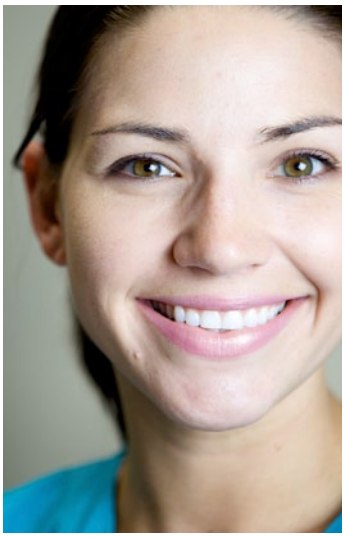
Adverse Health Events in Minnesota



Eighth Annual Public Report

JANUARY 2012

MINNESOTA MDH DEPARTMENT OF HEALTH

TABLE OF CONTENTS

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

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

EXECUTIVE SUMMARY

Adverse Health Events in Minnesota

Annual Report, January 2012

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 occurs and to conduct a thorough analysis of the reasons for the event. In 2011, the eighth year of reporting, the total number of events reported under the law is 316, a slight increase from the 305 events reported in 2010.

A closer look at the overall numbers shows that nearly all of the increase can be attributed to increases in just two categories of events: pressure ulcers and wrong procedures. The number of pressure ulcers rose to 141, an increase of 19 percent, while reports of wrong procedures increased by 63 percent, to 26. If the number of events in those two categories had been at the same level as the previous year, total reported events would have been lower than in 2010. In particular with pressure ulcers, this may be due to facilities doing a better job of identifying these events; for example, more pressure ulcers were found under or around devices such as cervical collars, after Minnesota hospitals began to focus on identifying these types of injuries.

The higher number of reported events in these two categories serves to mask significant improvements in two areas where Minnesota has implemented strong, statewide efforts over the last few years, falls and wrong site surgeries/invasive procedures, as well as an overall reduction in harm. Successes from 2011 include:

- The number of serious falls has declined to 71, a decrease of 11 percent from 2010 and a decrease of more than 25 percent from a high of 95 serious falls three years ago. Only the most serious falls are required to be reported through this system; that means that every fall that is prevented equals the prevention of a case of serious harm or death to a patient.
- After increasing for the last few years, wrong site surgeries/ invasive procedures declined by 23 percent this year (from 31 to 24).
- After two years of sustained work by staff and physicians in labor and delivery units to implement processes for counting sponges and other items, no retained foreign objects were reported in labor and delivery this year.
- A total of 89 events resulted in serious injury or death to a patient, down from 107 events last year. This is the lowest level of harm since 2007.

The successes of 2011 indicate that many of the committed, long-term efforts of patient safety leaders and clinical staff are starting to pay off, as best practices for prevention of falls and wrong site invasive procedures become imbedded in 'how we do business' in Minnesota. But the increases in pressure ulcers and wrong procedures illustrate the continuing barriers that many facilities still face when attempting to prevent harm.

In particular, system breakdowns related to accounting for all objects used during invasive procedures (including those which may break), invasive procedure scheduling, and maintaining the skin integrity of critically ill patients still lead to patient harm every year. Meanwhile, patient safety managers from around the state continue to report that they sometimes face challenges in getting the support they need to effectively develop and implement new safety initiatives, and that providers are not consistently held accountable for following best practices for every patient, every time.

MDH's goal, together with its partners, is to help clinical team members understand why these events happen, and how to prevent them. One of the most crucial things we have learned from the adverse health event reporting system over the last eight years is that just telling staff to 'remember to do the right thing' is not enough. To truly change practice, providers need to adopt solutions involving modifications in workflow or workspaces, staff roles, technology, team dynamics, and organizational culture. But to do this successfully, leadership needs to be fully engaged.

In the 2011 Adverse Health Events report, MDH recommended a number of steps that hospital and surgical center CEOs, senior executives, and boards of directors should take to improve patient safety. Those recommendations included incorporating patient stories of preventable harm into board and leadership meetings, observing clinical best practices in action, establishing policies to promote safe practices, and developing and enforcing performance expectations related to safe practices.

Those recommendations are just as important this year, and yet even they are insufficient. Facilities continue to face financial pressures and uncertainties related to state and federal health reform efforts, even as they prepare to meet standards for the electronic exchange of health information. In such an environment, deepening the commitment to patient safety and ensuring that it remains the highest priority will be critical if we want to prevent patient harm. This means that organizational

cultures need to be transformed so that safety, efficiency, and quality are continually at the forefront. Small technical changes or one-off actions will not be sufficient; complex, ongoing, sometimes uncomfortable adaptive change is needed.

One promising new avenue for driving this work forward is the Minnesota Alliance for Patient Safety's Roadmap to a Safe Culture, which is set to kick off in early 2012. The campaign will provide healthcare leaders in hospitals, clinics, surgical centers, and long term care facilities with evidence-based strategies for measuring and improving safety, increasing accountability for all providers, creating a learning and patient-centered environment, and imbedding continuous process improvement at all levels of the organization. MDH strongly encourages all healthcare providers to sign up for the campaign, and to participate in establishing new statewide community norms and standards for a safe organizational culture across settings. At the same time, MDH will continue to work with its partners across the state to provide resources and strategies to prevent patient harm.

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.

The Leapfrog Group

www.leapfroggroup.org

Hospital safety and quality ratings based on multiple factors.

HIGHLIGHTS OF 2011 ACTIVITIES

Under the Minnesota Adverse Health Care Events Reporting Law, hospitals and surgical centers are required to submit a report to the Minnesota Department of Health (MDH) whenever one of 28 serious reportable events occurs. The reports include details of the event, as well as a summary of the most important causes or contributing factors for the event (called a root cause analysis) and the corrective action plan that will be put in place to prevent a repeat of the event.

The MDH is directed to review all reported events, root cause analyses, and corrective action plans, and provide direction to reporting facilities to ensure that the actions they take will be effective in preventing future harm. In performing these functions, MDH works closely with several key stakeholder organizations, including the Minnesota Hospital Association (MHA) and Stratis Health. Highlights of the past year's activities are listed below.

Education

- Representatives from more than 20 hospitals and surgical centers participated in a Root Cause Analysis (RCA) training session in October 2011. This training is an important way of supporting facilities as they work to conduct robust root cause analyses.
- In October, MDH launched an online RCA toolkit, containing resources collected from hospitals across the state and country. The toolkit offers sample RCA forms, graphic organizers, RCA meeting agendas and overviews, position descriptions for RCA participants, and other resources to assist facilities in strengthening their investigative processes, and is designed to evolve over time as new resources are added.
- MDH and MHA collaborated with the University of Minnesota to offer five regional training sessions on prevention of wrong site surgery/invasive procedures. The day-long sessions focused on the rationale for the steps of the Minnesota Time Out and on effective auditing of time outs in the operating room.
- In March, MHA issued a safety alert related to wrong-level spine surgeries, including recommendations for proper spinal level localization.
- In 2011, MDH held two statewide conference calls for reporting facilities, to update them on changes to the reporting system, new projects, and upcoming training opportunities.

Strengthening the reporting system

- In February 2011, for the second 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 2011, MDH, MHA and Stratis Health worked to develop modifications to the secure, web-based registry used to report events. The upgraded registry, which is set to launch in early 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.

Partnerships

- In 2011, MDH worked with MHA, the Minnesota Medical Association, MMIC Group (Minnesota's medical liability company), the Minnesota Medical Group Management Association, and other key stakeholders to found the Minnesota Safe Surgery Coalition. The goal of the Minnesota Safe Surgery Coalition is to eliminate wrong-site, wrong-procedure and wrong-patient events within a three-year timeframe by using a multi-stakeholder, multi-pronged approach that engages physicians, front-line staff and facility leaders. The Coalition's first year was focused on launching and supporting a statewide campaign to drive adoption of the Minnesota Time Out for every patient, every procedure, every time. Additional information about the Coalition's activities is available on page 13.

Topic specific safety activities

MHA continued to convene expert groups to examine trends and develop evidence-based strategies for prevention of wrong-level spinal procedures, falls, pressure ulcers, retained foreign objects, and other surgical/invasive procedure events. In collaboration with the Minnesota Alliance for Patient Safety (MAPS), MHA and MDH also developed and worked to implement recommendations to address potential weaknesses in the process used for scheduling surgery and other invasive procedures.

A number of statewide and regional campaigns and individual facility efforts to prevent wrong site procedures, retained foreign objects, falls, and pressure ulcers were implemented or continued during 2011. Those efforts are described in the following sections.

2011 SUCCESSES AND CHALLENGES: FACILITY PERSPECTIVES

In November 2011, MDH conducted a survey of hospitals and surgical centers to learn more about their successes and challenges over the previous year and to allow facilities another avenue to provide input into the priorities and direction of the reporting system. Patient safety staff at 155 facilities were surveyed using an online survey tool, with 80 responses received (52 percent).

Respondents were asked to rate the usefulness of a number of tools, training sessions, and resources developed by MDH, MHA and Stratis Health during the 2010-2011 reporting period. Their responses indicate that most facilities made use of a range of resources during the previous year, and rated the majority of the tools and training opportunities to be very or somewhat useful (Figure 1).

The most highly-rated activities/resources were the five MHA Calls to Action and the tools/templates that accompany them. MDH/MHA safety alerts, the 2011 Case Study survey that measured facilities' awareness of reporting requirements through the use of vignettes, and RCA training were also highly rated. A number of respondents indicated that they were not familiar with one or more available resources; there may be new opportunities to publicize new resources or training opportunities in the future.

Facilities were asked to describe, in general terms, their biggest successes and challenges from the past year. Similar to last year, a number of respondents described increasing awareness of and engagement in patient safety initiatives by frontline staff and a greater understanding of what needs to be reported, as well as a greater willingness by staff to step into leadership roles around safety initiatives and serve as 'champions.' Many respondents also described successful efforts related to preventing particular types of adverse events, most commonly more consistent implementation of pre-surgical time outs, fall prevention activities, and pressure ulcer prevention steps. Still others described successes that fall outside the scope of the adverse event reporting law, including improvements in hand hygiene and infection rates.

FIGURE 1: FACILITY PERSPECTIVES

RESOURCES	VERY USEFUL	SOMEWHAT USEFUL	NEUTRAL	NOT VERY USEFUL
MDH/MHA safety alerts	54.5%	40.3%	5.2%	0.0%
MDH Case study survey	56.1%	31.8%	12.1%	0.0%
MDH statewide AHE conference calls	45.2%	38.7%	14.5%	1.6%
MHA 'Good Catch' awards program	10.4%	34.3%	38.8%	16.4%
MHA data sharing database	31.3%	40.6%	28.1%	0.0%
MHA Call to Action participation	71.2%	19.2%	9.6%	0.0%
MHA Call to Action listservs	40.9%	34.8%	22.7%	1.5%
MHA Call to Action tools/templates	63.0%	28.8%	8.2%	0.0%
Statewide Time Out Campaign participation	43.9%	39.4%	15.2%	1.5%
Measurement guide for adverse events	50.0%	34.7%	13.9%	1.4%
MDH Online RCA Toolkit	48.5%	27.9%	22.1%	1.5%
RCA training (Oct 2011)	51.6%	22.6%	25.8%	0.0%
Safe Surgery/Auditing training	30.6%	30.6%	33.3%	5.6%
MHA/Stratis Health regional patient safety/quality meetings	49.2%	39.7%	11.1%	0.0%
Participation in MHA patient safety or topic-specific advisory committees	50.0%	16.7%	26.7%	6.7%
Written comments from Stratis Health during review process	25.0%	36.5%	32.7%	5.8%
Phone/other consultation from Stratis Health during review process	34.8%	41.3%	21.7%	2.2%

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

But respondents also described an environment in which they face a number of challenges:

- A plethora of reporting requirements from various state and federal agencies, some of which don't seem useful or meaningful to staff. With data collection increasing, several respondents indicated that they do not have time to 'drill down' into data and identify improvement opportunities the way they would like to.
- Similarly, several respondents mentioned "initiative fatigue," where staff are trying to focus on too many facility or state-level campaigns at once, and become overwhelmed.
- Limited time to allow staff to work on developing new processes. As one respondent noted, new processes "seem to be better received if staff have been involved in recommending and working on developing change," but dedicated time to do so is rare.
- Pushback or lack of engagement/compliance from physicians or other providers who may not understand or support the rationale for specific measures, such as time-outs in procedural areas. This can be particularly difficult with visiting/floating staff or those who rotate between multiple facilities.
- Culture change is also difficult; leaders need to "help others overcome their discomfort with a coaching discussion that uses direct language related to at-risk behaviors."

