FOURTH ANNUAL PUBLIC REPORT

ADVERSE HEALTH EVENTS IN MINNESOTA

JANUARY 2008

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

For More Information Contact:
Division of Health Policy
Minnesota Department of Health
651-201-3550

INTRODUCTION

Adverse Health Events in Minnesota

Annual Report January 2008

In the eight years since the Institute of Medicine (IOM) published its landmark report on medical errors, To Err is Human, the landscape of patient safety, both nationally and in Minnesota, has changed dramatically. At the time the IOM report was published, the concept of sharing information about adverse events among hospitals was relatively new, and Minnesota was among the first states to develop a public reporting system focused on sharing knowledge about prevention of adverse events. Now, such reporting systems are becoming more common, and patient safety efforts are gaining momentum in Minnesota and across the nation.

New approaches to addressing patient safety are also emerging. In August of 2007, the Medicare program announced that as of October 2008 it would no longer pay the extra costs associated with treating certain preventable adverse events or conditions. The following month, Minnesota became the first state to announce that its hospitals would not bill patients or insurers for care made necessary by an adverse event. These important changes will ensure that patient safety remains in the forefront in Minnesota, and will offer new ways of gauging the effectiveness of different approaches to improving safety and reducing adverse events.

The core of Minnesota's network of patient safety activities remains the Adverse Health Event Reporting System, through which Minnesota hospitals, ambulatory surgical centers, and community behavioral health hospitals are required to report whenever one of 27 – now 28 - 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 on the wrong person or body part.

Between October 7th, 2006 and October 6th, 2007, 125 events were reported to the Minnesota Department of Health. This report provides information about where these events happened, why they happened, and what's being done to prevent them from happening again. This is important information for both providers and consumers of healthcare.

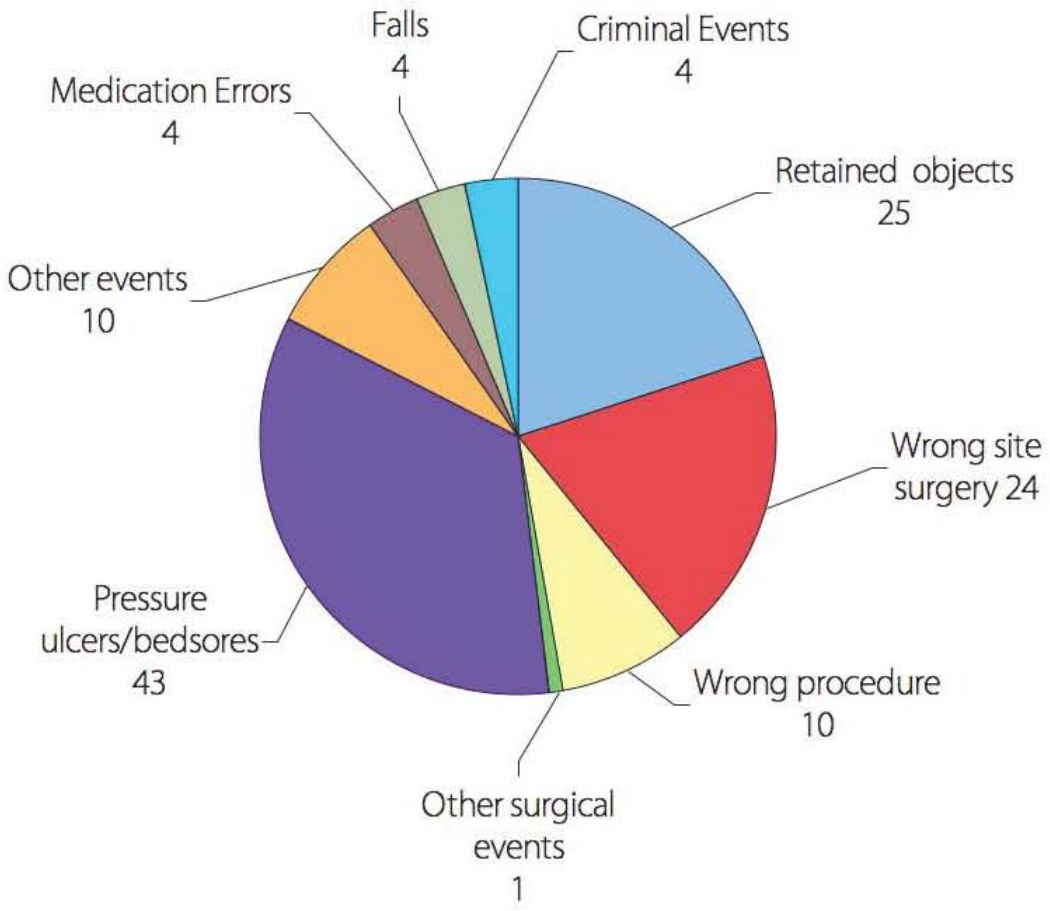
However, counting events will not, by itself, make the system safer. That's why the focus of this system has always been on learning why events happen, then sharing that information with healthcare providers so that they can improve their ability to prevent recurrences. Each facility that experiences one of these events is required to conduct an in-depth analysis of why it occurred, and to implement system changes to prevent similar events from happening again. Increasingly, key learnings from individual events and facilities are also being used to develop statewide and regional campaigns to prevent more common events. It is this type of shared learning and collaboration that will have the greatest impact on patient safety for all Minnesotans.

