ADVERSE HEALTH EVENTS IN MINNESOTA

NINTH ANNUAL PUBLIC REPORT / JANUARY 2013

MINNESOTA MDH DEPARTMENT OF HEALTH

TABLE OF CONTENTS

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

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EXECUTIVE SUMMARY

Adverse Health Events in Minnesota

Annual Report, January 2013

In 2003, Minnesota became the first state in the nation to pass a law requiring all hospitals, and later ambulatory surgical centers, to report whenever a serious adverse health event (Appendix A) occurs and to conduct a thorough analysis of the reasons for the event. In 2012, the ninth year of reporting, the total number of events reported under the law was 314, essentially unchanged from the previous year.

A closer look at the overall profile of reported events shows an increase in falls, wrong body part surgical/procedural events, and patient protection events (suicides/elopements), while showing a decrease in medication errors, retained foreign objects, and pressure ulcers. With respect to harm, there were 14 deaths (up from five in 2011) and 89 serious injuries (up from 83 in 2011) that resulted from the reported events.

While the number of total reported events is similar to last year, and the number of cases of harm increased, this masks improvement in several key areas. Examples of improvement in 2012 include:

- The number of pressure ulcers declined by eight percent. This is the first decline of this magnitude in the nine years of reporting. This year's total of 130 is down from an all-time high of 141 last year.
- Retained foreign objects declined by 16 percent. This is the first decline in this category in five years.
- Medication errors dropped by 75 percent from the previous year and were at the lowest level in all nine years of reporting.

Minnesota's reporting system has a strong focus on reporting, but also on learning. The overall purpose of the reporting system is to use the data that is gathered to identify issues and to learn from those issues, to prevent them in the future. Key learnings gleaned from 2011 events that were acted upon in 2012 include:

- In response to an increase in implant-related wrong procedures, MDH collaborated with the Minnesota Hospital Association (MHA) to issue a safety alert, which provided key practices that should be implemented to improve the implant verification process prior to a procedure.
- As a result of the data showing a continued increase in reportable events due to inconsistencies or lack of verification at various points in the scheduling process, best practices for safe surgical scheduling and verification were rolled out statewide through the MHA SAFE SITE 2.0 roadmap.
- Due to 25 percent of invasive procedure events occurring in radiology, a SAFE SITE 2.0 "mini roadmap" specifically targeted at areas for improvement in radiology was created and rolled out.

Going forward, the key learnings from 2012 events indicated a number of steps that MDH and its partners will take in order to improve patient safety in Minnesota, including, but not limited to:

- Exploring and piloting additional strategies for reduction of falls and fall injury, such as creating education, training and resources around linking specific fall risk factors with interventions.
- Working with hospitals and surgical centers on a targeted effort to prevent retention of broken/fragmented items as well as the accounting for, and handling of, packed items.
- Conducting a follow-up evaluation of the pre-procedure Minnesota Time Out process recommendations.
- Providing training to facilities on suicide prevention and violence to address issues uncovered this past year related to patients with behavioral health needs.

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.

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 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. In an organization with a safety-focused culture, staff should feel comfortable reporting potentially unsafe situations without fear of reprisal. In these cases, higher numbers may represent a positive trend towards greater attention to adverse events and their causes, rather than the opposite. What is important is that all events are seen as an opportunity for learning and system improvement – and that organizations follow up on the problems they identify.

SOURCES OF QUALITY AND PATIENT SAFETY INFORMATION

Minnesota Department of Health

www.health.state.mn.us/patientsafety

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

http://www.health.state.mn.us/healthreform/measurement/report/index.html

2010 Minnesota Health Care Quality Report, comparing quality at hospitals and clinics on a set of measures including diabetes, high blood pressure, asthma, and cancer.

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.

Minnesota Community Measurement

www.mnhealthcare.org

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

Stratis Health

www.stratishealth.org

A nonprofit organization that leads collaboration and innovation in health care quality and safety. Resources include tools to support clinical and organizational improvement, as well as training and education programs for professionals across the continuum of care.

Minnesota Hospital Quality Report

www.mnhospitalquality.org

Database of hospital performance on best practice indicators for heart attack, heart failure, pneumonia, surgical care and how patients experience care in the hospital.

HIGHLIGHTS OF 2012 ACTIVITIES

Under the Minnesota Adverse Health Care Events Reporting Law, the Commissioner of Health is directed to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities on how they can improve patient safety. In performing these functions, the Department works closely with a variety of stakeholders including the Minnesota Hospital Association (MHA), Stratis Health and the Minnesota Alliance for Patient Safety (MAPS). Highlights of the 2012 activities are listed below.

Education

- Representatives from more than 20 healthcare facilities participated in a Root Cause Analysis (RCA) training session in May 2012. This training is an important way of supporting facilities as they work to conduct robust root cause analyses.
- In May, MHA and MDH jointly issued a safety alert related to implant-related procedures, including recommendations for proper ordering and handling of implants (Appendix D).
- In July, MHA and MDH jointly issued a safety alert related to retained foreign objects specific to gynecological procedures (Appendix E).
- In 2012, MDH held two statewide conference calls for reporting facilities to update them on changes to the reporting system, trends in the data, new projects, and upcoming training opportunities.

Strengthening the reporting system

- In March 2012, for the third year, MDH surveyed hospitals and surgical centers to assess their knowledge of the reporting law's requirements. Facilities were provided with case studies, and asked to determine whether each case was reportable under the law. The results and correct answers were discussed with facilities statewide, with many facilities also using the survey as an internal training tool for staff.
- Throughout 2012, MDH, MHA and Stratis Health worked to develop modifications to the secure, web-based registry used to report events. The upgraded registry, which launched in September 2012, includes expanded information on root causes/contributing factors for events, as well as a system for rating the extent to which corrective actions focus on system changes as opposed to individual-level changes.

Collaborations

- MDH partnered with MAPS to hold a Culture Campaign kick-off in May 2012.
- In collaboration with MAPS, MDH continues to work to fully implement the Culture Roadmap in Minnesota. For more information on the roadmap, see page 13.
- MDH partnered with MAPS to hold the bi-annual MAPS conference, which is a three day education summit on patient safety and quality, in the fall of 2012, with over 400 attendees.

Topic specific safety activities

MDH collaborated with MHA to continue to convene expert groups to examine trends and develop evidence-based strategies for prevention of falls, pressure ulcers, retained foreign objects, as well as surgical/invasive procedure events. With regard to safe surgery/invasive procedures, MDH provided grant funding to the University of Minnesota to perform a follow up evaluation to the Time Out recommendations from 2011.

A number of statewide and regional projects and individual facility efforts to prevent surgical/procedural events, retained foreign objects, falls and pressure ulcers were implemented or continued during 2012. Those efforts are described in the following sections.

MDH Patient Safety/Quality Improvement Mini-Grant Program

In June 2012, MDH was able to award over $20,000 in Patient Safety/Quality Improvement Mini-Grants (maximum of $5,000 each) to support new practice implementation projects focused on prevention of reportable adverse health events. The grants were the first of their kind from MDH and challenged the health care community and the ability of organizations to develop new solutions to clinical scenarios in which adverse events could occur. The goal of this grant program was for the tools and procedures that emerge from these projects to be shared across the state to improve quality and patient safety at Minnesota hospitals and ambulatory surgical centers. More than 20 organizations applied and seven grantees were chosen by a panel of judges to receive the grant dollars (Figure 1). In early 2013, the learnings, as well as tools and resources developed from those projects, will be shared with all facilities in Minnesota. MDH plans to offer this grant program again in spring of 2013.

FIGURE 1: MDH PATIENT SAFETY/QUALITY IMPROVEMENT MINI-GRANT PROGRAM AWARDEES

AWARDEE	PROJECT SUMMARY
HealthEast-Bethesda Hospital	Funds will be used to conduct a three-day performance improvement event focused on the process of care related to pressure ulcer prevention and the development of standard work in the identified areas for improvement (every 2 hour turns, patient refusal of repositioning, patient education after refusal of repositioning).
Mille Lacs Health System	Funds will be used to trial the use of passive infrared motion sensor fall alarms on a geriatric psychiatry unit.
Minnesota Eye Laser & Surgery Centers, LLC.	Funds will be used to create a staff education video on correct time outs, specific to use in the ambulatory surgery setting.
Paynesville Area Healthcare	Funds will be used to create a formal hand-off process for the perioperative patient from admission to discharge, educate operating room/perioperative staff on the use of Braden assessment and National Database of Nursing Quality Indicators (NDNQI) pressure ulcer training modules. Funds will also be used to modify the electronic medical record (EMR) to include handoff documentation relating to skin integrity as well as to purchase equipment for the operating room to minimize risk of pressure ulcer development in the perioperative patient.
St. Cloud Surgical Center	Funds will be used to develop and disseminate educational materials related to "speaking up" in the peri-anesthesia and perioperative environments to be disseminated and available in digital format. Also an educational offering related to "speaking up" will occur, be recorded and disseminated.
St. Elizabeth's Medical Center	Funds will be used to implement MHA's SAFE SITE 2.0 "mini road-maps" for the areas outside of the operating room. Tools created during implementation will be disseminated.
Tyler Healthcare Center	Funds will be used to develop a nursing staff education video on a proper medication reconciliation process.

2012 SUCCESSES AND CHALLENGES: FACILITY PERSPECTIVES

In November 2012, MDH conducted a survey of all hospitals and surgical centers to learn more about their successes and challenges over the previous reporting year, as well as to allow facilities to provide input into the direction of the reporting system for the upcoming year. Patient safety staff members at 157 facilities were surveyed with an online tool, with a 40 percent response rate.

Respondents were asked to rate the usefulness of a number of tools, training opportunities and resources developed by MDH, MHA and Stratis Health during the 2011-2012 reporting period. Their responses indicate that the majority of facilities made use of a range of resources and training opportunities (Figure 2).

The most highly-rated activities were the MHA Call to Action resources, MHA/Stratis regional meetings, MDH/MHA Safety Alerts and participation in MHA advisory committees.

Facilities were asked to describe their biggest successes and challenges from the past year. With regard to successes, a number of respondents described increasing awareness of patient safety in their facilities, increased staff event reporting and creating a culture of safety in their organization. Many facilities also reported success around preventing particular types of adverse events, most commonly preventing events in the surgical/procedural areas as well as falls and pressure ulcers.

Respondents also noted a number of challenges:

- An increasing number of reporting requirements from various state and federal entities, some of which are confusing to staff.
- Time management and prioritization. Facilities are trying to work on multiple initiatives or projects and can get overwhelmed.
- A common challenge reported again this year was getting staff and physicians engaged in patient safety efforts. This can be particularly tough when staff do not understand the rationale for being asked to change their processes to a new way that might improve patient outcomes.

FIGURE 2: FACILITY PERSPECTIVES 2012

RESOURCES	VERY USEFUL	SOMEWHAT USEFUL	NEUTRAL	NOT VERY USEFUL
MDH/MHA Safety Alerts	77%	19%	3%	0%
MDH Case study survey (April 2012)	53%	31%	16%	0%
MHA 'Good Catch' awards program	19%	38%	30%	13%
MHA AHE data sharing database	51%	34%	13%	2%
Measurement guide for adverse events	59%	36%	3%	2%
MDH Online RCA toolkit	50%	44%	4%	2%
Participation in MHA Advisory committees	67%	15%	11%	7%
RCA Training (May 2012)	60%	16%	16%	8%
MHA/Stratis Regional Meetings (Spring 2012)	65%	16%	16%	2%
MHA Call to Action participation	63%	30%	6%	2%
MHA Call to Action listservs	35%	41%	20%	4%
MHA Call to Action resources and tools	67%	25%	7%	0%

** Responses are limited to facilities that indicated they had used/seen the resource.*

Respondents were also asked about resources that would be helpful to them in the coming year. The responses indicated that facilities would be interested in additional training and resources in the following areas, which MDH and partners will explore in early 2013:

- Safety culture training and resources
- Resources around medication reconciliation and preventing medication errors
- More tools to encourage staff buy-in
- Continued opportunities for Root Cause Analysis (RCA) training for staff
- Teamwork tools and resources
- Training and education around effective hand-offs

Lastly, respondents were asked what they see as the highest priorities for the reporting system in the coming year. The most common responses were:

- Effective team communication
- Continued work on surgery/procedural safety
- Care of mental health patients (restraint use, suicide and elopement prevention as well as violence).

MDH and its partners will move forward in 2013 with addressing the needs brought forth in this survey. It is important to note that many of the needs brought forth by the respondents require much work on the part of facilities as well. MDH will continue to do its best to support Minnesota facilities with making patient safety their highest priority.

OVERVIEW OF REPORTED EVENTS & FINDINGS

In nine years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on more than 2,000 events. MDH, along with its partners, has used the information from those events to identify ways to improve patient safety in Minnesota.

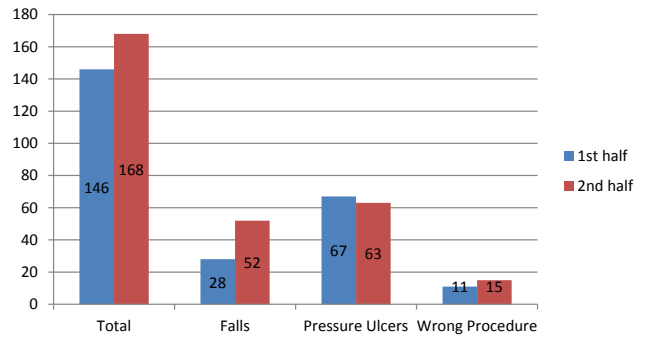
Currently 145 hospitals and 59 ambulatory surgical centers are licensed by MDH and required to report adverse health events under this law. Federally licensed facilities, such as those operated by the Veteran's Administration or the Indian Health Service, are not covered by the law.