Respondents were also asked about resources that would be helpful to them in the coming year. Their responses indicated that facilities would be interested in additional training, resources and tools in the following areas, which MDH will explore developing in 2012:

- An online library of successful improvement plans, including de-identified case summaries that include outcomes of corrective actions;
- More resources for ambulatory surgical centers;
- Specific tools related to fall prevention in geriatric and behavioral health populations;
- More opportunities to participate in beginning and advanced RCA training via video or web; and
- More tools, including peer-to-peer training, to encourage physician buy-in.

Responses from reporting facilities indicate that they appreciate the resources and training opportunities that are available from MDH, MHA and Stratis Health, but that they also face ongoing challenges to progress. Many of these issues are not related to front-line staff having the 'will' to move forward, but rather to conflicting demands on their time and challenges in engaging physicians.

MDH and its partners will move forward in 2012 with developing additional resources to meet identified needs for training, toolkits, physician engagement strategies, and best practices for different clinical areas. But many of these responses require action within hospitals and surgical centers themselves, and highlight the need for leaders to send a strong message, through actions and not just words, that patient safety is paramount, to ensure that sufficient staff and resources are available, and to consider the impact of new technologies such as electronic health records on safety, workflow, and staff time.

OVERVIEW OF REPORTED EVENTS & FINDINGS

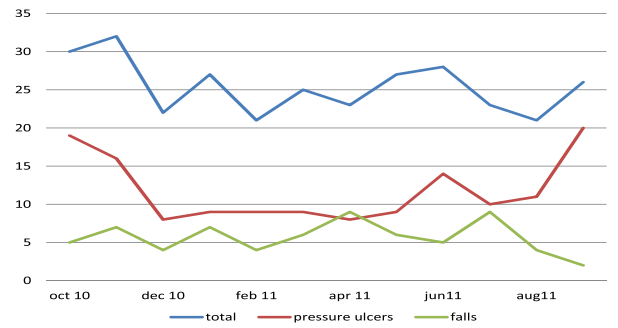
In eight years of public reporting of adverse health events, the Minnesota Department of Health has collected detailed information on more than 1,700 events. Data collected about each event includes the date, time and location of the event, the patient's age, a narrative of the event itself, the immediate response to the event, the results of the facility's root cause analysis, and the facility's intervention plan to prevent similar events from happening in the future. More detailed information is collected about some types of events, including patient characteristics and whether or not best practices for prevention were followed.

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, 2010, and October 6, 2011, a total of 316 adverse health events were reported to MDH, an increase of four percent from the 305 events in the previous reporting cycle.

FIGURE 2: EVENTS BY MONTH



**Note: October, 2010 figure includes some events that were included in the January 2011 annual report. Events that occurred prior to 10/1/10 but were discovered during the current reporting period are not included in this chart.*

Overall, the data show that:

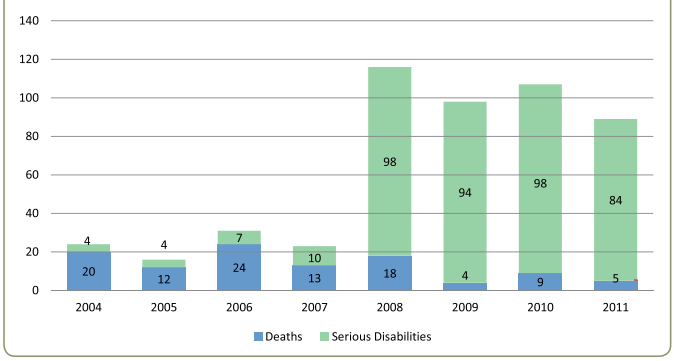
- The monthly average number of events declined slightly over the course of the year, and ranged from 21 to 32 events per month. Falls were reported in slightly lower numbers in the later months of the year; however, it is too soon to tell whether this drop signals the continuation of the trend towards fewer falls.
- There are currently 135 hospitals and 59 ambulatory surgical centers in Minnesota. Of those, 62 hospitals and seven ambulatory surgical centers reported events during this reporting period. Seven hospitals were first-time reporters, experiencing their first reportable adverse event in 2011.
- Since the inception of the reporting system, 106 hospitals have reported at least one event. This represents more than 75 percent of all hospitals, which together account for more than 95 percent of all hospital beds in Minnesota.
- During 2010, the most recent year for which preliminary data are available, Minnesota hospitals reported roughly 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 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. To do so, facilities must focus resources on discovering why events happen, developing strong responses to prevent their recurrence, and implementing practices that can minimize harm if adverse events do occur. Over time, this process will result in fewer incidents of patient harm, along with a reduction in the severity of harm. The reporting law is designed to support this process on a statewide level.

In 2011, fewer events resulted in patient harm than in the previous year. A total of 84 events (27 percent) resulted in serious disability and five events (1.6 percent) resulted in a patient's death (Figure 3). This is the lowest aggregate level of reported harm since the reporting system was expanded several years ago. The remainder of events resulted in no harm, a need for additional monitoring, or a longer stay.

FIGURE 3: PATIENT HARM



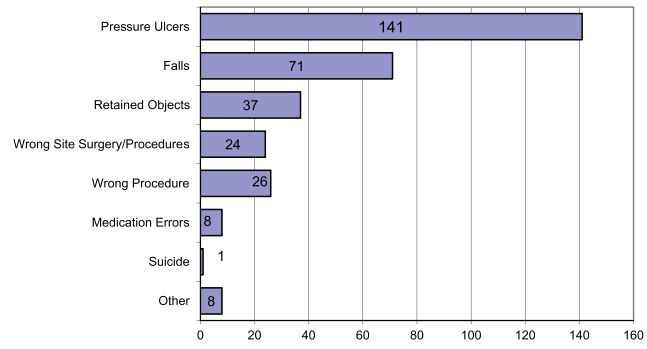
As in previous years, the type of event most likely to lead to serious patient harm or death was falls, and the statewide

reduction in serious falls was the biggest contributor to the lower levels of harm in 2011. Seventy one cases of harm or death were a result of falls, while medication errors accounted for eight cases (nine percent). 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.

Types of Events

As in previous years, pressure ulcers and falls were the most commonly reported types of events, accounting for two-thirds of all events reported in 2011. Over the eight years in which adverse health events have been reported, pressure ulcers and falls have accounted for roughly 60 percent of all reported events (Figure 4).

FIGURE 4: EVENTS BY CATEGORY



Root Causes of Adverse Events

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

The process of completing a root cause analysis is a crucial step in determining exactly ***what*** happened and ***why***. Without uncovering root causes, it is very difficult to prevent a recurrence of an event. It's important that facilities also look at patterns of events. If multiple similar events occur, analysis of their root causes can reveal patterns of vulnerability that might not be apparent from one event.

One of the biggest challenges that many facilities face when conducting root cause analysis is resisting the urge to stop too soon, and to determine that an event was due to a failure of an individual to follow a procedure or policy. In many cases, an analysis may reveal that a particular step of a process wasn't followed, or a procedure was done incorrectly. But that, in and of itself, is usually not the most actionable finding.

What's important is to determine why the policy was not followed. Was the policy confusing or its delineation of roles unclear? Did it fit with the usual workflow, or work against it? Had everyone been trained on how to carry it out? Was it unknown to the individual or team? Did the individual just forget to do it? Did they intend to do it, but workload or other issues intervened? Did the individual think it was not necessary, based on their assessment of the risk of the situation? Did the organizational culture within the facility promote staff taking shortcuts or not following certain policies? It is through this in-depth analysis that facilities can uncover systemic issues that often contribute not just to the individual event at hand, but to other potential events as well.

ROOT CAUSES/CONTRIBUTING FACTORS*

Communication	35%
Rules/Policies/Procedures	34%
Environment/Equipment	25%
Training	20%
Barriers	6%
Fatigue/Scheduling	0%

** Does not include events with no identified root cause.*

The term "root cause" is largely a misnomer; most events have more than one root cause, and several intertwining contributing factors. However, on occasion, facilities report cases where the complexity of a patient's clinical condition makes prevention of the event particularly challenging, or even impossible, and no root cause is identified. This is most common with pressure ulcers, which may not always be preventable in certain situations. The vast majority of events can be traced to breakdowns in larger systems of care rather than to individual patient characteristics or individual provider mistakes.

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. However, not all root causes fit neatly into these categories, and in many cases the causes are closely intertwined. Issues of organizational culture, which are not explicitly captured as part of the adverse event reporting system, can also come into play, particularly in cases where providers, staff, or patients feel uncomfortable speaking up if they perceive a risk.

Because the root causes of these events are complex and often system-wide, simple solutions or quick fixes are unlikely to succeed in the long term in preventing their recurrence. In the field of patient safety, interventions that rely on an individual's vigilance or memory are generally considered weaker interventions. Eventually, unless the underlying system or work process is changed, human nature will lead that individual or another to err, become complacent, or drift from best practice. For improvements to truly become imbedded in a facility, the 'correct' thing to do must also be the easy thing to do. That means that processes should be simplified where possible, strong technical fixes should be put in place to make it impossible to take shortcuts, and workflow and staffing should be organized in such a way that staff are able to make the right choice every time.

SPOTLIGHT STORY

ENGAGE AND EMPOWER: A FAIR PROCESS MATTERS —VAL ULSTAD, MD, MPA, MPH

Resistance from physicians to safety initiatives is legendary. It is often misinterpreted, unconsciously provoked and even worsened by the reactions of others. What seems like "docs don't care" may actually mean they care a great deal but don't feel included and are unable to see how to participate in shaping and owning the solution. Safe, high quality care is the work of everyone. What might happen if we collectively thought about resistance as a *signal* to try to work differently? How might systems invite greater participation in and leadership by physicians in making our hospitals safer?

The ability to influence and have a voice in shaping our new work is important to us as doctors. Physicians want to do the right thing and really hate having things done "to us." We bristle at mandates that seem to come out of the blue. We get angry when asked to "just accept" a way of doing things that seems destined to fail because realities as we see them were not faced thoroughly. How can organizations talk about safety initiatives in a way that will engage the heart, minds, creativity and powerful collegial influence of doctors? I want to offer four ideas.

First, **name the "why."** Frame the initiative, being honest and firm about what is not negotiable. Talk about what needs to be tackled and be transparent about the reason it must be faced now. Was it an incident, a regulatory mandate, or a new insight about patient safety? If it is, for example, an incident, educate yourself to the details and speak to it when you make the case. Tell the story of what happened, within privacy bounds, and how the incident represents a general vulnerability of the system. Be clear about the consequences to your patients and to your organization for not addressing it. If there is a new regulatory imperative, be very clear about what parameters are fixed by external agencies. Don't present the issue as optional if it is not.

Second, **co-create the approach to the "how."** Fundamentally this all starts with a shared desire to create safe, high quality places to give and receive care. Present the initiative in a way that is compelling, meaningful and clear and linked to that notion. We all want to give the kind of care we would want our loved ones to have. This isn't a time for people to be seeking the "OK" for their favorite workaround. Those leading initiatives should not collude in this type of avoidant behavior (and it is really tempting to do so!) but stay clear in purpose and willing to speak to that purpose often and passionately.