In the coming year, changes adopted in the 2007 legislative session will go into effect. These changes will broaden the adverse health events reporting system to include information about a wider range of events that affect patient safety. A 28th event related to artificial insemination with the wrong donor sperm or egg was added, and several existing events were also modified, one of them significantly. Starting in October of 2007, any fall associated with a serious disability became reportable, in addition to those that are associated with a death. In addition, an expanded definition of reportable pressure ulcers also went into effect in October of 2007. These changes will lead to a significantly higher number of reported events in these categories next year, but represent an improvement in our ability to track systems problems that can lead to patient harm.

As recently adopted federal and state policies show, adverse health events remain a serious issue here and across the country. We know that every reported event, regardless of the level of harm to the patient, represents a situation that should not have happened. But we also know that the factors that lead to these events are complex and often system-wide, making simple solutions or quick fixes unlikely to succeed. Achieving a significant and lasting reduction in the number of events will require a commitment of resources, time, and leadership by all levels of administration and staff within healthcare facilities, as well as support for front-line staff and patients when they speak up about concerns, questions or safety issues. 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, 2006 – October 6, 2007



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.

Identifying, reporting, and learning from potentially risky situations are the keys to improving patient safety. For consumers, the best way to play a role in improving safety is by using reports like these to identify situations of concern and to learn why they happen. Armed with that information, patients and family members can ask providers what is being done in their facility to prevent these types of events from occurring. In that way, the information in this report becomes a basis for further learning, rather than just a way to compare facilities based on incidence rates.

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

Reports might be higher or lower at a specific facility for a variety of reasons. A higher number of reported events does not necessarily mean that a facility is less safe, and a lower number does not necessarily mean the facility is safer. 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 and their causes, rather than the opposite.

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, pneumonia, and surgical care.

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 2007 ACTIVITIES

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

Over the last year, MDH has been involved 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 best practices, and spur high-level commitment to change within health care organizations. Highlights of the past year's activities are listed below.

Education

- More than 125 staff from 60 facilities 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.
- Patient safety professionals from hospitals and surgical centers around the state participated in an advanced root cause analysis forum. Participants shared challenges, successes and useful tools for dealing with difficult issues such as developing robust measurement systems, fostering facilitation skills, and linking corrective actions to root causes.
- More than 200 nurses, social workers, physicians, and other providers attended two workshops for healthcare workers on suicide prevention, focusing on how to ensure a safe environment for potentially suicidal patients and how to assess patients for risk of suicide.

Promoting organizational change

- Through a grant from MDH, human factors researchers from the University of Minnesota are observing the pre-operative processes hospitals use to ensure surgery on the correct body part and patient, to determine why these processes sometimes fail to prevent wrong-site or wrong-patient procedures.
- During 2007, MHA developed two year-long "calls to action," campaigns to prevent pressure ulcers and falls. Regular data submissions from the nearly 100 participating hospitals show that the percentage that have implemented evidence-based best practices to prevent these adverse events has increased significantly.
- A third call to action, which calls on hospital and surgical center CEO's to implement "hard stops" if appropriate protocols to prevent wrong-site surgery are not followed, began in December, 2007 with more than 90 hospitals and 24 surgical centers participating.

Sharing knowledge

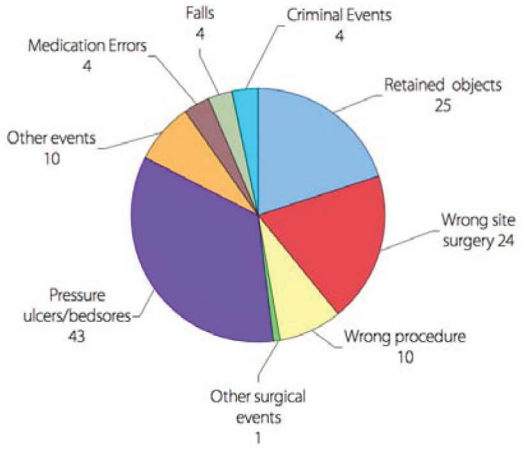
- In 2007, MHA and MDH released two patient safety advisories. The first alerted facilities to the potential risk of retention of the tip of a device in patients, and the second discussed the importance of including lens power in pre-operative checklists for eye surgeries.

Strengthening the reporting system

- The web-based registry was modified to collect additional information on where events occur, to enable better analysis of trends in adverse events by location or specific setting of events.
- MDH worked with hospitals to develop a process for collecting additional follow-up information about reported events. This will enable new analyses of the corrective actions that are most effective in preventing recurrence of adverse events, and improve our ability to monitor successful improvements in the long term.

OVERVIEW OF REPORTED EVENTS

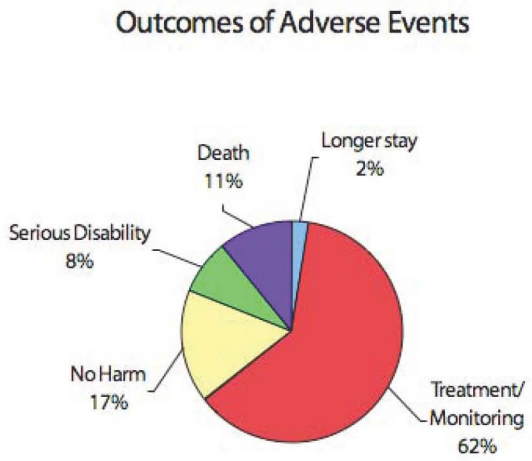
Between October 7, 2006, and October 6, 2007, a total of 125 adverse health events were reported to the Minnesota Department of Health (MDH). This figure represents an average of 10.4 events per month or roughly 2.4 events per week.