This annual report provides an overview of what the most recent year of data can teach us about the risk points for adverse health events and the best approaches for preventing them. As in previous years, the most common types of events (falls, pressure ulcers, surgical/invasive procedure events, and retained foreign objects) will be discussed in more detail.

Frequency of events

Between October 7, 2011, and October 6, 2012, a total of 314 adverse health events were reported to MDH. This figure represents an average of 26.1 events per month or roughly six events per week. Over the course of the reporting year the number of events that occurred per week remained constant at around six per week. Of note, the number of falls during the year showed a large shift in the 2nd half of the reporting year. In the first half of the reporting year, 27 falls were reported, while in the 2nd half 51 falls were reported. Other categories, such as pressure ulcers and wrong procedures, showed little variation.

FIGURE 3: EVENTS REPORTED, 1ST & 2ND HALVES OF 2012



Overall, the data show that:

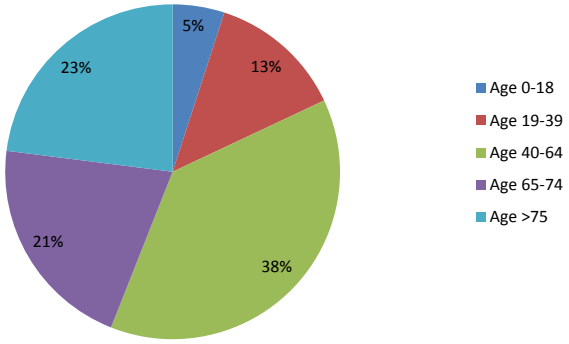
- The number of events per month ranged from 20 to 33 events per month, April having the highest number of events reported with 33 and October having the lowest with 20.
- There are currently 145 hospitals and 59 ambulatory surgical centers in Minnesota. Of those, 65 hospitals and six ambulatory surgical centers reported events during this reporting period. Five hospitals were first-time reporters, experiencing their first reportable adverse event in 2012. The remaining facilities did not report adverse health events for this reporting year.
- Since the inception of the reporting system, 112 hospitals have reported at least one event. This represents more than 75 percent of all hospitals, which together account for more than 96 percent of all hospital beds in Minnesota.
- During October 2011-October 2012, the most recent year for which preliminary data are available, Minnesota hospitals reported 2.6 million patient days. Accounting for the volume of care provided across all hospitals in the state shows that roughly 12.1 events were reported by hospitals per 100,000 total patient days.

Patient Characteristics

Overall the data show that:

- In 80 percent of reportable events, the patient involved was an inpatient, 16 percent were outpatient and the remaining four percent were in the emergency department or other location in the facility.
- Adverse health events happen to patients of a wide range of ages (Figure 4). From this year's data, the most likely population to experience an adverse event was age 40-64 with 120 patients in that age range.

FIGURE 4: EVENTS BY PATIENT AGE

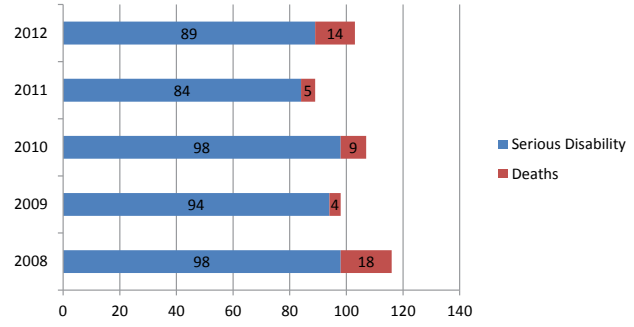


Patient Harm

While not all of the events that are required to be reported under Minnesota's adverse health events reporting law require harm to occur in order to trigger reporting, all are indicators of potential system issues that could lead to harm or death. The goal of this reporting system is to prevent any case of avoidable harm from occurring. In 2012, more events resulted in patient harm than in the previous year. A total of 89 events (28 percent) resulted in serious disability and 14 events (four percent) resulted in a patient's death (Figure 5). The remaining 211 events resulted in no harm, a need for additional monitoring, or a longer stay.

As in previous years, the type of event most likely to lead to serious patient harm or death was falls. Eighty cases of harm or death were a result of falls, while air embolisms and suicide or attempted suicide each accounted for four cases. Over the life of the reporting system, falls, medication errors, and suicide/attempted suicide have been the most common causes of serious patient harm or death.

FIGURE 5: PATIENT HARM, 2008 – 2012

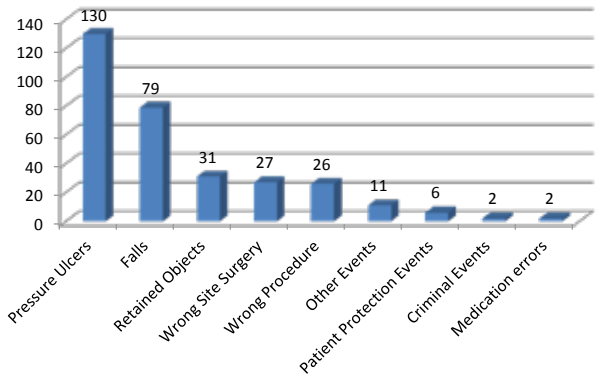


** Note, data prior to 2008 is not shown due to definitional changes that year that led to a higher number of serious disability cases being reported for some events.*

Types of Events

As in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for two-thirds (66 percent) of all events reported in 2012. Also, the four events that make up the surgical/procedural category accounted for another 27 percent of reported events this year. Of the 28 types of reportable events in Minnesota, 14 of them had at least one reported case in 2012 (Figure 6). A change from previous years was the number of suicides or attempted suicides, which this year stands at four (up from one case in 2011). In 2012, two criminal events were reported; there were none in the previous year.

FIGURE 6: EVENTS BY CATEGORY, 2012



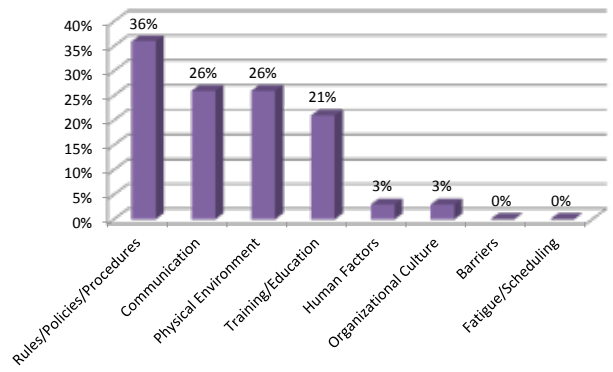
Root Causes of Adverse Events

When a reportable adverse event occurs, facilities are required by law to conduct a root cause analysis (RCA). This process involves gathering a team to closely examine the factors that led to the event. These factors can include communication, training, equipment malfunctions, failure to follow policies or protocols, or confusion about roles and responsibilities.

This type of analysis seeks to identify and address the root causes of events, as opposed to simply addressing their symptoms. By focusing direct corrective action on the identified root causes, the recurrence of similar problems can be prevented. RCA is often considered an iterative process and is viewed as a tool of continuous improvement, versus a one-time fix. To be effective, the RCA should establish a timeline or sequence of events to understand the relationships between the causal factors and root cause. In Minnesota, RCA is starting to help transform healthcare facilities from a reactive culture into a forward-thinking or proactive culture that can help to identify problems before they occur.

As in previous years, the majority of adverse events were tied to root causes in one of three areas: communication, policies/procedures, and environment/equipment (Figure 7). However, not all root causes fit neatly into these categories, and in many cases the causes are closely intertwined. Organizational culture issues can often come into play with adverse events, particularly in cases where providers, staff, or patients feel uncomfortable speaking up if they perceive a risk. In September 2012, RCA findings related to organizational culture, which were previously not captured in the reporting system, were added to the web-based reporting system.

FIGURE 7: ROOT CAUSES / CONTRIBUTING FACTORS



Does not include events without an identified root cause.

SPOTLIGHT STORY

BUILDING AN EFFECTIVE PATIENT SAFETY CULTURE: A COMPENDIUM OF BEST PRACTICES

At the foundation of successful patient safety and quality improvement efforts is a culture of patient safety within healthcare facilities. A strong safety culture can help minimize medical errors. Strong support from leadership is crucial to truly moving the needle on patient safety and quality across the organization.

Many of us are familiar with the phrase "Culture eats strategy for lunch". This phrase, originally attributed to management guru Peter Drucker, is increasingly heard at gatherings of patient safety leaders. Without a strong culture to support it, even the best strategy will fail. The importance of culture in sustaining patient safety improvement efforts is widely recognized, but the question remains—how do we change the culture in health care organizations to be more supportive of safety?

The Minnesota Alliance for Patient Safety (MAPS) believes it has found an answer to this question. Using known best practices and emerging national standards in the road map framework that has proven successful in Minnesota, the MAPS safety culture road map helps organizations build an effective organizational culture devoted to patient safety and quality.

MAPS initiated this work by bringing together patient safety experts from across the state in 2009. The work of this group evolved, local experts were consulted, best practices were identified in the literature, and tools and resources were gathered to help organizations implement the identified best practices. This work was organized into eight key culture domains:

- **Getting Started** – includes best practices around assessment & analysis, plan development, measurement and education;
- **Leadership** – a critical element in advancing a culture of safety, all organizations must get buy-in and support before proceeding to the remaining domains;
- **Communication** – includes strategies and tactics to improve the exchange of clinical information;
- **Justice** – includes resources to ensure that staff behaviors are fairly evaluated and that organizations are accountable for safe system design while individuals are accountable for their behaviors;
- **Teamwork** – draws on a large body of research available through the Agency for Health Quality and Research, that developed the TeamSTEPPS model for improving teamwork;
- **Learning** – includes strategies and tactics to help organizations gather data and information that can be used to learn and improve;
- **Patient/Resident Engagement** – includes strategies for engaging patients/residents and families, gathering input from them and conducting effective disclosure when an error does occur and;
- **Sustaining the Work** – provides tools designed to help with measurement, analysis, dissemination of findings, evaluation of performance and more.

Evidence shows that organizations successful in moving toward a culture supportive of safety improvement have implemented change in many, if not all of these domains.

MAPS is currently working in partnership with the Minnesota Hospital Association, MDH and Stratis Health to help hospitals, clinics and long term care organizations implement various components of the Safety Culture Road Map. The goal is to guide organizations through the work in a number of the domains so that they can achieve a change in their culture and more sustainable patient safety improvements. More than 50 hospitals are participating in the organizational culture work and are completing their assessment of the road map best practices in their organizations and working to close any gaps. A new long-term care work group has been formed and will help spread the best practices for a safety culture to this setting during 2013.

More information about the MAPS Safety Culture Road Map can be found at www.mnpatientsafety.org.

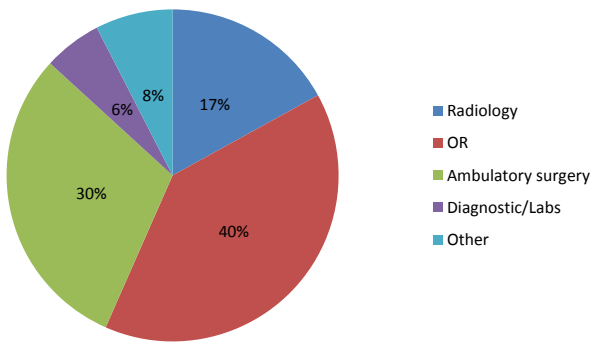
SURGICAL/INVASIVE PROCEDURE EVENTS

In the nine years of the reporting system, nearly 350 incidents of wrong site, wrong procedure or wrong patient surgeries/invasive procedures have been reported by facilities in Minnesota.

In the ninth year of reporting, the total number of surgical/invasive procedure events across the three reporting categories was 53. This slight increase was due to an increase in wrong site events from 24 in 2011 to 27 in 2012, while wrong procedure numbers remained the same. There were no wrong patient events this reporting year.

Of the reported wrong site, patient or procedure cases, 63 percent occurred in the operating room (including outpatient surgical procedures), and 17 percent occurred in radiology (Figure 8). In more than half of cases (56 percent), the patient was reported to have experienced no medical harm from the incident or required additional monitoring. Roughly 40 percent of patients required additional treatment, usually in the form of a second procedure, and one patient experienced a serious disability.

FIGURE 8: SURGICAL / INVASIVE PROCEDURE EVENTS BY LOCATION



Across all Minnesota hospitals and surgical centers, nearly 2.5 million surgeries and invasive procedures were performed in this reporting year. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one of every 47,000 invasive procedures.

WRONG SITE SURGERIES/INVASIVE PROCEDURES

In the nine years that Minnesota has been collecting data on adverse health events, wrong site surgeries/invasive procedures have been among the most commonly reported events. In 2011, the number of wrong site surgeries/invasive procedures dropped by more than 20 percent, the lowest point since 2007, but in 2012 that number rose to 27 (an increase of 12 percent from 2011). Even with this increase, the total number of wrong site surgery/procedure cases remains below the all-time high of 31 in 2010.