You don't need (and should not try) to *fix* every concern, but you do need to *hear* and consider every concern as the approach is formulated. Stay genuinely curious about what physicians, nurses and other stakeholders think it will take to do the work well under the given circumstances. Be very clear what is open for thoughtful input using the fixed parameters to bound the input. It is very unlikely that consensus will get the job done; don't pretend everyone will get their way. Invite docs to give their thoughts about how the issue can best be addressed, listen to what they have to say and seek to really understand their message. Name the ways to give input (meetings, written feedback) and clearly limit the length of time over which you will accept it.

It is essential for the authorities in our systems (chief executive officer, chief medical officer, chief of staff, or chief quality officer)to back those who are asked to exercise leadership to move an initiative. Although safety initiatives are often led by nursing, they are not the work of nursing alone. Nurses have frequently stepped up to lead safety work in our organizations but often at high personal cost. People who step up have to tolerate being seen as the one who embodies the new issue and therefore face personal attacks (being yelled at, bullied, having emails or meetings ignored, having one's competence called into question) that really represent reactions to the change. It is unfortunately a well-developed human reflex to derail a difficult conversation by making it about the character of the person courageous enough to start the conversation instead of talking honestly about what is being asked of them.

Helping a group take up new work requires helping others see that things can't remain the same but doing so at a rate that is tolerable to them. One of the things that makes the exercise of leadership really hard is that the people being led set the pace of progress (either unconsciously or consciously). The reactions of people—doctors and everyone else—are organizational symptoms to notice. If you are perceived to be going too fast, not really listening or being dictatorial, people *will* let you know—by their behavior. Leadership requires seeing and understanding that behavior and trying another way "in." There is no quick fix to helping people do new capacity-building work together. This requires leadership training, learning from experiences that didn't go well and the opportunity to have others to talk to in real time about what could be tried next.

Third, **present your synthesis of the input, declare how you will begin and explain how you will track the process**. Once the input has been gathered, communicate the approach your system will take clearly, concisely and courageously. Talk about why you decided what you did. Be willing to talk about what influenced the decision. Also be willing to talk about what is not going to happen. By doing this you are letting people know you heard them and that the process used the input from the community. You are informing people of how the work will begin and hopefully demonstrating an awareness

of what it will take in your unique system and culture. Don't open the discussion for revision but let physicians and other stakeholders know how you will assess the efficacy of the work and when you will reassess the approach you are beginning. This is what great clinicians do: they begin, reassess regularly and refine based on response to the intervention. Be clear what you are going to measure and report.

Finally, **hold everyone accountable including the implementation team**. Be consistent and fair. Do what you said you were going to do. Regularly report evidence of impact. This is more than measurement, and may include stories and anecdotes, or noticing people being effective and creative in implementing. Celebrate success and acknowledge hard work. Build collective confidence and pride in what can be done together.

The *process* is crucial and will be more effective if the purpose is compelling, widely shared and if the effort is respectfully implemented and felt to be fair. Physician work changes at a rapid speed. We physicians are trained to be experts and have been rewarded to act like experts. In the emerging world of health care, nobody is expert and everyone is learning in real time. In this new world, together we are confronting the issues that will improve our care of patients and make our hospitals safe places of rescue and healing. This requires all of us to behave differently.

As a physician my plea is this: don't present a new initiative to me fully baked. Include me, listen to me and after input is gathered, tell me why you decided to begin the way we are beginning. Remind me that giving me a chance to give input doesn't mean I get my way. Tell me I am an essential partner in executing important work—not just a difficult person who "just doesn't get it." Then, assure me you will keep an eye on how it is working, refine it as we go on with real evidence in many forms, and I will enthusiastically join with you.

Physician engagement is not going out convincing docs to "do it your way." What often makes people angry is feeling like they are asked to participate in consensus when a decision is already made—they feel manipulated. The process I am describing is not consensus, but it is transparent and fair. It's using physician input to create more robust solutions to serve patients. Our organizational cultures are how we actually behave—not how we *say* we behave. ***A culture of safety is ours to create—together***.

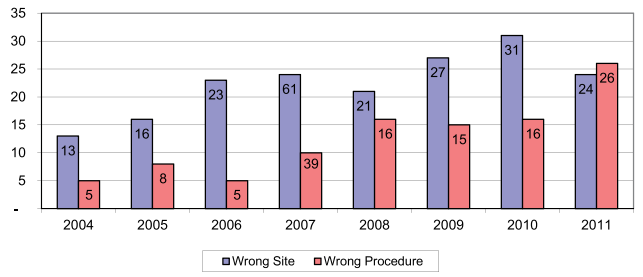
Val Ulstad, MD, MPA, MPH is an educator in independent practice, a process consultant focused on leadership capacity building in health care, a member the advisory board for the Institute for Physician Leadership, and a member of the Board of Directors of the Center for Courage & Renewal. A practicing cardiologist for over 25 years, she has served in a variety of leadership roles in medicine, and recently reframed her "heart practice" to focus on facilitating the development of individuals and organizations.

Reference - W Chan and Mauborgne, Renee (Jan 2003) Fair Process: Managing in the Knowledge Economy. Harvard Business Review.

SURGICAL/INVASIVE PROCEDURE EVENTS

Minnesota's reporting law includes three different categories of adverse events related to incorrect surgeries/invasive procedures. The more frequently reported events in this area are wrong surgeries/invasive procedures (the incorrect procedure performed on a patient) and wrong site surgeries/invasive procedures (the correct procedure performed on the wrong location of the body); the third involves procedures performed on the wrong patient. The total number of surgical/invasive procedure events across the three reporting categories rose from 48 in 2010 to 52 in 2011. This increase was driven by a higher number of wrong surgeries/invasive procedures in 2011; these events rose from 16 in 2010 to 26 in 2011, while wrong ***site*** surgeries/invasive procedures decreased from 31 to 24 (Figure 5).

FIGURE 5: WRONG SITE & WRONG PROCEDURE EVENTS



Of the reported wrong site, patient or procedure cases, nearly two-thirds (64 percent) happened in the operating room (including outpatient surgical procedures), and a quarter happened in radiology. In more than half of cases (56 percent), the patient experienced no 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.

Across all Minnesota hospitals, more than 2.6 million surgeries and invasive procedures were performed in 2010, with thousands more taking place in ambulatory surgical centers. Given the volume of invasive procedures performed in a year, these events are very rare, occurring in roughly one of every 50,000 invasive procedures.

Wrong site surgeries/invasive procedures

In the eight years that Minnesota has been collecting data on adverse health events, wrong site surgeries/invasive procedures have been among the most commonly reported events, rising to a high of 31 in 2010. In 2011, the number of wrong site surgeries/invasive procedures dropped by more than 20 percent to 24, the lowest point since 2007. If this trend continues, it will mark significant progress towards eliminating this nearly always preventable event.

Much of the work towards elimination of wrong site surgeries/invasive procedures has been focused on ensuring that every facility conducts a robust time out before every invasive procedure, as part of a comprehensive safe surgery process that also includes marking of the procedure site by the provider who will be performing the procedure. The University of Minnesota developed a human-factors based time out process (the Minnesota Time Out) in 2008 with support from MDH and MHA, but progress towards implementing this best practice consistently statewide has been slow due to lack of understanding of the steps in the process and how they fit with other recommendations, including those developed by the World Health Organization.

In 2011, MDH and MHA partnered with the Minnesota Medical Association, MMIC Group, and other stakeholders to establish the Minnesota Safe Surgery Coalition, with a goal of eliminating wrong site procedures within three years. The campaign's first year focus was on promoting the Minnesota Time Out for every patient, every procedure, every time. More detail about the work of the coalition is provided on the next page.

Key findings

Results from 2011 data show that the Safe Surgery Coalition's work may be starting to bear fruit; more facilities report following the steps of the Minnesota Time Out both in and outside of the operating room, and the average number of days between events (one way of measuring how frequently these rare events occur) rose from 11 prior to the campaign's kickoff to roughly 30 afterwards. But while hospitals and ambulatory surgical centers are beginning to make progress on consistently implementing a robust time out, room for improvement remains: a number of wrong site events in 2011 were related to inconsistencies or lack of verification at various points in the scheduling process, or to a lack of policy for site marking or time out in certain areas.

Root causes for wrong site invasive procedures in 2011 included:

- Source documents that did not include any indication of laterality;
- Difficulty identifying the correct vertebra for spinal procedures due to unusual anatomy or multiple degenerated vertebra; and
- The lack of a policy for site marking or for a time out when administering regional anesthetic blocks.

Wrong surgeries/invasive procedures

For the first time this year, the number of wrong surgeries/ invasive procedures outpaced the number of wrong-site events. Ten of these events were related to incorrect implants being placed: five during cataract surgeries in which the wrong power lens was placed, two during breast implants in which the wrong type of implants were placed, two during knee replacement surgeries, and one during an ankle surgery. Nearly all of the wrong procedure events took place in the OR; relatively few happened in interventional radiology or other procedural areas.

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. These processes can begin weeks before the event, when the procedure is initially ordered or scheduled by a physician's office, and continue up until the moment the procedure begins or even beyond. Often, these breakdowns occur when source documents do not include correct information at the time a procedure is scheduled or performed, or when that information is not included in the verification process.

Root causes for these events included:

- Right and left knee implant components being placed on the same cart, with similar labeling;
- Consent forms that did not include the specific implant to be used;
- Scheduling forms that were modified when the surgical plan changed, with no re-verification after the modification was made; and
- Electronic health records systems that include separate scheduling and ordering modules for different clinical areas and which do not always interface in real time.

Next steps

Work to prevent surgical/invasive procedure adverse events continues to accelerate statewide. Hospitals and ambulatory surgical centers continue to work towards full implementation of the more rigorous Minnesota Time Out process, and the Minnesota Alliance for Patient Safety has developed and is piloting a refined scheduling process that builds several 'hard stops' into the process of exchanging information between physician offices and hospitals/surgical centers. In 2012, the scheduling pilot will expand to new sites via inclusion in the ongoing MHA Safe Site campaign and as a second-year focus for the Minnesota Safe Surgery Coalition.

While these efforts are all necessary for prevention of wrong site invasive procedures and wrong procedures, they will not be sufficient to eliminate these events without a commitment on behalf of every organization and every provider to be accountable to statewide best practices for site marking and time out. Too often, during regional training sessions in 2011, OR teams described situations in which 99 percent of physicians are happy to comply with site marking and time out requirements – and even to participate in improving these processes – but the final few refuse to comply. In those cases, the influence of that final one percent outweighs their numbers; workarounds are developed, exceptions are made, and OR teams are put in the difficult position of trying to enforce policies without the authority to do so.

MDH's goal, together with its partners, is to give these team members the resources they need to understand the rationale for each step of a strong and safe pre-surgical verification process. But in order to succeed, organizational leaders need to set and enforce clear standards for compliance with all best practices for prevention of surgical adverse events – with no exceptions. To do otherwise puts patients at unacceptable risk and jeopardizes the progress that Minnesota has made towards eliminating these preventable events.

SPOTLIGHT STORY

PREVENTING WRONG SITE PROCEDURES IN MINNESOTA

Between 2003 and 2010, 155 (11%) of the 1,403 adverse events that were reported to the Minnesota Department of Health by hospitals and ambulatory surgical centers were wrong site surgeries/invasive procedures. The number of events in this category increased from 13 in 2003 to 31 in 2010, with nearly one-third resulting in a need for additional treatment, in some cases a second corrective procedure.

A thorough review of data submitted under the adverse events law, beginning in 2007, uncovered a number of common system breakdowns that contributed to these events, including the fact that site marking and time outs were only present in roughly half of all cases. Based on these findings, in 2008 MDH and the Minnesota Hospital Association began working closely with the University of Minnesota's Center for Design in Health, a research center that works to integrate human factors system design into healthcare work processes, to develop a more rigorous time out process grounded in human factors principles.

