ADVERSE HEALTH EVENTS IN MINNESOTA

FIFTH ANNUAL PUBLIC REPORT

JANUARY 2009

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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EXECUTIVE SUMMARY

Adverse Health Events in Minnesota

Annual Report January 2009

Minnesota has long been a leader in healthcare quality and patient safety, and was the first state to pass a law requiring that all hospitals and, later, ambulatory surgical centers report all cases of 28 serious adverse events, with each facility's events appearing in an annual public report. The Adverse Health Care Events Reporting Law passed in 2003 and has now been in place for five years.

The reporting law was envisioned as a system for enhancing both accountability and transparency in Minnesota. By creating an environment in which adverse events and their causes were shared, policymakers hoped to foster a culture of learning and accelerate the pace of change in the pursuit of the safest possible healthcare system. Five years into that journey, an evaluation of the reporting system reveals that the majority of reporting facilities feel that the law has been an important catalyst in making Minnesotans safer, and that it has helped to drive changes including greater involvement and awareness by boards of directors, increased transparency within and outside of the facility, more standardization of policies and processes, and a sense that patient safety is everyone's responsibility.

This annual report will provide analysis of reported events, and describe the most important findings from the current reporting year. This report covers events that were discovered between October 7, 2007 and October 6, 2008. Key findings include:

- This year, the definitions of two categories of events changed significantly. Reportable falls were expanded to include those resulting in serious disability, and pressure ulcers were expanded to include "unstageable" pressure ulcers. Those changes led to an increase in the number of reported events, from 125 to 312.
- Without the definitional changes, the total number of reported events would have been 141.
- A series of statewide campaigns developed by the Minnesota Hospital Association and centered around the most common types of events (falls, pressure ulcers, wrong-site surgery, and retained sponges in labor and delivery) has led to significant increases in the percentage of facilities that have adopted a bundle of best practices to prevent these events.
- While the overall number of events has increased, facilities have experienced dramatic success in preventing retained sponges after childbirth, with the number of retained sponges dropping from nine in the first six months of the reporting year to zero in the second half.
- The number of reported stage three and four pressure ulcers has declined for the second year in a row – a 25 percent decrease over the two years.
- Research funded by MDH and carried out by the University of Minnesota has led to the development of a set of recommendations for strengthening the pre-operative time-out and site marking processes, an important step toward preventing wrong site surgeries or invasive procedures. A group of pilot facilities is now beginning to implement these recommendations.

MDH and its partners have also focused on educating reporting facilities and on strengthening the web-based reporting system. Specifically:

- Staff from 27 hospitals and surgical centers attended in-depth, regional training on root cause analysis and the development of strong corrective action plans.
- Staff from 38 nursing homes attended a first of its kind training on root cause analysis in the long term care setting, learning how to delve more deeply into their serious events and develop more comprehensive and effective solutions.
- The reporting system now includes follow-up data on corrective action plans, to allow analysis of their effectiveness in preventing recurrence of events.
- Questions about 'best practices' were added to the web-based reporting system for falls and pressure ulcers. These questions are already providing important insight into risk factors for these events, and into where our work should focus in the coming year.

Going forward, the key learnings from this year's events indicate a number of steps that MDH and its partners will need to take in order to continue to improve, including:

- Expand the successful statewide campaign to prevent retained sponges in labor and delivery, to include strengthening the counting process in the OR.
- Increase standardization of surgical and other procedure scheduling and verification processes.
- Encourage adoption of recommendations for more robust, standardized pre-operative time-out and site-marking processes.
- Explore and pilot additional strategies to prevent pressure ulcers and falls such as hourly patient rounding.
- Continue to monitor trends and patterns in reported adverse events, and make data, case studies, and trend analyses more available to reporting facilities.

Patient safety is a complex and multifaceted concept, one that can be – and is – measured in many different ways by individual facilities and state/national organizations. Safety can be measured in terms of the absence of preventable harm to patients, the presence of a safe and transparent culture, implementation of evidence-based best practices, perceptions of patients that they are receiving safe and high-quality care, or performance relative to state or national goals.

The learning, tools, and sharing of information that stem from the adverse health events reporting system are an important driver of change, and have helped to accelerate adoption of best practices and increase reporting facilities' knowledge of why events happen and how they can be prevented. But given the complex nature of the journey towards a truly safe, transparent and accountable healthcare delivery system, this reporting system will always be just one aspect of a broader campaign and will require continued collaboration among all healthcare stakeholders.

Going forward, it will be important for these stakeholders to focus not just on technical fixes to persistent problems, but also on strategies for accelerating cultural change within reporting facilities so that patient safety improvements are sustainable and an environment of continuous learning and improvement is created.

For more information about the five-year evaluation of the adverse health events reporting system, visit MDH's website at **www.health.state.mn.us/patientsafety**.

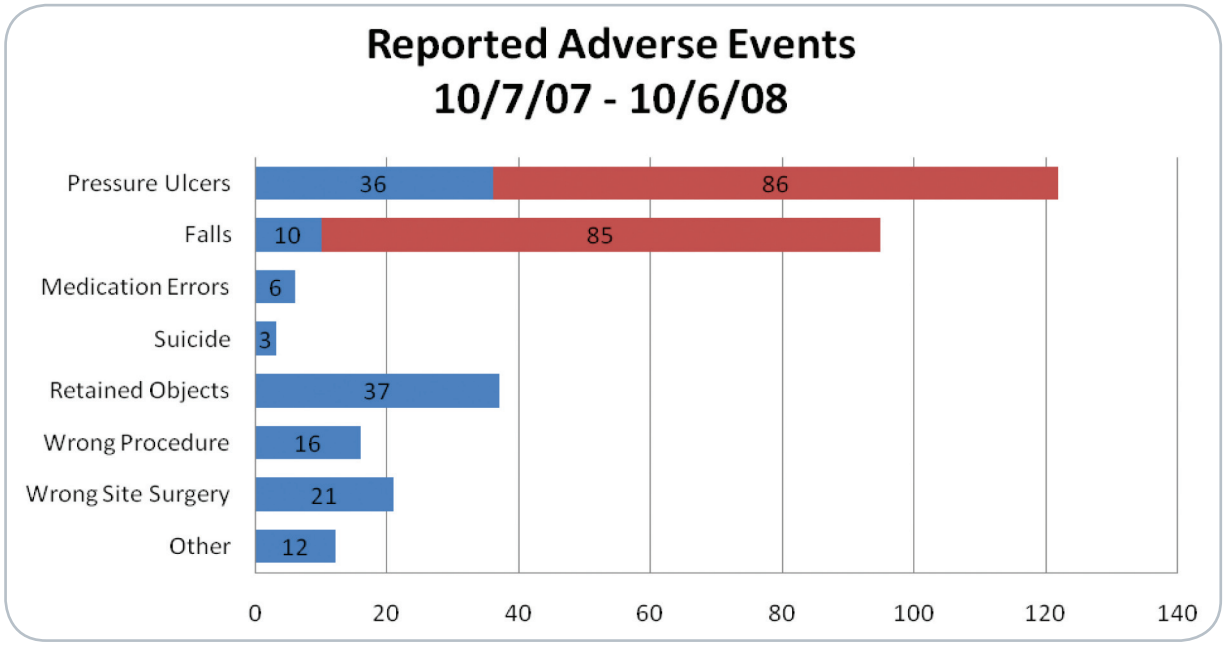
INTRODUCTION

The release of this report marks five years since Minnesota took the lead in the nation in establishing a statewide public reporting system for adverse health care events. Over the last five years, the Minnesota Department of Health and its partners have collected detailed information on more than 750 events, and have shared key learnings from those events with healthcare providers and consumers around the state, with a goal of preventing recurrence of future events.

The Adverse Health Care Events reporting system was passed as a landmark measure to increase transparency around patient safety in Minnesota, and as a strategy for developing a baseline for safe care based on the frequency of adverse events. As such, it is one of several important tools for ensuring accountability. For patients, having information about where to find the safest, highest-quality care – and knowing the right questions to ask their provider – is crucial. But as important as knowing how often adverse events happen is understanding why they happen, and what we can do to help healthcare providers implement systems and practices to prevent them from happening again.

In the last year, the requirements for reporting facilities have increased substantially, through an expansion in the number and type of reportable events. Due to these changes, the number of adverse health events reported to MDH in the last year has increased significantly, from 125 in the previous reporting cycle to 312 in the current reporting period. Nearly all of this increase was due to expanded reporting requirements; in the absence of those changes, the number of reported events would have been 141.

Although the vast majority of reportable adverse events are preventable, there are cases where the complexity of a patient's clinical condition or the presence of multiple comorbidities makes prevention particularly challenging or even impossible. While those cases are very rare, they can be especially disheartening for facilities that are struggling to prevent all events. They also highlight the importance of continually searching for process improvements that could reduce risk in clinically complex cases, and of looking at similar events in a more comprehensive way in order to unearth potential commonalities that might otherwise be overlooked.



***Note: Events listed in red became reportable starting on 10/7/07.** These event categories were not previously reportable as part of the Adverse Health Events reporting system.

Moving from collecting data to identifying and implementing best practices for prevention is the most important aspect of the reporting system, one that will in the long run lead to fewer adverse health events. During the last year, learnings from the adverse event system have led to significant and concrete changes in individual facilities and statewide, including:

- Implementation of statewide standards for sponge and sharp counting in labor and delivery that have resulted in a dramatic reduction in reports of retained sponges. Since this campaign began, no retained sponges have been reported after vaginal deliveries in six months.
- Development of a set of recommendations for a stronger, more standardized pre-surgical time-out process, which are being put in place by hospitals and ambulatory surgical centers around the state.
- The increasing adoption of new practices for patient rounding to prevent falls and pressure ulcers.