Currently, 135 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 December 2007, 51 ambulatory surgical centers and 11 community behavioral health hospitals were also subject to the reporting law. Of the 197 facilities covered by the law, 42 (21 percent) reported adverse events during this reporting period: 38 hospitals and 4 surgical centers.

During 2006, the most recent year for which preliminary data is available, Minnesota hospitals reported nearly 2.8 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 4.5 events were reported by hospitals per 100,000 patient days.

As in previous years, stage 3 or 4 pressure ulcers were the most commonly reported events, followed by retained foreign objects and surgery or any other invasive procedure on the wrong part of the body. These three categories of events accounted for more than 75 percent of reported events. This year, for the first time, the number of reported pressure ulcers and retained objects both decreased, with pressure ulcers down slightly and retained foreign objects dropping to their lowest level since reporting began. However, determining the causes of increases or decreases in the number of reported events is always difficult, and given the rarity of these events, a one-year increase or decrease is not statistically significant. If a lower rate of these events can be maintained over time, that may indicate that facilities have found sustainable long-term solutions for preventing these events.



Of the reports submitted during the reporting period, 17 percent resulted in no harm to patients, while 19 percent led to either death or serious disability. A majority of events, 62 percent, resulted in a need for additional treatment or monitoring, but not a longer stay in the hospital. Of the 13 deaths reported during this time period, four were due to falls, three were the result of suicide, and four were related to the malfunction of a product or device.

DETERMINING WHY:
ROOT CAUSE ANALYSIS

When an adverse event occurs, facilities are required to conduct a root cause analysis. This process involves gathering a team to closely examine the factors that led to the event. These factors can include communication, staffing levels, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities. The process of completing a root cause analysis (RCA) is a crucial step in determining exactly what happened and why it happened. Without uncovering a root cause, it becomes very difficult to prevent a recurrence.

It's also important that facilities look at patterns of events or system breakdowns. If multiple similar events occur, analysis of their root causes can reveal patterns of vulnerability that might not be apparent from one event. Addressing those broader systemic problems can lead to improved patient safety across departments or units. 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	
Rules/Policies/Procedures	63%
Communication	58%
Environment/Equipment	45%
Training	38%
Barriers	20%
Fatigue/Scheduling	6%

The majority of adverse events were traced to root causes in one of four areas: policies/procedures, communication, environment/equipment, and training. Among state and national organizations that study the causes of adverse events and medical errors, similar findings are common. The Agency for Healthcare Research and Quality (AHRQ), the Joint Commission, and other states with similar reporting systems have all found that communication breakdowns are at or near the top of the list of causes for adverse events, along with issues related to information flow and documentation and how rules or policies are followed.

Often, the causes that led to an event can cut across these categories. For example, even in cases where a policy is in place to prevent something from happening, it is not always implemented in the way that it should have been. The reasons for that can include lack of understanding of the roles of individuals in carrying out the policy (training), an inadequately written rule (rules/policies/procedures), pressure to complete a process quickly (scheduling), forgetting about a step or a rule at the end of a shift (fatigue), distractions (environment), misunderstandings about what has been done or needs to be done (communication), or physical factors that prevent staff from carrying out the policy (barriers). Cultural issues can also come into play, particularly in cases where providers, staff, or patients feel uncomfortable speaking up if a person has not followed a policy.

Communication breakdowns between providers on a care team, and between providers and patients, are one of the most common causes of 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. Sometimes, communication problems happen when team members don't know each other well enough to discuss risky situations. Other times, they happen when team members know each other so well that they assume the other person is doing the right thing.

Below is a summary of RCA information submitted by hospitals 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:

Retained Objects

- Process relied on provider's memory to check for retained sponges.
- Staff reluctant to voice questions or concerns to surgeons.

- Differences in staff practice for counting lap sponges individually or in groups of five.
- Staff moving in and out of operating room during procedure may miss some items placed in cavity if not verbalized by surgeon and written on white board.
- Staff felt rushed to prepare for next case, so sponge count was not consistent with policy.
- Radiologist doing post-op x-ray was not told to look for a potential foreign object.
- Policy was not in place to do sponge counts after vaginal deliveries.

Wrong site/wrong procedure/wrong patient

- Noise, interruptions, multiple competing responsibilities, or other distractions prior to surgery made it difficult to focus on the time-out or other pre-procedure verification policies.
- No policy in place for verifying certain aspects of implants.
- Policies or protocols that are used in the operating room to verify surgical sites may not be used in procedure rooms or during bedside procedures, or it may not be clear to staff that policies apply in other settings.
- Documentation or protocols for procedures conducted in other settings may not include a trigger for a time-out to stop the procedure and verify correct patient/site/procedure.
- Surgical drapes, betadyne, or equipment obscured the surgical site marking.
- Hand-written surgical schedule differed from surgeon's notes about procedure.
- Staff were reluctant to speak up when working with experienced surgeon.
- Patient was repositioned after surgical site was marked, and second time out after repositioning was not conducted.
- No policy in place for conducting second time-out in cases of internal laterality (paired organs or structures).