Researchers from the Center for Design in Health observed surgeries in eight facilities around Minnesota in 2008, to document weaknesses in pre-procedure verification processes. Across facilities, the team observed:

Inconsistent site marking practices, including cases without site marks, cases in which site marks were removed or obscured, and site marks that were made without reference to source documents.
Inconsistent time out processes, including cases with no time out, cases in which team members did not cease activity or actively participate, cases in which information was provided from memory, and cases where the time out was done without the surgeon present.
Based on these observations, the researchers developed a comprehensive pre-procedure verification process, the Minnesota Safe Surgery process. The steps in the time out portion of this process, and the rationale for each, are available at http://www.health.state.mn.us/patientsafety/ae/wsssummaryfs.pdf.

IMPLEMENTATION/DISSEMINATION

Since its development in 2008, the Minnesota Time Out process has been incorporated into statewide wrong surgery prevention work, with the goal of establishing this more rigorous time out as the statewide community standard across all facilities. To accelerate this work, the Minnesota Hospital Association convened a group that included the Minnesota Department of Health, the Minnesota Medical Association, the Minnesota Medical Group Management Association, the Minnesota Ambulatory Surgical Center Association and MMIC Group, a medical professional liability insurance company. This group established the Minnesota Safe Surgery Coalition to address challenges related to prevention of wrong site procedures and brainstorm strategies for leveraging each organization's resources and influence to push for statewide implementation of best practices to prevent wrong site procedure events.

During the spring of 2011, the Safe Surgery Coalition initiated a three-year campaign to eliminate wrong site procedures, with the first year focusing on ensuring that the Minnesota Time Out was conducted for every patient, every invasive procedure, every time. More than 100 hospitals and surgical centers signed up for the campaign.

Each facility that signed up to participate in the Minnesota Time Out campaign was required to have its CEO sign off on this commitment, and participating organizations would have access to training, videotaped simulations of the time out for auditing practice, and resources including time out videos, sample policies and scripts, talking points, and other materials.

To assist in engaging physicians in the process, MHA developed a "Physician Peer-to-Peer" DVD that featured prominent Minnesota surgeons talking about the importance, value, and simplicity of the Minnesota time out process.

While the journey to prevent wrong site procedures in Minnesota is far from over, this concerted statewide effort to implement the Minnesota Time Out is starting to bear fruit. One way of measuring how often these preventable but rare events happen is to count the number of days in between occurrences. During the first six months of the current reporting year, prior to the launch of the time out campaign, the average number of days between wrong site procedures was 11, and the state was on track for another increase in the annual number of events. In the latter half of the reporting year, the average number of days between events rose to roughly 30, and the final number of events reflected a more than 20 percent decrease from the previous year.

Time will tell whether these gains will hold, but Minnesota's experience in working to establish a consistent and effective time out process as the statewide community standard in hospitals and ambulatory surgical centers has provided a number of key lessons about how to develop and implement process changes within and across organizations, as well as the sometimes hidden barriers to change that often derail safety campaigns. The process has highlighted, once again, the important role of clear leadership expectations/standards, particularly for surgeons, in conducting the time out. It has also shown that a prescriptive process can be successful, as long as those who are carrying it out are well-versed in the rationale for the steps, know what to look for when auditing the process, and have the authority to speak up when the process is not being followed.

For more information about the Minnesota Time Out process and the Minnesota Safe Surgery Coalition, visit http://www.mnhospitals.org/index/timeout.

RETAINED FOREIGN OBJECTS

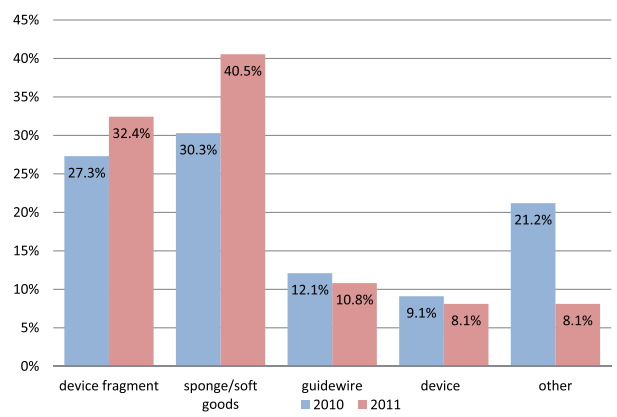
In 2011, 37 cases of retained foreign objects were reported, up from 34 in 2010. This year's data shows a slight shift in the types of objects that are most likely to be retained, with both device fragments and sponges/soft goods making up a larger proportion of retained objects than in previous years. Sponges, packing, or other soft goods were still the most commonly retained foreign objects (40 percent), with a number of events related to packed gauze after gynecological procedures such as hysterectomies. Device fragments (other than guidewires) accounted for 32 percent of all retained foreign objects. Three of these events involved protective device sleeves or caps (Figure 6).

Similar to last year, 70 percent of retained foreign objects happened in the operating room. Others were evenly distributed across diagnostic/laboratory, PACU/recovery, and other procedural areas.

The past several years have shown strong progress towards elimination of retained sponges in labor and delivery, following the initiation of a Minnesota Hospital Association-sponsored statewide campaign to eliminate these events. In 2011, there were no retained sponges in labor and delivery, a major success story that shows it is possible to successfully implement new practices in a consistent manner across the state. This second year of sustained reduction in retained foreign objects in labor and delivery led MHA to retire the "Safe Count" campaign in 2011.

As in previous years, more than half of all retained object cases led to a need for further treatment, usually a second procedure to remove the object. The time that elapsed between the retention and discovery of the object ranged from a few minutes to five years.

FIGURE 6: TYPE OF OBJECT RETAINED



Key findings

This year's retained foreign object events fall into two broad categories: device fragments and soft goods/packed items. In general, the root causes and contributing factors differ slightly for these two types of objects. In the case of device fragments, key findings included:

- Team members 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 tip was so small that it was not detected during inspections of the surgical field. This was most common with broken segments of wire.
- In at least two cases, the team relied on intraoperative x-rays or x-rays from a patient's previous surgery in order to identify potentially retained objects, but the x-rays did not offer sufficient visualization of the object for the team to recognize its presence.

In the case of soft goods and packed items (sponges or gauze pads that are placed in a wound or cavity to staunch bleeding, with removal planned for a later time), 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. While no retained sponges in labor and delivery were reported this year, several events involved vaginal packing that was placed but not removed due to communication breakdowns, during gynecological procedures in the operating room.

With both types of retained objects, reported root causes reveal that there continues to be variation in how items are accounted for. In some cases, the problem comes down to simple human error – an individual miscounted items, or a provider forgot in this particular instance to tell the team that they were placing a piece of gauze or a sponge. But in a number of cases, certain items were either not included in the counting/accounting process, or were introduced into the sterile field when they should not have been.

Next Steps

Humans will always be fallible; counting errors will inevitably occur, particularly in complex procedures involving many countable objects or in situations where team members are rushed or distracted. But the success in eliminating retained sponges in labor and delivery shows that it is possible to consistently implement not only stronger counting/accounting

policies but also a cultural shift in how team members view the risks of retained objects.

The continuing challenges that facilities face related to packed gauze and sponges show that, again, a practice of remembering to verbalize placement of items will not be sufficient unless accompanied by system-level changes. As part of its Safe Account campaign, MHA worked with clinical experts to develop best practices for placement and removal of packed items, including requiring physician order sets for removal of the item and using structured written, electronic and verbal methods to communicate about placement and planned removal. Moving forward, all facilities should adopt these and other best practices to prevent retention of packed gauze or other soft goods.

In the case of device or instrument fragments, the challenges are greater. Hospitals and surgical centers are working together to develop and implement strategies to account for the intactness of objects throughout the process beginning with inspecting packaging when selecting devices for a case to inspecting devices before and after they are used during the case and ensuring intactness after devices undergo sterilization processes. Work is also underway to investigate and trial various practices to account for lengths of wires that are used during procedures to verify that any pieces that are cut or break during the procedure are accounted for prior to the end of the procedure.

PRESSURE ULCERS

The number of reported pressure ulcers increased in 2011, rising from 118 to 141. The majority of reported pressure ulcers were found on the coccyx or buttocks (39 percent), on the head, neck or face (23 percent), or on the sacrum (13 percent).

Elderly patients or those who suffer from certain chronic conditions are generally more at risk for the development of pressure ulcers than younger, healthier patients. However, serious pressure ulcers are most frequently reported in those in the 40-64 age range. In 2011, the age profile of patients with pressure ulcers was similar to previous years; 36 percent were age 65 or older, while 42 percent were between ages 40 and 64.

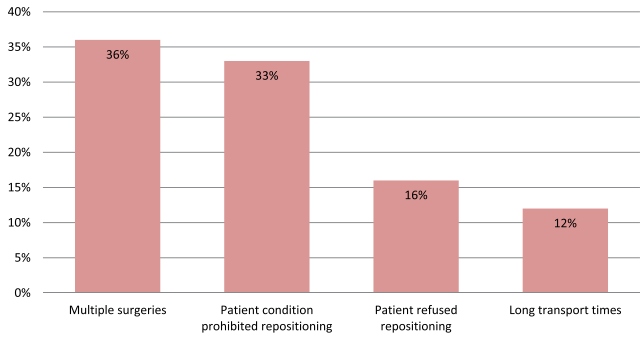
Key findings

Compared with other categories of reportable adverse events, pressure ulcers have some unique characteristics that might contribute to the increased number in 2011. Unlike other events that occur at a specific point in time, pressure ulcers develop over the course of hours, days or weeks. They can be challenging to identify in some cases, and they can exist and evolve before being discovered. This means that they are also more sensitive to changes in a facility's process for searching for them. It is difficult to measure whether improvements in pressure ulcer identification processes at certain facilities contributed to this year's increase, or whether it was due to a change in patient acuity, a drop in implementation of best practices, or other factors.

Many patients who developed pressure ulcers also had multiple comorbidities or conditions that may have increased their risk for skin breakdown, including respiratory failure, incontinence, malnourishment, diabetes, kidney failure, or sepsis (see table at right). More than 80 percent of patients with a reported pressure ulcer had at least one comorbidity or condition that increased their risk of pressure ulcer development; the average number was four. One–third of patients had conditions that prohibited repositioning to relieve pressure, while 16 percent could have been repositioned but refused (Figure 7). Roughly half of all reported pressure ulcers were found in patients while they were in an intensive care, critical care, or transitional care unit.

While patient factors such as those described above can increase pressure ulcer risk or make interventions more complicated or difficult to apply, the data continue to show that other factors also play a role. As in previous years, a significant number (35 percent) of pressure ulcers were related to device use, most commonly immobilizers and respiratory equipment. These ulcers have several distinct characteristics:

FIGURE 7: PRESSURE ULCER RISK FACTORS



- Device-related pressure ulcers were far less likely to be identified early in their development, at a point when additional preventive measures could be put in place. More than 80 percent of device-related pressure ulcers were not identified until they were already stage III, stage IV, or unstageable (the most severe wounds); less than 20 percent were discovered at Stage II.
- In contrast, non-device related pressure ulcers were usually recognized before they became as severe, although the wounds still progressed to a Stage III or Stage IV level. More than 40 percent of non-device related pressure ulcers were first identified when they were Stage I or Stage II.
- Device-related pressure ulcers are also much more likely to be found on the head, face or neck than non-device related pressure ulcers. Half of all device-related pressure ulcers were on the head, face or neck, compared with just eight percent of non-device-related pressure ulcers. Conversely, nearly 80 percent of non-device related pressure ulcers were located on the coccyx, buttocks or sacrum, and just four percent of device-related ulcers.

Even when devices contribute to the development of an ulcer, the root cause of the pressure ulcer is often more closely related to a lack of understanding of risk for skin breakdown with device usage and a breakdown in the implementation of appropriate steps for prevention of the formation or progression of such an ulcer. In some cases, nursing staff may not be familiar enough with the device to know how to inspect under or around it, or policies for when and how such inspections are done may be unclear. In other cases, information related to removal or proper fit of devices may not be effectively communicated from the ordering physician to the care team.

Device-related pressure ulcers may not always be preventable, particularly in cases where the patient's condition does not allow for regular removal or repositioning of the device. But in many of these cases, staff may need additional training and clearer guidelines on when and how to inspect and cleanse skin beneath devices.