The root causes of these events are complex and often system-wide, making simple solutions or quick fixes unlikely to succeed. Often, realizing lasting change is a cyclical process, involving repeated attempts to identify why a problem has occurred, define the best approach to address it, and implement the solution, and then continue to monitor progress until the solution has been shown to be successful and sustainable. This evolutionary process of change applies not only to individual facilities, but also to the reporting system in general.

This report will describe how that process is occurring statewide, as well as in individual hospitals and ambulatory surgical centers, with a particular focus on the most common types of events; falls, pressure ulcers, wrong-site surgeries or invasive procedures, and retained foreign objects. For each of these categories of events, this report will discuss what we have learned about why these events happen, what's being done to prevent them from happening again, and how we can continue to move down the path towards having the safest possible healthcare system.

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 continued efforts to engage patients and family members in the delivery of safe care. It will be neither an easy nor a quick process, but it is a process to which stakeholders around the state are committed.

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 and safety are listed at right and in Appendix D.

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

Patient awareness is a very important tool to improve safety, but it is important to keep these numbers in perspective. The events listed in this report represent a very small fraction of all of the procedures and admissions at Minnesota hospitals and ambulatory surgical centers, and not all are preventable.

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 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
Consumer guide to adverse events, database of adverse events by facility, fact sheets about different types of events, FAQs, and links to other sources of information.

Minnesota Alliance for Patient Safety
www.mnpatientsafety.org
MAPS is a broad-based collaborative that works together to improve patient safety in MN. Projects include informed consent, health literacy, medication reconciliation, and Just Culture.

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

StratisHealth
www.stratishealth.org
A non-profit organization that leads collaboration and innovation in health care quality and safety. Their resources include tools and resources to support clinical and organizational improvement, as well as training and education programs for professionals across the continuum of care.

Minnesota Hospital Quality Report
www.mnhospitalquality.org
Database of hospital performance on best practice indicators related to heart attack, heart failure, pneumonia, surgical care and how patients experience care in the hospital.

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.

OVERVIEW OF REPORTED EVENTS

Between October 7, 2007, and October 6, 2008, a total of 312 adverse health events were reported to the Minnesota Department of Health (MDH). This figure represents an average of 25.9 events per month or roughly 6 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 2008, 53 ambulatory surgical centers and 11 community behavioral health hospitals/regional treatment centers were also subject to the reporting law. Of the 199 facilities covered by the law, 63 (32 percent) reported adverse events during this reporting period: 59 hospitals and 4 ambulatory surgical centers. Under the new definitions of reportable events, 14 hospitals reported events for the first time in this reporting year.

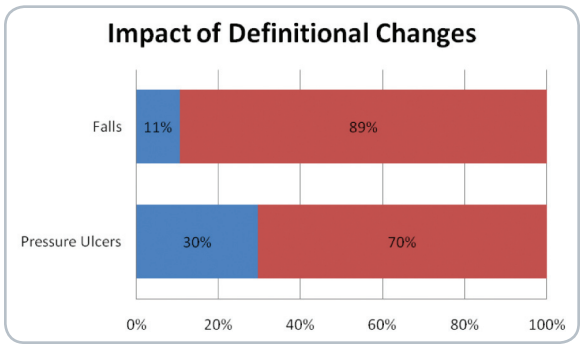
Frequency of Adverse Events

In previous years, stage 3 or 4 pressure ulcers have been the most commonly reported events, followed by retained foreign objects and surgery or an invasive procedure on the wrong part of the body. This year, definitional changes expanded the types of events that are required to be reported in two categories: pressure ulcers, which expanded to include "unstageable" pressure ulcers, and falls, which expanded to include falls associated with serious disability.

These newly reportable event types were the most commonly reported events during the reporting year, and alone accounted for 55% of all reported events. If the reporting requirements had not been changed, the total number of reported events over the course of the year would have been 141.

During 2007, the most recent year for which preliminary data are available, Minnesota hospitals reported roughly 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 10.9 events were reported by hospitals per 100,000 patient days. Removing the newly reportable events results in a rate of 4.8 events per 100,000 patient days.

With the exception of the newly reportable events, the general pattern of events was again roughly stable in this reporting period, with retained foreign objects and



***Note: Events listed in red became reportable starting on 10/7/07.** These event categories were not previously reportable as part of the Adverse Health Events reporting system.

stage 3 and 4 pressure ulcers as the most commonly reported events. The number of stage 3 and 4 pressure ulcers was down by 16 percent, the second decrease in a row, while the number of reports of retained foreign objects rose. Wrong-site surgeries or invasive procedures decreased slightly, while the number of reports of wrong-procedure events increased.

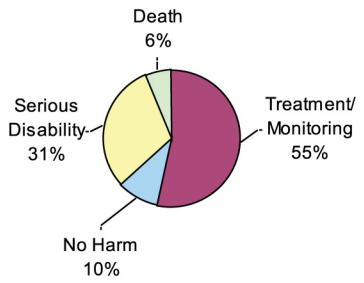
Determining the causes of increases or decreases in the number of reported events is always difficult, and given the rarity of these events, a one-year increase or decrease is not statistically significant. If a lower rate of these events can be maintained over time, that may indicate that facilities have found sustainable long-term solutions for preventing their recurrence.

Severity of Events

Of the reports submitted during the reporting period, 10 percent resulted in no harm to patients, while six percent led to death. This year, the percentage of events that resulted in serious disability rose from 10% to 31%. However, that change was a result of the expansion of the definition of reportable falls to include falls associated with serious disability rather than a change in overall severity level of other events. If the analysis of event severity were limited to only those events that were previously considered reportable, the severity profile would have been quite similar to the previous reporting period.

More than half of all events resulted in a need for additional treatment or monitoring, but not a longer stay in the hospital. Of the 18 deaths reported during this time period, ten were due to falls, two were the result of suicide, three were related to the malfunction of a product or device, one was a post-operative death, one was a maternal death, and one was a medication error.

Outcomes of Adverse Events including all reportable events



Outcomes of Adverse Events (excluding newly reportable event categories)

Root Causes of Adverse Events

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 is a crucial step in determining exactly what happened and why it happened. Without uncovering root causes, it becomes very difficult to prevent a recurrence of an event. 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.

The majority of adverse events were traced to root causes in one of four areas: communication, policies/procedures, environment/equipment, and training. Often, the causes that lead 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.

But while the causes for a single event can sometimes cut across multiple categories, individual events are often unique, which in some cases can limit the applicability of learnings or corrective actions from one event to an entirely new situation within a facility.

ROOT CAUSES/CONTRIBUTING FACTORS	
Rules/Policies/Procedures	63%
Communication	58%
Environment/Equipment	45%
Training	38%
Barriers	20%
Fatigue/Scheduling	6%

Prevention of Adverse Events

The goal of the Adverse Health Care Events Law is to improve patient safety by increasing awareness of why adverse events happen and knowledge about 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 broad collaborative groups have developed several notable initiatives to improve patient safety. Many of these efforts focus on standardizing processes across all units within a facility, providing additional training for staff on how to effectively carry out policies, improving communication between care team members and across shifts, departments, or facilities, and ensuring that all equipment and supplies are readily available, and their risks well understood by staff.

HIGHLIGHTS OF 2008 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, MHA and Stratis Health have 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 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

- Staff from 27 facilities attended an in-depth, day-long training on root cause analysis and the development of corrective action plans. Participants learned how to delve more deeply into the root causes of events and develop more effective corrective action steps. This training, offered one or more times each year throughout Minnesota, is an important way of supporting facilities as they work to conduct robust root cause analyses.
- Patient safety professionals from facilities around the state participated in an advanced root cause analysis forum focused on issues related to measurement.
- Staff from 38 nursing homes attended a two-day Root Cause Analysis training session for long term care facilities, designed to bring event analysis tools and techniques to new settings and improve the quality and effectiveness of corrective action plans developed by nursing home staff. Staff from MDH and Stratis Health will be monitoring the degree to which participating facilities are implementing the strategies that they have learned, and will explore repeating this training in the future.

Strengthening the Reporting System

- The web-based registry was modified to include the collection of 4-month and 8-month follow up data from reporting facilities for all Joint Commission sentinel events.[1] This enhancement of the reporting system 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.
- During 2008, "best practices" questions were added to the registry for all falls and pressure ulcers. Analyzing the responses to these questions has already revealed areas for learning or future study, including the contribution of 'culprit' medications to fall risk, the importance of using validated fall risk assessments, and consistency in skin inspection and patient repositioning.

Topic Specific Safety Activities

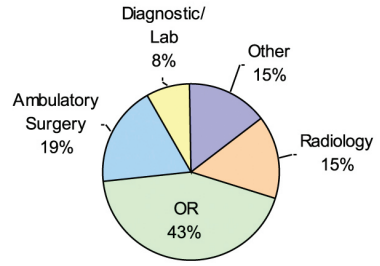
Statewide campaigns and individual facility efforts to prevent wrong site surgery, retained foreign objects, falls, and pressure ulcers are described in the following sections.

[1] With the exception of pressure ulcers, nearly all reportable adverse events are also considered Joint Commission sentinel events.