Care Management Events – Pressure ulcers:

- Failure to completely document patient's skin condition on admission.
- Communication breakdown between dietitian, therapist, and nursing staff about skin abnormalities.
- Dressing changes did not coincide with physician rounding; physician had to rely on verbal descriptions of ulcer progression.
- Regular skin inspections not done, or not reflective of current best practice.
- Care plan related to skin was not developed when new equipment began to be used with patient.
- 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 staff at shift change.
- 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.
- Staff not adequately trained on ulcer progression and appropriate treatment at different stages.
- High workloads or staffing shortages prevented some staff from attending training on skin safety.
- Lack of defined written process for performing skin assessment or communicating potential for skin breakdown.

Environmental Events – Falls:

- High-risk patient placed in room not visible from nursing station; staff could not hear bed alarm.
- Standard order sets did not include flag for physicians to consider fall risk when ordering certain medications that might increase risk.
- Unclear post-fall intervention protocol, or protocol not implemented as required.
- Transition from paper documentation to electronic medical record, with different communication processes, led to information being inconsistently shared.
- 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 or medications.

Note: each event can have multiple contributing factors.

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 how 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), and other sources outlined in Appendix C of this report.

Surgical Events

What Facilities Are Doing to Prevent Surgical Events

- Conducting second time-out and site marking when patient is repositioned or marking isn't visible.
- Assigning one individual to be accountable for implementation of time-out.
- Developing scripting for pre-operative procedures and clarifying who is responsible for calling time-out.
- Creating mandatory checklist for use during invasive procedures, including site marking.
- Ensuring that all site marking materials are indelible and designed to be clearly visible on all skin types.
- Improving labeling on equipment carts so that left/right implants and/or implant sizes are clearer.
- Replacing sponges with radio-opaque or tailed sponges.
- Standardizing sponge counting processes across units and departments.
- 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 Patients 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.** The surgeon should mark his or her initials on the site, or as close to it as possible. The site should also be visible at the time the surgeon or other provider begins the procedure.

SPOTLIGHT ON: WRONG SITE SURGERY

Both nationally and in Minnesota, wrong site surgeries and other invasive procedures are proving difficult to eliminate. In 2007, the Joint Commission convened a national group of experts for a summit on wrong site surgery, prompted by increasing reports of wrong site, wrong procedure, and wrong patient events in recent years despite increasing efforts to prevent them. Since 1995, the number of events voluntarily reported to the Joint Commission has risen from fewer than ten per year to more than 70. In Minnesota, as well, the combined number of wrong site, procedure, and patient events has increased slightly since the reporting system began.

Much of this increase is likely due to a better understanding of the breadth of events that are reportable as adverse events, rather than to an increase in their frequency. But given that wrong site procedures should never happen, their persistence is troubling.

Why do wrong site procedures happen?

All hospitals and surgical centers have policies in place that require certain steps be taken before a surgery or invasive procedure begins. These steps should include checking that the surgical schedule and the patient's informed consent form are correct and consistent, implementing a 'time out' to verify the patient's name and procedure, and having the surgeon mark the correct site with his or her initials. The Institute for Clinical Systems Improvement has developed a Safe Site Protocol outlining how and when these steps should happen; many facilities have adopted this protocol and use it to guide their policies and training.

In practice, though, many things can and do get in the way of carrying out the protocol as it was envisioned. Overconfidence, a perception that the risk of a wrong-site event is low, cognitive overload related to multi-tasking or distractions, and policies that don't sufficiently spell out who's responsible to call for the time-out can all contribute to an increased chance of a wrong-site surgery or other invasive procedure.

Issues related to the culture within the operating room often play a role in wrong site surgeries and other invasive procedures, as well. In the past, the surgical environment was more hierarchical, with nurses, technicians, and other OR team members supporting the surgeon but not having authority to speak up about problems or concerns. Today, surgical teams live up to their name. Everyone has a role, and there is a much higher level of trust and mutual respect than there was a generation or two ago. But some vestiges of the old system are difficult to shake, particularly the feeling of some team members that they can't or shouldn't speak up when they suspect that a mistake might be imminent. Some team members may feel that they don't know enough to speak up, or trust that an experienced surgeon 'must know what they're doing.' Others may be reluctant to hold up the process with a concern that may be unfounded. If a team member feels that they won't be supported by the facility's administration when they do speak up, that reluctance can be magnified.

What are we doing to prevent wrong site procedures?