CHARACTERISTICS OF PATIENTS WITH SERIOUS PRESSURE ULCERS

Respiratory failure:	54%
Clinically malnourished:	47%
Incontinence:	39%
Kidney failure:	38%
Diabetic:	37%
Sepsis:	35%
Obese:	11%
Multiple conditions:	82%

Source: Minnesota Adverse Health Events reporting system, 2010

Next steps

Nearly five years after it began, the MHA Safe Skin campaign entered a new phase in 2011 with the launch of Safe Skin 2.0 with participation by 112 of Minnesota's 135 hospitals. In response to trends identified through the adverse events reporting system, the updated campaign now includes implementation of best practices for prevention of pressure ulcers with the use of cervical collars and respiratory devices and during surgery or other invasive procedures.

In early 2012, a campaign will be launched with the goal of reducing serious pressure ulcers in intensive care units by 40% before October 2013. Key strategies include getting patients that cannot be easily repositioned on special surfaces to reduce pressure and performing at least hourly mini shifts off the tailbone. The campaign will also focus on protecting skin beneath devices.

For more information about device-related pressure ulcers in Minnesota, see '***Preventing device-related pressure ulcers: using data to guide statewide change.'*** Apold J, Rydrych D. Journal of Nursing Care Quality, 2012 Jan: 27(1): 28-34.

SPOTLIGHT STORY

INNOVATIVE PROGRAM AT REGIONS HOSPITAL TRYING TO MAKE BEDSORES GO THE WAY OF DINOSAURS

When you go into the hospital, the last thing you want is to develop some other medical condition or complication during your stay. Unfortunately, people who are in bed for an extended period of time can develop pressure ulcers, or bedsores. But at Regions Hospital, bedsores are becoming significantly less common, thanks to an aggressive prevention program.

"It really tugs at your heart strings when you see someone with a pressure ulcer," says Beth Heinly-Munk, critical care director of nursing. "People at Regions recognize that this is not a good patient experience. It's very distressing to the family when these things happen."

So about a year ago, the hospital formed an interdisciplinary team, co-led by Dr. Julibeth Petter and Dr. Gary Collins, to look at trends and any steps staff could take to prevent pressure ulcers. The team looked into every possible case in which a patient may be at risk. For instance, they looked at improvements to patient nutrition. In the OR, they looked at the padding on the tables, repositioning frequency, and are conducting research to determine if prophylactic dressings placed on certain pressure points would help in prevention. In the recovery room, staff is making it a priority to move patients from carts to beds as soon as possible.

Two critical care areas implemented a skin team that makes twice-weekly rounds, rolling patients over on a regular basis, checking their skin under every device and pulling in a doctor or physician assistant when necessary. Even the most innocuous looking skin redness can develop into a painful bedsore, so if the team sees any danger signs, it calls in a wound care nurse before it can get worse.

The results are encouraging. Hospital-wide, reportable pressure ulcers dropped 30 percent in the past year. In the surgical intensive care unit (SICU), where patients are at high risk of developing bedsores, there was just one reportable pressure ulcer since the program was implemented. The work helped earn the SICU a Minnesota Hospital Association Save Our Skin award.

"The key to the program was getting the staff at the bedside engaged and believing in the process," says Heinly-Munk. "The nursing staff really ran with it and did a great job. The medical directors also got engaged--they definitely saw the value and importance. All in all, it was really a fantastic team effort."

While patient comfort and satisfaction are the prime reasons to take on pressure ulcers, there's also the cost factor: Pressure ulcers increase the length of stay. By some estimates, a serious pressure ulcer can cost a health care organization an additional $30,000 per patient.

"It was a focused effort by an inter-disciplinary team," says Heinly-Munk. "Now the question is how do we sustain this good work?"

The prognosis looks good. With nurses, physicians, nutritionists and the rest of the staff fully engaged, the team's goal of eliminating pressure ulcers for all of its patients is well within reach.

FALLS

In 2011, the number of reported falls was lower than it has been at any point since this reporting category was broadened in 2007 to capture falls associated with serious injuries as well as those associated with deaths. Hospitals reported 71 falls in 2011, a decrease of 11 percent from the previous year. Three patients died from injuries associated with their falls, also a decrease from last year.

This marks the third year of steady or decreasing numbers of serious falls in Minnesota hospitals, a strong sign that stronger fall prevention efforts are beginning to take root.

The age profile for falls in 2011 is similar to previous years; just over 70 percent involved patients aged 65 or older, and nearly sixty percent involved patients 75 or older. But age is not the only risk factor; several falls involved patients younger than 20 years of age. Overall, the most common serious injury sustained during a fall was a hip fracture (45 percent), with other upper or lower extremity fractures accounting for an additional 27 percent of injuries.

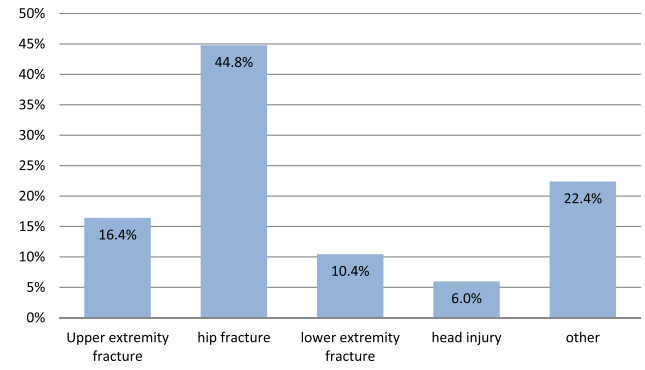
Key findings

In Minnesota and nationally, falls at home, in the hospital, or in long term care settings are a leading cause of injury and accidental death. In all of these settings, falls are more likely to happen to the elderly and to those with balance or gait problems, dizziness, or altered elimination/incontinence. Additional risk factors for falls include the use of multiple medications and cognitive impairments.

Falls reported in 2011 show little change in terms of where and how they occur. In general, these patterns have been stable over the years even as numbers have declined, and indicate that even when frequent rounding, visual indicators of fall risk, and other best practices for fall prevention are followed, falls can still occur:

- Many falls were related to breakdowns in the fall risk assessment process: patients were not appropriately placed at high risk, the risk was not adequately documented or communicated among team members or units, or the risk reduction interventions weren't matched to the patient's individual risk factors or weren't consistently applied.
- A third of all falls happened when patients were moving from the bed to the bathroom (either assisted or unassisted), or when they were in the bathroom or using a bedside commode.
- 70 percent of patients who experienced a serious fall had a visual indicator of their fall risk status posted in their room or on their body, such as an armband, wristband, colored slippers, or a falling star or other image.
- Just over half of all patients who had a serious fall were on one or more "culprit medications," medications known to increase fall risk, within 24 hours of their fall. Narcotics or other pain medications, anti-psychotic medications, anti-anxiety medications, hypertension medications, and sedatives were the most common culprit medications. Thirty percent of patients who suffered a serious fall were on multiple culprit medications.
- In nearly 40 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.

FIGURE 8: INJURIES ASSOCIATED WITH FALLS



Next steps

The Minnesota Hospital Association's statewide "Safe from Falls" campaign continued throughout 2011, with 121 hospitals participating and reporting that they have implemented more than 95 percent of the campaign's best practices. The campaign moved into a second phase in 2011, with an increased focus on proactive toileting with scripting for nursing staff, keeping patients at high-risk of injury from falls 'within arm's reach' when offering toileting assistance, reducing high-risk medications, and ensuring that medications are regularly evaluated for all patients who are at risk for falls.

Several hospitals are also continuing to pilot a new technique for analyzing serious falls called "causal tree analysis." The causal tree approach allows facilities to explore multiple potential contributing factors using a logic-based approach that shows cause and effect relationships between actions. This approach can help facilities to look at events and their causes more broadly, rather than narrowing in too soon on a single root cause. Based on the pilot's results, the use of the causal tree methodology will be expanded in 2012, with a template developed for analysis of all serious falls.

SPOTLIGHT STORY

ABBOTT NORTHWESTERN HOSPITAL AND ALLINA HOSPITALS & CLINICS

Members of Abbott Northwestern Hospital's Fall Prevention team know that the hospital can never take its focus off of fall prevention; the challenge to keep patients safe requires ongoing diligence and vigilance. The multi-disciplinary team meets monthly to review data, identify trends and determine strategies. Part of Allina Hospitals & Clinics, Abbott Northwestern participates in system-wide efforts by sending site leads to monthly falls prevention meetings that include representatives from 11 Allina hospitals.

Identifying and communicating patient fall risk among caregivers is the first step in preventing falls. New permanent sign holders which spell out "fall risk" rather than using a symbol were mounted outside each patient room. The "fall risk" sign can be displayed if the patient is at risk or can be hidden if the patient is determined not to be at risk. Thanks to a collaboration with Allina Clinical Decision Support,* when a patient is scored as being at risk, a message designating the patient's fall risk is automatically generated and displayed in the electronic medical record (EMR) for caregivers to see. In addition, when a patient "scores" as a fall risk or when the answer to a question about the patient's history of falls in the past 12 months is "yes," a message is displayed in the EMR which prompts the addition of the fall prevention care plan and patient education record.

Another area of focus identified by the Allina-wide Fall Prevention team was to reduce falls related to sleep medication. In 2010, working with the medical staff, pharmacists and Allina Clinical Decision Support, consensus was reached across Allina hospitals to remove sleep medications from order sets. Prior to implementing this change, nursing education was completed to promote non-pharmacological sleep interventions and foster discussion with patients about avoiding the use of sleep medication in the hospital. Administration of sleep medication decreased 50 percent from 2010 to 2011 and patients who fell after receiving sleep medication decreased ten percent across Allina Hospitals.

Patients who fall with suspected head injury require increased assessment and monitoring of neurological changes. In June, a pilot was initiated at Abbott Northwestern in which the Rapid Response Team (RRT) was called when patients had an unwitnessed fall, suspected head injury or other serious injury. RRT members provide advanced neurological assessment and assist with safe patient moving. Staff education regarding when to call RRT was provided. The pilot was successful and fully implemented. Currently, the Rapid Response Team is called for 20 percent of falls.

All of these key strategies have contributed to an eighteen percent decrease in the harmful fall rate at Abbott Northwestern between full-year 2010 and January-November 2011.

**Clinical Decision Support provides tools for clinicians that enable making doing the "right" thing as simple and direct as possible within the EMR. Content is derived from published literature and consensus best practice, as determined by clinical groups from within the organization. Examples of tools include standardized specialty order sets, care plans, and best practice advisories (alerts).*

CONCLUSION

Consistent, committed statewide work on implementation of best practices for prevention of falls and wrong-site invasive procedures appears to be starting to pay off in terms of decreases in both of these types of events. But while these successes should be celebrated, the overall pattern of events shows that there is still much progress to be made in preventing serious adverse health events.

In particular, system breakdowns related to procedural scheduling, the process to account for all objects used during invasive procedures (including those which may break), and maintenance of the skin integrity of critically ill patients still lead to patient harm every year. Meanwhile, patient safety managers from around the state continue to report that they sometimes face challenges in getting the support they need to effectively develop and implement new safety initiatives, and that providers are not consistently engaged in the development and implementation of these safety practices nor are they held accountable if practices are not followed for every patient, every time.

As we have seen over the previous eight years, every hospital and ambulatory surgical center in Minnesota has staff who are dedicated to patient safety and improving quality of care, and who come up with creative solutions to seemingly intractable problems. But until we get to a point where every board of directors, clinical leadership team, and CEO is willing to create workplaces that hold every provider accountable for following safe practices in every encounter, provide dedicated time and adequate resources for staff to work on developing and implementing safety solutions, and encourage a culture in which all staff are aware of and speak up about potential risks, these events will continue to occur at a consistent pace. It can be challenging to make this type of commitment in a time of financial pressure and increased reporting requirements. But without meaningful engagement at the top level of every facility, we will not move forward.