WRONG SITE SURGERY

Over the five years that the adverse events reporting system has been in place, more than 150 incidents of wrong site, wrong procedure, or wrong patient surgeries and invasive procedures have been reported by Minnesota hospitals and ambulatory surgical centers. In the most recent reporting period, these events accounted for 39 events or 12.5% of the total number of reported events. The most common types of reported wrong site events involved radiation therapy, regional blocks or other injections, and dermatological or orthopedic procedures.

Location of Wrong Site Surgeries/Invasive Procedures



Across all Minnesota hospitals, more than 2.5 million surgeries and invasive procedures were performed in 2007, with thousands more taking place in ambulatory surgical centers. Given the volume of procedures, these events are very rare. Of the reported wrong site or wrong procedure cases, nearly 40 percent happened outside of the operating room, in procedural areas such as radiology or cardiology, in the emergency department, or in the laboratory.

Key findings

As with other types of reportable adverse events, the root causes of wrong-site procedures are often related to a lack of consistency in processes. While policies requiring a time-out prior to surgery are in place in all hospitals and surgical centers, these policies are not always carried out in a reliable manner, and are not consistently in place outside of the operating room.

As a result, providers who perform invasive procedures at the bedside or in procedural areas may not routinely do a time-out, or different providers/teams may conduct the time-out in different ways. This has resulted in a cluster of wrong-sided regional anesthesia blocks, radiation therapy treatments, and biopsies, all of which were done outside of the OR. Inside the OR, as well, inconsistencies in the conduct or rigor of the time-out process are not uncommon.

Recently reported events have revealed several areas of risk related to surgical scheduling. In particular, there is wide variation across and between physician clinics, hospitals and ambulatory surgical centers in terms of who must verify patient and procedure information prior to

PREVENTING WRONG SITE SURGERY

ABBOTT NORTHWESTERN HOSPITAL, MINNEAPOLIS

Results: Abbott Northwestern has not experienced an adverse event in the operation room environment since 2004. Examples of actions that Abbott has taken to achieve these results include expanding its procedures for verifying critical information before beginning any type of invasive procedure and eliminating distractions, such as radios playing in the background, during the final safety check just prior to performing the procedure. An extensive audit process is in place to ensure that vital safety steps are being performed. The results of the audits are reported quarterly to the Allina board of directors.

Terry Voigt, Abbott Northwestern's director of surgical perioperative and anesthesia services: "I always have this gnawing at me about how we can avoid being fallible. It's a constant concern. [But] sharing near-misses and adverse events on that larger scale across the state, we learn more, and we can tweak our processes to account for those learnings. It's about constant vigilance, constant communication, and constant education."

About 120 Minnesota hospitals and surgical centers are participating in the Minnesota Hospital Association's SAFE SITE campaign, which works to prevent wrong-site, wrong-surgery and wrong-patient adverse health events.

surgery, when and by whom changes can be made to a scheduled procedure, and the source documents that are used to verify information. The lack of standardization in this process increases the risk that surgical scheduling errors can lead to a wrong site surgery or wrong procedure event.

A number of larger issues are also often at play when it comes to surgical events. Distractions, interruptions, and confirmation bias (the tendency to look for, or to see, only that information which confirms what we already thought was true) can all increase the risk of wrong site surgery. The culture within the OR can also play a role, particularly when junior team members are reluctant to speak up about potential errors,

Preventing surgical events

Statewide, much of the work around preventing surgical errors has focused on systematizing and strengthening the time-out process, and working to make the surgical scheduling process more reliable and consistent.

Statewide, MDH contracted with the University of Minnesota in 2007 to observe surgeries in a number of hospitals around the state. Out of those observations has come a series of recommendations to prevent wrong site, procedure and patient events through a strengthened and streamlined pre-surgical verification process. A number of hospitals are implementing these recommendations on a pilot basis, with the expectation that most or all hospitals and ambulatory surgical centers will implement them in the coming year.

More information about the time-out recommendations is available at **www.health.state.mn.us/patientsafety**.

The Minnesota Hospital Association kicked off the statewide "Safe Site" campaign against wrong-site surgery in late 2007. Currently, 120 hospitals and surgical centers are participating in the campaign, and have increased their average level of implementation of best practices to prevent wrong site surgery from 60 percent to more than 80 percent. The Minnesota Alliance for Patient Safety is also working with hospitals, surgical centers, and physician clinics around the state to document current practices around communicating patient and procedure information between clinics and hospitals, and to identify points where the process can be standardized and simplified to decrease risk for surgical scheduling errors. Individual facilities are also implementing specific strategies based on the root causes that they have uncovered. Corrective actions being implemented include:

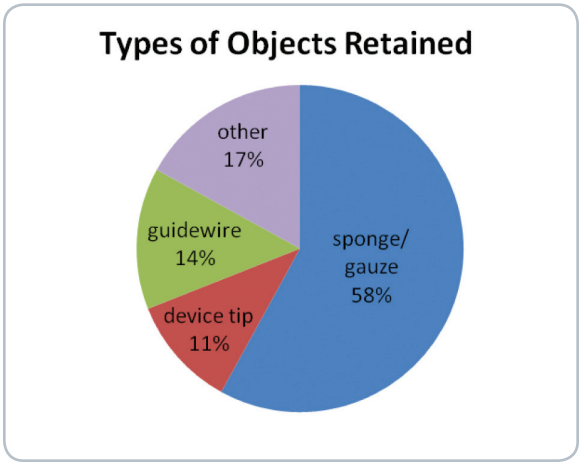
- Ensuring that staff in all procedural areas understand and follow time-out policies.
- Assigning one individual to be accountable for implementation of time-out.
- Developing scripting for pre-operative procedures and clarifying who is responsible for calling for a time-out.
- Creating mandatory checklists for use during invasive procedures, including site marking.
- Integrating consent documents and checklists into order sets in electronic medical record.
- Ensuring that team members who enter the OR after the time-out are fully briefed on the consented procedure, and that the informed consent is visible to all team members during surgery.
- Using a time-out towel or other barrier to cover the instrument tray prior to the procedure, which cannot be removed until a time-out is done.
- Requiring printed copies of source documents when surgery is scheduled, to be compared to informed consent and scheduling paperwork.

Next steps

In the coming year, Minnesota hospitals and ambulatory surgical centers will be focusing on continuing to systematize their pre-surgical and pre-procedure verification processes, with a particular focus on ensuring that time-outs are standard policy in all procedural areas and are conducted consistent with the recent recommendations, that site markings are clearly visualized in every case as part of the time-out process, and that leadership within the facility is actively supporting team members who speak up about concerns. In addition, these organizations are working collectively to address consistency in the site marking process and in instituting pre-procedure team briefings. Lastly, the Minnesota Alliance for Patient Safety will be working with clinics and hospitals to develop recommendations for strengthening the surgical scheduling process.

RETAINED FOREIGN OBJECTS

When people think about objects that have been retained in a patient's body during surgery, they most often think of surgical clamps or scissors. The reality, however, is that the most commonly retained foreign objects are small sponges or absorbent pads or, less commonly, guidewires or the small tips of instruments that have broken off during a procedure. The most common type of procedure linked with retained objects in Minnesota is childbirth; nearly a quarter of the retained foreign objects involved sponges left behind after a vaginal delivery.



Key findings

The most common reason why objects are retained is because items were not included in the pre-procedure or post-procedure counting process, because the counting process was inaccurate, or because no policy was in place to require counting of objects for a particular type of procedure. At the beginning of the year, the lack of a policy for counting sponges after vaginal deliveries was quite common. Most facilities also did not have a standard of a visual inspection after childbirth to identify any potential retained objects at that time, which meant that retained sponges were often found by the patient one to three days later.

Communication breakdowns also often play a role in retained objects, as when an object is placed in the body by one team member but either the placement or the removal is not documented properly or is not communicated adequately to other team members. This happened both in emergency situations and in routine procedures.

PREVENTING RETAINED OBJECTS

NORTHFIELD HOSPITAL, NORTHFIELD

Results: Northfield has reached 100 percent compliance with steps recommended to prevent sponges from being retained during a vaginal birth.

Since the SAFE COUNT patient safety initiative launched in April 2008, no participating hospitals have reported such occurrences involving sponges unintentionally left behind in patients' bodies during deliveries of newborns. In comparison, prior to the kick-off of the campaign, nine retained sponges had been reported in the previous six months.

The effort at Northfield has been so successful partly because physician champions have spearheaded the SAFE COUNT efforts, said Annette Sheldon, RN and director of Northfield's First Touch Birth Center. Because physicians are the ones who place and remove surgical sponges, it makes sense that they would be actively involved in the process to ensure sponges weren't left behind, Sheldon said.

About 65 Minnesota hospitals and surgical centers are participating in the SAFE COUNT campaign, which is the first of its kind in the nation. It works to prevent adverse health events involving retained foreign objects.

Preventing retained foreign objects

The Minnesota Hospital Association developed a statewide campaign in 2008 focusing on retained sponges in labor and delivery, after the discovery of a cluster of retained sponges in vaginal deliveries. This call to action included a number of best practices that all participating facilities were asked to implement, including establishing policies for counting sponges and sharps before and after delivery, using only radiopaque sponges (sponges that contain a marker that can be detected using an xray) and conducting a final visual inspection after every delivery.

Nearly 70 hospitals are participating in the Safe Count campaign, and their average level of adoption of a bundle of best practices for prevention of retained objects has risen from less than 50 percent to nearly 90 percent. Since the campaign began in April, 2008, no retained sponges have been reported after vaginal deliveries. Prior to the kickoff of the campaign, nine had been reported in the previous six months.