A further look at the data shows a decrease in wrong site surgeries/invasive procedures in radiology. At the close of this reporting year, radiology had not had a wrong site surgery/invasive procedure in over six months. Much of this decrease can be attributed to the roll out of the SAFE SITE 2.0 roadmap in April 2012 by MHA, which included a more focused roadmap specifically for radiology. This "mini-roadmap" was tailored specifically for radiology professionals with input from radiology experts throughout the state. It aims to help those in radiology to own the process of safe surgery/invasive procedures with procedures that work for their specific environment.

Much of the work toward elimination of wrong site surgeries/invasive procedures in 2012 was related to increasing awareness and focus on treating the anesthesia block prior to the surgical procedure as its own procedure with its own site marking and separate time out process. Thinking of the anesthesia block as its own procedure has not always been common practice in Minnesota. If the pre-procedure block is administered at the wrong location, (i.e. right vs. left), it sets the stage for the entire surgery/procedure to occur in the wrong location as well. However, since the block prior to the actual surgery/procedure is still an invasive procedure, those administered in the wrong location are also reportable under the adverse health event law. In the first half of the reporting year, 13 percent of the wrong site surgeries/invasive procedures were wrong site anesthesia blocks; in the second half of the year wrong blocks made up 54 percent. Some of this increase could possibly be attributed to heightened awareness that wrong site anesthesia blocks, prior to the actual surgery, are considered wrong events and work is currently underway to eliminate these types of events.

The other focus in 2012 was on wrong site surgeries/invasive procedures at the wrong level, most commonly spinal procedures. In the first half of the reporting year, 40 percent of the wrong site surgeries/invasive procedures were wrong level; however, in the second half of the reporting year, there were no wrong level procedures. This success can likely be attributed to facilities implementing the "Spine Localization Practices" disseminated by MHA in 2011 and again in early 2012 as a part of the SAFE SITE 2.0 roadmap. These practices take time for facilities to implement, however, strong effort has been put forth to eliminate wrong level procedures and that work appears to have come to fruition in the second half of the reporting year.

Key findings

As in years past, the root causes of wrong site events are often related to the lack of consistency with the verification process to confirm the intended procedure, prior to the procedure. These processes often begin in a clinic or other location and can begin weeks to months prior to the surgery/invasive procedure.

Root causes for wrong site invasive procedures in 2012 included:

- Failure to have radiographs or imaging present in the procedure area;
- Laterality or other critical information missing from informed consent documents;
- Lack of site marking and/or lack of policy for correct site marking; and
- Lack of consistent and well-known time out process.

WRONG SURGERIES/INVASIVE PROCEDURES

The number of wrong surgeries/invasive procedures remained constant this year at 26. Eight of those events (30 percent) involved incorrect lens implants being placed during cataract procedures. In previous years, this category has included a variety of wrong implants, such as wrong knee components during knee replacements and incorrect breast implants. However, in this reporting year, the only wrong implants involved cataract surgeries. Of the wrong lens implants reported, 62 percent took place in ambulatory surgery.

In May 2012, MDH and MHA issued a Safety Alert (Appendix D), addressing the increase in wrong lens implants. Included in the safety alert were recommendations for implant handling and verification. Since the release of the safety alert in May 2012, there have been no wrong lens implant procedures for 106 days (as of the close of this report). With consistent implementation practices this success with reducing or eliminating wrong lens implants will likely continue in 2013.

Also of note, there were four wrong surgeries/invasive procedures that involved wrong site spinal steroid injections, up from one event in 2011. Lastly, there were three wrong catheters placed; most commonly the procedure involved placing a short term catheter versus a long term catheter or vice versa.

Key findings

As with wrong site procedures, the root causes of wrong procedure events are often related to breakdowns in the verification processes that lead up to the procedure, this is especially the case with lens implants. The most common scenario was that source documents did not include information needed in the verification process (e.g. the cataract lens strength).

Root causes for these events included:

- Lack of standardized scheduling/ordering process led to confusion among staff and resulted in wrong procedure being ordered;
- Consent forms that did not include the specific implant to be used;
- Operating room schedule and informed consent did not match and this was not reconciled prior to the procedure;
- Use of a list with multiple patients names (rather than patient specific) and their lens prescriptions to gather lens for the cases; and
- Lack of verification of implant type prior to insertion.

Next steps

In the coming year, Minnesota hospitals and surgical centers will continue to focus on preventing wrong surgical/invasive procedure adverse events. MDH and its partners will provide ongoing support to facilities to hardwire the time out process, implement a standardized scheduling and verification process and engage leaders to support their staff in speaking up for patient safety when concerns arise. MHA's SAFE SITE 2.0 campaign continues in 2013, with 123 facilities participating.

Early in 2013, MDH and its partners will convene a group of surgeons and "Time Out Champions" from throughout the state to work on ways to engage physicians and surgeons in the statewide Minnesota Time Out campaign. In addition, MDH is providing a grant to the University of Minnesota to conduct a follow-up evaluation of the time out process recommendations from 2010, to determine the extent to which the recommendations are being successfully implemented. MDH will share all learnings and new recommendations from that evaluation broadly.

SPOTLIGHT STORY

PHILLIPS EYE INSTITUTE VERIFICATION PROCESS ELIMINATES INCORRECT IOL IMPLANTS

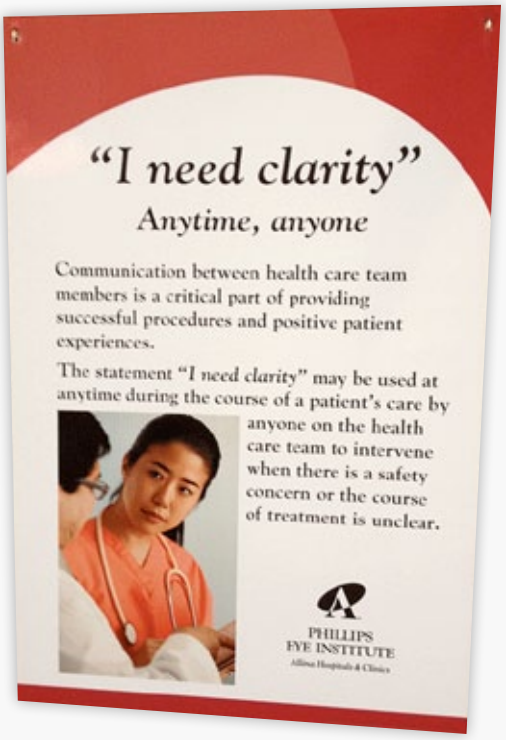
In 2011, close to 40 percent of all wrong site surgeries/procedures in Minnesota were related to wrong implants, and the most common wrong site procedures in the state involved intraocular lens (IOL) implants often used in cataract surgery. The potential for confusion with IOL implants is high due to variation in the number and types of lenses available for implant combined with varied patient needs. Yet Phillips Eye Institute in Minneapolis, part of Allina Health, has implemented a verification process that has essentially eliminated incorrect placement of IOL implants.

Since Phillips Eye Institute implemented the verification process in 2008, it has performed more than 25,000 cataract procedures with no incorrect IOL implants. Furthermore, its policy was the model on which the Minnesota Department of Health and the Minnesota Hospital Association developed best practice recommendations for hospitals issued in a 2012 safety alert.

Phillips Eye Institute performs more than 5,700 cataract procedures per year, so eliminating incorrect placement of IOLs represents a significant contribution to patient safety. In the past, the surgeon would bring a stack of lenses into the operating room for all the cases he/she would see that day. "That practice left a lot of room for error and was clearly not a best practice," said Carol Pilcher, Phillips Eye Institute assistant nurse manager of surgery.

To achieve its success, Phillips Eye Institute developed a policy for a standardized process for ordering and verifying IOL implants and conducting a robust Time Out for every patient, every procedure, every time. The process involves the use of a standard lens reservation form and the Phillips Eye Institute procedure safety checklist by approximately 45 different physician offices or groups. Key steps of the process are described below:

1. Surgeon completes the lens reservation form and the form is used in selecting/verifying the correct lens.
2. Reservation form is secured to lens box. The form is signed by appropriate staff to confirm that the reservation form specifications match the lens box specifications.
3. In conjunction with the Universal Protocol, the correct patient, lens and diopter are confirmed by circulating nurse and surgeon and documented using the Procedure Safety Checklist.
4. Operating room tech and nurse verify that lens model and diopter are correct when lens is introduced to the sterile field.
5. Implant confirmation, model, diopter, manufacturer and serial number are documented in the medical record.



To get all of the independent surgeons who perform implant procedures at Phillips Eye Institute engaged in the new process required communication among the health care team members. To facilitate the change, Phillips Eye Institute posted signs at the scrub area reminding everyone of the implant process, included communication in their physician newsletter, and conducted many one-on-one phone calls with the surgeons' scheduling staff.

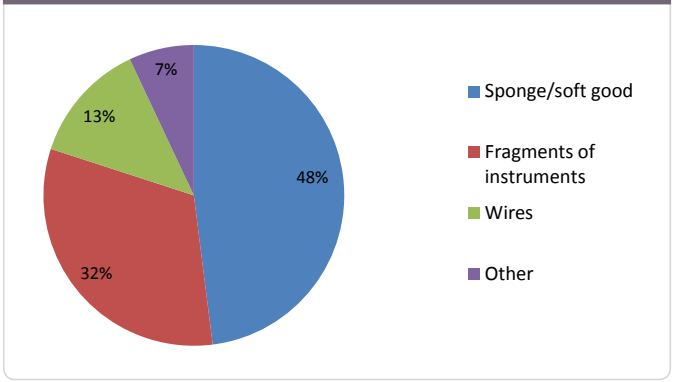
At the heart of this process is the permission and expectation for anyone on the health care team to use the phrase, "I need clarity" to intervene when there is a safety concern or the course of treatment is unclear. This provides a safe phrase to initiate a hard stop without making judgment about why the stop is needed. "We work in a fast paced environment, but safe care is the most important thing that we do," said Marge Watry, Phillips Eye Institute director of patient care.

RETAINED FOREIGN OBJECTS

In 2012, 31 cases of retained foreign objects were reported, a decline of 16 percent from 2011. This year's data has maintained the current pattern of items most likely to be retained, with both device fragments and sponges/soft goods making up a large portion of retained objects.

Sponges and other soft goods were still the most commonly retained foreign objects (48 percent, an eight percent increase from 2011). Packed items (items placed by the staff and intended to be removed prior to patient discharge) accounted for 17 percent of the total number of retained items which highlights the work needed in this area. Device fragments (other than guidewires) accounted for 32 percent of all retained foreign objects, which is similar to the previous year (Figure 9).

FIGURE 9: TYPE OF OBJECT RETAINED



Minnesota facilities recently marked over 900 days without a retained sponge in labor and delivery. However, this year there was one sponge retained in that care setting. This has led MHA to bring the focus back to labor and delivery, by reminding facilities to continue to audit their processes, even though these events are few and far between.

Further analysis of the data shows six events (19 percent) occurring during GYN procedures, with the majority being sponges retained following cesarean sections and vaginal hysterectomies. The most common root cause findings for these events were lack of communication of 'tucked items' (items placed during the procedure but meant to be taken out prior to the end of the procedure) and an incorrect/ineffective count process. These findings led MDH and MHA to issue a Safety Alert in July, 2012, around accounting for items in GYN procedures (Appendix E). This Safety Alert provides specific best practices for facilities to prevent retained objects during GYN procedures.

Key findings

Findings in the data this year are similar to last year, with retained foreign object events falling largely into two categories: device fragments/broken pieces and soft goods/packed items. In the case of device fragments, key findings include:

- Staff did not realize that a device had broken. This was often related to unfamiliarity with the device; either the team did not know what an intact device should look like, or they did not know that there was a risk for breakage with the particular device being used.
- In some cases, the retained device piece was so small that it was not detected during inspections of the surgical field. Over the years, this is most common with broken pieces of wire.
- The post-operative x-ray did not show the device fragment or piece due to its size.

In the case of soft goods and packed items (items placed by the staff and intended to be removed prior to patient discharge), root causes were more often related to a breakdown in communication around whether an item was placed, who was responsible to remove it, or whether all items were accounted for.

Next Steps

In 2011, MHA retired the "SAFE COUNT" campaign as a result of participating hospitals maintaining over 97 percent of best practices for many years, as well as those events hovering near zero for several years. In early 2013, MHA will also retire the "SAFE ACCOUNT" campaign, again as a result of participating hospitals implementing and maintaining over 97 percent of best practices. In 2013, MDH and MHA will continue to focus on retained foreign objects by focusing efforts on accounting for packed items and accounting for items being intact.

As facilities continue to be challenged by packed items, it is clear that communication barriers can and do impact patient safety and lead to retained foreign objects. MDH and MHA will collaborate to work with clinical experts to develop further best practices around placement and removal of packed items. In the future, all Minnesota facilities should adopt these best practices in order to prevent retained packed items.

With regard to retained pieces or fragments of items, facilities have a greater challenge. These items are often extremely small and often it is not immediately known to staff that the item has broken or split apart. Through its work in 2013, MDH will work with MHA to develop best practices to account for items being intact as well as staff education on all products that are used during procedures. As technology changes and instruments/products used in surgery and procedures continue to change, this effort will have to be ongoing.