The coming year holds promise for additional improvements in safety. The Minnesota Alliance for Patient Safety's (MAPS) Roadmap to a Safe Culture, which is set to kick off in early 2012, will provide healthcare leaders in hospitals, clinics, surgical centers, and long term care facilities with a clear path to improving safety, increasing accountability for all providers, creating a learning environment, and imbedding continuous process improvements and measurement at all levels of the organization.

Over the course of the coming year, MDH will be supporting MAPS' efforts to encourage all healthcare providers to sign up for the Roadmap to a Safe Culture campaign. The past eight years have taught us that the path to improved safety lies in creating new statewide community norms and standards that all providers adhere to because it is the right thing to do. By using this approach to change organizational culture, while continuing our work to implement best practices for prevention of specific types of events, we may finally be able to realize a sea change in how we provide high-quality, safe, reliable, patient-centered care.

The following section of this report provides information about adverse health events discovered by hospitals and ambulatory surgical centers between October 7, 2010 and October 6, 2011. 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, 2010 – October 6, 2011)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
SURGICAL/INVASIVE PROCEDURE	89 Events	Serious Disability: 1 Death: 0 Neither: 88
PRODUCTS OR DEVICES	2 Events	Serious Disability: 1 Death: 1
PATIENT PROTECTION	2 Events	Serious Disability: 2 Death: 0
CARE MANAGEMENT	152 Events	Serious Disability: 12 Death: 1 Neither: 139
ENVIRONMENTAL	71 Events	Serious Disability: 68 Death: 3
CRIMINAL	0 Events	—
TOTAL FOR ALL EVENTS	**316 Events**	**Serious Disability: 84** **Death: 5** **Neither: 227**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **SURGICAL/INVASIVE PROCEDURE** (October 7, 2010 – October 6, 2011)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
1. WRONG BODY PART	24 Events	Serious Disability: 1 Death: 0 Neither: 23
2. WRONG PATIENT	2 Events	Serious Disability: 0 Death: 0 Neither: 2
3. WRONG PROCEDURE	26 Events	Serious Disability: 0 Death: 0 Neither: 26
4. FOREIGN OBJECT	37 Events	Serious Disability: 0 Death: 0 Neither: 37
5. INTRA / POST-OP DEATH	0 Events	—
TOTAL FOR SURGICAL/INVASIVE PROCEDURE	**89 Events**	**Serious Disability: 1** **Death: 0** **Neither: 88**

Details by Category: **PRODUCTS OR DEVICES** (October 7, 2010 – October 6, 2011)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
6. CONTAMINATED DRUGS, DEVICES OR BIOLOGICS	0 Events	—
7. MISUSE OR MALFUNCTION OF DEVICE	1 Event	Serious Disability: 1 Death: 0
8. INTRAVASCULAR AIR EMBOLISM	1 Event	Serious Disability: 0 Death: 1
TOTAL FOR PRODUCTS OR DEVICES	**2 Events**	**Serious Disability: 1** **Death: 1**

Details by Category: **PATIENT PROTECTION** (October 7, 2010 – October 6, 2011)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
9. WRONG DISCHARGE OF INFANT	0 Events	—
10. PATIENT DISAPPEARANCE	1 Event	Serious Disability: 1 Death: 0
11. SUICIDE OR ATTEMPTED SUICIDE	1 Event	Serious Disability: 1 Death: 0
TOTAL FOR PATIENT PROTECTION	**2 Events**	**Serious Disability: 2** **Death: 0**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CARE MANAGEMENT** (October 7, 2010 – October 6, 2011)

TYPES OF EVENTS	ALL FACILITIES	SEVERITY DETAILS
12. DEATH OR DISABILITY DUE TO MEDICATION ERROR	8 Events	Serious Disability: 7 Death: 1
13. DEATH OR DISABILITY DUE TO HEMOLYTIC REACTION	0 Events	—
14. DEATH OR DISABILITY DURING LOW-RISK PREGNANCY LABOR OR DELIVERY	2 Events	Serious Disability: 2 Death: 0
15. DEATH OR DISABILITY ASSOCIATED WITH HYPOGLYCEMIA	0 Events	—
16. DEATH OR DISABILITY ASSOCIATED WITH FAILURE TO TREAT HYPER-BILIRUBINEMIA	1 Event	Serious Disability: 1 Death: 0
17. STAGE 3, 4 OR UNSTAGEABLE PRESSURE ULCERS ACQUIRED AFTER ADMISSION	141 Events	Serious Disability: 2 Death: 0 Neither: 139
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	**152 Events**	**Serious Disability: 12** **Death: 1** **Neither: 139**

Details by Category: **ENVIRONMENTAL** (October 7, 2010 – October 6, 2011)

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	0 Events	—
23. DEATH OR SERIOUS DISABILITY ASSOCIATED WITH A FALL	71 Events	Serious Disability: 68 Death: 3
24. DEATH OR DISABILITY ASSOCIATED WITH RESTRAINTS	0 Events	—
TOTAL FOR ENVIRONMENTAL	**71 Events**	**Serious Disability: 68** **Death: 3**

TABLE 2: STATEWIDE REPORTS BY CATEGORY

Details by Category: **CRIMINAL EVENTS** (October 7, 2010 – October 6, 2011)

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	0 Events	—
28. DEATH OR INJURY OF PATIENT OR STAFF FROM PHYSICAL ASSAULT	0 Events	—
TOTAL FOR CRIMINAL EVENTS	**0 Events**	**—**

TABLE 3: FACILITY-SPECIFIC DATA

TABLE 3.1

ABBOTT NORTHWESTERN HOSPITAL

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
952

Number of surgeries/invasive procedures performed:
139,622

Number of patient days:
242,469

How 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, 2010-OCTOBER 6, 2011)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
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
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	**7**	Deaths: 0;	Serious Disability: 7;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**17**	**Deaths: 0;**	**Serious Disability: 7;**	**Neither: 10**

* 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

AVERA MARSHALL REGIONAL MEDICAL CENTER

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

Website:
www.averamarshall.org

Phone number:
507-537-9240

Number of beds:
49

Number of surgeries/invasive procedures performed:
4,817

Number of patient days:
14,073

How 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, 2010-OCTOBER 6, 2011)

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: 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 3.3

BETHESDA HOSPITAL

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

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-2122

Number of beds:
254

Number of surgeries/invasive procedures performed:
598

Number of patient days:
37,842

How 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, 2010-OCTOBER 6, 2011)

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)	**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	**7**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 6**

* 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

BIGFORK VALLEY HOSPITAL

Address:
258 Pine Tree Dr.
Bigfork, MN 56628

Website:
www.bigforkvalley.org

Phone number:
218-743-4249

Number of beds:
20

Number of surgeries/invasive procedures performed:
2,314

Number of patient days:
3,371

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, 2010-OCTOBER 6, 2011)

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 3.5

BUFFALO HOSPITAL

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

Website:
www.buffalohospital.org

Phone number:
612-262-4986

Number of beds:
65

Number of surgeries/invasive procedures performed:
17,376

Number of patient days:
19,790

How 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, 2010-OCTOBER 6, 2011)

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 3.6

CENTRACARE HEALTH SYSTEM – MELROSE

Address:
525 Main St. W.
Melrose, MN 56352-1043

Website:
www.centracare.com

Phone number:
320-256-1761

Number of beds:
28

Number of surgeries/invasive procedures performed:
3,834

Number of patient days:
5,241

How 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, 2010-OCTOBER 6, 2011)

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 3.7

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:
153

Number of surgeries/invasive procedures performed:
24,870

Number of patient days:
71,127

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2010-OCTOBER 6, 2011)

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)	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
TOTAL EVENTS FOR THIS FACILITY	**5**	**Deaths: 0;**	**Serious Disability: 0;**	**Neither: 5**

* 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

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:
126

Number of surgeries/invasive procedures performed:
16,699

Number of patient days:
50,220

How 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, 2010-OCTOBER 6, 2011)

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 3.9

ESSENTIA HEALTH DULUTH

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

Website:
www.essentiahealth.org

Phone number:
218-786-3339

Number of beds:
165

Number of surgeries/invasive procedures performed:
19,247

Number of patient days:
188,287

How 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, 2010-OCTOBER 6, 2011)

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 3.10

ESSENTIA HEALTH SANDSTONE

Address:
109 Court Ave. S.
Sandstone, MN 55072-5120

Website:
www.essentiahealth.org

Phone number:
218-786-3339

Number of beds:
25

Number of surgeries/invasive procedures performed:
3,590

Number of patient days:
4,599

How 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, 2010-OCTOBER 6, 2011)

CATEGORY AND TYPE	NUMBER	OUTCOME		
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
A medication error	**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: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**2**	**Deaths: 1;**	**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 3.11

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:
30,492

Number of patient days:
53,831

How 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, 2010-OCTOBER 6, 2011)

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	**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
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	**4**	**Deaths: 0;**	**Serious Disability: 1;**	**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

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:
87

Number of surgeries/invasive procedures performed:
12,718

Number of patient days:
17,697

How 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, 2010-OCTOBER 6, 2011)

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

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:
380

Number of surgeries/invasive procedures performed:
71,975

Number of patient days:
105,077

How 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, 2010-OCTOBER 6, 2011)

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
Surgery/Other invasive procedure performed on wrong patient	**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	**6**	**Deaths: 0;**	**Serious Disability: 3;**	**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 3.14

FAIRVIEW LAKES MEDICAL CENTER

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

Website:
www.fairview.org

Phone number:
612-672-4164

Number of beds:
61

Number of surgeries/invasive procedures performed:
31,885

Number of patient days:
36,535

How 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, 2010-OCTOBER 6, 2011)

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)	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
A medication error	**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	**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 3.15

FAIRVIEW RIDGES HOSPITAL

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

Website:
www.fairview.org

Phone number:
612-672-4164

Number of beds:
150

Number of surgeries/invasive procedures performed:
58,312

Number of patient days:
69,493

How 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, 2010-OCTOBER 6, 2011)

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	**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 3.16

FAIRVIEW SOUTHDALE HOSPITAL

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

Website:
www.fairview.org

Phone number:
612-672-4164

Number of beds:
390

Number of surgeries/invasive procedures performed:
106,464

Number of patient days:
129,574

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2010-OCTOBER 6, 2011)

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	**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)	**4**	Deaths: 0;	Serious Disability: 0;	Neither: 4
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**11**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 10**

* 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

FAIRVIEW UNIVERSITY MEDICAL CENTER – MESABI

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

Website:
www.fairview.org

Phone number:
612-672-4164

Number of beds:
175

Number of surgeries/invasive procedures performed:
18,533

Number of patient days:
47,431

How 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, 2010-OCTOBER 6, 2011)

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 3.18

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

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

Website:
www.gillettechildrens.org

Phone number:
651-229-1753

Number of beds:
60

Number of surgeries/invasive procedures performed:
9,885

Number of patient days:
21,579

How 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, 2010-OCTOBER 6, 2011)

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 3.19

GRAND ITASCA CLINIC AND HOSPITAL

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

Website:
www.granditasca.org

Phone number:
218-999-1460

Number of beds:
64

Number of surgeries/invasive procedures performed:
11,373

Number of patient days:
33,487

How 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, 2010-OCTOBER 6, 2011)

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 3.20

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:
894

Number of surgeries/invasive procedures performed:
105,687

Number of patient days:
187,558

How 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, 2010-OCTOBER 6, 2011)

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
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**				
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**22**	Deaths: 0;	Serious Disability: 0;	Neither: 22
ENVIRONMENTAL EVENTS **Death or serious disability associated with:**				
A fall while being cared for in a facility	**9**	Deaths: 0;	Serious Disability: 9;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**33**	**Deaths: 0;**	**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 3.21

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:
66

Number of surgeries/invasive procedures performed:
13,587

Number of patient days:
23,576

How 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, 2010-OCTOBER 6, 2011)