Individual facilities are also implementing specific strategies based on the root causes that they have uncovered. Corrective actions being implemented include:

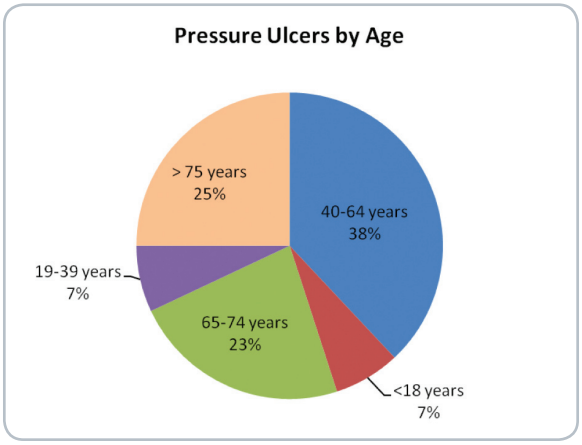
- Implementing policies to measure guide or localization wires before and immediately after procedures.
- Managing distractions during the count process by limiting presence in the OR to essential personnel only.
- Providing training for staff on any new device with multiple parts that may break off and be retained.
- Clarifying policies related to items required to be written on the white board and counted after being placed into a body cavity.
- Replacing devices that include tips that may break off, or that are difficult to visually differentiate from the body of the device.
- Revising sponge count policies to require that each individual sponge be counted, rather than "fanning" packs of sponges to count them without removing from the package.

Next steps

In the coming year, the retained foreign object Call to Action will be expanded to cover counting of sponges and sharps in the operating room, with increased guidance and tools for participating facilities on how to strengthen and standardize their counting processes.

PRESSURE ULCERS

Pressure ulcers, otherwise known as bedsores, happen when a patient's skin breaks down due to pressure or friction. The highest-risk patients are those who have limited mobility, circulation problems, or incontinence; elderly patients are generally more at risk. Of the pressure ulcers reported during the current reporting period, nearly half involved patients aged 65 or older. The majority of reported pressure ulcers were found on the coccyx or buttocks, on the head or neck, or on the ankles or feet.



Pressure ulcers can also occur in patients with none of these risk factors. In particular, pressure ulcers can form when patients are immobile during long surgeries, or when a device such as a tube or brace is in constant contact with the skin over a prolonged period. More than one third of pressure ulcer cases involved patients aged 40 to 64; these patients were likely to have had multiple comorbidities, long surgeries, or complicated courses of stay in the intensive or critical care unit.

PRESSURE ULCER STAGES

Stage 1: Intact, reddened skin

Stage 2: Partial thickness wound presenting as a shallow ulcer or blister

Stage 3: Full thickness tissue loss

Stage 4: Full thickness tissue loss with exposed muscle, tendon or bone

Unstageable: Full thickness tissue loss, covered with slough or scabbing so that the stage cannot be determined.

This report marks the first reporting period during which unstageable pressure ulcers, those for which a severity rating or "stage" cannot be determined, were required to be reported. Unstageable ulcers accounted for 70 percent of all pressure ulcers reported during this reporting period.

Key findings

Often, the root causes of pressure ulcers involve breakdowns in communication; risk factors or skin inspection results that were not documented properly or communicated between shifts or providers, or lack of communication related to appropriate interventions. Patient factors, such as morbid obesity or the presence of multiple comorbidities or trauma, can also contribute to pressure ulcers by making interventions more complicated or difficult to apply. Historically, many providers have felt that pressure ulcers are an unavoidable complication of care in the most severe cases, where skin integrity can become a lower priority than stabilizing a patient or tending to more urgent concerns.

Preventing pressure ulcers

Prevention of pressure ulcers can be a challenging and sometimes frustrating process. But as our knowledge of best practices for pressure ulcer prevention has improved, more and more facilities are implementing successful approaches to prevention, even in clinically complex cases. The Minnesota Hospital Association's Call to Action on pressure ulcers has been in place for more than a year, and has been successful in increasing adoption of a set of best practices among participating hospitals from less than 60 percent to more than 80 percent. In particular, implementation of processes for turning patients every two hours, having a designated skin safety coordinator, and incorporating skin assessment into staff competencies have all increased dramatically.

Individual hospitals are also taking a number of steps to prevent pressure ulcers, including:

- Using pressure-reducing surfaces in the operating room for high-risk patients or during longer procedures.
- Adding new functionality to electronic medical records to document patients' ability to comply with turning regimens, flag high-risk patients, and request specialty consults.

- Developing new decision-making algorithms to assist nursing staff in implementing appropriate interventions for at-risk patients.
- Purchasing special equipment to use for patients at risk for pressure ulcers.
- Increasing use of wound care or ostomy nurses as consultants.
- Providing additional training in skin assessment and inspection 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 risks for skin breakdown related to feeding tubes, TED stockings, vents, and other devices that are in place for prolonged periods, and providing guidance on how to assess skin integrity in patients with these devices.

Next steps

In the coming year, MDH and MHA will be working with wound care and ostomy nurses, as well as with other clinical advisors, to analyze common patient characteristics and clinical and environmental factors associated with pressure ulcers across facilities, and developing recommendations for preventing pressure ulcers in clinically complex patients.

PREVENTING PRESSURE ULCERS

FIRST CARE MEDICAL SERVICES, FOSSTON

Results: This fall, First Care Medical Services of Fosston became one of four Minnesota hospitals to achieve at least 90 percent compliance in all four of the Minnesota Hospital Association's patient safety campaigns.

At First Care, one new process helped reduce the number of pressure ulcers and falls while also boosting patient satisfaction.

That process required regular, periodic assessments of patients' pain levels, whether they needed help getting to the bathroom and making sure patients changed their body position to prevent pressure ulcers from forming.

Staffers created a question-and-answer document to help nurses explain that new safety protocol to patients.

"Initially … people had questions," said Devra Carlson, director of hospital patient care for First Care. "The script [helps] explain to patients that their safety is important to us, and 'This is what we're going to do.' "

The regular checks worked. And patients also stopped using their nurse "call" buttons as frequently — patient satisfaction with their call buttons consequently jumped from the 45th to the 92nd percentile from October 2007 to October 2008.

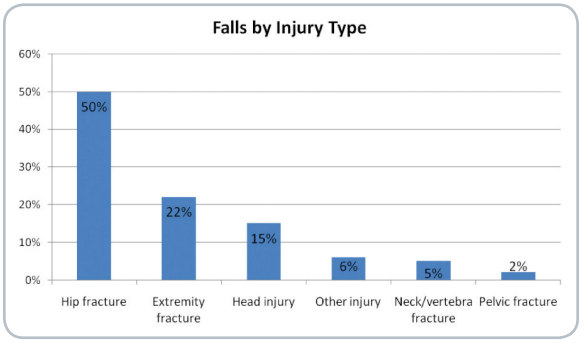
These days, the regular assessments are something patients have come to expect, Carlson said.

"Now if we didn't do it, we'd be suspect," she said.

More than 90 Minnesota hospitals are participating in the SAFE SKIN campaign.

FALLS

Both in the community and in the hospital, falls are more likely to happen to the elderly, and to those with balance or gait problems, dizziness, and altered elimination or incontinence. Additional risk factors for falls include the use of multiple medications and cognitive impairments. While not all of these factors are within the control of the hospital, a successful fall prevention program will create processes and environments that minimize each patient's risk, with added interventions for those who face more complicated risk profiles.



Of the 95 falls reported during this reporting period, 65 percent involved patients aged 75 or older. For the first time this year, facilities were required to report falls that were associated with serious disabilities as well as deaths. Overall, the most common serious injury sustained during a fall was a hip fracture, but the most common injury associated with death from a fall was a head injury.

Key findings

The most common causes of falls included breakdowns in the fall risk assessment process: either patients were not appropriately placed at high risk, the risk was not adequately documented or communicated, or the risk reduction interventions weren't matched to the patient's individual risk factors or weren't consistently applied. But the increased number of reportable falls in this reporting period also revealed other patterns:

- The majority of falls happened when patients were moving from the bed to the bathroom, or when they were in the bathroom. This suggests that more frequent toileting assistance, or increased education around the need to ask for help, may be needed.
- A slightly higher percentage of falls occurred at night than in the day, suggesting that sleep medications, drowsiness/disorientation, or lighting may have been contributing factors.

PREVENTING FALLS

LAKE REGION HEALTHCARE CORPORATION, FERGUS FALLS

Results: Lake Region Healthcare Corporation's efforts to prevent people from accidentally falling have been so successful that the organization won a related 2008 Minnesota Alliance for Patient Safety award.

Even before joining the Minnesota Hospital Association's SAFE from FALLS patient safety program in May 2007, the number of falls at Lake Region was already low, at 4 per 1,000 patient days. Then, after implementing 100 percent of the initiative's recommended prevention steps — and building upon the measures in its own way — the hospital's fall rate by October 2008 decreased to 1.7.

To get there, for example, the hospital better communicated patients' fall risk by having at-risk patients wear red slippers and bring a "passport" when they travel to other areas of the hospital such as the radiology department. The hospital also implemented, for instance:

- immediate post-fall "huddles," in which staffers discuss how a fall might have been avoided and what they will do to prevent similar future occurrences;
- hourly — instead of every two hours — patient "rounds." During the checks, caregivers now systematically do eight different things — from ensuring that the walkway from the patient's bed to the bathroom is clear to checking on the patient's pain level.