PRESSURE ULCERS

The number of reported pressure ulcers decreased in 2012, falling from 141 to 130, which is an eight percent decline. Similar to last year, the majority of reported pressure ulcers were found on the coccyx or buttocks (36 percent), on the head, neck or face (26 percent), or on the sacrum (14 percent).

Contrary to other medical conditions that tend to occur more often in elderly patients, the reported pressure ulcers tend not to follow that pattern. In 2012, the age profile of patients with pressure ulcers was similar to previous years; 63 percent of reported pressure ulcers were in patients younger than 65 and only 18 percent were in patients 75 or older.

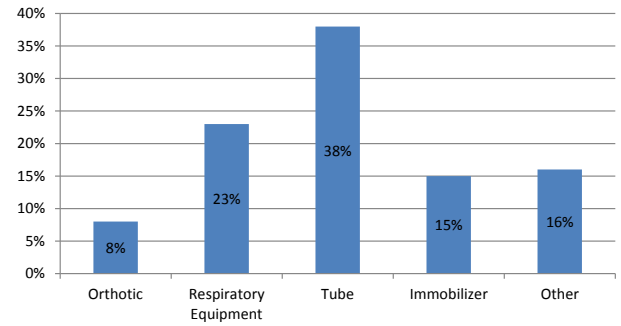
Key findings

Often, the root cause of patients developing pressure ulcers involves breakdowns in communication; this year is no exception. Nearly a third (29 percent) of root causes found with pressure ulcer events were due to a communication breakdown, usually due to the risk factors or skin inspection results not being communicated between shifts or staff members caring for the patient. The other leading root causes were risk factors or skin inspection results that were not documented properly, as well as policies and procedures that were not properly followed.

Over the course of the year, 30 percent of all reported pressure ulcers were found to be related to the use of medical devices; similar to past years of reporting. The devices that were most commonly linked with pressure ulcer formation were respiratory equipment and tubes (e.g. tracheostomy, endotracheal or feeding tubes) (Figure 10). Upon further review of the device-related pressure ulcers, there are some findings of note:

- There was a decrease in stage IV and unstageable pressure ulcers related to a device. This could suggest that these pressure ulcers are being identified sooner and therefore not progressing to stage IV or unstageable.
- There was a decrease in the number of patients with a pressure ulcer from immobilizers (from 15 last year to six this year) and from respiratory devices (from 15 to nine). This could stem from recommendations that were put out by MHA in 2011 around prevention of pressure ulcers under and around devices; such as respiratory equipment and cervical collars.
- There was an increase in patients with pressure ulcers from tubes, such as endotracheal tubes and feeding tubes, which identifies an opportunity for work in this area in the coming year.

FIGURE 10: DEVICES ASSOCIATED WITH PRESSURE ULCERS



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.

One of the most critical times for pressure ulcer development is if and when patients are in the intensive care unit (ICU). This has been a challenging area for many hospitals, as these patients are the most critically ill and many times cannot be repositioned as easily due to their tenuous condition. In addition to their immobility, many ICU patients are also on medications that can decrease their skin perfusion (the amount of blood that gets to the skin/tissues) as well. This year there was a seven percent decrease in patients who developed a pressure ulcer in the ICU, which could be a result of the spotlight that was placed on prevention of ICU pressure ulcers by MHA with the 'SAFE SKIN: ICU Campaign' in 2012.

While it is true that some of these patients cannot be readily turned or repositioned, this campaign provides best practices for hospitals around micro-shifts (small movements of the patient frequently to prevent ulcer development) and other ways that these patients can be kept moving to redistribute pressure. It has been shown through anecdotal data that these types of frequent, small shifts can prevent pressure ulcer development in the critically ill.

Patients may also get pressure ulcers in the operating room when they are undergoing a surgical/invasive procedure(s). In this reporting year, there was a significant decrease (13 percent) in the number of patients who had one or more surgeries prior to the development of a pressure ulcer. This is another area of focus within the SAFE SKIN campaign; prior to this campaign, few facilities were focusing on pressure ulcer prevention in the operating room.

Next steps

In 2011, MHA launched 'SAFE SKIN 2.0' with participation by 111 of Minnesota's 145 hospitals. As a part of this next level of the SAFE SKIN campaign, MHA hosted regional pressure ulcer prevention trainings in the spring of 2012. There were 77 organizations represented at the regional trainings, which focused on shifting the thinking around pressure ulcer prevention from performing an assessment and using a visual sign to identify that patient are at high risk for pressure ulcer development, to focusing on why that patient is at risk for a pressure ulcer and trying to mitigate that risk factor before it leads to skin breakdown. These trainings also highlighted ways to prevent pressure ulcers in the ICU and operating room.

In 2012, through a contract from the Center for Medicare and Medicaid Services (CMS) called Partnership for Patients, MHA has been working to develop a new high-tech training method for hospital staff on pressure ulcer prevention. It uses video gaming, simulation technology to teach staff about skin assessment, risk assessment and interventions in real-world scenarios. This technology will be available for use by hospitals in 2013.

SPOTLIGHT STORY

ST. CLOUD HOSPITAL NURSES USE CREATIVE ALTERNATIVES TO PREVENT IMMOBILE PATIENT FROM DEVELOPING PRESSURE ULCERS

Patients in the hospital are at risk of developing pressure ulcers, or bedsores, if their skin is exposed to long periods of unrelieved pressure. And for patients who are immobile, the risk is especially high. The injuries to the skin and underlying tissue are painful and increase risk for infection or other complications. Because of the critical thinking of staff at St. Cloud Hospital, a patient who spent 23 days in the hospital with severely limited mobility was able to avoid developing pressure ulcers.

St. Cloud Hospital follows a very specific standard of care to prevent patients from developing pressure ulcers, including performing a Braden Scale pressure ulcer risk assessment upon admission. When a 47-year-old female was admitted to the intensive care unit following a motor vehicle accident, her injuries were so severe that staff was unable to follow standard methods of pressure ulcer prevention. The patient had suffered a severe spinal cord injury resulting in impaired function below the chest. She was in spinal shock and had a closed-head injury, several lacerations, and fractures. The patient was intubated and sedated and was placed on dopamine to keep her blood pressure up. In addition to her immobility creating unrelieved pressure on her skin, the use of dopamine can increase the risk for skin perfusion issues.

After being seen by a neurosurgeon, the patient was placed in cervical traction to achieve optimal alignment of the spinal column and minimize additional damage to the spinal cord. The neurosurgeon wrote very specific orders that the patient was not to be repositioned. "Because of the patient's injuries, the nurses were prevented from delivering the normal care they were accustomed to in the ICU," said Aleen Roehl, director, Intensive Care Unit (ICU). In short, "she was a very complex patient whose severe injuries put her at huge risk for skin issues."

Understanding the extreme vulnerability of the patient, staff had to be creative to find alternative ways to relieve pressure on the skin. Rather than the standard repositioning every two hours, nurses performed microshifts, lifting the patient ever-so-slightly and rubbing her back and bony prominences every hour, and smoothing the sheets beneath her. They also elevated her heels and arms off the bed using pillows. The patient was flat on her back with no movement other than these microshifts for three days.

In total, the patient spent 23 days in the hospital, 15 of which were in the intensive care unit. Because of the extraordinary efforts of the nurses and staff, the patient had zero pressure ulcers. Their efforts earned them the Save our Skin Award from the Minnesota Hospital Association (MHA). When asked about the keys to their success, Roehl said it is important to get the wound ostomy and continence nurse (WOCN) involved right away to reinforce the care that is being given. "Their involvement brings higher awareness to the fact that the patient is at high risk," she said. It is also standard practice at St. Cloud Hospital to add the patient's specific interventions to the care plan so everyone can access it and know what the protocol is for the patient. Beyond that, St. Cloud Hospital has highly experienced ICU nurses whose background gave them many tools to address this situation appropriately. According to Roehl, this case demonstrates the importance of being highly aware of the risk for skin injury that happens after admission and reinforces how important the nurses' individual assessment and care is.

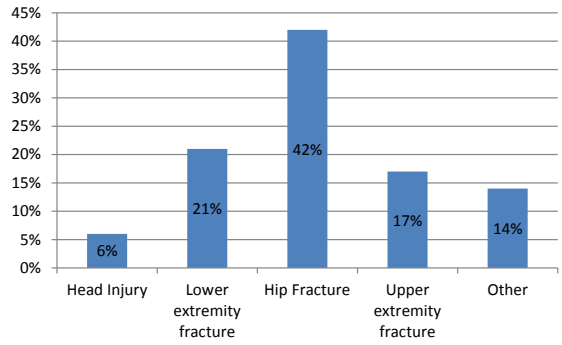
Roehl also believes that recognition for staff is critical. "What MHA is doing with recognizing a good outcome is very inspirational to staff. It reinforces the practice and responsibility for skin care more than anything else. No one expected follow up and recognition for doing their job, but when they were recognized it was very flattering," she said. "Our number one goal is to take care of patients and help them get out the hospital."

FALLS

In 2012, hospitals reported 79 falls, an increase of 11 percent from the previous year. Six patients died from injuries associated with their falls, also an increase from last year.

Overall, the most common serious injury sustained during a fall was a hip fracture (42 percent), with other upper or lower extremity fractures accounting for an additional 38 percent of injuries (Figure 11).

FIGURE 11: FALL INJURY TYPES

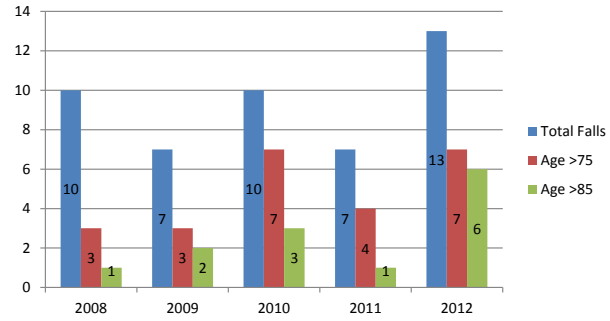


Key findings

Falls reported in 2012 show only slight change in terms of where and how they occur. In general, these patterns have been stable over the years. There are a few trends of note:

- Contrary to the previous year, the majority of patients that fell had been adequately assessed for fall risk. However, many falls are still related to breakdowns in the fall risk assessment communication process or the appropriateness of the chosen interventions; the fall risk was not adequately documented or communicated among team members or units, the risk reduction interventions weren't matched to the patient's individual risk factors or weren't consistently applied.
- Falls occurring in treatment settings for behavioral health nearly doubled this year (from seven last year to 13 this year). Of the falls occurring in the behavioral health setting, 54 percent were in patients age 75 and older and 46 percent were over the age of 85. Looking at data from 2008 to present, there is an increasing number of behavioral health falls in the elderly population (Figure 12). The data collected from these events shows this geriatric behavioral health population is often comprised of patients coping with a diagnosis of dementia and/or mental illness, a patient type that is at especially high risk for falls, and can have limitations in the effectiveness of patient education around fall prevention. This increase may be due to the aging population of patients who are seeking medical attention and is an opportunity for focused learning and education in the upcoming year.

FIGURE 12: BEHAVIORAL HEALTH FALLS, 2008–2012



- In nearly 60 percent of falls, a care team member had completed a rounding visit with the patient within 30 minutes prior to the fall, to check on pain, position and toileting needs, but the patient then got up on their own to use the toilet. This is an increase from the last reporting year, where only 40 percent of falls cases reported having a care team member complete a rounding visit within 30 minutes prior to the fall. It is a positive change that rounding is becoming a hardwired practice at facilities as this intervention has been found to be an important safety measure. However, even with diligent rounding falls can and still do occur.

Next steps

MHA's statewide 'SAFE from FALLS 2.0' campaign continued through 2012, with 119 hospitals continuing to work on this next phase. MHA hosted regional trainings on fall prevention during 2012 and brought in the nation's leading fall expert to discuss fall prevention, as well as fall injury prevention. Participants from over 80 hospital and surgical centers attended these trainings. MDH and its partners will continue to support facilities as they work to reduce falls. The focus in the upcoming year will be on linking risk assessment/injury assessment with individualized risk factors and proper interventions. The hope is that this will help to decrease overall falls and significantly decrease fall related injury.

MDH and its partners will work to develop tools and resources on preventing falls in behavioral health (specifically geriatric behavioral health). As has been noted in the data, falls in this area are increasing, signaling an opportunity for education.

In 2012, through The Center for Medicare and Medicaid Services (CMS) Partnership for Patients contract, the Minnesota Hospital Association has been working to develop a new high-tech training method for hospital staff on fall risk screening and assessment along with fall injury assessment and intervention. This technology will be available for use by hospitals in mid-late 2013.

SPOTLIGHT STORY

SAFE FROM FALLS 2.0 – PREVENTING INJURIES AND IMMOBILITY FROM FALLS

Falls are the most frequently reported adverse patient incident among adults in the inpatient setting[1]. Up to 51 percent of falls in hospitals result in some injury[2]. When the Centers for Medicare and Medicaid Services released the nine leading hospital adverse conditions for targeted reduction, they chose to focus on fall injury and associated immobility as primary outcomes, not the falls themselves. Injurious falls, especially those resulting in moderate to serious injury, can result in loss of function or loss of life. The interventions to protect patients from injury are separate and distinct from fall prevention.