Given this complex web of causes, providers have to work on multiple levels to eradicate wrong site surgery and other invasive procedures. Minnesota facilities are collaborating in several unique ways to prevent future events:

- MHA kicked off a statewide campaign to prevent wrong site surgery in December of 2007. More than 90 hospitals and 24 surgical centers signed up for the campaign. Participating facilities agree to implement a number of best practices to prevent wrong site surgery, including calling for a 'hard stop' whenever certain pre-surgical steps aren't taken, and creating an environment in which all staff are expected to speak up about risks. Participating facilities also agree to submit data quarterly to MHA, to allow for tracking of progress over time in implementing these steps.
- Through an MDH grant, human factors researchers from the University of Minnesota are observing surgeries at hospitals around the state, focusing on identifying the gaps in pre-surgical processes that allow these events to happen. Their results will be used to develop tools that all hospitals and surgical centers can use to decrease their risk of wrong-site surgery.
- A group of more than 20 hospitals and surgical centers from central and northern Minnesota formed the Greater Minnesota Initiative for Safe Surgery (GMISS) in February, 2007. GMISS provides an opportunity for these facilities to share problems and solutions related to wrong site surgery, as well as informed consent, antibiotic timing, DVT prophylaxis, and other issues. The group also works to educate community members about how to be wise consumers and advocates for their own best care.

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, ostomy and continence nurses as consultants.
- Increasing the use of visual aids and pictures to assist nursing staff in correctly staging pressure ulcers and in communicating skin issues upon shift transfer.
- Establishing pressure ulcer prevention work group to review all cases and look for common causes.
- Providing additional training to staff on working with patients or family members who are reluctant to cooperate with skin care practices.

What Patients Can Do to Prevent Pressure Ulcers

- **Participate in your own care by inspecting your own skin and ensuring that your caregivers do so daily.**[1] 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.

Falls

What Facilities Are Doing to Prevent Falls

- Implementing new fall risk assessment policies and standardized assessment tools.
- Using high-visibility indicators of patient's fall risk (stars, bands, colored slippers, etc).
- Modifying standard order sets so that a patient's fall risk status is consistently considered when ordering medications.
- Developing post-fall intervention protocol with clear assignment of roles.
- Implementing rounding at least every two hours to address patient's toileting and other needs.
- 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 Patients 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.

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

SPOTLIGHT ON:

Over the four years that the adverse event reporting system has been in place, serious pressure ulcers have consistently been among the top reported adverse health events. In 2006, pressure ulcers accounted for one third of all adverse health events.

There is a common misconception that pressure ulcers only affect the very elderly or those who are confined to wheelchairs or beds. However, pressure ulcers impact patients of all ages when certain conditions – including pressure, moisture, and immobility – exist.

To address the problem of pressure ulcers, the Minnesota Hospital Association (MHA) launched the SAFE SKIN program in February 2007. More than 90 hospitals signed up for the campaign, which offers peer advice, tools and care protocols aimed at reducing the number of pressure ulcers in Minnesota hospital patients.

"In 2006, the Institute for Clinical Systems Improvement developed best-practices for hospitals to prevent pressure ulcers," said Julie Apold, MHA patient safety director. "With this next step, we can help hospitals answer the question, 'How do I implement those best practices within my facility?'"

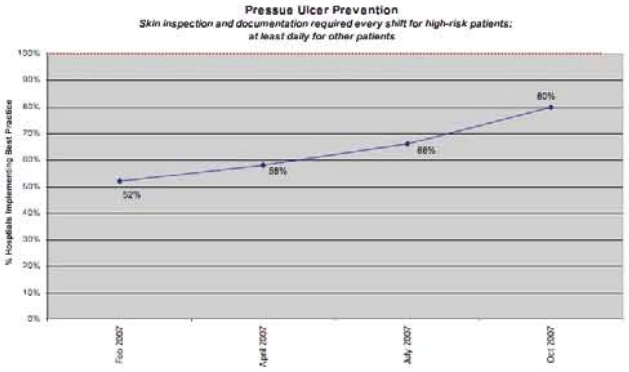
The central part of the campaign is an implementation "roadmap." The roadmap prescribes 32 specific steps hospitals should take to prevent pressure ulcers. Participating facilities report quarterly on their implementation of the roadmap steps, with a goal of eventually implementing all 32.

The term "SAFE" refers to the institutional measures hospitals must implement as program participants, such as creating interdisciplinary skin safety teams. The term "SKIN" stands for the patient-care components of the initiative:

Skin safety coordination
Accurate and concurrent reporting
Facility expectations
Education for patients and families.

Skin inspection
Keeping pressure off
Incontinence care
Nutrition

The program is working. By mid-October, participating hospitals reported that 78 percent of the best-practice steps were in place, compared with 59 percent before the project began. On individual components, such as the requirement for skin inspection and documentation every shift for high-risk patients, the progress has been even greater.



One facility that is making great strides is Redwood Area Hospital in Redwood Falls, which moved from 56 percent compliance to 97 percent compliance with roadmap steps. Leaders at Redwood conducted four-hour training sessions for all nursing staff. The education used pictures of wounds, case studies and demonstrations to reinforce safe skin care techniques. Leaders commented that the SAFE SKIN initiative gave them direction on the objectives, purposes and standards of care around pressure ulcer prevention.

For more information about the SAFE SKIN initiative, or to view the implementation roadmap, visit the Minnesota Hospital Association's website at www.mnhospitals.org.

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 to prevent harm to patients, that focus needs to be maintained throughout the year. Disseminating evidence-based best practices about patient safety, implementing these changes, making sure that they are sustainable over time, and educating patients about their role in patient safety are critical. As we move forward with an expanded list of reportable events in 2008, the Minnesota Department of Health and its partners will continue to create new opportunities for learning from the adverse events reporting system and for incorporating 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. 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, along with other sources of information, 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.