All the efforts have been well worth it, said R.N. Ginny Adams, Lake Region's director of quality improvement.

"We thought we were doing well before, since we were at the national benchmark rate for falls," she said. "But this is even better. This has been a great accomplishment for our team and our patients."

More than 100 Minnesota hospitals are participating in the SAFE from FALLS campaign.

- A number of falls involved patients who had previously always used call lights for assistance, but did not use the light when the fall occurred, or who had been ambulating independently prior to the fall.
- Not all fall risk assessments include previous falls as a risk factor, and not all are able to incorporate falls that occur during the hospital stay; this may mean that not all high-risk patients are correctly classified as at risk for falling.
- A number of patients who experienced serious falls were taking multiple medications, including anti-anxiety medications or sleep aids, that may have contributed to the fall.

Preventing falls

The Minnesota Hospital Association's statewide "Safe from Falls" campaign continued throughout 2008, with more than 100 hospitals participating. Since the campaign began in May 2007, participating hospitals have increased the average implementation rate of falls prevention best practices from less than 60 percent to more than 80 percent. For some best practices, including putting an interdisciplinary falls prevention team into place and having a system to alert staff to patient risk, the adoption rate is nearly 100 percent.

Individual hospitals also reported implementing a number of corrective actions in response to specific falls, including:

- Implementing new fall risk assessment policies and 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 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.

Next steps

In the coming year, hospitals will continue to explore innovative fall prevention activities, including implementation of hourly rounding systems, use of alternative fall risk assessment tools, and additional strategies and equipment to reduce the risk of harm if a fall does occur.

CONCLUSION

Improving patient safety is a long-term process. While the reporting system has been a catalyst for significant changes in commitment at all levels of healthcare organizations to patient safety, transparency and data sharing within and across facilities around adverse events, and implementation of best practices, 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 and quality 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 prevention of adverse events are a high 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.

As we move forward into the next five years of the reporting system, MDH and its partners will need to learn from the successes of the first five years, while also continually monitoring trends, working to support facilities as they implement new approaches to preventing events and finding new ways to share data and learning with reporting facilities. A particular challenge, going forward, will be to encourage facilities to adopt not just technical fixes to systems problems, but also approaches that will transform the culture within their organization to be one in which staff are always looking for patient safety risks, speaking up about them, and expecting others to do the same.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2007 and October 6, 2008. For each facility, a table shows the number of events reported in each category and the level of severity of each event in terms of patient impact. The events that became reportable for the first time in the current reporting period, falls associated with serious disability and unstageable pressure ulcers, are presented at the bottom of each facility's table under the heading "New event categories for 2008."

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:

- A fall while being cared for in a facility;
- 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;

- 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 (serious bed sores) or unstageable pressure ulcers acquired after admission to a facility;
- Artificial insemination with the wrong donor sperm or wrong egg

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.

Current statutory language is available on the MDH website at www.health.state.mn.us/patientsafety

TABLE 1: OVERALL STATEWIDE REPORT

Reported adverse health events: **ALL EVENTS** (October 7, 2007 – October 6, 2008)

TYPES OF EVENTS							
	SURGICAL	**PRODUCT**	**PATIENT PROTECTION**	**CARE MANAGEMENT**	**ENVIRONMENTAL**	**CRIMINAL**	**TOTAL**
ALL FACILITIES	77 events	3 events	3 events	130 events	98 events	1 event	**312 events New category events: 171**
SEVERITY DETAILS	Serious Disability: 3 Death: 1 Neither: 73	Serious Disability: 0 Death: 3	Serious Disability: 1 Death: 2	Serious Disability: 6 Death: 2 Neither: 122	Serious Disability: 88 Death: 10	Serious Disability: 0 Death: 0 Neither: 1	**Serious Disability: 98** **Death: 18** **Neither: 196**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL** (October 7, 2007 – October 6, 2008)

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	21 events	2 events	16 events	37 events	1 event	**77 events**
SEVERITY DETAILS	Serious Disability: 2 Death: 0 Neither: 19	Serious Disability: 0 Death: 0 Neither: 2	Serious Disability: 0 Death: 0 Neither: 16	Serious Disability: 1 Death: 0 Neither: 37	Serious Disability: 0 Death: 1 Neither: 0	**Serious Disability: 3** **Death: 1** **Neither: 73**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2007 – October 6, 2008)

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	2 Events	1 Event	**3 Events**
SEVERITY DETAILS		Serious Disability: 0 Death: 2	Serious Disability: 0 Death: 1	**Serious Disability: 0** **Death: 3**

Details by Category: **PATIENT PROTECTION** (October 7, 2007 – October 6, 2008)

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: 1 Death: 2	**Serious Disability: 1** **Death: 2**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2007 – October 6, 2008)

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	6 Events	0 Events	1 Event	1 Event	0 Events	122 Events 86 unstageable 36 stage 3 or 4	0 Events	**130 Events** **New category events: 86**
SEVERITY DETAILS	Serious Disability: 5 Death: 1		Serious Disability: 0 Death: 1	Serious Disability: 1 Death: 0		Serious Disability: 0 Death: 0 Neither: 122		**Serious Disability: 6** **Death: 2** **Neither: 122**

Details by Category: **ENVIRONMENTAL** (October 7, 2007 – October 6, 2008)

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	3 Events	95 Events	0 Events	**98 Events**
SEVERITY DETAILS			Serious Disability: 3 Death: 0	Serious Disability: 85 Death: 10		**Serious Disability: 88** **Death: 10**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2007 – October 6, 2008)

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	1 Event	0 Events	**1 Event**
SEVERITY DETAILS			Serious Disability: 0 Death: 0 Neither: 1		**Serious Disability: 0** **Death: 0** **Neither: 1**

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

Address:
800 E. 28th St.
Minneapolis, MN 55407-3723

Website:
http://www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
952

***Number of surgeries/invasive procedures performed:**
138,436

Number of patient days:
242,969

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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 serious disability)	4	Deaths: 0; Serious Disability: 0; Neither: 4
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	3	Deaths: 0; Serious Disability: 3; Neither: 0
Unstageable pressure ulcers	8	Deaths: 0; Serious Disability: 0; Neither: 8
TOTAL EVENTS FOR THIS FACILITY	**17**	**Deaths: 0; Serious Disability: 3; Neither: 14**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

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/invasive procedures performed:**
13,394

Number of patient days:
43,661

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

ANOKA METRO REGIONAL TREATMENT CENTER

Address:
3301 7th Ave. N.
Anoka, MN 55303-4516

Website:
www.dhs.state.mn.us

Phone number:
651-431-2380

Number of beds:
200

***Number of surgeries/invasive procedures performed:**
N/A

Number of patient days:
60,464

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

APPLETON AREA HEALTH SERVICES

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

Website:
www.appletonareahealth.com

Phone number:
320-289-2422

Number of beds:
15

***Number of surgeries/invasive procedures performed:**
640

Number of patient days:
1,918

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

AVERA MARSHALL REGIONAL MEDICAL CENTER

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

Website:
www.averamarshall.org

Phone number:
507-537-9240

Number of beds:
49

***Number of surgeries/invasive procedures performed:**
10,291

Number of patient days:
11,581

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Wrong surgical procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

BETHESDA HOSPITAL

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

Website:
www.healtheast.org

Phone number:
651-326-2273

Number of beds:
254

***Number of surgeries/invasive procedures performed:**
922

Number of patient days:
39,881

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
Unstageable pressure ulcers	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 2; Neither: 2**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

BUFFALO HOSPITAL

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

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
65

***Number of surgeries/invasive procedures performed:**
15,045

Number of patient days:
20,859

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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 procedure performed	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA-MINNEAPOLIS

Address:
2525 Chicago Ave. S.
Minneapolis, MN 55404-4518

Website:
www.childrensmn.org

Phone number:
612-813-6990

Number of beds:
153

***Number of surgeries/invasive procedures performed:**
30,087

Number of patient days:
72,876

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
****NEW EVENT CATEGORIES FOR 2008**		
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

CHIPPEWA COUNTY – MONTEVIDEO HOSPITAL

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

Website:
www.montevideomedical.com

Phone number:
320-269-8877

Number of beds:
30

***Number of surgeries/invasive procedures performed:**
4,556

Number of patient days:
11,434

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	1	Deaths: 1; Serious Disability: 0; Neither:
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

COMMUNITY BEHAVIORAL HEALTH HOSPITAL – WADENA

Address:
240 Shady Lane Drive
Wadena, MN 56482-3093

Website:
www.dhs.state.mn.us

Phone number:
651-431-2380

Number of beds:
16

***Number of surgeries/invasive procedures performed:**
N/A

Number of patient days:
2,799

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither:
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

COOK COUNTY NORTH SHORE HOSPITAL

Address:
515 5th Ave. W.
Grand Marais, MN 55604-3017

Phone number:
218-387-3260

Number of beds:
16

***Number of surgeries/invasive procedures performed:**
1,899

Number of patient days:
3,801

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without 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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

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/invasive procedures performed:**
10,991

Number of patient days:
13,357

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 2; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

FAIRMONT MEDICAL CENTER – MAYO HEALTH SYSTEM

Address:
800 Medical Center Drive
Fairmont, MN 56031-0800

Website:
www.fairmontmedicalcenter.org

Phone number:
507-238-8100

Number of beds:
57

***Number of surgeries/invasive procedures performed:**
9,833

Number of patient days:
26,134

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 2; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