The Minnesota Hospital Association's (MHA) Hospital Engagement Network is building upon a four-year track record of protecting patients from falls and injury[3]. While not all falls can be prevented, patients can be protected from moderate to serious injuries. Three essential steps to protect patients from injury are:

1. Assess patient's risk for injury and history of fall–related injury, particularly fractures;
2. Implement universal fall injury reduction strategies, such as eliminating sharp edges from patient rooms; utilizing protectors (floor mats, hip protectors, etc.) to reduce blunt force trauma when a patient falls; and
3. Bundle interventions specific to injury risk for vulnerable populations, taking into account age, risk for bone fracture, clotting disorders and whether the patient is post-surgical/ post-procedure, also known as ABCS:
   A = Age > 85 yrs
   B = Bones (risk for fracture)
   C = Anticoagulation or clotting disorder
   S = Post-surgical/procedure

Through organizational self-assessment and strategic planning, hospital teams are identifying opportunities to enhance and expand fall and injury prevention programs. Over time, MHA will monitor programs for such progress, and all hospitals will share through learning communities.

SMALL CHANGES HELP HUTCHINSON REDUCE FALLS

Hutchinson Area Health Care has made patient safety—and fall prevention—something that all staff are responsible for. Because of their efforts to better identify patients who are at risk for falling, and small changes that led to more time at the bedside for nurses, the hospital went 308 days without a patient fall. And although the hospital has since experienced a couple of falls, the number and severity are significantly reduced. Clinical Nurse Leader Dana Ratike credits their success to small changes, saying "We've been most successful by working on the small things first. It's important to know that it doesn't have to be a huge project. You can start small and the momentum builds."

Still, all hospitals need to analyze injury severity at the patient, unit and hospital level. Injury analysis by severity levels enables clinical and administrative staff to profile both vulnerability of their patients and effectiveness of patient safety programs. For example, if 70 percent of elderly patients who sustain lateral falls fracture their hips, one would suspect a large prevalence of osteoporosis. If one unit exceeds other units on their monthly fall rates and has higher injury rates, one would target that unit for evaluation and intervention. In addition to tracking injury and injury severity rates, another performance indicator is the number of days between major injuries. Increases in the length of time between major injuries are another indicator of the effectiveness of fall reduction programs.

— Pat Quigley, PhD, MPH, ARNP, CRRN, FAAN, FAANP, is the associate director of the VISN 8 Patient Safety Center of Inquiry at the James A. Haley Veterans' Hospital in Tampa, FL.

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[1] Currie, LM. (2008). Fall and Injury Prevention. In R. G. Hughes (Ed.), Patient Safety and Quality: An evidence-based handbook for nurses. AHRQ Publication No. 08-0043. http://www.ahrq.gov/qual/nurseshdbk/docs/CurrieL_FIP.pdf

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[3] Apold, J., & Quigley. P. (2012). Minnesota Hospital Association Statewide - Project: SAFE from FALLS, 2006-2010. Journal of Nursing Care Quality. 20(34). DOI: 10.1097/NCQ.0b013e3182599d1b.

SUICIDE/ATTEMPTED SUICIDE EVENTS

In 2012, there were four reported patient suicides or attempted suicides that resulted in serious disability or death. While these events are extremely rare, averaging two per year across the nine years that MDH has been collecting data, there are still some trends of note in the data. When looking at the patient population for these types of events, 83 percent of the patients who committed suicide or attempted suicide while in a healthcare facility were behavioral health patients. This means that they were actively being treated for a mental health/behavioral health issue. The majority of patients were being treated on a behavioral health unit; however, there were several cases where the patient also had a medical/surgical issue, and therefore was being treated on a different unit, such as a medical floor, as well as several cases where the event took place in the emergency department.

When looking deeper into the patient population that has attempted or committed suicide within a Minnesota healthcare facility, the data shows that at least 40 percent of these patients had previously attempted suicide one or more times. Therefore, many of these patients were on "suicide protocol" at the healthcare facility. As suicide protocols vary from facility to facility, it is difficult to draw conclusions about the effectiveness of any particular protocol. However, 63 percent of these patients were receiving checks from staff every 15 minutes or were on 1:1 status (one healthcare person was with the patient at all times). Reported suicides/attempted suicides most often involved hangings in the patient's room in the interval between frequent checks from nursing staff. This data shows that even with strict protocols and close observation in place, these events can still sometimes occur.

In 2007, MDH held a suicide prevention training conference. Due to the rise in patient suicides and attempted suicides, MDH will hold suicide prevention training in early 2013 and work with local suicide prevention experts to provide tools and resources to facilities for suicide prevention. In addition, MHA's Mental and Behavioral Health Task Force will continue to collaborate with MDH to address suicide and other adverse health events that impact patients with mental/behavioral health issues.

CONCLUSION

Improving patient safety at hospitals and ambulatory surgical centers in Minnesota has proven to be a continuous process focused on learning and accountability. The reporting system has shown to be an important learning tool to identify key issues from reported events, leading to the development of new best practices and statewide activity to implement those practices. This leads to new knowledge that can uncover new areas of reporting, learning, investigation and new standards of care.

This annual release of data on adverse health events is important, but it is crucial to remember that MDH and its partners are working throughout the year, continually looking at data and trends and providing timely recommendations, education and resources to facilities based on that data. Patient safety is not something only brought to the attention of facilities annually; facilities in Minnesota are working continuously to provide the highest quality, safest care possible each and every day.

Throughout this report, there are successes that are highlighted and should be celebrated, but the continued focus is on reducing and eliminating harm to patients in Minnesota. In particular, consistent and relentless focus is needed around reducing falls and eliminating fall injury, strengthening the time out process to eliminate wrong surgical/invasive procedure events and preventing suicides or attempted suicides in Minnesota healthcare facilities. As has been the case in all years of the reporting system, the issues are deeper than human error and are often system issues that take dedicated time, resources and consistent leadership to correct.

Over the course of the coming year, MDH and its partners will continue to encourage hospitals and surgical centers not only to apply technical solutions and best practices to patient safety problems, but to dig deeper into the heart of the issues, to the culture of the organization as a whole. The community standard in Minnesota needs to be one of ownership, one in which patient safety is top of mind for all staff, and leadership provides consistent encouragement for staff to speak up for patient safety, for every patient, every time.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2011 and October 6, 2012. For each facility, a table shows the number of events reported in each category and the level of severity of each event in terms of patient impact.

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW

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

SURGICAL/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.

TABLE 1: OVERALL STATEWIDE REPORT

Reported adverse health events: **ALL EVENTS** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
SURGICAL/INVASIVE PROCEDURE	84 Events	Serious Disability: 2 Death: 0 Neither: 82
PRODUCTS OR DEVICES	4 Events	Serious Disability: 2 Death: 2
PATIENT PROTECTION	6 Events	Serious Disability: 2 Death: 4
CARE MANAGEMENT	134 Events	Serious Disability: 5 Death: 1 Neither: 128
ENVIRONMENTAL	84 Events	Serious Disability: 77 Death: 7
CRIMINAL	2 Events	Serious Disability: 1 Death: 0 Neither: 1
TOTAL FOR ALL EVENTS	**314 Events**	**Serious Disability: 89** **Death: 14** **Neither: 211**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
1. WRONG BODY PART	27 Events	Serious Disability: 1 Death: 0 Neither: 26
2. WRONG PATIENT	0 Events	—
3. WRONG PROCEDURE	26 Events	Serious Disability: 1 Death: 0 Neither: 25
4. FOREIGN OBJECT	31 Events	Serious Disability: 0 Death: 0 Neither: 31
5. INTRA / POST-OP DEATH	0 Events	—
TOTAL FOR SURGICAL/INVASIVE PROCEDURE	**84 Events**	**Serious Disability: 2** **Death: 0** **Neither: 82**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	0 Events	—
7. MISUSE OR MALFUNCTION OF DEVICE	0 Events	—
8. INTRAVASCULAR AIR EMBOLISM	4 Events	Serious Disability: 2 Death: 2
TOTAL FOR PRODUCTS OR DEVICES	**4 Events**	**Serious Disability: 2** **Death: 2**

Details by Category: **PATIENT PROTECTION** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
9. WRONG DISCHARGE OF INFANT	0 Events	—
10. PATIENT DISAPPEARANCE	2 Events	Serious Disability: 0 Death: 2
11. SUICIDE OR ATTEMPTED SUICIDE	4 Events	Serious Disability: 2 Death: 2
TOTAL FOR PATIENT PROTECTION	**6 Events**	**Serious Disability: 2** **Death: 4**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
12. DEATH OR DISABILITY DUE TO MEDICATION ERROR	2 Events	Serious Disability: 2 Death: 0
13. DEATH OR DISABILITY DUE TO HEMOLYTIC REACTION	0 Events	—
14. DEATH OR DISABILITY DURING LOW-RISK PREGNANCY LABOR OR DELIVERY	0 Events	—
15. DEATH OR DISABILITY ASSOCIATED WITH HYPOGLYCEMIA	2 Events	Serious Disability: 1 Death: 1
16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPER-BILIRUBINEMIA	0 Events	—
17. STAGE 3, 4 OR UNSTAGEABLE PRESSURE ULCERS ACQUIRED AFTER ADMISSION	130 Events	Serious Disability: 2 Death: 0 Neither: 128
18. DEATH OR DISABILITY DUE TO SPINAL MANIPULATION	0 Events	—
19. ARTIFICIAL INSEMINATION WITH WRONG DONOR EGG OR SPERM	0 Events	—
TOTAL FOR CARE MANAGEMENT	**134 Events**	**Serious Disability: 5** **Death: 1** **Neither: 128**

Details by Category: **ENVIRONMENTAL** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
20. DEATH OR DISABILITY ASSOCIATED WITH AN ELECTRIC SHOCK	0 Events	—
21. WRONG GAS OR CONTAMINATION IN PATIENT GAS LINE	0 Events	—
22. DEATH OR DISABILITY ASSOCIATED WITH A BURN	3 Events	Serious Disability: 3 Death: 0
23. DEATH OR SERIOUS DISABILITY ASSOCIATED WITH A FALL	79 Events	Serious Disability: 73 Death: 6
24. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	2 Events	Serious Disability: 1 Death: 1
TOTAL FOR ENVIRONMENTAL	**84 Events**	**Serious Disability: 77** **Death: 7**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2011 – October 6, 2012)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
25. CARE ORDERED BY SOMEONE IMPERSONATING A PHYSICIAN, NURSE OR OTHER PROVIDER	0 Events	—
26. ABDUCTION OF PATIENT	0 Events	—
27. SEXUAL ASSAULT OF A PATIENT	1 Event	Serious Disability: 0 Death: 0 Neither: 1
28. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT	1 Event	Serious Disability: 1 Death: 0
TOTAL FOR CRIMINAL EVENTS	**2 Events**	**Serious Disability: 1** **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:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
644

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
133,834

NUMBER OF PATIENT DAYS:
244,669

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**5**	Deaths: 0;	Serious Disability: 1;	Neither: 4
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**13**	**Deaths: 0;**	**Serious Disability: 4;**	**Neither: 9**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.2

ASSOCIATED EYE CARE, L.L.C.

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

WEBSITE:
www.eyesee2020.com

PHONE NUMBER:
651-275-3113

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,637

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.3

AVERA MARSHALL REGIONAL MEDICAL CENTER

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

WEBSITE:
www.averamarshall.org

PHONE NUMBER:
507-537-9087

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
6,174

NUMBER OF PATIENT DAYS:
17,655

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.4

BETHESDA HOSPITAL

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

WEBSITE:
www.healtheast.org/patient-safety/reporting-adverse-health-events.html

PHONE NUMBER:
651-232-2184

NUMBER OF BEDS:
126

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
507

NUMBER OF PATIENT DAYS:
35,053

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**9**	Deaths: 0;	Serious Disability: 0;	Neither: 9
ENVIRONMENTAL EVENTS **Death or 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	**10**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 9**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.5

BUFFALO HOSPITAL

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-4986

NUMBER OF BEDS:
44

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
16,829

NUMBER OF PATIENT DAYS:
18,165

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
Use of or lack of restraints or bedrails 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.6

CAMBRIDGE MEDICAL CENTER

ADDRESS:
701 Dellwood St. S.
Cambridge, MN 55008-1920

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
72

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,442

NUMBER OF PATIENT DAYS:
33,695

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.7

CENTENNIAL LAKES SURGERY CENTER

ADDRESS:
7373 France Ave. S., Ste. 404
Edina, MN 55435

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,145

WEBSITE:
www.clsurgery.com

PHONE NUMBER:
952-832-9360

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.8

CENTRACARE HEALTH SYSTEM – LONG PRAIRIE

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

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-732-7210

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,724

NUMBER OF PATIENT DAYS:
6,037

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.9

CENTRACARE SURGERY CENTER – HEALTH PLAZA

ADDRESS:
1900 CentraCare Circle
Saint Cloud, MN 56303

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-229-4983

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,321

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.10

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA

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

WEBSITE:
www.childrensmn.org

PHONE NUMBER:
612-813-6615

NUMBER OF BEDS:
210

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
17,322

NUMBER OF PATIENT DAYS:
76,492

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**3**	Deaths: 0; Serious Disability: 0; Neither: 3
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0; Serious Disability: 0; Neither: 3**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.11

CHILDREN'S HOSPITALS AND CLINICS OF MINNESOTA, ST. PAUL

ADDRESS:
345 N. Smith Ave.
Saint Paul, MN 55102-2346

WEBSITE:
www.childrensmn.org

PHONE NUMBER:
612-813-6615

NUMBER OF BEDS:
138

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,600

NUMBER OF PATIENT DAYS:
50,092

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 0;**	**Neither: 3**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.12