Changes enacted during the 2007 legislative session, which will be reflected in the 2009 annual report, are not shown here.
Current statutory language is available on the MDH website at www.health.state.mn.us/patientsafety

TABLES AND DETAILED INFORMATION

TABLE 1:

Overall Statewide Report ..... page 19

- This table describes the total number of reported events for the state during the period from October 7, 2006 through October 6, 2007. 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 20–22

- 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 – 3.42:

Facility-Specific Data ..... page 23

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, 2006 – October 6, 2007)

TYPES OF EVENTS							
	SURGICAL	**PRODUCT**	**PATIENT PROTECTION**	**CARE MANAGEMENT**	**ENVIRONMENTAL**	**CRIMINAL**	**TOTAL**
ALL FACILITIES	60 events	5 events	3 events	49 events	4 events	4 events	125 events
SEVERITY DETAILS	Serious Disability: 1 Death: 0 Neither: 59	Serious Disability: 0 Death: 5	Serious Disability: 0 Death: 3	Serious Disability: 9 Death: 1 Neither: 39	Serious Disability: 0 Death: 4	Serious Disability: 0 Death: 0 Neither: 4	Serious Disability: 10 Death: 13 Neither: 102

TABLE 2: STATE-WIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (October 7, 2006 – October 6, 2007)

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	24 Events	1 Event	10 Events	25 Events	0 Events	60 Events
SEVERITY DETAILS	Serious Disability: 0 Death: 0 Neither: 24	Serious Disability: 0 Death: 0 Neither: 1	Serious Disability: 1 Death: 0 Neither: 9	Serious Disability: 0 Death: 0 Neither: 25		Serious Disability: 1 Death: 0 Neither: 59

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2006 – October 6, 2007)

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

Details by Category: **PATIENT PROTECTION** (October 7, 2006 – October 6, 2007)

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

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

Details by Category: **CARE MANAGEMENT** (October 7, 2006 – October 6, 2007)

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 HYPOGLYCEMIA	16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPERBILIRUBINEMIA	17. STAGE 3 OR 4 PRESSURE ULCERS ACQUIRED AFTER ADMISSION	18. DEATH OR DISABILITY DUE TO SPINAL MANIPULATION	TOTAL FOR CARE MANAGEMENT
ALL HOSPITALS	4 Events	0 Events	0 Events	2 Events	0 Events	43 Events	0 Events	49 Events
SEVERITY DETAILS	Serious Disability: 4 Death: 0			Serious Disability: 1 Death: 1		Serious Disability: 4 Death: 0 Neither: 39		Serious Disability: 9 Death: 1 Neither: 39

Details by Category: **ENVIRONMENTAL** (October 7, 2006 – October 6, 2007)

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

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

Details by Category: **CRIMINAL EVENTS** (October 7, 2006 – October 6, 2007)

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 HOSPITALS	0 Events	0 Events	4 Events	0 Events	4 Events
SEVERITY DETAILS			Serious Disability: 0 Death: 0 Neither: 4		Serious Disability: 0 Death: 0 Neither: 4

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address:
800 East 28th Street
Minneapolis, MN 55407-3723

Website:
http://www.allina.com/ahs/aboutall.nsf/page/patientsafety

Phone number:
612-775-9762

Number of beds:
952

***Number of surgeries performed:**
21,952

Number of patient days:
236,357

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1; Serious Disability: 0; Neither: 6**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

ALBERT LEA MEDICAL CENTER–MAYO HEALTH SYSTEM

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

Website:
www.almedcenter.org

Phone number:
507-373-2384

Number of beds:
107

***Number of surgeries performed:**
4,843

Number of patient days:
45,237

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

AUSTIN MEDICAL CENTER-MAYO HEALTH SYSTEM

Address:
1000 1st Drive N.W.
Austin, MN 55912-2941

Website:
www.austinmedicalcenter.org

Phone number:
507-434-1405

Number of beds:
82

***Number of surgeries performed:**
4,719

Number of patient days:
40,312

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

BETHESDA REHABILITATION HOSPITAL

Address:
559 Capitol Blvd
St Paul, MN 55103-2101

Website:
www.bethesdahospital.org

Phone number:
651-232-2000

Number of beds:
264

Number of patient days:
45,237

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
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 3.5