FAIRVIEW RIDGES HOSPITAL

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

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
150

***Number of surgeries/invasive procedures performed:**
58,867

Number of patient days:
66,443

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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
****NEW EVENT CATEGORIES FOR 2008**		
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

FAIRVIEW SOUTHDALE HOSPITAL

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

Website:
www.fairview.org

Phone number:
612-672-7061

Number of beds:
390

***Number of surgeries/invasive procedures performed:**
104,806

Number of patient days:
124,613

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither:2
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
ENVIRONMENTAL EVENTS		
Death or serious disability associated with: A burn received while being care for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
Unstageable pressure ulcers	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**9**	**Deaths: 0; Serious Disability: 4; Neither: 5**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

FAIRVIEW UNIVERSITY MEDICAL CENTER – MESABI

Address:
750 E. 34th St.
Hibbing, MN 55746-2341

Website:
www.range.fairview.org

Phone number:
218-262-4881

Number of beds:
175

***Number of surgeries/invasive procedures performed:**
18,250

Number of patient days:
49,747

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

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

Website:
www.gillettechildrens.org

Phone number:
651-229-1753

Number of beds:
60

***Number of surgeries/invasive procedures performed:**
10,291

Number of patient days:
19,213

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

GRAND ITASCA CLINIC AND HOSPITAL

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

Website:
www.granditasca.org

Phone number:
218-999-1454

Number of beds:
64

***Number of surgeries/invasive procedures performed:**
13,787

Number of patient days:
39,869

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

GRANITE FALLS MUNICIPAL HOSPITAL & MANOR

Address:
345 Tenth Ave.
Granite Falls, MN 56241-1499

Website:
www.gfmhm.com

Phone number:
320-564-3111

Number of beds:
30

***Number of surgeries/invasive procedures performed:**
1,817

Number of patient days:
14,089

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

HENNEPIN COUNTY MEDICAL CENTER

Address:
701 Park Ave. S.
Minneapolis, MN 55415-1623

Website:
www.hcmc.org

Phone number:
612-873-5719

Number of beds:
910

***Number of surgeries/invasive procedures performed:**
91,713

Number of patient days:
177,507

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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 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 serious disability)	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0; Serious Disability: 4; Neither: 7**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

HIGH POINTE SURGERY CENTER

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

Website:
www.hpsurgery.com/aboutus

Phone number:
651-702-7431

***Number of surgeries/invasive procedures performed:**
4,594

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

IMMANUEL ST JOSEPH'S – MAYO HEALTH SYSTEM

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

Website:
www.isj-mhs.org

Phone number:
507-625-4031

Number of beds:
272

***Number of surgeries/invasive procedures performed:**
34,691

Number of patient days:
59,586

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

KANABEC HOSPITAL

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

Website:
www.kanabechospital.org

Phone number:
320-225-3319

Number of beds:
49

***Number of surgeries/invasive procedures performed:**
8,655

Number of patient days:
13,868

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL 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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

LAKE REGION HEALTHCARE CORPORATION

Address:
712 Cascade St. S.
Fergus Falls, MN 56537-0728

Website:
www.lrhc.org

Phone number:
218-736-8361

Number of beds:
108

***Number of surgeries/invasive procedures performed:**
15,200

Number of patient days:
32,107

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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
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	**2**	**Deaths: 1; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

LAKEWOOD HEALTH SYSTEM

Address:
49725 County 83
Staples, MN 56479-5280

Website:
www.lakewoodhealthsystem.com

Phone number:
218-894-8610

Number of beds:
27

***Number of surgeries/invasive procedures performed:**
8,738

Number of patient days:
12,418

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

LONG PRAIRIE MEMORIAL HOSPITAL & HOME

Address:
20 Ninth St. S.E.
Long Prairie, MN 56347-1404

Website:
www.centracare.com/hospitals/lpm

Phone number:
320-732-2141

Number of beds:
34

***Number of surgeries/invasive procedures performed:**
2,515

Number of patient days:
5,503

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

MADELIA COMMUNITY HOSPITAL

Address:
121 Drew Ave. S.E.
Madelia, MN 56062-1841

Website:
www.mchospital.org

Phone number:
507-642-3255

Number of beds:
25

***Number of surgeries/invasive procedures performed:**
1,941

Number of patient days:
3,309

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

MEEKER MEMORIAL HOSPITAL

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

Website:
www.meekermemorial.org

Phone number:
320-693-3242

Number of beds:
38

***Number of surgeries/invasive procedures performed:**
5,677

Number of patient days:
12,661

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither:1
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

MERCY HOSPITAL

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

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
271

***Number of surgeries/invasive procedures performed:**
78,711

Number of patient days:
114,215

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS		
Death or serious disability associated with: A burn received while being care for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	4	Deaths: 0; Serious Disability: 4; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0; Serious Disability: 5; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

MERCY HOSPITAL & HEALTH CARE CENTER

Address:
710 S. Kenwood Ave.
Moose Lake, MN 55767-9405

Website:
www.mercymooselake.org

Phone number:
218-485-5858

Number of beds:
31

***Number of surgeries/invasive procedures performed:**
5,947

Number of patient days:
7,093

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 2; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

MILLER-DWAN MEDICAL CENTER (now known as SMDC Medical Center)

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

Website:
www.smdcmedicalcenter.org

Phone number:
218-727-8762

Number of beds:
165

***Number of surgeries/invasive procedures performed:**
24,367

Number of patient days:
64,432

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	1	Deaths: 0; Serious Disability: 0; Neither:1
CRIMINAL EVENTS		
Sexual assault on a patient	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

MINNESOTA ORTHOPAEDIC SURGERY CENTER

Address:
8290 University Ave. N.E.
Fridley, MN 55432-1847

Website:
www.tcomn.com

Phone number:
763-786-9543

***Number of surgeries/invasive procedures performed:**
2,025

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Wrong surgical procedure performed	**1**	Deaths: 0; Serious Disability: 0; Neither:1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

MONTICELLO – BIG LAKE HOSPITAL

Address:
1013 Hart Blvd.
Monticello, MN 55362-8575

Website:
www.mblch.com

Phone number:
763-271-1365

Number of beds:
39

***Number of surgeries/invasive procedures performed:**
16,857

Number of patient days:
15,569

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
Labor or delivery in a low-risk pregnancy	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 1; Serious Disability: 0; Neither: 0**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

NORTH COUNTRY HEALTH SERVICES

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

Website:
www.nchs.com (click on patient safety)

Phone number:
218-333-6422

Number of beds:
118

***Number of surgeries/invasive procedures performed:**
18,694

Number of patient days:
41,253

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**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
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1; Serious Disability: 3; Neither: 3**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

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/invasive procedures performed:**
102,356

Number of patient days:
160,762

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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 procedure performed	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 serious disability)	1	Deaths: 0; Serious Disability: 0; Neither: 1
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	7	Deaths: 0; Serious Disability: 7; Neither: 0
Unstageable pressure ulcers	7	Deaths: 0; Serious Disability: 0; Neither: 7
TOTAL EVENTS FOR THIS FACILITY	**18**	**Deaths: 0; Serious Disability: 7; Neither: 11**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

OLMSTED MEDICAL CENTER

Address:
1650 Fourth St. S.E.
Rochester, MN 55904-4717

Website:
www.olmstedmedicalcenter.org

Phone number:
507-292-7203

Number of beds:
61

***Number of surgeries/invasive procedures performed:**
12,537

Number of patient days:
41,761

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither:2
Surgery performed on wrong patient	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 0; Neither: 3**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

OWATONNA HOSPITAL

Address:
903 S. Oak Ave.
Owatonna, MN 55060-3200

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
77

***Number of surgeries/invasive procedures performed:**
13,673

Number of patient days:
18,883

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

PARK NICOLLET METHODIST HOSPITAL

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

Website:
www.parknicollet.com

Phone number:
952-993-3791

Number of beds:
426

***Number of surgeries/invasive procedures performed:**
110,344

Number of patient days:
156,371

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**3**	Deaths: 0; Serious Disability: 3; Neither: 0
Unstageable pressure ulcers	**8**	Deaths: 0; Serious Disability: 0; Neither: 8
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 0; Serious Disability: 4; Neither: 8**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

PAVILION SURGERY CENTER

Address:
920 E. First St., Ste. 101
Duluth, MN 55805-2203

Phone number:
218-279-6200

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL 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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

QUEEN OF PEACE HOSPITAL

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

Website:
www.queenofpeacehospital.com

Phone number:
952-758-8101

Number of beds:
49

***Number of surgeries/invasive procedures performed:**
6,652

Number of patient days:
11,833

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

REGENCY HOSPITAL OF MINNEAPOLIS

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

Website:
www.regencyhospital.com

Phone number:
763-302-8302

Number of beds:
92

Number of patient days:
13,494

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
Unstageable pressure ulcers	2	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 1; Neither: 2**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

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/invasive procedures performed:**
116,439

Number of patient days:
177,784

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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 performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical procedure performed	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		
Stage 3 or 4 pressure ulcers (with or without serious disability)	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
ENVIRONMENTAL EVENTS		
Death or serious disability associated with: A burn received while being care for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**6**	Deaths: 0; Serious Disability: 6; Neither: 0
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**16**	**Deaths: 0; Serious Disability: 8; Neither: 8**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