COOK HOSPITAL & C&NC

ADDRESS:
10 Fifth St. S.E.
Cook, MN 55723-9702

WEBSITE:
www.cookhospital.org

PHONE NUMBER:
218-666-6220

NUMBER OF BEDS:
14

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,314

NUMBER OF PATIENT DAYS:
2,545

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.13

DISTRICT ONE HOSPITAL

ADDRESS:
200 State Ave.
Faribault, MN 55021-6345

WEBSITE:
www.districtonehospital.com

PHONE NUMBER:
507-332-4798

NUMBER OF BEDS:
42

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,510

NUMBER OF PATIENT DAYS:
20,021

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.14

DOUGLAS COUNTY HOSPITAL

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

WEBSITE:
www.dchospital.com

PHONE NUMBER:
320-762-6194

NUMBER OF BEDS:
91

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
24,399

NUMBER OF PATIENT DAYS:
30,428

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.15

ESSENTIA HEALTH DULUTH

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-4154

NUMBER OF BEDS:
154

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
17,345

NUMBER OF PATIENT DAYS:
95,886

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
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 or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.16

ESSENTIA HEALTH ST. JOSEPH'S MEDICAL CENTER

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-828-7650

NUMBER OF BEDS:
162

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
25,417

NUMBER OF PATIENT DAYS:
51,192

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.17

ESSENTIA HEALTH ST. MARY'S HOSPITAL – DETROIT LAKES

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-847-0819

NUMBER OF BEDS:
41

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
12,831

NUMBER OF PATIENT DAYS:
19,301

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
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 or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.18

ESSENTIA HEALTH ST. MARY'S MEDICAL CENTER

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-786-4154

NUMBER OF BEDS:
316

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
67,752

NUMBER OF PATIENT DAYS:
107,797

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 1;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 1;**	**Serious Disability: 2;**	**Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.19

FAIRVIEW LAKES MEDICAL CENTER

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

WEBSITE:
www.fairview.org

PHONE NUMBER:
612-672-4164

NUMBER OF BEDS:
58

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
30,933

NUMBER OF PATIENT DAYS:
34,038

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
PATIENT PROTECTION EVENTS		
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 1; Serious Disability: 0; Neither: 0
ENVIRONMENTAL EVENTS **Death or serious disability 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: 2; Serious Disability: 0; Neither: 0**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.20

FAIRVIEW NORTHLAND MEDICAL CENTER

ADDRESS:
911 Northland Drive
Princeton, MN 55371-2172

WEBSITE:
www.fairview.org/hospitals/northland

PHONE NUMBER:
763-389-6451

NUMBER OF BEDS:
40

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
18,424

NUMBER OF PATIENT DAYS:
19,036

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/Other invasive procedure performed on wrong body part	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
Wrong surgical/invasive 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.21

FAIRVIEW RIDGES HOSPITAL

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

WEBSITE:
www.fairview.org

PHONE NUMBER:
612-672-7061

NUMBER OF BEDS:
143

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
60,136

NUMBER OF PATIENT DAYS:
64,864

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or 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: 4;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.22

FAIRVIEW SOUTHDALE HOSPITAL

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

WEBSITE:
www.fairview.org/hospitals/southdale/index.htm

PHONE NUMBER:
612-672-7061

NUMBER OF BEDS:
309

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
104,053

NUMBER OF PATIENT DAYS:
123,343

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0;**	**Serious Disability: 4;**	**Neither: 7**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.23

FIRSTLIGHT HEALTH SYSTEM

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

WEBSITE:
www.firstlighthealthsystem.org

PHONE NUMBER:
320-225-3328

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
9,937

NUMBER OF PATIENT DAYS:
14,720

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.24

GLENCOE REGIONAL HEALTH SERVICES

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

WEBSITE:
www.grhsonline.org

PHONE NUMBER:
320-864-3121

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,370

NUMBER OF PATIENT DAYS:
10,680

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.25

HENNEPIN COUNTY MEDICAL CENTER

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

WEBSITE:
www.hcmc.org

PHONE NUMBER:
612-873-3337

NUMBER OF BEDS:
450

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
93,437

NUMBER OF PATIENT DAYS:
188,513

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**20**	Deaths: 0;	Serious Disability: 0;	Neither: 20
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
PATIENT PROTECTION EVENTS				
Patient death or serious disability associated with patient disappearance	**2**	Deaths: 2;	Serious Disability: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**26**	**Deaths: 2;**	**Serious Disability: 1;**	**Neither: 23**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.26

HUTCHINSON AREA HEALTH CARE

ADDRESS:
1095 Highway 15 S.
Hutchinson, MN 55350-5000

WEBSITE:
www.hutchinsonhealthcare.com

PHONE NUMBER:
320-484-4526

NUMBER OF BEDS:
57

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,989

NUMBER OF PATIENT DAYS:
24,770

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.27

LAKEVIEW HOSPITAL

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

WEBSITE:
www.lakeviewhospital.org

PHONE NUMBER:
651-430-4503

NUMBER OF BEDS:
68

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,361

NUMBER OF PATIENT DAYS:
29,249

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.28

LAKEWALK SURGERY CENTER INC

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

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
9,498

WEBSITE:
www.lakewalksurgerycenter.com

PHONE NUMBER:
218-728-8505

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.29

LAKEWOOD HEALTH SYSTEM

ADDRESS:
49725 County 83
Staples, MN 56479-5280

WEBSITE:
www.lakewoodhealthsystem.com

PHONE NUMBER:
218-894-8429

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,428

NUMBER OF PATIENT DAYS:
23,108

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.30

LANDMARK SURGERY CENTER

ADDRESS:
17 W. Exchange St., Ste. 310
Saint Paul, MN 55102-1223

WEBSITE:
www.summitortho.com

PHONE NUMBER:
651-261-1717

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,595

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.31

MAPLE GROVE HOSPITAL

ADDRESS:
9875 Hospital Drive
Maple Grove, MN 55369-4648

WEBSITE:
www.maplegrovehospital.org

PHONE NUMBER:
763-581-1563

NUMBER OF BEDS:
84

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
17,249

NUMBER OF PATIENT DAYS:
25,598

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 1;	Serious Disability: 1;	Neither: 0
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/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**4**	**Deaths: 1;**	**Serious Disability: 1;**	**Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.32

MAYO CLINIC HEALTH SYSTEM IN AUSTIN

ADDRESS:
1000 1st Drive NW
Austin MN 55912-2941

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-434-1706

NUMBER OF BEDS:
81

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
12,673

NUMBER OF PATIENT DAYS:
40,779

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.33

MAYO CLINIC HEALTH SYSTEM IN FAIRMONT

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

WEBSITE:
www.mayoclinichealthsystem.org/locations/fairmont

PHONE NUMBER:
507-238-8101

NUMBER OF BEDS:
56

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
6,957

NUMBER OF PATIENT DAYS:
28,313

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
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	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.34

MAYO CLINIC HEALTH SYSTEM IN MANKATO

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

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
507-385-2938

NUMBER OF BEDS:
184

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
34,053

NUMBER OF PATIENT DAYS:
65,901

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 1;	Serious Disability: 2;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 1;**	**Serious Disability: 2;**	**Neither: 3**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.35

MAYO CLINIC HEALTH SYSTEM IN NEW PRAGUE

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

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
952-758-8101

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,010

NUMBER OF PATIENT DAYS:
9,934

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.36

MAYO CLINIC HEALTH SYSTEM IN RED WING

ADDRESS:
701 Fairview Blvd. P.O. Box 95
Red Wing, MN 55066-0095

WEBSITE:
www.mayoclinichealthsystem.org

PHONE NUMBER:
651-345-1176

NUMBER OF BEDS:
50

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
11,424

NUMBER OF PATIENT DAYS:
24,183

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A burn received 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.37

MAYO CLINIC – METHODIST HOSPITAL

ADDRESS:
201 West Center Street
Rochester, MN 55902-3003

WEBSITE:
www.mayoclinic.org/event-reporting

PHONE NUMBER:
507-284-5005

NUMBER OF BEDS:
307

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
159,325

NUMBER OF PATIENT DAYS:
143,922

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**10**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 7**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.38

MAYO CLINIC – 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:
861

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
128,384

NUMBER OF PATIENT DAYS:
299,131

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**18**	Deaths: 0;	Serious Disability: 0;	Neither: 18
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**2**	Deaths: 1;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**28**	**Deaths: 1;**	**Serious Disability: 4;**	**Neither: 23**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.39

MEEKER MEMORIAL HOSPITAL

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

WEBSITE:
www.meekermemorial.org

PHONE NUMBER:
320-693-4573

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
6,236

NUMBER OF PATIENT DAYS:
13,420

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.40

MERCY HOSPITAL

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-775-9762

NUMBER OF BEDS:
251

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
77,946

NUMBER OF PATIENT DAYS:
120,893

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
A burn received 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: 2;**	**Neither: 2**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.41

MILLE LACS HEALTH SYSTEM

ADDRESS:
200 Elm St. N. P.O. Box A
Onamia, MN 56359-7901

WEBSITE:
www.mlhealth.org

PHONE NUMBER:
320-532-3154

NUMBER OF BEDS:
28

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,778

NUMBER OF PATIENT DAYS:
18,983

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.42

MINNESOTA SURGERY CENTERS (EDINA, MAPLE GROVE)

ADDRESS:
7400 France Ave., Ste. 102
Edina, MN 55435

WEBSITE:
www.painphysicians.com

PHONE NUMBER:
763-537-6000 ext. 156

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
6,099

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.43

NEW RIVER MEDICAL CENTER

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

WEBSITE:
www.newrivermedical.com

PHONE NUMBER:
763-271-2385

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
13,688

NUMBER OF PATIENT DAYS:
20,634

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A burn received 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.44

NEW ULM MEDICAL CENTER

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

WEBSITE:
www.newulmmedicalcenter.com

PHONE NUMBER:
507-217-5209

NUMBER OF BEDS:
35

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
15,496

NUMBER OF PATIENT DAYS:
31,195

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Wrong surgical/invasive 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.45

NORTH MEMORIAL MEDICAL CENTER

ADDRESS:
3300 Oakdale Ave. N.
Robbinsdale, MN 55422-2926

WEBSITE:
www.northmemorial.com

PHONE NUMBER:
763-581-4645

NUMBER OF BEDS:
407

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
79,471

NUMBER OF PATIENT DAYS:
142,551

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**8**	Deaths: 0;	Serious Disability: 0;	Neither: 8
Hypoglycemia	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
ENVIRONMENTAL EVENTS **Death or 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	**14**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 12**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.46

OLMSTED MEDICAL CENTER

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

WEBSITE:
www.olmmed.org

PHONE NUMBER:
507-292-7203

NUMBER OF BEDS:
38

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
16,589

NUMBER OF PATIENT DAYS:
29,797

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.47

OWATONNA HOSPITAL

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-4986

NUMBER OF BEDS:
43

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
14,555

NUMBER OF PATIENT DAYS:
19,371

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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**		
A fall while being cared for in a facility	**1**	Deaths: 0; Serious Disability: 1; Neither: 0
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	**2**	**Deaths: 0; Serious Disability: 1; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.48

PARK NICOLLET METHODIST HOSPITAL

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

WEBSITE:
www.parknicollet.com

PHONE NUMBER:
952-993-6057

NUMBER OF BEDS:
426

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
109,086

NUMBER OF PATIENT DAYS:
154,654

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**6**	Deaths: 0;	Serious Disability: 0;	Neither: 6
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**8**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 7**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.49

PERHAM HEALTH

ADDRESS:
1000 Coney St. W.
Perham, MN 56573-2102

WEBSITE:
www.perhamhealth.org

PHONE NUMBER:
218-347-1304

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,912

NUMBER OF PATIENT DAYS:
7,196

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or serious disability 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.50

PIPESTONE COUNTY MEDICAL CENTER

ADDRESS:
916 Fourth Ave. S.W.
Pipestone, MN 56164-1890

WEBSITE:
www.pcmchealth.org

PHONE NUMBER:
507-825-6270

NUMBER OF BEDS:
44

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
5,145

NUMBER OF PATIENT DAYS:
6,236

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.51

RANGE REGIONAL HEALTH SERVICES

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

WEBSITE:
www.fairview.org

PHONE NUMBER:
612-672-7061

NUMBER OF BEDS:
81

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,198

NUMBER OF PATIENT DAYS:
42,523

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.52

RC HOSPITAL & CLINICS

ADDRESS:
611 E. Fairview
Olivia, MN 56277-4213

WEBSITE:
www.rchospital.com

PHONE NUMBER:
320-523-3447

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,637

NUMBER OF PATIENT DAYS:
4,890

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.53

REGINA MEDICAL CENTER

ADDRESS:
1175 Nininger Road
Hastings, MN 55033-1056

WEBSITE:
www.reginamedical.org

PHONE NUMBER:
651-480-6890

NUMBER OF BEDS:
39

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
12,975

NUMBER OF PATIENT DAYS:
13,229

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or 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: 0;**	**Serious Disability: 2;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.54

