information about how hospitals perform on several quality measures, including how well they provide the care that is expected for heart attacks, heart failure, and pneumonia.
- The Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States. The Joint Commission's mission is to continuously improve the safety and quality of care provided to the public. The Joint Commission provides a number of patient safety tips for patients and consumers at: http://www.jointcommission.org/GeneralPublic/

This list represents only a small fraction of the resources available on patient safety and quality. 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

THIRD ANNUAL PUBLIC REPORT | JANUARY 2007

MINNESOTA MDH DEPARTMENT OF HEALTH

FREEMAN BUILDING
625 ROBERT STREET NORTH
P.O. BOX 64975
ST. PAUL, MN 55164-0882
651-201-5000

WWW.HEALTH.STATE.MN.US