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

***Number of surgeries performed:**
2,746

Number of patient days:
18,979

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA-ST PAUL

Address:
345 North Smith Avenue
St. Paul, MN 55102-2346

Website:
www.childrensmn.org

Phone number:
612-813-6518

Number of beds:
126

***Number of surgeries performed:**
7,193

Number of patient days:
51,750

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

CUYUNA REGIONAL MEDICAL CENTER

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

Website:
www.cuyunamed.org

Phone number:
218-546-2300

Number of beds:
42

***Number of surgeries performed:**
4,210

Number of patient days:
12,217

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

DISTRICT ONE HOSPITAL

Address:
200 State Avenue
Faribault, MN 55021-6345

Website:
www.districtonehospital.com

Phone number:
507-332-4730

Number of beds:
99

***Number of surgeries performed:**
2,590

Number of patient days:
21,391

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

FAIRVIEW LAKES MEDICAL CENTER

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

Website:
www.fairview.org

Phone number:
612-672-6396

Number of beds:
61

***Number of surgeries performed:**
7,017

Number of patient days:
45,663

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

FAIRVIEW NORTHLAND MEDICAL CENTER

Address:
911 Northland Drive
Princeton, MN 55371

Website:
www.fairview.org

Phone number:
763-389-6451

Number of beds:
54

***Number of surgeries performed:**
3,102

Number of patient days:
29,135

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

FAIRVIEW RIDGES HOSPITAL

Address:
201 East Nicollet Boulevard
Burnsville, MN 55337-5799

Website:
www.fairview.org

Phone number:
612-672-6396

Number of beds:
150

***Number of surgeries performed:**
13,722

Number of patient days:
65,313

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

FAIRVIEW SOUTHDALE HOSPITAL

Address:
6401 France Avenue South
Edina, MN 55435-2104

Website:
www.fairview.org

Phone number:
612-672-6396

Number of beds:
390

***Number of surgeries performed:**
28,860

Number of patient days:
121,175

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/other invasive procedure performed	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
CARE MANAGEMENT **Death or serious disability associated with:**		
A medication error	**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 associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**9**	**Deaths: 1; Serious Disability: 1; Neither: 7**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

Address:
200 E. University Avenue
St. Paul, MN 55101-2507

Website:
www.gillettechildrens.org

Phone number:
651-229-1753

Number of beds:
60

***Number of surgeries performed:**
3,022

Number of patient days:
18,586

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

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

***Number of surgeries performed:**
9,221

Number of patient days:
175,357

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
CARE MANAGEMENT **Death or serious disability associated with:**		
Hypoglycemia	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 2; Serious Disability: 0; Neither: 8**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

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

Website:
www.isj-mhs.org

Phone number:
507-385-2691

Number of beds:
272

***Number of surgeries performed:**
6,715

Number of patient days:
61,466

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

LAKE CITY MEDICAL CENTER-MAYO HEALTH SYSTEM

Address:
500 West Grant Street
Lake City, Minnesota 55041-1143

Website:
www.lakecitymedicalcenter.org

Phone number:
651-345-3321

Number of beds:
18

***Number of surgeries performed:**
672

Number of patient days:
4,593

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

LAKEVIEW HOSPITAL

Address:
927 Churchill St. W.
Stillwater, MN 55082-6605

Website:
www.lakeview.org

Phone number:
651-430-4515

Number of beds:
97

***Number of surgeries performed:**
5,783

Number of patient days:
24,929

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

LANDMARK SURGERY CENTER

Address:
17 W. Exchange St., Suite 307
St. Paul, MN 55102

Website:
www.summitortho.com

Phone number:
651-843-5463

Number of surgeries performed:
4,941

How 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, 2006-OCTOBER 6, 2007)

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

MAPLEWOOD SURGERY CENTER

Address:
1655 Beam Avenue
Maplewood, MN 55109-1163

Website:
www.healtheast.org/quality/index.cfm

Phone number:
651-232-7787

Number of surgeries performed:
3,644

How 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, 2006-OCTOBER 6, 2007)

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

MERCY HOSPITAL

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

Website:
http://www.allina.com/ahs/aboutall.nsf/page/patientsafety

Phone number:
612-775-9762

Number of beds:
271

***Number of surgeries performed:**
14,143

Number of patient days:
107,971

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

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

***Number of surgeries performed:**
4,960

Number of patient days:
41,010

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

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

***Number of surgeries performed:**
16,941

Number of patient days:
158,637

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS **Death associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 1; Serious Disability: 0; Neither: 5**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

PARK NICOLLET METHODIST HOSPITAL

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

Website:
www.parknicollet.com

Phone number:
952-993-5000

Number of beds:
426

***Number of surgeries performed:**
16,462

Number of patient days:
150,490

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical/other invasive procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		
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	**7**	**Deaths: 0; Serious Disability: 0; Neither: 7**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

PHILLIPS EYE INSTITUTE

Address:
2215 Park Ave.
Minneapolis, MN 55404-3711

Website:
http://www.allina.com/ahs/aboutall.nsf/page/patientsafety

Phone number:
612-775-9762

Number of beds:
20

***Number of surgeries performed:**
10,181

Number of patient days:
7,428

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

REDWOOD AREA HOSPITAL

Address:
100 Fallwood Road
Redwood Falls, MN 56283-1828

Website:
http://www.redwoodareahospital.org/patient_safety.htm

Phone number:
507-637-4500

Number of beds:
25

***Number of surgeries performed:**
621

Number of patient days:
4,675

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
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	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical count on this page does not include regional anesthetic blocks and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

REGENCY HOSPITAL OF MINNEAPOLIS

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

Website:
www.regencyhospital.com

Phone number:
763-302-8326

Number of beds:
92

Number of patient days:
9,016

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
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

REGINA MEDICAL CENTER

Address:
1175 Nininger Road
Hastings, MN 55033-1056

Website:
www.reginamedical.org

Phone number:
651-480-4100

Number of beds:
57

***Number of surgeries performed:**
3,255

Number of patient days:
22,812

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

REGIONS HOSPITAL

Address:
640 Jackson St.
St Paul, MN 55101-2502

Website:
www.regionshospital.com

Phone number:
651-254-0760

Number of beds:
427

***Number of surgeries performed:**
14,183

Number of patient days:
161,120

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PATIENT PROTECTION EVENTS **Death or serious disability associated with:**		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		
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
CRIMINAL EVENTS		
Sexual assault on a patient	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1; Serious Disability: 1; Neither: 5**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