REGIONS HOSPITAL

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

WEBSITE:
www.regionshospital.com

PHONE NUMBER:
651-254-2475

NUMBER OF BEDS:
454

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
129,295

NUMBER OF PATIENT DAYS:
192,030

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**12**	Deaths: 0;	Serious Disability: 0;	Neither: 12
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**5**	Deaths: 0;	Serious Disability: 5;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
An intravascular air embolism	**1**	Deaths: 1;	Serious Disability: 0;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**22**	**Deaths: 1;**	**Serious Disability: 5;**	**Neither: 16**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.55

SANFORD BEMIDJI MEDICAL CENTER

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

WEBSITE:
www.bemidji.sanfordhealth.org

PHONE NUMBER:
218-333-5540

NUMBER OF BEDS:
118

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
26,574

NUMBER OF PATIENT DAYS:
38,419

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.56

SANFORD LUVERNE MEDICAL CENTER

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

WEBSITE:
www.sanfordluverne.org

PHONE NUMBER:
507-449-1298

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
4,621

NUMBER OF PATIENT DAYS:
7,100

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.57

SANFORD MEDICAL CENTER CANBY

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

WEBSITE:
www.sanfordcanby.org

PHONE NUMBER:
507-223-7277 ext. 259

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
2,314

NUMBER OF PATIENT DAYS:
4,025

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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.58

SANFORD WORTHINGTON

ADDRESS:
1018 Sixth Ave. P.O. Box 997
Worthington, MN 56187-2298

WEBSITE:
www.sanfordworthington.org

PHONE NUMBER:
507-372-3272

NUMBER OF BEDS:
48

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
8,164

NUMBER OF PATIENT DAYS:
11,462

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0; Serious 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.59

SLEEPY EYE MEDICAL CENTER

ADDRESS:
400 Fourth Ave. N.W. P.O. Box 323
Sleepy Eye, MN 56085-0323

WEBSITE:
www.semedicalcenter.org

PHONE NUMBER:
507-794-8440

NUMBER OF BEDS:
17

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,304

NUMBER OF PATIENT DAYS:
4,223

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.60

ST. CLOUD HOSPITAL

ADDRESS:
1406 Sixth Ave. N.
St. Cloud, MN 56303-1900

WEBSITE:
www.centracare.com

PHONE NUMBER:
320-229-4983

NUMBER OF BEDS:
444

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
93,139

NUMBER OF PATIENT DAYS:
185,435

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**6**	Deaths: 0;	Serious Disability: 0;	Neither: 6
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**3**	Deaths: 0;	Serious Disability: 3;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 8**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.61

ST. FRANCIS REGIONAL MEDICAL CENTER

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
86

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
27,463

NUMBER OF PATIENT DAYS:
36,317

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.62

ST. JOHN'S HOSPITAL

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

WEBSITE:
www.healtheast.org

PHONE NUMBER:
651-232-7122

NUMBER OF BEDS:
184

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
70,028

NUMBER OF PATIENT DAYS:
82,094

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
CRIMINAL EVENTS				
Death or significant injury of patient or staff from physical assault	**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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.63

ST. JOSEPH'S AREA HEALTH SERVICES INC.

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

WEBSITE:
www.sjahs.org

PHONE NUMBER:
218-237-5507

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
11,152

NUMBER OF PATIENT DAYS:
13,748

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
ENVIRONMENTAL EVENTS **Death or 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: 0;**	**Serious Disability: 2;**	**Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.64

ST. JOSEPH'S HOSPITAL

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

WEBSITE:
www.healtheast.org/patientsafety

PHONE NUMBER:
651-232-3122

NUMBER OF BEDS:
239

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
37,129

NUMBER OF PATIENT DAYS:
91,429

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Wrong surgical/invasive procedure performed	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**Serious Disability: 0;**	**Neither: 3**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.65

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:
49,812

NUMBER OF PATIENT DAYS:
85,154

HOW 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, 2011-OCTOBER 6, 2012)

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

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.66

STEVENS COMMUNITY MEDICAL CENTER

ADDRESS:
P.O. Box 660
Morris, MN 56267-0660

WEBSITE:
www.scmcinc.org

PHONE NUMBER:
320-589-7647

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,643

NUMBER OF PATIENT DAYS:
12,778

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.67

SWIFT COUNTY – BENSON HOSPITAL

ADDRESS:
1815 Wisconsin Ave.
Benson, MN 56215-1653

WEBSITE:
www.scbh.org

PHONE NUMBER:
320-843-1328

NUMBER OF BEDS:
18

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
1,846

NUMBER OF PATIENT DAYS:
3,665

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.68

TRIA ORTHOPAEDIC CENTER

ADDRESS:
8100 Northland Drive
Bloomington, MN 55431-4800

WEBSITE:
www.tria.com

PHONE NUMBER:
952-806-5321

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,518

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
A medication error	**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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.69

TRI-COUNTY HEALTH CARE

ADDRESS:
415 Jefferson St. N.
Wadena, MN 56482-1264

WEBSITE:
www.tricountyhospital.org

PHONE NUMBER:
218-631-7481

NUMBER OF BEDS:
25

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
7,372

NUMBER OF PATIENT DAYS:
15,259

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.70

UNITED HOSPITAL

ADDRESS:
333 N. Smith Ave.
Saint Paul, MN 55102-2344

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
462

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
92,620

NUMBER OF PATIENT DAYS:
162,051

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in serious disability	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**6**	Deaths: 0;	Serious Disability: 0;	Neither: 6
TOTAL EVENTS FOR THIS FACILITY	**8**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 7**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.71

UNITY HOSPITAL

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

WEBSITE:
www.allinahealth.org

PHONE NUMBER:
612-262-0605

NUMBER OF BEDS:
213

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
41,618

NUMBER OF PATIENT DAYS:
75,991

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.72

UNIVERSITY OF MINNESOTA MEDICAL CENTER, FAIRVIEW

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

WEBSITE:
www.uofmmedicalcenter.org

PHONE NUMBER:
612-273-3000

NUMBER OF BEDS:
731

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
171,726

NUMBER OF PATIENT DAYS:
311,298

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME		
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	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
PATIENT PROTECTION EVENTS				
Patient suicide or attempted suicide resulting in serious disability	**2**	Deaths: 1;	Serious Disability: 1;	Neither: 0
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**16**	Deaths: 0;	Serious Disability: 0;	Neither: 16
Hypoglycemia	**1**	Deaths: 1;	Serious Disability: 0;	Neither: 0
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**7**	Deaths: 0;	Serious Disability: 7;	Neither: 0
Use of or lack of restraints or bedrails while being cared for in a facility	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
CRIMINAL EVENTS				
Sexual assault on a patient	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**35**	**Deaths: 2;**	**Serious Disability: 9;**	**Neither: 24**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.73

VIRGINIA REGIONAL MEDICAL CENTER

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

WEBSITE:
www.essentiahealth.org

PHONE NUMBER:
218-749-9450

NUMBER OF BEDS:
83

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
3,684

NUMBER OF PATIENT DAYS:
9,939

HOW 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
ENVIRONMENTAL EVENTS **Death or serious disability 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 includes endoscopies, regional anesthetic blocks, and other invasive procedures, which are included as part of the definition of "surgery" in the Adverse Health Events Reporting Law.

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.74

WINONA HEALTH SERVICES

ADDRESS:
855 Mankato Ave. P.O. Box 5600
Winona, MN 55987-0600

WEBSITE:
www.winonahealth.org

PHONE NUMBER:
507-457-4157

NUMBER OF BEDS:
53

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
20,295

NUMBER OF PATIENT DAYS:
35,401

HOW TO READ THESE TABLES:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2011-OCTOBER 6, 2012)

CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious Disability: 0; Neither: 1**

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

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.75

WOODWINDS HEALTH CAMPUS

ADDRESS:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

WEBSITE:
www.healtheast.org/patientsafety

PHONE NUMBER:
651-232-6880

NUMBER OF BEDS:
86

NUMBER OF SURGERIES/INVASIVE PROCEDURES PERFORMED:
30,151

NUMBER OF PATIENT DAYS:
38,707

HOW 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, 2011-OCTOBER 6, 2012)

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

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

APPENDIX A:
BACKGROUND ON MINNESOTA'S ADVERSE HEALTH EVENTS REPORTING LAW

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 serious reportable events identified by the National Quality Forum and a public report that identified adverse events by facility. The law covers Minnesota hospitals and licensed outpatient surgical centers.

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

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

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

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

In 2007, the Adverse Health Care Events Reporting Law was modified to include a 28th event and to expand the definitions of certain other events. The most significant change was an expansion of reportable falls to include those associated with a serious disability in addition to those associated with a death. At the same time, the pressure ulcer category was expanded to include 'unstageable' pressure ulcers.

APPENDIX B:
REPORTABLE EVENTS AS DEFINED IN THE LAW

Below are the events that must be reported under the law. This language is taken directly from Minnesota Statutes 144.7065. Current statutory language is available on the MDH website at **www.health.state.mn.us/patientsafety**.

Surgical Events[1]

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

2. Surgery performed on the wrong patient;

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

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

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

Product or Device Events

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.

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

Care Management Events

1. Patient death or serious 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 (includes unstageable ulcers);
7. Patient death or serious disability due to spinal manipulative therapy; and.
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.

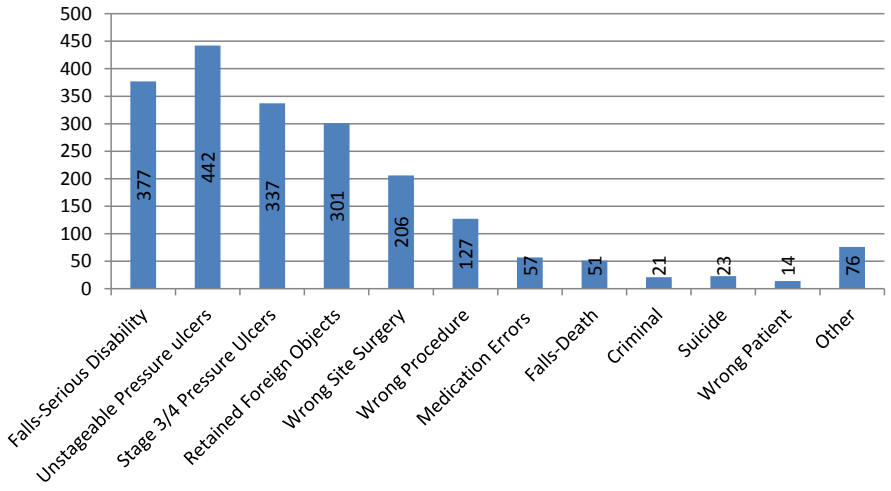
Criminal Events

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.

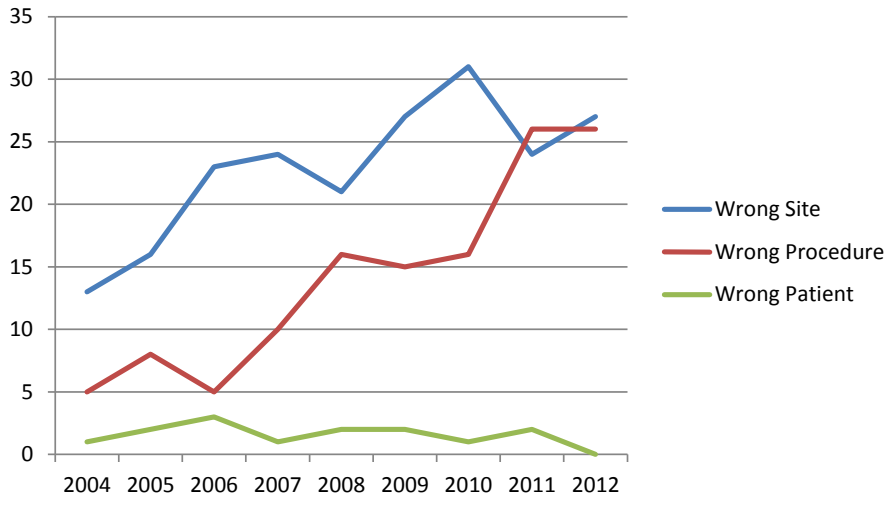
APPENDIX C:
ADVERSE EVENTS DATA, 2003-2012

Hospitals began reporting adverse health events data to the Minnesota Department of Health in 2003, with ambulatory surgical centers joining the list of required reporting facilities in December, 2004. Since that time, a total of 2,030 events have been reported to MDH.