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 3.22

ILBNC SPECIAL PROCEDURES SURGERY CENTER

Address:
15700 37th Ave. N., Ste. 210
Plymouth, MN 55446-3399

Website:
www.ilbnc.com

Phone number:
952-814-6644

Number of surgeries/invasive procedures performed:
5,856

How 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, 2010-OCTOBER 6, 2011)

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 3.23

LAKEWOOD HEALTH CENTER

Address:
600 Main Ave. S.
Baudette, MN 56623-2855

Website:
www.lakewoodhealthcenter.org

Phone number:
218-634-3401

Number of beds:
15

Number of surgeries/invasive procedures performed:
192

Number of patient days:
3,440

How 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, 2010-OCTOBER 6, 2011)

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 3.24

LANDMARK SURGERY CENTER

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

Website:
www.summitortho.com

Phone number:
651-968-5468

Number of surgeries/invasive procedures performed:
13,925

How 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, 2010-OCTOBER 6, 2011)

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

LIFECARE MEDICAL CENTER

Address:
715 Delmore Drive
Roseau, MN 56751-1534

Website:
www.lifecaremedicalcenter.org

Phone number:
218-463-4300

Number of beds:
25

Number of surgeries/invasive procedures performed:
2,354

Number of patient days:
10,980

How 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, 2010-OCTOBER 6, 2011)

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
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 3.26

MADISON HOSPITAL

Address:
900 2nd Avenue
Madison MN 56256-1006

Website:
www.mlhmn.org

Phone number:
507-642-3255

Number of beds:
12

Number of surgeries/invasive procedures performed:
1,639

Number of patient days:
3,393

How 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, 2010-OCTOBER 6, 2011)

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 3.27

MAPLE GROVE HOSPITAL

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

Website:
www.maplegrovehospital.org

Phone number:
763-581-1563

Number of beds:
90

Number of surgeries/invasive procedures performed:
15,357

Number of patient days:
17,249

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, 2010-OCTOBER 6, 2011)

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
Labor or delivery in a low-risk pregnancy	**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 3.28

MAYO CLINIC HEALTH SYSTEM - ALBERT LEA

Address:
404 West Fountain Street
Albert Lea MN 56007-2437

Website:
www.mayoclinichealthsystem.org

Phone number:
507-377-6394

Number of beds:
77

Number of surgeries/invasive procedures performed:
14,738

Number of patient days:
43,873

How 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, 2010-OCTOBER 6, 2011)

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

MAYO CLINIC HEALTH SYSTEM - AUSTIN

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

Website:
www.mayoclinichealthsystem.org

Phone number:
507-434-1407

Number of beds:
82

Number of surgeries/invasive procedures performed:
15,037

Number of patient days:
40,631

How 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, 2010-OCTOBER 6, 2011)

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 3.30

MAYO CLINIC HEALTH SYSTEM - FAIRMONT

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

Website:
www.mayoclinichealthsystem.org

Phone number:
507-385-2938

Number of beds:
57

Number of surgeries/invasive procedures performed:
9,270

Number of patient days:
28,022

How 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, 2010-OCTOBER 6, 2011)

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

MAYO CLINIC HEALTH SYSTEM - 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:
272

Number of surgeries/invasive procedures performed:
32,072

Number of patient days:
62,535

How 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, 2010-OCTOBER 6, 2011)

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 3.32

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:
794

Number of surgeries/invasive procedures performed:
145,589

Number of patient days:
140,397

How 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, 2010-OCTOBER 6, 2011)

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
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)	**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	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
PRODUCT OR DEVICE EVENTS **Death or serious disability associated with:**				
The use or malfunction of a device in patient care	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**12**	**Deaths: 0;**	**Serious Disability: 3;**	**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 3.33

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:
1157

Number of surgeries/invasive procedures performed:
134,031

Number of patient days:
257,894

How 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, 2010-OCTOBER 6, 2011)

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	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
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)	**38**	Deaths: 0;	Serious Disability: 0;	Neither: 38
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	**45**	**Deaths: 1;**	**Serious Disability: 0;**	**Neither: 44**

* 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

MEEKER MEMORIAL HOSPITAL

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

Website:
www.meekermemorial.org

Phone number:
320-693-4507

Number of beds:
35

Number of surgeries/invasive procedures performed:
6,738

Number of patient days:
13,195

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, 2010-OCTOBER 6, 2011)

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 3.35

MERCY HOSPITAL

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
271

Number of surgeries/invasive procedures performed:
81,069

Number of patient days:
118,113

How 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, 2010-OCTOBER 6, 2011)

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
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	**2**	Deaths: 0;	Serious Disability: 2;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 0;**	**Serious Disability: 2;**	**Neither: 4**

* 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

MINNESOTA EYE CONSULTANTS, P.A. (MAPLEWOOD)

Address:
1965 11th Ave. E.
Maplewood, MN 55109-5167

Website:
www.mneye.com

Phone number:
952-888-5800

Number of surgeries/invasive procedures performed:
5,718

How 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, 2010-OCTOBER 6, 2011)

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 3.37

NEW ULM MEDICAL CENTER

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
62

Number of surgeries/invasive procedures performed:
14,160

Number of patient days:
30,539

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

REPORTED ADVERSE HEALTH EVENTS
(OCTOBER 7, 2010-OCTOBER 6, 2011)

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 3.38

NORTH MEMORIAL MEDICAL CENTER

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

Website:
www.northmemorial.com

Phone number:
763-520-5183

Number of beds:
518

Number of surgeries/invasive procedures performed:
88,181

Number of patient days:
148,343

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, 2010-OCTOBER 6, 2011)

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	**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)	**5**	Deaths: 0;	Serious Disability: 0;	Neither: 5
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	**9**	**Deaths: 0;**	**Serious Disability: 2;**	**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 3.39

PARK NICOLLET METHODIST HOSPITAL

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

Website:
www.parknicollet.com/qualitypatientsafety

Phone number:
952-993-3791

Number of beds:
426

Number of surgeries/invasive procedures performed:
111,981

Number of patient days:
155,102

How 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, 2010-OCTOBER 6, 2011)

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	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
Surgery/Other invasive procedure performed on wrong patient	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**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)	**5**	Deaths: 0;	Serious Disability: 0;	Neither: 5
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**15**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 14**

* 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

PIPESTONE COUNTY MEDICAL CENTER

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

Website:
www.pcmchealth.org

Phone number:
507-825-6163

Number of beds:
25

Number of surgeries/invasive procedures performed:
5,023

Number of patient days:
6,361

How 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, 2010-OCTOBER 6, 2011)

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 3.41

RAINY LAKE MEDICAL CENTER

Address:
1400 Highway 71
International Falls, MN 56649-2154

Website:
www.rainylakemedical.com

Phone number:
218-283-4481

Number of beds:
25

Number of surgeries/invasive procedures performed:
4,814

Number of patient days:
9,402

How 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, 2010-OCTOBER 6, 2011)

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 3.42

REGINA MEDICAL CENTER

Address:
1175 Nininger Road
Hastings, MN 55033-1056

Website:
www.reginamedical.org

Phone number:
651-480-6890

Number of beds:
57

Number of surgeries/invasive procedures performed:
13,798

Number of patient days:
21,837

How 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, 2010-OCTOBER 6, 2011)

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 3.43

REGIONS HOSPITAL

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

Website:
www.regionshospital.com

Phone number:
651-254-0760

Number of beds:
454

Number of surgeries/invasive procedures performed:
117,007

Number of patient days:
184,052

How 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, 2010-OCTOBER 6, 2011)

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	**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)	**5**	Deaths: 0; Serious Disability: 0; Neither: 5
TOTAL EVENTS FOR THIS FACILITY	**7**	**Deaths: 0; Serious Disability: 0; 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 3.44

RIDGEVIEW MEDICAL CENTER

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

Website:
www.ridgeviewmedical.org

Phone number:
952-442-2191 ext.6102

Number of beds:
109

Number of surgeries/invasive procedures performed:
39,853

Number of patient days:
47,765

How 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, 2010-OCTOBER 6, 2011)

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 3.45

RIVERVIEW HEALTH

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

Website:
www.riverviewhealth.org

Phone number:
218-281-9412

Number of beds:
49

Number of surgeries/invasive procedures performed:
6,773

Number of patient days:
11,551

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, 2010-OCTOBER 6, 2011)

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)	**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
TOTAL EVENTS FOR THIS FACILITY	**3**	**Deaths: 0;**	**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 3.46

RIVERWOOD HEALTHCARE CENTER

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

Website:
www.riverwoodhealthcare.com

Phone number:
218-927-5501

Number of beds:
24

Number of surgeries/invasive procedures performed:
8,166

Number of patient days:
15,306

How 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, 2010-OCTOBER 6, 2011)

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

SAINT ELIZABETH'S MEDICAL CENTER

Address:
1200 Grant Blvd. W.
Wabasha, MN 55981-1042

Website:
www.ministryhealth.org/semc/home

Phone number:
651-565-5580

Number of beds:
31

Number of surgeries/invasive procedures performed:
2,493

Number of patient days:
3,922

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, 2010-OCTOBER 6, 2011)

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 3.48

SANFORD BEMIDJI MEDICAL CENTER

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

Website:
www.nchs.com

Phone number:
218-333-5540

Number of beds:
118

Number of surgeries/invasive procedures performed:
21,555

Number of patient days:
39,147

How 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, 2010-OCTOBER 6, 2011)

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: 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 3.49

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:
28

Number of surgeries/invasive procedures performed:
3,719

Number of patient days:
6,649

How 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, 2010-OCTOBER 6, 2011)

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 3.50

SANFORD MEDICAL CENTER THIEF RIVER FALLS

Address:
120 LaBree Ave. S.
Thief River Falls, MN 56701-2840

Website:
www.sanfordhealth.org

Phone number:
218-683-4400

Number of beds:
99

Number of surgeries/invasive procedures performed:
8,969

Number of patient days:
27,867

How 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, 2010-OCTOBER 6, 2011)

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 3.51

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:
64

Number of surgeries/invasive procedures performed:
6,708

Number of patient days:
11,776

How 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, 2010-OCTOBER 6, 2011)

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 3.52

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:
507-794-3571

Number of beds:
25

Number of surgeries/invasive procedures performed:
1,089

Number of patient days:
4,377

How 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, 2010-OCTOBER 6, 2011)

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

SOUTH CENTRAL SURGICAL CENTER

Address:
717 S. State St., Ste. 1000
Fairmont, MN 56031-4479

Website:
www.centerforspecialtycare.com

Phone number:
507-235-3939 ext. 3529

Number of surgeries/invasive procedures performed:
1,316

How 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, 2010-OCTOBER 6, 2011)

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 3.54

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:
489

Number of surgeries/invasive procedures performed:
97,654

Number of patient days:
174,485

How 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, 2010-OCTOBER 6, 2011)

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	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
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)	**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	**9**	**Deaths: 0;**	**Serious Disability: 3;**	**Neither: 6**

* 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

ST. FRANCIS REGIONAL MEDICAL CENTER

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
93

Number of surgeries/invasive procedures performed:
28,881

Number of patient days:
37,231

How 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, 2010-OCTOBER 6, 2011)

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	**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 3.56

ST. JOHN'S HOSPITAL

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

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-7122

Number of beds:
184

Number of surgeries/invasive procedures performed:
67,821

Number of patient days:
82,377

How 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, 2010-OCTOBER 6, 2011)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Surgery/other invasive procedure performed on wrong body part	**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)	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
A medication error	**2**	Deaths: 0;	Serious Disability: 2;	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	**6**	**Deaths: 0;**	**Serious Disability: 4;**	**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 3.57

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:
50

Number of surgeries/invasive procedures performed:
11,636

Number of patient days:
13,556

How 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, 2010-OCTOBER 6, 2011)

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

ST. JOSEPH'S HOSPITAL

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

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-5613

Number of beds:
401

Number of surgeries/invasive procedures performed:
36,512

Number of patient days:
90,348

How 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, 2010-OCTOBER 6, 2011)

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)	**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 3.59

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:
48,967

Number of patient days:
80,129

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2010-OCTOBER 6, 2011)