RIVERWOOD HEALTHCARE CENTER

Address:
200 Bunker Hill Drive
Aitkin, MN 56431-1865

Website:
www.riverwoodhealthcare.com

Phone number:
218-927-2121

Number of beds:
24

***Number of surgeries performed:**
1,944

Number of patient days:
12,793

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
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**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

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

***Number of surgeries performed:**
18,533

Number of patient days:
129,310

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		
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:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0; Serious Disability: 1; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1; Serious Disability: 1; Neither: 5**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

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:
1,157

***Number of surgeries performed:**
27,386

Number of patient days:
249,999

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		
An intravascular air embolism	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
The use or malfunction of a device in patient care	**2**	Deaths: 2; Serious Disability: 0; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**7**	Deaths: 0; Serious Disability: 3; Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 3; Serious Disability: 3; Neither: 6**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

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

***Number of surgeries performed:**
14,436

Number of patient days:
170,807

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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:**		
A medication error	**2**	Deaths: 0; Serious Disability: 2; Neither: 0
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS **Death associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
CRIMINAL EVENTS		
Sexual assault on a patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 1; Serious Disability: 2; Neither: 3**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

ST. JOHN'S HOSPITAL

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

Website:
www.stjohnshospital-mn.org

Phone number:
651-326-2273

Number of beds:
184

***Number of surgeries performed:**
10,369

Number of patient days:
83,811

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

ST. JOSEPH'S HOSPITAL

Address:
69 W. Exchange St.
St Paul, MN 55102-1004

Website:
www.healtheast.org/patientsafety

Phone number:
651-326-2273

Number of beds:
401

***Number of surgeries performed:**
6,106

Number of patient days:
89,708

How 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, 2006-OCTOBER 6, 2007)

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

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

ST. JOSEPH'S MEDICAL CENTER

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

Website:
www.sjmcmn.org

Phone number:
218-828-7641

Number of beds:
162

***Number of surgeries performed:**
3,568

Number of patient days:
56,975

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**		
The use or malfunction of a device in patient care	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

ST. MARY'S MEDICAL CENTER

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

Website:
www.smdc.org

Phone number:
218-786-2629

Number of beds:
380

***Number of surgeries performed:**
10,222

Number of patient days:
104,699

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 0; Neither: 3**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

TRIA ORTHOPAEDIC CENTER

Address:
8100 Northland Drive
Bloomington, Minnesota 55431

Website:
www.tria.com

Phone number:
952-806-5301

Number of surgeries performed:
5,574

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

UNITED HOSPITAL, INC.

Address:
333 N. Smith Ave.
St Paul, MN 55102-2344

Website:
http://www.allina.com/ahs/aboutall.nsf/page/patientsafety

Phone number:
612-775-9762

Number of beds:
546

***Number of surgeries performed:**
19,242

Number of patient days:
168,261

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
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:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

UNITY HOSPITAL

Address:
550 Osborne Road NE
Fridley, MN 55432-2718

Website:
http://www.allina.com/ahs/aboutall.nsf/page/patientsafety

Phone number:
612-262-0605

Number of beds:
275

***Number of surgeries performed:**
8,746

Number of patient days:
80,221

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/other invasive procedure performed	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

Address:
2450 Riverside Ave.
Minneapolis, MN 55454-1450

Website:
www.fairview.org

Phone number:
612-672-6396

Number of beds:
1,700

***Number of surgeries performed:**
28,893

Number of patient days:
275,862

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**6**	Deaths: 0; Serious Disability: 0; Neither: 6
CRIMINAL EVENTS		
Sexual assault on a patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0; Serious Disability: 0; Neither: 10**

* The surgical count on this page 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.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

WILLMAR SURGERY CENTER, LLP

Address:
1320-1st St. So.
Willmar, MN 56201

Website:
http://www.acmc.com/acmc_link.cfm?acmcLinkID=4

Phone number:
320-235-6506

Number of surgeries performed:
6,445

How 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, 2006-OCTOBER 6, 2007)

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

WORTHINGTON REGIONAL HOSPITAL

Address:
1018 Sixth Avenue
Worthington, MN 56187

Website:
www.worthingtonhospital.com

Phone number:
507-372-3272

Number of beds:
66

Number of surgeries performed:
1,928

Number of patient days:
12,608

How 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, 2006-OCTOBER 6, 2007)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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 community behavioral health hospitals.

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, the 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.

In 2007, the Adverse Health Care Events Reporting Law was modified to include a 28th event and to expand the definitions of certain other events. The most significant change was an expansion of reportable falls to include those that are associated with a serious disability in addition to those that are associated with a death. These events will be included for the first time in the January, 2009 report.

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. *Changes enacted during the 2007 legislative session, which will be reflected in the 2009 annual report, are not shown here. Current statutory language is available on the MDH website at www.health.state.mn.us/patientsafety*

Surgical Events[1]

1. Surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

2. Surgery performed on the wrong patient;

3. The wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;

4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and

5. Death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

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.

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

Care Management Events

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 28 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 JCAHO 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.

FOURTH ANNUAL PUBLIC REPORT

ADVERSE HEALTH EVENTS IN MINNESOTA

JANUARY 2008

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