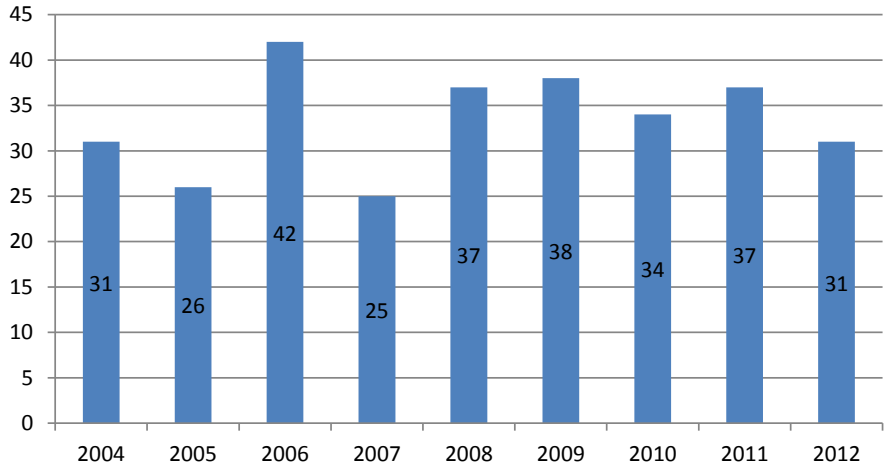
REPORTED ADVERSE EVENTS, 2003 – 2012



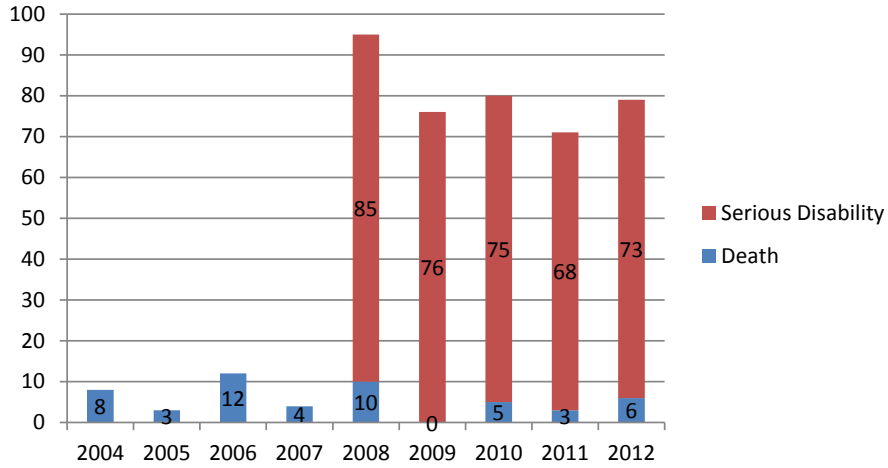
REPORTED SURGICAL EVENTS, 2003 – 2012



REPORTED RETAINED FOREIGN OBJECTS, 2003 – 2012

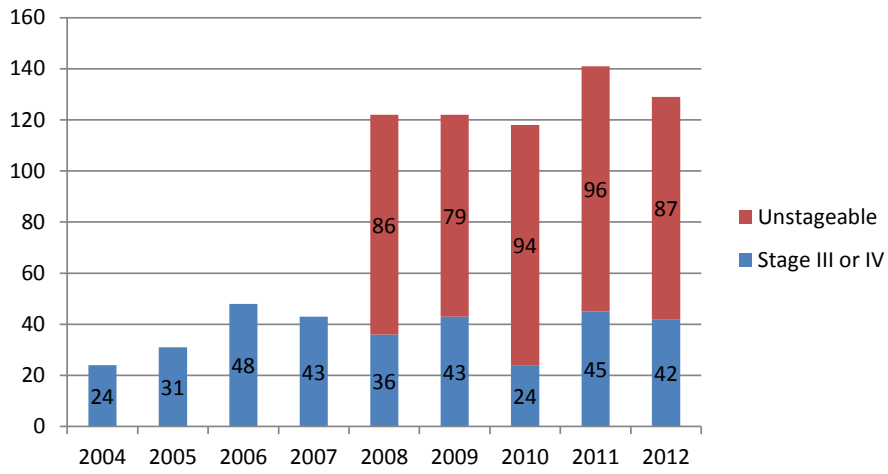


REPORTED FALLS, 2003 – 2012



*Note, prior to 2008, facilities were only reporting falls that resulted in patient death. In 2008, the law was expanded to include falls resulting in serious disability as well.

REPORTED PRESSURE ULCERS, 2003 – 2012



*Note, prior to 2008, facilities were only reporting "stage III and IV" pressure ulcers. In 2008, the law was expanded to include "unstageable" pressure ulcers.

APPENDIX D:
SAFETY ALERT: IMPLANT VERIFICATION SAFETY ALERT

Minnesota Patient Safety Alert

May 11, 2012

Implant Verification

Background

Close to 40% of wrong surgeries/procedures reported under the Minnesota Adverse Event Reporting Law last year (October 7, 2010-October 6, 2011) were related to wrong implants.

Review of reported wrong procedure events involving implants indicated issues with verification of the correct implant at each step of the process including:

- Scheduling
- Requesting the implant(s)
- Pulling the implant(s) prior to case
- Team Briefing
- Pre-procedure verification
- Time Out
- Selecting implant(s) from case cart

In January of 2007, a Minnesota Safety Alert was issued related to preventing wrong eye/wrong lens procedures: http://www.mnhospitals.org/inc/data/pdfs/Alert_Advisory_1-9-07.pdf.

The Minnesota Department of Health and Minnesota Hospital Association have reviewed: 1) the root cause analyses from wrong procedure events occurring this past year involving implants; and 2) national and local best practices to develop a set of recommendations for implant verification. The recommendations include verifications steps for:

1. Intraocular implants (IOL)
2. Other implants — when implant is known prior to the case
3. Other implants — when implant is not known prior to the case, e.g. hip or knee replacements.

The resulting recommendations are outlined beginning on page two of this safety alert.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393 or Rachel Jokela, Adverse Health Event Program Director, MN Department of Health, Rachel.Jokela@state.mn.us or (651) 201-5807.

Implant Verification Recommendations

May 11, 2012

These recommendations are intended to provide guidance to improve the consistency of implant verification practices across Minnesota hospitals and ambulatory surgical centers and address issues identified through the reporting of wrong procedures related to incorrect implants. The recommendations are not intended to address all implant related clinical and regulatory requirements.

Implants — Intraocular lens (IOL)

Verification of correct intraocular lens placement (IOL)

- The facility has a process in place to require ordering providers to submit IOL requests in writing.
- IOL requests must be received prior to case prep, at minimum, for the case to proceed.
- IOL requests include, at a minimum, the following key IOL information:
    - Date of surgery
    - Patient
    - Surgeon
    - Right vs. Left
    - Posterior vs. anterior
    - Model #
    - Diopter

- If the facility does not receive a written IOL request prior to case prep (ideally received earlier in the process) with completed key IOL information, the case does not move forward.

- If the surgeon selects the IOL for the case from the supply area, the written request including the key IOL information still needs to be completed by the surgeon prior to case prep.

- A process is in place to verify the correct lens at the following times, at minimum:
    - Selection of IOL implants for case from supply area
        - Verification: Verify correct lens against source documents such as the implant request form, patient's medical record, surgical notes.
    - Pre-operative team briefing
        - Verification: Verify implant is available for case.
    - Time Out process
        - Verification: Verify implant is available in the room for case.
    - Opening the implant to the sterile field.
        - Verification: 1) confirm the implant packaging against source documents, such as the implant request form; 2) read aloud the implant information from the packaging; and 3) show the packaging information to the surgeon.

- The source documents, such as the implant request form, and selected implant are kept together after selection of the IOL for the case.

- The facility requires that only one lens (per operative eye) per case is in the procedure room. If the surgeon requests more than one option, as soon as a decision is made on the correct lens for the case, the second lens is placed out of sight in a pre-designated area.

Implants — If implant is known prior to procedure (non-IOL procedures)

- The facility has a process in place to require ordering providers to submit implant requests in writing.

- Implant requests include, at a minimum, the following key information:
  - Date of surgery
  - Patient
  - Surgeon
  - Implant and specifications the facility will need to order or pull the implant for the case
  - Right vs. Left, if applicable
  - For breast implants: Saline vs. Silicone

- If the facility does not receive a written implant request prior to case prep (ideally received earlier in the process) with completed key information, the case does not move forward.

- A process is in place to verify the correct implant at the following times, at minimum:
  - Selection of implants for case from supply area, if applicable
    - Verification: Verify correct implant against source documents such as the implant request form, patient's medical record, surgical notes.
  - Pre-operative team briefing
    - Verification: Verify implant is available for case.
  - Time Out process
    - Verification: Verify implant is available in room for case.
  - Opening the implant to the sterile field.
    - Verification: 1) confirm the implant packaging against source documents, such as the implant request form; 2) read aloud the implant information from the packaging, including laterality if applicable; and 3) show the packaging information to the surgeon.

- The facility requires that only the implant needed for the case is in the procedure room. If the surgeon requests more than one option, as soon as a decision is made on the correct implant for the case, additional implants are placed out of sight in a pre-designated area.

- The facility has developed an orientation for vendors involved in selecting implants for procedures which includes expectations for the vendor's role in implant verification.

- The facility requires that vendors complete orientation prior to handling implants prior to, or during, a case.

- If a vendor selects the implant for the case, the implant is handed off to a member of the procedure team who completes verification of the implant against source documents.

- The vendor does not introduce the implant to the sterile field.

Implants — If correct implant is not known prior to procedure (e.g., need to trial multiple knee components during procedure prior to final implant selection):

- The facility has a process in place to require ordering providers to submit implant requests in writing.
- Implant requests include, at a minimum, the following key information:
  - Date of surgery
  - Patient
  - Surgeon
  - Right vs. Left, if applicable
  - Which implant options to have available
- If the facility does not receive a written implant request prior to case prep (ideally received earlier in the process) with completed key information, the case does not move forward.
- A process is in place to verify the correct implant at the following times, at minimum:
  - Selection of implants for case from supply area, if applicable
    - Verification: Verify correct implant against source documents such as the implant request form, patient's medical record, surgical notes.
  - Pre-operative team briefing
    - Verification: Verify implant is available for case.
  - Time Out process
    - Verification: Verify implant is available in room for case.
  - Selection of implant from case cart, if applicable
    - Verification: Verify correct implant against source documents such as the implant request form.
  - Opening the implant to the sterile field.
    - Verification: 1) confirm the implant packaging against source documents, such as the implant request form; 2) read aloud the implant information from the packaging, including laterality if applicable; and 3) show the packaging information to the surgeon.
- If cart is in procedure room with multiple implants, ideally only the cart with the correct side implants (L vs. R) is in the room. If carts are not able to be separated (L vs. R) due to storage or other issues, left and right components are clearly separated and labeled on the cart.
- The facility has developed an orientation for vendors involved in selecting implants for procedures which includes expectations for the vendor's role in implant verification.
- The facility requires that vendors complete orientation prior to handling implants prior to, or during, a case.
- If a vendor selects the implant for the case, the implant is handed off to a member of the procedure team who completes verification of the implant against source documents.
- The vendor does not introduce the implant to the sterile field.

APPENDIX E:
SAFETY ALERT: GYNECOLOGICAL PROCEDURE SAFETY ALERT

Minnesota Hospital Association

MINNESOTA MDH DEPARTMENT OF HEALTH

Patient Safety Registry

Minnesota Patient Safety Alert

July 24, 2012

Accounting for objects used during gynecological procedures performed in the operating room

Background

The Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH) reviewed data from the adverse health event reporting system and have identified a cluster of foreign objects being retained following gynecological (GYN) procedures performed in the operating room.

Since 2010, over a quarter (27%) of retained foreign objects have been related to GYN procedures performed in the operating room. The majority (40%) of the objects were retained following hysterectomy procedures; 20% were related to suburetheral sling procedures.

Vaginal packing was the most common (53%) item retained. Other items retained included: sponges; KOH ring instrument and balloon; plastic centering tab; and ultrasound transducer protective sleeve.

Findings from root cause analyses indicate that the most common (73%) reasons for the retention were issues related to communicating the presence of packed items to the next level of care and accounting for items being intact when removed or after use.

Recommendation

Packed Items

MHA and MDH recommend that facilities revisit their policies and processes to address the issue of ensuring items that are used for packing are removed as intended, with special attention to packing used in GYN procedures. The following recommendations should be considered in developing processes within your organization:

- The physician/provider placing packed item communicates the presence of packed item(s) to the team when placed;
- Any item placed, and its location, is documented in a manner that it can be accounted for at the end of the case (e.g., note in patient's chart, flag in EMR);
- There is a clear process for accounting for packed items at the end of the case;
- An order is written by the physician for packing removal, indicating when the packing should be removed;

- Order/instructions for removal includes: type and location of packed item(s) and instructions, including timing, if known, for removal;
- Orders/instructions for removal of packed items are made available to staff responsible for removal (e.g. readily accessible to staff in EMR);
- The presence of packed materials is communicated during hand-off to post-procedure staff;
- A standardized process and clear accountability is in place for removal of the item post-procedure. For example: A flag is placed in the medical record, visible across departments, that is present until the packing is removed;
- Person responsible for removal of packed item(s) removes the item(s)s and documents removal.

Accounting for Items Being Intact

MHA and MDH recommend that facilities revisit their surgical policies and processes to address the issue of ensuring objects used in procedures are intact. The following recommendations should be considered in developing processes within your organization:

- Responsibility is assigned to a specific team role for visualization of equipment/devices that will be used during the procedure to ensure the device and all of its components are intact prior to the procedure.

- Responsibility is assigned to a specific team role for visualization of equipment/devices and ensuring that the device is intact and all components areaccounted for following the procedure.

- Before deployment of a new device or equipment, staff should be educated on all component parts of the object that could potentially be retained or may be at higher risk for breakage.

- Any breakage or separation of device components during a procedure, even if the object is not retained, should be tracked to identify potentially higher-risk devices or instruments for breakage.

For more information on this alert, contact Julie Apold, MHA director of patient safety, at japold@mnhospitals.org or (651) 641-1121 or toll-free at (800) 462-5393 or Rachel Jokela, Adverse Health Events Program Director, Division of Health Policy, MN Department of Health, 651-201-5807.

ADVERSE HEALTH EVENTS IN MINNESOTA

NINTH ANNUAL PUBLIC REPORT / JANUARY 2013