RIDGEVIEW MEDICAL CENTER

Address:
500 S. Maple St.
Waconia, MN 55387-1752

Website:
www.ridgeviewmedical.org

Phone number:
952-442-2191

Number of beds:
109

***Number of surgeries/invasive procedures performed:**
37,328

Number of patient days:
40,962

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

RIVERVIEW HEALTHCARE ASSOCIATION

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

Website:
www.riverviewhealth.org

Phone number:
218-281-9412

Number of beds:
49

***Number of surgeries/invasive procedures performed:**
4,664

Number of patient days:
12,081

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Unstageable pressure ulcers	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

RIVERWOOD HEALTHCARE CENTER

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

Website:
www.riverwoodhealthcare.com

Phone number:
218-927-2121

Number of beds:
36

***Number of surgeries/invasive procedures performed:**
8,641

Number of patient days:
13,019

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

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/invasive procedures performed:**
131,623

Number of patient days:
143,033

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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
Death of a normal, healthy patient during or immediately after surgery	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
CARE MANAGEMENT **Death or serious disability associated with:**		
A medication error	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
Stage 3 or 4 pressure ulcers (with or without 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
****NEW EVENT CATEGORIES FOR 2008**		
Unstageable pressure ulcers	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**9**	**Deaths: 2; Serious Disability: 1; Neither: 6**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

SAINT MARYS HOSPITAL

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

Website:
www.mayoclinic.org/event-reporting

Phone number:
507-284-5005

Number of beds:
1,157

***Number of surgeries/invasive procedures performed:**
116,139

Number of patient days:
255,187

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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	**2**	Deaths: 2; Serious Disability: 0; Neither: 0
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 serious disability)	**8**	Deaths: 0; Serious Disability: 0; Neither: 8
ENVIRONMENTAL EVENTS		
Death associated with: A fall while being cared for in a facility	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**6**	Deaths: 0; Serious Disability: 6; Neither: 0
Unstageable pressure ulcers	**15**	Deaths: 0; Serious Disability: 0; Neither: 15
TOTAL EVENTS FOR THIS FACILITY	**37**	**Deaths: 3; Serious Disability: 7; Neither: 27**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

SANFORD HOSPITAL LUVERNE

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

Website:
www.sanfordluverne.org

Phone number:
507-449-1298

Number of beds:
28

***Number of surgeries/invasive procedures performed:**
3,541

Number of patient days:
7,972

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

ST. CLOUD HOSPITAL

Address:
1406 Sixth Ave N.
St Cloud, MN 56503-1900

Website:
http://www.centracare.com/hospitals/sch/quality/patient_safety.html#ahe_report

Phone number:
320-229-4983

Number of beds:
489

***Number of surgeries/invasive procedures performed:**
96,975

Number of patient days:
174,057

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
CARE MANAGEMENT **Death or serious disability associated with:**		
A medication error	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**7**	Deaths: 0; Serious Disability: 7; Neither: 0
Unstageable pressure ulcers	**4**	Deaths: 0; Serious Disability: 0; Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**18**	**Deaths: 0; Serious Disability: 8; Neither: 10**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.50

ST. FRANCIS REGIONAL MEDICAL CENTER

Address:
1455 St. Francis Ave.
Shakopee, MN 55379-3380

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
93

***Number of surgeries/invasive procedures performed:**
26,963

Number of patient days:
37,661

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Surgery performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither:1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.51

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/invasive procedures performed:**
73,803

Number of patient days:
85,141

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 1; Neither:1
CARE MANAGEMENT **Death or serious disability associated with:**		
Hypoglycemia	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 3; Neither: 1**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.52

ST. JOSEPH'S AREA HEALTH SERVICES, INC.

Address:
600 Pleasant Ave.
Park Rapids, MN 56470-1431

Website:
www.sjahs.org

Phone number:
218-237-5523

Number of beds:
50

***Number of surgeries/invasive procedures performed:**
7,681

Number of patient days:
13,863

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.53

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/invasive procedures performed:**
40,471

Number of patient days:
87,723

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
Unstageable pressure ulcers	1	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0; Serious Disability: 2; Neither: 2**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.54

ST. LUKE'S HOSPITAL

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

Website:
www.slhduluth.com

Phone number:
218-249-5389

Number of beds:
267

***Number of surgeries/invasive procedures performed:**
41,354

Number of patient days:
82,240

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither:2
****NEW EVENT CATEGORIES FOR 2008**		
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 0; Neither: 3**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.55

ST. MARY'S INNOVIS HEALTH

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

Website:
www.trustedcareforlife.org

Phone number:
218-847-0819

Number of beds:
87

***Number of surgeries/invasive procedures performed:**
9,994

Number of patient days:
13,539

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	1	Deaths: 0; Serious Disability: 1; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 1; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.56

ST. MARY'S MEDICAL CENTER

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

Website:
www.smdc.org

Phone number:
218-786-4000

Number of beds:
380

***Number of surgeries/invasive procedures performed:**
69,713

Number of patient days:
102,438

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Wrong surgical procedure performed	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
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
Unstageable pressure ulcers	3	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 1; Serious Disability: 2; Neither: 4**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.57

STEVENS COMMUNITY MEDICAL CENTER

Address:
400 E. First St.
Morris, MN 56267-0660

Website:
www.scmcmorris.com

Phone number:
320-589-7647

Number of beds:
54

***Number of surgeries/invasive procedures performed:**
2,260

Number of patient days:
13,693

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.58

UNITED HOSPITAL, INC.

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

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
546

***Number of surgeries/invasive procedures performed:**
88,686

Number of patient days:
169,752

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Surgery/other invasive procedure performed on wrong body part	**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 serious disability)	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
Unstageable pressure ulcers	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0; Serious Disability: 4; Neither: 7**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.59

UNITY HOSPITAL

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

Website:
www.allina.com/quality

Phone number:
612-775-9762

Number of beds:
275

***Number of surgeries/invasive procedures performed:**
35,125

Number of patient days:
77,982

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
CARE MANAGEMENT **Death or serious disability associated with:**		
A medication error	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 1; Serious Disability: 4; Neither: 0**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

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

Website:
www.fairview.org

Phone number:
612-273-6150

Number of beds:
1,700

***Number of surgeries/invasive procedures performed:**
142,808

Number of patient days:
289,504

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**5**	Deaths: 0; Serious Disability: 1; Neither: 4
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
Wrong surgical procedure performed	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
PRODUCT OR DEVICE EVENTS		
Death or serious disability associated with: An intravascular air embolism	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
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 serious disability)	**11**	Deaths: 0; Serious Disability: 0; Neither: 11
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	**4**	Deaths: 0; Serious Disability: 4; Neither: 0
Unstageable pressure ulcers	**24**	Deaths: 0; Serious Disability: 0; Neither: 24
TOTAL EVENTS FOR THIS FACILITY	**52**	**Deaths: 1; Serious Disability: 7; Neither: 44**

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

** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.61

WESTHEALTH

Address:
2855 Campus Drive, Ste. 465
Plymouth, MN 55441-2649

Website:
www.westhealth.com/quality_of_care.htm

Phone number:
763-577-7087

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL EVENTS		
Wrong surgical procedure performed	**2**	Deaths: 0; Serious Disability: 0; Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0; Serious Disability: 0; Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.62

WHITE COMMUNITY HOSPITAL & C&NC

Address:
5211 Highway 110
Aurora, MN 55705-1522

Website:
www.whitech.org

Phone number:
218-229-3961

Number of beds:
16

Number of patient days:
1,331

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

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/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.63

WOODWINDS HEALTH CAMPUS

Address:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-5613

Number of beds:
78

***Number of surgeries/invasive procedures performed:**
28,713

Number of patient days:
34,001

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 28 event types, organized under six categories. Categories and event types are not shown if no events were reported.

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2007-OCTOBER 6, 2008)