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
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	**6**	**Deaths: 0;**	**Serious Disability: 3;**	**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 3.60

ST. MICHAEL'S HOSPITAL & NURSING HOME

Address:
425 Elm St. N.
Sauk Centre, MN 56378-1010

Website:
www.stmichaelshospital.org

Phone number:
320-351-1750

Number of beds:
28

Number of surgeries/invasive procedures performed:
3,463

Number of patient days:
5,816

How 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, 2010-OCTOBER 6, 2011)

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 3.61

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:
10,699

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 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, 2010-OCTOBER 6, 2011)

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 3.62

UNITED HOSPITAL

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
546

Number of surgeries/invasive procedures performed:
90,298

Number of patient days:
152,697

How 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, 2010-OCTOBER 6, 2011)

CATEGORY AND TYPE	NUMBER	OUTCOME		
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)	**5**	Deaths: 0;	Serious Disability: 1;	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	**9**	**Deaths: 0;**	**Serious Disability: 5;**	**Neither: 4**

* 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

UNITY HOSPITAL

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

Website:
www.allina.com

Phone number:
612-775-9762

Number of beds:
275

Number of surgeries/invasive procedures performed:
43,009

Number of patient days:
77,248

How 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, 2010-OCTOBER 6, 2011)

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)	**3**	Deaths: 0;	Serious Disability: 0;	Neither: 3
Labor or delivery in a low-risk pregnancy	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
TOTAL EVENTS FOR THIS FACILITY	**6**	**Deaths: 0;**	**Serious Disability: 1;**	**Neither: 5**

* 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

UNIVERSITY OF MINNESOTA MEDICAL CENTER – FAIRVIEW

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

Website:
www.uofmmedicalcenter.org

Phone number:
TBD

Number of beds:
1,700

Number of surgeries/invasive procedures performed:
164,191

Number of patient days:
318,049

How 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, 2010-OCTOBER 6, 2011)

CATEGORY AND TYPE	NUMBER	OUTCOME		
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS				
Retention of a foreign object in a patient after surgery or other procedure	**6**	Deaths: 0;	Serious Disability: 0;	Neither: 6
Surgery/other invasive procedure performed on wrong body part	**1**	Deaths: 0;	Serious Disability: 0;	Neither: 1
Wrong surgical/invasive procedure performed	**2**	Deaths: 0;	Serious Disability: 0;	Neither: 2
PATIENT PROTECTION EVENTS				
Patient death or serious disability associated with patient disappearance	**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)	**17**	Deaths: 0;	Serious Disability: 0;	Neither: 17
A medication error	**1**	Deaths: 0;	Serious Disability: 1;	Neither: 0
Failure to identify and treat excessive bilirubin in newborns	**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	**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	**35**	**Deaths: 1;**	**Serious Disability: 8;**	**Neither: 26**

* 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

WESTHEALTH

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

Website:
www.westhealth.com

Phone number:
612-863-4801

How 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, 2010-OCTOBER 6, 2011)

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 3.66

WILLMAR SURGERY CENTER, LLP

Address:
1320 1st St. S. P.O. Box 773
Willmar, MN 56201-0773

Website:
www.acmc.com

Phone number:
320-235-6506

Number of surgeries/invasive procedures performed:
8,012

How 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, 2010-OCTOBER 6, 2011)

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 3.67

WINDOM AREA HOSPITAL

Address:
2150 Hospital Drive P.O. Box 339
Windom, MN 56101-0339

Website:
www.windomareahospital.com

Phone number:
507-831-0625

Number of beds:
35

Number of surgeries/invasive procedures performed:
4,206

Number of patient days:
6,077

How 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, 2010-OCTOBER 6, 2011)

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 3.68

WINONA HEALTH SERVICES

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

Website:
www.winonahealth.org

Phone number:
507-457-4470

Number of beds:
99

Number of surgeries/invasive procedures performed:
16,900

Number of patient days:
34,143

How 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, 2010-OCTOBER 6, 2011)

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 3.69

WOODWINDS HEALTH CAMPUS

Address:
1925 Woodwinds Drive
Woodbury, MN 55125-2270

Website:
www.healtheast.org/patientsafety

Phone number:
651-232-5613

Number of beds:
86

Number of surgeries/invasive procedures performed:
28,927

Number of patient days:
38,526

How 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, 2010-OCTOBER 6, 2011)

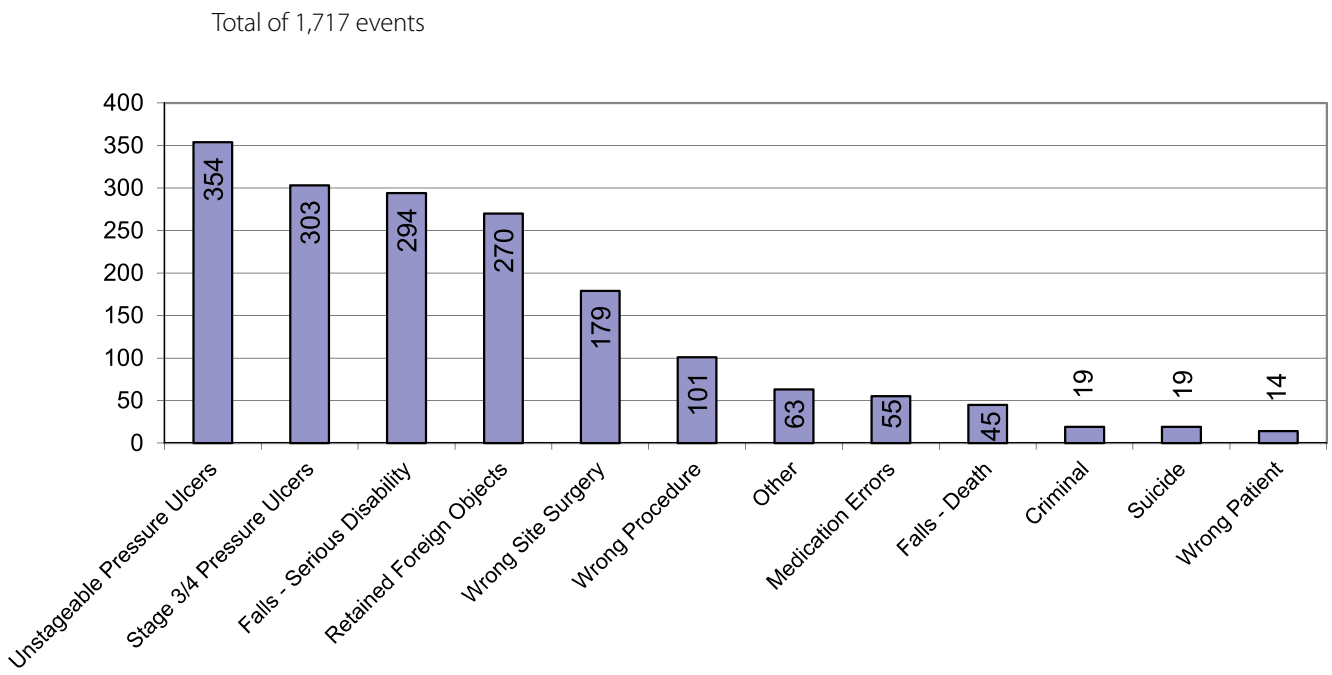
CATEGORY AND TYPE	NUMBER	OUTCOME
CARE MANAGEMENT EVENTS **Death or serious disability associated with:**		
Stage 3, 4 or unstageable pressure ulcers (with or without death or serious disability)	**1**	Deaths: 0; Serious Disability: 0; Neither: 1
TOTAL EVENTS FOR THIS FACILITY	**1**	**Deaths: 0; Serious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

APPENDIX A:
ADVERSE EVENTS DATA, 2003-2011

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 1,717 events have been reported to MDH.

REPORTED ADVERSE EVENTS, 2003–2011



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

In 2003, Minnesota became the first state in the nation to establish a mandatory adverse health event reporting system that included all 27 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 C:
REPORTABLE EVENTS AS DEFINED IN THE LAW

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

Surgical Events[2]

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

2. Surgery performed on the wrong patient;

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

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

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

Product or Device Events

1. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;

2. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Device includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and

3. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

1. An infant discharged to the wrong person;

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

3. Patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

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 D:
SAFETY ALERT: WRONG LEVEL SPINAL PROCEDURES

Minnesota Hospital Association

MINNESOTA MDH DEPARTMENT of HEALTH

Patient Safety Registry

Minnesota Patient Safety Alert

March 16, 2011

Spine Level Localization

Background

Approximately 30 percent of wrong-site surgeries reported under the Minnesota Adverse Event Reporting Law are wrong level spine procedures.

Review of reported wrong level spine procedures indicates that key localization issues include:

1) There are issues that make placing the radiopaque instrument for intra-operative imaging prone to misinterpretation. These include: abnormal anatomy (segmentation anomalies, arthritic changes); specific placement and/or movement of the marker; and patient size limiting quality of imaging.
2) The radiopaque instrument used to identify the current level for intra-operative imaging is often removed prior to placing a durable mark at that level resulting in the misinterpretation of the X-ray when it is available to be viewed in the room.

In November 2010, a work group of Minnesota spine surgeons met to review the findings from reported events and to develop recommendations to address identified key issues associated with wrong level spine procedures. The resulting recommendations are outlined 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 Diane Rydrych, Assistant Director, Division of Health Policy, MN Department of Health, (651) 201-3564.

Spinal Level Localization Recommendation

These recommendations are intended to provide guidance to improve the consistency of identifying spine levels for surgical procedures in Minnesota hospitals and to address issues identified through the reporting of wrong level spine procedures through the Minnesota Adverse Health Care Event Reporting Law. The recommendations are not intended to address all clinical and regulatory requirements related to surgical procedures.

- Appropriate pre-operative images, as determined by the person performing the procedure, are available for the case:
  - Good quality image
  - Available prior to induction of anesthesia
  - Immediately available for viewing throughout the case
  - If in the clinical judgment of the surgeon there are abnormalities or questions about the films, surgeons are encouraged to conduct a review of preoperative images with an attending radiologist.

- Site marking is completed using appropriate source documents.
  - Marking indicates:
    - Anterior or posterior approach
    - General level, i.e. cervical, lumbar, thoracic
    - Laterality, if applicable
  - Time-Out occurs just prior to incision and includes:
    - Procedure
    - Laterality, if applicable
    - Level

There are two options as the next step in the process:

Option 1	*or*	Option 2
➢ Real-time intra-operative imaging, such as fluoroscopy or stereotactic navigation, is used to verify proper placement of instruments. ➢ A pause is conducted before executing the procedure. o At a minimum, the person performing the procedure must verbalize the level and the procedure team confirms against source documents.		If real-time intra-operative imaging is not used, the spine level is localized by following the process below: ➢ ***Following incision and exposure of the vertebrae***, a fixed anatomic structure is marked with a radiopaque instrument/marker by the surgeon and correct placement confirmed by intraoperative imaging (unless pre-existing landmarks are obvious and sufficient): o Radiopaque instrument/marker should remain visible to surgeon throughout the case (when applicable, e.g., cases in which pre-existing landmarks are not obvious and sufficient) **or,** o If removeable radiopaque instrument is used during imaging, a durable mark or marker should be placed at the precise location as the instrument and should be placed at the same time the radiopaque instrument is placed. o Instrument/marker should be placed on a stable anatomic structure. ➢ After mark/er is placed and imaging available, the individual ultimately responsible for the procedure performs the count of the vertebrae to verify correct level. *Any discrepancies between the count, images and mark/er are resolved prior to continuing with the procedure.* ➢ A pause is conducted before executing the procedure. o At a minimum, the person performing the procedure must identify the marked level on the image, verbalize the level and the OR team confirm against source documents.

Adverse Health Events in Minnesota

Eighth Annual Public Report

JANUARY 2012

MINNESOTA MDH DEPARTMENT OF HEALTH

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

WWW.HEALTH.STATE.MN.US