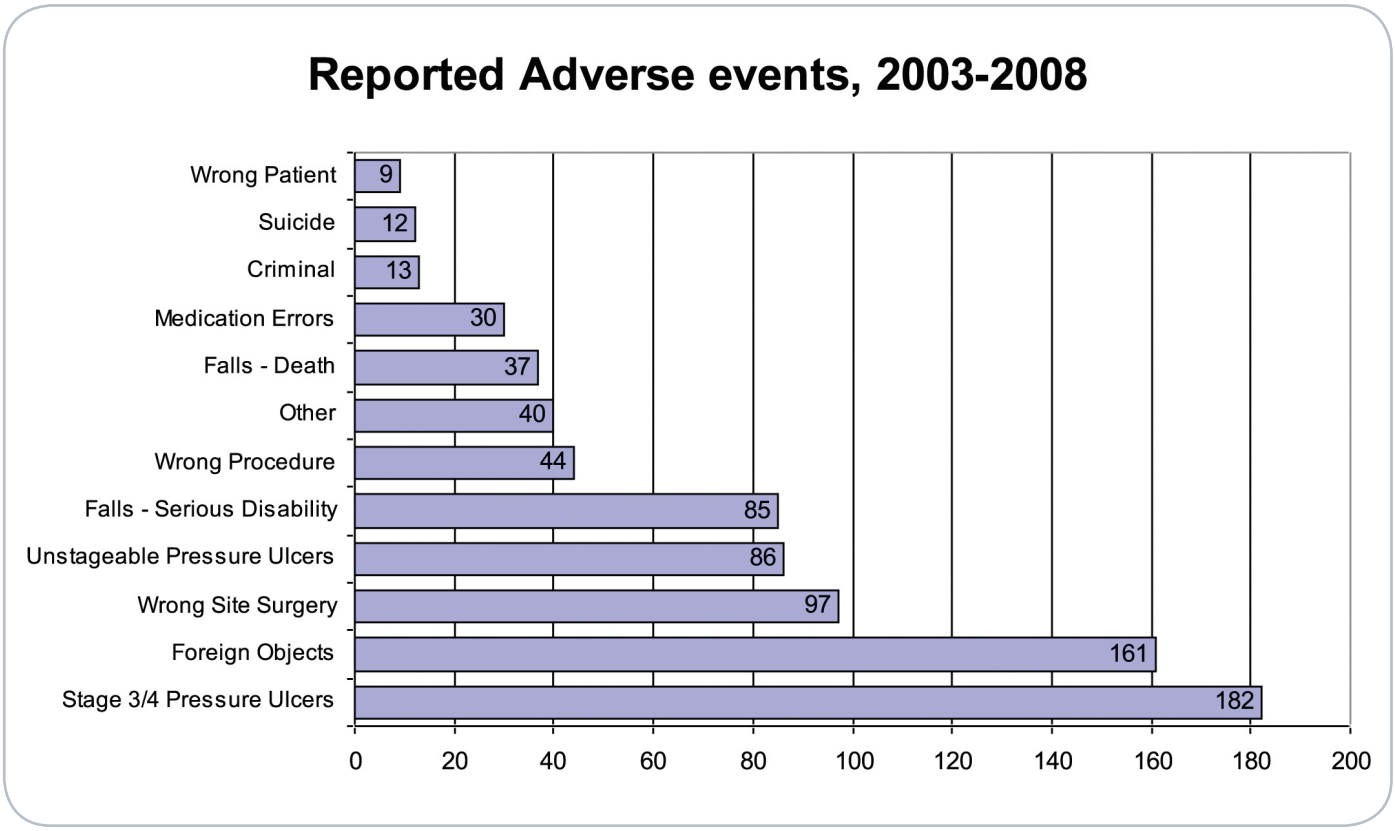
CATEGORY AND TYPE	NUMBER	BACKGROUND
ENVIRONMENTAL EVENTS		
Death associated with: A fall while being cared for in a facility	1	Deaths: 1; Serious Disability: 0; Neither: 0
****NEW EVENT CATEGORIES FOR 2008**		
Serious disability associated with: A fall while being cared for in a facility	2	Deaths: 0; Serious Disability: 2; Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 1; Serious Disability: 2; Neither: 0**

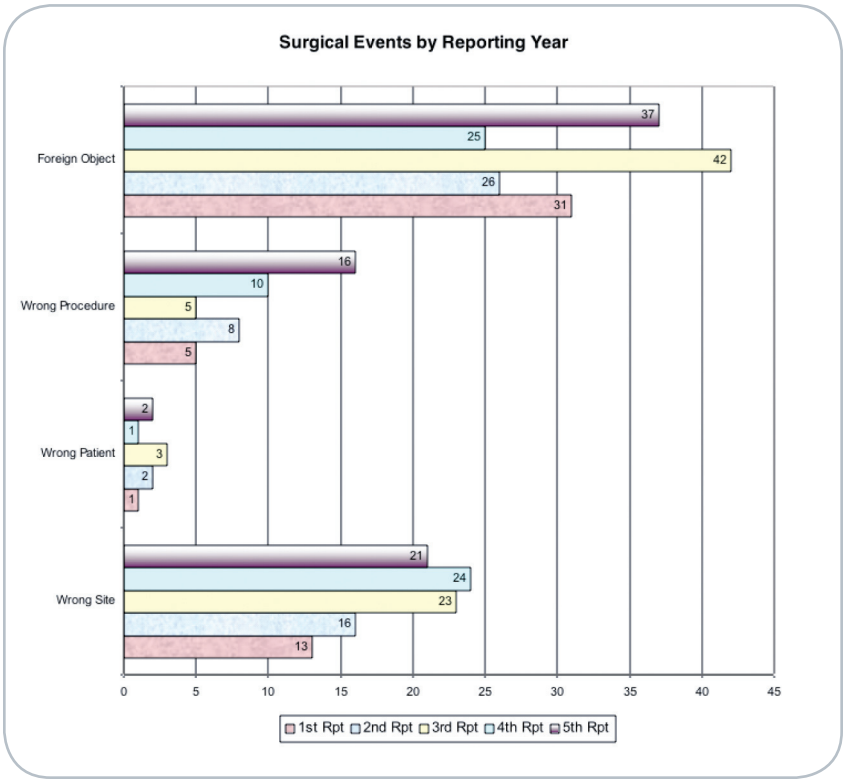
* The surgical/invasive procedure count on this page now includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law. In previous reports, this figure included only surgeries.

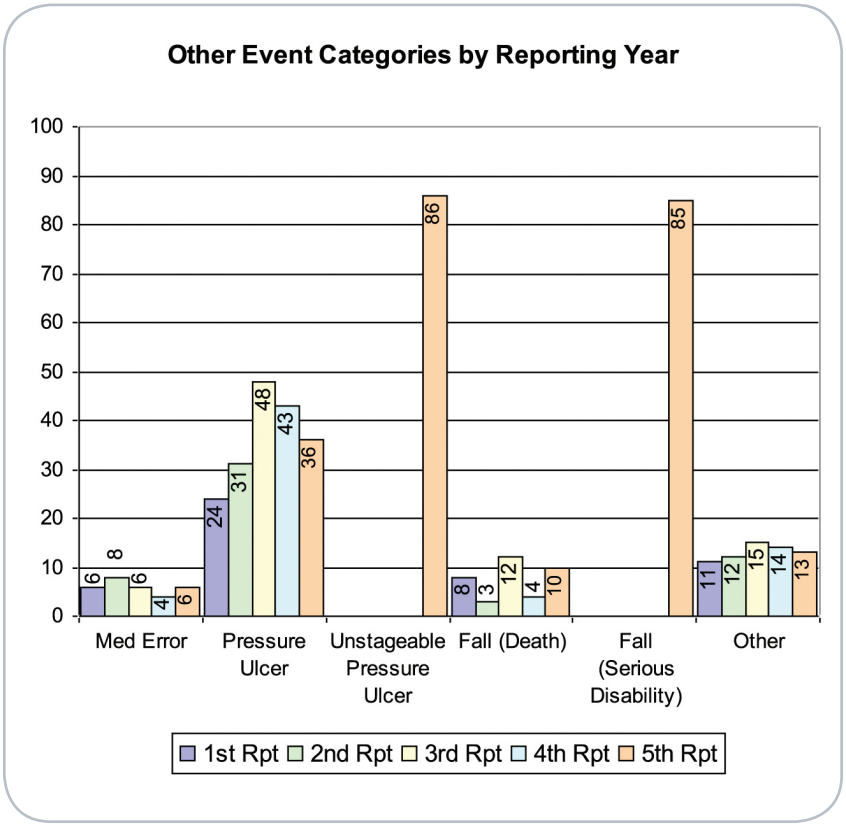
** **NEW EVENT CATEGORIES FOR 2008:** These events are now required to be reported to the MN Department of Health, starting with events discovered on 10/7/07. They have not been included in previous years.

APPENDIX A:
ADVERSE EVENTS DATA, 2003-2008

Hospitals began reporting adverse health events data to the Minnesota Department of Health in 2003, with ambulatory surgical centers joining the list of required reporting facilities in December, 2004. Since that time, a total of 796 events have been reported to MDH.




Surgical Events by Reporting Year
Foreign Object
37
25
42
26
31
Wrong Procedure
16
10
5
8
5
Wrong Patient
2
1
3
2
1
Wrong Site
21
24
23
16
13
0 5 10 15 20 25 30 35 40 45
1st Rpt 2nd Rpt 3rd Rpt 4th Rpt 5th Rpt


Other Event Categories by Reporting Year
100 90 80 70 60 50 40 30 20 10 0
6 8 6 4 6
24 31 48 43 36
86
8 3 12 4 10
85
11 12 15 14 13
Med Error
Pressure Ulcer
Unstageable Pressure Ulcer
Fall (Death)
Fall (Serious Disability)
Other
1st Rpt 2nd Rpt 3rd Rpt 4th Rpt 5th Rpt

APPENDIX B:
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 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 associated with a serious disability in addition to those associated with a death. These events are included for the first time in this report.

APPENDIX C:
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. Current statutory language is available on the MDH website at **www.health.state.mn.us/patientsafety**.

Surgical Events[2]

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

1. 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;

2. 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

3. 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

1. An infant discharged to the wrong person;

2. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have decision-making capacity; and

3. 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.

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

Care Management Events

1. Patient death or serious 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;

2. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;

3. 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;

4. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;

5. 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;

6. 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

7. Patient death or serious disability due to spinal manipulative therapy.

8. Artificial insemination with the wrong donor sperm or wrong egg.

Environmental Events

1. 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;

2. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

3. Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;

4. Patient death or serious disability associated with a fall while being cared for in a facility; and

5. 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

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

2. Abduction of a patient of any age;

3. Sexual assault on a patient within or on the grounds of a facility; and

4. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

APPENDIX D:
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. AHRQ's 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. JCAHO's website contains a number of resources for providers, including an online database of patient safety practices, at http://www.jointcommission.org/PatientSafety/PSP/

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/PatientSafety/

This list represents only a small fraction of the available resources on patient safety and quality. There are additional local and national resources on patient safety that can provide valuable information for patients, consumers, purchasers and policy makers.

ADVERSE HEALTH EVENTS IN MINNESOTA

FIFTH ANNUAL PUBLIC REPORT

JANUARY 2009

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